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Date Aug. 10, 1976
THE EXTENT OF ADOLESCENT PROBLEM DRINKING IN GALLATIN COUNTY
AND EXISTING TREATMENT PROGRAMS FOR THEIR REHABILITATION

by

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ABSTRACT

A stratified random sample of 587 students from ages 10 - 19 in Gallatin County were administered a modified Short Michigan Alcohol Screening Test. This was done in order to determine the adolescent problem drinking rate. All physicians, ministers, and school counselors in Gallatin County were surveyed to find out what programs they had for adolescent problem drinkers. Also, two agencies in Gallatin County were interviewed to find what programs they had for adolescent problem drinkers.

The problem drinking rate appeared to be 4 percent for the 587 students in Gallatin County. Another 6 percent were classified as possible problem drinkers. The following programs were reported as available in Gallatin County for adolescent problem drinkers: individual counseling (Problem Drinking Center, physicians, ministers, school counselors, psychologist, psychiatrist); family counseling (Problem Drinking Center); alcohol education counseling (Problem Drinking Center, ministers, physicians); group counseling (Problem Drinking Center, Alcoholics Anonymous); DWI school (Problem Drinking Center); Detoxification (physicians); Hospitalization (physicians).

Adolescent problem drinking in Gallatin County appear to range from 4 percent to 10 percent of 10 - 19 age range. Either figure is as high or higher than percentages listed in other areas of the nation. There appears to be a problem with adolescent problem drinkers in Gallatin County. The current treatment programs in existence need to be upgraded and coordinated. Also, they need to form a continuity between them. Several programs need to be started in Gallatin County. They include foster home placement, halfway homes, rehabilitation services, and intermediate care.

The Bozeman Problem Drinking Center could coordinate all of the above existing programs to insure continuity. Also, the Drinking Center could be used to coordinate the start of additional programs. Funding is essential, and at this point there are inadequate funds to do either job.
CHAPTER I

Introduction

Alcoholism (p. 5) had been a perplexing problem over the centuries. Some civilizations had almost no signs of alcoholism while others had a high rate. For example, the Lepcha, a Himalayan Tribe, and the Cuna, a Central American Tribe, had and drank alcoholic beverages in quantity, but had no alcoholism in their midst. On the other hand, many European nations have had alcoholic problems for centuries (Bacon and Jones, 1968). Man dealt with alcoholism by imprisoning, punishing, and even ignoring it. The causes of alcoholism and the cure had never been fully discovered. Over the last several decades, however, many discoveries lead to closer solutions to the problem.

Milbauer (1976) stated that adolescent alcoholism was brought to the public's attention in the last few years. Prior to this time, Bacon and Jones (1968) found that society thought that teenage alcoholism was "non-existent". The public generally believed that only adults were alcoholics. Research demonstrated that this ideology was a falsehood. For example, 10, 11, and 12 year olds had attended Alcoholic Anonymous (AA) groups across the country in increasing numbers, (Bean, 1975). Dr. Morris Chafetz, Director of the National Institute of Alcohol Abuse and Alcoholism, (Milbauer, 1976) stated, "All of the statistics over the past couple of years have pointed to the fact that the switch is on among young people - from a wide range of other drugs to alcohol, which is far and away the drug choice among youth . . . it's a far more serious
problem than we ever imagined" (p. 49).

The Montana Department of Health and Environmental Sciences (1972) said, "Montana has been classified a heavy drinking state" (p. 12). They also stated that the consumption rate for beer was the fourth highest rate per capita in the country. In addition, the percentage increase of beer consumption per capita was the fifth highest in the country. Finally, they reported (1973) that a twelve county area, which included Gallatin County, of Montana was rated as the highest amount of alcohol abusers in the state (p. 25).

Statement of the Problem

The problem of this study will be to determine the extent of adolescent problem drinking in Gallatin County and the programs available for the rehabilitation of the adolescent problem drinkers.

Purpose of the Study

In the 1975 Montana State Plan for Alcoholism and Alcohol Abuse, little was reported as being known about the extent of teenage alcoholism in Montana. Estimates were given by quoting authorities who predicted percentages for the general population only. However, the Montana Department of Health and Environmental Sciences (1975) quoted one study for Montana (pp. 2-3). That study was from the Rimrock Guidance Foundation which showed, in Yellowstone County, the age group of 15-19 was an especially high risk group for adolescent problem drinking. It also showed
that special emphasis must be directed toward this age group.

The results of another study were said to be an indicator for the rest of the country. Glasser and Greenberg's study (1975) was conducted in Pennsylvania and showed the following results:

There also appears to be a particularly serious problem with respect to alcoholism in counties dominated by small cities. The prevalence of alcoholism approaches the high rates found in the urban cities, but treatment is disproportionately far less available . . . at the same time lacking the resources which big cities have to cope with them (pp. 350-51).

Glasser and Greenberg's study indicated there could be a lack of adequate resources to treat alcoholics in Montana since the state was considered a rural area by their description of rural areas. Furthermore, this researcher talked with several professionals in Gallatin County and found that none knew what programs, other than their own, were in existence. Also, no one seemed to know the extent of adolescent alcoholism or problem drinking. The purpose of this study will be to research adolescent alcoholism and the treatments available in Gallatin County in the spring of 1976.

General Questions to be Answered

1. What is the problem drinking rate for adolescent youths in Gallatin County?

2. What counseling programs exist in Gallatin County for the rehabilitation of the adolescent problem drinker?
General Procedure

First, the Short Michigan Alcoholism Screening Test (SMAST) will be administered to a stratified proportional random sample group of adolescents in Gallatin County to determine the extent of problem drinking. Second, the population of professionals and agencies that work in the area of teenage alcoholic rehabilitation in Gallatin County will be sent questionnaires or be interviewed to find what programs are available for adolescent problem drinking rehabilitation. The findings will be summed up in Chapter IV while comparisons, conclusions, and recommendations will be made in Chapter V.

Limitations

One limitation will be the lack of funds and time to travel to each community in Gallatin County to administer the SMAST at every school. Therefore, the sampling will be limited to Bozeman and the surrounding area. The library at Montana State University is limited in literature in the area of alcoholism. The area of teenage alcoholism especially, has very limited resources. Many articles are not available at the Montana State University library. Another limitation is the lack of funds to send for those articles and also to send for the original data that is quoted in this study. One final limitation is the lack of time to conduct personal interviews with all the social agencies.
Definition of Terms

**Adolescent** - Any student from the age of 10 thru 19 years of age.

**Teenager** - Any student from the age of 13 thru 19 years of age.

**Alcoholic** - "A person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic (or school work) is substantially disrupted" (The Montana Department of Health and Environmental Sciences, 1975, p. 2 of HB 909).

**Problem Drinker** - Anyone whose life has been affected or changed in a negative way because of the use or abuse of alcohol.

