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Minnesota House of Representatives

House Health and Welfare Committee

Subcommittee on Treatment Facilities for Alcoholics and Drug Abusers

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Final Report
1969-70 Interim

HOUSE HEALTH AND WELFARE COMMITTEE

SUBCOMMITTEE ON TREATMENT FACILITIES FOR ALCOHOLICS AND DRUG ABUSERS

Final Report
1969-70 Interim

State of Minnesota
House Research Department
December 17, 1970

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ALCOHOLISM AND DRUG ABUSE IN MINNESOTA

I. History

A. The Subcommittee

As a result of Resolution 32 passed during the 1969 Session, the House Health and Welfare Committee activated a Subcommittee on Treatment Facilities for Alcoholics and Drug Abusers chaired by Representative Lyall Schwarzkopf, Minneapolis, to study the drug abuse problem in Minnesota. Of necessity, to more fully understand the problem of drug abuse, the Subcommittee heard testimony and did research on problems relating to all aspects of drug abuse in Minnesota as well as other states, rather than limiting itself specifically to treatment facilities.

Membership on the Subcommittee included:

Representative Lyall Schwarzkopf, Minneapolis, Chairman
Sam Barr, Ortonville
Frank DeGroat, Lake Park
Bertram Fuller, Hayfield
John Salchert, M. D., Minneapolis
Vernon Sommerdorf, M. D., St Paul
James Ulland, French River

B. Testimony

The Subcommittee met six times during the interim and heard testimony from the following:

Governor Harold LeVander
Representatives of state hospitals
Representatives of private alcoholism treatment institutions
Representatives of St. Paul-Ramsey and Hennepin County General Hospitals
Minnesota Commission on Alcohol Problems
State Pharmaceutical Board
Minnesota Pharmaceutical Association

Minnesota Medical Association
Bureau of Criminal Apprehension
Minneapolis and St. Paul Police Departments
Representatives of Methadone Maintenance Programs
Crisis intervention groups - YES, Teen Center
Several former addicts
High school students from Duluth
Governor's consultant on drugs
Panel of drug abusers undergoing treatment at a state hospital
The Metropolitan Area Safety Council
Two alcoholism counselors in county welfare departments
Alcoholics Anonymous
Narcotic Addict Rehabilitation Act (NARA) counselors
Representatives of halfway houses

Two of these meetings were on-site visits to treatment facilities: one trip to Willmar State Hospital, and a day and evening tour to various facilities in the metropolitan area. Two additional meetings were work sessions.

C. Background

Drug abuse is a problem which has not gone unrecognized in Minnesota. Drug abuse is usually defined as the "misuse of a chemical substance to the extent that it interferes with the life, health and social functioning of the individual." This definition includes alcohol, in addition to narcotics, prohibited drugs and hallucinogens presently regulated under Minnesota Statutes, Chapters 152 and 618. M. S. 253A.01, Subd. 4, defines an inebriate person as "any person incapable of managing himself or his affairs by reason of the habitual and excessive use of intoxicating liquors, narcotics or other drugs."

With the recognition that drug abuse problems exist in Minnesota, the Legislature has attempted to deal with these problems. M. S. 144.81 enacted in 1953 established a consultant on alcohol problems under the State Board of Health, Division of Preventive Mental Health Services, which was later moved to the Department of Public Welfare. M. S. 144.84

provided for a counselor on alcoholism as a county civil service position. Laws 1967, Chapter 893 (M. S. 144.831-.834) established the Minnesota Commission on Alcohol Problems. Chapter 1139, Laws 1969, appropriated $40,000 to the Governor's office for a consultant on drug abuse.

II. Observations

A. Public Institutions and Minnesota Programs

1. Department of Public Welfare

With the advent of the philosophy of a multi-phase campus and treatment close to home on a local as opposed to an institutional basis, each of Minnesota's state hospitals has established an alcohol and drug treatment unit. The attached sheet provides a breakdown of costs and resident population in each of the seven hospitals. Anoka State Hospital will concentrate on treatment of chronic alcoholics.

a. County Welfare Departments

Approximately 18 county welfare departments have hired or will be hiring alcoholism counselors. Some may act as drug counselors in addition. These counselors work with AA programs and provide counseling assistance to referrals from state institutions and others who may come to their attention.

b. Community Mental Health Centers

Minnesota presently has a total of 26 Community Mental Health Centers (CMHCs). Six of these are comprehensive or "federal style", and the remaining "state style." The primary difference between a federal and a state style is that the federal style centers can provide in-patient and emergency

hospitalization within the program, while the state style centers can provide emergency services only in an out-patient facility. All CMHCs can provide preventive services, education and informational program, consultation, out-patient and diagnostic treatment, rehabilitation services, particularly of a follow-up nature, and detoxification and alcoholism evaluation and service facilities.

Most of Minnesota's mental health centers provide some kind of on-going community treatment programs for inebriates. Some take part in extremely sophisticated treatment programs ranging from early recognition, hospitalization where necessary, and follow-up care.

A number of mental health centers have established programs for drug abusing youth. Programs range from limited counseling in most centers to extensive educational, rehabilitation and treatment programs. One outstanding program in this area is the Granville House non-resident therapy program for chemical abusers in St. Paul.

A number of mental health centers have received Omnibus Crime Control funds to establish a drug education and out-patient treatment program which would include walk-in centers and research. In addition, the MHCs may be eligible for federal alcoholism and narcotic rehabilitation monies should they become available (P. L. 88-164 and 90-574 Title III).

2. Department of Corrections

The Department of Corrections reported that alcoholism and drug treatment in their institutions is primarily limited to one or two three hour sessions weekly with an alcoholism or drug counselor with a relatively small number of inmates participating. Juvenile institutions consider drug abuse as symptomatic of the individual's total problems and utilize reverse peer pressure as specific treatment. Stillwater has recently initiated a NARA program.

Parole agents seem to have the best working relationship and follow-up success with drug abusers, probably because they work on a one-to-one relationship with the individual despite heavy caseloads. A special alcoholism and drug abuse unit has been established in the Field Services Division of Corrections.

3. Department of Education

M. S. 126.05 provides for training teachers in the effects of narcotics and alcohol. This training has been extremely limited until the past year. The teacher training institutions have now developed extensive drug education programs which will be implemented in the 1970-1971 academic year.

The Department of Education received a $60,600 grant in federal drug abuse education monies which will be used in three cities to develop school district-community action pilot projects. These programs will be available to other school districts on request.

Most school districts have counselors or teachers who have accepted drug counseling on an extra-curricular basis and now work with students.

The Division of Vocational Rehabilitation (DVR) of the Department of Education has one of the three NARA contracts in Minnesota which provide for a one-to-one vocational rehabilitation program for hard narcotics users. This program is expected to be revised in the near future. In conjunction with civil service, DVR sponsors an alcoholism program designed to treat and rehabilitate state employees. Approximately 2.3% of DVR clients have listed alcohol or drug abuse as a primary disability and are being processed through regular DVR channels.

4. Department of Health

The Department of Health has no programs directed specifically at drug use; although there are, of course, a number of on-going programs which would be involved with inebriates.

The school health officers works closely with the Departments of Education and Welfare in in-service teacher education, curriculum writing, etc. This department is presently planning to expand its services for school nurses and administrators, to assist them in developing such things as guidelines and policies in dealing with drug-related health problems.

The Hennepin County Board of Health and Hospitals and the Minneapolis Department of Health have taken the lead in alcoholism and drug activities in the greater Minneapolis area.

5. Commission on Alcohol Problems

The Commission was established in 1967 to coordinate activities, information and programs in Minnesota relating to alcoholism,

educate the public, encourage training and employment of alcoholism counselors, and accept funds to carry out its activities.

The Commission and office has moved in the direction of developing and disseminating drug education materials and programs. The Commission office is located at 555 Wabasha, St. Paul, Mn 55101.

6. Department of Manpower Services

The Department of Manpower Services has one alcohol placement specialist working the in the St Paul local office. This position is the only one of its kind in the United States. They have a regular handicapped placement program through which they would place drug abusers. The counselors specialize only in job placement, and may refer an alcoholic or drug abuser to another agency which would assist him with other problems, such as AA, Alcoholism Referral Service and mental health centers, but take no other action. They have not completely defined guidelines concerning drug abusers, and therefore have no specific programs outlined as yet.

The handicapped placement office has completed an extensive study on the 259 alcoholics in their active files as of May, 1970.

7. State Planning Agency

The State Planning Agency was established in 1965 to develop an integrated program for the state. Through its general responsibilities and the activities of two of its offices, the State Planning Agency plays a role in planning and programming concerning alcoholism and drug abuse.

The Health Planning Office directed by Dr. Ellen Fifer, is working with the comprehensive health planning programs and boards in a number of the 11 regions of the state. The primary emphasis will be on health and hospital planning. This office is responsible for coordinating P. L. 89-749, Section 314 monies utilized in some states for drug treatment projects.

The Governor's Crime Commission, directed by Emery Barrette, has funded a number of drug and alcohol treatment and education programs and community action councils around the state with Omnibus Crime Control Bill funds. These funds will finance community mental health center projects in drug education, research and treatment, citizens action programs, a detoxification center for Ramsey County, the St. Paul OIC methadone program, application has been made for halfway house funding by Pilot City and Pharm House.

The Office of Local and Urban Affairs coordinates and approves Model Cities monies, some of which are used for drug related programs.

8. Governor's Commission on Drug Abuse, Governor's Consultant

In order to pull together the various efforts and concerns relating to drug abuse into one single body, the Governor created by Executive Order on April 20, 1970, the Commission on Drug Abuse. Among the charges given to this group were to determine the nature and extent of the problem, to study current laws regarding drug abuse, to recommend a structure for the coordination and utilization of state funds and resources on an ongoing basis, to propose necessary provisions for treatment and rehabilitation, and to evaluate and

publicize existing programs and resources. Mr. William Appel, a Minneapolis pharmacist, is the chairman of the Commission. Staff assistance to the Commission is provided by Mr. Dennis Passens, Association Director of the Commission on Drug Abuse.

In December, 1969, Governor LeVander appointed Mr. Richard Bragg to his staff to coordinate existing efforts within the state, to stimulate additional resources and groups, and to assist in developing plans for future programs and legislative recommendations. Mr. Bragg also directs the Governor's Commission.

9. State Board of Pharmacy

The State Board of Pharmacy is responsible for regulating the quality and dispensing of drugs in Minnesota. It publishes Minnesota laws relating to pharmacy practices and the sale, distribution, possession and use of drugs, and bulletins to the state's pharmacists regarding alleged drug abusers and practices.

10. Criminal Apprehension Bureau

The Narcotics Division of the Criminal Apprehension Bureau is primarily involved with providing assistance to law enforcement agencies. Their main task involves investigation and apprehension, however members of the Bureau do participate in educational programs. The Crime Lab provides laboratory assistance in determining the kinds of drugs, etc. to outstate law enforcement agencies.

B. Private Agencies

Minnesota has a record of extensive and successful use of private and volunteer agencies and organizations. The areas of drug abuse and alcoholism treatment are no exceptions. Described below are some of the private programs in this area.

1. Hazelden

Hazelden is the largest private inebriate treatment facility in the United States. Minnesota residents make up 30-35% of its patient complement. Treatment is structured along AA lines. They refer patients needing additional residential care to a halfway house in St Paul. They are in the process of negotiating an agreement under which they will expand as a treatment facility for drug abusers.

2. Johnson Institute

Johnson Institute located in St. Louis Park establishes counseling and treatment programs for both alcoholics and drug abusers on a contract basis in hospital facilities in addition to counseling provided at their offices. They have contracts with two Minneapolis corporations providing for counseling of alcoholics and training sessions for executives in those companies. Their method of treatment is based on confrontation and utilizes AA groups for followup.

3. Hospitals

A number of metropolitan and outstate hospitals have developed alcoholism and drug abuse treatment programs, sometimes in conjunction with the community mental health center for that area. Several of these programs are described in full in the long report.

In addition, crisis intervention and psychiatric units provide medical assistance and initial treatment to drug abusers. Outstate hospitals generally provide detoxification beds for alcoholics.

4. Catholic Welfare Services, Catholic Social Services

The two Catholic Service agencies now hold two of the three NARA contracts. The NARA programs are being revised to include abusers of all drugs and the possibility of purchase of treatment services in Minnesota rather than at the federal hospitals. Byron Laher of Catholic Services will do the local evaluation and examination screening.

5. Youth Centers

A number of youth oriented centers have developed in the past two years. These centers serve the purposes of education, counseling and referral. They operate on both a "hot line" and walk-in center basis. The centers are generally staffed by one director, who may be salaried, an assistant director and secretary who may also be salaried, and a number of volunteers who staff the center and phones. Some religiously oriented societies have established treatment communities for drug abusers. Among the centers are YES, Pooneil Corner, Pharm House, Give & Take, Freedom Acres, the Christian Brothers centers, in St Paul, and several outstate centers in or near mental health centers.

6. Alcoholics Anonymous (AA)

Alcoholics Anonymous is the largest and most active volunteer group in Minnesota concerned with chemical abuse. They sponsor weekly therapy programs and work with institutional agencies in

preventive education and treatment. One group in northwestern Minnesota was instrumental in establishing a halfway house.

7. Citizens Action Councils

The Citizens Action Councils are a result of action by Governor LeVander to bring the citizens of Minnesota into implementing the solutions to the problems facing our state. Eventually Citizens Actions Councils will be developed in all 265 Minnesota communities over 1,000 population. The Citizens Councils work within the community to develop a wholesome youth environment utilizing or developing community youth programs and involving youth in the planning of these programs. They generally have concentrated in the area of drug abuse education. LEAA funds were distributed from the Governor's Crime Commission to the regional offices to assist in the establishing of Citizens Action Councils.

C. Federal Programs

Three federal core-city programs, all at least partially funded by HEW, have included drug abuse programs in the broad array of social service programs available to residents within their areas. Pilot City established a methadone maintenance program among its services. Model Cities in south Minneapolis utilizes Mt. Sinai hospital and includes a methadone program; they are beginning a small group therapy program and walk in center on a trial basis. St. Paul Opportunity Industrial Center (OIC), although primarily job oriented in their services, will establish a methadone maintenance program in the near future.

Narcotics Addict Rehabilitation Act (NARA) monies are available to three Minnesota agencies on a contract basis with the National Institute of Mental Health. The agencies provide social service and vocational counseling to narcotics addicts designated and assigned to them through the court processes.

The NIMH has begun to revise these contracts to include all drug abusers, and to provide for inpatient treatment at the local level on a cost reimbursable basis. Additional staffing monies will be available in the near future from the National Institute of Mental Health assuming Minnesota has developed a plan of action. The Catholic Service agencies have been designated as the local evaluation and examination screening agency.

SUMMARY OF ALCOHOLISM TREATMENT FACILITIES IN MINNESOTA

State Institutions	# of Beds Allotted	# of patients as of 9/1/70	Ratio of men to women 9/1/70	Av. Length of stay	Per diem Cost
Anoka	12 chronic alcoholics (PROGRAM NOT DUE TO START UNTIL NOVEMBER 2)				
Fergus Falls	70	55	10 men to 1 women	60.62 days	? Approx. $16.90
Hastings	60	55	3 men to 1 women	35 days approx.	?
Moose Lake	69	77	10 men to 1 women	28.5 days	Approx. $16.00
Rochester	25	10	8 men to 2 women	3 weeks	?
St. Peter	48 Alcoholic No # set aside spec. for drugs	20 alco. Approx. 2 for drugs	5 men to 1 women	Approx. 3 wks. (Alc. Unit opened only 8/17)	Approx. $17.00
Willmar	205 Alcohol 15 Drugs	205 Alcohol 15 Drugs	6 men to 1 women	45 days, alc. 3-6 mts. drug	?

