A County Health Department's Role in Drug Programs

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In recent years, as the terrible reality of high and unexpected drug abuse prevalence has confronted communities nationwide, drug control programs have correspondingly proliferated in kind and number. It is as if the agony and frustration of parents, teachers, and the community at large were seeking some way to express their concern. Although some areas and some groups "tune out" and will not admit that they have a drug problem, for the most part there is recognition of the problem and a zealous effort to produce one or more drug control programs.

Problems and Analysis

Unfortunately, good intentions and enthusiasm do not necessarily generate effective drug control programs. The subject is complex, and the following are only a few of the difficulties.

- Lack of reliable data on the nature and extent of the drug problem, although there have been recent positive developments in this area (*1*).
- Confusion in describing drug consumption among experimenters, occasional users, and "potheads" (regular users).
- Differences in sociological milieu, resources, and drug use patterns.
- Conflicts and incomplete understanding on the part of drug control groups.
- Erratic organization, fragmentation, and general lack of coordination of facilities.
- Excessive use of untrained and unexposed, but generally well-meaning, volunteers to man telephone lines, meet at all hours with students who have drug problems, and so on.
- Lack of adequate funding.
- Overlapping and uncertainty of objectives among educational (or preventive) and therapeutic regimens.

Treatment programs for drug abusers fall into three general categories, by analytic typology. Although there are differences in degree and kind within each group, their similarities are great enough to permit the following class descriptions.

Drop-in centers. Usually, the drop-in centers are information and referral stations for transient patients. They are staffed by volunteers, they have no screening or treatment plan, they are poorly organized, and they are funded by voluntary contributions. The attitude reflected by these centers is positive. Although they are supportive, they usually are not effective.

Mental health or psychiatric clinics. These clinics often represent an attempt to blend traditional psychiatric thinking with new mental health concepts. They usually are located in hospital outpatient departments and staffed mostly by professionals such as social workers and psychiatrists. Screening mechanisms and treatment plans often are confused, and patients may be shuttled between individual therapists and groups. The important determinant is the attitude of the chief of the department of psychiatry and of the medical staff toward the perceived mental health needs of the community. The clinics are well supported financially, as a rule. The attitude toward addicts and treatment, degree of community acceptability, and effectiveness are uncertain and variable.

Methadone maintenance programs. These are well-organized program complexes—good referral systems, screening methods, and treatment plans. The programs are staffed by trained, interested professionals and community paraprofessionals. They have a stable patient population, a positive attitude, and they are highly acceptable. The programs are well funded, although in-kind matching of funds may be required. All data since the early Dole-Nyswander report in 1965 (*2*) indicate high effectiveness.

Oakland County

Oakland County, Mich., directly north of Detroit, is about 30 miles square and measures 907.9 square miles. It is a metropolitan county with urban, suburban, and rural features. During the past two decades the total population has grown rapidly as a result primarily of in-migration of new residents, especially from Detroit. In 1970 the population reached 907,871, an increase of 31.5 percent over the 1960 figure. Because of this rapid growth, an unplanned sprawl pervades the county—office buildings, low-story apartment houses, shopping centers, small private homes, large estates, lakeside cottages, and dilapidated rural cabins.

The county has three cities with 70,000 or more residents (Pontiac, Southfield, and Royal Oak) and 18 rural undeveloped townships. Public transportation is inadequate. The roads are mostly north-south and congested, and the rural areas are poorly served.

Almost all of the county's black population, which has fallen from 3.5 to 3.1 percent over the past decade, lives in the city of Pontiac or the township of Royal Oak.

While all age groups in the county experienced some growth during the past decade, the 15- to 20-year old group expanded by 50 percent to number 10.2 percent of the total population. The economic level is high; the median family income of $7,576 in 1960 was the highest in the State. Other indicators of affluence are the high and increasing levels of education and the gradual shift in the population to relatively large numbers of white collar and professional employees.

There is little factual information about the prevalence of drug abuse in the county. Most of the available data are derived from unpublished studies of high school groups and such inferential measures as the high crime rates in Pontiac. However, there are substantial indications that considerable drug addiction (heroin) exists in the two congested, largely black, areas in the county and widespread drug abuse (amphetamines, hallucinogens, and others) among young, particularly affluent groups. Since no societal solutions to drug abuse appear imminent, the problem can only intensify as increasing numbers of newcomers, poor and affluent alike, move to the county and add their problems to the existing diversity and complexity of lifestyles.