Summary

Many people in Gallatin County are concerned with the problems of both the rate of adolescent problem drinking and the rehabilitations of such individuals. The concern of professional counselors, ministers, physicians, and social agency personnel in this area has lead this researcher into this study with hopes that the existence of current programs will be made known to everyone concerned. Also, the need for additional programs that might be necessary to treat these problems, will be brought out by this study. Furthermore, the current existence of problem drinking among teenagers in Gallatin County will be brought out. Hopefully, this study may be used to help existing programs by presenting other options that currently are not being considered.
CHAPTER II

Review of Literature

Several authors considered alcoholism treatment in three phases. Johnson (1973) suggested a three phase system consisting of: 1) Observation and Detoxification; 2) Inpatient Treatment, and; 3) Outpatient Treatment. Brunner-Orne (1967) suggested a similar three phase system consisting of: 1) Physiological; 2) Emotional, and; 3) Environmental.

This researcher will organize the first section of this chapter similar to that suggested by Johnson. First, the initial contact with the alcoholic and his detoxification will be covered. Second, the alcoholic's inpatient setting will be covered. Third, outpatient settings for the alcoholic will be examined. Fourth, several existing state programs (including that of the State of Montana) will be reviewed. Finally, several local programs will be evaluated.

The last section of the chapter will cover current literature on teenage alcoholism and its rate. Several areas of the country (including Montana) will be covered.

The pertinence of this chapter to the study will be to compare the programs in literature with the programs in Gallatin County. Also, the teenage alcoholic rates from across the country will be compared with those in Gallatin County. These comparisons will be made in Chapter V.
Treatments for Alcoholism

Contact and Detoxification

The first problem in dealing with alcoholics was to identify them. One of the best ways of identifying alcoholics was suggested by Cahn (1970). "Medical doctors probably see more alcoholic patients than psychologists or private practitioners, simply because there are mainly more physicians in private practice and people often turn to them for help with behavioral and emotional problems" (p. 138). This was substantiated by Ritson and Hassell (1970) in a study of the Edinburgh England Treatment Center. "The majority of patients (61 percent) were referred by general practitioners and 33 percent by specialists (mostly psychiatrists); only 3 percent referred themselves" (p. 24). Because of the physical abuse of alcohol on the body, many if not most alcoholics went to the doctor's office at one time or another. If the doctor had identified them as alcoholics and had started them in an alcoholic program, most alcoholics would have been identified and treated.

Another way of identifying alcoholics was again suggested by Cahn (1970). "There are probably more people with alcohol problems assisted by the public welfare system than by all other services and agencies combined. Yet, the public welfare system does not incorporate therapeutic services specifically aimed at the amelioration of alcoholic problems in its programs" (p. 165). Most of the alcoholics that didn't go to the doctor were probably on welfare. Therefore, the majority of alcoholics
would have been identified and referred for treatment. As Cain (1963) suggested, "the best first step to take, whenever possible, is to make a personal visit to your local alcoholism information center" (p. 80).

The next step, after identification was to get the alcoholic into treatment. This was the hardest step to take. Johnson (1973) suggested a confrontation take place. This confrontation had to be set up so that its effects were maximal. Also, it had to be set up by trained personnel. Once the alcoholic faced the fact that he was an alcoholic, treatment began.

The first step in treatment for many alcoholics was detoxification. Not all alcoholics needed this step, but those that did needed the following (Johnson, 1973, p. 114):

- Insure safe and complete withdrawal from alcohol and/or mood-changing chemicals.
- Examine the patient's general state of health.
- Determine the extent to which other hospital services may be necessary during the patient's treatment.

Johnson was describing the detoxification unit in St. Mary's Hospital in Minneapolis, Minnesota. The Vernon E. Johnson Institute was located there exclusively for the treatment of alcoholics. It was classified as a "full scale, appropriately staffed, interdisciplinary medical psychiatric specialized units located in large general hospitals" as described by Ottenberg (1972, p. 4). Ottenberg went on and described two other types of detoxification units. One was the "free-standing detoxification unit
which had relatively limited medical service but worked in close relationship with a nearby general hospital." The last type was the "nonmedical short-term emergency nursing care that operated with a minimum of medical supervision." Whatever type used was determined by the needs of each community.

There were basically two problems in treating inpatients. The first was the changing of the treatment center staff's attitudes. Fox (1967) described hospital helpers as being too rigid or too inclined to over-identify and to become over-involved. They tended to relate to the patient's drinking rather than to the patient. He stated that the staff should be retrained to "gut level" changes similar to those that the patient would undergo. Also, the staff of the therapeutic community should be composed of professionals from as many different backgrounds as possible. Finally, the staff should be moved from an authoritarian organization to a fluid staff team. Block (1967) agreed with this and said, "Successes in treating alcoholic patients can be encouraged by . . . manifesting an interest in the patient who has been rejected so often by society generally and by too many physicians" (p. 50).

Many hospitals turned away alcoholics unless they were being treated for other ailments other than alcoholism. According to Haymen (1966), "All general hospitals should be open to alcoholic patients, not only for the acute complications of alcoholism, but whenever it is necessary for the chronic alcoholic to be hospitalized to institute a program of rehabilitation" (p. 250).
The second problem in treating inpatient alcoholics was to institute a program to start their rehabilitation and change their attitudes. Block (1967) suggested that success in treating alcoholic patients was encouraged by:

1. Changing the philosophy of the patient so that he matures sufficiently to accept his limitation as other sick people must if they wish to recover.
2. Modifying the self-centeredness and dependency which characterize the alcoholic.
3. Effecting a change in the life of the patient, his attitude toward living and his desire for a different kind of life.
4. Interesting and acquainting the spouse with his or her responsibilities in this matter (p. 50).

In order to make the above changes, several institutions used the following treatments in their programs: 1) Didactic treatment; 2) AA as a treatment resource; 3) Group therapy; 4) Individual therapy; 5) Work therapy, and; 6) Discharge planning (Cahn, 1970; Mosher, Davis, Mulligan and Iver, 1975).

One institution that made effective use of most of Cahn's steps was the Vernon E. Johnson Institute in Minneapolis. The use of didactic treatment and the use of AA were part of the nonmedical treatment. The following outline was given to each patient as they entered the institute (Johnson, 1973, pp. 114-115):

Phase Two. Inpatient treatment (Phase One is described on p. 8)

After withdrawal, you will enter a period of inpatient therapy designed to help you:
1. Identify your illness.
2. Accept your condition as a chronically diseased person.
3. Formulate your personal rehabilitation program.
4. Continue medical treatment as needed under care.
of private physician.

5. Become familiar with 12-step program of AA which in practice has been proven effective.

Education: Through lectures, selected films, and prescribed readings, you receive current and accurate information concerning:

1. The nature and dynamics of your progressive and chronic disease.
2. The physical, social, and personal deteriorations which accompany it.
3. The basic understanding of a method for achieving and maintaining a comfortable way of life free from further dependency upon mood-changing chemicals.