III. Findings and Recommendations

A. Definitions of Terms

1. The subcommittee finds that there is a need to provide assistance to alcoholics and drug abusers, defined "inebriate" in state law, in the early stages of dependency. This assistance should, where possible, be provided without the necessity of court adjudication of inebriacy, however, still protecting the rights of the individual.

Inebriate as defined in M.S. 253A.01, Subd. 4, provides that "Inebriate person means any person incapable of managing himself or his affairs by reason of the habitual and excessive use of intoxicating liquors, narcotics, or other drugs."

The Subcommittee recommends that M.S. 253A.01 be amended to add a definition of "drug dependent person" as one who is an inebriate or one who is unable to function effectively or may be incapable of managing himself or his affairs by reason of, or resulting from, the use of a psychological or physiological dependency producing drug.

Note: Inebriates, both alcoholics and drug abusers, are generally considered "drug abusers" or "chemical abusers". The word "drug dependent person" in the following sections generally means both drugs and alcohol unless specifically termed alcoholic or non-alcoholic drug abuser.

2. Detoxification Centers

The State of Minnesota on the whole, has one of the best treatment programs for alcoholism in the United States. However, there are some areas which should be expanded or corrected in order to provide a total alcoholism treatment program. There is a need for early case finding. A partial answer to this problem will be found in findings and recommendations from the House Highway Subcommittee on Highway Safety, regarding drunken drivers. The Highway Subcommittee will recommend that a procedure for identification, referral and treatment of inebriate drivers be adopted.

The Subcommittee on Treatment Facilities for Alcoholics and Drug Abusers recommends that detoxification centers or beds be established throughout the state for initial treatment of drug dependent persons including inebriates as referred to in the Highway Subcommittee report. Such a detoxification facility should be established under the direction of a Mental Health Center, and it should be funded on a matching basis by the state and the counties in the Mental Health Center area. All persons arrested for drunkenness must be confined to a detoxification center pursuant to the provisions of M.S. 253A.01 - .21. Persons may voluntarily commit themselves to a detoxification unit, but shall pay for their care if able to do so. Such detoxification centers should be established by July 1, 1973. These services may be purchased from a local hospital or institution. Testimony given before the Subcommittee universally expressed a need for low cost detoxification facilities for alcoholics.

3. Residential Treatment Facilities (Halfway Houses).

The Subcommittee was told that there is a lack of residential treatment facilities. Although there are in excess of 2,000 treatment beds, only 200 halfway house or residential treatment center beds are available to alcoholics. Of these 200, most are privately sponsored or available only to certain groups. The five alcoholism halfway houses in Minneapolis and St. Paul are open to anyone who may qualify for entry, assuming there is an opening.

To date there are no halfway house facilities for non-alcoholic drug users while in treatment or released from a state hospital. There are two private "homes", functioning on a treatment community basis with emphasis on religion.

A further need was noted in the finding that, of the 200 beds, only 29 are for residential treatment and care for women who are drug dependent. These 29 beds were set up for alcoholics originally, but today most women using the facilities are both alcoholic and non-alcoholic drug abusers. It is estimated that another 100 halfway house beds for women are needed in the metropolitan area alone.

The Subcommittee recommends that the state provide construction loans or grants to non-profit, state approved organizations to buy, build or lease residential treatment facilities for alcoholics and separate treatment facilities for non-alcoholic drug abusers. The State Department of Health will be responsible for the licensing of such facilities and should if necessary develop appropriate licensing standards. The state-approved organizations shall obtain approval from the local Community

Mental Health Board and the Minnesota Commission on Alcoholism or Minnesota Commission on Drug Abuse as applicable.

Special emphasis should be given to residential treatment facilities for women drug abusers and for non-alcoholic drug abusers.

4. Long Term Treatment of Chronic Alcoholics

The Fearon decision handed down by the Minnesota Supreme Court in April, 1969, as well as previous decisions in other states, declared, in essence, that chronic alcoholism is a disease and the state should make provision for treatment of chronic alcoholics.

There is a lack of treatment facilities for the chronic alcoholic who may require institutional care for a period of six months to two years before being able to function in society. Anoka State Hospital is in the process of establishing such a unit which ultimately will treat 40 residents. They expect the majority of the unit's patients will be admitted from Hennepin County. The program opened December 7th for 12 persons whose records indicate that they have failed all traditional treatment programs over an extended period.

5. Follow-Up Care

The need for follow-up care in the local community was stressed by all who testified. This care should involve supportive social services and vocational assistance for both the drug dependent person and his family, in addition to AA or other counseling help to help him remain drug free. Minnesota's community mental health centers have taken action in this area as have a number of county welfare departments who have

hired alcoholism counselors. For the most part, there needs to be a coordinated program of after care available on a regular basis to all who have been institutionalized.

The Subcommittee recommends that the state provide staffing funds to equal at least half the cost of four counselors on drug dependency to community mental health centers serving areas with over 100,000 population, and at least two counselors for community mental health centers serving areas with less than 100,000 population; provided that this number is not to be construed to be a limiting factor in determining number of counselors. At least one of these counselors shall be familiar with the problems of alcoholics, and at least one shall be familiar with the problems of non-alcoholic drug abusers.

Further, the Subcommittee recommends that M.S. 144.84, regarding counselors on alcoholism, be amended to delete alcoholic and substitute in place thereof, counselors on drug dependency. These counselors should have educational or practical experience in the area of alcoholic or drug counseling. No Civil Service examination should be required on individuals with greater than three years experience working either part or full time, either for compensation or not, with an acknowledged service organization.

The Community Mental Health Center shall hire these counselors and the state shall pay for 1/2 of their salary. These counselors shall be employees of the community mental health centers, or of such agency as the community mental health center may purchase service. These counselors shall be responsible for counseling all referrals of drug

dependent persons, and making use of all supportive social service and rehabilitation programs available through public or private agencies.

A further need in the area of follow-up care seems to be the lack of communication between the public institutions and the local community following the release of an individual from institutional care. There are provisions presently in Minnesota law which require that the head of the hospital send information regarding a patient's records to the Commissioner of Public Welfare. M.S. 253A.15, Subds. 11 - 13, Discharge, provides that the head of the hospital shall notify the county welfare board of the patient's county one week before his release, and all benefits provided by the state law shall be made available in a continuing plan of after care.

The Subcommittee recommends that each state institution or hospital must notify the director of the local Mental Health Center when an individual who is drug dependent from that area is released from a public institution. Counselors on drug dependency must follow up with the released individual, along the lines of M.S. 253A.15, Subds. 11 - 13. These services may be contracted for if not otherwise available within the public sector. Private alcoholism and drug treatment institutions should be encouraged to notify the area Community Mental Health Center when they release a patient.

6. Community Mental Health Centers

Minnesota presently has an excellent program of Community Mental Health Centers described elsewhere in the Subcommittee report. Many have received federal funds for drug education and drug treatment programs,

and have taken upon themselves the responsibility of providing leadership in this area.

The Subcommittee makes the following recommendations concerning Community Mental Health Center activities:

a. That the alcoholism counselors or counselors on alcoholism now employed by the county welfare departments be abolished. The responsibility for performing these functions be transferred to the Community Mental Health Centers and that these centers give first consideration to hiring these alcohol counselors who are now employed by the welfare departments, but all responsibility for hiring and firing should rest with the Community Mental Health Centers.

b. That references to alcoholism in M.S. 245.61 be expanded to include all drug dependent persons. This section should also stipulate that services provided by the Community Mental Health Centers may be purchased from other public or private agencies.

c. M.S. 245.65, Limitation on Grants, provides "...Grants may be made for expenditures for mental health services whether provided by operation of a local facility or through contract with other public or private agencies." The Subcommittee urges that mental health services in this section be interpreted to include services for drug dependent persons. Further, that the grants, either state or federal monies, shall be available to approved public or private agencies with "street" acceptance.

M.S. 245.68 (c) Duties of Community Health Boards, provides "Promote, arrange and implement working agreements with other social service agencies both public and private, and with other educational and judicial agencies."

The purpose in citing the above two sections is to show that there is presently a means whereby state and federal monies could be channeled through Community Mental Health Centers to street accepted facilities. The problems inherent in this situation are twofold: 1) many crisis centers, halfway houses, etc. are dependent on raising their own funds or are dependent on foundation funding and may not have the money available for programs they feel are needed; 2) state or "establishment" monies are suspect at the street level.

If the goal is to reach people for prevention, education and treatment purposes, then they must be reached through programs and facilities which they can understand and are willing to come to or take part in. An austere clinical setting probably will not reach those who need help the most, however, the walk-in center with a comfortable setting can.

The crisis centers and halfway houses can employ, or use the volunteer services of, former drug dependent persons as counselors, group leaders, or listeners who may have greater effect on, and provide more help to, the person who needs it.

Informal facilities can be, and often are, open evenings and weekends when people need help or are able to utilize its services after their own working hours.

An example of this kind of service is a walk-in center in Minneapolis. The Center is a drug prevention, education and treatment facility funded by a non-profit private agency, which has now applied for Omnibus Crime Bill funds to run a halfway house.

d. Recently passed federal legislation (PL 91-513) will provide increased funding authorization for facilities and services for treatment of addicts and drug abusers for projects related to community mental health centers. The legislation also provides for special grants from HEW for treatment and rehabilitation projects including a broad range of services. The Mental Health Centers and the state agency should make every effort to obtain Minnesota's fair share of these additional funds.

e. Community mental health centers should be encouraged to assist, financially or through programming assistance, innovative treatment programs in their areas. Such programs may include but not be limited to Day-top and Synanon-type halfway houses.

7. Non-resident Therapy Programs

Granville House, funded primarily by a foundation, uses Ramsey Mental Health Center personnel in its non-resident therapy program for drug dependent women who, as a result, may never need to be institutionalized for their drug dependency problems.

The Subcommittee feels that non-resident therapy programs such as that at Granville House and its Minneapolis counterpart, Wayside House, are meritorious and urges that Community Mental Health Centers and/or

private agencies consider similar non-resident programs as one means of serving the purpose of drug education, prevention and early treatment, thus possibly preventing institutionalization of the drug dependent person. Pilot program grants should be made available through the appropriate Commission for the purpose of establishing such programs.

8. Education

The Subcommittee recognizes the need for preventive education concerning drug abuse. Preventive education is considered the most effective means of stemming future increases in drug abuse similar to those experienced in the past two years. Although a classroom approach may be the most practical means of reaching large numbers of young people, peer pressure is probably a more effective means of preventing drug use. Because children and teenagers spend much of their time in school, school administrative and faculty personnel should be alert to the physical and psychological symptoms of drug abuse.

In view of the above findings, the Subcommittee makes the following recommendations:

a. That M.S. 126.05 be implemented immediately, and that it be amended to include education concerning all forms of drug abuse, not only alcohol and narcotics.

b. That drug education programs be developed for use at all levels of elementary and secondary schools beginning in kindergarten or first grade. The Department of Education in developing these programs should consult

with, and take advantage of, recommendations of the Minnesota Commission on Drug Abuse, the three federal drug education pilot projects now in existence in Minnesota, and the findings of federal drug education and National Institute of Mental Health programs. The Department of Education programs shall be made available for use at all elementary and secondary levels at the start of the 1971 - '72 academic year.

c. Adult drug education programs should make use of, and be available to, community facilities. They should be a joint effort of school districts, community mental health programs, local governmental, civic and professional organizations to the purpose of educating all Minnesotans, adults and children alike, to the realities of drug abuse.

d. School teachers, health and counseling personnel should have knowledge concerning the dangers and symptoms of drug dependency. Referral information should be available within the school system so the student can be referred for necessary medical and/or professional assistance.

9. Youthful Drug Abuse

The Subcommittee has found that there are virtually no programs for the increasing numbers of young, dangerous drug and hallucinogenic abusers. Estimates of abuse given the Subcommittee indicate that the number of known drug abusers is probably only a small percentage of those actually using drugs.

Some individuals are referred to state hospitals in rare instances, the Community Mental Health Center, or placed on probation through the court process. Most young persons, if they need and receive treatment at all,

are placed in the psychiatric or mental health units of private hospitals by their parents. Correctional institutions indicate they attempt to treat underlying problems which led to drug use and use reverse peer pressure in providing for drug abusers in their institutions.

The Subcommittee has also found that in many instances young people using drugs may not need formal treatment and rehabilitation, but rather education or alternative constructive activities. Treatment for many may need to be no more than a quiet room and a soft voice talking him down, techniques which can be provided by a crisis intervention center.

The Subcommittee makes the following recommendations concerning youth:

a. Walk-in centers such as those described in 6C above, which can provide medical and professional referral assistance in addition to crisis intervention services should be considered a priority item.

b. An alternative might be youth activity centers available through public or private sources where young people can come, possibly for referral to professional or medical assistance, but primarily just to talk. These centers should be planned with the assistance and input of local youth working with the local Citizens Action Councils or Community Mental Health Centers. Care should be taken to assure that the centers are accepted by young people and staffed by persons they can relate to or the centers will not be successful. The Subcommittee suggests that this program can be most adequately handled at the local level involving local resources.

c. Bills introduced in the 1969 Session permitting treatment of minors by physicians should be introduced again this Session with the addition of a provision for treatment of drug abuse.

d. M.S. 253A.03 now provides that inebriate youth could be admitted to a public hospital under the Hospitalization and Commitment Act as voluntary patients. The Subcommittee urges that the courts suggest treatment in hospital under this provision for drug dependent persons as an alternative to incarceration or probation, and that state hospitals be required to take these voluntarily committed drug dependent patients or provision be made for treatment on a contract basis in a private hospital.

e. The Subcommittee notes that M.S. 158.13 regarding a Psychopathic Department of University of Minnesota Hospitals provides in part that "...Persons who are addicted to the use of habit forming drugs shall be proper patients for admission to and treatment in the psychopathic department."

The Subcommittee recommends that the language of this section be up-dated, particularly with regard for provision for treatment of abusers of psychological or physiological dependence producing drugs.

Further, the Subcommittee recommends that persons affiliated with the University community be provided treatment in the hospital or its related out-patient clinics.

10. Drunken Driving

While the Subcommittee did not hold hearings specifically on this subject, several witnesses testified to the damage created by the drinking

driver. The House Subcommittee on Highway Safety did hold hearings in this area and has submitted recommendations pertinent to the Subcommittee's charge concerning: 1) that a procedure for the identification, referral and treatment of inebriate drivers be adopted, and 2) the provisions of M.S. 169.121, Subd. 6, be utilized in early case finding and treatment of inebriate drivers.

The Subcommittee concurs in this recommendation, but in addition believes that the definition of inebriate should be changed to include drug dependent persons. The provisions should become mandatory.

11. Purchase funds for law enforcement agencies

The Subcommittee recommends a revolving fund be appropriated to the Bureau of Criminal Apprehension, which shall be available to purchase drugs for use in compiling evidence in cases concerning illegal sale of drugs.

12. Continuing Treatment for Drug Dependent Persons

The Subcommittee feels that there is a need for early case finding and continuous treatment for drug dependent persons.

The Subcommittee recommends that all drug dependent persons shall be provided treatment, therapy and counseling by the local community mental health center either through its own facilities or by way of working agreements with other public or private, nonprofit agencies. These persons shall be entitled to receive the benefits of any on-going public social service programs for which they meet eligibility requirements. The drug dependency counselor should maintain a continuing contact with the drug dependent person for three years following treatment.

13. Department of Health and Social Services

The Subcommittee recommends the establishment of a Department of Health and Social Services responsible for all programs relating to social welfare, supportive, rehabilitation, health, correctional, and institutional services available to the general public. The Minnesota Commission on Drug Abuse and the Minnesota Commission on Alcohol Problems shall be parts of this department.