The county is governed by a board of commissioners consisting of 27 members elected from each of the districts. In addition to the traditional board of health, the health department is responsible to a seven-man health committee of the board of commissioners. Thus, proposals or resolutions which originate in the health department (or board of health), or health-related countywide projects from any source, must be presented to the health committee for approval before they are submitted to the full county board of supervisors. The existence of this county committee is sometimes viewed as an added potential for delay, confusion, or intrusion of partisan or political interests into health affairs.

Drug Control in the County

In light of the foregoing, it is not surprising that drug control programs in Oakland County are fragmented, with many gaps and some overlaps. Moreover, there has been no perceived concern for public health roles or interest in health services. With respect to interest in services, the experience of Detroit and other cities is curiously different, because the health department was expected at the outset to perform valuable functions.

Public health nurses are introduced to the drug scene

Public health nurse Barbara Bates, R.N., reports for work at the Pontiac Methadone Maintenance Clinic

The language of the Detroit program is quite clear, as stated in an early 1970 paper, "An Out-Patient Methadone Program for the Treatment of the Heroin Addict," by Dr. H. R. Henderson, medical director of the Harper Hospital Methadone Clinic in Detroit: "There should, however, be one central coordinating agency which will handle medication, urine analysis, and addict population control. Hopefully, this central coordinating agency will be under the auspices of the Detroit Health Department."

In 1969 the board of commissioners of Oakland County appointed a committee to study drug abuse. The committee's recommendations for a countywide program resulted in 1970 (*3*) in the formation of a department of drug abuse control, which is responsible to the board of auditors and in turn to the health committee and the board of commissioners.

The new department has plans for a central treatment facility with community satellite centers, educational programs based on school districts, and methadone maintenance programs. The program prospectus emphasizes the use of matching funds by local municipalities (the public share is 70 to 80 percent for various programs), strict public accountability, and community involvement. The underlying thinking is that the drug abuse problem is monstrously large and can be effectively confronted only by an agency which has no other responsibility. However, the only shared function indicated for the county health department is a provision for health supervisory services necessary for the facility activities. At present no central treatment facility or community satellite center exists. A number of local and school programs have been funded by the county agency and are either operating or in the planning stages.

While the plans were being formulated and a few programs were started, a strange situation developed. Our public health personnel, excluded from any role in official drug abuse programs, were being requested increasingly to attend local drug abuse meetings and to devote time and services to unofficial programs. Administrators and public health nurses in particular were asked to participate as resource persons in "hot-line" activities, drop-in centers, common ground centers, awareness clinics, and similar facilities. Encouraged by the administration of the health department, the public health nurses responded. Many of the nurses visited drug groups and agencies after working hours, manned evening telephone lines, or participated in community based task forces to study drug problems in schools.

To guide our enthusiastic nurse participants toward useful allocation of their time, but not to deter them from involvement in this pressing public health issue, the following memorandum (condensed version) and attachment were issued December 16, 1970. This mechanism proved to be a useful stopgap measure, but it did not create or describe roles for the staff.

STAFF INTER-OFFICE MEMO, DECEMBER 16, 1970

Recently, this department has received increasing requests for service from local groups or agencies, such as schools, drug control organizations, poverty groups, etc. Needless to say, we always try to understand and to respond to the valid public health concerns of the community. However, our resources are limited and should be used mainly to support operational or planned programs. Therefore, to identify suitable groups for receipt of services, *all staff* should assist applicants in preparing the following documentation of their requests.

INFORMATION TO BE OBTAINED FROM AGENCIES SEEKING HEALTH DEPARTMENT ASSISTANCE

Agency structure and functions: (*a*) name and address of agency, (*b*) name and title of agency head, (*c*) name and title of person who placed request, (*d*) name and title of professional adviser, (*e*) funding of agency (governmental, voluntary, combined), (*f*) objectives of agency, (*g*) source of intake, (*h*) management or treatment plan (s), (*i*) facilities, (*j*) personnel available, (*k*) caseload, (*l*) days and hours of operation.

Request for assistance of health department: (*a*) nature of service requested; kind, frequency, temporary or permanent, (*b*) personnel requested, if any; part time or full time.