Group therapy: Repeated experiences in groups of people who suffer from the same affliction provide you with encounters designed to confront and break-down defense mechanisms and negative attitudinal postures which always accompany chemical addiction. Group therapy enables you to recognize and accept:

1. Who you are.
2. Which specific attitudes and behavior patterns must be modified in order to live comfortably without dependency on harmful chemicals.

Individual and family counseling: Particular life problems vary from patient to patient, and other members of your family are inevitably involved in the disruptions caused by your illness. Therefore, both individual and family counseling are viewed as essential to successful rehabilitation.

In order to initiate a change, most authorities used group counseling instead of individual counseling. Johnson (1973) said, "In any case, the counselor's goal in these one-to-one sessions is to discover and evaluate the inpatient's progress rather than to change him" (p. 98).

The change as Johnson described was the function of the group. Scott (1970) said that one of the reasons that the group was relied upon for change was to get the patient "not to blame others for faults, but to accept his part in what happened to him". Two statements by Mullan and
Sanguiliano (1966) finalized the importance of group therapy in treating alcoholics:

As a consequence of primary contributions of the group method to the alcoholic is the broadening and deepening of his limited base of identification so that he becomes more than merely alcoholic in a world which begins to expand for the first time (p. 204).

Frequently he (the alcoholic) maintains an intense symbiotic dependency with a spouse, parent or substitute parent. In this way the alcoholic is connected with another who serves as a focus for his fantasy productions. The alcoholic protects himself from the usual interpersonal conflicts. He does not mess with life's processes. He avoids commitment, responsibility and even the awareness of life's paradoxes . . . The many confrontations in group psychotherapy reverse, in part, these crippling avoidances of the alcoholic (p. 205).

**Outpatient Treatment (After-care)**

The success rate of any program depended on its after-care program. This was where and when the alcoholic had to decide whether to avoid alcohol or whether to return to it. M. M. Glatt (1958 as in Ritson and Hassall, 1970) stated, "The period of after-care is probably the most important phase in the therapy of alcoholism" (p. 23). This was proven in a study by Moore and Buchanun (1964 as in Hayman, 1966, p. 235). "The estimate of improvement by 171 state hospitals indicated that 60 percent were improved at discharge, 39 percent up to a year after discharge and 33 percent for periods over a year after discharge."

Because of the low rate of long term surveys, many programs had comprehensive outpatient or after-care treatments. The Johnson Institute had the following program for their patients (Johnson, 1973, p. 114):
Phase Three. Outpatient treatment

Because harmful chemical dependency is a chronic condition, each patient is to remain in weekly contact with the nonmedical program of treatment for a period of time up to two years after inpatient discharge. Continuing group experiences are designed to meet special problem areas in the initial stages of recovery. You will be expected to return to the chemical dependency treatment and rehabilitation center for:

1. A weekly therapy session.
2. Consultation and counseling with staff members as required for your continued successful recovery and rehabilitation.

For a continuing program of recovery, outpatients, spouses, and families are expected to attend:

1. Weekly AA meetings in your community.
2. Weekly Al anon for spouse.

The Johnson Institute claimed a 70 percent recovery rate for patients over a two year period as outpatients. This was over twice the recovery rate as stated by Hayman for patients not receiving after-care.

Several elements seemed to be necessary for comprehensive after-care treatment. Besides the program described by Johnson, other programs included the following as described by Pittman (1967):

The diversity and complexity inherent in alcoholism can be dealt with by the establishment of ten kinds of after-care:

1. Night hospitals: They allow patients to work during the day and receive therapeutic treatment and shelter at night.
2. Day Hospitals: The patient lives at home but receives intensive therapeutic treatment during the day. He is neither an in nor an outpatient.
3. Outpatient Clinics: Lives will not change unless new behavior is reinforced by easily accessible therapeutic treatment. Outpatient clinics should be attached to all inpatient alcoholism units.
4. Traveling Clinics: Since patients in rural areas are unable to avail themselves of regular outpatient clinics in urban cities, the outpatient clinic goes to the patient.
5. Domiciliaries: Full rehabilitation and integration into society will be impossible for many patients because of
age, physical and/or mental health, or other reasons. They do not need extensive treatment in a hospital. If other after-care programs prove unfeasible, they should be placed in domiciliaries instead of state hospitals. Domiciliaries should not become a home for the "living dead".

6. Community Houses: For patients with brain syndromes who lose to a significant degree their ability to function psychologically and socially, but can work. While regaining full use of their faculties, they find shelter in community houses instead of hospitals or half-way houses.

7. Half-way Houses: They offer alcoholics a place to live until they can establish themselves in the community. Some exist in most urban centers, but to few exist.

8. Foster Homes: Foster homes are an alternative to long-term hospitalization.

9. Social Centers: A place where alcoholics can find recreation facilities and companionship. It becomes an alternative to local taverns.

10. Referral Systems: Helps the alcoholic to be directed to appropriate treatment facilities. Helps select which type of facility is best for each patient. Helps client establish himself in community. It ties everything together.

Maters (1973) added another facility to the list. "The Quarter-way House is developed in conjunction with general hospitals and gives alcoholic patients needed support at the particularly crucial time . . . and frees hospital beds" (p. 21).

In order to get Federal assistance, the following list of services was required by the regulations for community mental health programs: "1) Emergency care, both medical and psychiatric; 2) Inpatient treatment; 3) Partial hospitalization, including both day and night treatment; 4) Outpatient clinic care, and; 5) Half-way houses" (Glasscote, Plaut, Hammersley, O'Neill, Chafetz, and Cuming, 1967, p. 28).

Tying all resources together as suggested by Pittman's Referral System, appeared to be the key for successful treatment. Most small
communities lacked any formal referral system. Sears (196?) suggested the following:

The community treatment format involves interaction amount the following people:

1. The Community Alcoholism Services Coordinator: In some large communities he may fill a full-time position and may work with other part-time coordinators. In many small communities his job is a part-time position filled by an already employed care-giver.

2. Community Alcoholism Workers: They are identified and oriented by the coordinator. These workers may be professionals employed by helping agencies or they may be volunteers.

3. A Helping Person: Each patient has one. He is identified and trained by the Community Alcoholism Worker. The helping person is a part-time volunteer member of the treatment team.

4. All Available Community Resources: Ones that can legitimately and appropriately aid in the treatment of the patient is chosen by the Community Alcoholism Services Coordinator and the Community Alcoholism Worker.

5. The patient: He is identified and assisted by the Worker, the Helper, and the various community resources (pp. 179-180).

State Programs

Connecticut. The final state plan reported by the commission was Connecticut. It has one state inpatient facility with five outpatient clinics within one hour drive from anywhere in the State. Also, there was one half-way house. The commission rated this program as one of the more advanced of the 42 state programs reviewed.

Florida. Florida had one state facility although other hospitals were reimbursed for treatments given to patients. There were five outpatient clinics. One of the major objections of the commission was that Florida's program has not expanded.
Georgia. One comprehensive study was conducted regarding state plans for alcoholism (Glasscote, et. al., 1967). This Joint Information Service Commission traveled throughout the country. Four state plans were included in their report. The first State was Georgia. There was one inpatient clinic for the State. Nine outpatient clinics were spread throughout the State. Alcoholics stayed for eight weeks and then were referred to one of the nine outpatient clinics. Those patients who lived away from any of the clinics had no supervision. The commission reported no data of the success of Georgia's program.