14. Para-medical Personnel

The Subcommittee urges that provision be made for the training of para-medical personnel in the field of drug abuse on a wider basis than present. The Higher Education Coordination Commission shall by July 1973 have prepared a comprehensive plan for education of such para-medical personnel in public post high school educational facilities of this state.

15. Governor's Commission on Drug Abuse

The Subcommittee finds there is a need for a central source for information and coordination of activities in all areas of drug abuse.

The Subcommittee recommends that the Governor's Commission on Drug Abuse be given statutory authority as the Minnesota Commission on Drug Abuse. The Commission should contain nine members of which seven shall be chosen from among the following disciplines: medical profession, legal profession, behavioral sciences, clergy, representative of drug treatment facilities, law enforcement or corrections agencies, a pharmacologist, a psychopharmacologist, pharmacy , former drug

abuser, education and a student. Two members of the Commission shall represent interested public. Commission members should be appointed for staggered six year terms.

A director should be appointed by the Governor for a coterminous four year term. Such other staff assistance as may be needed should be provided for.

The powers and duties of the Commission shall include the following:

1. Conduct, and foster basic research relating to the nature, extent, causes, prevention, and methods of diagnosis, treatment and rehabilitation of non-alcoholic drug dependent persons.
2. Coordinate activities and programs of various state departments as they relate to drug abuse prevention and education; control and law enforcement; treatment, counseling and rehabilitation; and research.
3. Research, develop and demonstrate new methods and techniques for the prevention of drug dependency through education; and for the diagnosis, counseling, and treatment and rehabilitation procedure for persons with drug related problems.
4. Gather and disseminate facts and information about non-alcoholic drug dependency problems to public and private agencies and the courts.
5. Inform and educate the general public on non-alcoholic drug dependency problems, and the resources for rehabilitation and treatment, so that such drug dependency may be prevented and such drug dependent persons may seek counseling and treatment.

6. Accept funds or property from the federal government or any other source needed to carry out the activities of the Commission.
7. Serve as the approving body for programs which may be partially or wholly funded by the federal or state government, in conjunction with such other departments as may be necessary. The Commission shall serve as the state agency which shall approve, in conjunction with the local Community Mental Health Center, programs and pilot projects of other public or private, non-profit organizations at the local level.
8. Encourage the specialized training of counselors on drug dependency and their employment in each mental health center in Minnesota.
9. Report to the head of the Department of Health and Social Services, the Governor and the Legislature biennially, incorporating such recommendations as it may deem necessary.

Meetings, compensation shall be essentially the same as provided in M.S. 144.833. The duties of the executive director shall be the same as provided in M.S. 144.834 and as determined by the Commission.

16. The Minnesota Commission on Alcohol Problems should be given authority similar to that provided in #7 of powers and duties of the Commission on Drug Abuse above, and be provided with a director and sufficient staff to enable them to implement properly the duties charged to the Commission.

17. The Subcommittee suggests that the Legislature consider a resolution asking the U.S. Congress to limit advertising on TV of those drugs which have a potential for abuse as they have done with tobacco advertising.

18. The Subcommittee supports the Willmar State Hospital proposed narcotic treatment program and secure cottage at Willmar State Hospital and urges that the appropriate funding bodies give it high priority.

19. The Subcommittee recommends that a judge who reasonably believes that a person appearing before him in violation of a law may be a drug dependent person, may file an order for a commitment hearing requiring such person to appear in probate court. The order shall set forth the name and address of such person, the name and address of his nearest relative and the reasons for the order. Such order shall be filed with the probate court, counselor on drug dependency, and the county welfare department and shall be subject to the provisions of M. S. 253A.01 to 253A.21. If such person is committed under the provisions of this clause, the period of commitment may, in the discretion of the judge concerned, be used to reduce any sentence imposed by such judge for violation of such law by such person.

In order to implement this program and the additional caseload created by referrals from detoxification centers, the Subcommittee recommends adequate financing be provided for personnel.

20. The Subcommittee recommends that if a judge who reasonably believes that a person appearing before him in violation of the controlled substances (Schedule I - V) law may benefit therefrom, he may require that person to attend a suitable drug education and rehabilitation program.

21. In some counties, agencies other than the Community Mental Health Center have been charged with the responsibility of developing, coordinating and overseeing programs for the prevention, education, treatment and rehabilitation of drug dependent persons. The Subcommittee recommends

that in those counties where the county board of commissioner, or the Mental Health-Mental Retardation Board, has vested drug dependency functions in another body, that body shall be responsible for the duties charged to the Community Mental Health Centers.

The Subcommittee also recognizes the fact that area-wide comprehensive health planning organizations for health services, manpower and facilities are being developed throughout the state, and where appropriate, these health planning organizations should be utilized.

22. Drug Laws

Because of the variances found in Minnesota law concerning drugs (Chapters 152 and 618), the Subcommittee recommends a recodification into Chapter 152 of all drug classifications, prohibitions and penalties to simplify Minnesota law in this area. The drug classification schedule should be similar to those suggested in PL 91513 (see attached sheet). In developing these schedules, standards should be established by persons knowledgeable in the classifications of drugs and their abuse potential, which in turn will facilitate the establishment of a more rational penalty structure.

The Subcommittee recommends that the State Board of Pharmacy retain the powers granted to them in M.S. 152.041 to determine classifications of new potentially abusable substances as well as determining classifications of drugs at this time.

Consideration should be given to enacting appropriate penalty provisions and should take into account the new federal penalty structure, but not be exclusively established on that basis, in view of differences in scope (interstate and even international) between the federal enforcement program which is high volume source oriented and the state enforcement program.

Federal penalties described in PL 91513 should be modified in state law to provide for maximum utilization of treatment and rehabilitation facilities available. Indeterminate sentences and fines should be authorized to provide maximum law enforcement control of dangerous substances where necessary, and still provide the utilization of the treatment - rehabilitation opportunities available.

23. The Subcommittee feels that a distinction should be made among persons who 1) use a drug on an experimental basis, 2) is a repetitive user, 3) is a wholesaler, manufacturer or dealer, and 4) has made manufacturing, selling and distribution of drugs a criminal enterprise.

The proposed penalty structure should take into account these levels of abuse as well as differences between drugs, the accepted medical use of the drug, the danger of using the drug, and the numbers of persons affected by it. Distinction should be made between possession for personal use and selling or distributing drugs on a wholesale basis.

24. The Subcommittee recommends that persons who engage in continuing criminal enterprises concerning the sale, manufacture or distribution of drugs shall be sentenced to imprisonment for not less than 10 years up to life, and fined in an amount of up to $100,000.

25. The Subcommittee recommends that M. S. 152.09 be amended to add provisions for fraudulent procurement of drugs now in M. S. 152.12, and further that the drugs be classified according to Schedules I - V of controlled substances in this section.

RECOMMENDED SCHEDULES OF CONTROLLED SUBSTANCES

Schedule I - in determining that a substance comes within this schedule, the State Board of Pharmacy shall find: A high potential for abuse and no accepted medical use in the United States and a lack of accepted safety for use under medical supervision.

Examples: Heroin, Lysergic acid diethylamide, Marihuana, Mescaline, Peyote.

Schedule II - in determining that a substance comes within this schedule, the State Board of Pharmacy shall find: A high potential for abuse and currently accepted medical use in the United States, or currently accepted medical use with severe restrictions and abuse may lead to severe psychic or physical dependence.

Examples: Opium, Coca leaves, and Opiate; any salt, compound, derivative, or preparation of Opium, Coca leaves, or Opiate, Methadone, Class "A" narcotics, Injectable methamphetamine.

Schedule III - in determining that a substance comes with this schedule, the State Board of Pharmacy shall find a potential for abuse less than the substance listed in Schedules I and II; and, currently accepted medical use in the United States; and, abuse may lead to moderate or low physical dependence or high psychological dependence.

Examples: Amphetamine, its salts, optical isomers, and salts of its optical isomers. Phenmetrazine and its salts, oral dosage forms which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers, Methylphenidate, any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid, except those substances which are specifically listed in other schedules; Doriden, Phencyclidine, Preludin, Pareldehyde.

Schedule IV - in determining that a substance comes within this schedule the State Board of Pharmacy shall find: a low potential for abuse relative to the drugs in Schedule III, currently accepted medical use in the United States, and limited physical dependence or psychological dependence liability relative to the drugs in Schedule III.

Examples: Chloral Hydrate, Meprobamate, Valmid.

Schedule V - in determining that a substance comes within this schedule, the State Board of Pharmacy shall find: a low potential for abuse relative to the substances listed in Schedule IV; and currently accepted medical use in the United States; and limited physical dependence and/or psychological dependence liability relative to the substances listed in Schedule IV.

Examples: Any compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, which shall include one or more non-narcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation, valuable medicinal qualities other than those possessed by the narcotic drug alone; Parapectolin.

SCHEDULE OF PENALTIES

Manufacture, Distribute, Sell, or Possess with intent to manufacture, distribute or sell

Schedule I and Schedule II narcotics	0-20 years, up to $25,000, or both
Schedule I and Schedule II non-narcotics	0-10 years, up to $15,000, or both
Schedule III	0-5 years, up to $15,000, or both
Schedule IV	0-3 years, up to $10,000, or both
Schedule V	0-1 years, up to $1,000, or both
Distribution of small amount of marijuana (1 oz.)	0-1 years, up to $1,000, or both
Sale to minor under the age of 18	First offense, double all penalties Second offense, triple all penalties

Simple Possession

Schedule I and Schedule II narcotics	0-5 years, up to $5,000, or both
Schedule I and Schedule II non-narcotics	0-5 years, up to $5,000, or both
Schedule III	0-3 years, up to $3,000, or both
Schedule IV	0-3 years, up to $3,000, or both
Schedule V	0-1 years, up to $1,000, or both
One oz. marijuana	Misdemeanor
Fraudulent Procurement	0-4 years, up to $30,000, or both
Continuing Criminal Enterprise	10 years to life, up to $100,000
Second offense of any of above	Double all penalties

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MINORITY SUBCOMMITTEE REPORT

The penalty for possession of one ounce of marijuana should be 0-1 years, up to $1,000, or both (gross misdemeanor).

COMMUNITY MENTAL HEALTH PROGRAMS

Description of Centers

In 1957, Minnesota enacted legislation which provides for community mental health centers, and authorizes the Commissioner of Public Welfare to make grants to counties or municipalities to assist in the establishment of such centers. The mental health centers were placed under the Division of Medical Services in the Department of Public Welfare. In 1963, Congress enacted PL 88-164, the Mental Retardation and Community Mental Health Centers Construction Act of 1963, which provided federal monies for staffing and construction on a matching basis, and establishment of a nation-wide program of Community Mental Health Centers.

Minnesota law and federal regulations provide that the Department of Public Welfare is the authorized agency to distribute state and federal funds for community mental health center purposes. The State Planning Agency is designated in Minnesota law as the agency for comprehensive health planning.

The state presently has a total of 26 community mental health centers. Six are comprehensive community mental health centers, called "federal style" ; the remaining 20 mental health centers are referred to as "state style". (See Map)

The means of funding both styles at the local level is provided for in MS 245.61-65. Communities may levy up to 2 mills to fund the center,

and may apply for state grants or assistance for up to 50% of total costs by submitting a plan and budget to the Commissioner of Public Welfare. The state actually funds approximately 49%. Federal construction and staffing grants are arranged through the state department for the six federal style centers. The state appropriation for community mental health centers for the last three biennia has been:

Community Mental Health Center Funding

1.	1965 - 1966	1,280,000
2.	1966 - 1967	1,300,000
3.	1967 - 1968	1,500,000
4.	1968 - 1969	1,770,000
5.	1969 - 1970	3,000,000
6.	1970 - 1971	3,500,000

The increase in the 1969 session was due to expansion of facilities and programs over the past two years and increased emphasis on the concept of community mental health care rather than institutional care.

SERVICES

Services provided by all community mental health centers are:

1. collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, and other psychiatric disabilities;

2. informational and educational services to the general public, and lay and professional groups;

3. consultative services to schools, courts and health and welfare agencies, both public and private;

4. out-patient diagnostic and treatment services;

5. rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism and other psychiatric conditions, particularly those who have received prior treatment in an in-patient facility;

6. detoxification and alcoholism evaluation and service facilities.

In addition, the six "federal style" centers provide in-patient hospitalization and emergency services. State style centers may provide emergency services if included under their out-patient facilities. The six federal style programs are at Willmar, St. Cloud, Rochester, Range Mental Health Center, Crookston, and Metropolitan Medical Center in Minneapolis.

Mental Health Center Inebriate Programs

The Mental Health Facilities Construction Plan, published by the Department of Public Welfare in 1969, describes the alcohol and drug abuse programs which are now in effect or anticipated needs as seen by the Centers. The plan and a discussion of each center's program are on file in the House Research Department.

As a whole, the centers recognize that alcoholism is a problem within their areas, and have instituted a follow-up program with the state hospital for that catchment area. Most indicate a need for local detoxification facilities.

Many of the Centers have added one or more alcoholism counselors to their staffs and make extensive use of local AA groups. The Northwest and Lakeland Mental Health Centers coordinate with the county welfare department alcoholism counselors in the northwestern quadrant of the state.

Drug abuse, for the most part, is not recognized as a problem at this time except within metropolitan or college areas. The Centers are beginning to move in the direction of providing drug prevention education for parents and professional persons, as well as young people.

The programs in Hennepin and Ramsey Counties are described below:

Hennepin County

Hennepin County and its community mental health center created a

separate alcoholism and inebriancy program in 1968. The Area MH-MR Board still reviews and oversees the program to comply with state guidelines for matching dollars, but the alcoholism and inebriate division apparently operates somewhat autonomously. (This unit has recently opened an alcoholic information and referral service which will be staffed by a former alcoholic who has been active in rehabilitation programs. The address and phone number is: 605 4th Avenue South, 330-8013.)

The division provides assistance to the Mission Farms and the Work house alcoholism programs. It works closely with Hennepin General Hospital and the Meadowbrook facility. It does not provide the kinds of programming services to halfway houses and through the mental health center which Ramsey does.

Present plans call for purchased services to a great extent; for example, treatment services along the lines of the Mission Farms program for alcoholics. A limited pilot project will be established to purchase beds in city hospital psychiatric units at hospital rates for the mentally ill with a goal of making facilities more accessible for individual voluntary commitment.

Title IV Social Security funds are being sought because they are on-going programs continuously funded once the county qualifies, unlike mental health or other project money which must be re-negotiated each year and is subject to variations in amount.

A pilot project has been recently negotiated between Hennepin and HEW to study this concept. Hennepin's philosophy is that alcoholics are potential welfare recipients, and therefore the county should be able to utilize Title IV Social Security funds to assist recipients who are residents in target areas (Pilot City and Model City), receiving a categorical aid, or recipients of alcoholism services who meet income eligibility requirements. Funding through Title IV will be on a $3 to $1, federal to local, basis. Presently, there is no medical assistance funding for alcoholism treatment.

Drug abuse treatment in Hennepin will be limited to activities in the Model City and Pilot City programs, and those provided by private agencies such as the Catholic Welfare Agency's NARA contract. The budget includes planning dollars with which the Alcoholism and Inebriate Task Force will survey existing programs and their effectiveness prior to starting a full scale drug treatment program. The county hopes to maximize cooperation with other resources. The Task Force hopes to be done with the survey and have a treatment program formed by June, 1971, the initial phase of which will be implemented in July at the start of FY 1972.

7-A Area WM - 1A - Swedish-St. Barnabas Hospitals (Metropolitan Medical, Mpls.)