Evaluation of request by reporter: (*a*) how valid do you

feel this request to be? (*b*) what input do you recommend that the department make to the agency problem?

The situation and its outlook seemed to become increasingly frustrating, not only because our health personnel had not been included in the official drug programs, but, more important, because the county health department was being prevented from providing a multitude of services and other benefits to such programs. We felt that the addicts were being unduly fragmented in the delivery of a specialized health service.

The addicts came largely from the segment of the county population with the highest rates of venereal and other communicable diseases, new cases of tuberculosis, and infant mortality. Perhaps many would have problems of alcoholism, mental illness, and substandard nutrition. The families of some addicts were known to the public health nurses, and many more would require home counseling, support, and demonstrations. Other talents and experiences in administration and planning and in the conduct and evaluation of mass public health surveys and programs were not being used. Some drug control groups had hired inexperienced general practitioners to establish screening criteria or to direct programs. Dollar savings, in terms of chest X-rays, tuberculin tests, VDRL test for syphilis, and other procedures which the county health department would have provided at no cost, were simply being disregarded.

Margaret Kinnard, L.P.N., prepares methadone for an addict

Plans for Delivery of Services

Months passed and the situation did not change. However, we felt that eventually the available contributions of the department would be recognized and that our personnel should be ready to meet the challenges of new programs. Fortunately, the nurses already had been exposed to many aspects of the drug problem through an excellent in-service training program, conferences, and continuing committee activities. Their daily field visits to patients had also provided valuable experience.

To confront the present issues, however, specific answers or responses were needed for the following questions:

1. What services could the department most suitably provide for each of the three general categories of drug abuse programs?
2. What roles could be conceptualized and particularized?
3. How could the staff's knowledge and skills be most effectively refined to meet a change in program demand?
4. What stratagems could then be pursued to arrange for the delivery of a full spectrum of public health services?

Since there could be no answer to question 4 before the occasion became reality, speculation on this item would be idle. Concentration on the other questions promised to be more fruitful.

Drop-in centers, with transient populations, poor sponsorship, and minimal or no treatment plans, did not seem suitable for the allocation of regular visits by public health nurses or other services. Instead, consultation would be offered on request by agencies. Although the mental health clinic could be viewed as a more useful source of home referrals and as an agency which might need help in screening procedures, its hospital or clinic location and the presence of many types of professionals were possible deterrents to the development of public health interests.

The methadone maintenance clinic, on the other hand, seemed to be the most promising candidate for health services. Its population was stable, screened (for proof of drug addiction for 2 or more years and for motivation to enter the program), and examined medically. Addicts reported daily for methadone and regularly for group conferences. They could be expected to be

aware of the dangers of serum hepatitis and to be interested in drugs, communicable diseases, and a variety of social problems. Accordingly, it was decided to allocate some health department services to a methadone maintenance clinic when an opportunity arose.

The next step was to structure and describe the roles of all the divisions in the health department as follows.

Administration: Planning participation and consultation on reporting, screening, procurement, and coordination of local health services; assistance with epidemiologic and other studies.

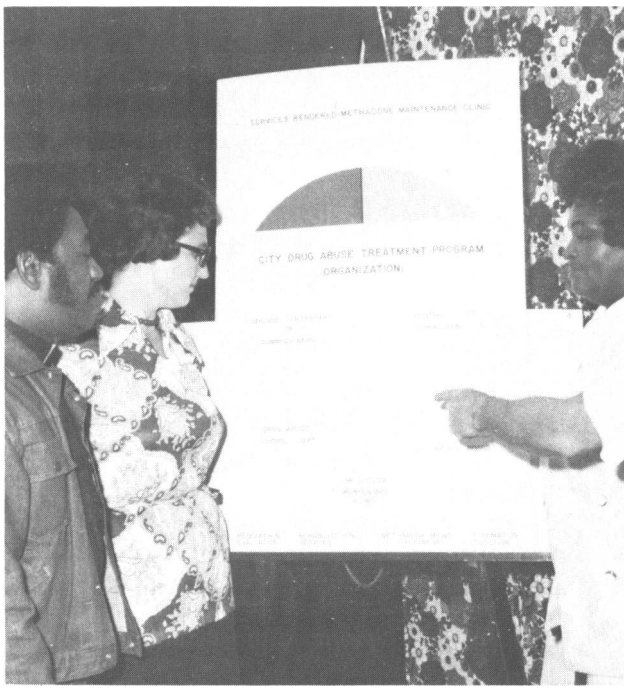
Clinic service: Chest X-ray, VDRL test for syphilis, and tuberculin test.