West Virginia. West Virginia showed a 67 percent abstinence and improvement rate after one year for its patients. There were three state hospitals and nine information centers located throughout the State. Also, a vocational rehabilitation counseling program was included. Patients discharged into areas with information centers had after-care supervision. Others were supervised by mental hygiene centers. AA was also recommended to some patients. The commission rated West Virginia as excellent although they lacked detoxification centers except at the state level.

Montana. The Montana State Plan for Alcohol Abuse and Alcoholism, Prevention, Treatment, and Rehabilitation was set up in 1972 by the Montana State Legislature. This plan told what facilities were in existence and what was necessary to expand further treatments in Montana. The 1973 State Plan stated the following resources for Montana:
The Montana facilities and programs that serve the alcoholic abuser, the alcoholic and the involved family members are wide spread in scope, in nature of service and in location. The range of services include information dissemination, preventive efforts, treatment plans, half-way house facilities, one comprehensive community alcoholism treatment center, and one state-funded treatment program. These services, programs, and facilities are located throughout the state with concentrations in the urban areas.

The programs serving the alcohol abuser in Montana are funded in a variety of ways. One is a state operated and funded program. Some are funded with federal monies, i.e., NIAAA, LEAA, some by private monies, some with combinations of funding sources and some with almost no funding at all (p. 43).

It went on to say that "little information of an evaluative nature is available regarding to effectiveness of these programs in terms of their stated goals and objectives" (p. 43). The 1975 State Plan takes a slightly different look at existing programs and said:

In Montana, the need exists for the development of comprehensive alcohol programs which can provide a full range of services to the general public. This range of services include: Prevention, outpatient care, intermediate care, inpatient services and emergency care. The means to establish these comprehensive services exists through legislation passed in the 1974 Montana Legislative Session. The implementation of this law is vital to the development of adequate care for the alcoholic and alcohol abusers in Montana (p. 13).

Apparently, the facilities listed in the 1972 and 1973 State Plan were not effective enough in treating alcohol abusers because of the 1975 State Plan's call for a need for development of more programs in order to have adequate care for them.

Gallatin County

The 1973 State Plan listed only two hospitals with 174 beds along
with AA as the only resources available in Gallatin County. Since then, the Bozeman Problem Drinking Center was opened. Any other programs in existence were unknown to the 1975 State Plan for Gallatin County. The only inpatient facility listed for Gallatin County was Warm Spring State Hospital. The 1973 State Plan also listed priority ratings to different areas of Montana. Catchment Area III (Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell, and Silver Bow Counties) had the following ratings for priority:

- Greatest population to be served - first priority.
- Greatest number of alcohol abusers - first priority.
- Need for greatest degree of comprehensive alcoholism programs - first priority.
- Need for greatest degree of comprehensive alcoholism planning - first priority.

Catchment Area III was rated first in total priority (p. 25).

Of the 35,000 alcoholics estimated in Montana, 2,800 are in Gallatin County.

**Local Programs**

**Santa Clara County.** Again, the Joint Information Commission (Glasscote, et al., 1967) reviewed several local programs and clinics. The Alcoholic Rehabilitation Center in Santa Clara County was funded by the State of California. Only a fraction of the population was served due to limited facilities. An outpatient clinic had some long term patients with some going to AA for help. Others came intermittently for treatment. Only 25 percent were regular for more than three months. The commission rated the center as "only one step beyond a demonstration . . ."
inadequate for population.

San Matao County. The mental health center in San Matao County, California, was rated better than most in the U. S. Even so, it was still rated very inadequate. It consisted of a nine bed inpatient unit. The outpatient clinic only had 50 percent remaining after one meeting while only a small percentage remained any length of time. All that was offered was vocational rehabilitation counseling.

Mendocino State Hospital. The State Hospital served a 14 county area in Northern California. It consisted of vocational counseling and rehabilitation. The only outpatient after-care was in a San Francisco area rest home. The commission rated the hospital as having a good attitude, but the success rate was unknown.

Hospital B. This hospital was located in a midwestern industrial city. It had a 100 bed alcoholic treatment center. Treatment was limited to a drying out period and a vitamin therapy. Also, serious general health problems were treated. The stay was for three to seven days. Alcoholics were then transferred to the state hospital for any further treatments. Only twenty patients were on outpatient status at any time. The rest had no after-care. The commission's impressions were that little opportunity for successful treatment was available.

Massachusetts General Hospital. Located in Boston, this hospital had a twenty-two bed inpatient unit to treat primarily emergency psychiatric patients. They rarely treated alcoholics. If they did, there was a 72 hour detoxification period. Then, many alcoholics were sent to
the state prison for a fifteen day voluntary stay. Treatment programs were minimal. Some agencies, such as nursing homes, welfare agencies, and Salvation Army, cooperated with the hospital. The commissions' impressions were the following: Commendable for the alcoholics that it treated; however, it did not treat alcoholics specifically so that the majority of alcoholics in Boston did not get treated.

**Teenage Alcoholism**

Teenage alcoholism rates varied from study to study. They varied from 2.1 percent in Boston to 10 percent in New York. Saltman (1973) and Demone (1973) conducted two separate studies in Boston. Both came up with the same figure for teenage alcoholism. Saltman found that out of 3,400 high school boys, 2 percent were alcoholics. Demone found that out of 3,235 boys in Boston, 2.1 percent were alcoholics. Furthermore, Demone broke down his study by age groups with the following results. Out of 450 fourteen year old students, 1.3 percent were alcoholics; out of 614 fifteen year old student, 1.6 percent were alcoholics; out of 677 sixteen year old students, 2.4 percent were alcoholics; out of 600 seventeen year old students, 3 percent were alcoholics; and out of 215 eighteen year old students, 7 percent were alcoholics. U. S. News and World Report (April 14, 1975) reported that a New York study had shown that almost 10 percent of that city's juniors and seniors were already or potential alcoholics.

Only two studies had been reported in Montana. Schwarz (1970) conducted a survey of five Montana high schools that showed that out of
287 high school students studies, five or 1.7 percent were "heavy drinkers" (drinking caused disrupted life patterns). The Rimrock Guidance Foundation in Yellowstone County conducted a study on alcoholism. The 15 - 19 age sub-group represented the highest percentage of high risk of all age groups surveyed. In conclusion, both studies indicated that alcoholism among teenagers did exist in Montana.

Summary

A three phase program was necessary for the successful treatment of alcoholics. First, alcoholics were identified, were persuaded to get treatment and detoxification, if necessary. Second, the alcoholic needed some sort of inpatient treatment including education about alcoholism, some type of personal counseling (group and/or individual), and discharge planning. Third, an adequate outpatient program or after-care supervision was implemented.