The Hennepin Mental Health Center has joined with Metropolitan Medical in programming. Swedish - St. Barnabas has qualified for a federal staffing grant. Much of the area served by the facility is also included in the Model Cities area of south Minneapolis, The West Bank, University of Minnesota,

Southeast and Northeast Minneapolis will also be served by this center.

Ramsey County

The Ramsey County Mental Health Center and a number of other public and private social service agencies are involved in an extensive alcoholism program. The Center provides assistance through direct programming funds, staff support, or serves as the administrative body through which funds are obtained for the many kinds of alcoholism programs in Ramsey County. Among the programs related to the Mental Health Center and utilizing staff or programming monies, or coordinating activities are the following:

Alcoholism Information Center and Referral Service is a United Fund agency. This agency supplies information concerning all known alcoholism treatment programs and coordinates with the mental health center.

St. Paul - Ramsey Hospital is the administrative office of the hospital. The drug dependency section in the psychiatric unit of the hospital serves as the detoxification and initial treatment center for the mental health center inebriate program.

The detoxification center at 297 Century Avenue, Maplewood, will be staffed by St. Paul - Ramsey personnel and mental health center alcoholism counselors. They will make referrals to Hastings or other mental health center alcoholism programs following the 3-5 day stay at the detoxification center.

The Walk-in Center at 529 Jackson is staffed and funded by mental

health center personnel. They serve both alcoholics and drug abusers in addition to other mental health service recipients. The Walk-in Center will be open one evening a week to assist drug abusers if they are successful in adding another psychologist to the staff.

Granville House and 565 House are halfway houses for alcoholics which now utilize mental health center alcoholism counselors and will receive programming funds when the federal funds are available. Their applications have been approved. In addition, Granville House has a non-resident group therapy and chemical abuse education program for alcoholics and drug abusers for which the Center provides an alcoholism counselor. Granville feels that this program has been successful in eliminating need for institutional and residential treatment for women inebriates.

People Inc., a private social service organization in St. Paul, is the owner of 565 House. They plan to open a halfway house for emotionally disturbed near Hamline within the next few months. People, Inc. eventually hopes to serve as an umbrella organization establishing and administering a number of different kinds of halfway houses utilizing programming funds for the mentally ill, convicts on parole, and others needing assistance in readjusting to the community as well as inebriates. The Senior Social Worker of Ramsey's Mental Health Center serves on the Board of Directors of People, Inc.

Center Activities in Minnesota

The resources of all 25 area program boards and the community mental health centers which they operate are available to persons with addictive problems. A brief description of services available around the state follows:

Central Minnesota at St. Cloud provides outpatient services at the Center and in-patient services at St. Cloud Hospital. The Center provides alcoholism counselors for the counties of Benton, Meeker, Sherburne, Stearns and Wright.

Dakota County in South St. Paul provides outpatient services.

Duluth Center provides outpatient services at the center. There is a clinic for problem drinkers with a number of counselors.

Hennepin now provides outpatient services at the Center and Pilot City, and emergency and in-patient services at General Hospital. The methadone project at Mt. Sinai Hospital utilizes some mental health staff.

Northwestern at Crookston has a federal grant for a drug abuse project in the local schools. The center provides an alcoholism counselor for a 6 county area, and works with Sunnyrest, a treatment center for alcoholics run in cooperation with the Northwest Council of Alcohol Problems.

Range Center at Virginia provides group therapy for adolescent drug abusers at Day Hospital in Hibbing. Two alcoholism counselors serve part of the St. Louis County area.

Ramsey provides a number of programs which are described above.

West Central Center at Willmar provides outpatient and adolescent group counseling on drug abuse. An alcoholism counselor works with patients from Willmar State Hospital who reside in the center's catchment area. West Central has applied for and received an Omnibus Crime Bill grant to establish a drug referral unit.

The Luther Youngdahl Human Relations Center has a youth program in which a number of drug abusers are included. They hope to expand to an informal walk-in center one evening a week. Staff members are group therapists.

Souix Trails Center at New Ulm provides an alcoholism counselor for a 7 county area and has recently received an OCB grant to develop a new drug program which will include a walk-in center.

The feeling of the Subcommittee was that Community Mental Health Center activities could be expanded to provide treatment, particularly for young drug abusers.

DEPARTMENT OF CORRECTIONS PROGRAMS FOR INEBRIATES

Correction Institutions - Alcohol and Drug Abuse Treatment Programs

All Minnesota state correctional institutions have drug dependency programs which center primarily around AA meetings held once or twice a week in the evening, for 2 or 3 hours, and weekly group therapy sessions with a consultant or specialist available to the institution for drug abusers.

Responses from the specific institutions indicate:

1. State Prison

Stillwater reported that the treatment program for the alcoholic in the state prison consists mainly of their AA programs. There are two separate programs: one for the minimum security unit and one for the main institution. Nearly 200 inmates are involved.

The program for drug users consists, for the most part of group therapy. Three separate group therapy sessions meet regularly each week with a total of 22 inmates participating. Dr. Frederick Gelbmann of the Department of Corrections met recently with a heroin group at the prison to discuss the establishment of a NARA group. He provided the group with material on a Daytop program which they plan to use to develop as a project proposal and seek funds to establish such a program in the prison.

2. Minnesota Correctional Institution for Women - Shakopee

The superintendent reported that other than AA representatives meeting with alcoholic inmates weekly, there is no other program for the problem drinker. Some individual counseling occurs with the institution case worker and consulting psychologist.

A small group of addicts meet weekly for 2 to 3 hours with an individual who had worked with addicts in California.

3. State Reformatory at St. Cloud

The superintendent reported that the treatment program for alcoholics at the reformatory has very little specialization. AA groups meet two nights each week, and outside visitors usually attend the meetings. The outside groups are ready to provide sponsors and support for alcoholics upon release. He also pointed out that the reformatory has other treatment, vocational and educational programs which they take part in.

There is a special group for drug addicts which meets twice a week in 90 minute sessions under the direction of the Director of Staff training. The group is limited to seven hard-core addicts, and the leader and group screen prospective candidates. Group members are assigned to one parole agent who specializes in working with addicts. No program has been developed for drug abusers other than those seven addicts who are termed "hard-core."

4. Juvenile Institutions

According to Mr. Delbert Leaf in Corrections, there are no specific programs for juvenile drug abusers. They treat drug abuse as a symptom of the total problems of the individual. Lino Lakes treatment consists of group-interaction sessions and peer group pressure against drugs but still within the framework of symptomatic of the juveniles total problems.

DEPARTMENT OF CORRECTIONS PROGRAMS FOR INEBRIATES

Field Services Division - Department of Corrections

Drug Abuse

The bulk of the Field Service efforts in the area of drug and alcohol addiction have been carried out by the newly formed special unit. In July of this year two agents were designated as drug addict specialists. Each will carry caseloads of twenty adult parolees and probationers with opiate addiction histories. At the present time they have twelve addicts on their caseloads and are increasing this monthly. These agents have been given the responsibility of gaining expertise in drug symptomatology and treatment in addition to maintaining close supervision with their clients. These agents have developed close relationships with a number of community agencies dealing with addicts. They have also been involved in determining the size of the addict population and in determining what types of programs are needed to deal with this problem of the clients. In addition to their own caseloads, they are available for consultation to other agents especially in the area of referral.

The special unit has established close contact with the Methadone Drug Maintenance Program at Mount Sinai Hospital and with the 40 month Federal Narcotic Hospital after care program (NARA) in Minneapolis. Mount Sinai presently has nine of their clients in their program. The division is aware of additional correctional clients in Methadone Maintenance in the Minneapolis Pilot City Program and in private medical practice. There is presently one adult parolee who is committed under the NARA who is under the dual supervision of that agency and the department.

This supervision includes four urine tests a month. The special unit has also been in contact with the U.S. Attorney's Office in Minneapolis which has been helpful in acquainting them with the civil commitment procedure. Because the special unit is new, it has not yet been able to set up as close a working relationship with narcotic agencies in St. Paul.

In the Duluth District Office, Merle Michaeu has been very active in a community organizational type of way in presenting the problem of addition to the people of northwest Minnesota. In connection with this he has obtained from the Palucci Family Foundation eleven films on addiction reported to cost a total of $4,000. He is doing this work on his own initiative and is still carrying a regular caseload.

Alcohol

A special unit agent has been designated as a specialist for alcoholics. Due to the more extensive community resources for alcoholism, his job has evolved into that of a coordinator and "social broker" for the field staff. They feel that St. Paul-Ramsey Hosptial's Detoxification Program has been extremely valuable. By using this in-patient treatment, they are able to intervene in alcoholic episodes before this leads to further criminal behavior. However, St. Paul-Ramsey is the only Twin City public hospital offering this service. At the present time the division is experimenting with mandatory, supervised use of antabuse by parolees. For a number of weeks, the parolees have come to a designated place and been given antabuse. If proved successful, this program will be used in the future.

Hennepin County Court Services

The court services department handles adult probation from district court. Dwight Dale of the department indicated that the pattern or the last two years shows that class A narcotics and opiate users are placed on probation and referred to the NARA programs for aftercare; however, the court retains jurisdiction. Some parolees are in the methadone programs at Pilot City and Mount Sinai by individual choice, and the department will make referrals to Mount Sinai.

Marijuana and dangerous drug abusers are a "preponderance" of their case load. These individuals are not referred to a specific agent or supervisor. Most agents have 80 - 100 cases, but they still try to maintain the 1 to 1 relationship. Their intake has shown a 150% increase over the past three years, primarily due to an increase in the number of drug abusers.

The agents work with the individual and utilize resource services in Minneapolis such as Pilot City, mental health clinics, private psychiatrists, and the various alcoholism resources. They consider detoxification of an alcoholic a medical problem and refer him to a hospital or obtain other medical services. They refer to halfway houses where there are openings, Willmar State Hospital, and private agencies for treatment programs.

The average age of parolees is in the lower 20s. There is no specific program for women, and, he felt, a disturbing lack of resources for treatment of women.

DVR ALCOHOLISM PROGRAMS - OTHER STATES

The states of California, Florida and Michigan have outstanding DVR programs for alcoholics and drug abusers according to Mr. Richard Lynch of the Minnesota Commission on Alcohol Problems. These programs, however, are relatively new or just in the planning stages, thus determination as to their effectiveness cannot be drawn. The California and Michigan programs are discussed below.

California

In 1969 the Department of Rehabilitation was authorized to administer community vocational rehabilitation programs or to cooperate with designated local agencies in administration of such programs. Local alcoholism programs must meet the requirements of the state plan and provide services in the areas of case finding, physicial restoration, training, maintenance, transportation, service to family members, job placement and follow-up. Community services and public and professional informational and education programs must also be provided.

The program is federally financed on a 80-20 basis with state and local sharing $3 for $1 the 20% non-federally reimbursed expenses. Three pilot programs were established:

1. Direct operation and staffing of a diagnostic evaluation center for alcoholics in Sacramento County utilizing a previous program.
2. Assignment of vocational rehabilitation counselors and clerical staff to existing out-patient alcoholism programs with case services funds available to purchase rehabilitative services not provided in the existing

program. Four counties use this program, then replaced it with the third model.

3. Department of Rehabilitation contracts with local community alcoholism programs for the operation of a rehabilitation program with the features of the state plan. The supervisor of the local alcoholism program is under the control of the Department of Rehabilitation office. This program is now implemented in 10 communities.

California is optimistic in terms of benefits the state hopes to derive from their program. To date 7,202 alcoholics have entered the program, and 2,303 have been closed as successful as measured by stable employment and adjustment. Most of the remaining participants stayed in the program only long enough for testing and referral assistance - about 3 weeks. Cost of the program per rehabilitated individual rise from a low of $579 in San Diego to a high of $5,142 in San Francisco, with the mean cost approximately $1,089.

Michigan

Michigan began the development of a vocational rehabilitation program for alcoholics and drug addicts on July 1, 1970. They have developed separate programs for drug addicts and alcoholics on a limited and still experimental basis. The programs will expand if successful.

The alcoholism program will begin by providing services to clients referred by county alcoholism information centers. One counselor, one case aide, and a part-time clerical position, plus case service funds would be assigned to each referral source.

It is planned that the alcoholism program will multiply over a five year period until 10 centers are included.

The drug program will begin by providing services to clients referred from the Marine Hospital in Detroit and the Methadone Maintenance Program of the Detroit Model Neighborhood program. They will receive case service funds and one counselor, case aide and clerical position per program for the first year. Expansion and rate of expansion of the drug program will in part depend on experiences of the 1971 fiscal year.

Drug addicts and alcoholism are entitled to the same vocational rehabilitation services as the general disabled population and under the same eligibility conditions. The major objective of the Michigan DVR is suitable employment of the vocationally handicapped. To this end, they provide the services of counseling, physical restoration services, training to prepare the client for employment, maintenance payments, transportation, placement, tools, and any other goods and services necessary to help the handicapped individual become employed.

The alcoholism budget for fiscal year 1970-1971 is $115,700 of which $75,000 will go for salaries and administrative costs, and $40,700 will be used for purchasing services for clients. The alcoholic program is funded by an innovation grant from the Rehabilitation Services Administration under Section III of the Vocational Rehabilitation Act which provides for a 90 - 10 federal-state matching money.

The total budget for the drug program is $65,000 of which $38,500 will be used to purchase services for clients and $26,500 for salaries and administrative costs. The drug program

is funded by Section II of the Vocational Rehabilitation Act which calls for an 80 - 20 federal-state money match.

Minnesota

The Minnesota Division of Vocational Rehabilitation program for alcoholics is limited to state employees at present and provides for counseling, makes arrangements for medical evaluation and coordinates other services to return the individual to employment after treatment. The alcoholism program was developed through the activities of the Commission on Alcohol Problems, the Civil Service Department and DVR. DVR was designated as the operating agency because of "its unique structure within state government" and the specialized training which is provided staff members. Also some funds might be available to DVR for the implementation of the individual's plan which might not otherwise be available.

Jerry Mihock was retained as the DVR alcohologist. He works with supervisory personnel in other departments to get an alcoholic employee into an appropriate treatment program, and then follows up with the employee to make sure he is continuing his treatment program.

Statistics provided by DVR indicate that approximately 1,100 alcoholics have applied for vocational rehabilitation and are being processed. The Division is currently providing services to 294 alcoholics. During fiscal 1970, 140 individuals were rehabilitated through the agency. Approximately 100 drug addicts have applied for vocational rehabilitation services and are in

process. Forty-seven are now receiving DVR services, and last year eight were closed as rehabilitated. These figures, according to the Division, are the number who are listed with drug addiction or alcoholism as the major or secondary disability. There may be others in other disabled categories.

General

The need for a low cost facility for detoxification and initial treatment for the alcoholic is readily apparent in Minnesota. The Fearon decision handed down in April, 1969, determined that a chronic alcoholic has no control over his drinking and that steps should be taken to treat and rehabilitate the chronic alcoholic. The Ramsey County Community Mental Health Center will establish a detoxification center in the near future. The center is described below.

Other States

There are four detoxification centers in the United States at present - St. Louis, Washington, D.C., Des Moines and Houston.

The programs of St. Louis, Washington and Des Moines are similar in that they provide 4 to 10 day treatment with the principle goal being to dry-out the alcoholic and refer him to future treatment and rehabilitation assistance either at the center or elsewhere. The staff complement generally consists of R.N.'s and aides with a visiting physician or medical students available.

Treatment consists of a 24 hour detoxification, then interviews with the alcoholic and referral to other rehabilitative programs where possible. AA meetings are held at the center and AA members play a role in treatment. The centers are generally short term, fast turnover facilities which may handle over 1,000 patients yearly in a 50 to 75 bed facility.

