newsletter

Community Council of the Atlanta Area inc.

Eugene T. Branch, **Chairman of the Board**
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for the COMPREHENSIVE AREAWIDE HEALTH PLANNING PROJECT

Raphael B. Levine, Ph.D. **Director** | Alloys F. Branton, M.B.A. **Associate Director** | Cynthia R. Montague, **Editor**

VOLUME I | **June, 1969** | **NUMBER I**

IN THE BEGINNING–THE LAW

Public Law 89-749 is cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966", and declares the following to be its findings and declaration of purpose. Sec. 2 (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources–national, state and local–to assure comprehensive health services of high quality for every person, but without interference with existing patterns of professional practice of medicine, dentistry, and related healing arts. (b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of state health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

The Partnership for Health Law requires that such planning be done with people rather than for people. Therefore, maximum participation of health "consumers", health professionals, governmental units and agencies, and other community organizations is a necessity. The law is telling the states and communities that they will be given increasing responsibility and power to determine their own best health interests, and that the current Federal practice of funding health-related projects through specific project-type grants will phase into a system of "block" grants to the states for use as local emphasis requires. Eventually, only communities which have organized themselves for comprehensive health planning may be eligible to receive Federal support.

Ideas of excellence need corresponding institutions; the Comprehensive Areawide Health Planning Project is an example of such an idea. Such ideas need feet and so the pioneering march has begun towards healthful social change of a magnitude never before undertaken.

THE SALUBRIOUS WIND STOCKING OF CHANGE

Vision of social and health planners of the Community Council of the Atlanta Area, Inc. (CCAA), made it possible for the Atlanta metropolitan area to be the first area in Georgia to receive an "organizational grant" for the purpose of defining and developing an agency which will be capable of doing comprehensive health planning and obtaining broad community support and participation in the planning effort. This grant, from the United States Public Health Service, through the Georgia Office of Comprehensive Health Planning, supports the CCAA in the professional and organizational effort necessary to instigate such an organization.

The term "comprehensive" means that every aspect of the health landscape in the six-county metropolitan area must be taken into account in the planning process. This includes not only the treatment of illness and injury but the prevention of same as well as compensation for any lasting effects received. In addition to the manifold activities of medical and paramedical personnel in the variety of health treatment facilities, planning must consider environmental controls of air, water, soil, food, disease vectors, housing codes and construction, and waste disposal. Needs for training of health personnel, for improvement of manpower and facilities utilization, and for access to health care must be considered. The fields of mental health, dental health, and rehabilitation should be included. There must be concern about the

THE CONVENORS

Eugene T. Branch, Chairman, Board of Directors, Community Council of the Atlanta Area, Inc.

Dr. Robert E. Wells, Chairman, Area Joint Health Professionals Committee on Comprehensive Health Planning

Gilbert R. Campbell, Jr., Chairman, Metropolitan Area Council of Chambers of Commerce

A necessary step in the organizational development of the Comprehensive Areawide Health Planning Project was the convening of a large "Community Involvement Panel", to which approximately 170 representatives of agencies, organizations, and governmental units were invited. In order to indicate the breadth of concern for health planning in this community, three major groups collaborated in issuing the invitation, and hence, became the "convenors" of the Panel. Shown are the chief officers (left to right) of the three groups: Eugene T. Branch, Chairman of the Board of Directors, Community Council of the Atlanta Area, Inc.; Dr. Robert E. Wells, Chairman of the Area Joint Health Professionals Committee on Comprehensive Health Planning; Gilbert R. Campbell, Jr., Chairman of the Metropolitan Area Council of

Raphael B. Levine, Ph.D.

DIRECTOR'S REPORT

On Thursday, June 5th, the long process of "community involvement" came to a successful climax, when the new "Metropolitan Atlanta Council for Health" met for the first time, and formally accepted the responsibility for guiding the destinies of comprehensive health planning in this six-county metropolitan area. The membership of the Council represents in the truest sense the "partnership for health" concept which is the basis of Federal support of comprehensive health planning. Local governments, major planning agencies, health providers, health consumers, public and private medicine, voluntary health agencies, poor and middle class, black and white, are all present on the Council. Moreover, they were selected for Council membership in the spirit of today's participatory democracy, rather than being appointed by a select body. I am enormously pleased with the caliber of this body of citizens, who will be making policy decisions on health matters for this community. I am convinced that, although they come from many different walks of life, they will function as the 18th Century Statesman, Edmund Burke, expected of the British Parliament:

"Parliament is not a congress of ambassadors from different and hostile interests, which interests each must maintain, as an agent and an advocate, against other agents and advocates; but Parliament is a deliberative assembly of one nation, with one interest, that of the whole—where not local purposes, not local prejudices, ought to guide, but the general good, resulting from the general reason of the whole. You choose a member, indeed; but when you have chosen him, he is not a member of Bristol, but he is a member of Parliament."

ORGANIZATIONAL EFFORT

The work during this organizational year has fallen into two major fields: (A) identification of the technical aspects of community health planning, and (B) development of an organization or agency capable of carrying out comprehensive health planning on a permanent basis.

A. Technical Aspects

The principal technical objectives of this project are (1) to identify the community's principal health problems, and the probable, most urgent planning efforts which will have to be undertaken by the permanent organization during its first year of existence—1970; and (2) to specify the numbers and qualifications of the technical staff who will be needed to carry out such planning. Two of the numerous activities undertaken by the staff and volunteers which bear on these objectives are (a) developing a "systems approach" in planning for the health field, involving cost-benefit analyses, and the building of community health "systems models", etc.; and (b) the use of volunteer "task forces" to identify and scope health problems through descriptions of problem areas, trends, resources, obstacles, and suggested solutions to the problems. A great deal of thanks is due to these hundreds of volunteers, both health professionals and other concerned citizens, for their efforts, expertise, and insights into the health picture of this community.

B. Organizational Development

The principal organizational objectives of the project are (1) to

organization, and (2) to devise an organizational structure for such operation, including corporate identity, policy Council, and the means of selecting the Council and writing its by-laws. Two of the activities undertaken in this field are (a) identification of community interest and decision groups involved in health activities, and holding literally scores of meetings with them; and (b) working out the detailed plans for permanent agency and obtaining acceptance and endorsement of them by important groups in the community: governments, health officials and consumers' groups.

COBB COUNTY HEALTH ADVISORY COUNCIL ESTABLISHED

In tune with the Comprehensive Areawide Health Planning concept, the Cobb County Health Advisory Council was recently born. The infant Council has the charge of determining the county's health needs in order of priority and how such needs should be met. Mr. William Thompson, Administrator for the Cobb Health Department, and Chairman of the newly formed Council has cited four areas of concern: service, manpower, finances, and facilities. The idea of such Health Advisory Councils grew out of the Partnership for Health Legislation of 1966 which established a program of providing matching funds to help communities obtain needed health services and facilities. Says Dr. Raphael B. Levine, Director of the Metropolitan Atlanta Comprehensive Areawide Health Planning Project, "Citizen participation in health planning at the local level as well as the metropolitan level is essential to a successful community-wide effort. It is most encouraging that the Cobb County Health Advisory Council has been formed", he concluded.

BACKGROUND—Dr. Raphael B. Levine

Dr. Raphael B. Levine was educated at the University of Minnesota. There he received a Bachelors and Masters degree in Physics and a doctorate in biophysics. His recent professional work has consisted of developing "intelligent" computors which can learn to recognize patterns of behavior in complex systems (biological or physical). Some of his previous research activities concerned man's reaction to physical and emotional stresses of atmospheric and space flight, as well as the electrical activity of the heart and brain. He has taught and done research at the University of Minnesota, the University of Illinois, and Ohio State University. Since 1958, he has been managing and performing research in the Human Factors Laboratory and the Systems Sciences Research Laboratory of the Lockheed-Georgia Company. In 1968, he became the consultant to and then the Director of the Comprehensive Areawide Health Planning Project for Metropolitan Atlanta under the Community Council of the Atlanta Area, Inc. He is currently serving as President of the Planned Parenthood Association of the Atlanta Area.

BACKGROUND—Alloys F. Branton, Jr.

Alloys F. Branton, Jr., was educated at the University of Minnesota where he received a Bachelor of Arts Degree, and at the University of Chicago where he received a Masters Degree in Hospital Administration. He was Health Division Secretary of the Council of social Agencies of Greater New Haven, Inc., New Haven, Connecticut. Next, he served as a Health Consultant to the Community Health and Welfare Council of Hennepin County, Inc., Minneapolis, Minnesota. He came to Atlanta as Assistant Director of the Hospital and Health Planning Department, Community Council of the Atlanta Area, Inc. He is now Associate Director of the Comprehensive Areawide Health Planning Project. He also has an appointment as adjunct faculty member, Course in Hospital

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VOLUME I November, 1969 NUMBER VI

MACHEALTH NOMINATING AND PERSONNEL COMMITTEES

Two very important committees were selected at the October meeting of MACHealth by nomination and vote of the membership. The Nominating Committee will propose a slate of officers for the first Annual Meeting and election in January. The work of those officers will, to a great extent, determine the success of MACHealth in its first full year. Another duty of the Nominating Committee will be that of selecting organizations who will name members to MACHealth in subsequent years. This will be done by collecting and evaluating a list of eligible groups in categories to be represented. A fair rotation and equal representation will be achieved in this way.

The Personnel Committee will select and recommend to the Council a candidate for Director of the Agency. It will also set personnel policies for the MACHealth staff.

Members newly elected are:

Nominating Committee

Hon. L. Howard Atherton, Mayor of Marietta. He is also President, Georgia Municipal Association, member of the Georgia House of Representatives, Chairman of Metropolitan Atlanta Council of Local Governments. He has been a tireless supporter of MACHealth since its early inception.

Mr. A. B. Padgett, Chairman Pro Tem of MACHealth. A Trust Officer of the Trust Company of Georgia, Mr. Padgett is on the Executive Board of the Community Council and was Chairman of the Steering Committee for the Comprehensive Health Planning Project.

Dr. Robert E. Wells, Chairman of the Board, Fulton County Medical Society. He is an orthopedic surgeon, and directed the Joint Health Professionals Committee for Comprehensive Health Planning, as well as participating on the Executive Committee of the early Steering Committee.

The Rev. Ervin B. Broughton, member of the Governing Board, Gwinnett County E.O.A. A retired Baptist minister, Rev. Broughton still pastors two churches, is a Mason and President of his Lodge, and works in his community for improved social conditions. He is a lifelong resident of Lawrenceville.

Personnel Committee

Hon. Walter M. Mitchell, Chairman, Fulton County Board of Commissioners and Executive Committee member of the Steering Committee.

Mr. Drew R. Fuller, Chairman, Health and Health Services Committee, Atlanta Chamber of Commerce. He was also on the Steering Committee's Executive Committee and has devoted much time and effort to the organization and success of MACHealth.

Mr. J. William Pinkston, Jr., Administrator, Grady Hospital. He has given many hours in service to the concept of Comprehensive Health Planning and in furthering its support.

Mrs. Loretta Barnes, Secretary Pro Tem of MACHealth. Her yeoman service to the Council has been evident from the start, and is unselfishly given in addition to her work for the Interdenominational Theological Seminary and as a busy mother.

Mr. Paul Cadenhead, lawyer in private practice, president-elect, Atlanta Bar Association, past president of both Atlanta Mental Health Association and Georgia Association for Mental Health.

MRS. ELIZABETH C. MOONEY

Vivacious Mrs. Elizabeth C. Mooney is a member of MACHealth. She was appointed to the MACHealth Board by Economic Opportunity Atlanta to represent the poor and near-poor. She resides in the Antoine Graves Homes, is secretary of the local Citizens Neighborhood Advisory Council (CNAC), and a member of the Atlanta EOA Health Committee.

Despite the absence of her larynx, she manages to speak quite audibly and eloquently whether she is conversing with Senator Russell in Washington about the welfare freeze or passing the time of day with someone on the street in Atlanta.

Mrs. Mooney, a retired nurse, has stood the test of survival for 64 years and is still going strong. She has battled a heart condition, cancer, diabetes and low blood pressure; she triumphs almost weekly over debilitative conditions of a more ephemeral nature such as eye trouble and toe infections.

Mrs. Mooney's hobby is working with people. She is always there, giving of herself; sometimes in the form of a flower arrangement which she has designed with her own hands, at other times, simply uttering comforting words from the heart.

Mrs. Elizabeth C. Mooney–humanitarian, friend of Grady Memorial Hospital, valuable member of MACHealth.

CONTRIBUTIONS FOR 1969 EFFORTS RECEIVED

We acknowledge with thanks the recent contribution of the Clayton County Commission of $2280 toward the current year's operations of the Comprehensive Health Planning Project. We are also pleased to report that the Gwinnett County Commission has appropriated $1748 for the same purpose. These amounts, added to previous receipts from Fulton, DeKalb, and Douglas counties, plus gifts from private sources, have made possible the work of the project to date. Such local funds have served to "match" equal dollar amounts from the U. S. Department of Health, Education, and Welfare.

MENTAL HEALTH HOUSE BILL NO. 1

Frank Adams Smith

In 1958, the General Assembly made a major revision in the law relating to hospitalizing the mentally ill, according to recommendations of the Joint Senate-House Mental Health Committee, chaired by Peyton Hawes.

Other minor revisions were made in 1960 and 1964. In 1969, another major revision, House Bill 1, was enacted.

In the 1969 Act, the procedure for Voluntary Admission and the judicial procedures for Involuntary Admission are substantially the same as in the current law.

While the protection of "rights of the patient" was a predominant characteristic of the 1958 Act and of succeeding Acts, the 1969 Law extends and broadens this protection.

The 1969 Act provides for emergency care up to 24 hours, and for evaluation and intensive treatment up to 5 days; and limits further hospitalization to an initial six months. Additional hospitalization can be warranted only by thorough examination

of the patient indicating such need and by the authorization of the Court of Ordinary. The patient, his attorney, guardian or representatives, if they desire, can request a hearing.

Emergency care, evaluation and treatment for a period of 5 days, and limitation of hospitalization, have not been provided in any prior law. Emergency care and evaluation plus short-term intensive treatment should prevent at least 50% of the patients now going to Central State Hospital from having to go there.

The limitation to six months of the initial order for hospitalization forevermore bans the "putting away for life" of any mentally ill person.

The philosophy of the 1969 law, simply stated, is that the mentally ill are in fact "ill" and should be treated as sick people and should have immediate and intensive care and treatment. This philosophy is identical with the philosophy of comprehensive mental health services enunciated by Congress in 1963.

The metropolitan Atlanta area is fortunate in having a Regional Hospital which will be both an Emergency Facility and an Evaluation Facility. Also Grady Memorial Hospital is now performing the functions of an Emergency and Evaluation Facility.

The governing authority of each county can choose between the "medical procedure," which is outlined in the new law, and the "judicial procedure" which is essentially the same as in the current law. No formal action is necessary for a county to operate under the "medical procedure" of H.B. 1, but formal resolution by the governing authority is necessary to function under the "judicial procedure." Such action can be taken only once a year.

In every step of the "medical procedure," the patient and representatives are notified of his right to an attorney, which the county must provide, if the patient is unable to pay for such services. The patient, his representatives and attorney are notified of patient's right to judicial intervention at any time they think his rights are abrogated.

The sections of the law relating to "rights of patient" became effective June 1, 1969. The remainder of the law becomes effective January 1, 1970.

Quote

How can we get more participation in solving environmental health problems? By encouraging community leaders to come to the Health Department and other agencies to learn all they can about the environmental health needs and then to approach the governmental officials in quest of meeting these needs.

Clifford Alexander,
Environmental Health Planner

Raphael B. Levine, Ph.D.

DIRECTOR'S REPORT

At the October meeting of MACHealth, the Council voted, after a spirited discussion, to approve the changes in language dealing with the responsibilities and influence of the new agency. A large majority of the members agreed with the committee appointed to negotiate the wording, that the new language fairly states the role of MACHealth in the health affairs of the six-county area. Several of the members felt, however, that MACHealth should play an even more influential role than indicated. I believe that all of the MACHealth staff and Council members want this new agency to be just as effective as possible, since the needs for comprehensive planning were never greater than at present. In fact, MACHealth has already been able to influence rather strongly some very important issues in the hospital and nursing home field, and the Council's power of review of all locally-originated action projects in the health field will continue to work toward a truly comprehensive, truly areawide kind of health planning.

With the new wording approved, the staff was able to enter the final stage of revising our proposal for funding by the Federal Department of Health, Education, and Welfare. When completed, the proposal will be published in a single binding, although the division into three volumes (project summary, budget and staff, and task force reports) will continue. We expect to print about a thousand of these volumes, and will be surprised if the demand for copies is any less than this number.

MACHealth is continuing to receive recognition from additional important agencies: governments, medical professional associations, hospitals, voluntary organizations, and the like. Since June, some 13 such agencies have added their recognition to the 45 who had done so by that date. The list now covers nearly all of the important health action agencies, as well as many of those concerned with matters closely related to health.

MORE AIR CURRENTS

Four people active in MACHealth affairs have recently been seen on the area television media: Mr. A. B. Padgett and Dr. Raphael B. Levine were seen on separate programs on Channel 11 in the series produced by the Urban Life Center of the Georgia State University. Mr. Duane W. Beck was a recent guest on the Ruth Kent "Today in Georgia" show, speaking about the Community Council of the Atlanta Area. Mr. Louis Newmark was interviewed by Linda Faye on Channel 11 in connection with a session of the State Conference on Aging of which he was chairman entitled "Involvement of Older People in the Community." The appearances of Dr. Levine on Pat Wilson's "Tempo Atlanta" show (Channel 36) began, and are scheduled to continue with a monthly appearance at 11:30 A.M. on the fourth Thursday of each month hereafter.

ENVIRONMENTAL HEALTH TOUR

The Environmental Health Tour as presented in the August, 1969, Newsletter will be held on Thursday, November 13, 1969. Notices with further details will be sent to all MACHealth members before that time.

MACHEALTH MEETING DAY CHANGED

The MACHealth meeting day has been changed by action of the Council to the second Thursday of each month. This was done in order to avoid a conflict with the Executive Committee of the Community Council of the Atlanta Area, Inc., which meets the first and third Thursday of each month.

MRS. KATHARINE B. CRAWFORD—Trothplighted

Comprehensive Areawide Health Planning's Organization Liaison, Miss Katharine B. Crawford, has left the organization to become the bride of Dr. Marvin D. Smith. The bride and groom will reside in Gadsden, Alabama where he has established a practice in Ophthalmology.

Miss Crawford has made a tremendous contribution to the efforts of Comprehensive Health Planning and her presence will be missed by her friends and co-workers. The best life has to offer is wished for her and Dr. Smith.

BACKGROUND—William F. Thompson—Consultant

A hardworking member for MACHealth is William F. Thompson, Administrative Officer of the Cobb County Health Department.

He finished secondary school at Young Harris Academy, going on to Piedmont College for a Bachelor of Arts Degree in mathematics and education. He was awarded a National Science Foundation Scholarship to Washington University and received his Master's Degree in Public Health Administration from the University of North Carolina. He has been a tuberculosis investigator; Director, Medical Self Help Program; and an instructor in the Medical College of Georgia, Graduate Nursing Division.

Supported in part by Areawide Comprehensive Health Planning Grant No. 41008-01-69 under section 314(b) of Public Law 89-749

Community Council of the Atlanta Area inc.

EUGENE T. BRANCH, *Chairman of the Board of Directors*
CECIL ALEXANDER, *Vice Chairman*
JOHN IZARD, *Vice Chairman*
MRS. THOMAS H. GIBSON, *Secretary*
DONALD H. GAREIS, *Treasurer*

DUANE W. BECK, *Executive Director*

ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE 577-2250

June 2, 1969

Hon. Ivan Allen, Jr.
Mayor of Atlanta
City Hall
Atlanta, Georgia 30303

Dear Mayor Allen:

This is to inform you of activity taking place since my earlier letter to you on the subject of your membership on the new Metropolitan Atlanta Council for Health. There has been a slight change in the meeting time of the Council because of room assignment conflict. The first meeting of the Council will be this Thursday at 11:30 A. M., in room 619 of the Glenn Building, 120 Marietta Street, N. W., Atlanta, Georgia.

The principal business of this Council meeting will be to discuss and approve the proposal to be submitted to the U. S. Public Health Service, and to certify that the Council accepts responsibility for the policy aspects of comprehensive areawide health planning in this metropolitan community, beginning in January 1970. Additional business will be to discuss and approve Council By-Laws, and to approve a program of activities for the balance of 1969. These are recommended to include (1) meetings, seminars, and field trips for familiarization of Council members with health problems of the community and the types of action the Council can take; (2) the naming of a Personnel Committee for the purpose of selection of a Director of Comprehensive Areawide Health Planning and the recruiting of staff prior to the beginning of operations in January 1970; and (3) the naming of a Nominating Committee for presenting a slate of permanent officers to the first Annual Meeting in January, 1970.

Enclosed with this letter are Volumes I and III of the Proposal, as they now exist. Additional material is still coming in, but the pages you have before you include all of the vital material on which your approval is being asked. Volume II of the Proposal contains detailed budgetary material, and will be covered at the meeting. I would like to invite your attention especially to the following pages in Volume I: i - ii, 2-3, 8-9, 16-17, 48-49, 54-55, 64-65, 88-89, 90-91, 92-93, 96-97, 98-99, and the By-Laws 100-107. Please read as much of the other material as you may have time for.

ATLANTA METROPOLITAN AREA

COMPREHENSIVE HEALTH PLANNING

PROPOSAL

VOLUME III

TASK FORCE REPORTS

Submitted by

METROPOLITAN ATLANTA COUNCIL OF LOCAL GOVERNMENTS

20 June 1969

This is an incomplete edition of VOLUME III,

PROPOSAL FOR COMPREHENSIVE
HEALTH PLANNING

Other work is in process of completion.

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FOREWORD TO VOLUME III

The descriptive reports in this volume represent the efforts of some 27 "task forces" organized to assist the comprehensive health planning staff in identifying the Atlanta area's health problems in sufficient detail to project the scope of the first year of effort by the permanent planning staff. Several hundreds of area citizens, both health providers and health consumers contibuted their time, expertise, and insights in the preparation of these reports. Although in many cases, the task force reports were quite detailed and voluminous, all have been condensed for inclusion in this volume. The points of view expressed in these reports are those of the task forces themselves, and their recommendations deal with the specific problem areas, rather than with the total community health situation. As input to the total planning process, these are valuable documents, and the staff expresses great appreciation to the task force chairmen and members.

SUMMARY:
EXISTING VACANCIES WILL INCREASE ALARMINGLY WITH POPULATION GROWTH UNLESS MORE INDIVIDUALS ARE ATTRACTED AND RETAINED. THESE PROFESSIONS SHOULD BE UPGRADED AND PUBLICIZED; EDUCATIONAL OPPORTUNITIES SHOULD BE DEVELOPED, AND TRAINING PROGRAMS COULD USE FINANCIAL SUPPORT. SYSTEMATIC EVALUATION OF EXISTING AND FUTURE NEEDS AND RESOURCES SHOULD BE DETERMINED AND UTILIZED AS THE BASIS FOR A COMPREHENSIVE EFFORT TO CORRECT THESE DEFICIENCIES.

Problem:

Demand grows faster than supply. Why?

--While existing vacancies are distressing,

--Population increases create new needs;

--Public and professional awareness of these professions is minimum;

--Required education (B.A. or corresponding degree) is not within the financial reach of many;

--Professional dedication is exacting;

Y E T

VOCATIONAL BENEFITS,
CAREER OPPORTUNITIES AND
PRESTIGE are inadequate.

--Training programs are still in the development stage in Georgia;

--Communication and coordination needed to unite all related health care groups behind a study and solution of this problem is lacking;

--Funds to develop programs, sponsor students; for research and patient care are not available.

--Accurate assessment of all needs - present and future, has not been made.

Resources:

There are clinical, medical, rehabilitation facilities which provide practical training, and while the number is increasing, further expansion will be necessary.

One graduate and two undergraduate programs in Allied Health Professions are presently under development, but these will require time to grow and graduate trained individuals. Even these, however, cannot fulfill the number or variety of available positions.

Solutions:

Undertake systematic analysis of the entire problem to serve as a realistic basis for planning and corrective action.

Provide financial support, develop career incentives, arouse public/professional interest in and for these professions.

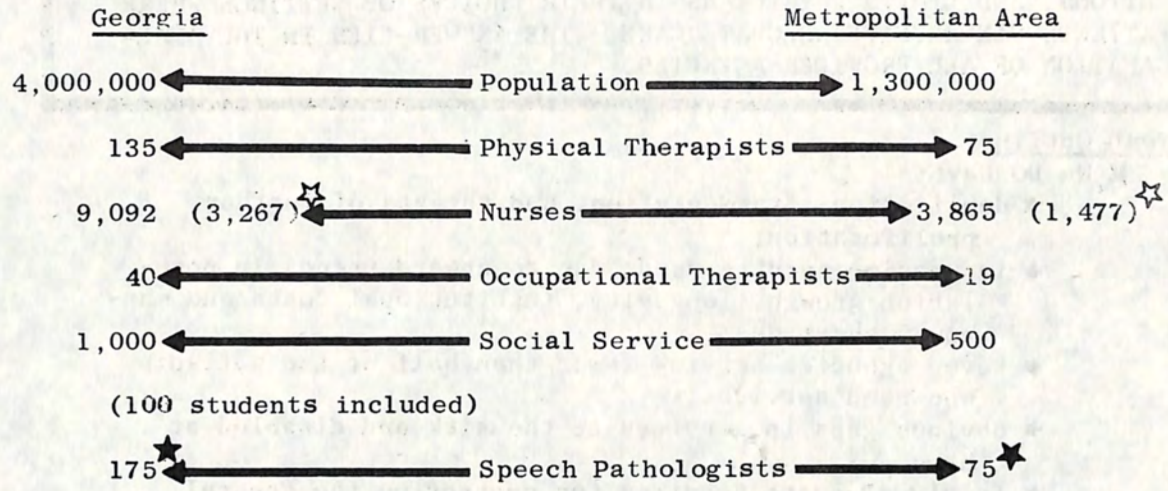
Develop transportation and communication networks in all areas: patients, employers, health professionals, institutional, organizations and associations, public and private agencies.

Empahsize broad health service rather than: crisis oriented care.

Improve and expand hospital and rehabilitation facilities to assist in training and improve use of present personnel.

Mount an aggressive campaign to recruit <u>and</u> <u>retain</u> - even recall - existing personnel.

NUMBER OF REGISTERED ALLIED PROFESSIONAL PERSONNEL IN GEORGIA AND IN THE ATLANTA METROPOLITAN AREA



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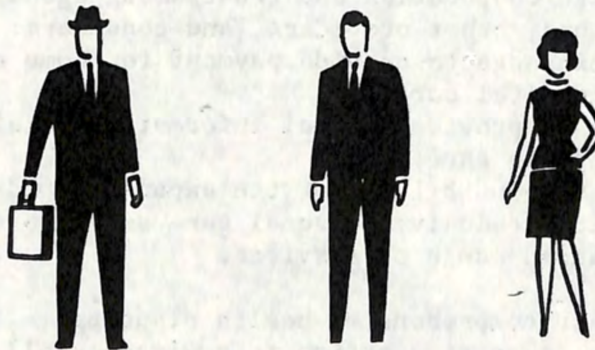
★ (public schools included)



Home Health Care

SUMMARY:

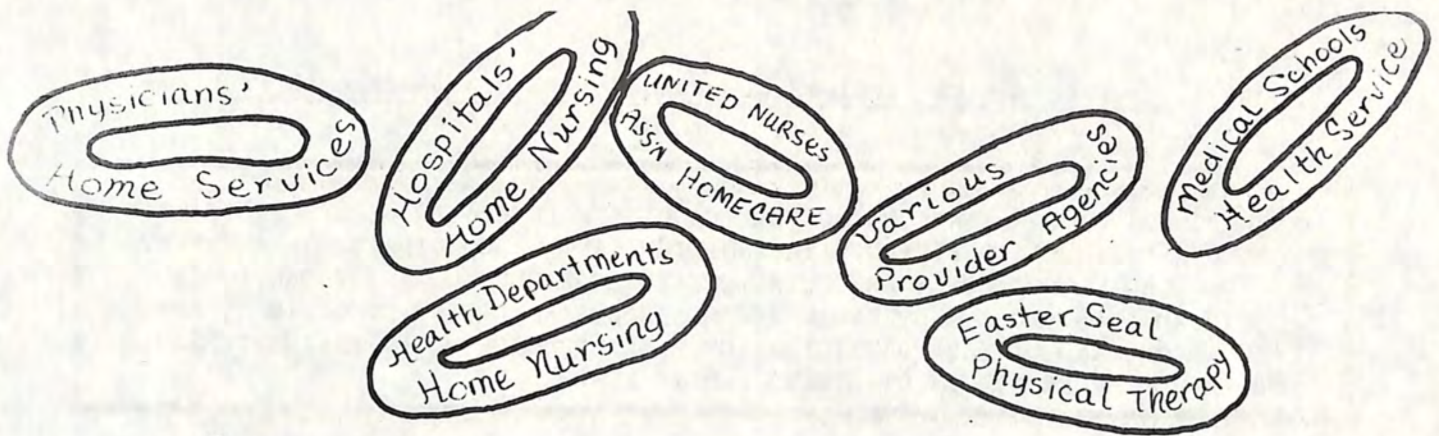
THE PAUCITY OF HOME HEALTH SERVICES IN THE ATLANTA AREA LEAVES MANY PATIENTS WITHOUT NEEDED CARE, CREATES SERIOUS BOTTLENECKS IN INSTITUTIONS, AND LIMITS PHYSICIANS IN THEIR CHOICES OF SETTINGS WHERE PATIENTS CAN RECEIVE ADEQUATE CARE. THE ANSWER LIES IN THE AMALGAMATION OF ALL PROVIDER AGENCIES.

Text Outline:

- We DO have:
  - duplication, fragmentation, and threats of further proliferation;
  - increasing service needs due to upward trends in population growth, longevity, institutional costs and manpower shortages;
  - seven agencies serving fewer than half of the patients who need services;
  - obvious gaps in services to the sick and disabled at home;
  - fairly adequate services for protecting the general community health; and
  - interest and concern for better coordination, primarily due to activity under special projects over the past three years.

- We DO NOT have:
  - a central coordinating and research unit;
  - the most efficient, economical, and effective utilization of our limited supply of personnel;
  - whole-hearted cooperation and trust among agencies, institutions, other providers, and consumers;
  - insurance exchange to provide payment for home care in lieu of hospital care;
  - a structure to provide central information, liaison, and easy access to care;
  - designated responsibility for the expansion and development of comprehensive personal care services at home; and
  - a well balanced range of services.

- Specific charge to comprehensive health planning:
  - Long Range: agressive action to amalgamate all agency providers of home health services; and
  - Immediate: central coordination and establishment of research and education programs in home health services.



Separate Links – no matter how strong – DO NOT MAKE A CHAIN!

The ATLANTA AREA needs a chain of home health services

Meeting Health Problems Compounded with Socio-Economic Problems

SUMMARY:
THE POOR AND DISADVANTAGED SUFFER INEQUITIES IN HEALTH LEVELS AND CARE UNDER EXISTING INSUFFICIENT, INCONSISTENT AND UNCOORDINATED ARRANGEMENTS WHICH ALSO DO NOT CONSIDER THE ALMOST INSEPARABLE SOCIAL, ECONOMIC AND CULTURAL PROBLEMS. A SYSTEM BASED ON IMPROVING LIVING CONDITIONS, HEALTH EDUCATION, AND CITIZEN PARTICIPATION WOULD PRODUCE MORE PERMANENT RESULTS WHILE MORE EFFECTIVELY UTILIZING PUBLIC FUNDS.

Problem:

Poor sanitation, inadequate and improper diet invite and perpetuate health problems.

The under and improper use of health services and resources lend to the seriousness and aggravation of health services and problems.

Quality of housing and overcrowding are related to certain diseases, accidents, and mental disorders.

All of these primary social and physical conditions are characteristic of the economic poor.

Health care tends to be piecemeal, poorly supervised, and uncoordinated.

Current Resources:

Public Health Department programs, services, facilities
Federal outlays of $465,453,901 in 1968 (HEW, HUD, OEO)
Charity hospital with more than one thousand beds
Local and State Government contributions
Over twenty health-centered voluntary agencies

Solution:

A health centered approach to these problems should:

* plan together with other social institutions, programs, and movements to develop adequate and safe living conditions in the areas of homelife, housing and neighborhood, transportation, health and general education, business and industry, legal arrangements, health resources, etc.; and

* encourage the development and improvement of medical resources and programs to meet technological, organizational, cultural, geographical, numerical considerations of what our society needs.

Trends:

Indications are that as things go, "the sick get poorer and the poor get sicker." In turn, it is their voice which is seldom heard and frequently not interpreted into programs designed for them.

PROBLEMS IDENTIFIED FOR COMPREHENSIVE HEALTH PLANNING BY A SAMPLE OF LOW-INCOME RESIDENTS

Problem	Meeting: 1 County: G Present: 24	2 F 15	3 G 10	4 F 5	6 F 8	7 F 18	8 F 6	9 F 8	10 F 6	TOTAL 102
HEALTH										
Knowledge of Services	☐		☐	☐	☆					4
Trash, litter, refuse	☐	☐			☆			☐		4
Emergency Care		☐	☐							2
Discrimination at Hospital			☐							1
Insufficient Personnel			☐		☆					2
Inadequate Services			☐				☆		☐	3
Sewage				☐	☆				☐	3
Garbage and Rats			☐							1
Limitation of Charity Care						☆	☆		☐	3
Special Envioronmental Need	☐	☐						☐		3
Health Problems Total										26
HEALTH RELATED										
Finances	☐			☐						2
Transportation	☐	☐	☐		☆		☆			5
Garbage Service	☐	☆	☐		☆					4
Code Enforcement			☐		☆			☐		3
Housing			☐		☆			☐		3
Street Lighting					☆					1
Fire Hydrants	☐									1
Housekeeping									☐	1
Mental Releasee Employment						☐				1
Health Related Problems Total										21
All Problems Total										47

G=Gwinnett County
F=Fulton County

☐ =mild concern
☆ =high concern

Problem Indicators:

ATLANTA (SMSA), 1960:

Overall:	
Families with income under $3,001	21%
Unsound housing units	19%
In Depressed areas:	
Families with income under $3,001	52%
Persons per residential acre	58
Non-white:	
Percent of total population	23%
Median income	$3,033.00
Median years of education	7.6

Title: Better Mental Health for the Atlanta Area

SUMMARY:
MENTAL HEALTH PROBLEMS GENERALLY ARE CAUSED BY STRESSES AND STRAINS ON PERSONS AND ARE DUE TO ENVIRONMENTAL, PHYSICAL, SOCIAL, ECONOMIC, EDUCATIONAL AND OTHER FACTORS. ONE OUT OF TEN PERSONS COULD BENEFIT BY RECEIVING SOME FORM OF MENTAL HEALTH SERVICES. BUSINESS AND INDUSTRY SUFFER HEAVY LOSSES FROM THE IMPACT OF MENTAL ILLNESS ON EMPLOYEES AND THEIR FAMILIES. SURVIVAL OF OUR DEMOCRATIC INSTITUTIONS IN THIS HIGH ENERGY NUCLEAR AGE MAY WELL DEPEND ON MOBILIZING THE RESOURCES OF EVERY COMMUNITY TO FIGHT AND PREVENT MENTAL DISORDERS AND TO PROMOTE POSITIVE MENTAL HEALTH.

Problem:
130,000 inhabitants of the metropolitan area (10% of population) could lead happier more effective lives if they had the benefit of modern mental health services.

Ten percent of school children have handicapping emotional and psychological problems. These children need help towards self-realization.

Heavy loss by business and industry in the metropolitan area due to impact of emotional and psychological disturbance on worker and family, can be drastically reduced by a comprehensive system of modern mental health services.

Greater involvement of general hospitals, physicians, and psychiatrists is essential to proper development of mental health programs.

Insurance coverage not yet adequate.

More MANPOWER must be made available; better use should be made of present personnel and new sources of manpower explored.

Mental health services must be brought to the people rather than administered for the convenience of the "establishment".

Full development of comprehensive community mental health centers in the ATLANTA AREA is a TOP PRIORITY.

Total resources of every community should be mobilized to treat and rehabilitate victims of mental illness, to PREVENT mental disorders, and to produce a climate conducive to better mental health for all.

Physicians could and should be first line of defense against mental illness, but their medical training has not prepared them for this role. The outpatient clinics, as a rule, are severely understaffed.

A crucial barrier to the developing mental health program is lack of trained personnel.

Current Status:
No general hospital in the Atlanta Area accepts patients who are mentally ill. Exceptions: Emory University operates a psychiatric unit of twenty beds for patients selected for teaching purposes; and Grady Memorial Hospital has a psychiatric unit of thirty-six beds for emergency short-term patients.

The public schools' staff, while improving in number and qualifications, is still inadequate.

The State Retardation Center is under construction.

Psychiatric units as components of comprehensive community mental health centers are under construction, as follows: Clayton County Hospital (25 beds); DeKalb General Hospital (44 beds); and Northside Hospital, Fulton County (25 beds).

There are four private psychiatric hospitals in the Atlanta Area (SMSA).

The State Regional Hospital (Atlanta) has been constructed and is being activated to serve fourteen counties.

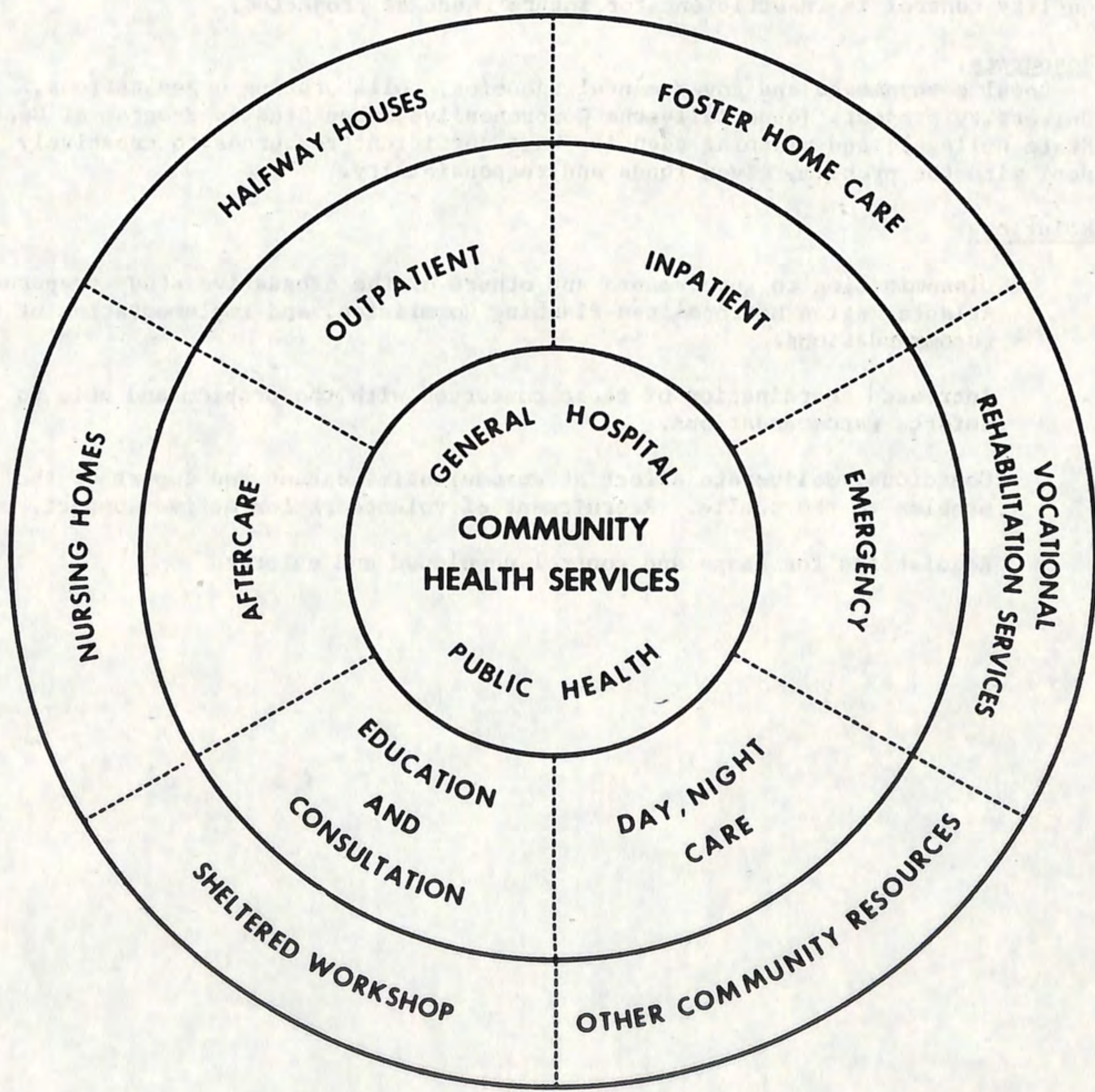
The State of Georgia has built the Georgia Mental Health Institute for the primary purpose of "training and research".

Possible Solutions:
The full development of at least ten proposed comprehensive community mental health centers in the Atlanta Area will alleviate for the present many of the problems when they become operational.

More MANPOWER must be made available, better use should be made of present personnel and new sources of manpower should be explored.

Total reliance must not be placed on hospitals, clinics, or mental health professionals to do the "job" of dealing with mental health problems; but rather every resource in the community, such as the schools, the churches, the courts, the health and welfare agencies, etc., should be fused with and oriented in basic principles of mental health, that each will be a positive force that will help create a climate conducive to better mental health for all.

COMPREHENSIVE COMMUNITY MENTAL HEALTH PROGRAM



Control of air, water pollution and waste disposal vital to Atlanta Area future.

SUMMARY:
THE CONSERVATION OF ENVIRONMENTAL RESOURCES OF AIR AND WATER AND THE RELATED CONTROL OF WASTE DISPOSAL ARE FUNDAMENTAL CONTRIBUTORS TO HEALTHFUL LIVING. IN THE ATLANTA METROPOLITAN AREA THE CRITICAL PROBLEM IS ONE OF AREAWIDE PLANNING AND IMPLEMENTATION IN TERMS OF PRESENT AND PROJECTED POPULATION NEEDS.

Problem:

Present water resources will be adequate for future needs only if handled properly on a planned basis. Waste water, solid waste, and air pollution are compounding problems as a result of lack of overall planning and coordination among governmental bodies. Pollution of rivers and streams threatens health, recreation and wildlife. Automobile graveyards, rodent-infested litter and dump areas illustrate to the observer an increasing solid waste problem. Air quality control is insufficient for future needs as projected.

Resources:

Local governments and governmental agencies, collaborating organizations, University projects (especially the Comprehensive Urban Studies Program of Georgia State College), and planning agencies have sufficient resources to creatively deal with the problem, given funds and responsibility.

Solutions:

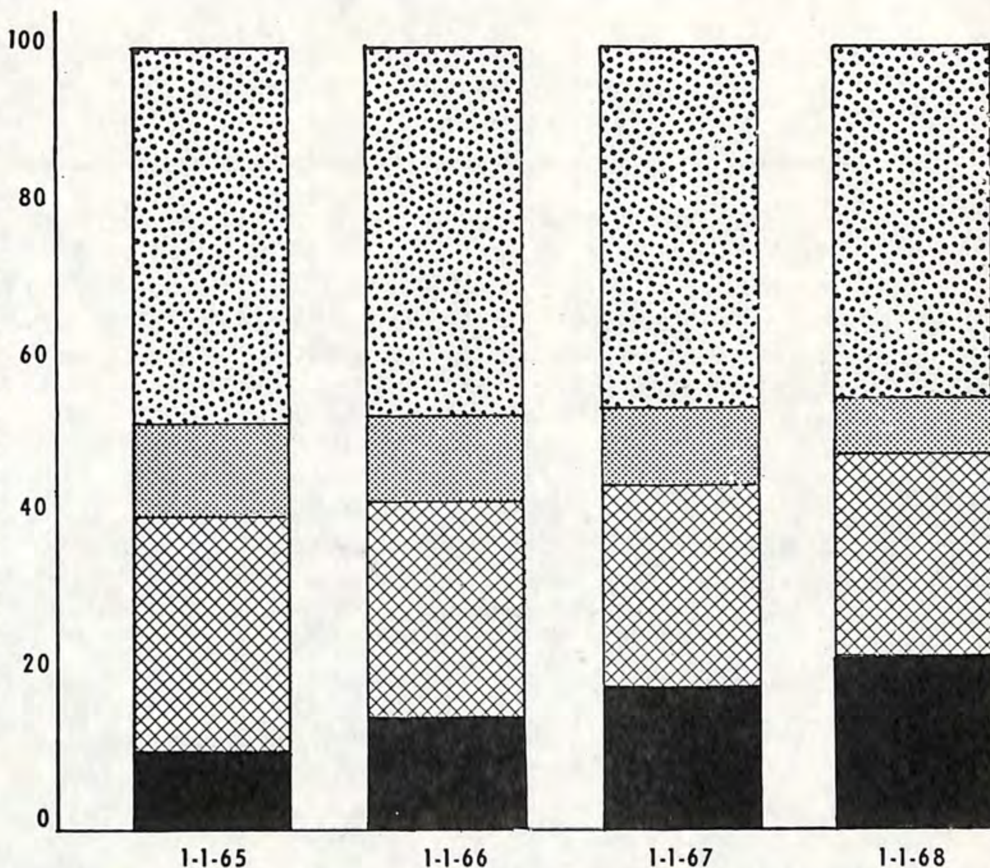
Dissemination to governments and others of the exhaustive study prepared for Atlanta Region Metropolitan Planning Commission, and implementation of its recommendations.