Environmental health service: Consultations regarding hygiene and sanitation of households and meeting places, especially of temporary quarters.

Special services: Consultations, discussions, and films on alcoholism and nutrition.

Public health nursing service: The public health nurse would be the "detached expert," as perceived by Litwak and Meyer (*4*). (The expert is viewed as detached, since she functions with relative autonomy and direct participation in the activities of a primary group. The objective is "to bring group norms and values into harmony with those of the organization.") The nurse would (*a*) read tuberculin tests, (*b*) "rap" on drugs, health, hepatitis, venereal disease, and prenatal care, (*c*) make health education literature available, including material on communicable diseases and family planning, (*d*) arrange for immunizations, chest X-rays, VDRL test for syphilis, smears, and venereal disease diagnosis and treatment, preferably at the center, (*e*) search out referrals and followup families needing visits by nurses, (*f*) provide general and special counseling and guidance to families of patients in order to create effective therapeutic settings at home, and (*g*) join a school or community group and become a member of a task force where the public health nurse is viewed as an expert.

Obviously, the number and variety of public health services which the department can deliver to a methadone maintenance clinic are extensive. Lest some services be considered unrealistic or dubious, we cite the following example: the environmental health service once assisted the director of a "cold turkey" clinic in a church basement to improve the sanitary facilities of the improvised premises where four to six addicts and a number of aides were housed.



G. Caronis, program administrator of the Pontiac clinic, explains the organizational set up to Rev. William F. Spann and the nurses

The public health nurse is, of course, the star performer, playing leading roles in the methadone maintenance clinic and in community involvement. Other services also have important and active inputs, in special counseling and in showing films; for example, alcoholism is a major problem for many addicts whether they are on methadone or other therapy.

Before undertaking the indoctrination of nurses and other health personnel into the drug scene, we determined that their knowledge base in this area was sound and broad. Thus, efforts were to be directed toward increasing specific knowledge of drug characteristics and treatment methods, to improve the understanding of community influences and behavior, and to enhance the capacity to deal and communicate with members of what is regarded as a deviant subculture.

Training Program

The knowledge base for involvement of public health personnel in drug control programs was outlined under three major headings: the drugs, the patients, and the community. These may be likened to the epidemiologic triangle of agent, host, and environment.

The health professional in any setting must know the details of available facilities. Although

this is difficult because of rapid changes in drug programs, efforts should be made to keep the lists up to date.

The training program described here was started with two nurses. Current plans are to include successive groups of two to four persons from the health department in this in-service indoctrination by placing them on detached "workshop" duty for several days.

The Drugs

The following material is largely familiar to professional health personnel. However, the legal implications and antidotes for acute drug abuse merit special attention.

General characteristics: (*a*) classification, individual drugs, (*b*) legal concerns—national, State, local, (*c*) effects—dependence, tolerance, (*d*) side effects, (*e*) withdrawal.

Acute drug abuse (overdose): (*a*) antidotes, (*b*) treatment methods.

Chronic drug abuse: (*a*) drugs used, (*b*) heroin addiction treatment—"cold turkey," Synanon, methadone, psychiatric counseling, and others; complications and their treatment; management with methadone (reduction or maintenance, or both; organization of clinic and treatment plan; problems).

The Patients

It is useful to bring out the differences in age groups, in usage patterns, and in emerging profiles of drug users (*5*). There is insufficient attention to and little understanding of the reasons why people take drugs. Some possible motivations are suggested in the following outline. An understanding of the drug abuse population should result in greater sensitivity and ability to communicate.

School-age population: (*a*) nature and extent of the problem—prevalence (junior and senior high schools); pattern and frequency of use, efforts at reduction, abstinence; characteristics of "takers" and "users"; demographic (age, sex, socioeconomic status, associations, aspirations, school, home, personal behavior) and sociopsychological (values, beliefs, goals—importance of genuine or alleged alienation or disaffiliation, peer influence, rebellion, search for "fun" or adventure, self-identification or discovery, "mind expansion," retreat from painful or threatening reality) (*b*) treatment—education (preteenagers to develop personal and social values, and teenagers to modify behavior); counseling; groups and group therapy; psychiatry.