The reported advantages of a detoxification center over "drunk tanks" are:

1. Better medical and nursing care for patients.
2. More positive environment in which to motivate patients to do something about their drinking problems.
3. Greater emphasis on good nutrition.
4. More encouragement for patient utilization of supportive community mental and social welfare resources upon discharge.

The three detoxification facilities discussed aobve have one important thing in common - police support. Action and funding assistance through police departments developed the centers as a more humane response for the "revolving door drunk" than the drunk tank in the local jail. Police department and courts saw the need for initial stages of treatment of the disease of alcoholism through a detoxification center, rather than jailing of the public intoxicant. In all cases, police officers can take the alcoholic to the center rather than the station for booking. AA plays an important role in the beginning stages of treatment in the centers.

Minnesota Activities

Minnesota has limited detoxification facilities, usually in a private hospital or state institution, and only as the initial step in treatment. Cost of care is generally at usual hospital rates.

St. Paul has applied for and received a total of $431,500

of Omnibus Crime Bill funds over a three year period to establish a detoxification center at 297 Century Avenue in Maplewood in conjunction with the Ramsey County Workhouse.

The facility will provide beds for 30 men and 5 women. Only Ramsey County will be served by the center. The administering agency will be the St. Paul-Ramsey Mental Health Center. Arrangements have been made with St. Paul-Ramsey Hospital for the treatment of medical problems. The facility will open as soon as the 60% firt year grant funds are received. The 40% local funds will be provided in kind.

Treatment will be medically oriented and initial in-take will be done by RNs. The minimum stay will be 72 hours, and the maximum 5 days. Patients will be referred to other local resources and AA for follow-up. Police will bring the individual directly to the center rather than going through the booking and court process.

The grant application is on file in the House Research Department.

EXISTING STATE FACILITIES FOR ALCOHOLISM AND DRUG ABUSE (INEBRIATES)

A. State Hospitals

Five state institutions receive alcoholic patients on a regular basis. In addition one state hospital has just opened an alcoholic unit and another is expected to open in November.

The philosophy and type of treatment for all hospitals except Anoka is essentially the same: the patient is admitted for 30 or 60 days for treatment which is generally based on the AA approach, and the supposition that the individual is dependent on alcohol to the extent that it interferes with his life and the lives of others. Alcoholism is considered as a multi-phase illness which should be treated in a number of ways to help the individual become able to handle his own problems.

During his first few days, the patient at the state institution is detoxified if necessary, given a psychological and physical examination and lab tests, and necessary medication. Also during this period his personal history is taken, and he is introduced to therapy.

Therapy generally consists of daily large group lectures on the subject of alcoholism and its effects. Smaller group and individual therapy sessions, AA meetings and "Alumni" meetings are held during the evening. Recovered alcoholics are used as counselors because they are more effective in reaching the patients. Patients are given work assignments at the hospital. Members of the alcoholics family are interviewed at Moose Lake. At Hastings, family group therapy sessions begin one week after admittance.

Prior to release, the hospitals attempt to find an AA sponsor for the individual patient in his home community. Patients are referred to county welfare departments, alcoholism counselors at mental health centers and other community resources for follow-up care.

The state hospitals have conducted in-service seminars for industry, unions, clergy, and law enforcement and judiciary.

Hospitals generally provide beds in a ration of 2.5:1 men to women. This situation, generally found statewide in all treatment facilities, indicates that society as a whole is more willing to recognize and attempt to cure alcoholism in men than women. It must also be recognized that the female alcoholic is often in a better position to hide her problem. Further, there is a greater likelihood that she will be treated through private channels at the instance of her family.

The Fergus Falls State Hospital has designated beds for 60 alcoholism patients of which 50 were filled on August 15, 1970. Patients enter Fergus Falls State Hospital from the 26 county northwestern portion of the state.

Hastings State Hospital serves the counties of Ramsey, Washington and Dakota. On August 18, 1970, 67 patients were in the 70 bed facility. The program was established in September, 1968, with 80% of its patients coming from the 3-5 day treatment program at St. Paul Ramsey Hospital.

Moose Lake State Hospital serves the northeastern portion of the state: on August 14, 1970, 75 patients were in treatment.

St. Peter State Hospital opened its 48 bed facility on August 18, and within 2 weeks were treating 18 patients. It serves the 11 county south central portion of the state.

The Rochester SH serves the Southeastern portion of the state. On 9/1/70 10 patients were in the 25 bed unit.

Willmar State Hospital, established in 1970 as the inebriate hospital and still the largest alcoholic treatment facility, serves the 21 county southwesterns corner of the state primarily, and also acts as a receiving center for combination drug and alcohol abusers and drug abusers for 72 counties. As of August 18, 1970, 210 patients were undergoing treatment of which seven were drug abusers. The Willmar Hospital staff conducts an in-service training program of short duration for alcoholism counsellors.

The newly devised St. Peter State Hospital alcoholism program will be similar to that of Willmar, Hastings and Moose Lake. Its only difference is that drug abusers will be dealt with in the psychiatric units.

At Anoka State Hospital a 48 bed unit (28 for men and 12 for women) will open on November 1, 1970. The hospital program will emphasize treatment for long term chronic alcoholics. The average length of stay is expected to be 6 - 12 months. Patients will be admitted on a selective basis through information and referral services such as the county welfare department, Pioneer House, etc. The unit will serve Anoka, Hennepin, Sherburne and Wright counties. It is anticipated that the majority of patients will be from Hennepin County.

Treatment at Anoka will consist of the didactic AA approach and social rehabilitation. The hospital is presently waiting for a NIMH grant to finance its program. Prior to receiving the grant for which federal funds are unavailable at this time, the hospital plans to open a limited 12 bed facility utilizing unexpended funds presently in its budget.

Costs

The average patient cost per day for treatment in the state hospitals is less than $20 for all costs attributable to the unit including building costs, operational and salary expenditures.

Recovery Rates

Recovery rates vary according to interpretation of the term. A 78% recovery rate is claimed by those who consider treatment successful if the patient is able to achieve and maintain a "workable sobriety." Recovery ratios, however, are generally considered to be in the neighborhood of 35 - 40% after treatment in one of the state hospitals. Another 30% become "revolving door drunks", in one institution after another. These individuals are often single - divorced, or never married, - unemployed, older men who are chronic alcoholics and have been addicted to alcohol over a period of 15 - 20 years.

Recovery percentages seem to be better in counties where there is adequate follow-up care such as an alcoholism counselor, than in counties where little or no special care is provided (60% in one county versus 35 - 40% generally).

In addition, a recent study by the staff at Moose Lake State Hospital shows that the married employed alcoholic has a far better chance of remaining sober than the single unemployed alcoholic. The recovery ratios decrease as there is less stability in his life as is illustrated below.

working married	50 - 75% can achieve and maintain sobriet
married	50%
single working	25%
single unemployed	10%

Most hospitals count each admission as a separate case and do not consider it unusual for an individual to come back as many as four times to that particular hospital.

B. Private Institutional Facilities

1. St. Paul Ramsey Hospital has for the last three years admitted alcoholics and other drug dependent persons into the Psychiatry Unit for medical reasons such as withdrawal as well as to provide the first step in a rehabilitative program.

Upon admission to the Psychiatric Unit, the patient is given a medical workup and consultation. He is screened by a member of the psychiatric staff and referred to the drug dependency service. The patient in this unit takes part in a daily program which include a group therapy and policy meeting during which he is told what treatment or legal resources are available and why he should participate in them. An individual session is held with the patient on a daily basis and prior to his leaving the hospital. The staff also contacts the patient's family and, with permission, his employer to involve them in the rehabilitation of the alcoholic. Patients are expected to attend the AA meetings which are held three times a week at the hospital.

Characteristics of the Patient

A recent survey by the hospital indicated that 46% or 78 persons a month admitted to the unit were diagnosed as drug dependent. In addition, some 35% of their patients experience no withdrawal symptoms or medical complications and only 22% show complications which might require hospitalization. Figures from surveys taken in previous years indicate that approximately 30 - 40% are readmissions. Thirty per cent are involuntary (committed by probate court or police custody) admissions and

that the male - female ratio is 3.5:1.

Costs and Disposition of Patients

The average stay in the unit is 4 days. The average cost is approximately $80 per day, with a cost of $100 on the first day. Of the admissions, close to 25% are released with a referral to an AA group; 12% leave against medical advice with no referral; 10% are releases to treatment centers (Hastings); 5% to the police, 8% to board and care facilities, 5% to private treatment centers and 3% to a correctional institution.

The hospital feels that case finding and follow-up services for alcoholics are necessary components in the treatment of alcoholism; without the follow-up medical treatment per se is of limited value. Judicial commitments to a specialized treatment unit has been shown to be of value in a follow-up study conducted last year which indicated recovery rates slightly higher for committed individuals than for those who enter treatment programs voluntarily.

2. Meadowbrook - Hennepin County General Hospital

At present Hennepin County General has no alcoholism unit and a policy of not taking alcoholics unless necessary. A unit is scheduled at this time to open in January, 1971, which will provide a hospital treatment facility rather than a detoxification center.

Meadowbrook, which will open in St. Louis Park in late fall, will be a 22 bed residential treatment center and part of General Hospital's total program. The center will be located near Methodist Hospital and will be licensed as a convalescent

and nursing care facility thus requiring a larger professional staff. Anticipated costs per individual will be $45 per day. Treatment will be AA oriented and will consist of 7 - 14 days of counseling and follow-up care. The center will also operate as a clinic for walk-ins. Patients will be admitted on the recommendation of a personal physician.

3. Minneapolis Facilities

Two Minneapolis hospitals have established alcoholism treatment units. St. Mary's Hospital's 44 bed unit is directed by Rev. Vern Johnson and has a 4 bed detoxification unit which is available only to those entering the treatment program; however if all beds are filled they will detoxify elsewhere in the hospital. Cost of the program is $49 per day. They utilize the hospital social worker staff to assist in their rehabilitation effort.

Northwestern Hospital has a 28 bed unit directed by Rev. Philip Hansen, with a psychologist and three full time counselors, one of whom serves as a liaison with halfway houses and outside AA groups. Their cost is $46.00 per day. Both are licensed as hospitals by the Department of Health, therefore charge regular hospital rates which are covered by most large hospitalization insurance companies.

The treatment programs in both are similar and consist of a 21 day lecture series following the 12 steps of AA. AA meetings are arranged for evenings and the patient is referred to an outside AA group. Family group therapy sessions meet evenings and ex-patients and spouses are encouraged to come. Patients in both units stay approximately one month.

4. Hazelden - Center City

Hazelden is the largest private treatment facility for alcoholics in Minnesota and admits 1,400 - 1,450 patients per year to the 150 bed institution. The majority are voluntary admissions who stay for an average of 28 days. Some 30 - 35% of those admitted are Minnesota residents, the balance coming from out of state or Canada. The minimum treatment period is 22 days and costs $54.17 for 1.5 days during with the patient is detoxified and medical and social history obtained and $27.37 for the balance of the treatment program. The treatment program is AA oriented. Hazelden is licensed as a board and care unit with the exception of the infirmary.

After detoxification, the admittee is interviewed by a recovered alcoholic and placed in a rehabilitation unit of 18 - 22 beds where he is further interviewed on an individual basis by a psychologist and a clergyman, and is introduced to group therapy sessions 2 - 3 times per week. He attends 3 lectures daily on alcoholism and drug abuse, and may also begin family therapy.

Fellowship Club in St. Paul is Hazelden's halfway house to which men are referred if additional follow-up care seems to be in order.

5. Sunnyrest - Crookston

This facility was originally funded by vocational rehabilitation and has since been taken over by the Northwest Council on Alcohol Problems, an association of area AA groups.

The center provides a total "in-house to halfway house" treatment program for alcoholics and their families, and coordinates its activities with the Northwest Community Mental Health Center board and facilities.

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HALFWAY HOUSES FOR ALCOHOLICS

There are 15 halfway houses in Minnesota, all generally oriented towards the AA system of treatment. Representatives of several testified before the subcommittee, each stressing a particular emphasis in their activities.

Residents usually enter a halfway house through referral from one of the state's treatment centers or correctional institutions. The individual must be an alcoholic and amenable to treatment to become a resident.

As many as 93% in one halfway house may be homeless chronic alcoholics who need the motivation and assistance to return to a normal way of life. The halfway house provides him with a home and companionship while he adjusts to life without alcohol. Most are staffed by former alcoholics on the premise that they are more able to understand the problems of readjustment.

Most halfway houses in Minnesota derive income through support by the residents, donations from former residents and outside AA groups and other individuals, as well as receiving grants from private foundations. The county welfare or relief office or veteran's administration may provide some assistance to an individual during the early weeks. Several are church-supported or church related, notably House of Charity in Minneapolis, New Hope Center, Minneapolis, Union Gospel Mission, and the Salvation Army. The Indian Guest House is funded through the Upper Midwest Indian Center and Citizens Community Center in Minneapolis. Two houses near state hospitals are partially funded with Division of Vocational Rehabilitation monies through

the Department of Education. Lake Venoah, a quarterway house in Carlton, provides a sheltered workshop situation and is AA oriented. Lake Venoah is supported by the Union Gospel Mission of Duluth, and encourages spiritual rehabilitation as part of its program. St. Francis at Atwater, provides a similar program for Willmar State Hospital.

Cost figures from several sources indicate that with the exception of NuWay House in Minneapolis, most run at an operating loss when comparing room and board income from the residents to the cost of the halfway house and its program. Most enjoy tax exempt status, although NuWay House pays the City of Minneapolis a special assessment tax through a permit obtained from the City Council. All others are tax-exempt foundation funded or government organizations and do not pay city assessments or service charges.

1. NUWAY HOUSE

NuWay House and NuWay House 2 located in Minneapolis operate on the principle that asking an individual to help pay for his treatment will help him to readjust. They charge each man $31.50 per week. Residents attend a Monday evening AA meeting held at NuWay. Prior to the opening of the second house, Thursday evening meetings on living problems were held at which guest speakers lectured or led discussion groups on related problems such as DVR programs, finances and legal problems.

NuWay Houses are unique, according to their director, Harvey Swager, in that they are the only halfway houses in the

country run by alcoholics for alcoholics and are self-sustaining. He stressed that the halfway house must be large enough - about 30 residents - to bring in sufficient income to meet expenses. He pointed out, however, that a community should be large enough or willing to help the home and with sufficient industry willing to hire residents. Part of this necessity for a large self-supporting house is sufficient income to pay a director, cook and other staff assistance to run the home and perhaps provide programming direction so the halfway house can function as a total unit.

2. 565 HOUSE

Another view of the philosophy that a halfway house must be self-sustaining is embodied in 565 House established by People, Inc. in St. Paul. Their premise is that a halfway house must be small enough - 12 - 15 residents - to provide an optimal setting and small enough groups for the group therapy sessions required as part of the program. This, they maintain, is not possible or is poorly done in a halfway house with a larger population. Residents of this house are supported by the Ramsey County Welfare Department until they have a job, and then are asked to pay all or as much of the rent as ability will allow. An integral part of their philosophy is that a man will make more progress if he is allowed to keep what he earns and save for the period following residence rather than turning it over to the halfway house.

Problems in establishing halfway houses are primarily financial. Difficulty is also encountered in locating a suitable

facility. The 565 House was donated upon assumption of the mortgage. People, Inc. is also purchasing a residential facility for emotionally disturbed on a contract for deed from Hamline University with the help of low-cost loans from area churches. NuWay House sold certificates and obtained foundation grants to pay for its first house, and paid for the second from "profits" from the first house.

After obtaining financing, the halfway house must locate a facility, remodel it to comply with city codes, determine programs and obtain various state and local licenses, generally boarding care.