Increased coordination of those concerned with the problem and able to enforce recommendations.

Conscious, deliberate effort at communicating extent and import of the problem to the public. Recruitment of volunteers for active support.

Regulations for usage and control developed and enforced.

PROGRESS TOWARD PROVISION OF ADEQUATE SEWAGE TREATMENT IN GEORGIA



DATE

LEGEND

Adequate Treatment

Sewers, No Treatment

Inadequate Treatment

Not on Sewerage

POLLUTED STREAMS

POLLUTED AIR

Proctor Creek - Case Study of a Multiple-Impact Health Hazard

SUMMARY:
PERIODIC FLOODING OF PROCTOR CREEK, A HIGHLY POLLUTED WATERWAY IN SUBURBAN ATLANTA, RESULTS IN CONTAMINATION, DROWNINGS, INCREASE IN NUMBER OF PESTS, DESTRUCTION AND LOSS OF PROPERTY. REDUCTION IN POLLUTION AND FLOOD LEVELS MUST BE SOUGHT TO IMPROVE OVERALL CONDITIONS IN THE NEIGHBORHOOD.

Problem:

An area involving 1200 residences and 6000 families encounters the following problems as direct result of pollution and flooding of the creek:

Seven drownings in six years.

Illnesses directly related to pollution.

Sewage backup and overflow conditions in homes.

Uninhabitable basements resulting from constant sewage backup.

Severe, oppressive odors.

Proliferation of pests, insects, rats.

Property erosion, damaged building foundations, loss of large articles in floods.

Fire hazard from oil and other flammable materials in creek.

Current Resources:

Georgia Water Quality Control Board, Public Works Department of Atlanta, the Corps of Engineers, and area industrial plants.

Solutions:

Alternative plans and detailed study of cost alternatives and benefits will be necessary for improvements of the creek and adjacent areas. Possibilities include:

Channel improvements, floodwalls, enclosure, zoning restrictions.

Controlled access to prevent drownings.

Clean stream beds and banks of unsightly and hazardous objects that block stream flow.

Separation of sanitary and storm sewers.

Make area adjoining stream part of a lineroe regional park.

Evacuate residents and fill creek.

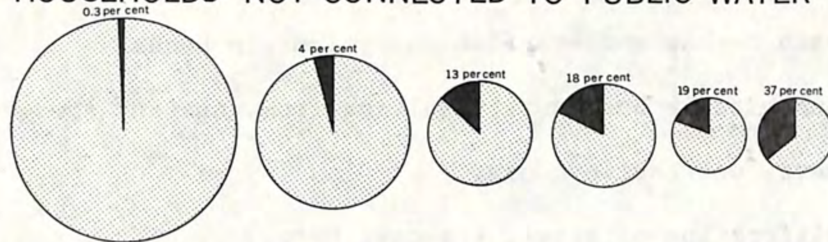
Indict companies contributing to pollution.

Park site demolition

SOLID WASTE

AIR POLLUTION

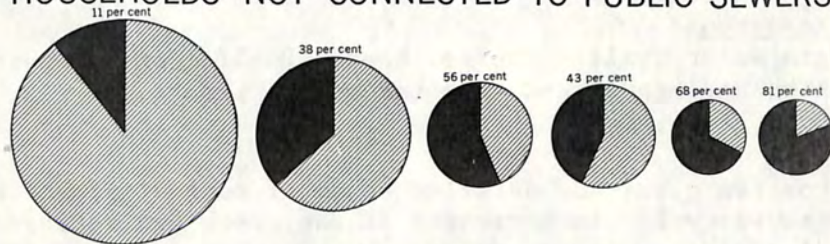
HOUSEHOLDS NOT CONNECTED TO PUBLIC WATER



	Atlanta	DeKalb Co. outside Atlanta	Cobb Co.	Fulton Co. outside Atlanta	Clayton Co.	Gwinnett Co
Connected	153,696	60,523	28,702	26,124	10,415	7,974
Not Connected	441	2,518	4,425	6,194	2,449	4,770

SEWAGE

HOUSEHOLDS NOT CONNECTED TO PUBLIC SEWERS



	Atlanta	DeKalb Co. outside Atlanta	Cobb Co.	Fulton Co. outside Atlanta	Clayton Co.	Gwinnett Co
Connected	137,182	39,223	14,587	18,332	4,116	2,384
Not Connected	16,955	23,818	18,540	13,986	8,748	10,360

OPEN SEWERS

PROBLEMS OF PROCTOR CREEK

ODOR PROBLEM

SOLID WASTE DISPOSAL

SOIL EROSION

DROWNING

FLOOD PROBLEM

Public Health, Budgets, Boundaries and Personnel

SUMMARY:
THE NUMBER OF PERSONS TREATED WITHIN PUBLIC HEALTH SERVICES, ALMOST WITHOUT EXCEPTION, IS DIRECTLY RELATED TO THE COUNT OF MANPOWER, FACILITIES, AND POPULATION OF A GEOGRAPHICAL AREA RATHER THAN TO COMMUNITY HEALTH. OF COURSE, THIS IS A CONVENIENT ARRANGEMENT OF OUR MARKET ECONOMY AND JURISDICTIONAL SUBDIVISIONS. IF SERVICES WERE BASED ON MORE EXTENSIVE INVESTIGATION AND DOCUMENTATION OF HEALTH NEEDS RATHER THAN A CAPACITY TO PROVIDE SERVICES, PRESENT RESOURCES AND EFFORTS COULD BE MORE EFFECTIVE.

Problem:

Programs in Public Health are dependent upon both county and state funds and budgeting policies.

While these policies do take into account health needs and demands, they are directly affected by grant-in-aid formula.

As grant-in-aid monies are received on a local level, local directors are required to decide on where local (matching) money, furnished by the county governments, will be spent.

A thorough analysis of community consumer needs has not been developed.

It is patently impossible for the same individual to both operate and objectively evaluate program areas.

Confining program operations along county lines has adversely affected certain state health programs.

Reciprocity is provided for and is even discouraged by budgets.

A planning agency could:

Broaden the voice of dècision in programs to include lay, governmental, and professional consumers as well as providers.

Share the burden of public health officials in allocation decisions.

Extend planning and establish communication across county lines in such programs as water and air control, industrial hygiene, sanitation, etc.

Title: Emergency Health Services - The Systems Approach

SUMMARY:
PRESENT EMERGENCY HEALTH SERVICES DEPEND UPON DECISIONS OF MANY INDEPENDENT LOCAL AUTHORITIES. LACK OF COORDINATION AND COMMUNICATION, AS WELL AS LACK OF INFORMATION ON WHAT CARE IS AVAILABLE AND HOW TO UTILIZE IT RESULT IN OMISSIONS, DUPLICATIONS AND DISSERVICE TO THE PUBLIC.

Problem:

There is much adequate emergency health care being planned and provided (especially for disaster and mass casualty) but uncoordinated efforts are resulting in dynamic deficiencies:

NEEDS	Unfulfilled	in some vital areas
STAFFING FACILITIES	Inadequate	numbers quality distribution
SERVICES	Incomplete Restricted Part-time	and often tardy to some classes death follows no clock
INFORMATION	Fragmented	in-service and to the public who often most need to know
TRAINING	Insufficient	for public self-help or service personnel needs
TRANSPORTATION	Dangerous	clogged urban corridors delay help/cause accidents
FINANCING	Marginal	and less in urban areas
COMMUNICATION	Infrequent	between the private and public power structures most involved in health services
PLANNING	Duplications & Omissions Unimaginative	uncoordinated efforts of all 6-county area groups; emergency health programs; reluctant public and professional acceptance of new methods

Needed:

One comprehensive system administered by one community-wide representative agency.

Solution:

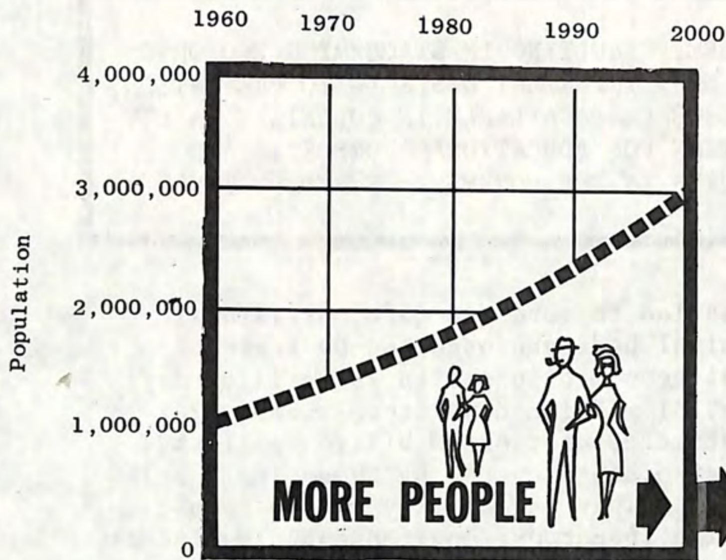
The Systems Approach: The involvement of all health-concerned institutions, organizations -- including governmental units and officials, both legislative and executive under the experienced guidance of health professionals.

The Goal: One central agency, one overall plan, to provide total, adequate emergency health services and care throughout the community.

Objectives:

* Increase staffing and facilities
* Provide adequate ambulance service
* Train the public in first-aid and medical self-help
* Establish hospital affiliated neighborhood health care centers
* Initiate two-way radio communication between hospitals, fire, police, hospitals, and other emergency care units
* Hold actual disaster and mass casualty exercises

EMERGENCY SERVICES



Total Population; Atlanta Five-County Source: Atlanta Region Metropolitan Planning Commission

<u>Emergency Health Services in the Atlanta Area???</u>

Health care is divided into a number of categories. One of the most important of these is emergency health care. The following:

Hospital emergency room care
Emergency care in physicians' offices
Emergency care in neighborhood health centers
Emergency care in industrial situations
First aid training of the public
Accident prevention
Ambulance services
Marking of evacuation routes
Helicopter evacuation and landing facilities
Emergency psychiatric and acute alcoholic care
Poison control and poison control centers
Blood banks
Communications between institutions and organizations providing emergency health care
Public information on sources of emergency health care
Education and continuing education of personnel providing emergency health care
Disaster and mass casualty reception

are not emphasized and organized in the Atlanta area.

Prevention of Accidents Can Significantly Reduce Area Toll of Deaths and Injuries

SUMMARY:
ACCIDENTS CONSTITUTE A MAJOR HEALTH PROBLEM, RESULTING IN STAGGERING ECONOMIC AND MANPOWER LOSSES. PUBLIC APATHY, THE MOST IMPORTANT OBSTACLE TO PREVENTION, MAY BE OVERCOME BY WELL PLANNED USE OF RESOURCES AVAILABLE IN VOLUNTARY SAFETY CONTROL, LEGISLATION, IMPROVED COMMUNICATION FOR EDUCATIONAL PURPOSES, AND PLANNING FOR BETTER SAFETY PHYSICAL FEATURES IN THE MOVEMENT OF PEDESTRIANS AND VEHICLES.

Problem:

An ever-increasing flow of traffic has led to more and more collisions, injuries, and deaths. Nearly 50% of hospital beds are occupied by accident victims. National figures indicate annual economic losses in 132 million days bed-disability, 94 million days work loss, 11 million days school loss, 22 million hospital bed days, and a total estimated cost of 12 billion dollars. Home, traffic, and other accidents are most often incurred by those least able financially and socially to bear the burden. This may chiefly be the result of compounded difficulties -- poor education, hazardous environment, low income.

Current Status:

Mortality statistics indicate the problem has reached epidemic proportions. Accidents are the leading cause of death to persons under the age of 44, and rank fourth as cause of death in all ages, following heart disease, cancer, and stroke.

Obstacles:

A major challenge is that of changing the viewpoint of those who still think of accidents as uncontrollable events. Public apathy exists, in this more than any major area, largely as a result of ineffective communication between experts and lay people. Indicative of this is fear of loss of personal freedom when strict preventive legislation is proposed.

Solutions:

1. Increased cooperation between safety councils, legislators, and mass media for planning and communication.

2. Increased use and standardization of drivers education in schools and defensive drivers courses in adult organization.

3. Increased financial support for safety-involved organizations.

4. Research into human behavior aspects of safety/accident problems.

5. Better street and highway design in the Atlanta Area.

6. Elimination of unnecessary roads and streets in order to provide for better pedestrian and vehicle movement.

7. Planned program of railroad, street and pedestrian "grade separation" in the Atlanta area.

8. Institution of a streetlighting program.

MAJOR FACTS ABOUT ACCIDENTAL INJURIES AND DEATHS-1968
(Statistics provided by: Epidemiology and Surveillance Branch Division of Accident Prevention,State of Georgia)

Following are estimates of the annual toll of accidents for the United States:

Persons killed	112 thousand
Persons killed motor vehicle	53 thousand
Persons injured	52 million
Persons injured,moving motor vehicle	over 3 million
Persons bed-disabled by injury	11 million
Persons receiving medical care for injuries	45 million
Persons hospitalized by injuries	2 million
Days of restricted activity	512 million
Days of bed-disability	132 million
Days of work loss	90 million
Days of school loss	11 million
Hospital bed-days	22 million
Hospital beds required for treatment	65 thousand
Hospital personnel required for treatment	88 thousand
Annual cost of accidents	$16 billion
Annual cost of accidental injuries	$10 billion

It is estimated that the prevalence of physical impairments caused by injuries in the non-institutionalized population of the United States is over 11 million.

Medical and Dental Service/Information and Referral

SUMMARY:

INFORMATION ON THE HEALTH SERVICE NETWORK IN THIS AREA IS FRAGMENTED AND UNCOORDINATED. REFERRAL PROCEDURES LACK STANDARDIZATION. CHANGING POPULATION AND INDUSTRIAL CHARACTERISTICS SUGGEST RE-APPRAISAL OF CURRENT AREAS OF CARE CONCENTRATION AND COORDINATION. MANY OF THE CAUSAL FACTORS ARE BEYOND THE CONTROL OR EVEN THE PURVIEW OF THE PRACTITIONER.

A CENTRAL PLANNING AGENCY COULD GATHER, MAINTAIN AND DISSEMINATE THE INFORMATION BOTH CARE PROVIDERS AND USERS NEED.

Problem:

Direct health care involves doctors, dentists, other health workers, hospitals, health centers, associations, programs and community organizations. The patient enters the system at any point, in highly varied states of health, wealth, intelligence and experience. Both parties suffer strain and are inefficiently serviced due, in part, to incomplete, haphazard information and referral systems.

Atlanta Has:

Health characteristics that are frequently below National par, consistently below those of Northeast metropolitan areas, but that rate favorably with other parts of the South.

Population increases and related rising health service demands that are offsetting past numerical gains in medical personnel, facilities and agencies.

Aggravated problems of age, youth and working women arising from rapid urbanization and industrial growth.

Complex administrative, educational and personnel procedures resulting from complicated Federal programs and financing.

One large hospital supplying quality care to a vast but limited number of indigent sick of two counties. Patients needing some types of care cannot be adequately treated, and even normal sicknesses exceed the plant's capacity.

Medical societies and voluntary agencies making outstanding efforts in community health planning and implementation for several but incomplete areas.

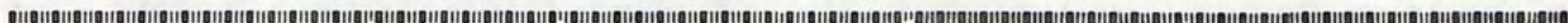
Atlanta Needs:

Formal communication between demands and provisions of services. Increased and more efficient use of existing personnel and facilities.

Broader and more intense coverage of community health problems.

SELECTED CHARACTERISTICS OF METRO ATLANTA WHICH AFFECT MEDICAL CARE SERVICES

Characteristic	Primary effect on Medical Care Services
More older persons	Domicillary and extended care, treatment for special diseases and impairments, third-party payment
More younger persons	Treatment for infectious diseases, including venereal disease, accidents, impairments, handicaps, maternal and child care.
Urbanization and industrialization	
Special groups	Special deliveries of care (migrants, veterans, etc.)
Affluence	Greater quantity and quality of care.
Poverty	Public provision of care.
Congestion	Epidemiological control.
Suburbanization	Geographical redistribution.
Formal groups	Special interests.
Mobility	Fragmented care.
Work shifts	Full time availability.
Working females	Convenience, special diseases.
Organization and Bureaucratization	Third-party payment, insurance, prepayment
Federalization	Public programs and financing
Medical centers, schools special institutions	Personnel demands
Technological advancement	Development of medical science Greater expectations from public mediums of broader communication



Title: Alcohol and Drug Abuse - Causes Human Suffering

SUMMARY:
RECOGNIZED AS THIRD LARGEST HEALTH PROBLEM, BUT CHARACTERIZED BY NEGLECT, STIGMA AND REJECTION. PUNITIVE REACTION TO PROBLEM MUST YIELD TO A CONSTRUCTIVE APPROACH OF ASSISTING THE PERSON TO RECOUP AND REGROUP HIS PSYCHOLOGICAL RESOURCES FOR A MORE ADEQUATE RESPONSE TO LIFE'S RESPONSIBILITIES AND OPPORTUNITIES.

Problem:

Atlanta area (SMSA) leads nation in rate of arrests for public intoxication.

Largest market in world for bootleg whiskey.

Area has estimated 50,000 victims of alcoholism.

$5 million expended annually for local care of victims of alcoholism and their families.

$12 million annual loss to local industry due to alcoholism; absenteeism, accidents, lowered efficiency, etc.

Human suffering due to alcoholism cannot be estimated.

General Hospitals of area reluctant to accept victims of alcoholism as patients. Ditto doctors.

No facilities for treatment of drug addicts.

Current Resources:

Are limited in scope. The Georgian Clinic division of the Georgia Mental Health Institute and limited private programs, serve the entire state population. This service is incidental to the institute's research and training mission. The Emory University Vocational Rehabilitation Alcohol project which has served the chronic court offender alcoholic will probably be discontinued due to expiration of a three-year federal grant program. The Georgia Division of Vocational Rehabilitation provides limited rehabilitation services for alcoholics. A start has been made in the Atlanta Region (SMSA) toward preventing alcohol drug abuses through integrating services for individuals with the plans for comprehensive community mental health programs.

Treatment, care and rehabilitation of victims of alcoholism and persons addicted to drugs must be incorporated in the services of the proposed comprehensive mental health centers of the area, including some adjacent counties.

Additional reliable data is needed on the extent, nature and scope of the local problems of alcohol and drug abuse on a basis upon which to plan effective and innovative programs for prevention, control, treatment and rehabilitation of alcohol and drug abuse.

★ Changing attitudes and concerns of communities by information, education and consultation.

★ More effective enforcement of drug laws and regulation of drugs.

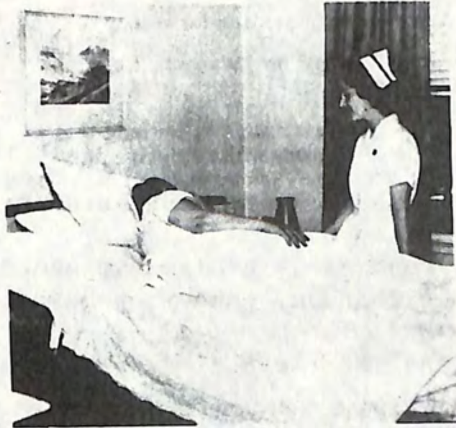
Trends:

Since most authorities and federal officials embrace the view that alcohol and drug addiction is a problem of living and probably symptomatic of an emotional illness that should be treated (a non-criminal circumstance) it logically appears that newly developing programs associated with community mental health centers will evolve as well as a thrust toward improving conditions in deprived neighborhoods where addiction is most common.

Goals and Objectives:

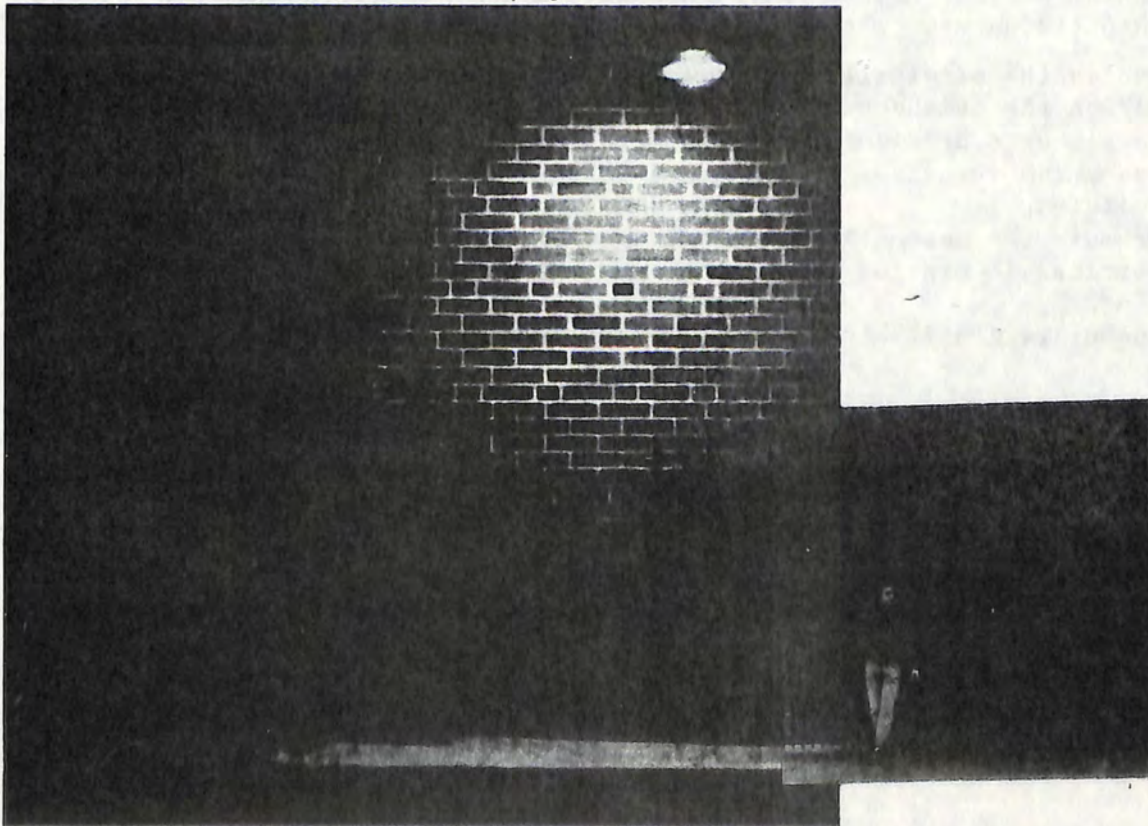
The Georgia Legislature has expressly recognized alcoholism as a disease and declared it to be a public health problem with administrative responsibility for alcoholic rehabilitation given directly to the Division of Mental Health of the State Department of Public Health and indirectly to the County Boards of Health and Public Health Departments. Comprehensive programs for alcohol and drug abusers can be developed in conjunction with or as an integral part of comprehensive mental health programs. The range of services that will be provided by the community mental health programs are very nearly the range of services required for dealing with alcohol and drug problems. The goals of these programs and services will be: (1) improved health and prevention of disease; (2) separation of the alcohol and drug abuser from alcohol and drugs; (3) repairing the physical and emotional damage and preventing further damage; (4) changing community institutions, programs and services to meet the special needs of the alcohol and drug abuser. While federal funds will be helpful in launching programs, state and local governments cannot presently rely upon federal funds for long-range support, although such continued federal support may well represent the only hope for programs for the alcohol and drug abuser in Georgia.

DRUNKS DON'T BELONG IN JAIL



By Henry Jackson

DRUG ABUSE: The Empty Life



Balancing the Costs of Health Care

SUMMARY:

THE COSTS OF MEDICAL CARE ARE RISING SHARPLY, EVEN MORE THAN THE COST OF LIVING. ILLNESS, DISABILITY AND PREMATURE DEATHS CREATE DISPARATE COSTS - BOTH DIRECT AND INDIRECT - TO FAMILIES ACCORDING TO CIRCUMSTANCES WHICH THEY CANNOT APPRECIABLY CONTROL: INCOME AND OCCUPATION, TYPE OF DISEASE AND TREATMENT.

Problem:

The costs of health make it prohibitive to some families and ultimately contributes to poorer health and additional costs to the community.

Current Status:

1. Federal assistance is directed to special groups of persons: Aged, maternal and infant, indigent, etc.
2. Federal programs are developed around certain diseases and disabilities: Crippled children, tuberculosis, blindness, cancer, venereal disease, etc.
3. Middle-income groups use physicians' services at a lower annual rate than other income groups.
4. Certain businesses and industries promote health and coverage from debilitating health expenses.
5. The costs of health insurance rises with the cost of medical care, especially hospital rates.

Possible Solutions:

The rising cost of health may be stabilized and the entire community brought into its purview within an area plan which can:

1. Review the eligibility requirements of tax-supported health services.
2. Reduce the demand on rare skills by providing information and referral services to providers and consumers.
3. Recommend the wider inclusion of extra-hospital services in insurance policies.
4. Promote the assembling of complex equipment, professional skills and services to provide for extensive, continuous, non-domicilary treatment.
5. Encourage architectural and organizational modernization in hospitals.

THE COSTS

OF BEING UNHEALTHY

NUMBER OF DISABILITY DAYS* PER PERSON PER YEAR BY FAMILY INCOME, TYPE OF DISABILITY AND AGE

In the United States, July 1966-June 1967

	All Incomes**	Under $3,000	$3,000-4,999	$5,000-6,999	$7,000-9,999	$10,000 and over
RESTRICTED ACTIVITY						
All ages	15.4	27.6	16.3	13.7	12.3	11.9
Under 17 years	9.6	9.2	9.1	9.9	9.7	10.1
17 - 24 years	9.6	12.8	9.8	9.0	9.3	7.9
25 - 44 years	13.8	24.8	17.0	14.1	11.9	11.3
45 - 64 years	21.4	43.5	25.5	18.0	15.9	14.8
65 years and over	35.2	39.8	29.2	36.2	34.8	29.0
BED DISABILITY						
All ages	5.6	9.7	5.9	5.3	4.4	4.5
Under 17 years	4.3	5.1	4.2	4.6	4.0	4.2
17 - 24 years	4.1	4.5	4.4	4.0	4.5	3.5
25 - 44 years	4.8	9.0	6.5	4.6	4.1	3.9
45 - 64 years	6.9	14.3	7.5	6.3	4.6	4.8
65 years and over	11.9	13.2	9.2	12.9	10.7	12.5
WORK-LOSS DAYS AMONG CURRENTLY EMPLOYED* **						
All ages	5.4	7.9	6.7	5.8	4.4	4.6
Under 17 years		—	—	—	—	—
17 - 24 years	3.9	4.7	4.5	4.3	4.2	2.7
25 - 44 years	4.8	8.1	6.6	5.3	3.7	4.2
45 - 64 years	6.6	10.3	7.9	7.3	5.5	5.7
65 years and over	6.3	7.0	7.9	5.0	****	6.7

*Refers to disability because of acute and/or chronic conditions.

**Includes unknown income.

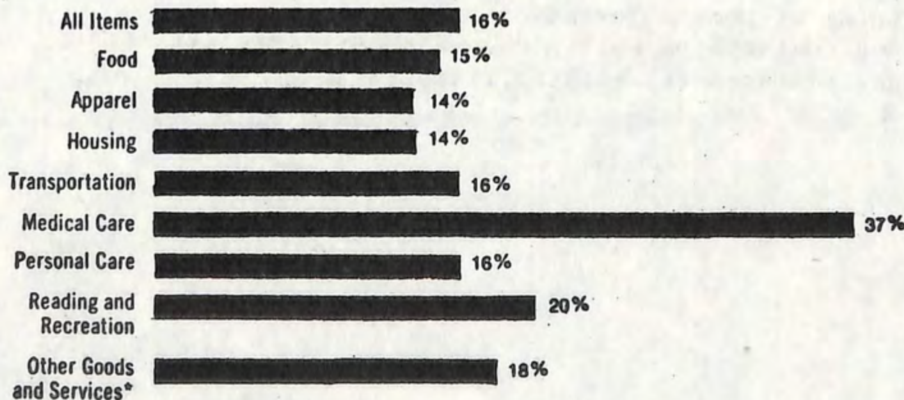
***Based on currently employed population 17+ years of age.

****Figure does not meet standards of reliability or precision.

Source: United States National Health Survey, United States Department of Health, Education and Welfare.

INCREASES IN MEDICAL CARE AND OTHER MAJOR GROUPS IN THE CONSUMER PRICE INDEX

In the United States, 1957-59 — 1967



*Comprises tobacco, alcoholic beverages, legal services, burial services, banking fees, etc.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

THE COSTS

OF BEING HEALTHY

Coordination of Planners

SUMMARY:
A COMMUNITY-WIDE HEALTH PLAN CANNOT SUCCEED WITHOUT STRONG COORDINATION OF ALL INTERNAL AND EXTERNAL SPECIALIZED PLANNERS. THE VARIETY AND INTERDEPENDENCY OF MODERN PLANNING AGENCIES REQUIRE A CAREFULLY CONSIDERED LONG-TERM BASIS FOR BENEFICIAL INTERACTION AND EXCHANGE WITHOUT LOSS OF CREATIVE AUTONOMY. PRESENT SHORT-RANGE, INFORMAL, INCOMPLETE COORDINATION, WHICH CAN RESULT IN DUPLICATIONS AND OMISSIONS, SHOULD BE STRENGTHENED BY A COMPREHENSIVE, CONSENSUAL LONG-RANGE PLANNING FRAMEWORK.

Text Outline:

- Reasons for coordination:
  - The informal, unstructured coordination among local planners are inadequate to the pace of change in the modern community.
    - Present planning coalitions are arranged around limited groups and mainly for short range goals.
    - While there are 60 agencies listed as serving the physically disabled, the gaps and overlaps are only suggested, the interrelationships are not well established.
  - Cities are receiving increasing amounts of federal aid and attention yet no projective framework for land-use, transportation, services, health care, etc., has been adopted by relevant providers.
    Physical and population rearrangements are widespread and require accompanying service rearrangements.

- How coordination could be achieved:
  - Provision of channels of communication and programs of active cooperation by:
    - exchanging of skills and controls (personnel, data, funds, etc.);
    - use of computer based techniques;
    - interlocking decision-making arrangements;
    - overlapping of common jurisdictions;
    - organized contacts on multiple levels of staff; and
    - meetings, conferences, mailing lists.

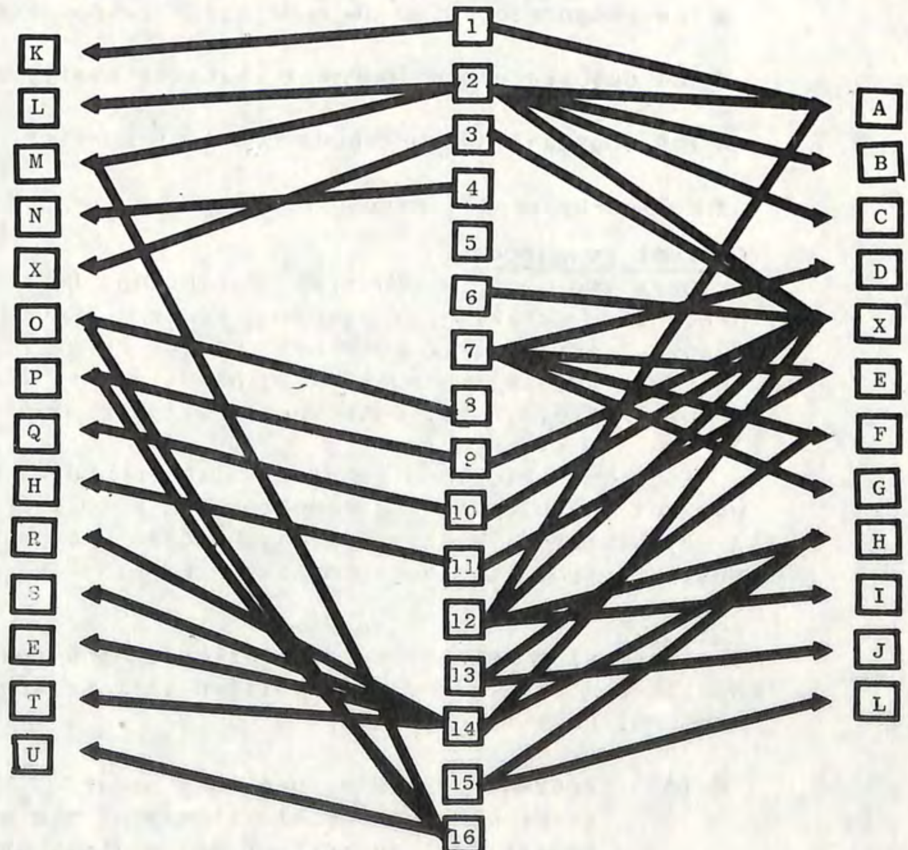
PROFILE OF HEALTH AND HEALTH RELATED PLANNING AGENCIES

Agency (Coded) — Characteristic (Yes = ■)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Characteristic
■	■	■	■	■		■	■	■	■	■		■	■	■	■	Permanent
		■	■		■	■	■		■		■					Official
■		■		■		■	■	■			■	■	■	■	■	Serves more than 1 county
■	■	■		■	■		■	■	■	■	■		■	■	■	Directly related to health
■		■	■		■			■	■	■		■	■		■	Advisory function
■	■	■	■	■	■		■			■	■	■	■	■	■	Implementing function
	■							■			■		■	■		Direct evaluation procedure
■	■	■		■	■	■		■	■	■	■		■		■	Collects health data
						■									■	Reports published (health)
■	■	■			■	■		■	■	■	■	■	■	■		Uses outside consultations
■			■		■	■	■	■	■	■	■		■			Reports on request
■	■	■	■		■	■		■	■	■	■	■	■	■		Immediate future plans
■	■	■	■				■	■	■	■			■	■	■	Formal interagency relations
■		■	■					■	■		■		■	■	■	Finance interagency coord.
■	■						■	■	■	■			■			Formal planning structure

EXTENT AND DIRECTION OF INTERCHANGE AMONG A SELECTED GROUP OF PLANNERS

PLANS WITH — PLANNER — CONSULTS



Note: Numbers and letters are coded for names of agencies. A decoded listing may be found in the Appendix.

Suicide Prevention - Crisis Intervention

SUMMARY:
THE MAGNITUDE, URGENCY AND COMPLEXITY OF SUICIDAL AND PSYCHIATRIC CRISES MAKE THEM PUBLIC HEALTH PROBLEMS. THE TRAGEDY, CHRONIC RECURRENCE AND OFTEN LENGTHY HOSPITALIZATION CONNECTED WITH THESE EMERGENCIES CAN BE AVERTED OR ALLEVIATED BY CONSISTENT PREVENTIVE CARE. THE PROPOSED COMMUNITY COMPREHENSIVE MENTAL HEALTH CENTERS COULD EFFICIENTLY PROVIDE THESE NEEDED MULTI-DISCIPLINE SERVICES.

Problem:

Past reluctance of the general lay and medical public to openly become involved in the recognition, research, cooperation and sympathetic treatment these crises demand.

Suicide nationally, ranks among the top ten causes of death; is fourth in cause for all male deaths between 20-45, and is second highest cause among college fatalities.

In the Atlanta Metropolitan Area, the suicide rate exceeds the National average by about 25%.

For each actual death by suicide, 8-10 serious attempts occur.

Psychiatric crises--that often end in suicide or physical violence to others, can often be foreseen by trained personnel in the complex web of social, economic, cultural and health problems that aggravate mental instability.

* The essence of time demands quick responsive help.
* The desperate bewilderment requires easily available aid.
* The constant danger needs constant service, on a 24 hour basis.
* Follow-up of all cases is basic.

Current Resources:

Only two Georgia counties, Fulton and DeKalb, are served by a suicide-prevention, crisis-intervention center. Coordinated with Grady Memorial Hospital psychiatric services and the respective County Health Departments, the program has two multi-discipline crisis teams available 24 hours a day. A total of 4,375 patients were treated in 1968.

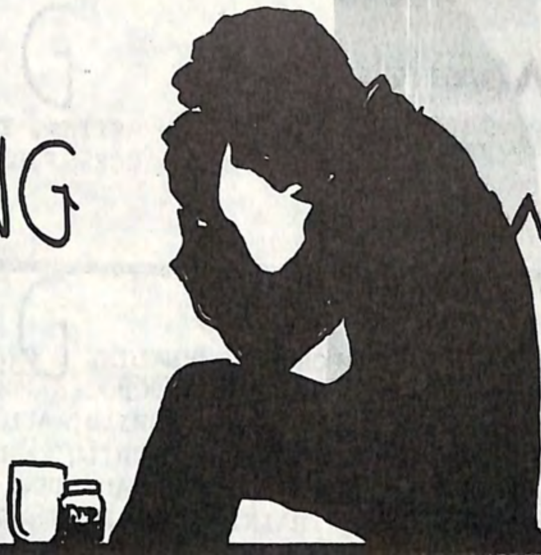
A unique telephone service, also manned 24 hours a day, 7 days a week, was set up to cover ten counties, on a toll-free basis. The "staff" includes a psychiatrict, a clinical psychologist, a psychiatric nurse, three public health nurses, two sociologists, and six "lay counselors."

Solution:

The fastest possible implementation of the ten proposed Community Mental Health Centers in the Metropolitan Atlanta Area, with the backup of Georgia Regional Hospital-Atlanta.

* To: Prevent crises before they occur.
  Eradicate the social stigmas of the problems.
  Enlist full support of all medical and political units.
  Make effective use of current knowledge and resources.

DEBATING with DEATH



FULTON-DeKALB EMERGENCY MENTAL HEALTH SERVICE
CASES BY COUNTY - FIRST 18 MONTHS

Fulton.........	1530	44.1%	Gwinnett.........	45	1.3%
DeKalb.........	622	17.9%	Douglas	10	.3%
Cobb	130	3.7%	Other	57	1.6%
Clayton.......	70	2.0%	Unknown	1009	29.1%

PSYCHIATRIC SERVICES - GRADY MEMORIAL HOSPITAL
January - December, 1968

I	Emergency Patients	4375
II	Inpatients	1912
III	Outpatients	4022
IV	Consultations:	
	A. Medical Inpatient Service	356
	B. Pediatrics	166
	C. Obstetrics	757
V.	Drug Clinic Opening July, 1968-December, 1968	803
VI.	Crisis Service Opening August 19, 1968-December, 1968	421
VII.	Psychiatric Day Center Opening November 4, 1968-December, 1968	36

MENTAL RETARDATION (MR) PROGRAM NEEDS: MORE, BETTER, EARLIER, MORE ACCESSIBLE

SUMMARY:

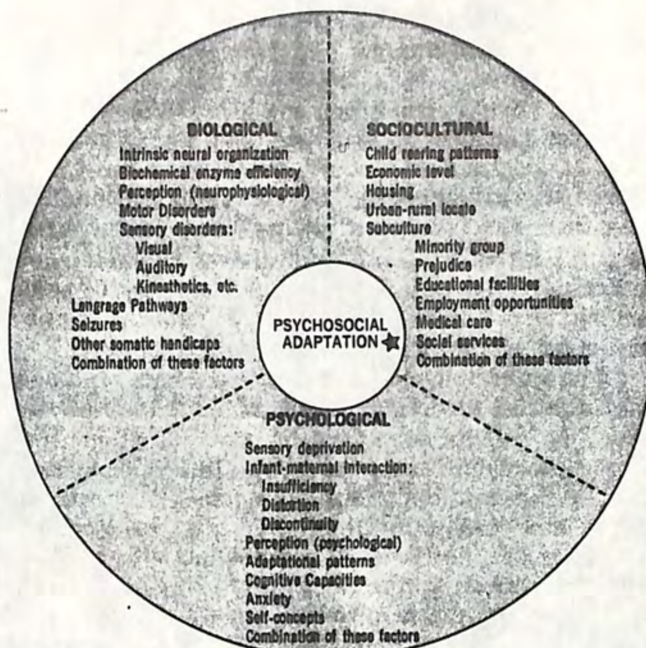
MENTAL RETARDATION IS ONE OF THE FOREMOST HEALTH, SOCIAL AND ECONOMIC PROBLEMS IN THE METRO ATLANTA AREA. PUBLIC SCHOOLS PROVIDE LESS THAN 50% OF THE SERVICE NEEDS OF THE EDUCABLE MR CHILD, AND APPROXIMATELY 50% OF THE SERVICE NEEDS OF THE TRAINABLE MR CHILD. MINIMAL SERVICES ARE OFFERED THE PRE-SCHOOL AND POST SCHOOL RETARDATE. DIAGNOSTIC AND EVALUATION CLINICS, EDUCATION AND TRAINING PROGRAMS AND ADULT SERVICES MUST BE GIVEN PLANNING EMPHASIS. SERVICES ARE WASTED HOWEVER UNLESS PLANS ARE MADE TO INSURE DELIVERY OF THESE SERVICES TO THE CONSUMER. A TRANSPORTATION PLAN MUST THEREFORE BE A VITAL PART OF PROGRAM DESIGN.

The Problem: The MR person is one who, from childhood, experiences unusual difficulty in learning, and is relatively ineffective in applying what he has learned to the problems of life. He needs special training and guidance to make the most of his capacities.

Current Status: In Metro Atlanta, there are an estimated 42,647 retarded persons. At the present time, only 6,804 individuals by our survey are receiving education and training, residential services, vocational rehabilitation or other adult services from appropriate community agencies.

Needs: While all the metropolitan area school systems offer some services for mentally retarded children, many are not served. Private residential facilities serve only non-ambulatory neurologically impaired children. Vocational Rehabilitation works with retardates enrolled in public school special education programs, and with a limited number of MR from the community at large. Expansion of all these programs is needed. Day training facilities for the severe and moderate pre-school, severe school age, and severe and moderate adults should be established.

Structure of Planning Organization: The responsibility for area wide mental retardation planning should rest in a 6 county planning body made up of representatives from the 6 local health districts. Each district would appoint 6 representatives, drawn from vocational rehabilitation, the health department, family and children's service, public schools, associations for retarded children, and recreation departments. An MR specialist should be employed.



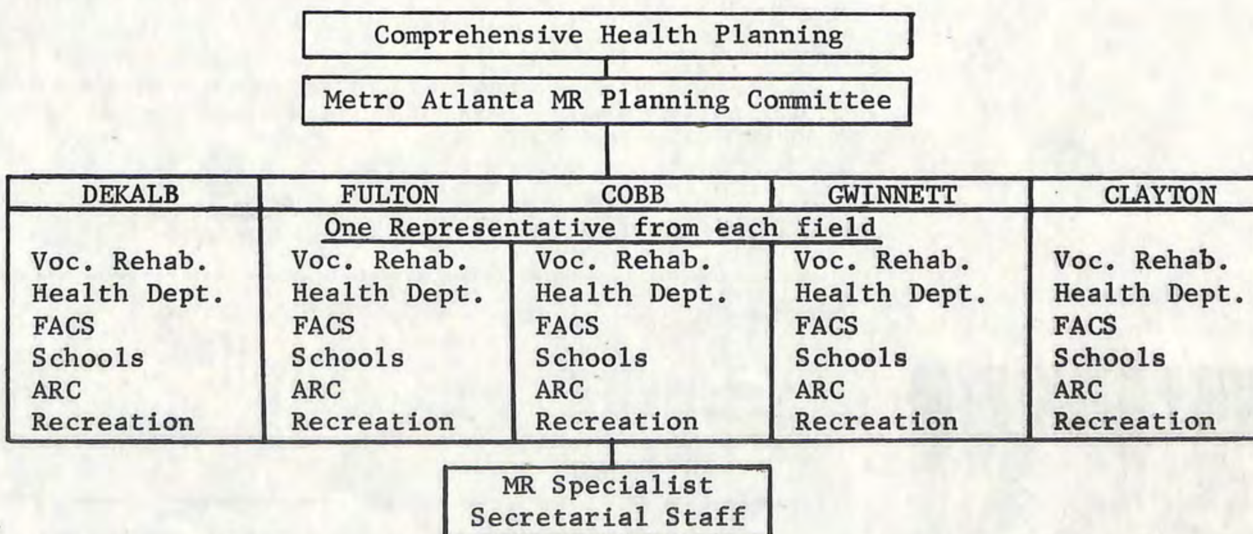
Estimated Number of MR Persons in the 5 County Area**

Level of Retardation	Chronological Age Range			
	0 - 5	6 - 17	18+	Total
Mild	5409	9554	24506	39469
Moderate	305	537	1375	2217
Severe	108	191	493	792
Profound	22	42	105	169
		Grand Total		42,647

Existing Services in the 5 County Area**

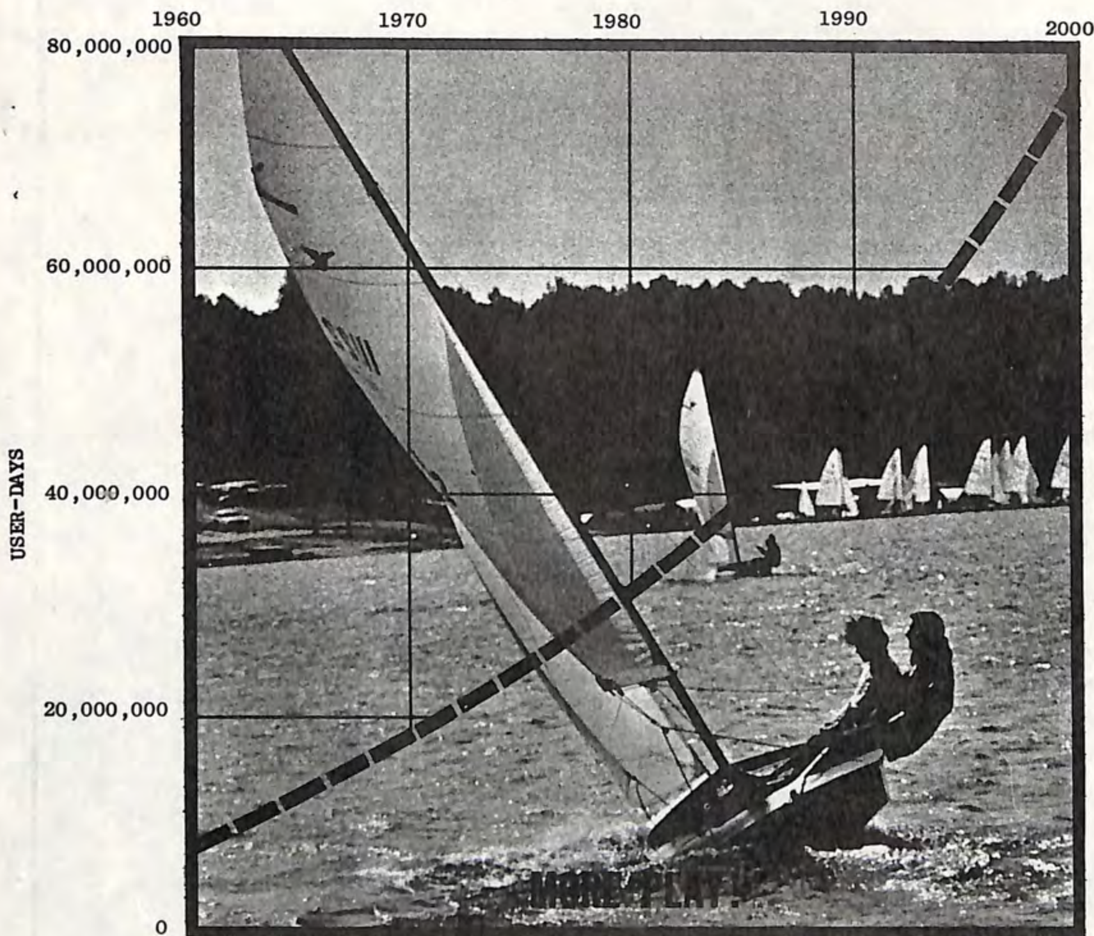
Public Schools		Private Schools		Residential		Voc.	Adult
EMR	TMR	EMR	TMR	Private	Public	Rehab.	Act.
5151	377	40	225	106	120	703	82

Organizational Chart**



* 1. Conceptual Visual Aid: Interaction of Multiple Factors. (From Richmond, J. B., and Lustman, S. L., J Med Educ 29:23 (May) 1954).