Teenage alcoholism was in existence in Montana. Its full extent was not known. Very few surveys have been conducted to find the extent of alcoholism in Montana. Further comparisons between Gallatin County and the literature will be made in Chapter V following the results listed in Chapter IV. Conclusions and Recommendations will also be made.
CHAPTER III

Procedures

Little has been done in Gallatin County to determine the extent of adolescent problem drinking. Also, no one seems to know the extent of programs available for the rehabilitation of the adolescent problem drinker. The procedures of this chapter will outline a method of surveying both problems. First, the adolescent problem drinking rate will be surveyed. Second, programs for the rehabilitation of these problem drinkers will be explored.

Population Distribution and Sample Procedures

The first population is the adolescents of Gallatin County. Adolescents will be considered from ages 10 - 19 and in school in Gallatin County. The population size is approximately 4,345 according to the Montana Schools Directory published by the Superintendent of Public Instruction (1975). A sampling size of approximately 15 percent or 600 students will be used. This will be a stratified proportional sample. Two classrooms at each grade level 5 - 12 will be sampled in two schools to be picked at random. This will insure approximately the same number of students at each age level for the survey.

The second population is professional helpers that are composed of ministers, physicians, psychiatrists, psychologists, school counselors, and workers at social agencies. These people will at one time or another come in contact with problem drinkers in order to offer treatment programs.
All ministers and general practitioners as well as physicians of internal medicine, school counselors, psychologists, and psychiatrists in Gallatin County will be surveyed. Therefore, the sample size will be the same as the population size.

Method of Collecting Data

A modified brief form of the Michigan Alcohol Screening Test will be administered to the adolescent sample group. This test was chosen because of its validity .83 (Gamma = .95) and .94 (Gamma = .99) and because of its reliability .76, .78, and .93 according to tests done by Selzer, Vinoker, and Rooijen (1975). Scoring of the test will be done as suggested by Selzer, et. al., (1975). A score of 0 - 1 indicates a non-problem drinker. A score of 2 indicates a possible problem drinker. A score of 3 or more indicates a problem drinker. This test is used primarily in institutional settings for screening alcoholics. Since this test will be administered in a non-institutional setting, those with scores of 3 or more will be termed problem drinkers instead of alcoholics.

The second sample of professional helpers will be sent a survey of possible treatment procedures for adolescent problem drinkers in Gallatin County. This survey will be sent to all those professional helpers listed in the Gallatin County phone directory. Social agency workers will be interviewed instead of being sent a survey.
Method of Organizing Data

The data will be presented in several tables. Adolescent problem drinkers will be presented in two tables. These tables will contain a break-down of the data by age (10, 11, 12, 13, . . .), sex (male or female), and score (drinkers and non-drinkers). The data will be in the form of numbers and percentages. Percentages will be used instead of numbers for purposes of clarification of data and of facilitation in comparing this data with that of the review chapter of literature.

The survey of professional helpers will be broken down into three tables. The first tables will break-down the data given by professionals (physicians, ministers, school counselors). They will also include items checked by each. The second table will list data gathered from workers at social agencies. Finally, the third table will list all programs available for adolescent problem drinkers.

Analysis of Data

The data will be descriptive. It will be converted into the form of percentages since this is the form most often used in literature. The data for adolescent problem drinkers will be broken down into percentages of problem drinkers compared with the total sample population at each age level. The data for rehabilitation programs will also be broken down into percentages of those items responded to in comparison with the total population.
Summary

The procedures in this chapter will give adequate data to determine both the rate of adolescent problem drinking in Gallatin County and the programs currently available for their rehabilitation in Gallatin County. This data will be compiled in Chapter IV. It will then be compared with the review of literature chapter for the purposes of conclusions in Chapter V. Finally, recommendations will be made about the problem.
CHAPTER IV

Results of Data

Adolescent Problem Drinking Rates

Several schools in Gallatin County were approached for permission to administer the revised Short Michigan Alcohol Screening Test (NAST) (Appendix A). Two schools refused the study and two others accepted it. In one school, two classrooms at each grade level (5 - 12) were randomly selected by the administration and were administered the test. In the other school all students in grades 5 - 11 were administered the test. Grade 12 did not receive the test since they had already graduated and were not in attendance. A total of 590 students took the test. Of those students three forgot to fill in their ages, and therefore, their tests were not used. Consequently, 587 tests were counted in the final results. Of the 587 students 318 (54 percent) were male, and 269 (46 percent) were female.

Table I shows the break-down by age and sex of those students who said that they had tasted an alcoholic beverage and of those students who had not tasted an alcoholic beverage. Out of the total of 587 students, 484 (82 percent) said that they had tasted an alcoholic beverage. Of the 484 who had tasted an alcoholic beverage, 273 (56 percent) were male and 211 (44 percent) were female. Of the 103 students who had not tasted alcoholic beverages 45 (44 percent) were male and 58 (56 percent) were female.
TABLE I
Number and Percentage of Students Who Have and Who Have Not Tasted Alcoholic Beverages

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Tasted Alcohol</th>
<th>Never Tasted Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>19</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>41</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>70</td>
<td>43</td>
<td>20</td>
</tr>
<tr>
<td>16</td>
<td>69</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>15</td>
<td>79</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>14</td>
<td>76</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>13</td>
<td>84</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>12</td>
<td>78</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td>11</td>
<td>67</td>
<td>21</td>
<td>29</td>
</tr>
<tr>
<td>10</td>
<td>17</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>587 (100%)</td>
<td>273 (47%)</td>
<td>211 (36%)</td>
</tr>
</tbody>
</table>
TABLE II

Number and Percentage of Students Tasting Alcohol Who Received Each Score on the Michigan Alcohol Screening Test

<table>
<thead>
<tr>
<th>Age &amp; Sex</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 M/F</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 M/F</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 M/F</td>
<td>29</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 M/F</td>
<td>16</td>
<td>12</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>6</td>
<td>2</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 M/F</td>
<td>30</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>16</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 M/F</td>
<td>34</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>4</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 M/F</td>
<td>27</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>22</td>
<td>6</td>
<td>1</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 M/F</td>
<td>25</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 M/F</td>
<td>16</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 M/F</td>
<td>6</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total M/F</td>
<td>198</td>
<td>41</td>
<td>19</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>155</td>
<td>31</td>
<td>16</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>353</td>
<td>72</td>
<td>35</td>
<td>9</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent.</td>
<td>73%</td>
<td>15%</td>
<td>7%</td>
<td>2%</td>
<td>2%</td>
<td>.4%</td>
<td>.2%</td>
<td>.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In Table II, those who received a score of 0 - 1 were considered non-problem drinkers; those who received a score of 2 were considered probable problem drinkers, and those who received a score of 3 - 10 were considered problem drinkers. The term, "problem drinker", was sometimes used synonymously with alcoholism, depending on the definition. The students included in Table II are the 484 students who said that they had tasted an alcoholic beverage. There were 353 (73 percent) who received a score of 0 and 72 (15 percent) who received a score of 1. This means that 425 (88 percent) were termed non-problem drinkers. There were a total of 35 (7 percent) who received a score of 2 and were classified as probable problem drinkers. The remaining 24 (5 percent) received scores of 3 or more and were termed problem drinkers. In summary, of the total sample population of 587 students, 35 students (6 percent) were probable problem drinkers, and 24 students (4 percent) were problem drinkers.