Minneapolis Halfway Houses do not seem to utilize existing welfare and mental health facilities, and apparently have little contact with alcoholism counselors. St. Paul, on the other hand, has made extensive use of existing social service programs in using welfare department assistance for living costs, and working with the community mental health center, and programming funds and grants available through them, to provide a greater degree of therapy for residents as well as extensive non-resident programs which are considered preventative treatment.

HALFWAY HOUSES FOR WOMEN

Of the 15 halfway houses in Minnesota, only two are for women. These two are Granville House in St. Paul with 17 beds, and Wayside House in Minneapolis with 12 beds.

Wayside House opened in 1958 as a residence for homeless women and 1963 changed its emphasis to alcoholics. Now 90% of the residents are dependent on alcohol and soft drugs. In 1969, 44 women stayed at Wayside House. The average age was 43.5 years and the average stay 4 to 5 months, although residents may stay longer if necessary. Only applicants referred by treatment centers or the workhouse and screened by their consulting psychologist are accepted, and then only if it is felt the woman will respond to their program and fit in with the group. Not all are residents of Minnesota.

The average cost per woman is $49 per week, of which she pays an average of $36. Out of state residents are charged more. The balance is made up from donations or grants. Board and room is sometimes paid by the Minneapolis Relief office or is given without charge until the woman obtains employment.

Foundation funding has been obtained for a non-residential informational and educational lecture program on chemical abuse which is conducted twice weekly. One afternoon a week is devoted to a group therapy session led by an alcoholism therapist from Hennepin County General Hospital. The Wayside program is AA oriented and utilizes all available community resources including ministerial, mental health services, court services and vocational rehabilitation for their residents.

Granville House, St. Paul, is the Ramsey County halfway residence for women. All but three of the 48 residents last year were drug abusers rather than alcoholics thus the emphasis of the Granville program has changed somewhat from a strictly AA oriented treatment program. Granville is an "approved home" licensed by the City of St. Paul and the State. Their program is funded by the Community Mental Health Center, operating costs are paid by residents or welfare if they qualify for public assistance. Bush Foundation money is also utilized by Granville.

A unique feature of Granville House is its non-resident day program which has provided an on-going community program of treatment while the participant is able to live at home. The program is now undergoing review by a citizen's committee to ascertain the need for such a program. A partial purpose of the program and day care center would be to cut down on the need for additional halfway houses and hospital treatment facilities for women.

Mrs. Margaret Rudolph, director of Granville House, stated that they had about 100 "walk-ins" or referrals during the months of April, May and June of 1970. She felt that many women would never need to go to treatment facilities if they could be detoxified at St. Paul-Ramsey and then referred to the non-resident program at Granville. This would often save family relationships in addition to the dollars spent on treatment by the family and the state.

Mrs. Rudolph also pointed out that institutional treatment programs are generally conducted for and from the viewpoint

of men, thus women are unable to identify with the program. Often, she said, the Granville program must reorient the woman who has come from a state hospital through their therapy programs.

CITIZEN ACTION COUNCILS

The concept of the Citizens Action Council was instituted by Governor Harold LeVander in his 1967 Inaugural Address when he expressed the need for the development of volunteer citizen involvement to prevent and control the many problems which faced Minnesota communities. He expressed a desire at that time for a coordinated effort from both the youth and the adults of Minnesota communities to seek solutions to these problems.

The result of this was the creation of a task force entitled "Prevention through Citizens' Action" which conducted investigation of the problem areas and developed a number of alternatives to best effectuate the concept of civic involvement and action.

As a result of the task force's study, Mr. Ray Johnson and Mr. Richard Bragg, Special Assistant to the Governor on Drug Abuse, developed the framework for a Community Action Council and established three pilot programs in the state at Albert Lea, Cambridge, and Duluth. The information received from these communities helped to solve the many problems inherent in trying to develop a statewide, non-political, well-coordinated effort.

The first step in expanding this program throughout the state came in the spring of 1970 with the "Governor's Conference on Drug Abuse and Youth Environment". At this meeting, many experts and concerned knowledgeable individuals discussed the youth environment in the state with special emphasis on the abuse of drugs. A brochure, prepared by Mr. Ray Johnson, was part of the material provided to the participants in an effort to educate them in the ways of establishing a program. More specifically, this brochure indicated what a local council could do, the type of people within a community to have on the council, a listing of sample programs with concentration on drug abuse and youth service, and a brief description of persons, resources, agencies and

organizations available for direct assistance/

The Governor's conference produced requests for direct assistance from 52 communities in less than a month, and many additional communities have since that time sought the same type of aid. This aid and any other assistance comes from seven regional offices throughout the state which have been established specifically for this purpose and are staffed by at least one full time field representative. In each region this coordinator or representative will provide the following assistance or services:

1. Assist councils to assess and identify youth-adult problems through contact with families of the community, churches, schools, businesses and other organizations. Furthermore to document community needs, problems and priorities for assessment and evaluation by governmental professionals and elected officials.

2. Provide information as to the resources available to combat the existing problems. This will be accomplished primarily by the establishment of a community resource center providing available community based resources, and bringing the resources available through a proposed regional educational resource and information center to bear on the problems of local community needs. St. John's University will function as the initial outstate resource center. Southwest State and Mankato State colleges are presently designing similar centers to provide for statewide coverage.

3. Assist in the promotion and development of community seminars and educational programs directly related to the problems of drug abuse, juvenile delinquency, and other youth-adult environmental problems. These may include drug clinics, enrichment seminars and youth-adult dialogues.

4. Assist local community action councils to serve as innovators in developing applications directed at the prevention of youthful crime

and the problems affecting youth.

5. Assist the local countils in coordinating existing programs by promoting effective communication between agencies and organizations, both public and private, currently providing assistance within the community.

It is planned that eventually all 265 communities in the state with a population in excess of 1,000 will be operating an independent community action council or support such a program jointly with another nearby community.

DRUG EDUCATION IN OTHER STATES

The information in this section was obtained from other states in response to a request for recent statutes and reports on drug education programs in their state.

The first thirteen states mentioned have statutes requiring drug education. Generally, they require a study of the nature of narcotics, alcohol and other stimulants and the effect of such substances on the human body.

The remaining seven states either have legislation pending or some form of a research committee. Most of these states are presently researching drug abuse and drug education.

ARIZONA:

Public Health and Safety statute 36-142 (1958) authorizes the Commissioner of Public Health to develop alcohol and drug abuse services.

ARKANSAS:

Statute 80-1618 (1937) requires the State Board of Education to include in its physiology and hygiene courses the effects of alcohol and other narcotics. Such instruction is given from the 3rd grade through the 8th grade.

ILLINOIS:

Statute 2-10 incorporates the study of the nature and effects of narcotics into physiology and hygiene courses given from grade 3 through grade 10. It also calls for appropriate college level courses instructing teachers.

MISSISSIPPI:

House Bill No. 83 passed on January 27, 1970 requires the supervisor appointed by the State Board of Education to compile information related to alcohol, narcotics, etc., and to recommend methods of teaching as well as to furnish said information. He is also to cooperate with other state personnel in carrying out the program. The supervisor is required to make an annual report.

NEBRASKA:

School statute 79-1270 requires health education in public supported schools with reference to the effects of alcohol, narcotics, etc.

NEW JERSEY:

Statute 18A: 35-4 provides that drug and alcohol education appropriate to the 'age and understanding' of the student be taught in all schools.

NEW YORK:

Statute 804-a provides for drug education beyond Grade 8 as prescribed by the Commissioner of Education. It is required that private secondary schools shall have similar courses. No teacher shall be licensed to teach at the secondary level who has not taken and passed the appropriate college level courses in such subjects.

NORTH DAKOTA:

Statute 15-38-07 (1943) requires that hygiene be taught through all the primary grades and that it include instruction concerning the nature and effects of drugs. Statute 19-02.1-22 allows the Department of State Laboratories set up by the "Food, Drugs and Cosmetics Act" to disseminate information concerning drugs in the interest of public health.

PENNSYLVANIA:

Pennsylvania has a 1949 statute 15-1513 mandating the incorporation of the study of narcotics into courses on physiology and hygiene. There were several bills introduced into the 1969 session to make drug education more specific. Senate bill No. 45, proposed amendment to 15-1513, makes special reference to the study of L.S.D., marijuana and other narcotics. This was referred to the Rules Committee. House bill No. 1710 called for a year of study of the harmful effects of dangerous drugs in both the 7-9 and 10-12 grades. It also provides for instruction for teaching the effects of drugs on the college level. This was referred to the Education Committee. House bill No. 102 proposes that a drug study course be required for one or more years on the 10-12 grade level. House bill No. 1245 provides that the Department of Public Instruction shall have the power and duty of providing clinics, films and printed material for the study of marijuana as well as providing college level courses

regarding all habit forming drugs. This was referred to Rules. Pennsylvania also issued a comprehensive guide for instructing health courses.

RHODE ISLAND:

A statute listed under Title 16, Chapter 22-23 provides for instruction on the effects of narcotics and other stimulants within physiology and hygiene courses. Rhode Island also has a curriculum and resource guide put out by the State Department of Education entitled, "An Educational Program Dealing with Drug Abuse". It outlines, step by step, a comprehensive drug education program divided into three sections: K-3, 4-6, and 7-12. Its appendix lists an excellent selection of articles and perspectives on drug abuse. Resource materials concerning the various drugs and their effects are also included.

SOUTH CAROLINA:

Statute 2-1412.2, concerning subjects of instruction, requires that films and special instruction concerning the nature and effects of narcotics be taught in all junior high and high schools. (1969).

TENNESSEE:

In setting up the elementary school curriculum, statute 49-1901 (1932) makes a provision that instruction in hygiene shall include the nature and effects of narcotics.

TEXAS:

H.B. No. 467 passed in 1969 requires instruction on the dangers of crime and narcotics for all students from grade 5 through 12. It establishes 'The Crime and Narcotics Advisory

Commission' which has included in its duties the development of a curriculum and teaching materials. Annual instruction sessions for teachers on such subjects will be provided.

VIRGINIA:

In Virginia, drug education is integrated into health courses. In the 1970 session, two bills were passed. H.B. No. 429 created a 'Council on Drug Abuse' to collect information and to formulate plans for the prevention and control of drug addiction. The council is to incorporate federal, state, local and private agencies into its program as well as to evaluate the need for treatment and other facilities. Funds are appropriated (rehabilitative) from the general fund. The 'Amendment in the Nature of a substitute for H.B. No. 395' creates the 'Bureau of Alcohol and Drug Studies and Rehabilitation' which has among its duties the promotion of educational programs.

The following seven states, although without specific statutes relating to drug education, either have legislation pending or are involved in the research of drug education.

KENTUCKY:

Kentucky is in the process of developing a drug abuse program. It is interested in pending Federal legislation dealing with drug education. A report of the Kentucky Legislation Research Commission (Research Report #57 "Narcotics; Background to a Problem" August 1969) reviews the drug situation in Kentucky and gives a brief history on drugs and selected programs of Maryland, California, Synanon, Britain and Narcotics Anonymous. It also provides a look at the college drug situation with surveys of fifteen colleges. The report notes that historically the drug education effort has been directed at the drug user but that presently the effort should be aimed at the non-user giving him tools to evaluate, but not a 'moralizing approach.'

OKLAHOMA:

Two Resolutions have been introduced into the legislature. Senate Resolution No. 46 establishes a Committee to evaluate and research certain recommendations on drug abuse which have been made by the United States Department of Justice, the National Institute of Mental Health and other appropriate sources. Senate Concurrent Resolution No. 43 is in support of Resolution No. 46.

MAINE:

Maine has a nine member Drug Education Project Advisory Committee which issued a "Drug Education" pamphlet intended to provide a framework for the organization of drug education courses by teachers. It was emphasized that a drug education program should be concerned with all drugs, and be taught from grade K through grade 12 as part of health education courses. The report also stressed developing community interest and dealing with the moral, social and personal aspects of drug problems.

MASSACHUSETTS:

An eleven member commission was authorized by the legislature to study the abuse of drugs in Massachusetts and to recommend legislation. The existing services in Massachusetts are summarized and recommendations are made in the 1968 "Report of the Special Commission to make a Study relative to the extent of the use of harmful, injurious, and illegal drugs within the Commonwealth". Prior to the report an unimplemented and unfunded legislative mandate was made to assure drug education from grade K through 12.

SOUTH DAKOTA:

There are two Senate bills and one House bill pending. H.B. No. 693 calls for public and private instruction on the elementary and secondary school levels in the nature and effects of alcoholic drinks and drugs. S.B. No. 192 would establish the office of the Commissioner of dangerous substances control whose duties include co-ordinating and regulating educational programs concerning drug abuse. S.B. No. 193 defines dangerous substances which includes other pharmaceuticals with abused drugs.

VERMONT:

The Governor's Committee on Children and Youth appointed a subcommittee to investigate drug abuse and alcohol. The subcommittee in its report, "Drugs and Youth: Aspects of the Problem in Vermont" (Sept. 1968), supported a grade K through college program. It endorsed 'Peer teaching', the avoidance of 'scare tactics', and the spelling out of both the pros and cons of drug abuse and use as effective educational approaches.

WYOMING:

Wyoming presently has a curriculum steering committee composed of the State Department of Education, the Department of Health and local education agency personnel. It's plans include helping districts in curriculum development for drug abuse education. The Department of Education has listed tentative minimum standards for drug abuse education which, if approved, will become State Board regulations. The emphasis of the program is a cooperation between the State Department of Education, the State Department of Public Health, the State Hospital, Law enforcement agencies, the legal profession and the clergy in sensitizing teachers to the drug problem. The program would be in elementary and secondary grades with course mechanics formulated on a local level.

PROPOSED DRUG EDUCATION PROGRAMS IN MINNESOTA

During the spring of 1970 a state curriculum committee was organized to develop resource units on drug abuse education. This committee included representation from school administration, elementary and secondary teachers, teacher education, the Department of Health, the State Department of Public Welfare and the State Board of Pharmacy. There was also representation from both the medical and legal communities on this committee.

As a result of their meetings, resource units have been developed for the primary, intermediate, junior high school and senior high school levels. Each of these resource units includes suggested concepts, learning experiences and resource materials.

In each of these units there are eight major concepts to be explored with a number of subconcepts for each grade level. With each subconcept are several suggested learning experiences or classroom activities. These will vary depending on the grade level. More specifically these units contain the following types of suggested activity.

Major Concept No. 1

Maturity is the ability to deal with situations in one's life in a realistic and effective way appropriate to one's age level.

Subconcept (a) - under certain circumstances, following the crowd can be dangerous.

Primary Learning Experiences

1. Dramatize a situation in which a student is urged by his friends to take a dare such as candy from strangers. Discuss the consequences.

2. Make a booklet (a creative story and illustrations) showing the sequential order in making a decision to follow the crowd, denoting positive or negative outcomes.

3. Engage in group discussions on how to make one's own decisions, to be a good leader and a sensible follower.

Intermediate Learning Experiences

1. Role play a situation in which a person with a bottle of pills offers one of them to a younger student who resists the sale and reports the attempt to a responsible person.

2. Engage in group "buzz" sessions on how to make one's own decisions, to be a good leader and a sensible follower.

3. Discuss: Why do children sell chemicals? (Popularity or monetary gain)

4. Read and write stories that will illustrate children whose behavior indicated that they were growing up.

Junior High School Learning Experiences

1. Write a paragraph or paper on "Acting My Age." What my parents expect, what I expect, what my peers expect.

2. Role play a number of situations where peer group pressure might be detrimental. Example: A teenager goes to a party and chemicals are being used; what is the reaction of the teen being offered the chemical? Example 2: Two boys are going to steal from a store and a third boy is a very good friend of the other two. What will the reaction of all the boys be?

High School Learning Experiences

1. Select a number of the class to role play a situation in which a teenager is invited to a party, and while at the party friends try to persuade him to take a particular chemical. Promote class discussion of problems that would be faced by any student who might find himself in a similar situation.