Adult population: The nature and extent of the problem and treatment are similar to the items outlined for the school-age population. In addition, note history of arrests, convictions, jail sentences, and drug recidivism.

The Community

The community is regarded as a social system with input, action-reaction, end product of attitude-program, and feedback. The influence or control mechanism follows the definitions of Katz and Kahn (*6*). The community is shown here without the effect of authority, that is, as if all elements of community factors and community groups were equal in influence—a manifest unreality. Since communities vary greatly—in Oakland County there are two enclaves of black residents in an essentially white county—it is simple to understand why attitudes which determine community behavior and its programs will also vary. In a locality where law and order are prized, a program to improve parent or teacher awareness may not be successful. Still, the countering influence of feedback must not be ignored.

Community attitudes and behavior: see chart.

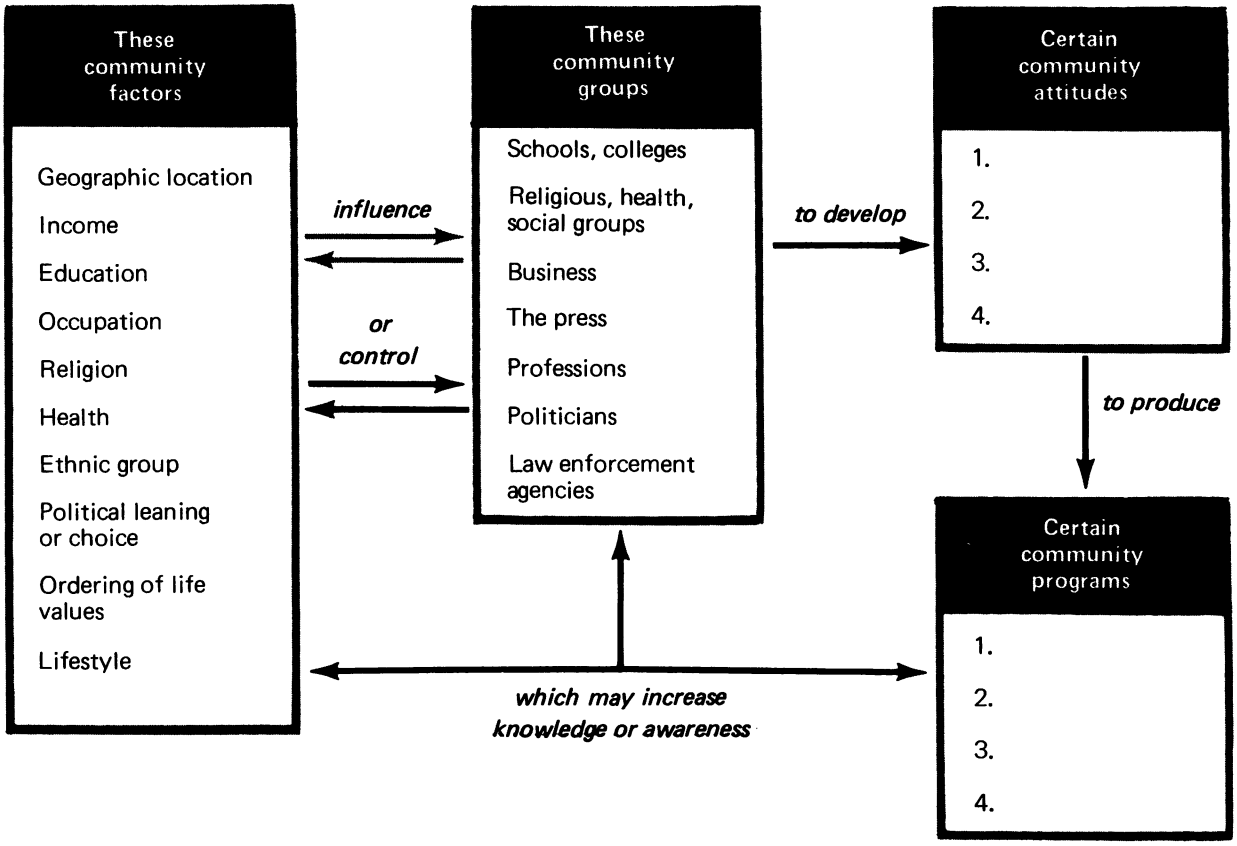
Programs and facilities: (*a*) operating agency staff, (*b*) treatment plan, (*c*) referrals, screening, intake, fees, (*d*) days and hours of operation.