The break-down of the number of problem drinkers in the entire sample of 587 students by age was the following. Out of the 4 nineteen year olds, 1 (25 percent) was termed a problem drinker. However, since the number of nineteen year old problem drinkers in the sample was so small, the figure of 25 percent was considered unreliable due to an inadequate sample number. Of the 41 eighteen year olds, 5 (12.2 percent) were potential problem drinkers while 3 (7.3 percent) were problem drinkers. Of the 70 seventeen year olds, 6 (8.6 percent) were probable problem drinkers while 5 (7.1 percent) were problem drinkers. Of the 69 sixteen year olds, 2 (2.9 percent) were probable problem drinkers while 4 (5.8
percent) were problem drinkers. Of the 79 fifteen year olds, 6 (7.7 percent) were possible problem drinkers while 5 (6.3 percent) were problem drinkers. Of the 76 fourteen year olds, 5 (6.6 percent) were possible problem drinkers while 1 (1.3 percent) was a problem drinker. Of the 84 thirteen year olds, 2 (2.4 percent) were possible problem drinkers while 2 (2.4 percent) were problem drinkers. Of the 78 twelve year olds, 4 (5.1 percent) were possible problem drinkers and 1 (1.3 percent) was a problem drinker. Of the 67 eleven year olds, 4 (6 percent) were possible problem drinkers and 2 (3 percent) were problem drinkers. Finally, of the 17 ten year olds, 1 (6 percent) was a probable problem drinker while no problem drinkers were indicated.

The break-down of the numbers by sex are the following. Of the 35 students who scored 2 and were classified as probable problem drinkers, 19 (54.3 percent) were male and 16 (45.7 percent) were female. Of the 24 students who were termed problem drinkers, 15 (62.5 percent) were male and 9 (37.5 percent) were female.

Programs for Adolescent Problem Drinkers

All physicians, ministers, and school counselors were sent a survey (Appendix B) in order to find existing programs for adolescent problem drinkers. Of the 45 physicians surveyed, 18 (40 percent) returned their surveys. Of the 27 physicians who did not return the surveys, 12 were specialists who were not involved with alcohol problems. Two others were on vacation, and 3 physicians had moved. Four of the remaining
physicians were called in order to sample the non-respondents. No difference was found between the responses of those who responded and those who did not. This was determined by comparing the responses of the follow-up phone calls with the responses on the returned surveys.

A total of 40 ministers were sent surveys. Eighteen (45 percent) were returned. Of the 22 ministers not responding, 3 had moved. Ten of the remaining 19 were phoned in order to get a sample of non-respondents. No difference was found between the responses of those who responded and those that did not. This was determined by comparing responses of the follow-up phone calls with the responses on the returned surveys.

Nineteen school counselors were sent surveys. Twelve were returned. None of the 7 non-respondents were phoned on a follow-up because the school year had ended. At least one counselor for every school responded.

Table III showed the results of the survey. On question 1, "I am aware that there are adolescent problem drinkers under my supervision and/or care," 24 of 52 surveyed (including follow-ups) said yes. Of 19 surveyed physicians, 9 said yes; 10 of 24 ministers said yes; and 5 of 12 counselors said yes.

Of the 24 surveyed that said yes to question 1, the majority or 12 of referrals on question 2 came from family members of the adolescent problem drinker, and 10 came from the adolescent problem drinkers themselves. Schools referred 7 of the problem drinkers; the courts referred 1; the church referred 2; and other sources referred four. The other
TABLE III
Adolescent Problem Drinking Survey of Physicians, Ministers, and School Counselors

<table>
<thead>
<tr>
<th>Question</th>
<th>Physicians</th>
<th>Ministers</th>
<th>Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am aware that there are adolescent problem drinkers under my supervision and/or care.</td>
<td>(Yes) 8 (1)</td>
<td>8 (2)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>(No) 5 (2)</td>
<td>10 (4)</td>
<td>7</td>
</tr>
<tr>
<td>2. Adolescent problem drinkers are referred to me by:</td>
<td>Courts</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Church</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Member</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Schools</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Self</td>
<td>5 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td></td>
<td>Alcoholics Anony.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1 (1)</td>
<td>1</td>
</tr>
<tr>
<td>3. When adolescent problem drinkers come to my attention, I</td>
<td>Refer them to someone</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Counsel them</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Have treatment program</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4. I have the following programs for adolescent problem drinkers:</td>
<td>Individual counseling</td>
<td>7</td>
<td>5 (2)</td>
</tr>
<tr>
<td></td>
<td>Group counseling</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Alcohol Ed. counseling</td>
<td>1</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Detoxification</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospitalization</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug treatment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vitamin treatment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient treatment</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
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<td>2</td>
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</tbody>
</table>

( ) indicates follow-up response
Table III (Cont.)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Physicians</th>
<th>Ministers</th>
<th>Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>I refer adolescent problem drinkers to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Courts</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Drug Court</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Help Center</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Alcoholic Anonymous</td>
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<tr>
<td>Professional help</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

6. Please list any programs, other than your own, that you are aware of that treat adolescent problem drinkers. 2 5

( ) indicates follow-up response
category included staff and students (schools), hearsay, and the group home.

On question 3, "When adolescent problem drinkers came to my attention, I," the majority or 19 of the surveyed professionals said that they counseled them. Thirteen said that they referred them to someone else. Three said that they had treatment programs for them and 1 said that "they had not confronted them in any specific way yet". Finally, some checked more than one answer; so there are several that do a combination of alternatives.

On question 4, "I have the following program(s) for adolescent problem drinkers," the prevalent program appeared to be individual counseling 18. Again several people checked more than one program. The three that marked "other" dealt more with question 5 on referrals. One used the Johnson Institute (described in Chapter II); another said that he referred problem drinkers to a physician; and the third said that he referred problem drinkers to the Teen Challenge Centers.

Several other programs were listed in question 6. They were the following: Hazeldon; Teen Challenge; Calvary Rehabilitation Center in Phoenix and Flagstaff, Arizona; Galen; Denver, Colorado; Seattle, Washington; Pine Rest Psychiatric Center in Grand Rapids, Michigan; Bethesda Hospital in Denver, Colorado; Friendship House in Gallup, New Mexico; and the Montana Regional Services.

Only three said that they would let their programs be listed on a general listing so that others may be aware of them. Dr. Edward G. Allen,
a physician, listed the following programs that he offers for adolescent problem drinkers: Individual counseling and detoxification and hospitalization. He also used the services of other professional help (psychologists, etc.). Dr. Frank C. Seitz, a psychologist, listed several programs: individual counseling, outpatient treatment, and referral to physicians. He also used most of the other referral agencies listed under question 5 in Appendix B, except the courts. Pastor John Weaver of the Assembly of God Church listed individual counseling and Teen Challenge as two programs that he offered.