2. Write a paper on "What is Maturity?"

3. Show the film "What Time is it Now?" and discuss such things as conformity and peer group pressure.

These resource units which have recently been completed are to be field tested during the 1970-1971 school year by schools that request them. Information concerning their availability has been sent to all school districts in the state and those interested in the drug abuse problem are being urged to implement this program this coming school year. The reaction received from those schools which do utilize these resource units will be used in revising the program the following year to more effectively relate to the students and their needs.

DRUG ABUSE EDUCATION ACT OF 1969

H.R. 14252, known as the Drug Abuse Education Act of 1969, has passed the House and is in the Senate Committee on Labor and Public Welfare. If enacted into law, this bill would authorize the Secretary of Health, Education, and Welfare to make grants to those agencies or institutions which conduct special educational programs and activities concerning the use of drugs.

It is declared in this bill that drug abuse diminishes the strength and vitality of the people of this country; that such abuse of dangerous drugs is increasing in urban and suburban areas, that there is a lack of authoritative information and creative projects designed to educate students and others about drugs and their abuse; and that prevention and control of such drug abuse require intensive and coordinated efforts on the part of both governmental and private groups.

The purpose of this proposed act is to encourage the development of new and improved curricula on the problems of drug abuse, to demonstrate the use of such curricula in model educational programs and also to evaluate the effectiveness of those programs. It is the further intent of this act to disseminate curriculae materials for use in various educational programs, to provide training for teachers, counselors, law enforcement personnel and other public service and community leaders, and to offer community education programs for parents and others, on drug abuse problems.

If enacted, the sums provided by this bill will be used

to educate the public on the problems of drug abuse by making grants to or entering into contracts with institutions of higher education and other public or private agencies, institutions, or organizations for such things as curricula development, pilot projects, and distribution of the developed materials.

Funds will also be available to provide preservice and inservice training programs for teachers and to provide community education programs on drug abuse for parents and other concerned parties.

This bill also provides for the establishment of an Interagency Coordinating Council on Drug Abuse Education which will consist of the Attorney General, the Commissioner of Education, the Director of the National Institute of Mental Health and representatives of such departments and agencies as the Secretary of Health, Education and Welfare may designate. It would be their responsibility to review all applications for funds and to make recommendations on the merits of the proposed program.

It is also provided that the Secretary of Health, Education and Welfare shall appoint an advisory committee on drug abuse education. This committee would have the responsibility of advising the Secretary of Health Education and Welfare on matters of administration and program operation, make recommendations regarding allocation of funds, review applications, and evaluate programs and projects carried out under the act. The membership of this committee would consist of persons familiar with education, mental health, and the legal problems

which are associated with drug abuse and young people.

This bill has received considerable support from both the liberal and conservative elements of the Congress. It appears, however, that its failure to move through the Senate as quickly as it did through the House may be attributed to several factors. These factors were expressed by Rep. Gross of Iowa when he was reported in the Congressional Quarterly as saying "I intend to vote for this bill but I have serious misgivings about it. In the first place, I think it is overly funded for a trial run ($7 million - 1970, $10 million - 1971, $12 million - 1972). I do not like the advisory board, the creation of a brand new advisory board, in the government . . .I am sick and tired of building up a bureaucracy that fails to produce results . . . unless it shows real results, I will have no hesitancy in cutting down the appropriation or abolishing the program altogether."

From the debates reported in the Congressional Record it appears that this expresses the sentiments of many. They will vote for passage but are skeptical about the institution and administration of a new program and in many cases question the effectivness of an educational program in combating drug abuse.

DRUG EDUCATION PILOT PROJECTS

The State of Minnesota recently received a $60,000 grant from the U.S. Office of Education for drug education. This money has been given to the Duluth, Stillwater, and Willmar school districts for the establishment of a demonstration drug education program in those cities.

This demonstration program will involve in-depth in-service training for teachers and curriculum development in the schools. Since this is to be a community wide program, the project will also include parent education, a youth referral system such as "YES" in Minneapolis or "Smarteen" in Stillwater, and also a community involvement aspect.

The direction of these projects will come from a 16 member advisory board selected by the superintendent of schools. These boards will consist of four educators, four students, four parents, and four from the community at large.

It is hoped that the 3 pilot projects will develop programs that can eventually be used by all interested communities or groups in the state and that they will work with the local community action councils to develop a community wide concern for, and action against, the abuse of drugs.

EXISTING DRUG TREATMENT PROGRAMS IN MINNESOTA

Institutional

Drug treatment programs in Minnesota are few in number and limited primarily to opiate and dangerous drug users.

Although all state hospitals ostensibly receive and treat drug abusers in their inebriate units, only Willmar at present has an actual drug treatment program established. St. Peter opened a drug treatment program in August in which drug abusers are patients in the psychiatric units. No data is available to date on their efforts.

The other hospitals either refer to Willmar or receive combination alcoholism and barbiturate abusers who are treated for their alcoholism, and only incidentally for the drug abuse. Testimony given before the subcommittee indicated that only 1 - 3% of patients in alcoholism units were drug abusers, although all representatives of alcohol treatment facilities expected that figure to increase in the future.

Willmar State Hospital according to M.S. 254 is the state hospital for certain drug abusers. M.S. 254.09 provides for the compulsory treatment of habitual users of narcotics. Willmar is generally designated as the only state hospital with a formal narcotics treatment program.

Willmar has a separate cottage for alcoholics and drug abusers in which all inebriate activities are centered. The drug abusers are given the same lectures, AA oriented treatment and work therapy as the alcoholic with two exceptions. They have their own group therapy session with a counselor who is

a former drug abuser, and the average length of the program is six months as opposed to 60 days for the alcoholic.

Willmar has applied to the Legislative Building Commission for funds to develop a secure cottage which could house 30 - 50 drug abusers, primarily opiate addicts or drop-outs from methadone programs, or dangerous drug dependents who have behavioral problems. This would provide all necessary facilities in one unit. A one page description of their proposed unit was presented to the subcommittee and is attached. In addition to the facility, they would like an expansion of physical education, recreational facilities and staff, crafts, and industrial counseling facilities and programs for the longer term stay for drug abusers.

The Willmar alcohol treatment administration as a whole is unwilling to receive voluntarily committed drug abuse patients because it is an "open hospital" setting. It is thus difficult to keep patients at the hospital and drug free during the first stages of treatment. The open setting is one reason some courts will not commit drug patients to Willmar, however, patients do come on the basis of probation to obtain treatment rather than face charges. One-third of their patients are voluntary admittees.

Upon admittance patients are placed in a withdrawal unit for a period of 2 - 4 weeks. Methadone is used to assist withdrawal of opiate addicts. During this period personal, social and addictive histories are taken, a medical and psychological examination given, and the patient is assigned to a counselor and therapy group which meets 2 - 3 times weekly. He also

attends the lectures provided in alcoholic treatment every morning and three evenings a week. Patients are assigned to work therapy and some recreation is provided.

One major problem is that the Willmar treatment program has been for the 60 day alcoholism program. They do not feel they have the staff, facilitis for industry or recreational therapy to keep drug abusers busy and employed during the six months stay.

Drug treatment follow-up is limited due to lack of facilities and time. The hospital uses existing community resources such as DVR, probation departments, etc. The patient panel which appeared before the subcommittee stressed the need for follow-up care and halfway houses, preferably run by or staffed with former drug abusers. Individuals apparently find it difficult to readjust to society after a period of institutional treatment, and most find it difficult to readjust after being on drugs.

A suggested solution in addition to a halfway house was a drug treatment facility near the Twin Citites which could utilize the Huber Law. A disadvantage to this location, however, is the need for a separate relatively unaccessible environment during the early stages of drug treatment.

Few minority individuals come to Willmar for treatment of drug abuse. The feeling seems to be that only those patients with individuals or groups interested in them are sent for treatment. Either little outside interest or lack of knowledge concerning referral sources on the part of minorities is a partial reason for the low numbers of minority patients. A

program had been arranged with The Way, a black neighborhood group in Minneapolis, but was unsuccessful. It might also be noted that law enforcement statistics show a greater number of Caucasians arrested on drug charges.

St. Peter State Hospital opened its alcoholism and drug program on August 18, 1970. The alcoholism facility is in a separate unit. The drug abusers will be placed in psychiatric wards and will undergo the same social rehabilitation treatment programs as the mentally ill patients. This treatment includes resocialization through a number of programs such as token economy, rehabilitation therapy, group and individual psychotherapy and medication.

Dr. Arthur Funke of the Department of Public Welfare under whose office the alcoholism and drug abuse programs are situated expressed concern that drug abusers might be "lost in the treatment program."

St. Paul-Ramsey Hospital's drug program is similar to the alcoholism program and process described earlier. Of admittees, 21% of the men are dependent on both drugs and alcohol, and 4% drugs only, as opposed to 76% alcoholism. The percentage of women abusing both drugs and alcohol is higher - 50%, 8% were dependent on drugs, and 42% alcohol only.

Dr. James Kincannon, consulting psychologist in St. Paul-Ramsey's drug dependency unit, felt that hospitalization is not always necessary in the treatment of non-narcotic and hallucinogen users, although hospitalization might be necessary for the underlying causes of drug use. He strongly emphasized the need for out-patient treatment.

PROPOSED NARCOTIC TREATMENT PROGRAM — DRAFT III

TYPE OF PATIENT	TREATMENT NEEDS	FACILITY	STAFF
1. Narcotic addicts (Methadon dropouts). 2. Other drug dependent with behavioral problems.	24 hour per day planned activity. SECURITY: Either on ward or with "guards" off ward. Physical education. Recreation. Library. Crafts. Group meetings g.o.d. Industrial counseling. Intensive individual counseling - heavy concentration!! Food service on ward or assigned area in cafe with supervision. OPEN: Continuation of above -- possibly many on Methadon maintenance. Planned Industrial-Work habit therapy. Highly individualized program. Planned post-hospital follow-up with Training, education, and close supervision to meet individual needs. Contact to be made with Hennepin County, Ramsey County, State and Federal agencies. Special laboratory procedures, i.e. urinalysis (use of Federal Testing Program???).	30-50 beds??? SECURITY: ½ floor maximum. ½ floor open. (Methadon) Offices: Counselor Social Worker Interview Room. Group Room. Day Room. Craft Room.	20 Technicians 1 Counselor 1 Social Worker 1 Rehab (½ day) 1 R.N. Psychological evaluation. Psychiatric consultation. Chaplain Assignment from corrections??? Attendant Guard???

HALFWAY HOUSES FOR DRUG ABUSERS

Present

There are no halfway houses for drug abusers in Minnesota.

Granville House finds that an increasing number of its residents are drub abusers, as are many of those in the non-resident program. The Granville House program is described elsewhere.

Proposed

A halfway house has been proposed for the north Minneapolis area by Head Foundation, Inc., an outgrowth of the Pilot City Methadone Maintenance program and a drug education and prevention organization. They have applied to the Governor's Crime Commission for funding of a Re-entry House. The purpose of the Re-entry House would be twofold: 1) to serve individuals in a drug-free rehabilitation program, and 2) to work with individuals - youths, primarily - who are experimenting with drugs but are not yet physically or psychologically dependent. It might also serve as a resource for treatment for individuals needing emergency care.

They have an estimated yearly cost of $_____ to maintain Re-entry House including staff and operating expenses. A copy of the proposed budget and application to the Governor's Crime Commission for the house is attached.

Hennepin County has passed a resolution approving of the education and prevention section of the Re-entry program and indicated it will administer the funds as required by federal regulations. Head Foundation is attempting to raise additional funds through use of their speakers bureau and private donations. for three of the four sections of the total program.

Other State's Programs

Halfway Houses for drug abusers have been established in other states. Most follow the treatment program and funding methods described below for Phoenix Houses in New York. Additional information is available in the House Research Department.

Phoenix Houses

New York's narcotic treatment program is one of the most extensive in the country. In addition to several privately funded programs and the state program, New York City operates its own drug program under the city Addiction Services Agency which operates 70 facilities for rehabilitation and prevention of drug abuse.

The 70 facilities consist of a chain of residential treatment Phoenix Houses and Phoenix Re-entry Houses. The first Phoenix House opened in May, 1967, and since that time has grown to a complex of 20 houses serving 1,000 addicts. The largest population is at Hart Island where five houses serve 325 residents. Hart Island is a former work house and reformatory for misdemeants. The addicts stay in a Phoenix House for an average of 2 to 2 1/2 years, then "graduate" to a re-entry program for vocational training and final resocialization during which he lives out and attends day or evening meetings.

Phoenix House facilities are open to heroin addicts, dangerous drugs and hallucinogen abusers. Those admitted must be legally and physically able to participate in treatment and exibit the motivation needed for an open-door self-help approach to treatment. Phoenix Houses are generally situated in high-drug use neighborhoods. For this reason, new residents

are not allowed visitors or permitted to leave the residence alone for at least two months. To check for drug use in residents, a weekly urine test is given to residents selected on a random basis.

Each Phoenix House has three paid staff members: one director, and one man and one woman assistant director. All are former drug abusers, alcoholics or were mentally ill. Many have come through the program or a similar one such as Synanon. In addition to the paid staff, each house has two coordinators and seven department heads who are house residents who have progressed in treatment to positions of responsibility. Use of former addicts as counselors and directors gives incoming residents a role model to follow and incentive to stay in treatment.

Each Phoenix House has 70 - 80 residents, of whom 20 - 30% are women. Residents have been drug users for an average of 10 years. The mean age is 27, but ranges from 10 - 73. Most have arrest records. Few have been educated beyond the 11th grade and 90% of the women and 53% of the men have no regular occupation.

The Phoenix House budget for 1969/70 and 1970/71 is $3.5 million. Phoenix receives funds from the Addiction Services Agency (ASA) of the City of New York, the Narcotic Addiction Control Commission (NACC) of New York, contributed welfare grants of residents who are on welfare and donated funds, goods and services from the community. ASA pays salaries of most of the staff, NACC pays for the Hart Island program, and the welfare grants and contributions for the maintenance of residents. Private donations and contributions of goods and services provide

1/3 of the income for Phoenix Houses; city, state and federal funds are 1/3 and resident's welfare grants the remaining 1/3. ASA estimates cost of treating an addict at approximately $10.50 per day, and total cost to treat and rehabilitate to the point of reentering society at slightly less than $10,000 per individual.

In three years, Phoenix has graduated 79 addicts, all but two have remained drug free. Of the 77, 59 are working in a Phoenix or similar program. There have been a total of 2,110 admissions, of which 1,113 left before treatment was finished. This drop-out ratio is average for a drug treatment facility.

There are a number of similar treatment programs and residential facilities in New York and around the country. All operate on essentially the same principles of treatment over a 2 - 3 year period for those who are accepted, and vary only in techniques as, for example, encounter v. classical group therapy.

METHADONE

Description

Methadone is a synthetic opiate analgesic having similar actions as morphine. The drug was synthesized by German chemists and available after World War II. It is used in treatment of heroin or morphine withdrawal symptoms and in maintenance therapy with addicts. It is nearly as effective in oral doses as in injections. Ten to 20 mg in a drug free person will create a euphoric effect which can cause psychological dependence.

Physical dependence upon methadone occurs after continuous administration with withdrawal symptoms less severe than those of opiate dependence but longer lasting. A narcotic antagonist such as Nalline will induce more severe withdrawal symptoms in a methadone addict than simple gradual withdrawal of the drug.