** Douglas County not included in the above 5 county tables and charts.



NUMBER OF USER DAYS PER YEAR FOR NON-URBAN OUTDOOR RECREATION FACILITIES, ATLANTA FIVE-COUNTY REGION.

Sources: U. S. Study Commission/Southeast River Basins; Atlanta Region Metropolitan Planning Commission. (1960 figure is based on annual 8 user-days per person, and 2000 figure is based on annual 26 user-days per person.)

CURRENT STATUS:

THE LAST PUBLISHED INVENTORY OF PARKS SHOWED 2,405 ACRES OF PUBLIC PARK LAND. THIS INCLUDED 67 PARKS AND 98 GREEN SPACES. THE FOLLOWING TABLE SHOWS THE DETAILS OF SIZE AND NUMBER.

SIZE	NUMBER	TOTAL ACREAGE PER CATEGORY	PERCENTAGE OF TOTAL ACREAGE
OVER 100 A	7	1233 A	51%
30-100 A	8	472 A	20%
15-30 A	9	156 A	6%
LESS THAN 15 A	43	390 A	16%
GREEN SPACES	98	155 A	7%
TOTAL	165	2405 A	100%

BY NATIONAL STANDARDS, PARK SYSTEM HAS GREAT INADEQUACIES. THESE STANDARDS ARE BASED ON YEARS OF EXPERIENCE IN PROVIDING RECREATION UNDER A VARIETY OF CONDITIONS. ON THE MOST GENERAL LEVEL, THEY CALL FOR A TOTAL OF 10 ACRES OF PARK LAND PER 1000 POPULATION; ATLANTA AREA SMSA, CURRENTLY HAS ABOUT 4.6 ACRES PER 1000 POPULATION. STANDARDS PROPOSED IN THIS REPORT WOULD INCREASE THE OVERALL CITY AVERAGE TO 7.2 ACRES PER 1000 POPULATION BY 1983 AND TO 10 ACRES PER 1000, IF FLOOD HAZARD AREAS ARE ADDED TO THE SYSTEM AS PROPOSED.

Title: Parks' and Recreation's Lag in Facilities, Services and Manpower.

SUMMARY:
GREATER RECOGNITION, FINANCIAL SUPPORT AND PARK/RECREATION PLANNING SHOULD BE GIVEN THE GROWING DEMANDS FOR RECREATION AND PARK FACILITIES, PROGRAMS AND SERVICES THROUGHOUT THE ATLANTA AREA, (SMSA). IT BEHOOVES LEGISLATOR, RECREATION AND PARK EXECUTIVES TO OBSERVE AND CORRECT THE PRESENT LAG OF FACILITIES SERVICES AND PROFESSIONAL MANPOWER NEEDS IN THE FASTEST GROWING CITY IN THE SOUTHEAST.

Problem:

Unfortunately, Atlanta does not have the park system and recreation program it needs and deserves. There is:

lack of good public relations

lack of public and city support

inadequate local financing

rising cost of land

insufficient maintenance

insufficient acreage

staff personnel occupying position without proper training

absence of public information on parks and recreation

past segregation and apathy of current integration

lack of a comprehensive plan to guide park and recreation development

lack of standards at the state and local level.

Possible Solution:

To provide recreation programs and facilities in all neighborhoods of the city.

To encourage housing project and apartment owners to include recreation facilities.

To insure close supervision of staff and a good in-service training program for staff members that are not professionally trained.

To recruit professionally trained personnel for staff position.

To provide a well-balanced program for all ages, with a wide variety of interests.

To involve residents in planning and operation of public recreation.

To provide minimum standards for all recreations programs.

Trends:

These are not theoretical standards. A survey done in 1965 showed that 49 out of 189 cities met the acreage standards. As part of this study, comparisons were attempted with other cities the same size as Atlanta. Overlapping governmental jurisdiction made these comparisons difficult, but it appeared that out of 20 similar cities, 15 to 7 had more park acreage per population than Atlanta. About one-half met the acreage standards.

Inadequate open space.

Inadequate Planning.

Lack of interest at the Board of Aldermen level.

Diverted funds.

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RALPH WILLIAMS
1903-1960

TELEPHONE 522-2508
AREA CODE 404

February 28, 1969

Dan
Brief me on
this

Honorable Ivan Allen
Mayor, City of Atlanta
City Hall
Atlanta, Georgia

Re: Volunteer Citizens Services

Dear Mayor Allen:

I am writing to you as Chairman of the Board of the Community Council of the Atlanta Area. I, and the others who will be with me, appreciate and look forward to talking with you on next Wednesday afternoon, March 5, regarding a plan for the greater use of individual and group volunteers in the Atlanta area.

Those with me on Wednesday will be Dede Hamilton, who is the current President of the Atlanta Junior League, and John DeBorde, who is the representative of the Atlanta Chamber of Commerce working with us on our volunteer project. You perhaps know John. He is the general agent here for New England Mutual Life Insurance Company.

Some months ago there was a meeting of representatives of the Community Council, the Atlanta Chamber of Commerce, and E.O.A. at which we discussed the possibilities of jointly establishing a means of making a more effective use of volunteers. Dan Sweat was also present and is generally familiar with what has taken place. Following this meeting there was a larger luncheon meeting of about 16 or 17 organizations at which there was a general discussion of the same subject. A Steering Committee was appointed to formulate a means of effectively recruiting, screening, training, and placing of

April 10, 1969

Mr. Eugene T. Branch
Chairman of the Board of Directors
Community Council of the Atlanta Area, Inc.
c/o Jones, Bird and Howell
Haas-Howell Building
Atlanta, Georgia 30303

Dear Mr. Branch:

The City of Atlanta has been fortunate in having many citizens and groups volunteer their time and services to help resolve important needs in our community.

As the City has grown and the interest and concern of our citizens has increased, it has become more and more difficult to effectively and efficiently utilize volunteers in meeting the needs of the city. It is extremely encouraging to see the efforts being put forth by the Community Council, the Chamber of Commerce, the Community Chest and the Atlanta Junior League in developing a vehicle for providing orderly assignment and utilization of volunteer manpower.

It is essential that there be a central point whereby community needs can be catalogued and consolidated and volunteers enlisted and trained to help fulfill these needs. I believe only through such a coordinated effort can the talents and skills of Atlanta's volunteer citizens be marshalled and utilized to the best advantage of all the people of the city.

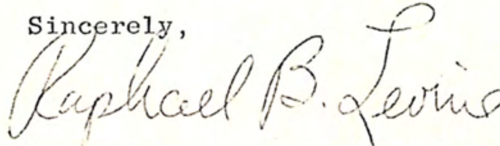
Sincerely yours,

Ivan Allen, Jr.
Mayor

IAJr:fy

I am looking forward to meeting with you on June 5th, and to future meetings and activities involving both the Council and the present staff.

Sincerely,



Raphael B. Levine, Ph. D., Director
Comprehensive Areawide Health Planning

RBL/la

enclosures

This is an <u>incomplete</u> edition of VOLUME I,

PROPOSAL FOR COMPREHENSIVE
HEALTH PLANNING

All pages considered crucial to the intent of the proposal are included here. Other work, denoted here by missing pages, is in process of completion.

Foreword to the Proposal

THIS PROPOSAL REPORTS WORK SUPPORTED BY AN ORGANIZATIONAL GRANT TO THE COMMUNITY COUNCIL OF THE ATLANTA AREA FROM THE U. S. PUBLIC HEALTH SERVICE, AND CONTAINS RECOMMENDATIONS FOR THE ESTABLISHMENT OF A PERMANENT COMPREHENSIVE HEALTH PLANNING AGENCY FOR THE METROPOLITAN ATLANTA AREA. THE PROPOSAL CONSISTS OF THREE VOLUMES: PROJECT SUMMARY, BUDGET AND STAFF, AND TASK FORCE REPORTS.

Agency Responsible

The Community Council of the Atlanta Area, supported by organizational grant No. 41008-01-69 from the U. S. Public Health Service, has been the agency responsible for conducting the work and, with the cooperation of many other offices, groups, and organizations, making the recommendations herein for the establishment of a permanent comprehensive health planning agency for the Metropolitan Atlanta Area.

Staff

The material was prepared by the Comprehensive Health Planning Project staff, directed by Raphael B. Levine, Ph. D., under the general supervision of Duane W. Beck, Executive Director of the Community Council of the Atlanta Area.

Consultation and Other Assistance

A number of persons gave continuing support to the Project on consultant basis, and several hundred persons from governments, health professions, educational institutions, commerce, and the population of health "consumers" gave invaluable assistance in the compilation of information and in the formulation of conclusions. The staff tenders its sincere thanks to all these individuals.

Funding

50% of the costs of this effort were borne by the Public Health Service grant mentioned above. The remainder was contributed by local sources, including county governments, foundations and the Community Chest, public, private, and voluntary health organizations, and individuals. The community owes much gratitude to these donors.

Organization of the Proposal

The proposal is divided into three volumes: project summary, budget and staff, and task force reports. Each pair of facing pages makes up a self-contained "story". The gist of each "story" may be gained from the bordered summary material alone, with details added in the text and illustrative material.

COMMUNITY COUNCIL OF THE ATLANTA AREA

Eugene T. Branch, Chairman of the Board
Duane W. Beck, Executive Director
A. B. Padgett, Chairman, Committee on Comprehensive Health Planning

COMPREHENSIVE HEALTH PLANNING PROJECT

Raphael B. Levine, Ph. D., Director
Alloys F. Branton, M.B.A., Assoc. Director
Harriet E. Bush, Director of Research
Clifford Alexander, Jr., Environmental Planner
Katharine B. Crawford, Organization Liaison

Mary Lou Ashton, Senior Secretary
Mildred W. Thorpe, Secretary

CONSULTANTS (on continuing basis)

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Loretta B. Roberts, RN, Community Council of the Atlanta Area
Ella Mae Brayboy, Community Council of the Atlanta Area
William F. Thompson, Administrator, Cobb County Health Department
Carolyn L. Clarke, Health Educator, Gwinnett County Health Department
Edna B. Tate, Health Coordinator, Economic Opportunity Atlanta

ORGANIZATION OF THE PROPOSAL

Volume I. Summary of Project
- Section 1. Introduction and Supportive Material
- Section 2. Narrative Project Summary
- Section 3. Appendices

Volume II. Budget and Staff
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- Section 2. Personnel

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SUMMARY:
IN ORGANIZING THE ATLANTA METROPOLITAN COMMUNITY FOR COMPREHENSIVE HEALTH PLANNING, EXTENSIVE ACTIVITIES IN TWO MAJOR ASPECTS HAVE BEEN NECESSARY: THE TECHNICAL ASPECTS OF IDENTIFYING, PROJECTING AND SEEKING POSSIBLE SOLUTIONS TO HEALTH PROBLEMS AND THE COMMUNITY INVOLVEMENT ASPECTS OF BRINGING TOGETHER THE VARIED ELEMENTS OF THE COMMUNITY INTO A PARTNERSHIP FOR HEALTH PLANNING AND POLICY-MAKING.

Technical Aspects

The technical objectives of this project have been (1) to identify the community's principal health problems and the probable, most urgent planning efforts which will have to be undertaken by the permanent organization during its first year of existence — 1970; and (2) to specify the numbers and qualifications of the technical staff who will be needed to carry out such planning. Some of the activities bearing on these objectives have been:

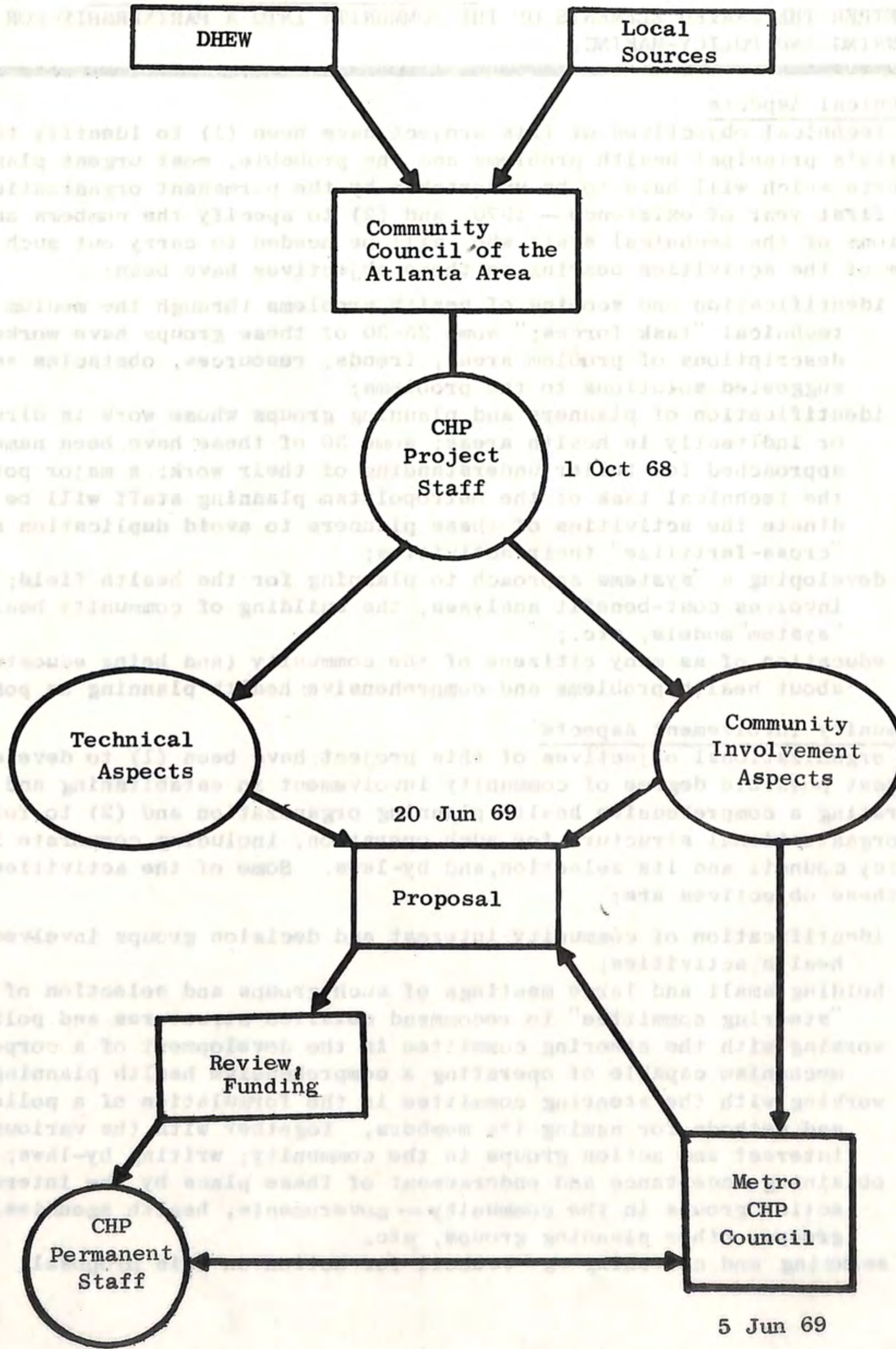
- identification and scoping of health problems through the medium of technical "task forces;" some 25-30 of these groups have worked up descriptions of problem areas, trends, resources, obstacles and suggested solutions to the problems;
- identification of planners and planning groups whose work is directly or indirectly in health areas; some 50 of these have been named and approached for fuller understanding of their work; a major portion of the technical task of the metropolitan planning staff will be to coordinate the activities of these planners to avoid duplication and to "cross-fertilize" their activities;
- developing a "systems approach to planning for the health field;" this involves cost-benefit analyses, the building of community health "system" models, etc.;
- education of as many citizens of the community (and being educated by them) about health problems and comprehensive health planning as possible;

Community Involvement Aspects

The organizational objectives of this project have been (1) to develop the largest possible degree of community involvement in establishing and operating a comprehensive health planning organization and (2) to formulate an organizational structure for such operation, including corporate identity, policy council and its selection, and by-laws. Some of the activities bearing on these objectives are:

- identification of community interest and decision groups involved in health activities;
- holding small and large meetings of such groups and selection of a "steering committee" to recommend detailed structures and policies;
- working with the steering committee in the development of a corporate mechanism capable of operating a comprehensive health planning agency;
- working with the steering committee in the formulation of a policy Council and methods for naming its members, together with the various health interest and action groups in the community; writing by-laws;
- obtaining acceptance and endorsement of these plans by the interest and action groups in the community — governments, health agencies, consumers' groups, other planning groups, etc.
- selecting and convening a council for action on this proposal.

ESTABLISHMENT OF METROPOLITAN COMPREHENSIVE
HEALTH PLANNING AGENCY



SUMMARY:
THE ATLANTA AREA, PRESENTLY INCLUDES SIX COUNTIES. THIS IS NOT IDENTICAL WITH THE OFFICIAL BOUNDARIES OF THE CENSUS BUREAU, WHICH DEFINES THE ATLANTA AREA AS A STANDARD METROPOLITAN STATISTICAL AREA CONSISTING OF FIVE COUNTIES. TO MAKE THIS DISTINCTION THESE BOUNDARIES ARE DEFINED.

BOUNDARIES: Atlanta Area: Douglas, Clayton, Cobb, DeKalb, Fulton and Gwinnett counties.

Atlanta Area (SMSA): Clayton, Cobb, DeKalb, Fulton and Gwinnett counties.

PRESENTLY:

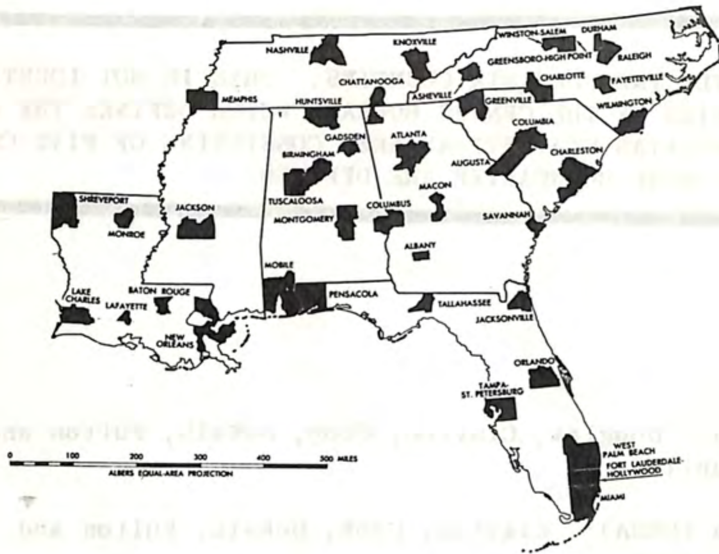
ATLANTA AREA IS:

- the "regional capital" of the Southeastern United States resulting from continued growth and a central transportation network;
- the "major growth center" in the State of Georgia; and
- the central "regional city" for the ATLANTA AREA and contiguous counties.
- the "medical center" for the surrounding counties.

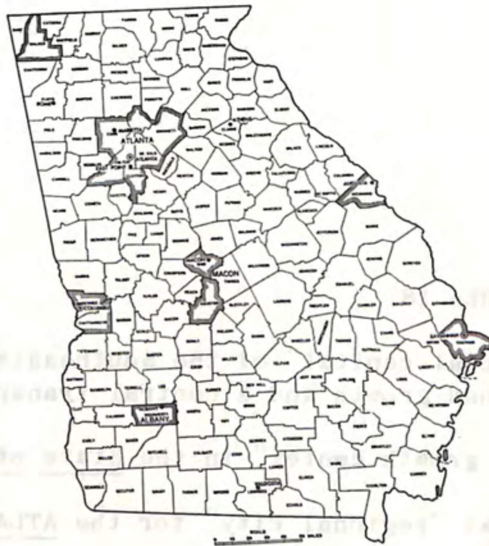
THE ATLANTA AREA COMPREHENSIVE HEALTH PLANNING DESIGN:

permits addition of contiguous counties or other planning areas whenever feasibility or desirability are indicated. (Douglas County, the newest member of the ATLANTA AREA has shown initiative and set a precedent for non-SMSA's joining its sister counties for health planning.)

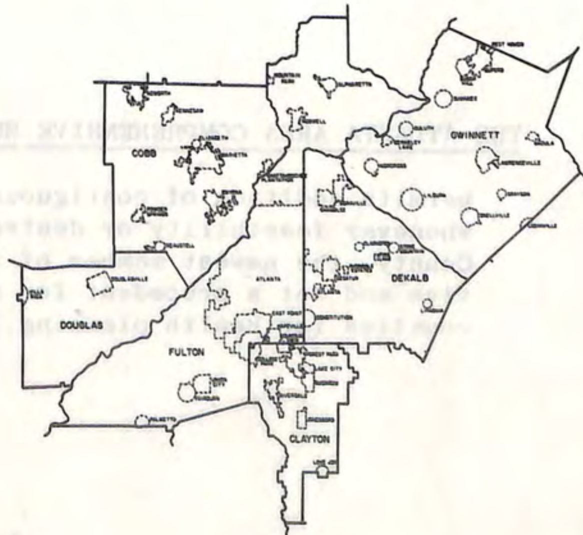
SOUTHEASTERN UNITED STATES



STATE OF GEORGIA



SIX COUNTY ATLANTA AREA



Atlanta Area Governmental Units and Current Population

SUMMARY:
BESIDES THE SIX COUNTIES, THE ATLANTA AREA CONTAINS APPROXIMATELY 50 INCORPORATED MUNICIPALITIES, OF WHICH 10 HAVE POPULATIONS OF MORE THAN 4,500. THE LARGEST CITY, ATLANTA, COVERS PORTIONS OF FULTON AND DEKALB COUNTIES, AND HAS A POPULATION IN EXCESS OF 500,000. THE TOTAL POPULATION APPROXIMATES 1,300,000.

The Atlanta Area, Compared with the Standard Metropolitan Statistical Area

The Atlanta Area SMSA is comsposed of five counties:

County	Population (1968)
Fulton	605,400
DeKalb	353,500
Cobb	174,600
Clayton	78,700
Gwinnett	59,800

Douglas County, with a population of 23,900, is the sixth county that makes up the entire six-county ATLANTA AREA for purposes of comprehensive health planning.

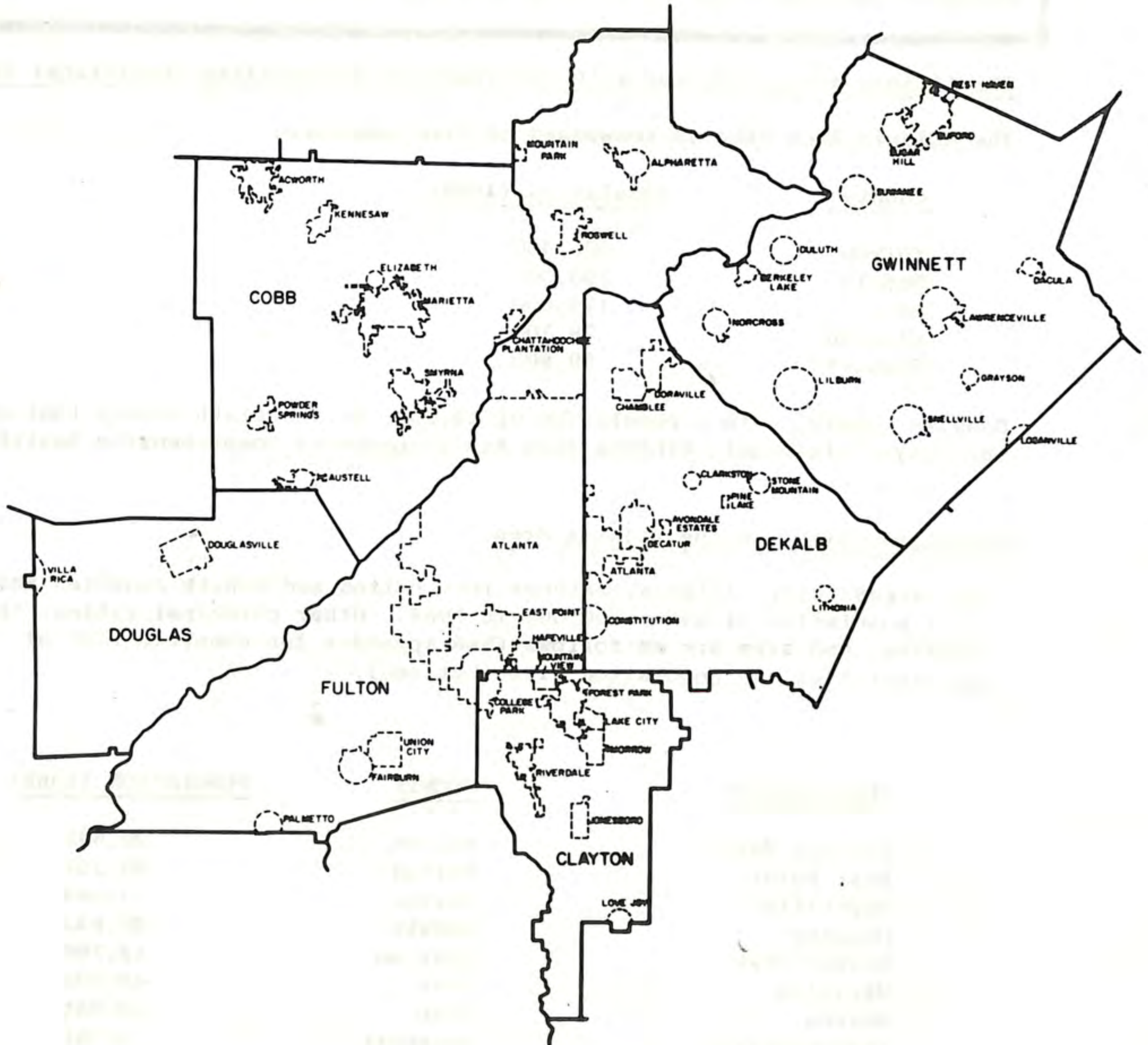
Principal Cities in the Atlanta Area

The largest city, Atlanta, extends into Fulton and DeKalb counties and had a population of about 500,000 in 1968. Other principal cities, their counties, and size are as follows (See Appendix for complete list of municipalities and population distribution.):

MUNICIPALITY	COUNTY	POPULATION (1968)
College Park	Fulton	20,691
East Point	Fulton	39,257
Hapeville	Fulton	9,268
Decatur	DeKalb	20,943
Forest Park	Clayton	18,766
Marietta	Cobb	28,003
Smyrna	Cobb	16,365
Lawrenceville	Gwinnett	4,561
Douglasville	Douglas	6,000

NOTE: These figures are estimates made by the Atlanta Region Metropolitan Planning Commission, 1 April 1968.

ATLANTA AREA



Nearby Cities Affect the Market and Service Patterns of the Atlanta Area

STANDARD METROPOLITAN STATISTICAL AREAS CLOSE TO THE ATLANTA AREA:

Within a 100-mile radius of the ATLANTA AREA (SMSA) there are 14 smaller SMSA's which are close enough to affect the economy, commerce and health service trade patterns of the ATLANTA AREA. These are:

Macon	Huntsville
Columbus	Gadsden
Chattanooga	Greenville
Albany	Asheville
Augusta-Columbia	Charlotte
Birmingham-Tuscaloosa	Knoxville
Montgomery	Nashville

Atlanta Area, a Place of Growth and Variation

SUMMARY:
THE ATLANTA AREA IS A RAPIDLY GROWING METROPOLIS WITH BOTH URBAN AND RURAL TERRAIN AND WAYS OF LIFE. THE MAJOR DEMOGRAPHIC CHARACTERISTICS INDICATE A CONTINUING PRESSURE AND A GREAT CAPACITY FOR INCREASED AND APPROPRIATE SERVICES.

Major Characteristics:

AGE of the population is young: The number between 20 and 29 will double between 1960 and 1980.

DENSITY of population covers a wide range: 5 to 52 persons per acre.

SIZE is expanding: 27% increase from 1960 to 1967, passing 2 million by 1980.

CLIMATE is warm and humid: 48 inches annual precipitation.

URBANIZATION is increasing moderately: 6% from 1960 to 1967.

EDUCATIONAL opportunities are numerous: About 175 schools, nine 4-yr. colleges, 6 special purpose institutions, 3 area technical schools.

OCCUPATION's largest demand is in retail and wholesale trade, government, service business, manufacturing.

INCOME varies greatly: One county with 36% over $10,000 another with 25% below $3,000.

CAPITAL INVESTMENT was near 300 million from 1963-1967, much of this for transportation equipment.

TRADE is active: 3 interstate highways intersect, 8 airports with 800 daily flights, 13 railroad lines of 7 systems.

FINANCIAL headquarters of Sixth Federal Reserve District.

OFFICE SPACE abundant: Fifth in nation.

COMMUNICATIONS extensive via telephones, mail, 4 daily and 20 weekly newspapers, 5 television and 19 radio stations.

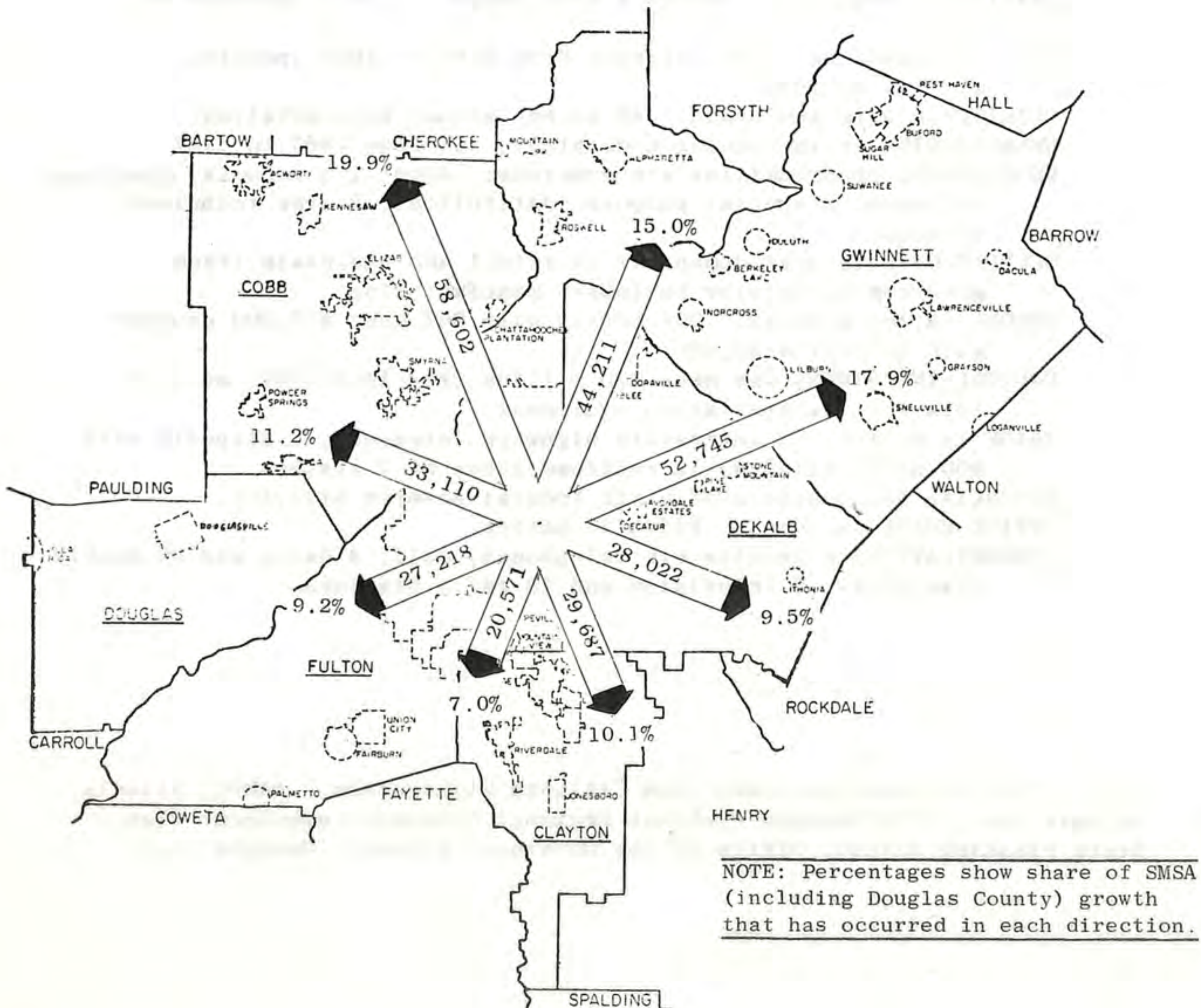
Note: This information taken from "Atlanta Silhouettes," ARMPC, Atlanta, Georgia n.d.; "The Georgia Piedmont Regional Economic Investment Plan," State Planning Bureau, Office of the Governor, Atlanta, Georgia, n.d.

1960 - 1980 Population, Estimates and Projections

County	1960 (1)	1965 (2)	1970	1975	1980
Fulton	556,326	599,300	649,425	704,046	829,163
DeKalb	256,782	350,400	485,541	658,520	757,518
Cobb	114,174	150,900	209,722	281,481	337,019
Clayton	46,365	66,000	93,483	135,988	161,126
Gwinnett	43,541	54,600	58,077	66,192	76,094
Douglas (3)	16,741	21,339	29,700	36,500	45,000
Total	1,033,929	1,242,539	1,525,948	1,882,727	2,205,920

(1) U.S. Census
(2) Long-Range Plan, Hospital and Health Planning Dept., CCAA, Atlanta, Ga., Jan. 1968, p. 6 (mimeographed).
(3) Douglas County Figures, 1965-1980, interpolated from Land Needs, 1968, Douglas County, Ga., ARMPC, Table D.

DIRECTIONS OF POPULATION GROWTH 1960 - 1968
ATLANTA SMSA



NOTE: Percentages show share of SMSA (including Douglas County) growth that has occurred in each direction.

Population Trends Require Continuous Review of Health Needs.

SUMMARY:
THE NUMBER OF PEOPLE IN THE AREA IS GROWING AT A RATE OF 2.8% ANNUALLY. THERE IS ALSO A MARKED INCREASE OF YOUNGER AND OF OLDER PERSONS. THE MIGRATION OF PERSONS INTO THE AREA FROM NEARBY TOWNS AND PLACES IS ACCOMPANIED BY A GROWTH TOWARD THE OUTER COUNTIES.

Text:

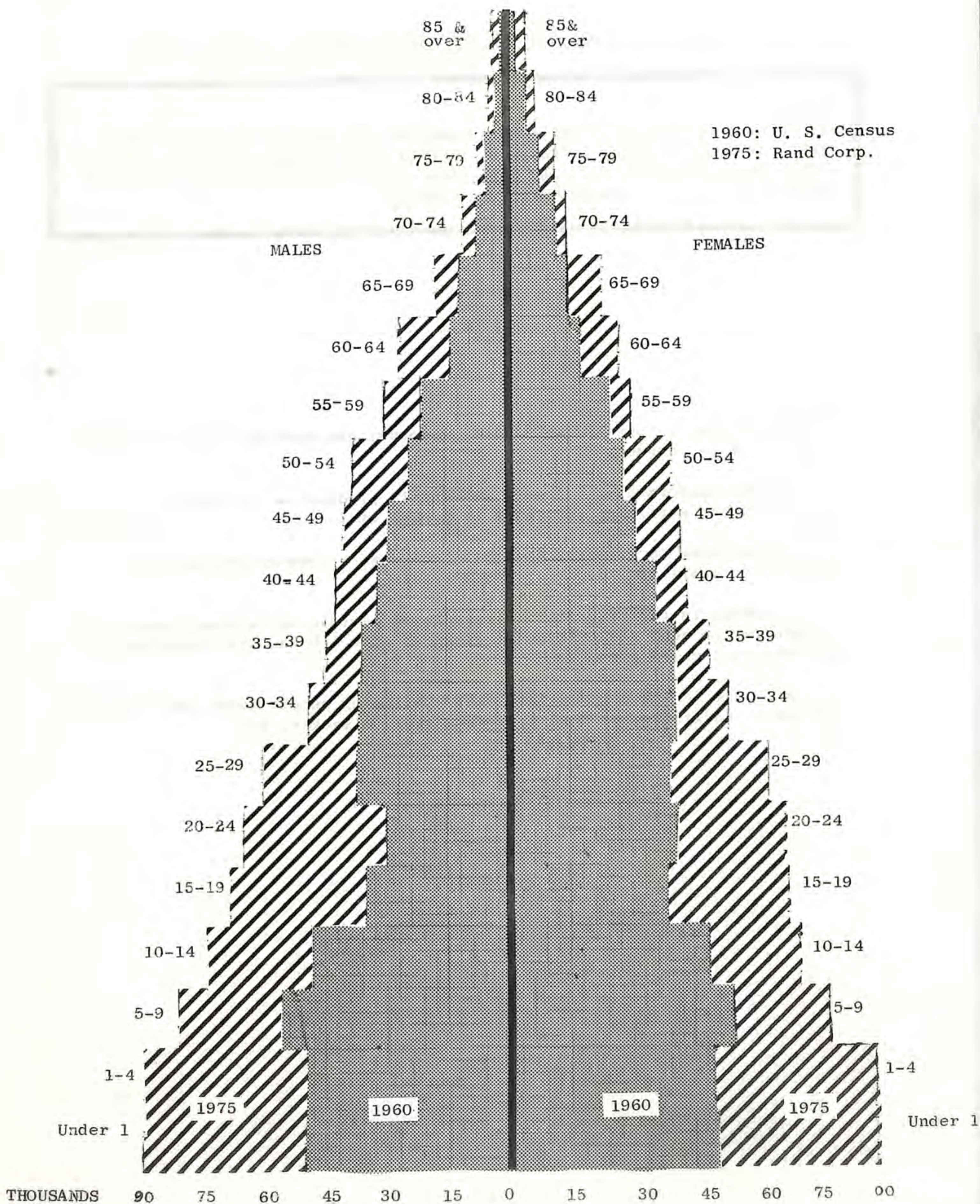
The needs for health facilities, manpower and services must be anticipated well in advance.

Present information allows a reasonable prediction of the size, constituency and settlement patterns of groups of people.

An increase in numbers of people indicates a greater demand on the amount of facilities, manpower and services.

A change in the proportion of people in certain age groups indicates a change in the need for particular types of care - home care, impairments, maternal and child care, etc.

A change in the geographical distribution of people indicates a need for review of environmental health, communicable diseases, etc.



85 & over
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
1-4
Under 1
MALES
FEMALES
1960: U. S. Census
1975: Rand Corp.
1975
1960
1960
1975
THOUSANDS
90
75
60
45
30
15
0
15
30
45
60
75
00

The Planning Area Boundaries Observe other Programs, Anticipate Expansion

SUMMARY:
THE STATE OF GEORGIA IS DIVIDED INTO MANY DIFFERENT AREAS, DISTRICTS AND REGIONS FOR SPECIAL PLANNING OR IMPLEMENTATION OF PROGRAMS AND ACTIVITIES. SOMETIMES THE FIVE COUNTY "STANDARD METROPOLITAN STATISTICAL AREA" OF ATLANTA IS USED AS A UNIT. SOMETIMES PROGRAMS ARE SUBDIVIDED BY COUNTIES OR COUNTIES ARE COMBINED IN OTHER WAYS. THE SIMILAR JURISDICTIONAL AREAS ARE CONVENIENT AND THERE IS A TENDENCY TOWARD MAKING BOUNDARIES OF RELATED PROGRAMS IDENTICAL. IN ANTICIPATION OF THIS TREND AND EXPANSION OF ATLANTA (SMSA) BY THE BUREAU OF CENSUS, THE COMPREHENSIVE HEALTH PLAN WILL HAVE ADJUSTABLE BOUNDARIES.

A R E A   G R O U P I N G S[1] →

(1) Much of this material taken from An Atlas of Multi-County Organizational Units, Department of Geography, Univ. of Ga., 1968

PROGRAMS, REGIONS, AREAS, AND DISTRICTS	Douglas	Gwinnett	DeKalb	Fulton	Clayton	Cobb	Operates Outside Area
Area Planning and Development Commission	2	2	2	2	2	2	no
Superior Court Circuits	35	19	34	2	9	10	yes
Industrial Development Division (Ga. Tech.)(◆)	Ca	A	A	A	A	A	yes
Civil Defense: Operational Areas, Control Centers	7	7	7	7	7	7	yes
State Nurses Assoc. Districts	13	9	5	5	4	13	yes
Community Action Agencies	23	10	8	10	4	X	yes
State Representative Districts	27	22	117-119	120-141	35	101-103	yes
Congressional Districts	7	9	4	5	6	7	yes
State Senatorial Districts	31	48	41-43	34-40	44	32-33	yes
Cooperative Extension Service Districts	6	6	6	6	6	6	yes
Georgia Hospital Assoc. Districts	NW	NE	A	A	A	A	yes
Economic Development Regions (★)	A	A	P	P	P	P	yes
State Highway Department Division	6	1	6	6	3	6	yes
Vocational Rehabilitation Services (☆)(□)	A	D	D	A	D	A	yes
Vocational (Medical/Behavioral) Areas	A	A	A	A	A	A	yes
Georgia Regional Medical Program (■)(◇)	WC	N	N	WC-N	WC	N	yes
Metro Atlanta Council Local Govts.	A	A	A	A	A	A	no
Soil & Water Conservation Districts	12	8	7	7	8	7	yes
State Employment Service Districts	23	3	3	3	17	23	yes
Office of Economic Opportunity (●)	T	A	D	A	Cl	X	yes
Community Council Social Planning Areas	X	36-38	39-49	1-29	50-52	30-35	no
State Dept. of Family & Children Services Districts	7	9	5	5	4	7	yes
Farmers Home Administration Districts	1	2	2	1	1	1	yes
Soil Conservation Districts (◆)	Ca	D	D	D	D	D	yes
Federal Judicial Districts (■)	N	N	N	N	N	N	yes
State Highway Department Divisions	6	1	6	6	3	6	yes
Federal Land Bank Association Districts	2	9	9	9	9	9	yes
Vocational-Technical School Area (◆)	Ca	Cl	Cl	A	G	M	yes
Forestry Districts	4	9	9	9	4	7	yes
Georgia Bureau of Investigation Districts	9	2	1	1	1	9	yes
Medical Facility Service Areas	D2	R3	D1	B1 D3	D3	D2	yes
Public Health Districts	28	29	36	38	30	28	yes

X Does not participate
(★) Appalachia & Piedmont
(☆) A Atlanta District
(□) D Decatur District

(■) N Northern District
(◇) WC West Central District
(◆) Ca Carrollton District
Cl Clayton District
M Marietta District

(●) T Tallatoona

Organizational and Procedural Arrangements for Comprehensive Health Planning

SUMMARY:
THE PROPOSED COMPREHENSIVE HEALTH PLANNING AGENCY WILL BE STRUCTURED SO AS TO BE IN CLOSE COORDINATION WITH THE METROPOLITAN ATLANTA COUNCIL OF LOCAL GOVERNMENTS AND WITH THE COMMUNITY COUNCIL OF THE ATLANTA AREA. THE ARRANGEMENT ALSO ENCOURAGES COOPERATION AND COORDINATION WITH THE ATLANTA REGION METROPOLITAN PLANNING COMMISSION, THUS INVOLVING ALL THE AREA'S MAJOR PLANNING AGENCIES. OTHER PLANNERS IN HEALTH OR HEALTH-RELATED FIELDS WILL BE INVOLVED TO VARYING DEGREES.