Programs Offered by Agencies in Gallatin County

Two agencies, the Gallatin County Drug Center and the Bozeman Problem Drinking Center were interviewed.

TABLE IV

Programs Available to Adolescent Problem Drinkers by Gallatin County Agencies

**Bozeman Problem Drinking Center**
- Individual Counseling
- Family Counseling
- Group Counseling
- DWI School
- Physician Referral
- Detoxification Referral
- Alcoholic Anonymous Referral

**Gallatin County Drug Center**
- Counseling for combined Alcohol-Drug users if funded
- Alcohol Education Program
The Gallatin County Drug Center did not have a specific program for adolescent problem drinkers. They did handle drinking problems in relation to the use of other drugs. They did have an alcohol education plan but lacked funding to implement it. This program was geared mainly for adolescents and involved the following topics: Why Do We Drink? Limits of Consumption; and Recognizing Limits of Consumption.

The Bozeman Problem Drinking Center had several programs available for adolescent problem drinkers: Individual counseling, family counseling, group counseling, DWI school, and an alcohol education program for schools during the school year. They also referred problem drinkers to a physician if necessary. Also, problem drinkers were referred to Galen for detoxification or to a private detoxification center. Home detoxification was offered to those without severe withdrawal symptoms. In addition, one other group was available for adolescent problem drinkers and that was Alcoholic Anonymous.

Summary

The adolescent problem drinking rate for the select schools in the survey in Gallatin County was 4 percent for ages 10 - 19. That was based on the 24 students who responded positively to three or more items on the NAST. The 24 students came from the original sample 587. The number and percentages of adolescent problem drinkers by age was as follows: Eighteen year olds 7.3 percent, seventeen year olds 7.1 percent, sixteen year olds 5.8 percent, fifteen year olds 6.3 percent, fourteen
year olds 1.3 percent, thirteen year olds 2.4 percent, twelve year olds 1.3 percent, and eleven year olds 3 percent. Another 6 percent of the sample population were classified as possible problem drinkers.

Physicians, ministers and school counselors varied in programs available for adolescent problem drinkers. Of the 56 who responded to the survey, 27 had some kind of program available. However, most of these had listed only individual counseling. Also, some of these had not as yet had any adolescent problem drinkers but would do individual counseling if one came to them. The remaining 29 had no programs available for adolescent problem drinkers.

The Bozeman Problem Drinking Center was the only agency in Gallatin County that had programs specifically for problem drinkers. They offered individual counseling, family counseling, group counseling, DWI School, physician referrals, detoxification, and Alcoholic Anonymous referrals.
Summary

Adolescent Problem Drinking Rates

The overall adolescent problem drinking rate for the surveyed sample of adolescents from select schools in Gallatin County was 4 percent. This can be compared with Demone's study (1973) of adolescents in Boston who had an overall 2.1 percent rate of alcoholism. Saltman (1973) completed a similar study in Boston and came up with a 2 percent problem drinking rate. U. S. News and World Report (April 14, 1975) reported an almost 10 percent problem drinking rate for adolescents in New York City. Schwarz (1970) showed a 1.7 percent adolescent problem drinking rate in four Montana schools. There is also a comparison by age of problem drinkers in Gallatin County and Boston. This researcher found that fourteen year olds had a 1.3 percent problem drinking rate, fifteen year olds had a 6.3 percent problem drinking rate, sixteen year olds had a 5.8 percent problem drinking rate, seventeen year olds had a 7.1 percent problem drinking rate, and eighteen year olds had a 7.3 percent problem drinking rate. Demone (1973) found that in Boston, fourteen year olds had a 1.3 percent problem drinking rate, fifteen year olds had a 1.6 percent problem drinking rate, sixteen year olds had a 2.4 percent problem drinking rate, seventeen year olds had a 3 percent problem drinking rate, and eighteen year olds had a 7 percent problem drinking rate.
drinking rate.

The results presented in this paper indicate that the problem drinking rate in Gallatin County among the selected schools was 4 percent compared to the various averages of 2 percent - 10 percent nationwide.

Treatment Programs Available

In Gallatin County, the following programs are available for adolescent problem drinkers: Individual counseling (Problem Drinking Center, Physicians, Ministers, Counselors, Psychologist, Psychiatrist); Family counseling (Problem Drinking Center); Alcohol Education counseling (Problem Drinking Center, Ministers, Physicians); Group counseling (Problem Drinking Center, Alcoholic Anonymous); DWI school (Problem Drinking Center); Detoxification (Physicians); and Hospitalization (Physicians). There also appears to be some referrals between the various professionals involved in treating adolescent problem drinkers. At the same time there appears to be a lack of referrals with those that do not have treatments for adolescent problem drinkers. Some physicians, ministers and counselors feel that adolescent problem drinkers are not a problem. Others feel that it is a problem, but they do not know what to do about it. Also, it appears that others do not know where to turn to get help for adolescent problem drinkers. It also appears that there is considerable inter-agency referral with no one main agency or person responsible for a complete program.

Nation wide, several plans have been established to treat problem
drinkers (alcoholics). The Montana Plans (1972, 1975) listed several essential components for a comprehensive service/treatment system for problem drinkers and alcoholics. They include inpatient services; outpatient services; emergency services twenty-four hours a day; intermediate care such as day care, night care, and weekend care; and consultation and educational services for the community, community agencies, and professional personnel. Other recommended components listed are diagnostic services; rehabilitation services including vocational and educational programs; pre-care and after-care services in the community including foster home placement, home visitations, and half-way houses; and research and evaluation. In addition to these, Cahn (1970) lists several other essential components in mental health and medical care for alcoholics. First, facilities should be staffed primarily by personnel trained and skilled in assisting patients with psychological and social problems. Second, these personnel must be available to serve a wide range of alcoholics. Third, the personnel must be coordinated with and closely related to other major or care giving services such as mental health, public health, medical care, and public welfare. Fourth, they must be so organized as to insure continuity of care between various elements. Finally, they must be guaranteed continued support by legislative bodies and professional groups.
Conclusions

Adolescent Problem Drinking Rates

The adolescent problem drinking rate for Gallatin County appears to be 4 percent among the sample group with a possibility of another 6 percent of the adolescents fitting this category. This means that of the approximately 4,345 students in Gallatin County from ages 10 - 19, from 174 and up to 435, students could be considered problem drinkers. If this entire population were placed in one school, it would be larger than the size of Three Forks High School or almost 16 percent to 40 percent of the Bozeman High School. Since this population is spread over several schools, the problem is not as noticeable as it would be if they would be placed in one school.

The adolescent problem drinking rate in Gallatin County is greater than in the Boston area and appears to be possibly as high as New York City. Also, Gallatin County could have a larger population of adolescent problem drinkers than the Montana schools surveyed by Schwarz (1970).