Tolerance will develop through continued usage. Because methadone is effective orally, it is given in this form in maintenance therapy to wean the patient from heroin by substituting another addiction under medical supervision. Addicts report once daily, less often at later stages in treatment, for a dose of 100 to 180 mg. In massive doses a tolerance to all opiate drugs is built up in the addict for a 24 hour period. This is referred to as the "blocade effect." Because heroin will not have any effect on the addict, after he ingests methadone, he ostensibly has no motive to continue using it. After the addict has been heroin-free for a period and resocialized, he theoretically can be withdrawn from methadone.

Methadone can be used only for opiate addiction.

Advantages and Disadvantages

Critics of the methadone maintenance therapy treatment put forth the following arguments:

1. Addicts probably can never be withdrawn from methadone.
2. Some addicts have reported side difficulties or the feeling of being in a drugged state.
3. Advocates of the psycho-group therapy system such as Synanon say that methadone therapy does not affect the roots of the addicts problems and thus he has no chance to adjust and become totally drug free.
4. Individuals on methadone programs are highly motivated and the "cream of the crop" and would succeed in any drug treatment program.

Defenders of methadone point out:

1. Methadone is a chemical therapy which breaks the drug circle by substituting a legal and controlled addition in a clinical or outpatient setting.
2. It provides the addict with a chance for rehabilitation and enables him to hold a job and function in society.
3. Methadone costs less than 10¢ per dose, far less expensive than cost per individual in a correction institution or in theft losses, etc.

Similar Drugs

Dolophine, a similar synthetic opiate developed by the Germans is available on the street and is sometimes used by an addict to break his habit. Another type of maintenance therapy being tested is based on cyclazocine, a narcotic antagonist which can be administered orally or by injection and reduces psychological

and physiological effects of opiates. It will precipitate withdrawal symptoms in opiate addicts, then in maintenance doses, creates the blockade effect against heroin. This drug is said to be subjectively pleasant, thus patients are motivated to continue in treatment. Physical dependence develops, but the withdrawal symptoms are milder than heroin and the patient does not crave cyclazocine after withdrawal.

Until 1963, the only means of treating heroin addicts was detoxification and psychotherapy at the federal narcotics hospitals in Forth Worth and Lexington. Treatment success was about 2%.

In 1963 Dr. Marie Nyswander, a psychiatrist from the Lexington Hospital, and Dr. Vincent Dole, a physician specializing in metabolic research, began research at Rockefeller University to find another solution for the numbers of heroin addicts who needed treatment. After working with two volunteers, they initiated a methadone maintenance program at Beth Israel Hospital in New York which seemed almost immediately to be more successful than any other treatment to that time. The most recent evaluation of the program involved 2,862 patients and determined that the program was a success and should be continued and expanded.

Present Status

The federal government recently recognized the validity of methadone as a treatment for opiate addiction, however, the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs placed certain restrictions on those in methadone maintenance and called for further research in the area.

Notice to conduct a methadone maintenance program must be filed with the FDA giving the name and address of sponsor, description of drug, resume' of individual(s) responsible for the program, a description of the facilities to be used, and a statement of treatment protocol. The FDA and BNDD now permits municipalities and organizations in addition to physicians to utilize methadone if adequate controls over use are provided. Previous to the new regulation issued in June, 1970, only physicians were utilizing methadone in a treatment program.

Among restrictions on use imposed in the treatment protocol are that persons under 18, pregnant women, and persons with a psychosis or serious physical disease are prohibited from participating in a methadone maintenance program.

Minnesota Programs

Three methadone maintenance programs are presently being conducted in Minneapolis, one of which is private and two are federally funded through inner-city programs. Dr. Maslansky has 30 patients in private practice and is no longer taking methadone treatment patients. The Model Cities program at Mt. Sinai presently has 70 patients in methadone maintenance under the care of Dr. Maslansky. The Pilot City methadone maintenance permit is chrged to Dr. Graham Beaumont; they are presently treating 80 plus individuals. A fourth program will be conducted by the St. Paul OIC upon receipt of a LEAA grant.

Copies of the FDA/BNDD prescribed protocol and that of OIC and Mt. Sinai are on file in House Research. With the exception of Pilot City where approximately 20% of the patients

are under 21, all stipulate an age limit of over 21.

The goals of the three programs were summed up by OIC in its application for funding:

1. Reduction of welfare recipients or criminal convictions.
2. Increase in gainful employment and education.
3. Emotional maturity and meaningful reinvolvement in family and community.
4. Eventual detoxification from methadone.

POLICE STATISTICS

Data provided by the Minneapolis and St. Paul Police Departments and the Criminal Apprehension Bureau indicate an ever-increasing number of drug charges. Law enforcement agencies in the metropolitan areas as well as statewide have established special drug units or provided special narcotics training for members of the police departments or sheriffs' offices.

Statistics supplied by the Minneapolis narcotics squad, which handles adults only, indicate an increase in specific drug charges from 216 in 1967, 418 in 1968 and 681 in 1969. At the end of the six-month period ending June 30, 387 adult drug arrests and 121 juvenile arrests on drug charges had been made in Minneapolis. The St. Paul Police Department has a four-man narcotics squad which was organized in 1968. St. Paul drug arrest figures rose from 59 in 1968, to 187 for 1969, and 67 adults and 60 juveniles for the first six months of 1970.

BCA figures from sheriffs' offices are compiled at year-end only; thus the 1970 figures will not be available until March or April of 1971. Their figures show statewide drug and narcotic arrests totaling 662 in 1968 and 1,196 in 1969, an increase of 80.7%.

The above figures indicate arrests and charges only. Booking figures including those arrested for other offenses but with drugs in possession show a quite different picture. For example, arrest sheets for January, 1970 for the City of Minneapolis show 77 individuals brought in on drug or related charges. Thus the arrest figures cited by representatives of the Minneapolis

and St. Paul Police Departments in giving testimony would show only a portion of drug offenses, and would not provide an accurate picture of drug use in the Twin Cities or statewide.

The CAB reported that the 1969 arrest total of 1,196 represented an increase of 80.7% over 1968 (662 arrests) and a 404.6% arrest increase over 1967. The narcotics violations were specified in the following table:

	1969	1968	1967
Opium or cocaine and derivatives	39	53	33
Marijuana	381	252	62
Synthetic narcotics/manufactured narc.	145	42	18
Dangerous non-narcotic drugs	377	120	33
Narcotic not specified (Mpls juveniles)	254	195	91
Total	1196	662	237

Characteristics

The narcotics arrests in 1969 were for 968 males and 228 females. Ethnic origins of those arrested showed 1,086 caucasian, 64 Negro, 41 Indian, and 5 other. Persons of younger age groups comprise the greatest portion of the arrests with those 17 and younger totaling 561 or 46.9%. Another 344 were between the ages of 18 and 21.

Of the 1,196 arrests in 1969, 330 were taken into district court. The other cases were handled in juvenile or municipal court, dismissed or disposed of in some other manner. Of the 330 defendants arrested and charged in district court, 42 were

dismissed and 10 acquitted by juries, a total of 15.7% who were not convicted. Of the remaining 278, 80.6% were placed on probation or gived a stayed or suspended sentence. Seven were committed to an institution, three to the reformatory, and four to the prison. Six fines were imposed.

Disposition of Cases

Sentence	Number	
Prison or reformatory	7	
YCC	14	
Stayed sentence	175	62.2%
Suspended sentence	1	
Probation	50	18.0%
Jail	3	
Workhouse	24	
Fine	6	

Crime Lab Activities

The State Crime Lab of the CAB is authorized to conduct tests and give technical assistance to out-state law enforcement agencies in narcotics and drug testing as well as other crimes. During F.Y. 1970 the lab conducted examinations on 1,101 cases involving questionable drug or narcotics materials, an increase of 119.8% over the previous fiscal year. Of these 1,101 cases, 775 were actual drug or narcotics materials.

Of the 775, 195 were for sheriffs' offices and 580 for police departments, highway patrol, probation officers, county attorneys, and a variety of state and federal offices as well as the University of Minnesota; 72 counties were involved.

Estimated drug use in school age individuals

A number of schools have conducted surveys within their

institutions to determine the extent of drug usage. School administrators generally indicate usage at approximately 3-10% of students, but not including experimental marijuana use. The students generally estimate drug use at approximately 75%, including experimental pot smoking. A number of schools have established school liaison officers, generally juvenile officers who spend part or all of their time at junior and senior high schools. Conversations with some of these officers indicate that drug use of high school students is probably in the 35-50% bracket. Drug use in this instance would include smoking marijuana 2-5 times or more. This estimate of drug usage seemed to hold true across the state, with the higher rate being in the Twin City area.

HEAD FOUNDATION

The Head Foundation (Health Education About Drugs) is a Minneapolis based non-profit organization which was established as a unique approach to drug education.

This organization takes former drug addicts who are willing to tell the story of their addiction, and trains them to effectively present the facts to fit the particular audiences. Programs have been developed for schools, churches, and other community groups and will vary according to the age group involved.

The Head Foundation is also involved in activities other than providing speakers and group discussion leaders. They are in the process of gathering existing materials on the use and abuse of drugs and are also publishing their own materials to distribute to interested parties. Research programs are also being conducted to help determine the evidences of drug exposure and use in elementary, junior high, high school and college and an attempt is being made to evaluate the existing prevention and treatment programs.

The programs carried out by the Head Foundation are done so without any guaranteed funding. Their income is derived from private donations and the fees charged for program presentations. These fees range from $50 for a 1 hour presentation of a former drug addict to $400 per day for a program which includes a former addict, a psychopharmacologist, law enforcement personnel and a drug counselor.

PHARM HOUSE

Pharm House was founded by Johnson Institute of St. Louis Park as a response to a need for a location to treat or "talk down" drug abusing youth. Johnson Institute hopes to develop an innovative program which would be more effective and considerably less expensive than present treatment programs. They initiated a three-phase program, and are in the middle of the second phase.

Phase 1 included getting established in the West Bank community and doing research into the kinds of drugs being abused. During this phase, they opened a walk-in center at 1607 5th Street South and started a flying squad which served the purpose of crisis intervention. They have made arrangements with two local hospitals for emergency medical treatment and have obtained volunteer services of two physicians.

Phase 2 includes a Free University course on drug abuse, training of 30 volunteers in group leadership and counseling techniques who will staff Pharm House and can lead group and "rap" sessions, in addition to continuing the activities of Phase 1.

The Pharm House has applied to the Governor's Crime Commission for funds to implement Phase 3, which will consist of an in-patient treatment program lasting two months for 10-12 persons, who will then graduate to a four-month intensive out-patient program designed to handle up to 40 individuals. Treatment will consist of a combination of encounter groups and didactic seminars.

They anticipate treating a total of 192 patients yearly at a cost of under $500 each. The Phoenix House and similar programs cost approximately $10,000 per individual over a 2½ to 3 year

period, or approximately $3,000+ yearly. Pharm House has requested $38,000 Omnibus Crime Control bill funds for the first year. Johnson Institute anticipates paying salaries and operating expenses in the amount of $52,380 for the year, for a total operating and programing budget of $91,180.

Research initiated in Phase 1 will be carried through Phase 3. Johnson Institute hopes to compile statistical data on drug users as well as additional information concerning:

"1. What are the pre-drug characteristics, if any?
2. What are the emotional and psychological needs drugs promise to meet?
3. What is the nature and degree of physical and emotional deterioration?
4. What are the social limitations and effects on education, employment, family relationships and civic responsibilities" of drug use?

Taken from the grant application.

POONEIL CORNERS

In November of 1969, a group of Macalaster College students and faculty members organized for the express purpose of providing informal counseling and advice to students with relatively minor problems and to act as a link between students with more serious problems and those professional people and organizations that would be equipped to deal with those difficulties. These community resources were to include doctors, lawyers, psychologists, and various clinics and agencies in the twin city area.

Since its inception, the scope of the organization has broadened to serve the entire St. Paul area and headquarters have been established in a house provided by the Wilder Foundation. It is this house and the organization which bears the name Pooneil Corner - which was taken from a song recently popular among students.

The original founders of Pooneil Corner became involved in this type of a program through their concern for people who had such problems as lonliness, depression, drugs, suicide, family, jobs, and unwanted pregnancy. They felt there was a lack of resources or communication with resources that could handle problems of this nature. The calls that they do receive are quite varied in subject matter, yet indicate that their original concern was well founded and their services are used by many including adults as well as students.

At the present time there are approximately 75 students and professors who are involved in what they describe as "crises

intervention" work. Its basic premise is . . . people turning to one another in times of stress. It is the contention of those involved in this program, and the theory of crises intervention, that other people, through careful listening, empathizing and offering new perceptions of a problem can help a person in crises to discover new ways of comping with his problem.

Each of the volunteer workers at Pooneil Corner goes through a training period of 30 or 40 hours before he actually begins work on the telephones. Most of this training is done through small groups led by the more experienced members. In these groups, the volunteers attempt to develop their ability to listen, to be aware of other people's feelings and also to be able to express their own feelings as well. In addition to this the volunteers, realizing that in many cases the caller will need professional help, learn to refer him to one of the many professionals who have volunteered to assist in this program.

Although most of Pooneil Corners' workers are students and instructors from Macalester, the group has no official connection with the college. They are presently engaged in recruiting volunteers from throughout the community for not only phone work, but also for fund raising, public relations work and resource gathering.

In measuring the impact of this organization it should be noted that they have been averaging nearly 400 calls per month. This figure fluctuates with the amount of advertising and public relations work that is done and for this reason the organization intends to greatly increase their radio and newspaper advertisements and school bill boards circulation.

Future plans also call for the expansion of their facilities to include a walk-in counseling center, and eventually the development of a library.

SMART SET INTERNATIONAL

Smart Set International is a non profit organization established with the intention of making abstention from drugs attractive to young people. There is no charge made to those who wish to join; what is required for membership is the signing of a pledge not to use marijuana, drugs or narcotics and also the promise to help other young people to do the same.

Based on the premise that most young adults do not want to use drugs or narcotics, but are impelled to join the crowd because of peer pressure, this organization has developed several different approaches to combat this problem. First of all it ridicules the judgment and intelligence of the user and instead of a non-user being defensive and embarrassed by the charge of "chicken" he substitutes with a countercharge of "stupidity" directed at the drug user.

The organization also provides and distributes posters, decals, bumper stickers, membership pins, radio tapes, films, pamphlets and a youth oriented monthly newspaper. In addition to these materials, the organization and its local chapters provides speakers for educational, professional, civic and service groups, school assemblies and other special interest groups.

It appears that this attack on the stupidity of using drugs is an effective tool in keeping many youths from using or experimenting with drugs who might otherwise succumb to peer pressure. Its success has been evidenced by formal endorsement by many states and the establishment of numerous

local chapters.

In Washington County, local chapters have been organized through the encouragement and efforts of Judge John I. McDonough and others. The program is now operating in all three school districts in that county - they are Stillwater, Cottage Grove, and Forest Lake.

The experience in Washington County with this program has been very successful in the junior high schools with an estimated 90% student participation but has reportedly met with little success to date on the senior high school level. This situation can be attributed perhaps to a general dislike of organized activities in the later stages of secondary school, and also the the types of activities sponsored by the local groups. Poster painting contests and group participation activities seem to appeal more to the younger students than to those older and more sophisticated.

YES

The Youth Emergency Service (YES) is a Minneapolis based organization which provides the same type of services as Pooneil Corners, those being telephone counseling and professional referral.

YES has been in operation longer than Pooneil has and receives an average of 50 calls per day. The nature of these calls is essentially the same as those received at Pooneil and the method of handling them is also the same - talking to the caller about his concern or if the nature of the problem requires it, referring him to one of the nearly 300 professional agencies, institutions or individuals which have volunteered their services.

Unlike Pooneil, YES has 3 paid employees who handle the training of some 100 volunteers and the administration of the office. They, along with some of the volunteers, also speak to various civic, church, and school organizations which are interested in their experiences with young people and their problems.