Applicant:

In order to facilitate interaction of the major planning groups in the metropolitan area, the Metropolitan Atlanta Council of Local Governments (MACLOG) will be the applicant agency for comprehensive health planning. In order to do this, MACLOG is taking action to change its status as a voluntary association and become an incorporated entity. In the event that the necessary legal arrangements require more time than is available prior to submission of this proposal, the interim applicant agency will be the Community Council of the Atlanta Area, Inc. (CCAA). The organization for supervising and conducting comprehensive health planning is indicated herein as the Metropolitan Comprehensive Health Planning Council (Metro CHP Council).

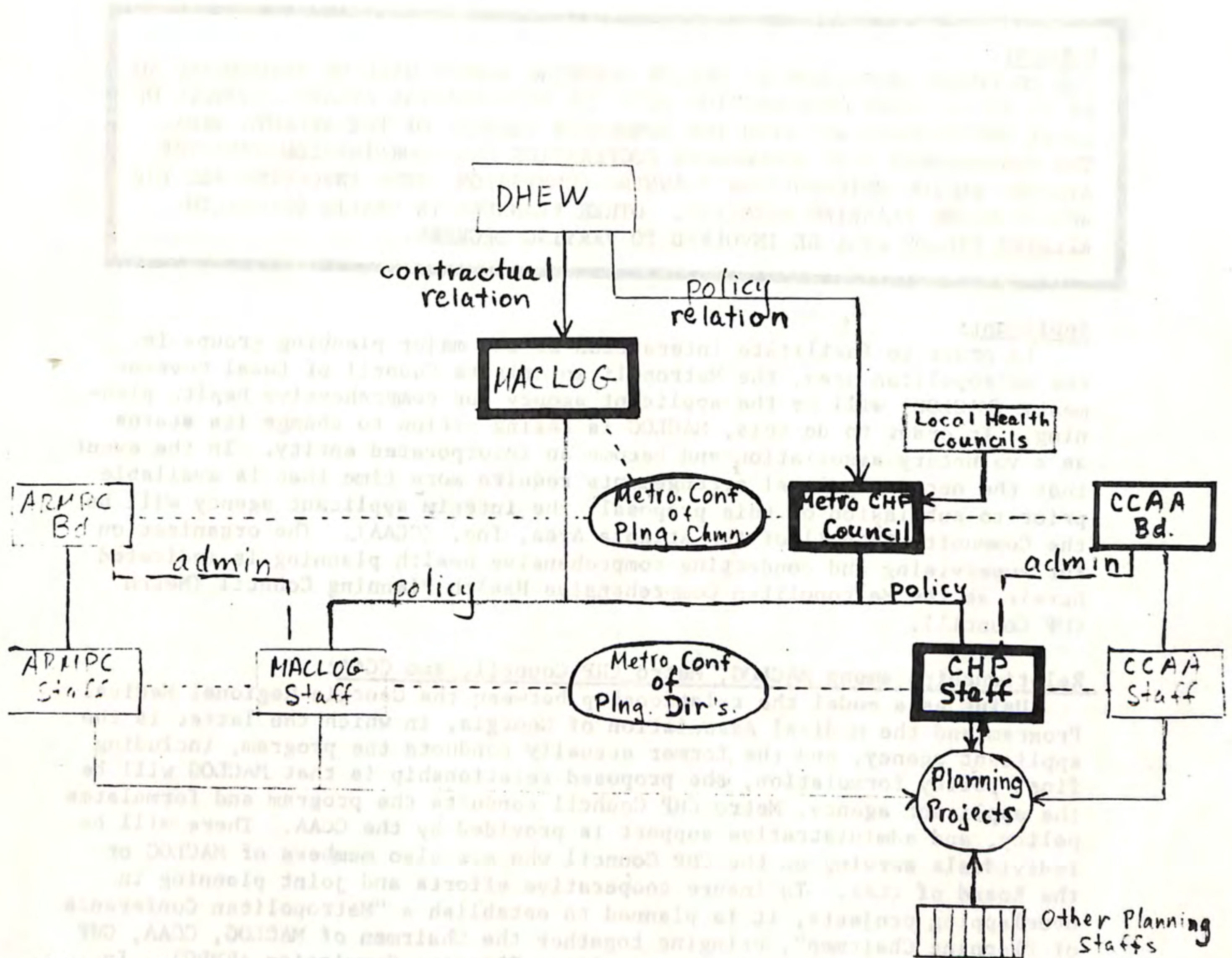
Relationships among MACLOG, Metro CHP Council, and CCAA:

Using as a model the relationship between the Georgia Regional Medical Program and the Medical Association of Georgia, in which the latter is the applicant agency, and the former actually conducts the program, including final policy formulation, the proposed relationship is that MACLOG will be the applicant agency, Metro CHP Council conducts the program and formulates policy, and administrative support is provided by the CCAA. There will be individuals serving on the CHP Council who are also members of MACLOG or the Board of CCAA. To insure cooperative efforts and joint planning in overlapping projects, it is planned to establish a "Metropolitan Conference of Planning Chairmen", bringing together the Chairmen of MACLOG, CCAA, CHP Council, and Atlanta Region Metropolitan Planning Commission ARMPC). In addition, there will be a "Metropolitan Conference of Planning Directors", bringing together the executives of the four agencies. From time to time, other planners will be invited to participate in these conferences. It is anticipated that joint staff activities will occur where projects involve physical planning (ARMPC), social planning (CCAA), health planning (CHP), and other forms of planning such as crime and delinquency (MACLOG). Of course, major portions of health planning will continue to be done in other planning staffs, such as hospital authorities, city and county planning offices, etc. These will be coordinated, insofar as health aspects are concerned, by the Metro CHP staff.

Facilities:

MACLOG, CCAA, ARMPC, and CHP will be housed in the same building. This close proximity will make possible sharing of numerous facilities, such as library, public information, duplication and mailing, etc. For additional information, see the section on Facilities in the second Section of this proposal volume.

ORGANIZATION FOR COMPREHENSIVE HEALTH PLANNING

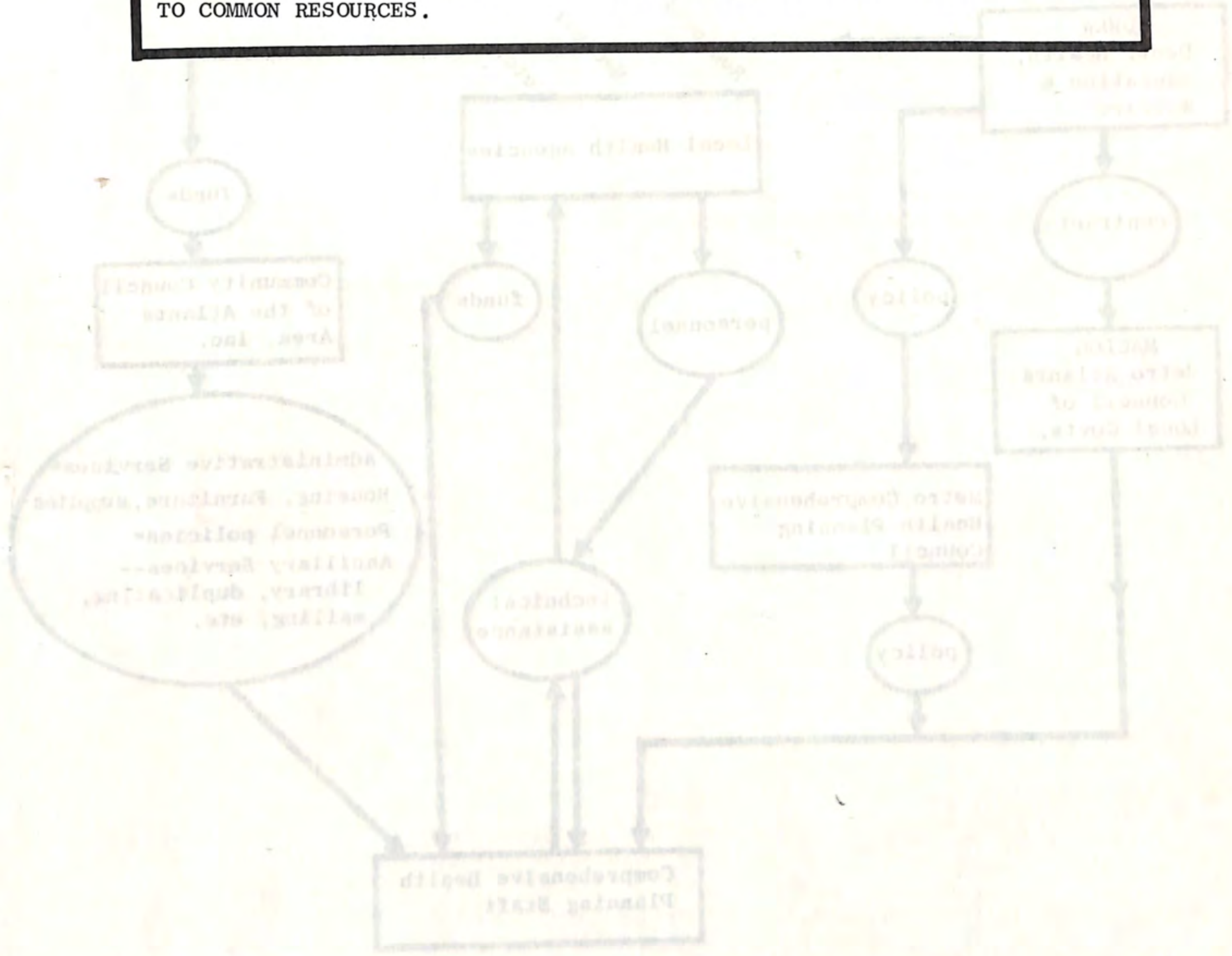


Abbreviations:

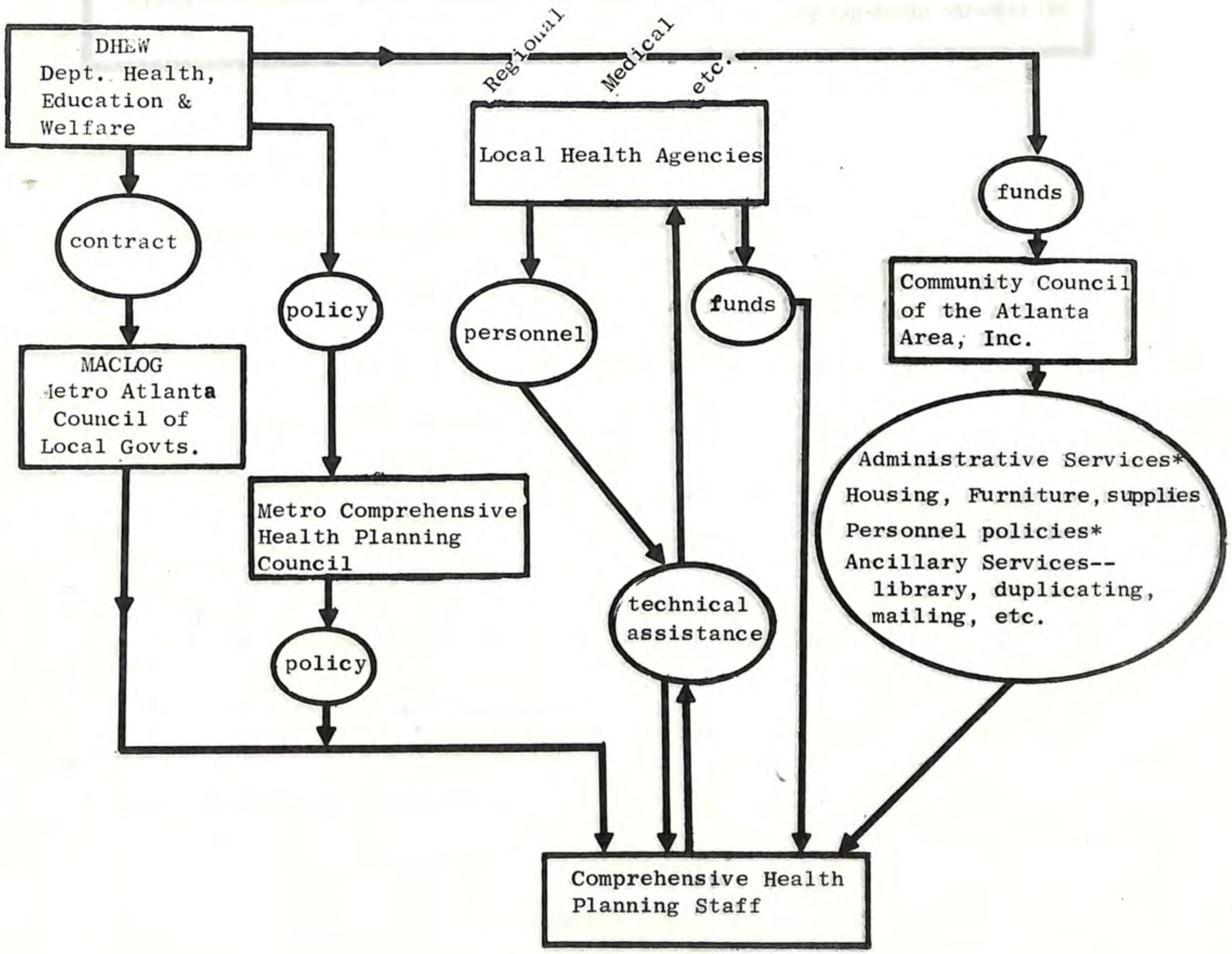
ARMPC = Atlanta Region Metro. Planning Commission
CCAA = Community Council of the Atlanta Area
CHP = Comprehensive Health Planning
DHEW = (U.S.) Department of Health, Education & Welfare
MACLOG = Metro. Atlanta Council of Local Governments
Bd = Board
Conf = Conference
Dir's = Directors
Chmn = Chairmen
Plng = Planning

Title: Cooperative Arrangements made for funds, personnel, services, facilities

SUMMARY:
THE COMPREHENSIVE HEALTH PLAN IS AND WILL BE LINKED FORMALLY WITH THE APPROPRIATE ORGANIZATIONS TO ASSURE THE JOINING OF ALL HEALTH EFFORTS TO COMMON RESOURCES.



COOPERATIVE ARRANGEMENTS WITH OTHER PROGRAMS



*See Appendix for Details.

Planning is Based Upon Commonly Available Data

SUMMARY:
THE LOCAL RESOURCES FOR QUANTITATIVE DATA IN THE HEALTH CARE FIELD ARE RATHER LIMITED BOTH IN AMOUNT, AVAILABILITY, AND COMPARABILITY, THE COMPILATION OF INFORMATION IN A CENTRAL CENTER WARRANTS PRIORITY FOR FUTURE PROBLEM-SOLVING. SOCIAL, ECONOMIC, AND DEMOGRAPHIC STATISTICS ARE MORE FULLY DEVELOPED THAN HEALTH DATA. BOTH ARE OFTEN SCATTERED AND FAR FROM IDEAL. INFORMATION ALONG THESE LINES IS AVAILABLE AND COMMONLY USED FROM MORE THAN A DOZEN SOURCES.

Implications for Comprehensive Health Planning in Environmental Health Fields

SUMMARY:
THE METROPOLITAN ATLANTA AREA HAS MADE NOTABLE STRIDES TO IMPROVE ENVIRONMENTAL FACTORS IN RECENT YEARS. NEARLY EVERY AREA CONCERNED HAS HAD SOME PREVIOUS WELL-PLANNED PROGRAMS. THE ROLE OF COMPREHENSIVE HEALTH PLANNING WILL BE THAT OF COORDINATING EFFORTS, ENCOURAGING IMPLEMENTATION, AND INCREASING EFFICIENCY IN OPERATION.

Text:

Environmental Health programs being developed or recommended for the Metropolitan area include:

1. Water and sewer plan implementation - a natural follow-up to current water and sewer planning should include recommendations for long range pollution control systems and management of water resources.
2. Up-dating open space and recreation plan and program for the metropolitan area.
3. Capital improvements programming: a continuation of the work ARMPC is doing now.
4. Metropolitan Solid Waste Plan - MACLOG.
5. Mobile Home Park - ARMPC - Study of requirements on location.
6. Vector Control Program - EOA - Demolition Project.
7. Comprehensive study of problems and possible long-range solution for solid waste and garbage collection and disposal.
8. Development of a long-range plan for industrial and office parks throughout the area - ARMPC.
9. A study of future housing requirements: as they relate to population forecasts, income, employment, and location. This study is now being held in abeyance.
10. Up-dating of Airport Plan - ARMPC.
11. Study, up-date and revise all elements of land development and facilities plans.
12. ARMPC - The need for nature preserves and related outdoor recreation facilities has been established. Implementation is now needed.
13. Flood control project by Corps of Engineers.
14. Atlanta Housing Authority: re-develop public housing area; rat control; health clinics for project area; and neighborhood renewal project (yearly basis).
15. Georgia Safety Council: organizing Teen Safety Councils in all high schools in the state of Georgia; conducting industry safety seminars throughout the state; driver improvement for truck drivers; driver improvement through the defensive driver course; conducting injury control program.

ONE OF THE great community benefits of urban renewal is the removal of unsafe, unsanitary and inadequate buildings.

ATLANTA HOUSING AUTHORITY

Auditorium-Convention Hall Complex

McDaniel Street construction

The Urban Life Center - A Solver of Urban Health Problems For the Future

SUMMARY:
THE NEWLY ORGANIZED URBAN LIFE CENTER AT GEORGIA STATE COLLEGE, WHEN FULLY OPERATIONAL, WILL PROVIDE A DYNAMIC INSTRUMENT FOR SOLUTION AND PREVENTION OF HEALTH AND HEALTH RELATED PROBLEMS. IT FOCUSES THE RESOURCES OF THE MAJOR EDUCATIONAL INSTITUTIONS IN THE ATLANTA AREA AND THE STATE OF GEORGIA ON BROADENING THE INTELLECTUAL BASE OF THE POPULATION, ENHANCING THE PROFESSIONAL AND CULTURAL COMMUNITY, INTENSIFYING AND DIRECTING MOTIVATIONAL POTENTIAL AND PROVIDING SERVICES INVOLVING PEOPLE AS INDIVIDUALS AND GROUPS.

Purpose:

Early in January, 1969, the Urban Life Center and the City of Atlanta were designated one of six national research centers on urban problems. (These centers were selected by the National League of Cities acting under contract with Departments of Housing and Urban Development and Health, Education and Welfare.) This network of "Urban Observatories" represents an effort to concentrate efficiently and economically the resources of higher education in the assault on urban problems.

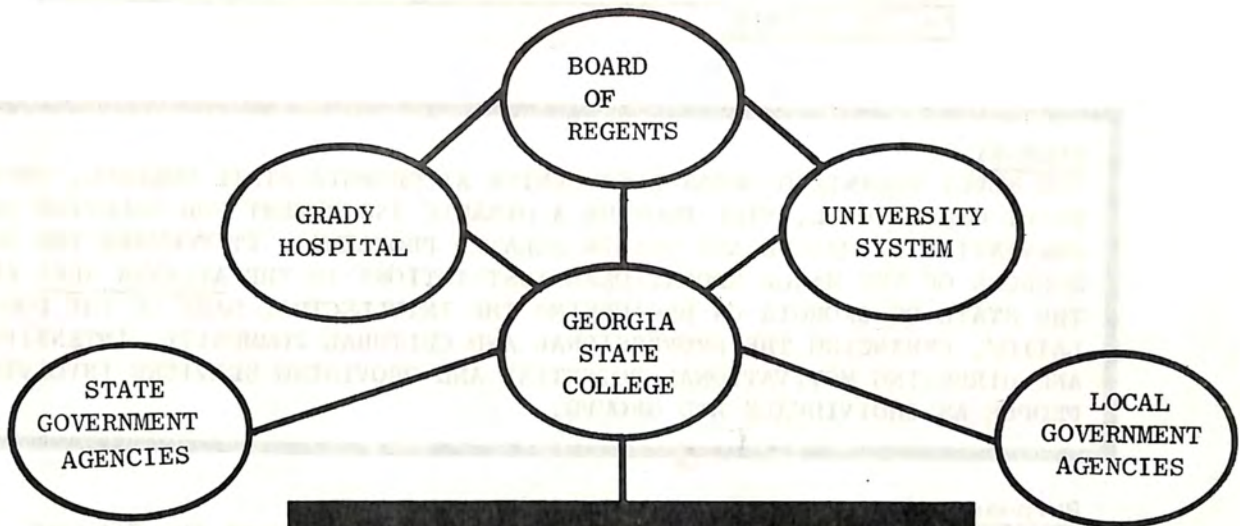
Concept:

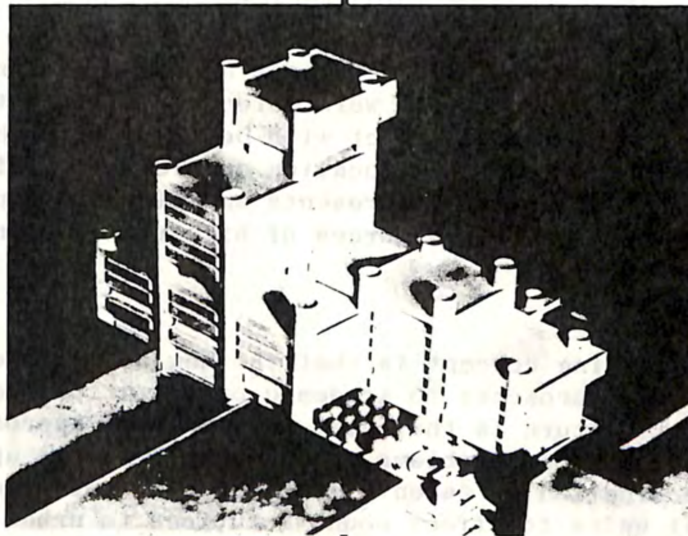
The guiding concept is that the new problems of the cities necessitate new approaches to academic organization and operation. An important feature is the inter-disciplinary approach to the study and solution of urban problems. Emphasis is placed upon the concentration and coordination of talents from all relevant disciplines and organizational units to effect sound solutions to urban problems.

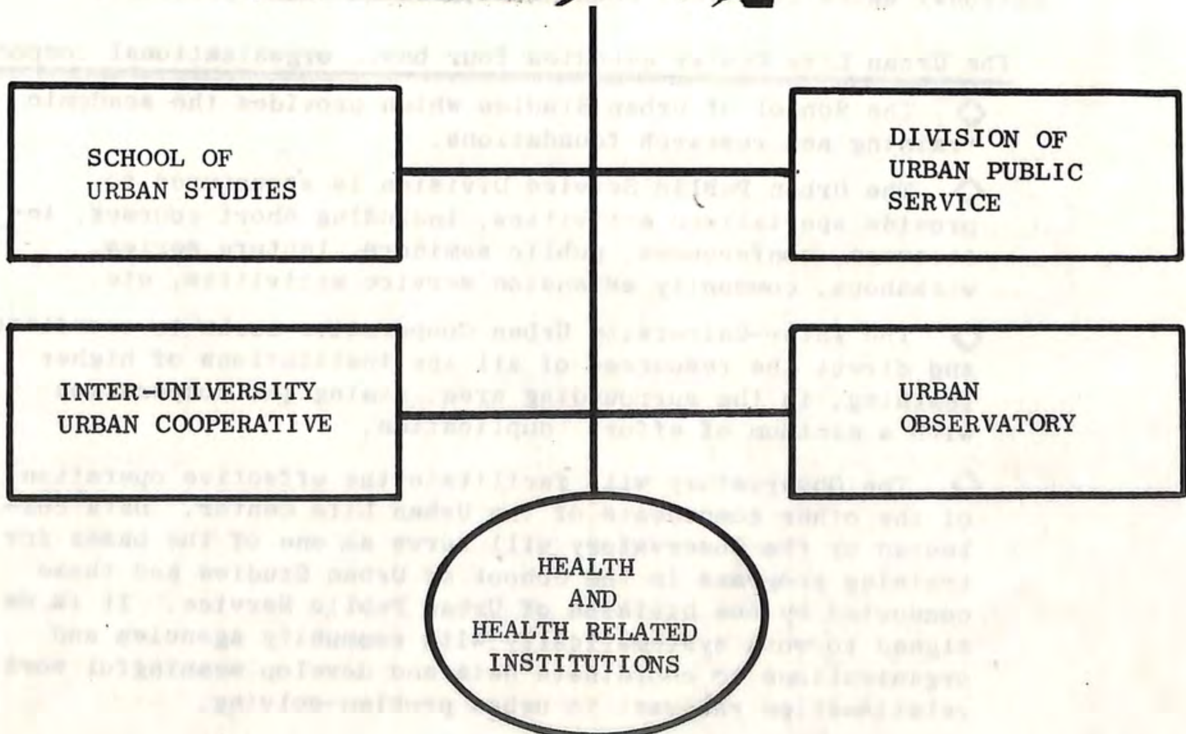
The Urban Life Center embodies four basic organizational components:

- The School of Urban Studies which provides the academic training and research foundations.
- The Urban Public Service Division is structured to provide specialized activities, including short courses, institutes, conferences, public seminars, lecture series, workshops, community extension service activities, etc.
- The Inter-University Urban Cooperative seeks to coordinate and direct the resources of all the institutions of higher learning, in the surrounding area, aiming for cooperation with a minimum of effort duplication.
- The Observatory will facilitate the effective operation of the other components of the Urban Life Center. Data collected by the Observatory will serve as one of the bases for training programs in the School of Urban Studies and those conducted by the Division of Urban Public Service. It is designed to work systematically with community agencies and organizations to coordinate data and develop meaningful working relationships relevant to urban problem-solving.

THE URBAN LIFE CENTER







Local Health Departments, Atlanta Area

CENTERS AND CLINICS

Fulton County

Main Center & offices
Adamsville
Alpharetta
Ben Hill
Buckhead
Center Hill
College Park
Collins
East Point
Fairburn
Hapeville
Howell Mill
Jere Wells
Lakewood
Roy W. McGee
Neighborhood Union
Northeast
Palmetto
Red Oak
Rockdale
Roswell
Sandy Springs
South Fulton
Techwood

DeKalb County

Main Center & offices
Doraville
Kirkwood
Lithonia
North DeKalb
Scottdale
Southwest Dekalb
Stone Mountain
Tucker

Cobb County

Marietta
Acworth

Cobb County (cont'd.)

Austell
Mableton
Powder Springs
Smyrna

Clayton County

Main Office
Forest Park
College Park
Fayetteville

Gwinnett County

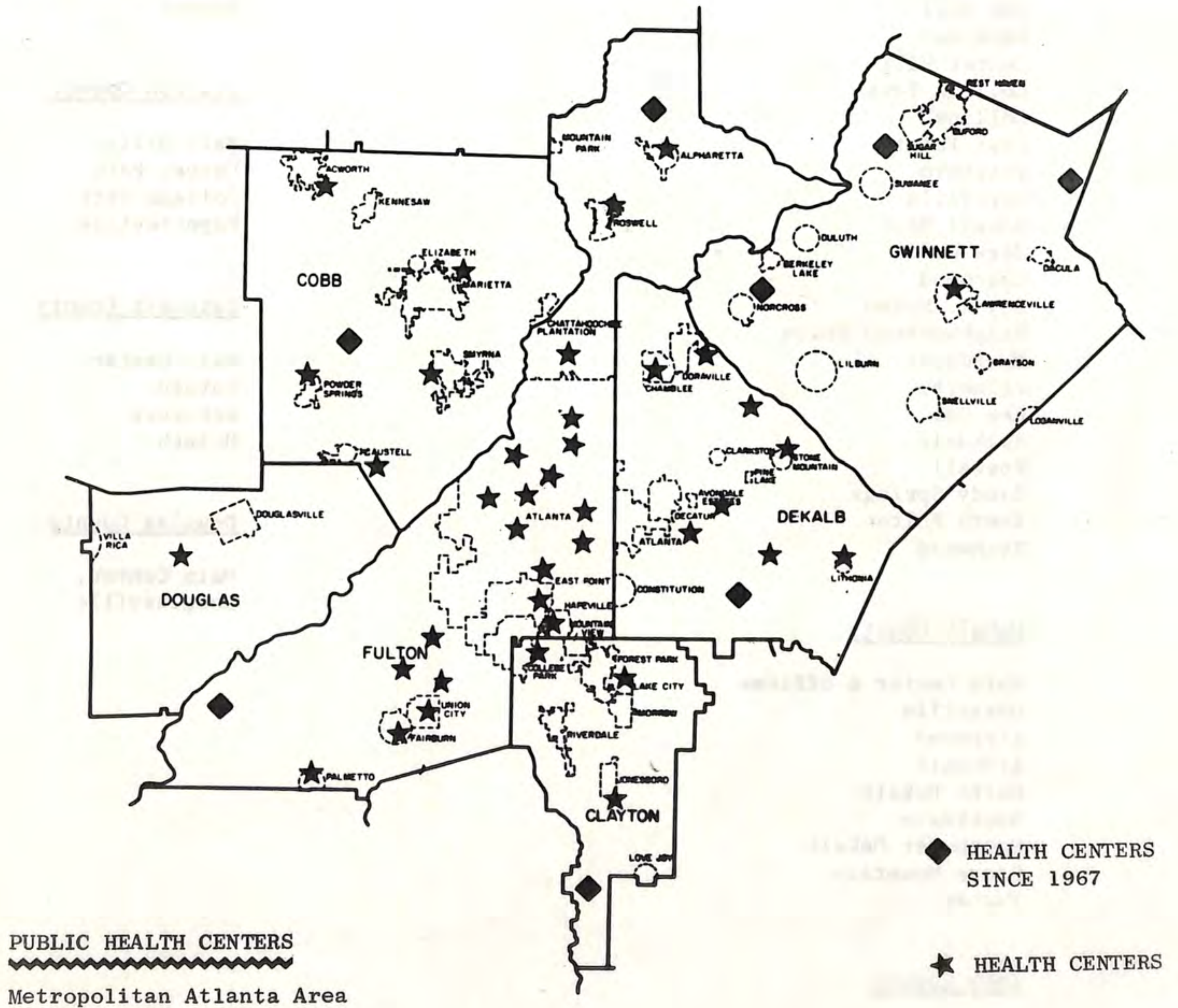
Main Center
Buford
Norcross
Duluth

Douglas County

Main Center,
Douglasville

County	Financing State Allotments July '67 - June '68	Centers	Manpower	Admission by Service		
				Mental Health	V.D.	T.B.
Fulton	$ 403,181	24	425	7,479	83,109	6,919
DeKalb	269,127	9	199	2,925	63	3,363
Cobb	122,271	6	47	2,169	128	1,080
Clayton	52,049	4	38	964	6	517
Gwinnett	18,760	4	21	484	4	595
Douglas	21,119	1	8	*	14	*

*not readily available



HEALTH CENTERS SINCE 1967

HEALTH CENTERS

PUBLIC HEALTH CENTERS

Metropolitan Atlanta Area

1968

WATER AND SEWER DISTRICTS IN THE ATLANTA AREA

EXISTING FACILITIES

1. Atlanta - R. M. Clayton Plant
2. Atlanta - Sandy Creek Plant
3. Atlanta - Utoy Creek Plant
4. Atlanta - South River Plant
5. Atlanta - Intrenchment Creek Plant
6. Atlanta - Flint River Plant
7. Fulton County - Industrial Waste Plant
8. Fulton County - Marsh Creek Plant
9. Fulton County - Morning Creek Lagoon
10. Jointly Owned Camp Creek Plant
11. Fairburn - Northside Plant
12. Fairburn - Southside Plant
13. Palmetto Plant
14. Alpharetta Lagoon
15. College Park - Southeast Plant
16. Clayton County - Flint River Plant
17. Clayton County - Rock Cut Road Lagoon
24. Atlanta Army Depot Plant
25. DeKalb County - Shoal Creek Plant
26. DeKalb County - Snapfinger Creek Plant
27. DeKalb County - Lagoon
28. Lithonia - East Sewer Outlet
29. Lithonia - South Sewer Outlet
30. Conyers - South Sewer Outlet
31. Conyers - North Sewer Outlet
32. Norcross Lagoon
33. Lawrenceville Plant
34. Lawrenceville Lagoon
35. Buford Plant
36. Cumming Lagoons
37. Acworth Plant
38. Kennesaw Plant
39. Marietta - West Side Plant
40. Marietta - South Side Plant
41. Marietta - East Side Plant
42. Marietta - Southeast Side Plant
43. Lockheed Plant
44. Cobb County - Church Road Plant
45. Cobb County - South Cobb Plant
46. Smyrna - Bohannon Creek Plant
47. Austell Plant
48. Douglasville Plant

SYMBOL LEGEND

- SECONDARY SEWAGE TREATMENT
- PRIMARY SEWAGE TREATMENT
- UNTREATED SEWAGE
- POTABLE WATER INTAKE

ATLANTA REGION METROPOLITAN PLANNING COMMISSION
900 Glenn Building Atlanta Georgia 30303

Comprehensive State Health Planning Agency - "A" Agency

Develops comprehensive state health plan.
Identifies health problems.
Recommends policies and programs.
Provides consultation and coordinates programs.

State Health Planning Council

Advises "A" Agency in carrying out its goals

Areawide Planning Agencies - "B" Agencies

Relates health programs in an area within a comprehensive framework.
Liaison with appropriate health agencies in an area to help carry out goals.
Conduct periodic evaluations and studies.
Review local grant applications.
Gathers and analyzes data.

Public health agencies (local)

Voluntary health agencies (local)

Community Council of the Atlanta Area inc.

EUGENE T. BRANCH, *Chairman of the Board of Directors*
CECIL ALEXANDER, *Vice Chairman*
JOHN IZARD, *Vice Chairman*
MRS. THOMAS H. GIBSON, *Secretary*
DONALD H. GAREIS, *Treasurer*

DUANE W. BECK, *Executive Director*

ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE 577-.

May 23, 1969

Donald F. Spille, Ph.D.
Executive Director of Metropolitan Atlanta
Mental Health Association
209 Henry Grady Building
Atlanta, Georgia 30303

Dear Dr. Spille:

As you know a proposal will be sent to HEW, Washington, in early June, setting up a mechanism for comprehensive health planning in the metropolitan Atlanta area, and requesting a 5-year grant to assist with such planning.

HEW must be assured that the proposed comprehensive health planning will have cooperation of all parties and agencies involved.

This is to request that you write us a letter, as soon as possible, assuring us of your cooperation in this project.

Sincerely yours,

Raphael B. Levine

Raphael B. Levine, Ph.D.
Director, Comprehensive
Areawide Health Planning

RBL:az
Encl.

Community Involvement in Comprehensive Health Planning

SUMMARY:
DOCUMENTED HEREIN (SEE APPENDIX) ARE INDICATIONS OF SUPPORT FOR COMPREHENSIVE HEALTH PLANNING FROM COMMUNITY ORGANIZATIONS AND GOVERNMENTAL AGENCIES. IT IS ANTICIPATED THAT COMPLEMENTARY RELATIONSHIPS OF MUTUAL BENEFIT WILL BE SOLIDIFIED IN THE EARLY STAGES OF PERMANENT OPERATION.

Note: Letter of the opposite page has been sent to following groups in the six-county area:

- County Commissions
- Mayors of Cities
- Medical and Dental Societies
- Nursing Associations
- Hospital Council
- Nursing Home Association
- Chamber of Commerce
- Colleges and Universities
- Health Care Centers
- Voluntary Health Agencies
- Representative Organizations of the Poor and Near-Poor

ORGANIZATIONAL CHART OF COMMUNITY DEVELOPMENT IN COMPREHENSIVE HEALTH PLANNING

N

W

E

S

Key:

25-member core of planning efforts to direct task force assignments.

Chamber of Commerce Board of Directors.

Local County communities. These communities will be analyzed and local citizens (with a wide range of representative types) will be asked to participate in discussions. Some representatives to consider will be age, race, sex, income, geographic location, etc.

The basic philosophy is to establish task force and community involvement simultaneously and then pool these thoughts into final recommendations. This obviously is an oversimplification of the process and many problems will have to be overcome if efforts are to be successful.

Sub-Areal Health Councils. Cobb County: Example in Experience

SUMMARY:
COMPREHENSIVE HEALTH PLANNING EFFORTS IN COBB COUNTY, AS IN OTHER AREAS OF METROPOLITAN ATLANTA, ARE IN THE NEOPHYTE STAGE. ORGANIZATION OF A COBB COUNTY HEALTH COUNCIL HAS MET WITH ENTHUSIASTIC COMMUNITY SUPPORT. COOPERATION AND EFFECTIVE COMMUNICATION WITH THE METROPOLITAN COMPREHENSIVE HEALTH PLANNING COUNCIL WILL PRODUCE AN EXEMPLARY RELATIONSHIP IN EFFORTS TO MEET HEALTH NEEDS OF THE AREA.

History of Cobb County Health Council:

While in recent years much progress has been made, gaps in Cobb County's health services have been dramatically evident. For example, a new family found the nearest physician twenty miles away. One hospital is often overcrowded while another has many available beds. Solutions to these and other problems are necessarily a task for large scale cooperative planning.

The present twenty-five member CCHC had its beginning in February, 1969, with a meeting of five health-oriented community leaders under auspices of the Chamber of Commerce. Health problems were recognized in four basic categories:

Services
Facilities
Manpower
Financing

Task forces of the Council and other community members have been assigned to determine needs, resources, and possible solutions in these areas.

Implications for Success:

1. The Chamber of Commerce has had a leading and beneficial role in organizing the CCHC. Support and participation have already been secured from major segments of the community.

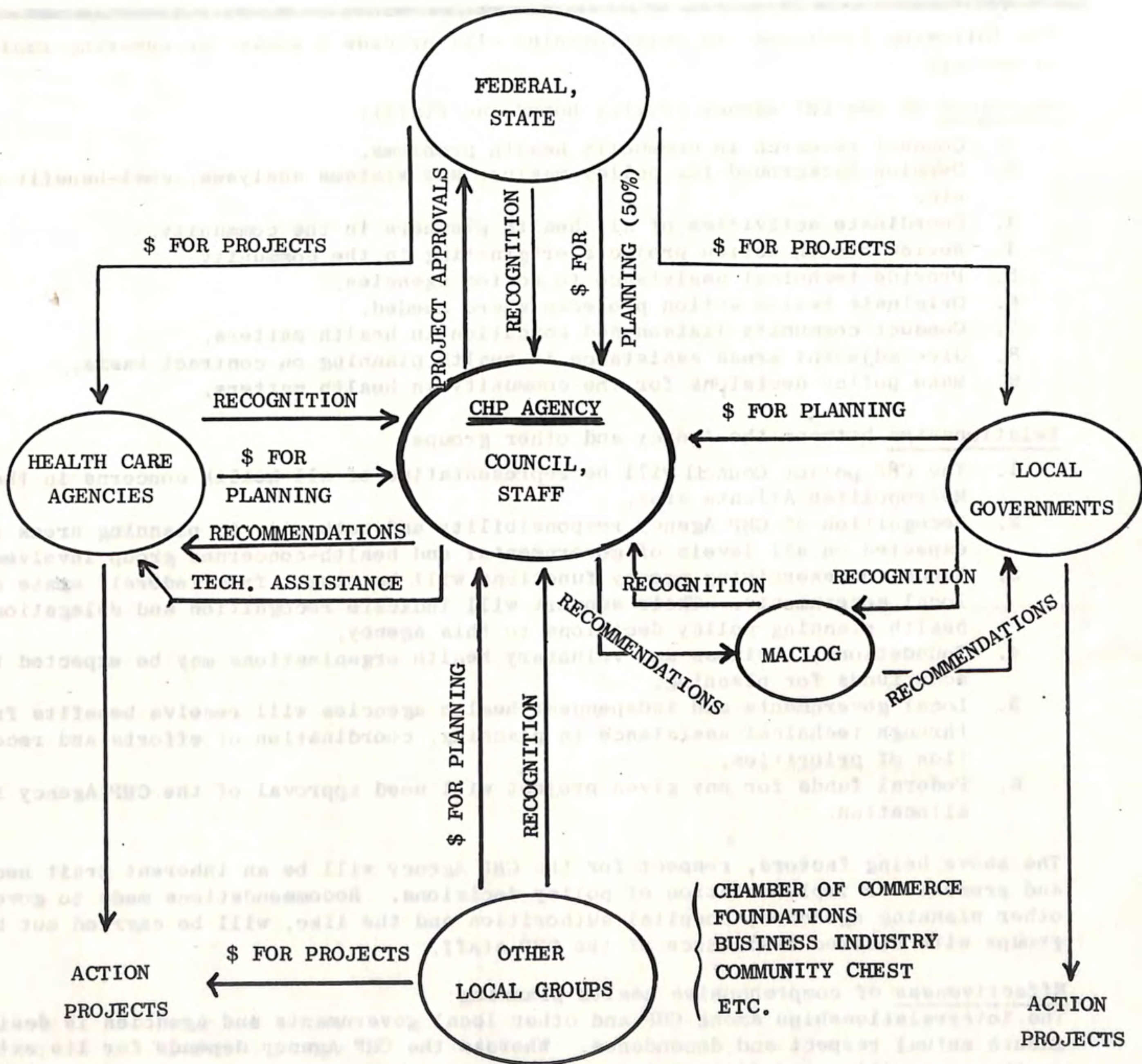
2. Planning involves government officials, health providers, and consumers working together to improve the total health system.

3. From the beginning, members of the CCHC have recognized the potential for inter-relationship with the Metropolitan Council. Understanding and coordination of efforts will combine resources leading to the solution of health problems.

Implications for Overall Local Liaison

The Cobb County Health Council is farther advanced than those in other counties and neighborhoods, although beginnings have also been made in Gwinnett and Clayton Counties. Basically, these local Councils serve two major purposes: (1) they extend the capability of the metro Council to spotlight special needs in local areas, and (2) they bring into participation additional citizens who generate citizen information activities and buil support for CHP.

POLICY - RECOGNITION - SUPPORT - ACTION



SUMMARY:
FUNCTIONS OF THE METROPOLITAN CHP AGENCY WILL INCLUDE RESEARCH, COORDINATION OF VARIOUS GROUPS, AND POLICY DECISIONS IN THE HEALTH FIELD. AS A PLANNING BODY, THE COUNCIL AND STAFF WILL DEPEND UPON ACTION GROUPS FOR IMPLEMENTATION OF ITS POLICY. FEDERAL, STATE AND LOCAL GOVERNMENT RECOGNITION OF THE AGENCY WILL BE KEY FACTORS IN THE ABILITY TO INFLUENCE ACTION WHICH WILL IMPROVE HEALTH FACILITIES AND SERVICES.

The following functions and relationships will provide a basis for ensuring implementation of policy.

Functions of the CHP Agency (Policy Board and Staff):

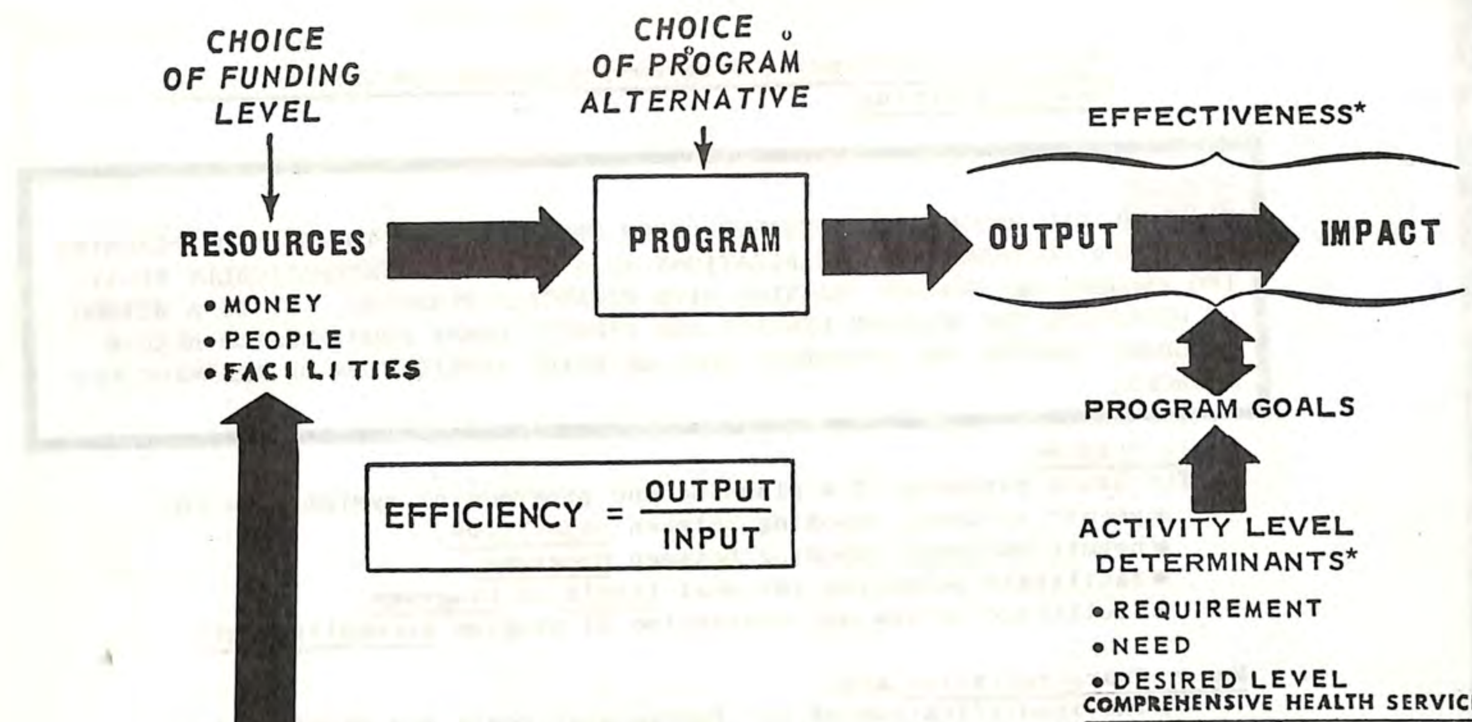
1. Conduct research in community health problems.
2. Develop background for policy-making; use systems analyses, cost-benefit analyses, etc.
3. Coordinate activities of all health planners in the community.
4. Review health action projects originating in the community.
5. Provide technical assistance to action agencies.
6. Originate health action projects where needed.
7. Conduct community liaison and education in health matters.
8. Give adjacent areas assistance in health planning on contract basis.
9. Make policy decisions for the community in health matters.