Finally, this researcher's study appears to substantiate the study done by the Rimrock Guidance Foundation (Montana State Plan, 1975) in that this age group (10 - 19) appears to be a special high risk group and special emphasis must be directed toward this problem (problem drinking) and age group. Since the high rate of problem drinking among adolescents over the other parts of the country are considered to be a serious problem and since the rates obtained in the sample are greater than some and
almost equal to others, Gallatin County appears to have an adolescent drinking problem.

Treatment Available in Gallatin County

In comparing the essential elements for adequate treatment of problem drinkers as recommended by authorities in the field and by those found by this researcher in Gallatin County, several components of treatment appear to be present in Gallatin County. Some types of treatment appear to be missing entirely.

For example, inpatient services are available in Bozeman. The hospital does have a two bed unit for patients with severe withdrawal symptoms. However, only two doctors mentioned this as being available and being used. Next, only five doctors said that they had outpatient care for their patients. No one stated that they had emergency room service at the hospital. In addition, no one offered intermediate care services. However, several professional people are available for consultation and education services to the community. Also, diagnostic services are available from physicians. Nevertheless, there are no rehabilitation services. The only pre-care and after-care services are home visitations. In addition, little research and evaluation is done in Gallatin County. However, there are a number of personnel trained in Gallatin County, although the number of such personnel is too low to ideally handle the problem. These professionals are available to everyone. Moreover, there is a lack of coordination with closely related and
other major care-giving services. Also, there is a lack of continuity of care between professionals dealing with adolescent problem drinkers. Finally, there is not a guarantee of continuing support for existing programs. There appears to be an inadequate number of treatment programs for adolescent problem drinkers at the present time.

Recommendations

Several essential components need to be established while those in existence need to be improved. Both can be done by first establishing an agency to coordinate all programs that deal with problem drinkers, both adolescents and adults. There are already two existing agencies that could handle this job; the Bozeman Problem Drinking Center and Gallatin County Drug Center. Both have the experience to expand and take on this job; however, more qualified personnel would have to be obtained to help. This coordinating agency would also establish continuity between all programs.

The second step is for this agency to establish needed cooperation and continuity among existing programs. Also, existing programs will have to be improved. For example, inpatient facilities are inadequate unless the patients are treated in facilities a long distance away. However, existing local facilities could be improved and could be used extensively if they would be improved. Also, the hospital could improve the 24 hour emergency treatment. The Bozeman Public Schools could contribute greatly
to the statistical process by allowing for a similar study to be conducted in their school system.

Probably the most important program to be improved would be the consultation and education program. A greater amount of educational and rehabilitation programs could be established in the schools. Also, the general public need more awareness to problem drinking and treatment programs.

Intermediate care, pre-care and after-care facilities should be established. Places such as foster homes and half-way homes would enhance the full treatment program.

A continuing research and evaluation program is essential. The effectiveness of programs has to be evaluated consistently in order to make changes to improve their effectiveness. This could easily be done with the cooperation of Montana State University and the schools in Gallatin County.

The final recommendation is a commitment from government officials to continually support these programs with adequate funding. Many programs get good starts only to be cut off financially just as they start having good results.

Overall, there are strong potentials for an adequate rehabilitation program for adolescent and adult problem drinkers. This potential will be best capitalized on by an all-out, cooperative effort by all existing professional people and agencies. Also, an all-out publicity and public education program is necessary in order to get rid of the negative
"Alcoholic" and "Problem Drinking" stigmas that currently prevent most of these individuals from seeking help.
References


Schwarz, R. J. The Drinking Habits of Students and Their Knowledge of Alcohol in Selected Montana High Schools. Unpublished masters professional paper, Montana State University, 1970.


APPENDICES
APPENDIX A

A SURVEY OF ADOLESCENT DRINKING IN GALLATIN COUNTY

Directions: Please fill in the appropriate information. Read each item carefully before you answer. If you have any questions, please raise your hand.

1. Your age at your last birthday. _____
2. Your six (M or F). _____
3. Your grade in school. _____
4. Do you drink alcoholic beverages (Yes or No)? _____

IF YOU PUT DOWN NO, DO NOT FILL OUT THE REST OF THE QUESTIONS. IF YOU PUT DOWN YES, CONTINUE TO READ THE NEXT SET OF INSTRUCTIONS.

The following questions will help to determine the drinking attitudes and habits of adolescents in Gallatin County. Please check ( ) Yes or No for each of the following questions. There are no right or wrong answers on this survey. Answer each one as it applies to you.

1. Do you feel you have a problem with drinking? Yes No _____
2. Do friends and relatives question you about your drinking? Yes No _____
3. Have you or any member of your family attended a meeting of Alcoholic Anonymous (AA)? Yes No _____
4. Have you ever lost friends or girlfriends/boyfriends because of drinking? Yes No _____
5. Have you ever gotten into trouble at work or school because of drinking? Yes No _____
6. Have you ever neglected your obligations, your family, your work, your school work because you were drinking? Yes No _____
7. Have you or any member of your family had delirium tremens (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking?  
   Yes  
   No  

8. Have you ever gone to anyone for help about your drinking?  
   Yes  
   No  

9. Have you ever been in a hospital because of drinking?  
   Yes  
   No  

10. Have you ever been arrested for drunk driving or driving after drinking?  
    Yes  
    No
APPENDIX B

A SURVEY OF TREATMENTS FOR ADOLESCENT PROBLEM DRINKERS IN GALLATIN COUNTY

The following survey deals with adolescents from ages 10 - 19. Please fill in the appropriate blanks for each question that applies to you. More than one blank may be appropriate for each question.

1. I am aware that there are adolescent problem drinkers under my supervision and/or care.
   ___ Yes
   ___ No

2. Adolescent problem drinkers are referred to me by:
   ___ Courts
   ___ Church
   ___ Family member
   ___ Schools
   ___ Self
   ___ Alcoholics Anonymous (AA)
   ___ Other (specify) ________________________

3. When adolescent problem drinkers come to my attention, I:
   ___ refer them to someone else.
   ___ counsel them.
   ___ have treatment program(s) for them.
   ___ Other (specify) ________________________
4. I have the following program(s) for adolescent problem drinkers.

- Individual counseling
- Group counseling
- Alcohol Education Counseling
- Detoxification (where?) ________________________________
- Hospitalization (where?) ______________________________
- Drug treatment
- Vitamin treatment
- Outpatient treatment
- Other (specify) _____________________________________

5. I refer adolescent problem drinkers to:

- Parents
- Courts
- Church
- School
- Problem Drinking Center
- Help Center
- Physician
- Alcoholics Anonymous
- Professional help (psychologist, etc.)
- Other (specify) _____________________________________

6. Please list any programs, other than your own that you listed, that you are aware of that treat adolescent (19 - 19) problem drinkers.
7. I would like my programs listed on a general listing so that others may be aware of it.
   _____ Yes
   _____ No

8. I would like a copy of the results.
   _____ Yes
   _____ No