Delivery of Services

Fortunately, the opportunity we sought arrived soon after the program had been formulated. We received an invitation to attend a regular meeting of the board of the Pontiac City Methadone Maintenance Clinic, a newly formed agency which was in the process of screening applicants for its addict complement of 50. The outline of the services which the county health department could contribute was presented at the meeting. This was well received, and, in a rapid series of actions, the assignment of a public health nurse (as the first health professional to make regular visits to the methadone maintenance clinic) was assured. The following sums up the actions taken or planned.

- Followup of presentation at the methadone maintenance clinic by a letter confirming the offer of available services.
- Meetings and discussions at the clinic concerning the roles and functions of health personnel.
- Agreement to use part-time services of a public

System schema demonstrating community behavior and feedback in response to a local drug problem



health nurse on a regular basis.

- Selection of a nurse.
- Joint meeting of nurse, nursing supervisor, health administrator, and clinic director to arrange hours.
- Nurse undertakes her regular assignment to the methadone maintenance clinic.
- Program is presented to the Board of Health of Oakland County. It is accepted and unanimously supported.
- At a later date, a resolution will be presented to the board of health, for its endorsement to the board of county commissioners, to the effect that the plans of all drug abuse activities funded by the county be coordinated at an early stage with the county health department and that a representative of the department be appointed to the agency or activity council or steering committee.
- Plans are underway for visits to the clinic by other members of the health department, such as the alcoholism project director.

Comments

While certain professional groups, such as physicians, have been exhorted by local and national medical societies (*7*) to respond to President Nixon's call and "to take the lead in the drug fight," a review of the literature reveals only a rare reference to roles appropriate to a county health department in support of a drug control program. In a paper concerning public health investigators in Los Angeles County, Mathias and Shook (*8*) stated: "All roles of the investigator are not yet identified or clearly defined in the drug abuse program. The roles may very well expand and alter direction as the program evolves." In another report of the activities of the Los Angeles County Health Department, Krain and associates (*9*) refer briefly to the employment of public health nurses in youth clinics since 1968 and in five drug clinics since 1970.

Drug abuse is complicated; programs vary from place to place and change rapidly. We believe that

a stable, organized agency, such as a methadone maintenance clinic, is a most suitable vehicle for the delivery of public health services. Staff personnel should be trained for their work in drug programs by careful indoctrination. For this purpose, we found that a step-by-step methodology and systems model were useful.

Local stratagems to implement planned services must be devised at suitable times. A valuable expedient, where necessary and feasible, is the modification of legislation to require early and continued participation of the health department in drug control activities. In effect, there appears to be virtually no alternative to the persistent involvement of the health department in the political process as well as in the community it serves.

Summary

A general review of the recent proliferation of all types of drug control programs reveals that confusion, conflicts, erratic organization, funding inadequacy, and other defects complicate the delivery of effective services. Of the three general types of treatment facilities, drop-in centers, mental health clinics, and methadone maintenance clinics, the latter are viewed as the most suitable for delivery of public health services because of their stable populations and sound organization.

The drug control programs of Oakland County, Mich., offered plans for a number of countywide facilities, but did not provide a role for the county health department. The programs were thus deprived of the many benefits of health department services—coordination, planning, direct services, and dollar savings.

When the staff of the county health department became unofficially involved with informal participation in drug control programs, a training program was formulated. The first phase was a description of suitable roles for the various services in the department. Staff knowledge, awareness, and communications skills were to be supported and refined in their application to drug abuse problems.

For training purposes, the psychosocial analytical approach to the drug-user profile was suggested together with a behavior model of the community as a social system. A series of successive administrative steps culminated in the assignment of a public health nurse (part time) to a local methadone maintenance clinic.

The county's experience indicates that the role of the health department should be clearly defined in future government-funded drug control programs.

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