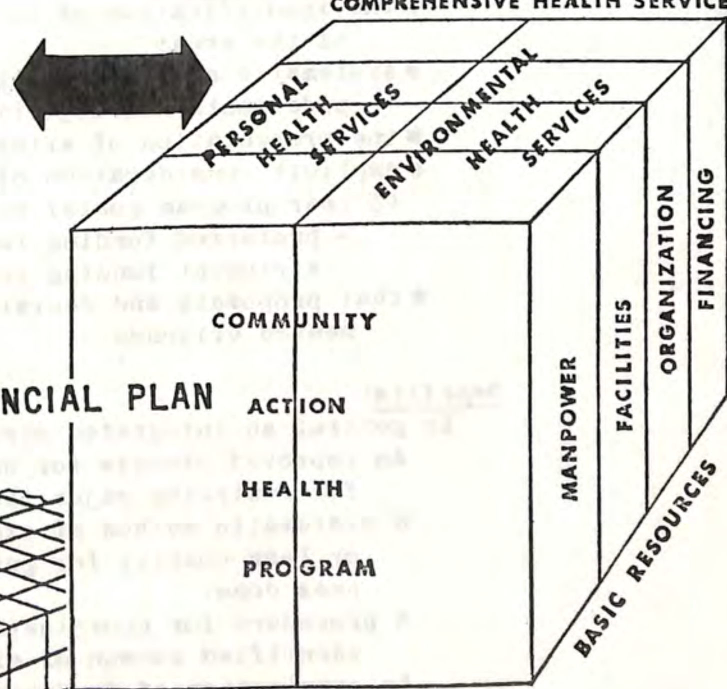
Relationships between the Agency and other groups:

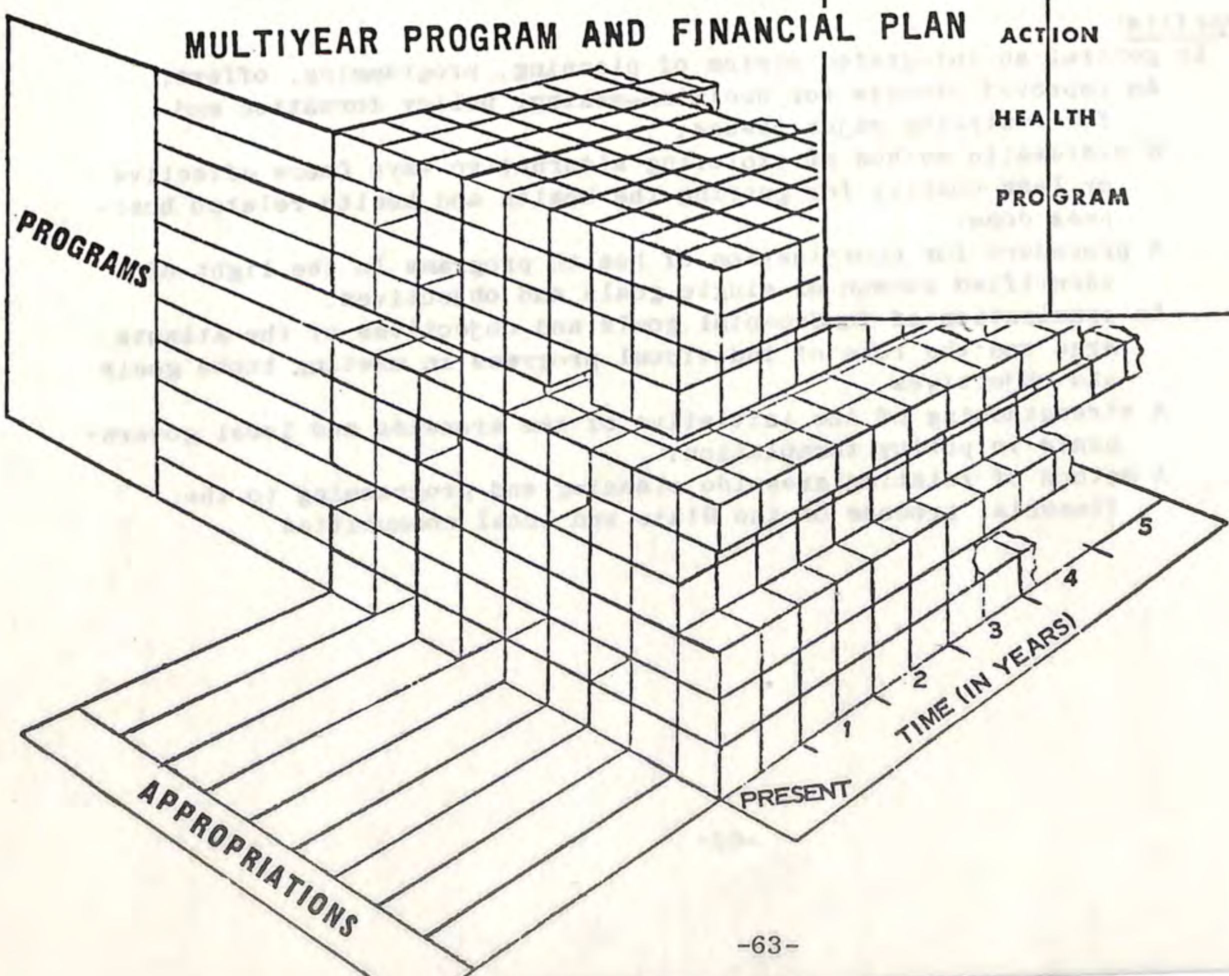
1. The CHP policy Council will be representative of all health concerns in the Metropolitan Atlanta area.
2. Recognition of CHP Agency responsibility and authority in planning areas is expected on all levels of governmental and health-concerned group involvement.
3. Funds for exercising agency functions will be sought from federal, state and local governments. Their support will indicate recognition and delegation of health planning policy decisions to this agency.
4. Foundations, business and voluntary health organizations may be expected to provide some funds for planning.
5. Local governments and independent health agencies will receive benefits from CHP through technical assistance in planning, coordination of efforts and recommendation of priorities.
6. Federal funds for any given project will need approval of the CHP Agency for allocation.

The above being factors, respect for the CHP Agency will be an inherent trait necessary and present for implementation of policy decisions. Recommendations made to governments, other planning agencies, hospital authorities and the like, will be carried out by those groups with desired assistance of the CHP staff.

Effectiveness of comprehensive health planning:
The interrelationships among CHP and other local governments and agencies is designed to insure mutual respect and dependence. Whereas the CHP Agency depends for its existence on the recognition and financial support of the other groups, they, in turn, depend on the existence and recognition by State and Federal offices of the CHP Agency for much of the Federal funding they require. And whereas the CHP Agency depends on the respect for its competence and fairness by local groups for its effectiveness in originating new plans, the local groups depend on the CHP Agency review for implementation of plans which they originate. Thus, it is in the interests of all that relationships begin and continue on a harmonious and mutually helpful basis.


CHOICE OF FUNDING LEVEL
CHOICE OF PROGRAM ALTERNATIVE
EFFECTIVENESS*
RESOURCES
• MONEY
• PEOPLE
• FACILITIES
PROGRAM
OUTPUT
IMPACT
PROGRAM GOALS
EFFICIENCY = OUTPUT / INPUT
ACTIVITY LEVEL DETERMINANTS*
• REQUIREMENT
• NEED
• DESIRED LEVEL


COMPREHENSIVE HEALTH SERVICE
AREAWIDE PLANS
PERSONAL HEALTH SERVICES
ENVIRONMENTAL HEALTH SERVICES
COMMUNITY
ACTION
HEALTH
PROGRAM
MANPOWER
FACILITIES
ORGANIZATION
FINANCING
BASIC RESOURCES


MULTIYEAR PROGRAM AND FINANCIAL PLAN
PROGRAMS
APPROPRIATIONS
PRESENT
1
2
3
4
5
TIME (IN YEARS)

The Need for Planning Programming System for Comprehensive Health Planning

SUMMARY:
PLANNING AND PROGRAMMING SYSTEMS OFFER GREAT PROMISE TO AREAWIDE PLANNING AND OTHER GOVERNMENTAL ORGANIZATIONS AS A MEANS OF SYSTEMATICALLY RELATING PROJECT OR PROGRAM PLANNING WITH FINANCIAL PLANNING. IT IS A METHOD OF OBTAINING THE MAXIMUM BENEFIT AND EFFECTIVENESS FROM RELATED HEALTH PROGRAMS THROUGH THE EFFICIENT GOAL-ORIENTED APPLICATION OF AREAWIDE RESOURCES.

Basic Purpose:

The basic purposes of a planning and programming system are to:

- permit rational choosing between objectives,
- permit rational choosing between programs,
- facilitate selecting rational levels of programs,
- facilitate review and evaluation of program accomplishment.

Major Characteristics are:

- the identification of the fundamental goals and objectives of the area;
- systematic analysis of alternative ways of meeting the areawide goals and objectives;
- the presentation of alternatives to the decision-maker;
- explicit consideration of future year fiscal implications (5-year program goals) at;
  - preferred funding level, or
  - stringent funding level; and
- that proposals and decisions are properly supported by documented evidence.

Benefits:

In general an integrated system of planning, programming, offers:

An improved process for decision-making, policy formation and for analyzing major issues.

A systematic method of exploring alternative ways (more effective or less costly) for getting the health and health related business done.

A procedure for coordination of health programs in the light of identified common or single goals and objectives.

An examination of fundamental goals and objectives of the Atlanta Area and the role of individual programs in meeting those goals and objectives.

A strengthening of the initiative of the areawide and local governments in policy formulation.

A method of relating areawide planning and programming to the financial process of the State and local communities.

HEALTH SYSTEM

Information
Air
Water
Food Pharmaceutical
Radiati n
Settlements Residence
Waste disposal
Sanitation

PLANNING
RECORDING
NURSING HOME
OUT-PATIENT
PHARMACY
HOME CARE
Rehabilitation
VOLUNTARY AGENCY
P. Health AGENCY
Special CLINIC
LABORATORY
INSURANCE-Pay
HEALTH Economics
Other Hospital
GENERAL Hospital
DENTIST
PHYSICIAN-Specialist
AMBULANCE Emergency

AGE, SEX,
Income,
Residence,
Occupation,
Religion,
Race,
Household,
Transportation
Education

USER

Type of training, education. →
Source of recruitment →

Training Education
Recruitment
Provider ↑

MD
MD/PhD
NURSE
NURSE
TECH
CLERK

Subsystem

Title: Information Gathering and Analysis Systems and Techniques to be Used

SUMMARY:
THE BASIC INFORMATION SYSTEM WILL INCLUDE THE (A) COLLECTION, (B) QUANTIFICATION, (C) STORAGE, AND (D) UTILIZATION OF DATA PERTINENT TO THE OTHER PHASES OF THE PLANNING PROCESS, PROBLEM AND RESOURCE DETERMINATION, IMPLEMENTATION, AND EVALUATION. EVALUATION OF THE PLANNING ITSELF SHALL BE DONE BY THE COMMUNITY AT LARGE THROUGH ITS EXERCISE OF SUPPORT. EVALUATION OF PARTICULAR PHASES OR OPERATIONS WILL BE BUILT INTO COSTS-BENEFITS ANALYSIS AND SUPPLEMENTED BY INDEPENDENT INVESTIGATION.

Research Technique

Data shall be organized according to a total functional model; i.e., under a scheme which takes into account units, their relationship to each other, and their relationship to a larger whole.

The units or subsystems of the health system, the entire health system, the total environment, and the "functional flow" of the user through it is suggested in the diagram on the opposite page.

This technique provides a basis for costs-benefits analysis of alternative plans for action.

Evaluation Technique:

A baseline for measurement of impact will be the purpose of an initial collection of information.

A systematic, continuous feed-back on effectivenss of programs will be built into each program in a simple manner.

Elaborate evaluations of particular phases or troublesome operations will be conducted.

Both the subjective and objective appraisal of efforts in terms of their impact upon the particular problem and the long-range goal will be made.

The entire planning process will be subject to the periodic evaluation of the organized community in the form of their extending or withdrawing financial and cooperative support.

The decision makers themselves will be subject to evaluation by "recall" or failure to election to the CHP Board by their respective groups.

The "public" will be an implicit evaluator through its use and non-use of programs.

PRIORITY AREAS FOR COMPREHENSIVE HEALTH PLANNING EFFORTS

Loading on health manpower - quantity and utilization.

Loading on health facilities - quantity and utilization.

Discrepancy between needs and care received by the poor.

Maternal and child health; family planning.

Mental Health

Environmental sanitation; pollution, waste disposal.

Public health and prevention; vector control.

Emergency health services.

Injury control.

Dental problems.

Drug abuse and alcoholism.

Degenerative and chronic diseases.

Citizen role in prevention and care.

Costs of health care; insurance patterns.

Scope of Program Health Concerns

SUMMARY:
A PRINCIPAL EFFORT DURING THE ORGANIZATIONAL PERIOD HAS BEEN TO IDENTIFY THE HEALTH PROBLEM AREAS OF THIS COMMUNITY WITH SUFFICIENT PRECISION TO BE ABLE TO PROJECT THE SCOPE OF THE PERMANENT PLANNING AGENCY'S FIRST YEAR OF OPERATIONS, AND DETERMINE THE STAFF NEEDS THESE OPERATIONS ENTAIL. OF THE MORE THAN 40 SUCH PROBLEM AREAS IDENTIFIED BY THE STAFF, 27 WERE STUDIED IN SOME DETAIL WITH THE ASSISTANCE OF AS MANY "TASK FORCES", DRAWN FROM THE COMMUNITY AT LARGE, AND INCLUDING HEALTH CONSUMERS AS WELL AS HEALTH PROVIDERS. SOME 14 PROBLEM AREAS HAVE BEEN IDENTIFIED AS MOST LIKELY TO DEFINE THE SCOPE OF THE FIRST YEAR'S PROGRAM.

Need for Identification of Health Problem Areas

Although the staff during this organizational period is not in a position to perform actual planning for this community, and therefore does not need the detailed information about community health problems and prevention and care mechanisms which will be necessary for a systems analytical approach to planning, it was necessary to identify the health problems with sufficient precision to be able to project the scope of the permanent planning agency's first year of operations. This scope, in turn, determines the size and skills which will be needed in the permanent staff.

Study of Health Problem Areas

During initial staff conferences, augmented by consultants from a number of health fields, and through the mechanism of two large community"technical aspects" meetings, more than 40 problem areas were identified as needing attention and improvement in the metropolitan health picture. These were divided into priority categories on the basis of the impressions developed to that time, and about half of them were designated as needing further study. This, in turn, was accomplished through the mechanism of problem area "task forces".

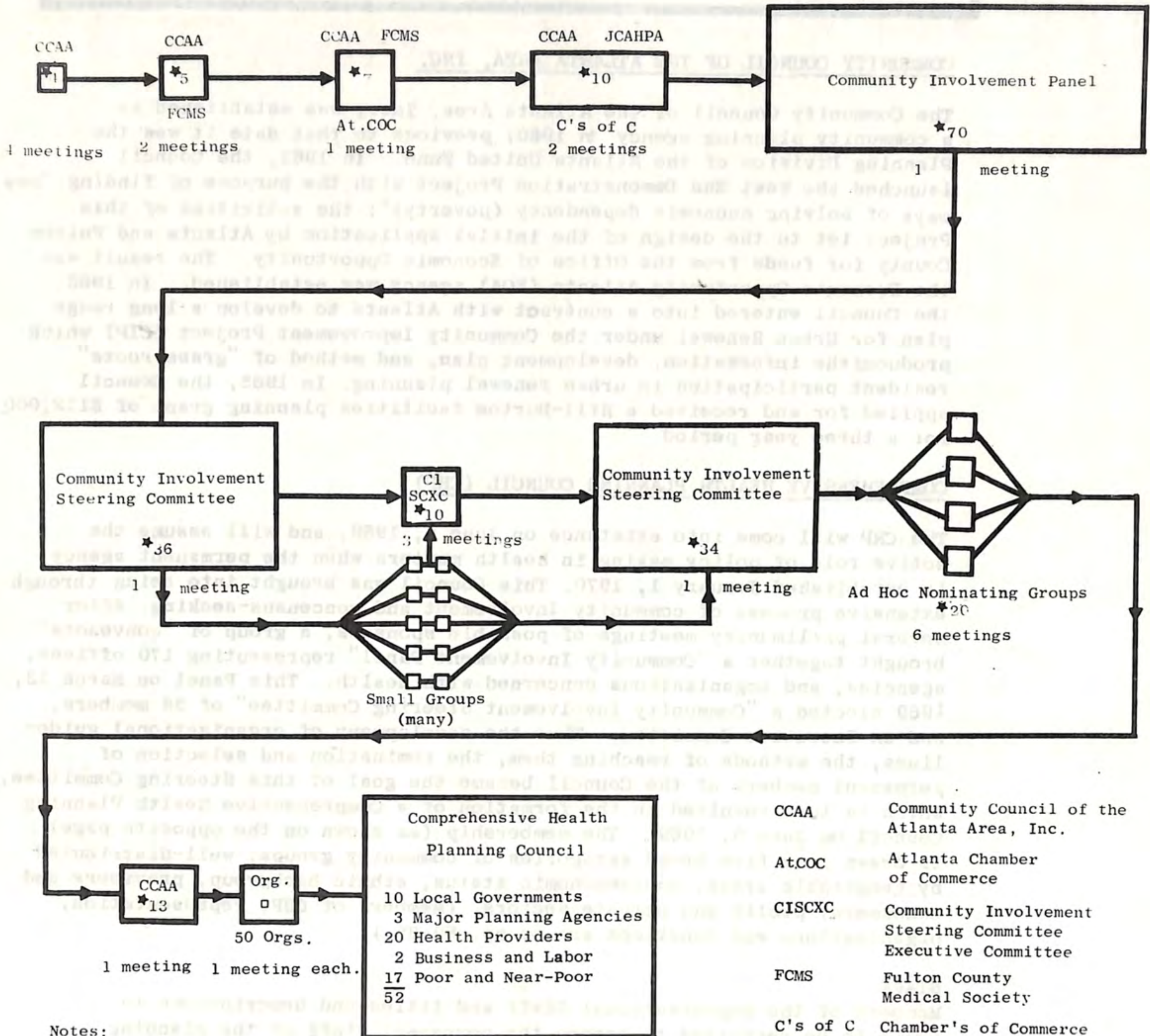
Problem Area Task Forces

Groups of interested and knowledgable persons in the community were asked by the various staff members to form "task forces", each of which was to study one of the assigned problem areas in the detail necessary for determining the scope of the 1970 comprehensive health planning effort. The task forces ranged in size from two or three individuals to more than 20. They were given instructions as to how to go about gathering their data and how to report their findings (see Appendix), and were assisted and encouraged by one of the staff. Some 27 of these task forces were eventually formed, and their reports, in many cases quite voluminous, are presented in Volume III of this proposal (in condensed form). A great deal of thanks is due to these hundreds of people, health providers and consumers alike, for the insight which they contributed to the understanding of this community's problems.

Scope of the 1970 Effort

The 14 problem areas shown on the facing page now seem likely to define the scope of the first year's efforts of the permanent comprehensive health planning agency.

COMMUNITY INVOLVEMENT ROUTE FOR BUILDING A POLICY BOARD BY CONSENSUS



Notes:

- ✱ indicate number of people at meeting(s).
- ▫ several members per organization

SUMMARY
THE COMMUNITY COUNCIL OF THE ATLANTA AREA, INC., A NON-PROFIT CORPORATION CHARTERED UNDER THE LAWS OF THE STATE OF GEORGIA WILL ACT AS THE APPLICANT AGENCY FOR COMPREHENSIVE HEALTH PLANNING. POLICY IN THE HEALTH ACTIVITIES WILL BE FORMULATED BY THE COMPREHENSIVE HEALTH PLANNING COUNCIL (CHP COUNCIL), WHICH WAS BROUGHT INTO BEING BY A COMMUNITY INVOLVEMENT PROCEEDURE RESULTING IN SUBSTANTIAL CONCENSUS. THE STAFF WILL CONSIST OF THE CHP ORGANIZATIONAL STAFF, AUGMENTED BY ADDITIONAL PROFESSIONAL AND SUB-PROFESSIONAL MEMBERS.

COMMUNITY COUNCIL OF THE ATLANTA AREA, INC.

The Community Council of the Atlanta Area, Inc., was established as a community planning agency in 1960; previous to that date it was the Planning Division of the Atlanta United Fund. In 1963, the Council launched the West End Demonstration Project with the purpose of finding "new ways of solving economic dependency (poverty)"; the activities of this Project let to the design of the initial application by Atlanta and Fulton County for funds from the Office of Economic Opportunity. The result was the Economic Opportunity Atlanta (EOA) agency was established. In 1965, the Council entered into a contract with Atlanta to develop a long range plan for Urban Renewal under the Community Improvement Project (CIP) which produced the information, development plan, and method of "grass roots" resident participation in urban renewal planning. In 1965, the Council applied for and received a Hill-Burton facilities planning grant of $112,000 for a three year period.

COMPREHENSIVE HEALTH PLANNING COUNCIL (CHP)

The CHP will come into existance on June 5, 1969, and will assume the active role of policy making in health matters when the permanent agency is established January 1, 1970. This Council was brought into being through an extensive process of community involvement and concensus-seeking. After several preliminary meetings of possible sponsors, a group of "convenors" brought together a "Community Involvement Panel" representing 170 offices, agencies, and organizations concerned with health. This Panel on March 13, 1969 elected a "Community Involvement Steering Committee" of 36 members, and an Executive Committee. Thus the development of organizational guidelines, the methods of reaching them, the nomination and selection of permanent members of the Council became the goal of this Steering Committee, which in turn resulted in the formation of a Comprehensive Health Planning Council on June 5, 1969. The membership (as shown on the opposite page) is drawn from five broad catagories of community groups; well-distributed by geographic areas, socioeconomic status, ethnic backgroup, providers and consumers, public and private sectors. (Members of CHP, representation, organizations and functions are on pp. 80-85.)

STAFF

Members of the Organizational Staff and titles and descriptions to staff to be recruited to become the permanent staff of the planning agency are listed on pages 78 and 79.

BACKGROUND OF HEALTH PLANNING EFFORTS

Health Planning with: (1)

Economic Opportunity, Atlanta, 1964.

Hill-Burton and National Institute of Mental Health, continuous.

Georgia Regional Medical Program, continuous.

Home Health Care Service, 1969.

Nursing Homes, 1967

Ga. State College, Kennesaw College, DeKalb College, Clayton Junior College, medical personnel training, 1967.

Fulton County Medical Society: Southside Comprehensive Health Center, Vine City Health Services. 1967.

Appalachian Funds, 1967.

Model Cities Program, 1968.

Areawide Comprehensive Health Planning, 1969.

Studies: hospitals, nursing homes, services, patients, physicians, senior citizens.

Related Planning: (1)

Community Improvement Program: Atlanta Urban Renewal
Senior Citizens Agency
Alcoholics Program
Information and Referral
Recreation: Atlanta Parks and Recreation
Community Participation organizations
Neighborhood Central Information Files.

(1) See Appendix for more complete descriptions.

Community Council Has Extensive Involvement in Health and Planning

SUMMARY:
ONE OF THE PRIMARY INTERESTS OF THE COMMUNITY COUNCIL, ATLANTA AREA, INC., IS THE HEALTH OF THE COMMUNITIES, THE FAMILIES, AND THE INDIVIDUALS OF THE METROPOLITAN AREA. ACTIVE SUPPORT AND PARTICIPATION IN PLANS AND PROGRAMS RELATED TO HEALTH HAVE BEEN CONDUCTED SINCE 1960. THE COUNCIL HAS WORKED CLOSELY WITH FEDERAL, STATE, AND COUNTY AND CITY AGENCIES, PROFESSIONAL AND VOLUNTARY GROUPS AND INDIVIDUALS TO RAISE THE LEVEL OF HEALTH.

Current Status:

The following paragraph taken from "Narrative Plan for Comprehensive Health Planning" by which the Governor designated the Georgia Department of Public Health as planning agent for the State of Georgia attests to the capacity of the applicant planning group:

> "There are only three staffed organizations in the state directed by boards adequately representative of the total community which are engaged in human resources-health planning. These are the Community Council of the Atlanta Area Inc. the United Community Service of Savannah-Chatham County, Inc., and the Georgia-Tennessee Regional Health Commission. The Department has maintained liaison with these agencies throughout their existence because of their broad interest in human resources planning This relationship is expected to continue."

Goals and Aims of the Planning Project:

SUMMARY:
THE PRINCIPAL GOAL OF AREAWIDE COMPREHENSIVE HEALTH PLANNING IS THE SAME AS THAT FOR STATE AND NATIONAL LEVELS: "PROMOTING AND ASSURING THE HIGHEST LEVEL OF HEALTH ATTAINABLE FOR EVERY PERSON". LOCALLY, THIS MEANS DEVISING AND ADOPTING STRATEGIES FOR THE USE OF HEALTH RESOURCES WHICH WILL MATERIALLY RAISE THE LEVEL OF HEALTH, PROGRESSIVELY, IN THE ENTIRE COMMUNITY. SUCH A TASK IS SEEN AS A PROBLEM IN "SYSTEMS" ANALYSIS AND DEVELOPMENT, BY WHICH BACKGROUND FOR POLICY DECISIONS MAY BE GENERATED. MAXIMUM PARTICIPATION BY ALL CONCERNED ELEMENTS IN THE COMMUNITY WILL BE NECESSARY FOR SUCCESSFUL IMPLEMENTATION OF POLICY.

In 1966, the United States Congress enacted Public Law 89-749, the "Partnership for Health" act. Under this law, the States, and through them, areas within the States, must assume responsibility for comprehensive health planning. The Congress declared that "fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts. and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources--national, State , and local--to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts".

The term "comprehensive" means that every aspect of the health picture in the six-county metropolitan area must be taken into account in the planning process. This includes not only the treatment of illness and injury, but their prevention, and the compensation for any lasting effects which they may leave. Thus, in addition to the manifold activities of medical and paramedical personnel in the variety of health treatment facilities, planning must consider environmental controls of the air, water, soil, food, disease vectors, housing codes and construction, waste disposal, etc. It must consider needs for the training of health personnel, for the improvement of manpower and facilities utilization, and for the access to health care. It includes the fields of mental health, dental health, and rehabilitation. It must be concerned with the means of paying for preventive measures and for health care.

The term "planning" means, first, that problem areas and potential problem areas in the entire field must be identified,and their magnitudes assessed. The trends of the problems must also be assessed, and projected for future years. Technical and organizational bottlenecks must be identified, and "planned around". Second, the community's resources in meeting its health needs must be equally carefully identified and projected, in terms of professional and subprofessional skills, facilities, and financial resources.

Third, since a considerable amount of planning is already being done for a number of projects, hospital authorities, counties, and municipalities, which affects the community's health picture, ways must be found to make maximum use of this capability, and coordinate it into a community-wide comprehensive planning effort. Finally, planning must preserve and encourage the highest level of professional competence in the entire health system, and must make use of the insights of all concerned in the community health system.

The overall task of putting together such an organization is thus seen to be a problem in "systems" analysis and development. Since the total resources of the community are likely to remain smaller than the demands which an ideal health system will place on the resources, rational and just methods of assigning priorities to the various needs must be developed. A cost-benefit analysis is essential to any such decision process, and, considering the literally hundreds of specific health needs in the community, it is likely that the cost-benefit model must rather soon make use of modern computer techniques.

The Partnership for Health law requires that such planning be done with people rather than for people. Therefore, maximum participation of health "consumers", health professionals, governmental units and agencies, and other community organizations is a necessity. The law is telling the States and communities that they will be given increasing responsibility and power to determine their own best health interests. In order to exercise this power most effectively, a maximum degree of concensus must be attained among those community elements concerned with health. To this end, participation of such elements is mandatory, so that a true "partnership for health" among governments, health providers and consumers, rich and poor, black and white, urban and rural, may be achieved.

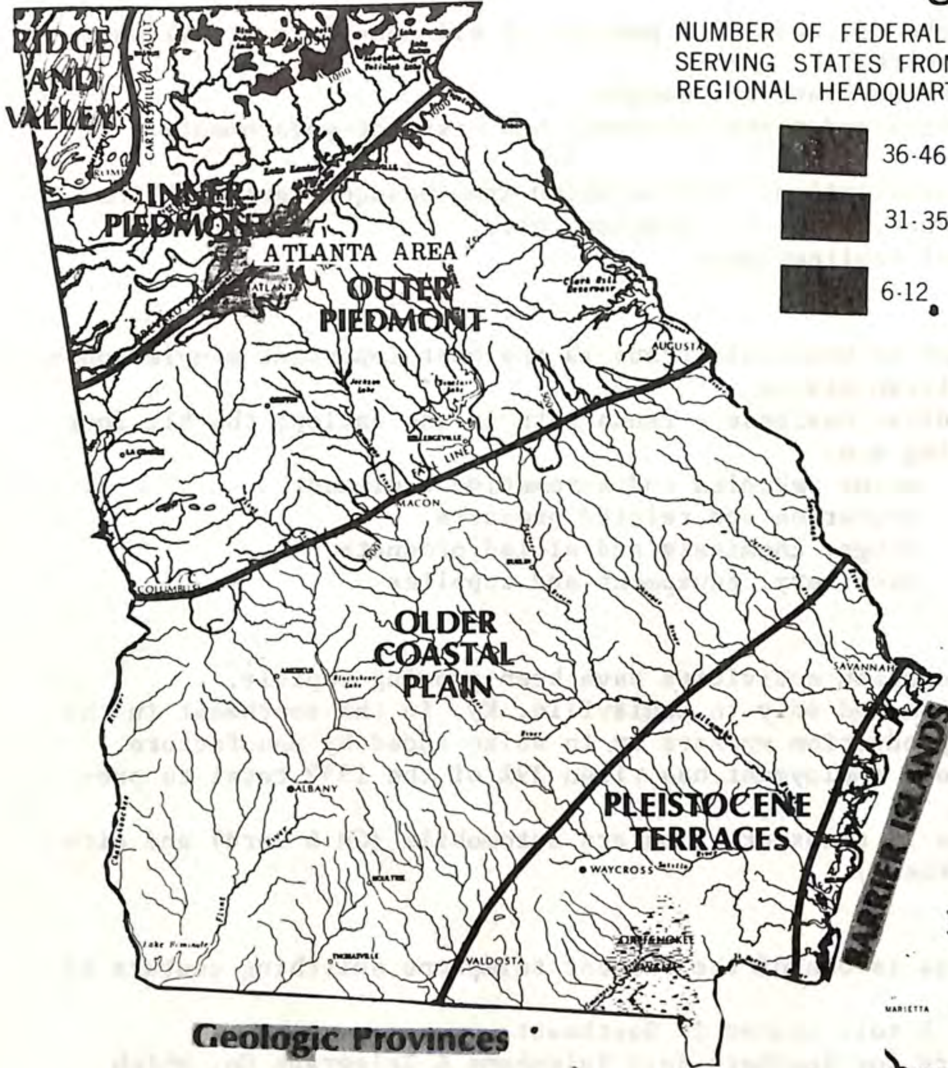
* * * * *

GOAL FOR 1975:

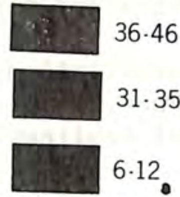
from Atlanta Journal and Constitution
25 May 1969
"Tumbleweeds" by Tom K. Ryan

government

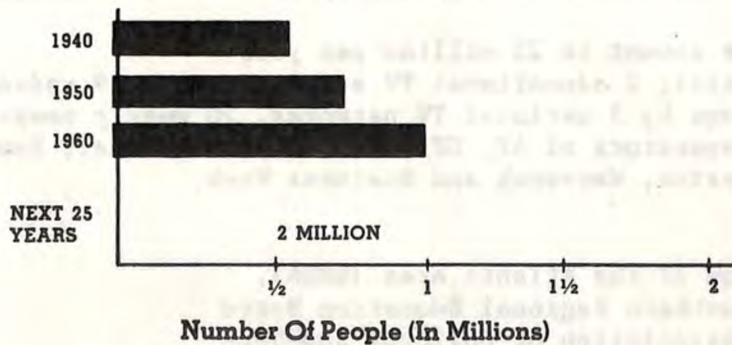
STATE OF GEORGIA



NUMBER OF FEDERAL AGENCIES SERVING STATES FROM ATLANTA REGIONAL HEADQUARTERS.



ATLANTA POPULATION



Rapid Transit Is A MUST . . .

REGIONAL CAPITAL OF THE SOUTHEAST

- provides jobs for over 13.5 percent of all non-agricultural wage and salary workers;
- capital for the State of Georgia;
- houses federal and state, regional and district governmental offices;
- military installations such as Third Army Headquarters, Dobbins Air Force Base, Naval Air Station, etc.;
- U.S. Federal Penitentiary.

Wholesale Trade

- Concentration of wholesale trade is the most important single index to metropolitan status
- 4 billion dollar business - ranks 13th in the nation; the big four in wholesaling are:

  motor vehicles and automotive equipment
  groceries and related products
  drugs, chemicals and allied products
  machinery, equipment and supplies

Manufacturing

Atlanta's production activities have been growing rapidly.

- Atlanta is second only to Louisville, Ky. in the southeast in the number of production workers or in value added by manufacture.
- Durable goods employment has risen 39% of the 1952 total to present 47.5%
- Major items in transportation are automobile (GM & Ford) and aircraft (Lockheed).

Communications

- Atlanta Area is one of the largest telephone switching centers in the U.S.
- Only Class I toll center in Southeast
- Headquarters for Southern Bell Telephone & Telegraph Co. which serves nine states and Southeastern headquarters of American Telephone & Telegraph Co.
- Atlanta Western Union office is one of 15 automatic high speed switching centers in the nation (it handles approximately 2 million telegrams a month)
- Gross postal receipts amount to 25 million per year
- Atlanta has 3 commercial, 2 educational TV stations; over 19 radio stations, news coverage by 3 national TV networks, 20 weekly newspapers and regional operators of AP, UPI, Wall Street Journal, New York Times, Time Magazine, Newsweek and Business Week.

Higher Education

A major regional function of the Atlanta Area (SMSA).

- Headquarters of the Southern Regional Education Board and for the Southern Association of Colleges and Secondary Schools.
- There are a number of recognized colleges and universities in the Area of great importance to its economic potential.

The Economic Status of the Atlanta Area

SUMMARY:
THE ATLANTA AREA HAS MANY SPECIFIC URBAN PROBLEMS. WHILE GENERALLY PROSPEROUS DUE TO ITS GROWTH AS AN INDUSTRIAL, BUSINESS, FINANCIAL, EDUCATION, COMMUNICATION AND TRANSPORTATION CENTER, THERE ARE SIGNIFICANT AREAS OF BLIGHT, UNEMPLOYMENT AND INADEQUATE COMMUNITY FACILITIES. THE VARIETY AND QUANTITY OF INTERNAL TRAFFIC FLOW PROBLEMS IN THE VITAL MOVEMENT OF GOODS AND PEOPLE CONTINUOUSLY REQUIRE THE DESIGN AND CONSTRUCTION OF MASS TRANSIT AND CIRCUMFERENTIAL HIGHWAY SYSTEMS. POPULATION INCREASES, IMMIGRATION OF WORKERS FROM RURAL AND OTHER URBAN CENTERS, LONGER LIFE SPAN, TECHNOLOGICAL INNOVATION AND MEDICAL ADVANCEMENTS HAVE CREATED HEAVIER BURDENS ON HEALTH AND HEALTH RELATED SERVICES AND FACILITIES, BOTH SHORT AND LONG TERM. THE ATLANTA AREA PRESENTLY NEEDS APPROXIMATELY 1800 BEDS FOR MEDICARE, MEDICAID AND TREATMENT FOR THE "MEDICALLY INDIGENT". AS TRENDS INDICATE CONTINUED ECONOMIC GROWTH WITH RELATED POPULATION INCREASE, THERE WILL BE EVEN GREATER NEED FOR ADDITIONAL HEALTH FACILITIES AND MANPOWER RESEARCH TO SOLVE UNEMPLOYMENT, LABOR AND HEALTH RELATED PROBLEMS.

Topography:

The Atlanta Area is centrally located in the Southeast and stands alone as the only metropolis in its population class south of Washington and east of Dallas and Houston.

- Economically similar to other inland regional centers such as Kansas City, Minneapolis, St. Paul and Dallas.
  - Developable land areas abound in every direction.
- Physically, the Atlanta Area is:
  - --located in the Piedmont region which lies south of the Appalachian region and north of the Coastal Plains region;
  - --north of Georgia's fall line and bisected to some extent by the Brevard fault;
  - --characterized by low rolling hills containing metamorphic and igneous type rocks;
  - --generally blessed with a warm, humid climate (average winter low=45°; average summer high=77°)
  - --ideally suited for impoundment of almost any size lakes due to its annual average precipitation of 48 inches:

- Pine and a few other hardwood trees are found throughout the Area.
- Water for the Area comes from the Chattahoochee River, several creeks and lakes.
  - --Lake Lanier and Allatoona Lake are within 50 miles of Atlanta
- The reddish clay-soil of the Area is moderately fertile, but susceptibility to erosion has diverted much of the land to less demanding uses such as pasture and forests.

- Notable Features:
  - --Stone Mountain (a granite peak and State Park), reputedly the world's largest granite monolith
  - --Kennesaw Mountain, an historic Civil War battle site

Transportation

Key to the Area's economic growth.

-Railroads - 13 main lines of 7 railroad systems radiating in all directions.

-Interstate Expressways - Six legs scheduled to go through the area

-Air Transport - Six major airlines serve the area; two of the airlines are headquartered in Atlanta. 800 scheduled arrivals and departures daily.

-Waterway Transport - has potential for both recreation and trade.

Finance

One of the most significant forces in the ATLANTA AREA (SMSA) is its economic growth as a financial center. Factors effecting the financial growth are:

- selection for Federal Reserve bank (based on flow of trade in 1914)
- headquarters for Sixth Federal Reserve District
- growth in Atlanta's correspondent bank relationships

Business

ATLANTA AREA (SMSA) is an office "Headquarters city" with continued business growth indicated for the future.

- since WW II more than 8 million square feet of rentable office space has been built
- leader in advertising, blueprinting, photocopying, research, and development, etc., in Southeastern United States.

Manpower

(See chart page 42, Health Manpower Resources, 1968)
(See chart page 13, Population Distribution by Age and Sex)

Major problems in the Area's working population will arise from:

- inexperienced individuals, in large numbers, born in the 40's and 50's who will enter the job market in the 60's and 70's;
- women, who increasingly tend to accept regular employment;
- middle-aged males, industry's supervisory personnel pool, who will scarcely increase in number;
- older people, growing in numbers, who will create a demand for retirement homes, medical care facilities and passive recreation equipment; this will affect construction and industrial production;
- impact of automation which will accelerate competition for available jobs.

Government

Government is big business in the ATLANTA AREA.

SELECTED RANKINGS & CHARACTERISTIC OF GEORGIA (From State Data & State Rankings, Part 2 of 1966-67 edition of Welfare Trends)

HEALTH MANPOWER

	U.S Rank
Physicians	38
Dentists	48
Professional Nurses	43
General & Special Hospital Admissions	48
Mental Hospital Admissions	19
Tuberculosis	27
Expenses (total)	47
Expenses (General Short-term)	39
Expenses (General Long-term)	2
Expenses (Mental)	46

Existing Manpower

SUMMARY:
THE NUMBER OF PRIVATE PHYSICIANS AND DENTISTS AVAILABLE TO THE PATIENT IN THE 6-COUNTY AREA IS ALMOST THE SAME AS THE NATIONAL RATIO. OTHER PARTS OF GEORGIA HAVE RELATIVELY FEWER PHYSICIANS AND ABOUT HALF AS MANY DENTISTS FOR THE POPULATION. REGISTERED NURSES ARE CONSIDERABLY MORE ABUNDANT IN THE ATLANTA AREA THAN NATIONALLY OR ELSEWHERE OVER GEORGIA. THE NUMBER OF SANITARIANS ALSO COMPARES FAVORABLY WITH OTHER AREAS.

THE COMPARISIONS MADE HERE ARE NOT RELATED TO NEEDS, WHICH IN MANY CASES IS GREATER IN METROPOLITAN AREAS, THAN IN SMALLER AREAS.

HEALTH MANPOWER RESOURCES, 1968

Area	Physicians		Dentists		Registered Nurses		Sanitarians
	Private Practice	Persons per Phy.	Registered	Persons per Dentist	Active	Persons per Active Nurse	
Douglas	6	3983	7	3314	34	493	1
Gwinnett	16	3738	9	6478	81	538	3
Clayton	20	3935	14	5564	125	371	2
Cobb	135	1294	52	3242	358	319	7
DeKalb	216	1637	109	3452	1,571	164	1
Fulton	864	701	419	1440	1,730	322	35
6 County	1257	1031	603	2152	3,899	266	49
Georgia	3165	1143	1296	3744	12,368	502	
U.S.	188772	1036	90716	2157	909,131	329	324

National & State data are taken from Health Resources Statistics,1968,U.S. Dept. HEW

Sanitarians: Provided by Mr. Furman B. Hendrix, R.S., Ga. Society of Professional Sanitarians, May, 1969.

Nurses: Roster of Registered Prof. Nurses, Board of Examiners of Nurses for Ga.,1968.

Dentists: Office of Dental Health, Ga. Dept Public Health, June, 1968.

Physicians: Bio-Statistics Service, Ga. Dept. Public Health

For more complete table see Appendix.

* PROFILE OF PERCENTAGE OF NEEDS MET AND UNMET FOR HEALTH FACILITIES IN HILL-BURTON SERVICE AREAS, ATLANTA, SMSA, 1968

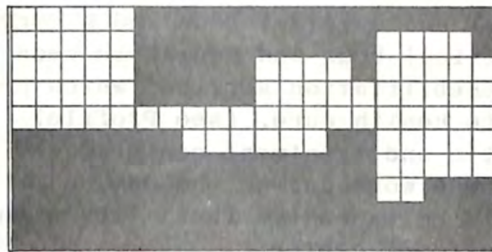
Rehabilitation | General Hospital | Long Term Care | Diagnostic and Treatment

KEY

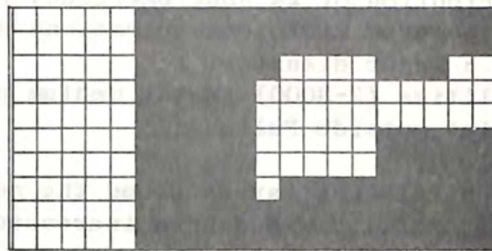
% Met Needs ■

% Unmet Needs □

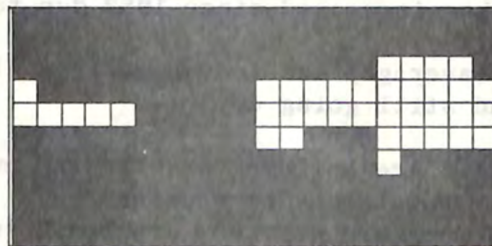
		Population



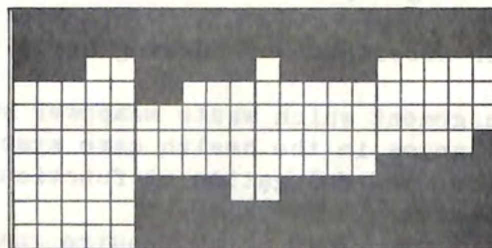
MARIETTA AREA
Cobb, Paulding, Douglas — 209,200



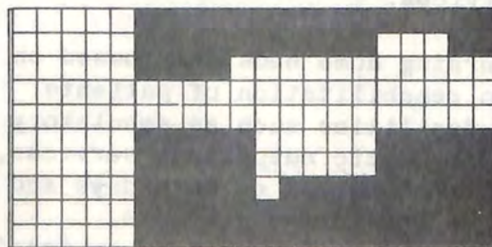
SOUTH FULTON AREA
South Fulton, Clayton
Coweta, Fayette — 221,700



DECATUR AREA
DeKalb, Rockdale
North Fulton — 437,200



CITY OF ATLANTA AREA — 460,000



LAWRENCEVILLE AREA
Gwinnett, Barrow, Walton — 95,800

* Based on the Georgia State Plan for Hospitals and Related Facilities, Revised 7/1/68, Branch of Medical Services and Facilities Planning, Georgia Department of Public Health

Facilities: Indluding Hospitals, Nursing Homes, Outpatient Clinics and Neighborhood Health Centers

SUMMARY:
THERE MUST BE DESIGNED A COMMUNITY PLAN FOR THE USE OF FACILITIES IN AN ORGANIZED ARRANGEMENT OF MEDICAL RESOURCES SO AS TO BRING THE INDIVIDUAL, WHEREVER LOCATED, INTO CONTACT WITH HIS PHYSICIAN AND OTHER MEMBERS OF THE HEALTH CARE TEAM AT THE LEVEL OF CARE THAT HE REALISTICALLY NEEDS.

Problem:

1. General shortage of medical and surgical beds and a corresponding underutilization of obstetrical beds and pediatric beds
2. Need for development of rehabilitation services which prevent or lesson the demand for acute health care. (see Profile)
3. Lack of extensive diagnostic and treatment centers, and of night clinics to serve the poor who work during the day.
4. Lack of agreement on providing expensive facilities such as a community radiological treatment center.
5. Lack of geographical distribution of 24 hour emergency care services; need for an independently powered radio communications system between hospitals in the event of a major disaster.
6. Lack of nursing home facilities (2-3000) in the medium price range, and particularly in counties outside Fulton.

Current Status

1. Utilization of general hospitals has far exceeded the population trend; particularly in metropolitan areas have increased population brought additional demand for services.
2. The average patient stay has increased since 1962 due to Kerr-Mills and Medicare programs.
3. The cost per patient day (average) has increased from $12.95 in 1950 to $43.97 in 1967 and still going up.

Trends

1. At least six major hospitals are building or planning nursing home units and two are planning ambulatory care units.
2. Organized Home Care and Homemakers services are beginning to be sought.
3. Hospitals are developing emergency care 24 hour services with full-time paid physicians.
4. Utilization committees in hospitals and nursing homes are gaining status.

Obstacles

1. Traditions in patient management which waste manpower and facilities.
2. Lack of money for major changes in the health care system.
3. Underutilization of manpower and delegation of functions to lesser trained patient care personnel.
4. Distorted insurance benefit structure which require inpatient status to pay for diagnostic services.

Possible Solutions

1. Build new hospital and nursing home beds only based on effective demand.
2. Give greated attention to rehabilitation of patients.
3. Develop progressive care facilities such as ambulatory self care.
4. Develop "Day Hospitals" diagnostic outpatient services, night clinics.
5. Operate full services of the hospital on Saturdays and Sundays, or "round the clock" double shifts for surgery etc.
6. Remove the stipulation that the patient occupy an inpatient bed in order to get insurance coverage for diagnostic and minor treatment services.

The Plan Has Continued In-Put from Existing Resources

SUMMARY:
NOT ONLY HAS THE INVOLVEMENT OF RELATED GROUPS REDUCED THE THREAT OF CHANGE, BUT IT HAS BROUGHT INTO REALITY THE BASIC THEME OF THIS PROPOSAL: PARTNERSHIP -- SOUGHT AND DEVELOPED. THE COMMUNITY COUNCIL'S HOSPITAL AND HEALTH PLANNING STAFF HAS BEEN IN CLOSE TOUCH, BOTH FORMALLY AND INFORMALLY, WITH OTHER RELATED PROGRAMS, PROJECTS, ACTIVITIES AND RESOURCES. NUMEROUS PRIVATE AND PUBLIC ORGANIZATIONS HAVE CONTRIBUTED IN SIGNIFICANT WAYS TO THE PREPARATION OF THIS PLAN AND HAVE BEEN INCORPORATED INTO THE DESIGN FOR A CONTINUING PLANNING PROCESS TO IMPROVE THE LEVEL OF HEALTH IN THE ATLANTA AREA.

Methods of Involvement:

Joint board members (mandatory and voluntary)

Staff exchange

Review procedures

Referral arrangements

Information exchange

Consultation (formal and informal) (1)

Umbrella organizations

Staff meetings (regular and called) (1)

Committee and Task Force memberships

(1) See Appendix for Chart of INTERAGENCY RELATIONSHIPS: HEALTH PLANNING, which lists some specific contacts.

Current Resources:

Level	Resources
FEDERAL	Dept. Health, Education, Welfare, Community Profile Center (info. exchange, consultation) Communicable Disease Center (consultation)
REGION	Office Economic Opportunity (info. exchange) Dept. Health, Education, Welfare (info. exchange, consultation) Dept. of Labor, Dept. of Labor Statistics (consultation, info exchange) Emory University Medical School (consultation)
STATE	Dept. of Public Health: Planning Office, Office of Comprehensive Health Planning, Office of Bio-Statistics, Branch of Environmental Health, Facilities and Construction Division, Licensure Division (info. exchange, consultation, board members, review) Univ. of Ga. Center for Management Systems, (info. exchange, consultation), Georgia State College (consultation), Ga. Tech, School of Sanitary Engineering (consultation, info. exchange) Georgia Hospital Association (consultation) Medical Association of Georgia (consultation) Ga. State League for Nursing (staff exchange) Ga. Nursing Home Assoc. (staff exchange) Health Insurance Council (info. exchange)
AREA	Atlanta Region Metropolitan Planning Commission (info exchange, consultation, board members) Georgia Regional Medical Program (umbrella organization, review) Georgia District Hospital Association (consultation, joint board) Atlanta Area Society of Registered Professional Sanitarians (info. exchange, consultation) Metro. Atlanta Mental Health Association (staff exchange) Ga. Society for Crippled Children & Adults (consultation, info. exchange, staff exchange, joint board) Visiting Nurses Association (staff exchange, joint board) Ga. State Nurses Association Training Program (staff exchange) Blue Shield & Blue Cross (info. exchange, consultation) American Cancer Society, Georgia Div. (joint board, consultation) Ga. Heart Association, Inc., (joint board, consultation) Community Chest, Agency Relations & Allocations Division (joint board/staff) Senior Citizens Service of Metro Atlanta, Inc. (staff exchange)
LOCAL	Model Cities (consultation, staff exchange) Atlanta University (consultation) Economic Opportunity Atlanta (staff exchange, consultation, joint board) County Public Health Depts. (staff exchange) Fulton County Medical Society (consultation, joint boards) Cobb County Medical Society (consultation) City of Atlanta, Air Pollution Control Division (consultation, joint board) Atlanta School System, P.T. Association and Adult Education (info. exchange)

The Comprehensive Health Planning Staff

SUMMARY:
THE FUNCTIONS OF THE COMPREHENSIVE HEALTH PLANNING STAFF ARE (A) TO CONDUCT RESEARCH IN COMMUNITY HEALTH PROBLEMS, (B) TO DEVELOP BACKGROUND FOR POLICY-MAKING THROUGH SYSTEMS ANALYTICAL METHODS, (C) TO COORDINATE THE ACTIVITIES OF ALL HEALTH PLANNERS IN THE AREA, AND (D) TO PERFORM CONTRACT SERVICES AND TECHNICAL ASSISTANCE ACTIVITIES. THE STAFF INCLUDES A DIRECTOR OF COMPREHENSIVE AREAWIDE HEALTH PLANNING AND OTHER PROFESSIONAL AND SUB-PROFESSIONAL PERSONS.

Planning Functions

The planning functions of the staff consist of two major sections: (a) the coordination and review of plans originating in the health and health-related offices throughout the community, and (b) the origination of plans in areas not covered by other offices and agencies. The latter is expected to consist in large part of systems-analytical studies, including cost-benefit analyses, which cover the entire range of health problems and possible solutions.

I N C O M P L E T E

COMPREHENSIVE HEALTH PLANNING STAFF
INITIAL ORGANIZATION

Director
Secretary 4

Associate Director
Systems Research & Evaluation

Systems Analyst
Research/Evaluation Planner
Environmental Health Planner
Liaison Planner
Statistician
Secretary 3
Secretary 2

Associate Director
Admin. & Organizational Liaison

Organization Liaison
Neighborhood Liaison
Plan Review/ Technical Assistance
Secretary 3

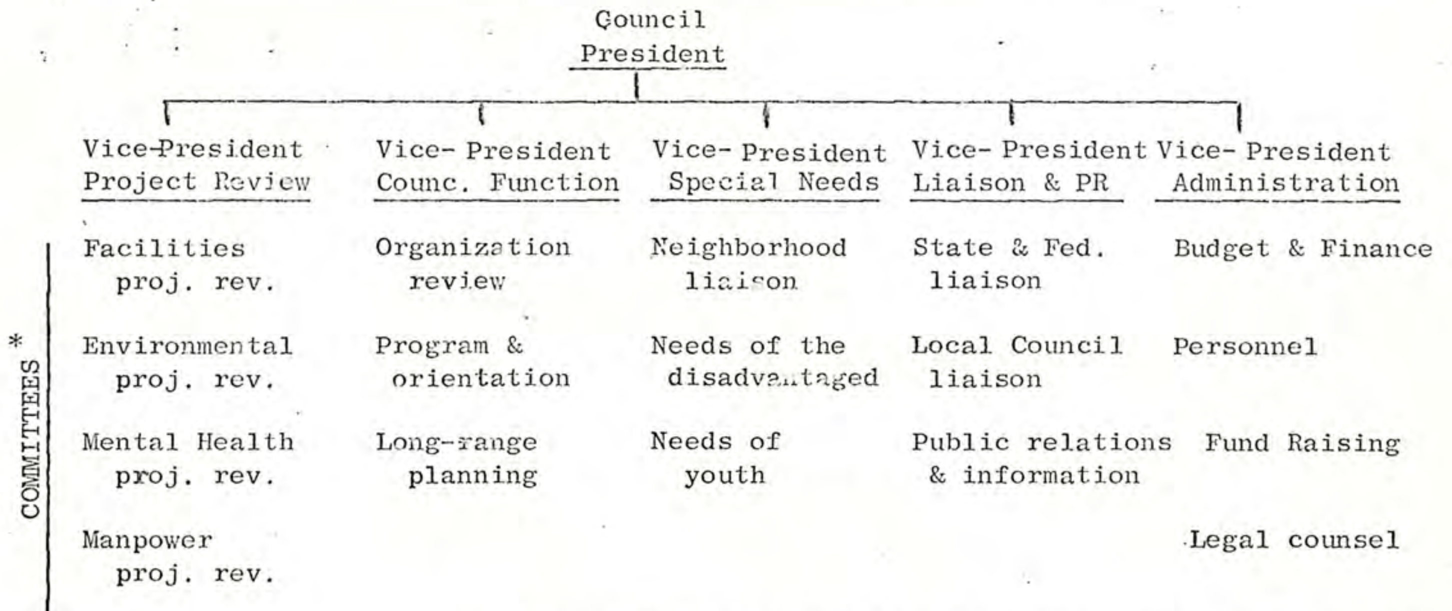
SUMMARY:
THE FUNCTIONS OF THE METROPOLITAN ATLANTA COUNCIL FOR HEALTH ARE (A) TO MAKE POLICY FOR THE METROPOLITAN COMMUNITY IN HEALTH MATTERS AND (B) TO SET POLICY FOR GUIDANCE OF STAFF ACTIVITIES. THE COUNCIL REVIEWS HEALTH ACTION PROJECT PLANS ORIGINATING WITHIN THE COMMUNITY, AND ORIGINATES HEALTH ACTION PLANS WHERE NEEDED. THE COUNCIL IS RESPONSIBLE FOR CONDUCTING COMMUNITY LIAISON AND EDUCATION IN HEALTH MATTERS.

Council Structure

As provided in the By-Laws, the Council is structured as a "working board". All policy matters are decided by the full Council. To facilitate such activity, the Council will form several groups of committees for specific tasks, each group supervised by a vice president. The committees will report to the Council, and recommend actions in their areas of competence. A number of the committees will work closely with the staff in such areas as project review and community liaison.

I N C O M P L E T E

COMPREHENSIVE HEALTH PLANNING COUNCIL - STRUCTURE



*Each committee is chaired by a Council member; Vice-Presidents of Council oversee and encourage activities of the groups of committees shown.

Executive Committee:

President of Council

Vice-Presidents (5)

Secretary

Duties:
- Carry on activities between Council meetings; recommendations subject to Council review

Nominating Committee:

Selected from membership of Council, with due regard to makeup of the Council.

Duties:
- Nominate a slate of officers prior to the annual meeting
- Nominate a new nominating committee prior to the annual meeting
- Nominate organizations, on a rotating basis, which will name members of the Council to take office at the next annual meeting
- Nominate replacements for vacancies as they occur

Personnel Committee

Selected from Council membership and community at large.

Duties:
- Recommend selection and salary of Director for Council action
- Formulate personnel policies, including salary ranges

Membership on the Council

SUMMARY:
MEMBERSHIP ON THE COUNCIL SHALL BE DRAWN FROM TWO MAJOR GROUPINGS: THOSE WHO WILL SERVE BY VIRTUE OF OFFICE IN A MAJOR PLANNING ORGANIZATION OR LOCAL GOVERNMENT, AND THOSE WHO SERVE THROUGH BEING NAMED BY APPROPRIATE ORGANIZATIONS OF HEALTH PROVIDERS AND CONSUMERS. MEMBERSHIP IS DRAWN FROM SOURCES BROADLY REPRESENTING THE ECONOMIC, ETHNIC, AND GEOGRAPHIC BACKGROUND OF THE COMMUNITY.

I N C O M P L E T E

MEMBERSHIP ON COUNCIL - Scheme 6

Number	Group	Selected/elected by
3	MACLOG, CCAA, ARMPC	virtue of office (chairmen)
6	County commissions	virtue of office (chairmen)
1	City of Atlanta	virtue of office (mayor)
3	Municipal governments of counties	municipal associations or county commissions (in rotation)
20	Health providers:	
	4 MD's	medical societies (in rotation)
	1 MD, psychiatry	Ga. Psychiatric Assoc.
	2 DDS's	dental societies (in rotation)
	2 Public health	public health departments (in rotation) (recommended: 1 MD, 1 other specialty)
	2 Health facilities	hospital, nursing home associations, etc. (both private and authority-- in rotation)
	1 Medical educator	school of medicine
	1 Paramedical educator	allied sciences schools, etc. (in rotation
	1 RN	nursing associations (in rotation)
	2 Voluntary health agencies	CCAA Permanent Conference and State Association of voluntary agencies (in rotation)
	1 Social worker	NASW local chapter
	1 Skilled paramedical	technical associations (in rotation)
	1 Semi-Skilled paramedical	organizations, if any; otherwise nominated as an individual
	1 Health ins. industry	Health Insurance Council
17	Poor and near-poor	
	7 EOA's	Atl-Gwinnett, Clayton, DeKalb-Rockdale
	2 Model Cities	
	3 PTA's	Cabbagetown, Cobb, Douglas (others in rotation)
	5 other organizations	NWRO, Southside Health Center, TUFF, NAACP, Urban League (1 each) (others in rotation)
2	Business and labor	Chambers of commerce, unions (in rotation)
52	TOTAL	

The term of "virtue of office" members to coincide with occupancy of office. Term of other members, three years, one-third rotating off each year. "In rotation" indicates that at successive elections different organizations or groups within the same category will be asked to select members.

A nominating committee of the Council will be responsible for assuring such rotation. For the first election ad hoc nominating committees in the major categories above are being asked to submit names of organizations, for review by CCAA Executive Committee.

Title: Working to Ensure Effectiveness of the CHP Council

SUMMARY:
THE METROPOLITAN COMPREHENSIVE HEALTH PLANNING COUNCIL IS A NEW KIND OF POLICY MAKING GROUP. EFFECTIVENESS WILL BE MEASURED BY THE EXTENT TO WHICH MEMBERS PERFORM SPECIFIED FUNCTIONS OF BOARD MEMBERSHIP. A WIDE RANGE OF COMMUNITY RESOURCES WILL BE USED IN TRAINING FOR BOARD ACHIEVEMENT.

Characteristics of the CHPC Board:

- Consumers and providers, economic and ethnic mix, geographic distribution.
- Veteran policy-makers and persons with little group and no policy-making experience.
- Wide range of educational and social backgrounds.

Traditionally, health providers and consumers (particularly low income groups) have not planned together or worked as equals.

Perception of health problems will be influenced by the special interest which each member represents.

Thus, successful functioning of the Board will depend upon effective participation of members both as representatives of subgroups and as citizens in the community of solution.

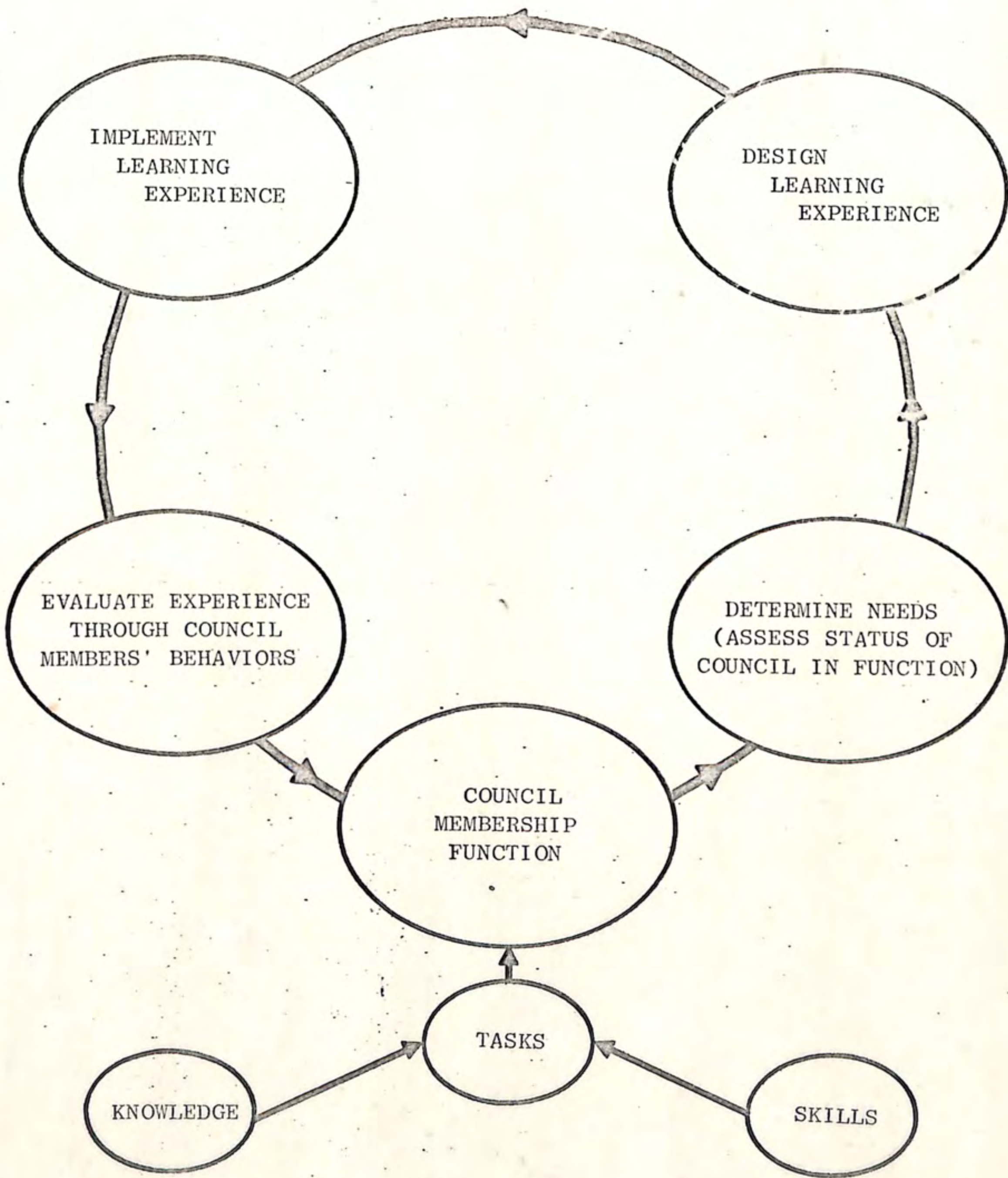
Some Specific Training and Familiarization Activities

After the Council's initial action of accepting responsibility for the policy aspects of comprehensive areawide health planning in this metropolitan community, beginning 1 January 1970, some 6½ months will elapse before the Council is called on for official functioning. During this period, a number of activities are planned for the purpose of familiarizing the Council members with the extent of the health planning actions which they will be called on to evaluate and guide. The period will also be used to acquaint the Council members, one with another, so that they can select Personnel Committee and Nominating Committee members most effectively, several months prior to the Annual Meeting in January, 1970.

Some of the training and familiarization activities contemplated are:

- o introduction to principal health problems in the area
- o field trips to health facilities and areas of severe health need
- o training in effective Council and committee participation
- o experience (with Community Council staff) in reviewing planning projects
- o introduction to systems analytical procedures, and methods of basing decisions on cost-benefit analyses, etc.
- o joint meetings with other planning groups and with health activity staffs

TRAINING for COUNCIL EFFECTIVENESS



By-Laws of the Council

SUMMARY:
THE BY-LAWS OF THE COUNCIL ARE DESIGNED TO FACILITATE MAXIMUM POSSIBLE PARTICIPATION IN HEALTH POLICY MATTERS BY THE MEMBERS OF THE COUNCIL, AND TO "BUILD BRIDGES" TO LOCAL ORGANIZATIONS CONCERNED WITH HEALTH MATTERS. THEY SPECIFY THE BROAD FUNCTIONS OF THE COUNCIL AND STAFF, BUT ARE INTENDED TO PROVIDE FOR SUFFICIENT FLEXIBILITY THAT THE COUNCIL CAN COPE WITH CHANGING AREA CONFIGURATIONS AND HEALTH NEEDS.

The By-Laws consist of 13 Articles:

I. Name and Location
II. Purpose
III. Membership
IV. Duties and Powers of the Council
V. Meetings
VI. Officers and Executive Committee
VII. Committees
VIII. Legal Counsel
IX. Audit
X. General
XI. Adoption
XII. Associate and Affiliate Memberships
XIII. Ammendments

Important Provisions:
Some of the principal by-law provisions are shown on the facing page (99).

Other By-Laws:
Current By-Laws of the Metropolitan Atlanta Council of Local Governments and of the Community Council of the Atlanta Area, Inc. are included in the Appendices to this volume of the proposal.

CHP COUNCIL - PRINCIPAL BY-LAW PROVISIONS

A. Council Membership and Terms

1. Chairmen of major agencies (3) and of county commissions shall serve for the duration of their terms
2. Representatives of organizations shall serve three-year terms (except for some elected at the first election); 1/3 of these shall be selected each year.
3. Two three-year terms, maximum
4. Majority shall be health "consumers"
5. Approximately 1/3 shall be poor and near-poor consumers
6. Selection process shall take into account geographic and ethnic distributions in the community
7. Selection process shall be determined by a nominating committee made up of Council members. In selecting organizations and groups who will name members to the council, the nominating committee shall achieve rotation among eligible groups and organizations.Typical eligible organizations or groups are indicated in the following:
   a. municipal governments group: municipal associations
   b. health providers group: medical societies, dental societies, hospitals and other facilities, mental health professional organizations, public health departments, voluntary health organizations, nursing associations, skilled paramedical associations, unskilled paramedical groups, social work agencies, educational institutions, insurance councils.
   c. business and labor groups: chambers of commerce, labor organizations
   d. poor and near-poor: EOA's, PTA's, HUD projects (e.g. Model Cities), voluntary agencies (e.g. Urban League, Legal Aid), spontaneous organizations (e.g. Welfare Rights, TUFF, etc.)
8. Alternates may be designated; specifically understood that they act for regular members

B. Council Meetings

1. At least six per year (contemplate monthly)
2. Quorum is 20 voting members
3. Majority of voting members shall decide
4. Roberts Rules govern

C. Council Structure

1. Officers nominated by nominating committee, or from floor; elected by majority vote of Council
2. Executive Committee shall consist of the officers (7)
   handles business between Council meetings
   actions subject to review by Council at next meeting
3. Nominating Committee selected from members of the Council
4. Personnel Committee selected from Council members and others
5. Other standing and ad hoc committees as needed .

BY-LAWS

ARTICLE I - NAME AND LOCATION

1. The name of this organization shall be "The Metropolitan Atlanta Council for Health", hereinafter referred to as the "Council".

2. The Council's principal office shall be located in the City of Atlanta, Georgia.

ARTICLE II - PURPOSE

1. The principal objectives and purposes of the Council are:

A. To establish and maintain comprehensive areawide health planning activities, identifying health needs and goals of the overall community and its sub-areas to stimulate action to coordinate and make maximum use of existing and planned facilities, services and manpower in the fields of physical, mental and environmental health.

B. To establish a system for gathering and analyzing data on the characteristics of health problems in this area.

C. To recommend goals and methods of achieving them, and to make policy decisions for the community in health planning matters.

D. To coordinate activities of all health planners in the community.

E. To collaborate with adjacent health planning areas, and to perform health planning services on a contract basis for adjacent area units, as requested.

F. To review health action project plans originating in the community.

G. To provide technical assistance to public and voluntary action agencies in preparing plans and procedures for the attainment of health goals; to provide similar assistance to Georgia State health planning efforts.

H. To originate health action project plans where needed.

I. To provide continuing liaison and informational services to ensure communication of planning progress to the general public and the appropriate agencies and organizations involved in carrying out the intent of Congress as set forth in Public Law 89-749 relating to comprehensive areawide health planning.

ARTICLE III - MEMBERSHIP

1. The Council shall be composed of not less than thirty-five (35), nor more than fifty-five (55) members. Members shall be drawn from the following organizations and community groups, broadly reflecting economic, ethnic, and geographic background distribution of the area:

A. Members by virtue of office shall serve for the duration of their terms of elective office:

1) Chairmen of County Commissions
2) Chairmen of major planning agencies
3) Mayor of the City of Atlanta

B. Members named by community agencies and organizations

1) Organizations naming members shall be designated in the following categories:

a) Municipal governments
b) Health providers
c) Business and labor
d) Poor and near-poor consumers

2) At the first election, the term of office for one-third of these members shall be fixed at three years; the term of an additional one-third of these members shall be fixed at two years; and the term of the final one-third of these members shall be fixed at one year. At the expiration of the initial term of office of each respective member, his successor shall be named to serve a term of three years. Members shall serve until their successors have been elected and qualified. No member shall serve more than two (2) consecutive three-year terms.

3) The selection process for these members shall be determined by a Nominating Committee of Council members. In selecting organizations and groups who will name members to the Council, the Nominating Committee shall achieve rotation among eligible groups and organizations.

C. A majority of the Council members shall be non-providers of health services.

D. Approximately one-third of Council members shall be poor and near-poor consumers.

E. Each organization shall be authorized to file with the Secretary of the Council the names of alternate members, not to exceed the number of representatives to which it is entitled. Any regular member of the Council may call upon alternate(s) from his organization to attend and

to vote in his stead at any meeting which the regular member is unable to attend.

F. Organizations other than those constituting the Council at the time these rules and regulations are adopted may be invited to name representatives in a stated number to the Council upon recommendation by the Nominating Committee and approval by the Council at any meeting of the Council, provided that ten (10) days advance notice of such proposed action is mailed to each member at his last known post office address.

ARTICLE IV - DUTIES AND POWERS OF THE COUNCIL

1. The Council shall be the final authority for approval of activities proposed in planning actions, and on all matters of policy related to comprehensive areawide health planning.

2. The Council shall consider the annual budget presented by the Budget and Finance Committee, and after any revision, it may determine to be advisable, it shall adopt the same. It shall make such subsequent revision on the budget as it may deem advisable after consultation with the Budget and Finance Committee and the Director of Comprehensive Areawide Health Planning.

3. It shall have the power of approval of the President's appointments of committee chairmen and legal counsel.

4. It shall appoint the Director of Comprehensive Areawide Health Planning, and fix the terms of his compensation, tenure, and responsibilities, giving due consideration to the recommendations of the President and the Personnel Committee.

5. It shall appoint the auditor as provided in Article IX of these BY-LAWS.

6. It shall require periodic reports on operations from the various committees and from the Director of Comprehensive Areawide Health Planning.

7. It shall fix the time and place of the Annual Meeting of the Council.

8. It shall pass on applications for admission to the Council of additional adjacent areas desiring to participate in comprehensive health planning with the metropolitan Atlanta area.

ARTICLE V - MEETINGS

1. The Council shall hold at least six (6) regular meetings per year, to be called for the first Thursday in the scheduled month, or on such other convenient day as may be decided from time to time by majority vote.

2. Special meetings may be called by the President and shall be called by the Secretary at the request of fifteen (15) members of the Council.

3. Notice of each meeting shall be mailed to each member of the Council at his last known post office address at least ten (10) days in advance of the meeting.

4. Twenty (20) members of the Council shall constitute a quorum for the transaction of business at any meeting of the Council; the presence of less than a quorum may adjourn a meeting until such time as a quorum is present.

5. A majority in number of members present and voting at a meeting at which a quorum is present shall be required for approval of any action by the Council.

6. Each member of the Council is entitled to one (1) vote at any meeting at which he is present.

7. No proxy votes shall be allowed. A duly appointed alternate member, however, may vote in the absence of a regular member representing the organization for which he is designated alternate. In such case, the alternate member shall be considered a member for the purpose of determining a quorum.

8. The Council may act by mail, wire, or telephone between regular meetings, but in such case the concurrence of a majority in number of members shall be necessary and shall be subject to confirmation at the next meeting of the Council so that such action shall be recorded in the minutes.

9. The first meeting of the Council, after January 1 each year, shall be considered the Annual Meeting for the seating of new members named by organizations, and election of officers and nominating committee members.

10. The Administrative Year of the Council shall extend from Annual Meeting to Annual Meeting.

ARTICLE VI - OFFICERS AND EXECUTIVE COMMITTEE

1. Officers

A. Officers of the Council shall be a President, five (5) Vice-Presidents, and a Secretary, who shall be elected annually from among members of the Council by a majority vote of members present and voting at the Annual Meeting.

B. Officers so elected shall serve for one year, or until their successors have been elected. No officer shall hold the same office for more than three (3) consecutive terms.

C. Vacancies in offices occuring between Annual Meetings of the Council may be filled by election by a majority vote of members present and voting at any meeting of the Council. Officers so elected shall serve until the next Annual Meeting of the Council.

2. President

A. The President of the Council shall be the chief officer

of the organization and shall preside at all meetings of the Council and Executive Committee. The President shall, subject to the approval of the Council, appoint the chairmen of all committees, except the Nominating Committee, and shall be a member, ex-officio, of all committees; and shall, with the Secretary, sign all obligations authorized by the Council which may be beyond the authority of the Director of Comprehensive Areawide Health Planning; and shall, with the approval of the Council, appoint legal counsel.

3. Vice Presidents

A. There shall be five or more vice presidents, who shall assist the President, and shall coordinate the activities of groups of committees of the Council. These officers shall be designated Vice-President for Council Function, Vice President for Liaison and Public Relations, Vice President for Special Needs, Vice President for Project Review, Vice President for Administration, and such others as the Council may designate.

4. Vice Presidents may preside

A. A Vice President shall preside at any meeting of the Council or Executive Committee in the absence of the President, and in such case shall have all the responsibilities and perform all the duties of the President. The order of precedence for this function shall be: Vice President for Council Function, Vice President for Liaison and Public Relations, Vice President for Special Needs, Vice President for Project Review, and Vice President for Administration.

B. The Vice Presidents shall have and perform such other duties as may be assigned by the President or by the Council.

5. Secretary

A. The Secretary of the Council shall handle the general correspondence of the Council and shall cause notices to be sent of all regular or special meetings of the Council.

B. He shall cause minutes to be kept of all meetings of the Council, and shall see that these minutes are distributed to members of the Council within a reasonable period of time after each meeting.

C. He shall preside at meetings of the Council in the absence of the President and the Vice Presidents and in such case shall have all the responsibilities and perform all the duties of the President.

D. The Secretary shall have and perform such other duties as may be assigned by the President or the Council.

5. Executive Committee

A. The Executive Committee shall consist of the President, Vice Presidents and Secretary of the Council.

B. Duties of the Executive Committee shall be to handle matters pertinent to Council business during intervals between meetings of the Council.

C. Actions and recommendations of the Executive Committee shall be subject to Council review and approval at the next meeting of the Council.

ARTICLE VII - COMMITTEES

1. Statutory Committees

A. A Nominating Committee shall be elected from members of the Council, with due regard to the makeup of the Council. The duties of the Nominating Committee shall include:

1. Nominating a slate of officers prior to the Annual Meeting.

2. Nominating a new Nominating Committee prior to the Annual Meeting.

3. Nominating organizations, on a rotating basis, which will name members of the Council to take office at the next Annual Meeting.

4. Nominating replacements for vacancies as they occur.

B. A Personnel Committee shall be elected from Council membership and the community at large. The duties of the Personnel Committee shall include:

1. Recommending selection and salary of Director for Council action.

2. Formulating personnel policies, including salary ranges.

The Chairman of the Personnel Committee shall be a member of the Council.

2. Other Committees

A. Other standing and ad hoc committees may be designated, elected or appointed, as needed. Chairmen of all standing committees shall be members of the Council.

ARTICLE VIII- LEGAL COUNSEL

1. Legal counsel shall be appointed by the President with the approval of the Council. All matters involving interpretation of State and Federal law, local ordinances, and tax questions shall be promptly referred to such counsel for opinion and advice.

ARTICLE IX - AUDIT

1. The fiscal records of the comprehensive areawide health planning activities shall be audited annually by a certified public accountant, appointed by the Council. The auditor's report shall be filed with the records of the organization.

ARTICLE X - GENERAL

1. Waiver

A. Any notice required to be given by these By-Laws may be waived by the person entitled thereto.

2. Contravention

A. Nothing in these By-Laws shall contravene applicable rules and regulations, procedures, or policies of the U. S. Public Health Service, or of the Georgia Office of Comprehensive Health Planning.

3. Parliamentary Procedure

A. The latest revision of Robert's Rules of Order shall cover the parliamentary procedure at all meetings of the Council and of the Committees, where not in conflict with these By-Laws.

4. Publicity

A. No publicity releases to the media shall be made or authorized by any organization represented on the Council, or by any member of the Council without prior clearance by the Director of Comprehensive Areawide Health Planning.

5. Acceptance of By-Laws

A. Any organization accepting invitation to designate membership on the Council shall by their acceptance attest to their active participation and to their agreement to abide by these By-Laws.

ARTICLE XI - ADOPTION

1. Effective date

A. These By-Laws shall become effective immediately upon adoption by the Council.

ARTICLE XII - ASSOCIATE AND AFFILIATE MEMBERSHIPS

1. Associate Membership

   A. At the discretion of the Council, sub-areal comprehensive health councils may be admitted to associate membership in the Council. The Council shall fix general qualifications for such associate membership.

   B. As a condition of associate membership, sub-areal comprehensive health councils shall admit to membership all members of the Council residing in the area of the sub-areal council.

   C. Each associate member council is entitled to send an observer to meetings of the Council.

2. Affiliate Membership

   A. At the discretion of the Council, organizations other than sub-areal comprehensive health councils may be admitted to affiliate membership in the Council. These may include such organizations as voluntary health agencies, professional societies, citizens' associations for health concerns, etc. The Council shall fix general qualifications for such affiliate membership.

   B. Each affiliate member organization is entitled to send an observer to meetings of the Council.

ARTICLE XIII - AMENDMENTS

1. Method

   A. These By-Laws may be amended or repealed by a majority vote of the members of the Council present, and voting at any meeting of the Council at which a quorum is present, provided that written notice of such proposed changes shall have been sent to all members not less than ten (10) days prior to the date of such meeting.

STEERING COMMITTEE

Mrs. Thelma Abbott
521 W. Columbia Avenue
College Park, Georgia

Hon. S. S. Abercrombie, Chairman
Clayton County Commission
Clayton County Courthouse
Jonesboro, Georgia 30236

Hon. L. H. Atherton, Jr.
Mayor of Marietta
P.O. Box 609
Marietta, Georgia 30060

Miss Dorothy Barfield, R. N.
Chief Coordinator of Nursing Services
Georgia Department of Public Health
47 Trinity Avenue
Atlanta, Georgia 30334

Mr. G. X. Barker, Ex. V. P.
International Brotherhood of Electrical Workers
Fifth District Office
1421 Peachtree Street, N. E.
Atlanta, Georgia 30309

Hon. Ernest Barrett, Chairman
Cobb County Commission
P. O. Box 649
Marietta, Georgia 30060

Dr. J. Gordon Barrow, Director
Georgia Regional Medical Program
938 Peachtree Street, N. E.
Atlanta, Georgia 30309

Mr. M. Linwood Beck, Executive Director
Georgia Heart Association
2581 Piedmont Road, N. E.
Atlanta, Georgia 30324

Mr. Herschel T. Bomar, Chairman
Douglas County Commission
Douglas County Courthouse
Douglasville, Georgia 30134

Hon. William H. Breen, Jr.
Mayor of Decatur
c/o First National Bank Building
Decatur, Georgia 30030

Dr. Napier Burson, Jr.
Baptist Professional Building
340 Boulevard, N. E.
Atlanta, Georgia 30312

Hon. T. M. Callaway, Jr.
DeKalb County Commission
c/o Callaway Motors
231 West Ponce de Leon Avenue
Decatur, Georgia 30030

Mrs. Mary June Cofer
443 Oakland Avenue
Atlanta, Georgia 30312

Mr. Gary Cutini, Regional Rep.
Health Insurance Council
Life of Georgia Building
600 W. Peachtree
Atlanta, Georgia 30308

Dr. F. William Dowda
490 Peachtree Street, N. E.
Atlanta, Georgia 30308

Mr. J. Wm. Fortune
Mayor of Lawrenceville
290 Old Timber Road, S. W.
Lawrenceville, Georgia 30245

Mr. Drew Fuller
Fuller & Deloach
1726 Fulton National Bank Bldg.
Atlanta, Georgia 30303

Miss Jo Ann Goodson, R. N.
Wesley Woods
1825 Clifton Road, N. E.
Atlanta, Georgia 30333

Mr. Fred J. Gunter, Administrator
South Fulton Hospital
1170 Cleveland Avenue
East Point, Georgia 30344

Dean Rhodes Haverty
Georgia State College
School of Allied Sciences
33 Gilmer St., S. E.
Atlanta, Georgia 30303

Mr. Maynard Jackson
Emory Community Law Firm
551 Forrest Road, N. E.
Atlanta, Georgia 30312

Mr. Purch L. Jarrell
Route # 1
Box 24
Duluth, Georgia 30136

Hon. Walter M. Mitchell, Chairman
Fulton County Commission
409 Administration Building
165 Central Avenue, S. W.
Atlanta, Georgia 30303

Mr. John L. Moore, Jr.
Attorney-at-Law
C & S National Bank Building
Room 1220
Marietta and Broad Streets
Atlanta, Georgia 30303

Dr. William W. Moore, Jr.
Suite 616
1293 Peachtree Street, N. E.
Atlanta, Georgia 30309

Mr. A. B. Padgett, Trust Officer
Trust Company of Georgia
P. O. Drawer 4655
Atlanta, Georgia 30302

Mr. Dan Sweat
Assistant to Mayor
City of Atlanta
City Hall
Atlanta, Georgia 30303

Dr. Charles B. Teal, Jr.
Gwinnett County Health Department
300 South Clayton St.
Lawrenceville, Georgia 30245

Mr. Bill Traylor
1397 Oxford Road, N. E.
Atlanta, Georgia 30307

Dr. T. O. Vinson, Director
DeKalb County Health Department
440 Winn Way
Decatur, Georgia 30033

Mr. Lyndon A. Wade, Executive Dir.
Atlanta Urban League
239 Auburn Avenue, N. E.
Room 400
Atlanta, Georgia 30303

Dr. Robert E. Wells,
1938 Peachtree Road, N. W.
Atlanta, Georgia 30309

Joseph A. Wilbur, M. D.
615 Peachtree Street, N. E.
Atlanta, Georgia 30308

Mrs. Daisy Bigsby
585 Gibbons Drive
Scottdale, Georgia

MEMBERS OF EXECUTIVE COMMITTEE
OF
COMMUNITY INVOLVEMENT STEERING COMMITTEE
FOR
AREAWIDE COMPREHENSIVE HEALTH PLANNING

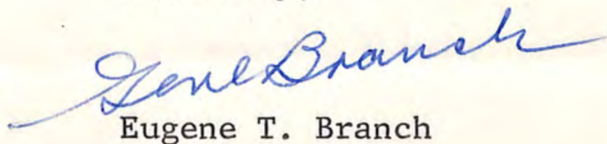
NAME	AFFILIATION	VIEWPOINT
Hon. Howard Atherton	Mayor of Marietta	municipalities
Mr. Linwood Beck	Director, Georgia Heart Assoc.	voluntary agencies
Hon. Thomas Callaway	Commissioner, DeKalb County	Maclog
Mr. Drew Fuller	Chmn. Health Committee, Atl. C. of C.	commerce
Mr. Fred Gunter	Administrator, So. Fulton Hospital	hospitals
Hon. Walter Mitchell	Chmn., Fulton County Commission	county govts.
Mr. A. B. Padgett	Chmn, CHP Steering Committee	Community Council
Dr. Oscar Vinson	Director, DeKalb Board of Health	Public Health
Mr. Lyndon Wade	Director, Atlanta Urban League	consumers
Dr. Robert Wells	Chmn. Fulton County Med. Soc. Board	medical professions

volunteers, both individuals and groups. Since that time the Steering Committee has been at work and we have now come up with a specific proposal for the establishment of such a volunteer agency. As it now stands, it appears that the sponsors will be the Atlanta Junior League, the Community Council of the Atlanta Area, Community Chest, the Atlanta Chamber of Commerce, and E.O.A.

We simply want to talk with you and Dan and get your suggestions and reaction to the plan. We believe that volunteers constitute the largest untapped resource for help on our urban problems. Making this resource truly effective is not an easy task, but it has been done in other cities and there is no reason why we can't do it here. Also, we feel that a permanent organization of this type will provide a means for injecting newcomers to Atlanta into activities involving their interests which will help us to maintain a sense of community as Atlanta expands. I understand that our appointment is for 2:00 o'clock, and we look forward to seeing you.

Best personal regards.

Sincerely,



Eugene T. Branch

ETB:hm

Enclosures

cc: Mr. Dan Sweat

. DRAFT

A VOLUNTEER COORDINATING AGENCY

Purpose:

To provide a central point where volunteer activities could be coordinated, developed and organized so that the vast reservoir of man and woman power who are looking for ways to make constructive, significant contributions to the community can be utilized. This would be more than the traditional volunteer bureau. It would not only work with existing programs but also develop new areas of service for individuals and groups and be innovative in its approaches. For the most part it would be organized, administered and operated by volunteers and its functions would vary according to the group or organization it was working with.

Functions:

1. AGENCIES REGISTER NEEDS - It would be a place where agencies can register their needs for individual volunteers and group projects.
2. VOLUNTEERS REGISTER - It would be a place where individuals or groups can register and become known to an agency or program where his capabilities and interests can be used to best advantage.
3. SCREENING - It would conduct an initial screening of volunteers to protect the agency from clearly unsuitable applicants, while the agency retains its right to select its own volunteers.
4. EFFECTIVE - It would offer leadership on the effective use of volunteers. Develop innovative programs and provide new areas of service.
5. TRAINING - It would provide orientation and training to volunteers of both a general and specific nature so that volunteers would be

PRELIMINARY DRAFT NOT FOR PUBLIC RELEASE

better prepared for and have a clearer understanding of their assignments and how they fit into the health and welfare picture of Atlanta.

6. COUNCIL OF CIVIC ORGANIZATION - It would provide a framework for communication among civic organizations regarding their own areas of community participation.

7. EDUCATE PUBLIC - It would conduct regular programs to educate the public about projects and problems in the fields of health, welfare and enrichment.

8 WORKSHOPS - It would develop as part of its educational program the following workshops:

   a. Workshops with supervisors of volunteers.

   b. Workshops with "administrative volunteers" (policy making boards,etc.).

   c. Workshops designed to acquaint new-comers (and others) with programs and agencies, problems and opportunities in the fields of health, welfare, enrichment and education.

   d. Separate workshops for volunteers in the areas of

      1. arts
      2. health
      3. education
      4. poverty
      5. recreation

Organization:

It would be staffed by a full-time, well qualified paid Executive Director and a full-time paid secretary at the out set. Staff would be added as necessary to take care of the expanding program. (See Job Description)

The Executive Director would be assisted by volunteer chairmen of Recruitment, Screening Education, Job Development, Agency Relations and Public Relations. They would serve for a two year term.

The agency would be government by a Board of Directors with a total membership of 25. It would be composed of the above mentioned volunteer chairmen; representatives of agencies, serving on a rotating basis; a representative each from the Community Council of the Atlanta Area, Inc. and the Chamber of Commerce; people who are representative of volunteer programs (Model Cities, Economic Opportunity Atlanta, Urban Training, VISTA); people who are representative of organizations (Junior League, Council of Jewish Women, Junior Chamber of Commerce, Kiwanis, Women's Chamber of Commerce, United Church Women, etc.); people who are representative of labor and the business and professional community. These Board members would be selected as individuals by the agency's nominating committee to be representative of a certain sector, interest or expertise rather than to represent their own organization.

Sponsors:

The following agencies and organizations have shown interest in it and indicated support. Representatives have been meeting as a Steering Committee and have helped shape this proposal.

1. Atlanta Junior League
2. Community Council of the Atlanta Area, Inc.
3. Community Chest
4. Atlanta Chamber of Commerce

Location:

Preferably the physical facilities should include the following:

1. Office space for a minimum of seven people (four staff and three full time volunteers).
2. Adequate parking nearby for a minimum of fifty cars.
3. Be in an area that is well lighted, and where staff and volunteers would feel comfortable when attending meetings at night.
4. A large meeting room in the building or nearby that could be utilized for training sessions or conference meetings.

BUDGET

Personnel	Cost	Total Cost	
Project Director	$ 12,500		
Executive Secretary	5,000		Minimum staff
Fringe benefits	1,900	$ 19,400	
Permanent Equipment			
6 desks, executive @ $150	$ 900		
6 chairs, executive @ 90	540		
1 desk, secretarial	150		
1 chair, secretarial	80		
7 side chairs @ 30	210		could be donated
1 electric typewriter	550		
3 manual typewriters @ 220	660		
4 file cabinets, 5 drawer @ 100	400		
equipment maintenance	500	$ 3,990	
Consumable Supplies			
Office supplies and postage	$ 1,150		minimum necessary to train 300 volunteers
Educational materials	1,200	$ 2,350	
Travel			
Local, 15,400 miles @ .10 per mi.	$ 1,540		to reimburse 6 people for travel and public relations
1 out-of-town trip	300	$ 1,840	
Miscellaneous Expenses			
Rent - 1,200 sq. ft. @ $3.00 per sq. ft. per year	$ 3,600		could be donated
Telephone	900		
Insurance and bonds	150		
Promotion and publicity	1,000		could be donated
Auditing	600		could be donated
Organization dues	250		
Publications	75		
Meeting space for training classes and board meetings, 80 days @ $30 per day	2,400	$ 8,975	could be donated
	Total Costs	$ 36,555	

Staff - (Job Descriptions)

The Project Director will be responsible to the Board of Directors.

a. Duties and Responsibilities

(1) Administration of the program. Guidance and supervision of all staff engaged in the project.

(2) Promote the Volunteer Project in all necessary areas particularly public and voluntary agencies, and to the general public. Interpretation of the goals to the Volunteer Project.

(3) Responsible for all publicity of the program. Review all assignments for speaking engagements.

(4) Supervisor of volunteers who will organize, plan and develop all training classes.

(5) Select and work with volunteers and agencies in developing curriculum for classes. Edit training manual and select all materials used in course.

(6) Work with Board of Directors of the Volunteer Project and sub-committees in operation of program.

(7) Work with volunteers to develop contracts with agencies and organizations for training programs for other volunteers.

(8) Program planning and development for future expansion of the Volunteer Project.

b. Qualifications

(1) Executive ability necessary for the administration, promotion and implementation of the Volunteer Project.

(2) Ability to relate to individuals and groups both professionals and volunteers. Good judgement in selection of staff, faculty and trainees.

(3) Experience and skill in community organization. A thorough knowledge of the health, welfare and education resources of the community.

(4) Understanding of the needs of lower income people in order to plan training programs that will equip volunteers to make significant contributions toward meeting some of these needs.

(5) Background and academic degree in Education, psychology, social work or a related field.

(6) Administrative experience.

2. Secretary

The secretary of the Volunteer Project shall be responsible to the Director of the Volunteer Project.

a. Duties and Responsibilities

(1) Personal secretary to the Project Director, i.e. appointments, telephone calls, personal files, etc.

(2) Supervision of all office clerical work. Should be capable of properly coordinating all work, insure proper distribution of workload and relieve the Director of tasks which come with supervision of clerical work.

(3) Personally responsible for all documentary typing, program development, evaluation, proposals, budgets, etc.

(4) All dictation and transcription for entire department.

(5) All typing for recruitment and publicity.

(6) Record all sessions in connection with evaluation and in regular training sessions when necessary.

(7) Minutes of all meetings requiring the use of shorthand.

(8) Direct supervision of all filing procedures. See that all records are filed regularly and properly.

(9) Keep complete records of all supplies and postage charged to the Volunteer Project

b. Qualifications

(1) Good typing speed.

(2) Excellent shorthand speed to enable her to take verbatim notes at all conferences and teaching sessions where necessary.

(3) Good overall understanding of office procedures and policies.

(4) Ability to work well with people, with initiative to do a job on her own without involved instructions. Ability to supervise additional clerical staff.

MG:ja
2/13/69

NEW SLOT FOR THE VOLUNTEER

A Talk With
Joyce Black and Dr. Timothy Costello

Waiting for a bus or subway that never comes, sending a child off to a school that doesn't open, or trying to keep warm in an apartment that has no heat is all part of everyday life in New York City. But, a new form of government, which New Yorkers have come to think of as "the Lindsay style," has emerged. By efficiently using an almost untapped resource known as "volunteer power," the nation's largest and most problem-prone city is surviving the urban crisis.

Back in 1965, when the Federal government first launched its "war on poverty," New York City's Economic Opportunity Committee (the local administrative anti-poverty agency) found itself inundated with offers of help from numerous individuals and organizations. Mrs. Ruth Hagy Brod, then an EOC staff member, was asked to channel these offers into neighborhood anti-poverty agencies.

The complexities of the city made Mrs. Brod's task a monumentally complicated one and an advisory committee of community leaders was soon formed to assist her in conducting a study of the patterns and potentials of volunteerism in New York City. The result of their study was this: Anti-poverty agencies were unable to absorb any significant number of volunteers, but there was a great potential for them in almost every department of city government. Out of this study, the Volunteer Coordinating Council — the first central volunteer bureau to be co-sponsored by city government and the voluntary sector — was born.

In December 1966, the VCC was officially inaugurated by Mayor Lindsay. Deputy Mayor Timothy Costello was named Chairman, and Mrs. Hiram D. Black (AJLA's Director of Region III) was named Co-Chairman. Mrs. Brod was appointed Director.

During the first two years of its operation, the VCC has played a vital role in city government. To find out if similar bureaus could be used to advantage in Detroit, Chicago, Los Angeles, or even in Waterloo, Iowa, we met with Dr. Costello and Mrs. Black in the Deputy Mayor's office, and we asked them:

Why do you use volunteers in New York's city government?

Dr. Costello: I think there is a simple answer and a subtle answer. The simple answer is that we need to render perhaps ten times as many services as we're able to with the amount of civil service people we have. Beyond that, volunteers bring something that you cannot get from the person whose services you're buying. They bring spirit, a sense of dedication, freedom from being captured by procedures, motivation and willingness to work — sometimes under conditions where you couldn't pay someone else to work.

I don't know if this concept is original with me, but for a little while, for a long while maybe, many people felt that New York was such a big, sophisticated, cosmopolitan town, that it was nobody's home town. But that's not the way people feel now. They're beginning to feel that it is their home town; they want to be involved in it; they want to do something for it. This is true of big business and it's also true of the people living in Staten Island, Queens, or Manhattan. They want to say "I'm doing something for my city."

Mrs. Black: We hope this kind of program will be duplicated in other cities for similar reasons. Once you're involved with a city in the public sector, you understand many things that you never understood before, and you can interpret them to the community in a much better way.

Dr. Costello: Maybe the point that is being made is a lesson in civics. I don't mean just where City Hall is, and what the Board of Estimate does, but the subtle kinds of things: Why does it take so long to get things done? Why can't you always solve a problem in the most rational way? Sometimes there are community blocks and political considerations that are quite legitimate but keep you from doing things in what my wife would say is the common-sense way.

Do volunteers need any special skills?

Dr. Costello: Volunteerism is a very, very sensitive activity requiring professional skills. One of the skills required is learning to build a demand for volunteer help that doesn't outdo your supply, and that doesn't produce a demand in agencies where volunteers don't belong and won't be properly used. The desirable thing would be to have a Director of Volunteers in every agency of city government who would report to us on what the agency is looking for. We're flooded with demands from agencies, many of which we don't want to meet because they're not suitable, and many of which we can't meet because we just haven't got an adequate supply of volunteers.

How does the VCC work with city agencies?

Mrs. Black: We tried to divide the Council's activities into two sectors, with program development in both the public sector and in the private, non-profit sector — better known as the volunteer sector. If an agency desires our advice in developing volunteer programs, we are available, and we also will seek them out if we feel that there should be a use of volunteers there. We've been very fortunate in New York because we do have an understanding administration and a Deputy Mayor who took us under his wing. The Council has to fit into a slot in the city; this type of program just can't be off on its own.

Dr. Costello: That's right, you simply can't graft it on to something that is not receptive to it. It won't work. The VCC is kind of a prototype; we're trying to encourage college students and universities to contribute their services, but this won't work unless you've got receptivity in the top level of administration all the way down the line.

Does the VCC suggest projects or placement for volunteers in other agencies?

Dr. Costello: Yes. It creates them. You've got a creative group of volunteers who suggest things either because they have an idea or because somebody comes in and says: "Look, this is what I can do; is there any place I can do it?" That's how VCC programs begin. You look for some place where the volunteer can do what he wants to do. That's pretty much what happened with Riker's Island — am I correct, Joyce?

Mrs. Black: Yes. When men are released from prison — from Riker's Island — very often they come out without anything: without a family, without funds, without a heavy winter coat. Ruth Brod was telling me the other day that she had to get a winter coat for one of the men. He couldn't get a job either, because no one wants to give a job to a newly-released prisoner. In a sense, the volunteer involved with these men is going to be involved in the buddy system. Each prisoner, when he is released, is now being met by one of our staff people and taken to a place where he is employed or trained by a union. We also find a place for him to live, and give him pocket money obtained from private sources to supplement him until he gets his welfare check, which isn't for two weeks after he is released.

Dr. Costello: This is exactly where volunteerism comes in. There is no combination of services that the city can provide which would do all of these things: that is, reach out and obtain a job, worry about whether the man has a coat or carfare, worry about where he is going to sleep or eat. Because these men sometimes fail — they don't report for duty, or they goof off — the volunteers go back and talk them into trying again. There's no service like that. You simply can't buy that kind of service anywhere.

What does the VCC do?

Mrs. Black: It does two things. It recruits volunteers, interviews them, and refers them to traditional or non-traditional settings, depending on what kind of service they want to do and what their hours are. But it also is a program-development kind of agency.

Dr. Costello: Maybe the term "marriage maker" ought to come into this picture, too, because Ruth Brod and the people around her are frequently matchmakers. There might be some group who have ideas for something to do, but they haven't got the resources. They may not have a bus to provide transportation, they may not have the money to underwrite something, or they may not have access to something. So Mrs. Brod finds somebody who has what the group needs and puts them together. For example, in Operation Suburbia, she put the families in ghettos and the families in suburban areas together, and she put the coffee house people (*See* Junior League Magazine, *Sept./Oct. '68*) together with some people who had money. The Council is always trying to spin programs off.

Mrs. Black: We act as a catalyst. And I think this is a word that we should use more and more because volunteer organizations are not going in where they're not wanted. Not only do we have to be asked to participate but we also work with the people in the inner-city by not inflicting or imposing any of our thinking upon them. This is certainly the way of the future, and it's the way they want it.

Many city agencies are troubled with quick changeover of personnel, money difficulties, and a host of other problems. Does this make it more difficult for you to find volunteers to work with them?

Mrs. Black: Not really. We do not put volunteers into a situation where there is no one to supervise and train them. The Council doesn't actually train volunteers; the training is done in the individual agencies. If we went into training, we'd have to have a couple of hundred people on the staff. We give them only a small orientation to the field of volunteerism.

Dr. Costello: Sometimes the word "volunteer" applies to a group of people who are part of the target population

themselves. That is, they have an idea, and they want to do something. So you don't send white middle-class people into that neighborhood to help those people. They are already there, they just need a little support, a little money, a little access, a little building, a little equipment, or whatever, to continue their own voluntary efforts in their community. And that's a new kind of volunteerism.

I know Ruth was very upset one day when I suggested that maybe you couldn't ask poor people to volunteer; they are too busy. And she said, "You can't deny them the opportunity to be part of a volunteer program. Now you may have to provide carfare occasionally, or a little baby-sitting money, but you've got to give them the chance to give something as well as to take something."

Have any of your volunteers had problems in the inner-city areas?

Mrs. Black: We haven't had trouble because we simply don't send anybody unless they're truly wanted and asked for. Of course, the other thing is that if we were sending some volunteer for a specific reason — into part of the Haryou complex, for example — we would most likely send a black person in who probably would be accepted. This is a complex situation.

Dr. Costello: No psychiatrist would ever attempt to treat a patient unless

the patient wanted help, and I think the same rock-bottom principle applies to volunteer assistance — you don't impose it on anyone who hasn't asked for it. That is not to say that you don't cultivate the demand. You don't sit back in your ivory tower and wait for people to come. It wouldn't happen like that. Nor would we send anybody down to Harlem and say, "Here are some people; they're eager; they talk English. Can't you use them?" No good, it wouldn't happen that way.

Does the Council do a lot of work with any of the new-line poverty agencies such as the Urban Coalition?

Mrs. Black: We have been working with Urban Coalition, and Mrs. Brod has been developing volunteer programs with them. Because it's just getting off the ground, the Urban Coalition hasn't been as involved with volunteers as they wished to be, or hope to be in the future. Eventually they want to have a pretty strong volunteer program, and they've recently hired a Director of Volunteers.

What about MEND or UPACA or any of the grass roots community organizations?

Mrs. Black: Yes, we have worked with the community organizations — UPACA is one. But don't forget we are also working within the city in public departments. When we started, we only had volunteers in the hospitals and in the schools. Now we have them all over the place: in the Rent and Rehabilitation Department, in the Police Department, in the Mayor's Action Center — everyplace.

What do you see for the future? In what direction do you see the Council moving?

Mrs. Black: One of our goals is to have it move into other cities. Our first phase of operation is over — the phase of developing volunteer opportunities in the public sector. Now, the second phase is to more fully develop programs in which the volunteer sector and the public sector cooperate. I see the VCC moving more and more in the direction of cooperative programs. I also see it moving into more programs in the inner-city and into areas where no one has ever before thought of using volunteers.

In the future, we want a main office in the heart of the city at City Hall, and then we plan to decentralize. We'll keep our central office, but we also hope to have Borough offices. Our most recent proposal asks for funds to establish the Borough offices on a mobile basis, with a mobile unit going around recruiting and interviewing. We feel that this would be less expensive than opening an office in each Borough. We've got a lot of people in Queens who don't want to volunteer in Brooklyn or in Manhattan and vice versa. We need Borough offices in order to reach all the people who really want to volunteer. Maybe next year we can tell you that we have decentralized. Or maybe in a couple of years.

Do you feel that the Council has become a fairly needed component in city government? (You probably can't call it essential because volunteers are certainly not an essential component.)

Dr. Costello: If you talk about good government in the largest sense — involving people, and reducing the guilt that people feel, giving them the chance to contribute things that you can't buy — then it's essential. Now if you're talking about the minimum society, where you just get a minimum of services, and minimum involvement from citizens, then of course it's not essential. But in terms of good spirit, morale, and the capacity of people for getting to know the other side of life — both sides — then I think volunteerism *is* essential for the health of society. No doubt about it.

Would it be safe to say that you think volunteers are becoming a more important part of society?

Dr. Costello: I certainly do. I've been reading Herman Kahn's book, *The Year 2,000*, and he says that increasingly we are not only developing primary occupations and secondary occupations, but also tertiary occupations. Woman's prime role is becoming less central to her life, and less capable of satisfying her full range of interests. Most of us are going to have to find volunteer activities in order to fulfill all the capacities and needs we have. It's going to become increasingly important, not only in terms of what the city needs, but in terms of what the individual needs.

People are getting less personal satisfaction than they used to because they're becoming mechanized or automated; the human element is taken out of them. You have that kind of a job; so you earn your living that way. But you really satisfy yourself on what you plan to do on a voluntary basis, because you've got some command of what is going to take place there.

Do you think the role of the volunteer in government will be increasing — not just in New York City, but in other cities, and possibly on the national level?

Dr. Costello: We distinguish ourselves from the national level because certainly it's hard to bring volunteers from all over the country to Washington. And the Federal government doesn't get represented in any dramatic way at the city level. I think the cities are the places where you can really do things. I would say that if we can get other cities to do what we've been doing, and if we can continue to build relationships between different segments of society by having volunteers from these various groups work together, then we've made a mighty contribution. You can legislate integration. You can kind of force it by housing. But the real integration comes when people choose to work together on a problem and solve common goals. And, this is something that can be accomplished by volunteerism alone.

Barbara Bonat and Christine Rodriguez

JAMES L. McGOVERN
EXECUTIVE DIRECTOR

METROPOLITAN ATLANTA COMMISSION ON CRIME AND JUVENILE DELINQUENCY, INC.

52 FAIRLIE STREET
ATLANTA, GEORGIA 30303
524-3869

April 10, 1967

Honorable Ivan Allen, Jr.
Mayor of the City of Atlanta
204 City Hall
Atlanta, Georgia

To Dan Sweat

Dear Mayor Allen:

The Community Council of the Atlanta Area, Inc. and the Metropolitan Atlanta Commission on Crime and Juvenile Delinquency, Inc. are co-sponsoring a meeting to be held Tuesday, April 18 at 3:00 p.m. in the conference room of the Trust Company of Georgia to discuss the problem of the chronic alcoholic court offender.

We feel that such a conference at this time is imperative in view of the recent decisions of the federal Courts of Appeal which held that the chronic alcoholic should not be confined as a criminal but rather should be treated as one in need of medical assistance.

Enclosed is a list of those persons invited to attend this meeting as well as some material relating to the problem of the alcoholic and a treatment plan prepared by the Community Council.

We are hopeful that an overall plan in which the representatives of the City, County and State will participate will be forthcoming.

Yours very truly,

James L. McGovern

James L. McGovern

JLM:ls

Enclosure

Community Council of the Atlanta Area inc.

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CECIL ALEXANDER, *Vice Chairman*
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Report 67-1
March, 1967

TREATMENT PLAN FOR THE CHRONIC ALCOHOLIC COURT OFFENDER

This report is the result of the work of the Advisory Committee on Alcoholism of the Community Council of the Atlanta Area, Inc., and was compiled and written by staff of the Council. Approved by the Executive Committee of the Community Council on March 2, 1967.

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Mrs. Inez B. Tillison, Assoc. Dir., CCAA

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Bruce Herrin, Emory Univ. Alcohol Vocational Rehabilitation Project
Dr. Sidney Isenberg, Fulton County Medical Society
Henry Jackson, St. Jude's House, Inc.
Wilbur Stanley, Georgia Department of Education
Mrs. Nita Stephens, Fulton County Dept. Family & Children Services
Major John Strang, Salvation Army
Reverend Russell Strange, Atlanta Union Mission
Ernest Wright, Georgia Department of Labor

TREATMENT PLAN
for
THE CHRONIC ALCOHOLIC COURT OFFENDER

I. Background

The problem of the chronic alcoholic court offender is not a new one in Atlanta. The courts and many other agencies have been aware of it for many years, and attempts have been made to meet it. Over 10 years ago, Municipal Court judges became concerned with the problem because it was occupying an increasing amount of the court's time. It became increasingly evident that repeatedly arresting these individuals, trying them, sentencing them, and having them pay fines, serve time or both, was not alleviating the problem. Even turning these individuals over to a higher court as habitual drunkards helped only to the extent that men spending 12 months in prison could not be rearrested and appear in court during that time. A large percentage of those who did serve 12 months in prison were back in jail for "plain drunk" within days and sometimes even hours after being released from prison.

At about this time, the judges were approached by several individuals, some of whom were ex-alcoholics, who volunteered their services as a Helping Hand Society to do what they could to help these individuals caught in what is regarded as the "revolving door of drunkenness"--arrest-jail-release-drunkenness-arrest, etc. At this same time, Mr. Henry Jackson, who had 18 years of extensive experience working with alcoholics, was added to the Municipal Court staff as the Director of the Alcoholic Rehabilitation Program.

Judge James E. Webb accepted the offers of help and set up a system whereby individuals who were brought to court for plain public intoxication could, by request, be probated to the Helping Hand Society. At the discretion of the judge and representatives of the Helping Hand Society, an individual was accepted on the program, and for a probation period of 60 days he was expected to cooperate with the Society. The program consisted of three essential things: 1) being a friend to the individual with a drinking problem; 2) helping him find food, clothing and shelter; 3) providing fellowship for the individual in a new environment away from drinking establishments.

Because of the lack of proper facilities to carry out the functions of the Helping Hand Society, the program, although successful with some, was unable to reach the majority of the chronic court offenders, and the Municipal Court caseload continued to grow at an alarming rate.

In 1961, Judge Webb and the leaders of the Helping Hand Society decided that if an increase in facilities for the treatment of alcoholism were at their disposal, they could do a better job of rehabilitating larger numbers of chronic alcoholic court offenders. They approached the Community Council of the Atlanta Area, Inc. The Council recommended that further study be done.

The City of Atlanta, Fulton County, and a group of business leaders agreed to provide the funds for a one year study to be made by the Department of Psychiatry of Emory University. The study was designed to gather data,

analyze the data, and make recommendations based on this data to better deal with the problem of the chronic alcoholic court offender and his family. The study began on July 1, 1962 and ended June 30, 1963. The following is a summary of the committee's recommendations:

1. That a new facility, an Intensive Treatment Center, be established with City and County funds to provide inpatient and outpatient services using a multi-discipline approach. That these services be coordinated with all other treatment and rehabilitation services for alcoholism.

2. To continue the present Helping Hand Halfway House, with some City and County funds made available for this facility, as a model for the establishment and development of other halfway houses in the community.

3. That at least one Alcoholic Information and Referral Center be established on an experimental basis, in one of the neighborhood areas of particularly heavy drinking, this Center to be staffed primarily with volunteers.

4. To provide better training to policemen in the recognition of "intoxication" and its various causes.

5. That there be medical screening in the City Jail of all intoxicated prisoners immediately following the arrest of these persons. That those in need of any medical attention be immediately transferred to Grady Memorial Hospital for this medical care.

6. That the legal procedures now existing be revised so that an individual can be processed from the time of his arrest until disposition of his case has been made by the multi-discipline team previously mentioned.

7. That some of the approaches to alcoholics at the City Prison Farm be modified so that treatment and rehabilitation can be carried out in this setting. That an effort be made in the City Prison Farm to evaluate the mental and physical condition of the alcoholic prisoners and a program of rehabilitation be instituted for each of these persons.

Some strides have been made in implementing these recommendations, but we still have a long way to go as will be seen in other sections of this report. Lack of funds, shortage of staff and public apathy have combined to hinder progress.

Recent events, however, have made it imperative that we develop and carry out plans for the chronic alcoholic court offender.

There have been two court cases concerning the chronic alcoholic which have grave implications for Atlanta. One decision, in the Easter Case, was handed down by the U. S. Court of Appeals in Washington, D. C., and the other, the Driver Case, by the Fourth U. S. Circuit Court of Appeals in Richmond, Virginia. Both decisions were similar and indicative of what path other courts will take.

The decisions stated that chronic alcoholics could not be charged with drunkenness because they have lost the power of self-control in the use of intoxicating beverages. In Washington, the judge said that a 1947 federal law on rehabilitation of alcoholics described chronic drinkers as sick people who needed proper medical and other treatment. However, commitment for treatment of chronic alcoholics as contemplated by Congress was not mandatory. The accused may be released but he may not be punished. It was also the judge's decision that chronic alcoholism is a "defense to a charge of public intoxication and, therefore, is not a crime, however, this does not absolve the voluntarily intoxicated person of criminal responsibility for crime in general under applicable law."

The case is now coming up before the Supreme Court and there is every reason to believe that the decision will be upheld. Therefore, it is only a matter of time before Atlanta is faced with the problem and some planning must be done so that facilities for rehabilitative services for the chronic alcoholic will be available, otherwise, there will be chaos and confusion with wasted effort, time and money.

The problem is a complicated one. Treatment of the alcoholic--to be effective and lasting--requires coordination of services and a combination of many resources and practices. A multi-disciplinary, as well as a family centered and reaching out approach, must be used.

Treatment should be directed to three main goals:

1. Permanent separation of the alcoholic from alcohol.

2. Repairing the physical and emotional damage and preventing further damage.

3. Changing community institutions, programs and services to meet the special needs and problems of the alcoholic. Community resources should be made as readily available and easily accessible as others.

In addition, any planning for the chronic alcoholic court offender should be integrated with the planning being done for all other alcoholics and for other phases of mental health and physical illness. They are all a part of the same problem and should not be segmented, if at all possible.

II. Target Population in Atlanta

A. Over half of the arrests made by the Atlanta Police Department in 1966 for non-traffic offenses involved public intoxication.

   1. Total non-traffic arrests - 79,092 (does not include juveniles)

   2. Arrests involving drunkenness - 47,305. These consist of approximately 12,000 individuals and that about one-half, or 6,000, of these individuals were arrested on this charge from 2 to 20 times

during the year. It is difficult to say how many of these can be rehabilitated fully or to some extent.

From the experience of the staff of the Emory University Alcohol Project in their three and a half years of operation, it is their belief that with the proper approaches, facilities and staff, a considerable number of these persons might be at least partially rehabilitated. They are not willing to dismiss the possibility of assisting even the most hard-core chronic alcoholic. It is sometimes extremely difficult to determine accurately in advance just who can be helped or how long it might take. They believe that it is essential to at least make a sincere effort to treat each one of these individuals. It is really only through giving each of them an opportunity for treatment and rehabilitation that we can determine whether or not they can be helped. It is conceivable that approximately 10,000 of this group of 12,000 alcoholic offenders can be assisted to improve their total well-being significantly.

B. Characteristics of the Chronic Alcoholic Court Offender

1. General Characteristics:

   a. Product of a limited social environment who has never attained more than a minimum of integration within the community.

   b. Dependent personality without much individual resourcefulness.

   c. Individual who has difficulty in communicating with others.

2. The following specific data has been taken from the original study done by Emory University:

   a. Average age of white male - 48.0 years
Negro male - 42.9 years

   b. Rate of tuberculosis in this group was found to be ten times greater than the rate in the general population.

   c. 10% of the white males and 3.6% of the Negro males had been hospitalized in a mental hospital previously.

   d. 50% of the white males went beyond the eighth grade in school. In this group, there was no correlation between the number of court appearances and levels of education.

   e. The Negro males did demonstrate a correlation of the level of education with the number of court appearances.

      1) 50% of the Negro males in the 1-2 court appearance group went through the ninth grade.

2) 50% in the 3-6 court appearance group went through the eighth grade.

3) 50% in the 7 or more court appearance group went only through the seventh grade.

f. Employment

1) 77% of the Negro males were classified as unskilled labor; while 32% of the white males were in this group.

2) 40.9% of the white males had had special job training; while only 24.8% of the Negroes had.

3) 52% of both races were unemployed.

4) 26% of the white males and 14% of the Negro males were receiving some type of financial assistance.

5) At the time of arrest, 42% of the white males and only 6% of the Negro males had money available to pay a fine.

III. Elements to be considered in a Treatment Plan for the Chronic Alcoholic Court Offender

A. Legal and Legislative

1. Legislation to give city authority to spend funds for local alcoholic rehabilitative measures.

The city of Atlanta is in a peculiar position. Under the Reorganization Plan of 1951, health functions were made the responsibility of the county and police functions were made the responsibility of the city. Therefore, city police can arrest an alcoholic for public drunkenness, but the city cannot spend tax money to rehabilitate him, since rehabilitation is a health function. The Fulton-DeKalb County Hospital Authority says alcoholism is a chronic illness and it assumes no responsibility for chronically ill. The Fulton and DeKalb County Health Departments have no outpatient clinics for the alcoholic. The State Health Department feels that it has no responsibility for the alcoholic until reasonable rehabilitative measures have been made at the local level.

2. There must be a change in the police handling of chronic inebriate offenders. The following quotation from Peter Barton Hutt, the attorney who presented the appeal in the Easter Case in the Distric of Columbia, gives an indication of some of the problems involved:

"With regard to the police handling of chronic inebriate offenders, it is my opinion that it is not a false arrest for a policeman to charge an unknown inebriate with public intoxication, even after the Easter and Driver decisions. The police should not be required, at their peril, to make a judgment on the street as to whether an intoxicated individual is or is not a chronic alcoholic.

"In the case of known chronic alcoholics, however, this problem raises a far more difficult legal issue. To some, the availability of the defense of chronic alcoholism still seems more properly an issue for the courts than for the police.

"But more important, the community should not place the police in jeopardy in this way. There is no reason why the police should be burdened with the ignominious task of sweeping chronic inebriates off the public streets. I was recently called upon in the District of Columbia to assist a man who had been arrested 38 times since the Easter decision. When you take into consideration the amount of time he spent incarcerated in jail and in various hospitals, this amounted to 1 arrest for every 2 days that he appeared on public streets. Certainly, the answer to the Easter and Driver decisions is not just to arrest derelict alcoholics every day, duly bring them to trial and then immediately release them back on the streets without assistance, only to repeat the process over and over again. This succeeds only in speeding up the "revolving door," and in further persecution and degradation of chronic inebriates. It cannot contribute to the elimination of these abuses, as the Easter and Driver decisions demand.

"In my opinion, the police can and should take two immediate steps to end the revolving door process, pending development of a broader community program that I will discuss later in this talk. First, they should assist any drunken person to his home, whenever that is possible. Second, where an individual is unable to take care of himself, the police should assist him to an appropriate public health facility where he can receive the necessary attention. Under no circumstances should they arrest known alcoholics time and time again.

"The question arises, of course, whether the police may properly assume responsibility for intoxicated individuals and escort them to an appropriate public health facility to receive proper medical attention. If the inebriate does not consent, would the police incur liability for a false arrest? I have long been of the view that the police have duties of a civil nature, in addition to their responsibility for enforcing the criminal law. When a policeman escorts a heart attack victim to the hospital, he certainly is not arresting him. Thus, in my opinion, the police have both a right and a duty to take unwilling intoxicated citizens who appear to be unable to take care of themselves, whether or not they are alcoholics, to appropriate public health facilities. And I might

add that, in the oral argument in the Easter case, all 8 of the judges indicated agreement with this proposition. Nevertheless, law enforcement officers have expressed considerable apprehension about the possible liability of policemen for false arrest under these circumstances. Certainly, this question should be resolved immediately, preferably by enactment of state statutes, in order to lay the necessary legal foundation for the proper medical handling of alcoholics."

3. The court procedure must also be modified. Again, the quotes are Peter Barton Hutt:

"With regard to the judicial handling of chronic court inebriates, once a judge becomes aware, through any information of any kind, from any source, that a defendant charged with public intoxication may have available to him the defense of chronic alcoholism, he is, in my opinion, clearly obligated to make certain that the defense is adequately presented. Cases in the District of Columbia, involving the analogous defense of mental illness, hold that even if the defendant protests, the judge is required to inject the defense into the case sua sponte, which means of his own motion, to make certain that an innocent man is not convicted. Failure to do so is reversible error, as an abuse of the judge's discretion. And a decision handed down by the United States Supreme Court in March of this year is wholly consistent with this position. There is no reason why these precedents should not be equally applicable to the defense of chronic alcoholism.

"This means, of course, increased responsibility for the judiciary. Under the Easter and Driver decisions, each trial judge is obligated to take affirmative action to bring an immediate end to the traditional "revolving door" handling of the chronic court inebriate in his court. No judge, in my opinion, may properly remain neutral, simply waiting for a defendant to raise the defense of alcoholism.

"Indeed, statistics I have reviewed suggest that, throughout the country, approximately 90-95 per cent of the drunkenness offenders who appear before the courts have serious drinking problems. In my judgment, this statistic in itself places upon trial judges an obligation to inquire into the possibility of the defense of chronic alcoholism for virtually every drunkenness offender who appears in the courts. A failure to undertake this inquiry amounts, in my view, to a derogation of judicial responsibility.

"This also means the demise of the so-called court honor or probationary programs for alcoholics which have sprung up all over the country as the judiciary's ad hoc answer to the failure of public health officials to treat alcoholism as a disease. If a defendant is found to be eligible for a court alcoholic program, then obviously he should not be convicted in the first place. The Easter

and Driver decisions are, in my judgment, fundamentally in conflict with any type of judicially-sponsored post-conviction program for the treatment of alcoholism. However benevolent such programs may be, constitutionally they are a thing of the past. For my part, I shall be very happy to see the courts step aside in this area, and to see public health officials take over problems which they should have taken over many years ago."

4. Legislation to provide for involuntary commitment of alcoholic until rehabilitation process is complete. Should be on a health and treatment basis rather than through courts with penal approach.

5. The responsibilities of the state and local communities must be defined and clarified.

6. The responsibility of after-care when the patient has been released from the hospital should be determined. Who follows-up--the state or local community?

B. <u>Treatment Facilities</u>

1. Intake Center and Detoxification Unit

Before any kind of evaluation, diagnosis or therapy can begin, it is necessary that the individual be detoxified as quickly and as safely as possible so that the effects of acute intoxification are no longer present. There is no doubt that the hospital is the best setting for such treatment. Emergency measures are at hand, the staff is available and all necessary equipment is there. In Fulton and DeKalb County, Grady Memorial Hospital seems to be the logical place for a Detoxification Center. It is authorized to take care of emergencies, it has space and is conveniently located. It does take care of alcoholics in its emergency clinic. Experience has shown that there is very little difficulty encountered in treating alcoholics. Records of hospitals that have admitted these patients will confirm the report that most of these patients offer no more difficulty than any other sick person. It is difficult to estimate how many beds Atlanta would need to take care of the problem to a fairly adequate degree. St. Louis, Missouri, opened a 30-bed unit to serve the entire city. Officials reported that in the first two months of operation, the station operated at or near capacity with only the alcoholics from two police districts. It is obvious that if facilities exist they will be used. Based on the St. Louis experience, which was concerned with a lower rate of arrests than Atlanta has, it is felt that approximately 100 beds would be needed. Staff for 24 hour duty would be required. This would mean: 9 registered nurses, 9 licensed practical nurses, 15 attendants (nurses aides or orderlies).

Exact plans would have to be worked out in detail with Grady Memorial Hospital and other professional people who are concerned and working with the problem.

2. Inpatient Diagnostic-Evaluation Center

Following the individual's detoxification, he could be transferred to an inpatient diagnostic-evaluation center where a complete work-up could be prepared on his medical, social, occupational, family and other personal history.

This could conceivably be the present City Prison Farm, which, when alcoholics can no longer be incarcerated there, would have room. Alterations and modifications in the structure would have to be made, but this would not present much of a problem.

The Center should have a multi-disciplinary team approach. Its staff should consist of medical, psychiatric, psychological, social work, vocational, and rehabilitation personnel. The individual would stay approximately 5 or 6 days or until plans were complete for future treatment.

It is hoped that as much as possible treatment would be on a voluntary basis and that commitment would be only used when absolutely necessary. Full cooperation and willingness of the individual to undergo treatment would facilitate the rehabilitative process.

3. Outpatient Rehabilitative Treatment

The success of the Emory University Vocational Rehabilitation Alcohol Project demonstrates that these men can be treated successfully in an outpatient setting. Even those who will become only partially self-sustaining should be treated as those who eventually will be fully rehabilitated.

The most important and unique feature of the proposed method of treating the chronic alcoholic court offender is based on the recognition that these individuals are totally dependent upon others to take care of them. Knowing and accepting this makes the task of rehabilitation less difficult and more certain.

Any outpatient service should be based on the Emory Project and its experience should be fully utilized. The service should use a multi-disciplinary approach. Represented on the staff should be vocational rehabilitation counselors, social workers, clinical psychologists, chaplains, physicians and psychiatrists. The main emphasis in rehabilitation should be on "reaching out" for the clients rather than the traditional waiting for the client to request services. This reaching out is necessary because of the passive, dependent nature of the alcoholic. Once he is involved in the rehabilitation process, he must be continuously supported until his total dependency can be changed so that he is sufficiently independent to function in society and to maintain employment.

4. Inpatient Extended Care Program-Rehabilitative Service

The Georgia Health Code Act No. 936 (H.B. 162) 1964 session of the General Assembly, 88-403, states:

"The administrative responsibility for alcoholic rehabilitation as provided herein shall be vested in the Department of Health. The Department of Health shall study the problem of alcoholism, including methods and facilities available for the care, custody, detention, treatment, employment, and rehabilitation of alcoholics. The Department of Health shall promote meetings for the discussion of the problems confronting clinics and agencies engaged in the treatment of alcoholics and shall disseminate information on subject of alcoholism for the assistance and guidance of residents and courts of the State. The Department of Health is hereby authorized to establish and maintain hospitals, clinics, institutions, outpatient stations, farms, or other facilities for the care, custody, control, detention, treatment, employment, and rehabilitation of alcoholics, and is further authorized to accept for care and custody alcoholics voluntarily applying for treatment or ordered hospitalized by court order as hereinafter provided, and is further authorized to confine and detain such alcoholics for treatment and rehabilitation."

This, then, definitely places the responsibility on public health and any planning should be done with this in mind. Also, as with all other phases of the plan, this should be integrated and coordinated with the state and local plans for mental health.

In a conference Community Council staff had with the State Mental Health Division, it was pointed out that it was the policy of the Mental Health Division to require that all local mental health programs should include some provision for the care or handling of chronic alcoholics. The exact methods to be utilized are not specified, but this problem must be considered and provided for in some manner in any mental health program at the local level. Dr. Donald Spille, Executive Director of the Metropolitan Atlanta Mental Health Association, Inc., is a member of the Community Council's Committee on Alcoholism and will help keep the Committee advised on mental health program plans.

The inpatient extended care rehabilitative service could be part of a regional hospital or a center by itself. The stress should be on rehabilitation to prepare the individual to be a self-sustaining member of society.

Treatment techniques should include:

a. Counseling and evaluation
b. Physical therapy
c. Work therapy
d. Group therapy

e. Self government
f. Lectures and films
g. Drug therapy
h. Recreation therapy
i. Pastoral counseling

Specific plans should be developed by experts in the field.

At present, we have the Georgian Clinic located in Atlanta and supported by the Georgia Department of Public Health. Fees charged to the patient are based on income. It is a 50-bed resident patient hospital and also provides day care and night care. This serves all residents of Georgia and the patient must be free of alcohol for 24 to 48 hours. There are also a few private hospitals or sanatoriums that accept chronic alcoholics but facilities are extremely limited and almost nonexistent for those who cannot pay.

C. <u>Supportive Services</u>

1. Housing - a great many of these individuals have no place to live. Some need temporary shelter while undergoing treatment. Some place must be provided for them which will give them support and keep them from drinking. Others will need more permanent arrangements if they cannot return to their own homes or live independently.

   The following are some of the kinds of housing that are recommended:

   a. Hostel - a semi-institution preferably in town. Should have a structured program with some medical personnel in attendance. Can be large, serving several hundred individuals. There is nothing like this in Atlanta.

   b. Halfway homes - smaller, more individual, less structured.

      St. Jude's House, Inc., is at present the only halfway house in Atlanta. It is supported by rents from residents, contributions from churches, individuals and foundations. It has beds for 40 residents and provides meals for an indefinite period of time in a protective setting. The men must be 20 years and older, must have an arrest record for drunkenness, must be screened psychologically and physically by the Emory University Alcohol Project. They must also be suitable for employment.

   c. Shelters for homeless men that include alcoholics.

      The Atlanta Union Mission which is supported by individual contributions and fees. The Mission provides shelter, food,

clothes, Christian counsel and employment for indigent men. On the average, 200 men are taken care of per night. Approximately 85% of these are alcoholics.

The Salvation Army provides over 700 men with shelter a week. About 90% of these are alcoholic. It does not accept anyone in a severe drunken state since no medication or special treatment is available. These are sent by cab to Grady Hospital or turned over to the police. The men from the Emory Project will occupy a special section. The Army staff is responsible for giving the medication prescribed and will see that the men cooperate with treatment.

Women alcoholics are housed at 242 Boulevard, N.E. Since August, 1966, there have been 4. Women are always referred to Grady Hospital, the Emory Project or the Georgian Clinic.

d. Individual rooming houses or hotels. The Emory University Alcohol Project now has a staff member developing these facilities. With help and supervision, many of these places could be made acceptable, kept from deteriorating and provide pleasant places to live. In most of the "flop houses" and cheap hotels, the man is exposed to other drinkers and the atmosphere is not conducive to a healthy state of mind.

e. Social clubs where individual can go when not in treatment or when not working. A.A. meetings provide a form of this.

f. Facility for individual who cannot be rehabilitated but will always remain partially dependent on treatment. Social improvement, even if it implies dependency upon the hospital, is perhaps the most that can be expected as a goal of therapy for this group.

   1) Farm where he can be self-supporting.

   2) Work outside of facilities with aid of treatment, but return to facility for night and free time.

Atlanta Union Mission Rehabilitation Farm for alcoholics and the aged will open in May. It will house 32 alcoholics to begin with and the master plan calls for 64. In order to be accepted, the client must be without a drink for at least 48 hours, sign a statement of his own free will of intent to stay a minimum of 60 days, to cooperate with the staff and its program of worship, work and education. The client will not be permitted to leave the mission farm for the first 2 weeks and afterwards only when accompanied by Mission Farm personnel. There will be a charge of $62.50 per month for every man. However, his ability to pay will not determine his acceptance.

2. Financial Assistance - part of society's basic obligation is to provide for the destitute. This allows them income while undergoing treatment and supplements income of those who need permanent care.

   The Fulton County Department of Family & Children Services cooperate completely with the existing facilities for treatment of the chronic alcoholic. The individual receives temporary financial assistance as long as he is cooperating and undergoing treatment. The Special Service Section, which carries a reduced caseload, takes care of most of the alcoholics so that they can be given more intensive case work. When an individual applies for financial help and is an alcoholic, every attempt is made to get him to treatment.

D. Public Education

Public apathy has been one of the most severe obstacles in working with the chronic alcoholic court offender. As a rule, he is a forgotten man, relegated to a flop house or prison and given up as a hopeless case. He remains a burden to society and is one of the most important contributors to the reservoir of poverty in this country. Once the public understands and its interest is aroused, the resulting action can become a powerful force in accomplishing a constructive objective.

A public education program should concern itself with the following aspects:

1. Develop community leadership to alert people to the needs and potential of an adequate and sympathetic approach to the problem.

2. Acknowledging that alcoholism is a public health problem and, therefore, a public responsibility.

3. Showing that the penal approach to the public alcoholic is expensive and inhumane. It has only perpetuated the problem and in no way eased it.

4. Demonstrating that there is no simple solution. That treatment of the public alcoholic to be effective and lasting requires coordination of services and a combination of many resources and programs.

5. Understanding of the public alcoholic and homeless individual.

6. Explaining of problems arising in developing programs and service.

   a. Legal and legislative
   b. Economics or funding
   c. Facilities and services that have to be developed

7. Describing and explaining kind of comprehensive plan Atlanta needs, elements involved and how we go about implementing such a plan.

A public education program should be directed at public officials, special interest groups, as well as the general public.

The Metropolitan Atlanta Council on Alcoholism, working with the Community Council, could be the motivating force behind an education program.

E. Central Registry and Information Retrieval

The full extent of Atlanta's alcoholic problems is not known. The United States Public Health Service considers alcoholism the fourth most serious health problem in the country and the picture in Atlanta is most likely no different than that in any other city. According to the national average, it is estimated that there are from 20,000 to 25,000 alcoholics in Metropolitan Atlanta. This is far from a complete number for statistics are not available for those using private facilities and for those that never come to the attention of the public. We know that in 1965, 48,783 arrests were made in Atlanta involving drunkenness. We have these isolated figures but nothing complete, and some agency should be charged with the responsibility of keeping accurate statistics on alcoholics and facilities available for rehabilitation.

In addition, the need for a central clearing house has been felt by many agencies. Alcoholics seek help in many places and often at the same time, and there is no way of knowing where they have been or what treatment they have received. A central clearing house or central registry cannot succeed, however, unless it receives the full cooperation of all participating agencies. The Metropolitan Atlanta Council on Alcoholism might be able to organize one under a special grant so that money would be available for trained staff.

F. Staff Training

Before any kind of service or program can be instituted, personnel on all levels must be available. At the present, there is a severe shortage of staff and there is a pressing need for training in the field. Inducements must be made so that individuals will be interested in working in the area of alcoholism. All facilities and programs concerned with the treatment of the alcoholic should be involved with the training program and this should again be coordinated with the State's comprehensive plan for mental illness of which training is an important part. The Georgian Clinic has an extensive training program which could be expanded. The Clinic could possibly act as the coordinating agency for a training program.

G. Evaluation

For a program of this kind, there should be a built-in system of evaluation of services. Only on the basis of such an evaluation would we be

able to strengthen and develop the program, accomplish any worthwhile long-range planning, and establish accurate guidelines for the further development of the program.

The Research Division of the Community Council will help develop the evaluation and the plan for it will be incorporated in the final report.

"IMPACT OF THE EASTER DECISION ON THE DISTRICT OF COLUMBIA"

by

Richard J. Tatham
(D.C. Department of Public Health)

This is Richard J. Tatham, Chief of the Office of Alcoholism and Drug Addiction Program Development, for the District of Columbia Department of Health. I've been asked to relate to you some of our recent experiences in the District of Columbia which have resulted from a U.S. Court of Appeals decision last March 31, 1966, in the case of DeWitt Easter vs the Court of Columbia. As many of you know, the result of this court decision was a reversal of court decisions which found DeWitt Easter to be guilty of the crime of intoxication, in spite of the fact that he had clearly established that he was a chronic alcoholic. This decision was appealed to the U.S. Court of Appeals and it was found that alcoholism is an illness and that it would constitute cruel and unusual punishment for a sick person to be convicted and punished for exhibiting a symptom of his illness in public, and it was further established that the essential common law element of criminal intent is lacking when an alcoholic becomes intoxicated. As a result of this case, the Court of General Sessions began utilizing the Alcoholic Rehabilitation Act of 1947, which authorized that court, in the District of Columbia, to suspend criminal hearings whenever a defendant was suspected of having an alcoholism problem and to commit that person to the Department of Public Health for diagnosis, classification, and treatment. The 47th Statute had been used on the average of 100 times each year between the years 1950 and 1963, and was, therefore, nothing new to the court or to the Health Department. However, in more recent years its use was discontinued as the court began to develop its own probation program for alcoholic offenders. Last year the U.S. Court of Appeals strongly urged the District of Columbia to use its 47th Statute once again and as a result of this admonition some 3500 individuals have been adjudicated under the 47th Statute to be chronic alcoholics and the majority of these have been committed to the Health Department for treatment. At the time of the Easter Decision, the D.C. Health Department operated three alcoholism treatment facilities; namely, an outpatient clinic, known as the Alcoholic Rehabilitation Clinic; a hospital unit for intensive medical care at the D.C. General Hospital; and, a brand new comprehensive in-patient, out-patient unit at our Area C Mental Health Center. However, the latter facility was only in its beginning phases with a skeleton staff and was not really able to participate appreciably to handle a court alcoholic problem. Likewise, the in-patient facility at D.C. General Hospital concentrated on the short-term intensive treatment for delirium tremens, hallucinosis, and other serious complications of alcoholism, and so very few of the court-committed alcoholics were eligible for this service. The only remaining treatment facility is our out-patient clinic. Now in the month immediately following the Easter Decision, only six patients were committed to the Health Department. In the month of May, the number jumped up to 100 and by June, 300 new patients were committed to us. By this time, patients were being transported from the court to the out-patient clinic by the busload with as many as 50 or more arriving at a time. The out-patient clinic had no choice but to accept these in spite of the fact that the clinic was not designed to accommodate the needs of the patients we were receiving. Utter chaos followed. All attempts to utilize existing Health Department resources resulted only in the addition of a few part-time people on an over-time basis in order that the clinic could operate evenings and Saturdays. Now, nine months after the Easter Decision, the same situation prevails with one exception - we now have an additional facility - a 425-bed, extended-care rehabilitation center located just outside the District of Columbia in Occoquan, Virginia. This facility opened November 14, 1966, and was filled to

capacity in less than six weeks, so once again the Health Department is unable to accommodate all the patients who require in-patient treatment and these patients are once again going to our out-patient clinic.

A recent article in the Washington Post indicated that the Director of this out-patient clinic is threatening to leave the Health Department unless the situation is alleviated somehow. The patients are still coming to clinic in droves. While they are there, they have entered into fights with other patients, members of the clinic staff have been assaulted, patients have urinated and expectorated in the clinic and this has created a situation which threatens the entire survival of a treatment program that has been in existence since 1949.

The solution of this problem is not a simple one. One might believe that the Health Department had not anticipated the reversal in the Easter Case; however, this is not true. Well in advance of the Easter Decision, the Health Department, along with representatives from Vocational Rehabilitation, Correction, Administration, and Welfare Departments prepared an ad hoc report dealing with the possible impact of an Easter Decision. This report clearly pointed out some of the problems which might arise and also outlined certain new services and facilities which might be needed. However, no action was taken by our Board of Commissioners. The reason for this included the fact that the Commissioners had no assurance that the Easter Case would be reversed and even if it would be reversed they had no assurance that the impact would be great. For example, even though the Easter Case would be reversed, the judges in our local courts might insist that the question of alcoholism would have to be introduced by the defendant himself and many alcoholics appearing in court, of course, would choose not to introduce the problem of alcoholism. By avoiding the question of alcoholism they could return to their workhouse where they have been long-time residents - they knew that they would serve an average of 21 days and then could be released without any parole or any other obligations. However, if they should bring up the question of alcoholism, they might very well be committed to the Health Department for 90 days with a possibility that a second 90-day committment would follow. With this in mind, there was much speculation that the courts would not use the Easter Decision as a base of future action in very many cases. In addition to this, the problem was complicated by the fact that the corporation counsel, known in other cities as a prosecuting attorney, felt very strongly that according to the definition of our 1947 Statute, there could not possibly be more than 20 or 30 chronic alcoholics in the entire District of Columbia. Activities since then have proven quite the contrary. The problem has become so great that it was necessary to set up a court-coordination program and patient control system in order to just keep track of the multitude of patients being committed to us by the court. The situation became so bad that the Health Department was instructed that it must cut off all voluntary patient admissions at its treatment facilities in order to make room for the court-committed patients.

In evaluating the problems that have occurred since the Easter Decision, the Department has consistently fallen back on its basic comprehensive community mental health plan, which points out the needs for various facilities ranging from the extended care rehabilitation center we now operate to mental health center alcoholism units providing both in-patient and out-patient treatment to detoxification centers to residential facilities such as hostels and half-way houses. The big problem, obviously, is the magnitude of the program which we have proposed and the fact that one or two components of the program still do not alleviate the problem of handling court-committed patients. Until a complete

system is available and operating which can provide all of the services needed by this particular patient population, there will be chaos in treating the chronic court offender. If we do not have community based residential facilities, then we will either have to expand our in-patient hospital at Occoquan, Virginia, or we will have to substitute out-patient treatment with all its inadequacies for this homeless patient group.

The District of Columbia is presently spending approximately $3,000,000 per year on the alcoholic patients seen by the Health Department. Of this figure, approximately $1,000,000 a year is expended on the care of alcoholics having psychosis who are admitted to St. Elizabeths Hospital and paid for by the Health Department on a contract basis. The other $2,000,000 accounts for our present services at the rehabilitation center, at the Area C alcoholism unit and at our out-patient clinic. Also, the figure includes the cost of providing our court coordination and patient control system, a small alcoholism TB Program at Glendale Hospital, and our new demonstration detoxification unit.

As we are busily trying to expand our services to accommodate the needs of the court-committed patients, we are faced with a new problem which has come to light within the past few weeks in Washington. Our information indicates that two new bills are to be introduced to Congress this session. One by the administration, a second by Congressman Hagan from Georgia. Each bill would introduce a new concept in law enforcement as each would remove intoxication from the criminal code entirely. This would mean that if either of these bills was passed, an individual could not be arrested for being intoxicated only in the District of Columbia. It would mean that if an intoxicated person is helpless, has no place to go, he could be escorted by a police or Health Department official to a health facility for detoxification. He would be kept in such a detoxification faciltiy until his blood alcohol content returned to the legal limits of sobriety and then could be continued in treatment for alcoholism as a voluntary patient or released outright. This would mean that our attention to the problems of getting sufficient hospital care resources for court-committed alcoholics would shift almost immediately to the problem of obtaining sufficient in-patient detoxification resources within the community itself. I think this is an excellent example of how dynamic the field of alcoholism has become as a public health problem and indicates the importance of planning coupled with flexibility; and, above all, it impresses with the importance of the magnitude of the problem. Most communities have never accepted the full impact of the statement that alcoholism is the nations third or fourth public health problem. We have mouthed this saying without realizing the financial impact that it carries. As I said earlier, our community is expending approximately $3,000,000 a year on alcoholics. Now I'm talking about the Health Departments budget - I'm not adding to this figure what the Police Department, what the courts, what the Department of Corrections, and other departments are allocating to the care of alcoholics - just the Health Department. This $3,000,000 figure, in our estimation, will probably have to be doubled to a $6,000,000 annual figure just to take care of the immediate emergency problems arising from the Easter Decision and the possible new legislation which would remove intoxication from the criminal code. Now, in creating these new services, of course we would hope any new program would be considered an additional resource for voluntary patients also; but, it's interesting to note that our 1947 Statute and the Easter Decision and the possible new statutes removing intoxication from the criminal code, all focus on the alcoholic who is a law offender and quite often the most important patient in this group is the chronic drunkenness offender with fifty or more previous arrests for drunkenness. This means that today, alcoholism, even though a public health problem, is reaching the public's attention through the judicial activities of the community and of the nation; that a complete

revision of some rather well established principles is being questioned; and that new approaches are being encouraged; and that these new approaches will require new funds of considerable magnitude unless the community is satisfied that the treatment of the chronic alcoholic offender should consist of removing him from the streets only - and I think this is a very real problem that we face in firmly maintaining that alcoholism, the skid row alcoholic, the chronic drunkenness offender, is to become truly a public health problem. That the high quality treatment, the high standards of services that we provide other alcoholic patients are made available to the chronic drunkenness offender - now this does not mean that the chronic offender necessarily can benefit from the same type of treatment that our other alcoholic patients are involved in; but it does mean that whatever services are provided for them, they are the highest possible quality of services to meet the needs of this important patient population.

I have been impressed as I have visited many alcoholism facilities throughout this nation with the fact that even though the Easter Decision is more than nine months old and that a similar decision in the case of Joe B. Driver in the Fourth Circuit Court of Appeals at Richmond, Virginia, have established a new legal precedent, and that these precedents have been set on both a constitutional and common-law basis and there is no doubt that the precedent will spread from state to state and circuit to circuit; yet in spite of all these things, many alcoholism programs do not seem to be planning to take care of this situation when it inevitably happens in their own state and community and I was, therefore, very pleased to see that in Atlanta there is planning being initiated and that the Community Council here in Atlanta is drafting a proposal which will be submitted as an answer to the problems that can arise here; that there are a number of people interested in the chronic alcoholic offender; and that services are being demonstrated now which can be extremely important in meeting the treatment, the rehabilitation, the residential, and other needs of this impoverished group. We feel quite strongly in the District of Columbia that we have been bogged down in our own problems for over a year and that it's now perhaps our responsibility to communicate our experiences and observations to others throughout the country and Canada in order that some of the problems, the mistakes, and the frustrations experienced in Washington can be minimized elsewhere and it has been with this thought in mind that I have shared these comments with the staff of the Georgian Clinic and others who might come into contact with this tape recording.

Richard J. Tatham, Chief
Office of Alcoholism & Drug Addiction
Program Development
Government of the District of Columbia
Department of Public Health
Washington, D.C.

RJT: 2-24-67

Community
Council of the
Atlanta
Area inc.

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INVITATION LIST FOR MEETING ON THE
CHRONIC ALCOHOLIC COURT OFFENDER

Co-sponsored by
Community Council of the Atlanta Area, Inc.
Metropolitan Atlanta Crime Commission

Tuesday, April 18
3:00 P.M.
Conference Room, Trust Company of Georgia

1. Dr. John Venable, Director
   State Board of Health
   47 Trinity Avenue, S. W.
   Atlanta, Georgia

2. Dr. P. K. Dixon, Chairman
   State Board of Health
   Gainesville, Georgia

3. Dr. Addison Duval, Director
   Division of Mental Health
   Department of Public Health
   47 Trinity Avenue S. W.
   Atlanta, Georgia

4. J. William Pinkston, Executive Director
   Grady Memorial Hospital
   80 Butler Street, S. E.
   Atlanta, Georgia

5. Mr. Edgar J. Forio, Chairman
   Fulton - DeKalb Hospital Authority
   P. O. Drawer 1734
   Atlanta, Georgia

6. Dr. John Hackney, Commissioner of Health
   Fulton County Health Department
   99 Butler Street, S. E.
   Atlanta, Georgia 30303

7. Mr. P. D. Ellis, Chairman
Fulton County Health Department
3230 Peachtree Road, N. E.
Atlanta, Georgia 30305

8. Dr. T. O. Vinson, Director
DeKalb County Health Department
126 Trinity Place West
Decatur, Georgia

9. Dr. John R. Evans, Chairman
DeKalb County Board of Health
Stone Mountain, Georgia

10. Mayor Ivan Allen, Jr.
City of Atlanta
204 City Hall
Atlanta, Georgia

11. Richard C. Freeman, Chairman Police Committee
Board of Aldermen, City of Atlanta
1116 First National Bank Building
Atlanta, Georgia

12. John M. Flanigan, Chairman Prison Committee
Board of Aldermen, City of Atlanta
245 Third Avenue, S. E.
Atlanta, Georgia

13. Henry L. Bowden, City Attorney
William Oliver Building
Atlanta, Georgia

14. Judge Robert E. Jones
165 Decatur Street, S. E.
Atlanta, Georgia

15. Judge E. T. Brock
165 Decatur Street, S. E.
Atlanta, Georgia

16. Judge T. C. Little
165 Decatur Street, S. E.
Atlanta, Georgia

17. Judge Robert Sparks
165 Decatur Street, S. E.
Atlanta, Georgia

18. Police Chief Herbert T. Jenkins
165 Decatur Street, S. E.
Atlanta, Georgia

19. James H. Aldredge, Chairman
Commission of Roads & Revenues, Fulton County
Fulton County Administration Building
165 Central Avenue, S.W.
Atlanta, Georgia 30303

20. Charles Brown, Fulton County Commissioner
Fulton County Administration Building
165 Central Avenue, S.W.
Atlanta, Georgia 30303

21. Walter M. Mitchell, Fulton County Commissioner
Fulton County Administration Building
165 Central Avenue, S.W.
Atlanta, Georgia 30303

22. Harold Sheats, County Attorney
Fulton County Court House
Atlanta, Georgia 30303

23. James P. Furniss, Chairman
Board of Directors
Community Council of the Atlanta Area, Inc.
C & S National Bank
Atlanta, Georgia 30303

24. Brince Manning, Chairman
Board of Commissioners, DeKalb County
DeKalb Building
Decatur, Georgia 30030

25. George Hearn, Assistant Attorney General
State of Georgia
Judicial Building
Atlanta, Georgia 30303

26. Paul Cadenhead, Chairman
Community Council Advisory Committee on Alcoholism
2434 Bank of Georgia Building
Atlanta, Georgia 30303

27. Eugene Branch, Chairman, Permanent Conference, CCAA, Inc.
401 Haas-Howell Building
Atlanta, Georgia 30303

28. Charles Methvin, Director
State Alcoholic Rehabilitation Unit
1260 Briarcliff Road, N.E.
Atlanta, Georgia 30306

29. Jack Watson
King & Spalding
Trust Company of Georgia Building
Atlanta, Georgia 30303

30. Captain Ralph Hulsey
    City Prison Farm
    561 Key Road, S.E.
    Atlanta, Georgia 30316

31. Dr. James A. Alford
    Alcohol Rehabilitation Project
    41 Exchange Place, S.E.
    Atlanta, Ga. 30303

32. Mrs. Marian Glustrom, Planning Associate
    Community Council of the Atlanta Area, Inc.
    1000 Glenn Building
    Atlanta, Ga. 30303

33. Duane W. Beck, Executive Director
    Community Council of the Atlanta Area, Inc.
    1000 Glenn Building
    Atlanta, Ga. 30303

34. James L. McGovern, Executive Director
    Metropolitan Atlanta Commission on
    Crime & Juvenile Delinquency
    52 Fairlie Street, N.W.
    Atlanta, Ga. 30303

March 16, 1967

RECENT COURT DECISIONS ON ALCOHOLISM:

IMPLICATIONS FOR ATLANTA AND THE STATE OF GEORGIA

Skid Row has long been recognized as the bilge of our communities. And the derelict inebriates who reside there represent perhaps the lowest form of humanity. For centuries, these derelict alcoholics have been virtually ignored, not only by the average citizen, but indeed by the very public officials who are charged by statute with caring for them. Instead of receiving the attention and help that they deserve and so urgently need, they have received nothing but private disdain and public condemnation. They have been herded mercilessly through our courts and jails, in every city in this country, and especially in Atlanta, in an endless and futile parade.

Early last year two United States Courts of Appeals sought to put an end to this senseless parade. These courts recognized, as anyone who stops to think about it must recognize, that this was a parade as much of our nation's blind stupidity as it was of the serious affliction -- chronic alcoholism -- from which these unfortunate people are suffering. It is these legal decisions, and the ramifications that they will inevitably have upon Atlanta and the entire State of Georgia, which I will discuss today. I will be as forthright as I can be in my remarks. And I trust that you, in turn, will be forthright in your comments and criticisms of my suggestions.

I

It is appropriate to begin by asking whether Atlanta has a problem of this kind. After all, if you are fortunate enough to have no Skid Row, to have no derelict alcoholics, or to provide humane and enlightened treatment for your chronic inebriate population, then we need proceed no further.

The facts that have been made available to me demonstrate that Atlanta does, indeed, have a very grave problem. Both a Georgia statute and an Atlanta ordinance prohibit public intoxication. In Atlanta, there were 40,811 arrests for drunkenness during 1966, and an additional 6,494 arrests for "drunk and disorderly," making a grand total of 47,305 arrests for intoxication. And this figure would be substantially increased if arrests for other offenses closely related to intoxication, such as vagrancy and loitering, were included.

The recent Report of the President's Commision on Law Enforcement and Administration of Justice, released to the public just last month, has singled out Atlanta and the District of Columbia as the two jurisdictions where chronic inebriate offenders are most harshly persecuted with constant arrest and conviction for public intoxication. On a per capita basis, the District of Columbia seems to have outstripped Atlanta slightly in its zeal to put these men in jail, according to the 1965 statistics used by the President's Commission. As a result of the Easter case, however, Atlanta may by now have taken over from the District of Columbia the dubious distinction of being the Nation's leading exponent of the theory that sick men should be arrested and convicted for displaying the symptoms of their illness in public.

During one sample month, November 1966, approximately one-third of the persons arrested for intoxication in Atlanta paid a $15 fine before coming to court. By paying this fine, they avoided the distasteful experience of appearing

in Drunk Court. The remaining two-thirds apparently could not raise $15 and therefore had no choice but to be brought before the Court.

I have made no study of the Atlanta drunkenness offenders, and therefore can only extrapolate from national data and rely upon local data obtained from your State officials. But a national survey conducted during the past two years has indicated that between 90% and 95% of the drunkenness offenders who are not able to pay a fine upon arrest, and who therefore are forced to appear in Drunk Court, have very serious drinking problems. As I shall describe later, these statistics have been confirmed with a vengeance in our District of Columbia Drunk Court during the past 12 months. And I would imagine that the situation is no different in Atlanta.

In a study conducted by Emory University during 1962 and 1963, it was found that 6,000 chronic alcoholics accounted for 30,000 arrests. More recently, the Emory staff has concluded that Atlanta has a population of up to 12,000 individual chronic inebriate offenders. Whether the correct figure is 6,000 or 12,000, or somewhere between, it is readily apparent that the problem is staggering. It could be dismissed only by assuming what the President's Commission on Crime in the District of Columbia has described as "a callous disregard for human life." And it can be attacked only by what that Commission has characterized as "a determination for the first time to grapple with the deep-seated disabilities of the City's derelicts."

Now let us look at the kind of help given to these people by the City of Atlanta. Again, I rely upon information that has been furnished to me.

It is my understanding that, as a result of the first Emory study, a comprehensive plan to attack the problem of the chronic inebriate offender in Atlanta was drawn up. Although bits and snatches have been implemented, it has basically gone unheeded.

Drunken derelicts who are arrested receive no routine medical treatment, and are taken to Grady Memorial Hospital only if they exhibit a serious medical problem. Nor is medical help or rehabilitation services available at the Stockade, where they are sent after conviction.

Paradoxically, Atlanta has a reputation throughout the country of progressive treatment for alcohlics. The Georgian Clinic is frequently cited for its work -- but I was distressed to learn just a few days ago that it has only 50 beds, and is expected to serve not just Atlanta, but the entire State of Georgia. The Emory University Alcohol Project has also been receiving nation-wide attention -- but, again, I was distressed to learn that its patients apparently come only from prison, not from the streets, and only for vocational rehabilitation, not for general treatment for their alcoholism.

Finally, your State Legislature has enacted a statute for the rehabilitation of alcoholics. But a perusal of that statute readily demonstrates that it is far more punitive than any criminal statute could be. Upon determination that an individual is a chronic alcoholic who is in need of hospitalization, and upon agreement by the Department of Health to admit the individual as a patient, that man can be held against his will for an indeterminate length of time. There is not even a requirement that the court find that he is dangerous to the public safety, or that the Department of Health has adequate and appropriate treatment programs and facilities for him. Ant it is readily apparent that in Atlanta and the State of Georgia today, there is no adequate and appropriate treatment program or facilities for derelict alcoholics.

Thus, there is no question but that Atlanta and the State of Georgia do have a problem. There is good reason for all of you to come here today to consider this matter.

II

The problem of public drunkenness has been with us for centuries. Under early English common law, public intoxication was not considered criminal activity. Drunkenness was considered entirely proper unless it resulted in an illegal breach of the peace.

Mere public intoxication was first made a criminal offense by an English statute in 1606. And, today, it remains a criminal offense, with varying penalties, in virtually every part of the United States.

We need not trace, today, the history of the criminal law as it has applied to alcoholism from 1606 to the present. Suffice it to say that the early courts concluded that, because alcoholism is a voluntarily-acquired disease, an alcoholic's drinking must be deemed to be voluntary as a matter of law. And since it is a well-established legal principle that an individual is responsible for all of his voluntary acts, alcoholics have been held criminally liable for their public intoxication, and any anti-social behavior it has caused, down through the years.

The health professions have recognized, of course, that an alcoholic does not drink voluntarily. In 1947, the United States Congress enacted a District of Columbia statute, based upon the best available medical testimony, which explicitly recognized that an alcoholic has lost control over his drinking. In 1956, the American Medical Association officially recognized chronic alcoholism as an illness which should properly be treated by physicians. And in 1966, the courts caught up to the legislatures and to the medical profession.

III

I would like to take a moment to describe the two recent court decisions because of their fundamental importance to the subject we are considering today.

Both cases were based upon the conclusion that chronic alcoholism is now universally accepted as an illness. In Easter v. District of Columbia, the United States Court of Appeals for the District of Columbia Circuit held that because a chronic alcoholic drinks involuntarily, as a result of the disease with which he is afflicted rather than as a result of his own volition, he cannot be branded as a criminal. The Court recognized that public intoxication is only a symptom of the disease of chronic alcoholism, and ruled that common law principles preclude criminal conviction merely for exhibiting a symptom of a disease in public.

In Driver v. Hinnant, the United States Court of Appeals for the Fourth Circuit reached the same result, but on Constitutional grounds. The Fourth Circuit held that to convict a chronic alcoholic for his public intoxication, which is merely the inherent symptom of a serious illness, would violate the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution.

These decisions represent rare unanimity in our Federal courts. A total of 11 judges considered these two cases -- the full en banc court of 8 judges in the Easter case, and a panel of 3 judges in the Driver case. Not one judge dissented from the conclusion that an alcoholic may no longer be convicted for his public intoxication.

It makes no difference whether this result is reached by the Constitutional approach used in the Driver case, or by the common law approach of the Easter case. The conclusion is the same. No longer may the age-old problem of the chronic inebriate be handled by the criminal process. A new method of handling this problem must, under these decisions, be found by our local communities.

The Easter and Driver decisions are not legally binding in the courts of the State of Georgia. But it is just a matter of time before the results of those cases will become applicable here. Unlike public officials in the District of Columbia, you still have a little time to head off a real crisis before it occurs. Georgia has the choice whether to take advantage of the time left before action is forced upon it, or simply to sit back and ignore the problem. I would certainly urge that immediate action be taken, that intelligent long-range plans be formulated, and that the type of chaos that has followed the Easter decision in the District of Columbia thereby be avoided. I will now turn to discuss the planning and the new procedures that should be instituted in Atlanta and the State of Georgia.

IV

No individual, and no single group, can possibly undertake a program to replace the present revolving door handling of indigent inebriates through the courts and jails of Georgia, by a modern program of rehabilitation and public health facilities. It will take a community of effort, among all public officials and all interested private groups, to make a revolutionary program of this kind become meaningful. I will therefore discuss the role that I believe the police, the prosecuting attorneys, the judiciary, and public health personnel should play in undertaking new procedures for handling the chronic court inebriate problem.

In discussing this, I shall rely heavily upon two authoritative reports just recently issued: the Report of the President's Commission on Crime in the District of Columbia, released to the public on January 1 of this year, and the Report of the President's Commission on Law Enforcement and Administration of Justice, released on February 19. I acted as a consultant to both Commissions, and I am happy to state that the Commissions and I were in virtually complete agreement on the recommendations that they should make with regard to the handling of public intoxication by local communities. The two Reports are, in my opinion, essential reading for anyone interested in the chronic court inebriate problem.

A. Let us first examine the police handling of chronic inebriate offenders. In my opinion, it is not a false arrest for a policeman to charge an unknown inebriate with public intoxication, even after the Easter and Driver decisions. The police cannot be required, at their peril, to make a judgment on the street as to whether an intoxicated individual is or is not a chronic alcoholic.

In the case of known alcoholics, however, this problem raises a far more difficult legal issue. To some, the availability of the defense of chronic alcoholism still seems more properly an issue for the courts than for the police. But to a growing number of responsible lawyers, who have watched the District of Columbia police persecute chronic inebriates by daily arrest after the

<u>Easter</u> and <u>Driver</u> decisions, any police detention of a known chronic alcoholic for his public intoxication should be condemned as illegal, as well as unconscionable. This is therefore still an unresolved legal issue.

But more important, the community should not place the police in jeopardy in this way. There is no reason why the police should be burdened with the ignominious task of sweeping chronic inebriates off the public streets. Last September I was called upon to assist a man who had been arrested 38 times for drunkenness in the District of Columbia just since the <u>Easter</u> decision. When you take into consideration the amount of time he spent incarcerated in jail and in various hospitals, this amounted to 1 arrest for every 2 days that he appeared on the public streets. Certainly, the answer to the <u>Easter</u> and <u>Driver</u> decisions is not just to arrest derelict alcoholics every day, duly bring them to trial, and then immediately release them onto the streets without assistance, only to repeat the process over and over again. This succeeds in speeding up the revolving door, and in the persecution and further degradation of chronic inebriates. It cannot contribute to the elimination of these abuses, as the <u>Easter</u> and <u>Driver</u> decisions demand.

In my opinion, the police can and should take two immediate steps to end the revolving door process, pending development of a broader community program which I will discuss later in this talk. First, they should assist any drunken person to his home, whenever that is possible. Second, where an individual is unable to take care of himself, the police should assist him to an appropriate public health facility where he can receive the necessary medical attention. Under no circumstances should they arrest known alcoholics time and time again.

The question arises, of course, whether the police may properly assume responsibility for intoxicated individuals and escort them to an appropriate public health facility to received proper medical attention. If the inebriate does not consent, would the police incur liability for a false arrest?

I have long been of the view that the police have duties of a civil nature, in addition to their responsibility for enforcing the criminal law. When a policeman escorts a heart attack victim to the hospital, he certainly is not arresting him. Thus, in my opinion, the police have not only a right, but indeed a duty, to take unwilling intoxicated citizens, who appear to be unable to take care of themselves, whether or not they are alcoholics, to appropriate public health facilities. Certainly, this question should be resolved immediately preferably by enactment of a state statute, in order to lay the necessary legal foundation for the proper medical handling of alcoholics.

I am confident of one thing about our police personnel. Once new procedures are instituted for handling the chronic court inebriate as a public health problem, the police will be only too happy to cooperate. The police have long suffered under the public's command that they daily sweep this human refuse from the streets, a task which provided no possible benefit for their unfortunate victims. They will be only too happy to see the old system replaced by procedures which will allow them to help these people back on the road to recovery, rather than just push them further down into their sodden Skid Row environment.

B. With regard to the handling of chronic alcoholics by prosecuting attorneys, it is instructive to refer to the Canons of Ethics of the American Bar Association. Canon 5 provides that "the primary duty of the lawyer engaged in public prosecution is not to convict, but to see that justice is done."

This does not mean, of course, that a prosecutor is obligated to defend the man that he is prosecuting. It does mean, however, that he is obligated to make certain that an innocent man is not convicted. And in the context of the Easter and Driver decisions, this means, in my judgment, that a prosecuting attorney is obligated either to drop the charges, or at the very least to inform the judge of the relevant facts, whenever he has reason to believe that a defendant may have available to him the defense of chronic alcoholism. It is then up to the judge to protect the defendant's rights.

A truly responsible prosecutor, moreover, would take it upon himself to review the defendant's record prior to any court proceeding, and to make appropriate recommendations to the court on his own motion. The prosecutor is, after all, an arm of the court and a representative of the community. As such, he cannot properly remain neutral. He should therefore take affirmative steps to make recommendations for the non-criminal handling of any chronic alcoholic he is assigned to prosecute.

Of course, prosecutors are not qualified to diagnose alcoholism. In most instances, however, the defendant's past record will readily demonstrate a drinking problem, and will be quite sufficient to lead a prosecutor to recommend to the court that an appropriate medical examination be made.

The problem, in short, is not to devise ingenious methods by which the prosecutor may responsibly exercise his public duty. Rather, the problem is to educate prosecuting attorneys about alcoholism, and to persuade them to take time from their demanding duties to assist the alcoholics with whom they come in contact in their daily work.

C. Let us now examine the judicial handling of chronic court inebriates. Once a judge becomes aware, through any information, of any kind, from any source, that a defendant charged with public intoxication may have available to him the defense of chronic alcoholism, he is, in my opinion, clearly obligated to make certain that the defense is adequately presented. Cases in the District of Columbia, involving the analogous defense of mental illness, hold that even if the defendent protests, the judge is required to inject the defense into the case on his own motion, to make certain that an innocent man is not convicted. Failure to do so is reversible error, as an abuse of the judge's discretion. And a decision handed down by the United States Supreme Court in March of last year is wholly consistent with this position. There is no reason why these precedents dealing with the insanity defense should not be equally applicable to the defense of chronic alcoholism. The D.C. Crime Commission concluded that they are applicable and that they compel the trial judge sua sponte to protect the alcoholic defendent's legal rights.

This means, of course, increased responsibility for the judiciary. Under the Easter and Driver decisions, each trial judge is obligated to take affirmative action to bring to an immediate end the traditional "revolving door" handling of the chronic court inebriate in his court. No judge, in my opinion, may properly remain neutral, simply waiting for a defendant to raise the defense of alcoholism.

I have already mentioned recent information which suggest that, throughout the country, approximately 90-95% of the drunkenness offenders who appear before the courts have serious drinking problems. In my judgment, this statistic in itself places upon trial judges an obligation to inquire into the possibility of the defense of chronic alsoholism for virtually every drunkenness offender who appears in the courts. A failure to undertake this inquiry amounts, in my view, to a derogation of judicial responsibility.

Some will contend that, because the Easter and Driver decisions are not binding upon the courts of Georgia, it is neither permissible nor desirable for local judges to apply these decisions in their own courts, even though they may believe them to be a proper statement of law. Some trial judges believe that, until an appellate decision is handed down in their jurisdiction, they are compelled to follow the old view of the law even though they disagree with that view. In my opinion, this is an erroneous concept of a trial judge's responsibility to the community.

A trial judge has an obligation, usually stated in his oath of office, to uphold the Federal and State constitutions. That obligation is far deeper, and far more important, than the principle of stare decisis. If a trial judge is convinced that the Easter and Driver decisions are correct statements of the law, he is in my opinion obligated to implement them in his own court without waiting for an appellate court to order him to do so. A municipal court judge in California recently took it upon himself to declare the local intoxication law unconstitutional, as applied to a chronic alcoholic, and I have not heard it seriously suggested that he overstepped his judicial authority.

The second way in which local judges have avoided applying these decisions is by refusing to raise the defense of alcoholism on their own motion. It requires little imagination to realize that the average Skid Row derelict does not read the Federal Reports, much less the newspapers, and has absolutely no knowledge whatever about his legal rights. Even if he did understand, in some vague way, that he might have a defense to the charge of intoxication, he probably could not begin to understand the ramifications of raising that defense. And of course, none of these derelicts are represented by counsel. Thus, unless the trial judge assumes the obligation of protecting this man's rights, those rights never will be protected.

In those areas where the judges have not raised the defense of alcoholism on their own motion, it has only very seldom been raised by the defendants. Joe Driver, himself, has been convicted for public intoxication in Durham on more than one occasion after the Fourth Circuit handed down the decision which bears his name. I find this perversion of law enforcement intolerable.

Many of the judges who have chosen not to follow the Easter and Driver decisions have done so because of a sincere conviction that it would be more inhumane to throw derelict alcoholics back out into the streets, to an uncertain fate, than it would be to throw them into jail, where they will at least be cared for. I have no quarrel with the sincerity and humanity of these judges. But I firmly believe that what passes for humanity in the short run becomes the worst form of cruel and unusual punishment in the long run.

Acquiescence in the criminal handling of alcoholics virtually precludes ever breaking out of the revolving door method of handling alcoholics in our courts. To the extent that the judiciary and the local Bar permits the community to handle derelict alcoholics as criminals, the community may have little or no incentive to change that procedure. Edmond Burke once said that "All that is required for the triumph of evil is that good men remain silent and do nothing." If the good men in the judiciary and the Bar remain silent and do nothing, the Easter and Driver decisions could go down in Georgia history as a theoretically intriguing, but practically meaningless, judicial aberration. And the evil of handling alcoholics as criminals could be perpetuated in this State.

One example of what a vigorous and conscientious local court can accomplish may be seen in the activities of the District of Columbia Court of General Sessions since the Easter decision was handed down on March 31 of last year. A majority of the judges in that Court concluded that they are obligated to raise the defense of alcoholism sua sponte for virtually all of the defendants who apeear in the Drunk Court charged with public intoxication. As of March 9, 1967, 4,382 individuals had been adjudged chronic alcoholics, and therefore can never again be convicted of public intoxication in the District of Columbia. And I would estimate that only a handful of those 4,382 individuals raised the Easter defense by themselves. In virtually all cases, the trial judge raised the issue on his own motion and referred the defendant to a court psychiatrist for diagnosis.

The response of the District of Columbia Government to the Easter decision had initially been one of disinterest and disinclination to act. Our Court, by making it clear that the decision would be implemented vigorously, soon forced public officials to abandon this posture of indifference.

These public officials then attempted to put into operation wholly inadequate procedures which, in effect, would have done no more than change the sign over our local Workhouse to read "Hospital" rather than "Jail." Again, our courts responded by refusing to commit any adjudicated alcoholics to this new so-called health facility, when testimony proved that adequate treatment for alcoholics was not available there. As a result, comprehensive treatment programs and modern facilities are now coming into being. These programs and facilities could not have been made possible were it not for the courage and sense of community responsibility of our local judges. This was judicial integrity at its pinnacle. Our community, and judges throughout the country, can take great pride in these men.

Some of you might think that the press and the citizens' groups in the District of Columbia would have heaped abuse upon our judiciary for releasing this tremendous number of derelict alcoholics upon the community. These derelicts certainly did not present a pleasing sight to the eye, and some undoubtedly died who might have lived had they been sent to jail. But the public did not blame the judiciary. Just the opposite was true. Our judges have been publicly praised for refusing to continue to punish intoxicated alcoholics, in spite of the community problems this has raised. But the public press, citizens' groups, the Bar Association, and the President's Crime Commission, have severely criticized the District of Columbia officials who have failed to provide public health facilities for derelict alcoholics. And I believe that the same attitude would prevail in any community in the United States in which the judiciary and the Bar similarly had the courage to lead the way to new, more humane procedures for the handling of its chronic inebriate population.

D. Correctional officials should have little or no responsibility for the treatment of chronic alcoholics. If the prosecuting attorneys and the judiciary adequately perform their functions, chronic alcoholics will no longer populate our prisons, as they currently do. And it is quite clear that a prison setting is hardly the atmosphere in which to attempt to persuade a chronic inebriate offender to change his ways.

There will remain in our prisons, nevertheless, some who have been properly convicted of more serious crimes, who have a drinking problem unrelated to those crimes. It would obviously be wise for public health personnel to suggest to correctional officials that some form of appropriate treatment be provided for these people while they are still in jail, in order to head off future alcoholism problems.

E. The primary responsibility for developing practical programs for helping our chronic inebriate population necessarily rests, however, with professional public health personnel: doctors, nurses, social workers, and others working in the area of alcoholic rehabilitation. A judge can find an alcoholic not guilty of a given crime with which he is charged, but he cannot develop an effective rehabilitation program, nor can he order state or federal health officials to build facilities and develop adequate programs. A prosecutor can, similarly, only exercise his discretion to prosecute or to drop charges. And lawyers can defend chronic alcoholics charged with crime but cannot offer them the treatment necessary to prevent similar court appearances day after day after day. In the last analysis, therefore, we must all rely upon public health personnel to initiate changes in the present procedures.

They will readily find that when new procedures for handling chronic inebriates are presented, the police, the courts, and local attorneys will offer their full cooperation. But the point that concerns me most, I must admit, is that up to now the health professions have not greeted the Easter and Driver decisions with the sense of challenge and responsibility that I had hoped for. Now is the time for them to step forward with imagination and dedication to present new procedures for handling inebriates, new treatment programs designed to rehabilitate alcoholics, and new legislative proposals to develop an appropriate legal structure under which these new objectives may be properly pursued. Unless this happens in the State of Georgia, the opportunity afforded by the Easter and Driver decisions may be wasted, and the efforts that have been made to adopt an enlightened legal approach toward the chronic inebriate offender may be in vain.

One would hope that these new procedures will come voluntarily from the health professions. If they do not, however, then all law enforcement personnel in the State -- the police, the prosecutors, the judiciary, and the local Bar -- should take every step possible to force these new programs into existence. The legal profession has long assumed the duty of a public protector of the rights and liberties of all citizens. We must be as zealous in protecting the rights of our derelict population as we are in protecting the rights of those citizens who are more fortunate in life. I have already described what we have accomplished in the District of Columbia in just one year. Comparable humane results can be obtained in Atlanta.

In an article that appeared in the Atlanta Constitution on March 1 of this year, a representative of the Atlanta Area Community Council was reported to be pleading for time, and to be making efforts to forestall legal action in Atlanta that would push for adoption of the Easter and Driver decisions as binding law in Georgia. I most sincerely hope that there is no delay here, and that plans for a test case move ahead rapidly. Such a case would be a necessary catalyst to speed up the reforms that are so badly needed in Atlanta's handling of its chronic inebriates.

Of course, police and lawyers are not competent to decide exactly what type of non-criminal public health procedures are most likely to result in rehabilitation of chronic inebriates. But we are competent, and we do have the duty, to make certain that the present criminal procedures are not continued. The public cannot be expected to respect a system of criminal justice that condemns sick people to jail because they are sick. We need drastic changes in the handling of chronic inebriates in our local courts, and the legal profession has the power and the duty to make those changes.

V

Because of my interest in this problem, I have discussed with a number of public health authorities the type of new procedures that might be adopted for handling chronic inebriates. I will now outline, for your consideration, my own conclusions, and those of the two Crime Commissions appointed by the President, about appropriate new procedures.

For purposes of my analysis, I separate what we might refer to as the derelict, or Skid Row, or homeless inebriates, on the one hand, from the inebriates who do have homes, families, and personal resources upon which they can rely. Although the derelict inebriates represent a relatively small proportion of the total alcoholic population -- ranging from 3 to 15 per cent, depending upon the statistics on which you choose to rely -- they obviously represent the vast bulk of the chronic inebriate problem in our courts and jails.

I would begin by suggesting, as I already have above, that any inebriate who has a home and family to take care of him should be escorted promptly to that home by the police, rather than arrested. Of course, if it appears to the policeman that the inebriate is in medical danger, he should either be taken directly to a medical facility or his family should be informed that medical help would appear to be required.

Perhaps at some future time, when we have completely solved the problem of handling drunken derelicts, we will be able to provide public facilities and programs also for inebriates who are not direct public charges. But at this time, when we cannot even begin to handle our drunken derelict population, I see no reason why we should also attempt to take charge of those who do have resources of their own, beyond making certain that they do get back home safely.

Thus, I would concentrate ourpublic resources almost completely upon the chronic inebriate derelict. And my initial suggestion is that the old criminal method of handling this population should be discarded and replaced by civil procedures. This should be done, in my opinion, regardless whether all or only part of the derelict inebriates found on the streets may have available to them the defense of chronic alcoholism provided by the Easter and Driver decisions.

Let us examine for a moment whether there is any valid public policy reason why a legislature should brand an intoxicated person who is causing no public disturbance as a criminal. We must face reality. The public intoxication laws in the District of Columbia never have been, and never will be, enforced uniformly upon the public as a whole. And I doubt that the situation in Atlanta is different. Police do not pick up intoxicated party-goers emerging from elegant dinner parties or our suburban country clubs. I will not be the first to point out that there are as many intoxicated people on the streets of the exclusive residential areas of our cities as there are in the Skid Row areas, and you will not be surprised that very few of the prosperous drunks are arrested. Public intoxication statutes are enforced against the poor, and in particular, the homeless man.

Should we as a civilized nation enact criminal laws aimed solely at a very small, virtually defenseless, esthetically unacceptable segment of our population, with the intent of simply sweeping them off the street and into oblivion? In my opinion, the public intoxication statutes now on the books have no redeeming social purpose, regardless of the issue of alcoholism, and they should not be retained. Even worse, by substituting criminal sanctions for public health measures, these statutes preclude the use of preventive techniques to head off

incipient alcoholism problems. Disorderly conduct statutes are quite sufficient to protect the public from harm and these statutes should both be retained and fully enforced.

The two Crime Commissions appointed by the President have, for these reasons, recommended that the present public intoxication statute be amended to require disorderly conduct in addition to drunkenness. And the President's Commission on Crime in the District of Columbia has explicitly recognized that the usual manifestations of drunkenness, such as staggering, or falling down, or noisiness, do not constitute any threat of harm to the public, and should not be considered illegal disorderly conduct.

What, then, should be done with derelict inebriates found intoxicated on the streets? I would suggest a three-part program.

First, an inebriate who, in the judgment of the police or authorized public health personnel, is unable to take care of himself, should be brought to a detoxification center that is staffed with public health personnel, to receive whatever medical help for his acute intoxication may be necessary. This should be a voluntary facility. The individual might be required to remain there for some specified period of time in order to make certain that he will again be able to take care of himself when he leaves. But he will not have been arrested, and could not be detained for a longer period against his will.

Second, those inebriates who have a drinking problem will be encouraged to remain for a longer period of time in an in-patient diagnostic center, where a complete work-up can be prepared on his medical, social, occupational, family, and other personal history. In my view, this should also be a completely voluntary facility. A genuine offer of meaningful assistance should be the only inducement used to persuade an inebriate to make use of it. And I might add that, never before in our history, has <u>any</u> community reached out to these unfortunate people with such an offer.

Third, a network of after-care facilities should be established to provide food, shelter, clothing, vocational rehabilitation, and appropriate treatment, rather than simply dumping the derelict back onto Skid Row. Perhaps the most important aspect of this part of the program would be residential facilities, to provide an entirely new atmosphere that will, hopefully, reverse the process of degradation that has gradually forced the derelicts down to their present position. As with the other facilities, these should, in my judgment, be entirely voluntary.

I would like to emphasize that a new program of this nature should not, in my opinion, contain a long-term residential in-patient treatment facility of the type now used to house the mentally ill. I would oppose any such facility on both medical and legal grounds.

First, the public health authorities with whom I have conferred have convinced me that long-term involuntary commitment to a residential facility makes effective treatment for alcoholism more difficult. From their viewpoint, incarceration in a health facility has the same degrading effect on the derelicts as incarceration in jail. Both rob the inebriate of any willingness to attempt to find his way out of his present situation in life, and make him more passively dependent upon institutionalization. Those who are currently running programs inform me that voluntary out-patient care, when supported by residential facilities, has been highly successful. If the community will only reach out to the derelict alcoholic with adequate and appropriate help, he will respond. Once the crutch of jail is removed, derelict inebriates voluntarily ask for assistance with their problems.

My second reason for opposing involuntary commitment procedures is on constitutional grounds. We can all agree, I believe, that the derelict inebriate poses no threat of actual harm to society. And he poses no greater threat of harm to himself than do airplane test pilots, epileptics, mountain climbers, cigarette smokers, Indianapolis Speedway drivers, and any number of people who may refuse medical assistance for their non-communicable illnesses. None of these people are involuntarily committed to institutions, nor could they be. I therefore see no constitutional basis for depriving chronic alcoholics of their freedom against their will.

The type of program that I have outlined is not a Utopian dream. It has been recommended by both Presidential Crime Commissions. And although there was some dispute among the 28 members of these two Commissions, there was no dispute whatever on these recommendations. In his February 6th message to Congress on Crime in America, President Johnson specifically singeld out these recommendations for public attention. And Congressman Elliott Hagan of Georgia has now introduced a bill in the House of Representatives, H.R. 6143, that would adopt this approach for the District of Columbia. It is, therefore, an entirely realistic and practical objective, and not just an idealistic hope.

Of course, a program of the type that I outline will not eliminate the problem of the chronic inebriate. There will undoubtedly be a significant number of hard-core inebriates who will not change their ways regardless of what type of treatment program is offered voluntarily or forced involuntarily upon them. We must, therefore, forthrightly face the question of what should be done with them.

Since we can no longer handle them as criminals, as a result of the Easter and Driver decisions, we are left with two choices. We can either warehouse them forever on some type of an alcoholic farm, or we can process them through the type of program I have described above. In my judgment, it would be unwise to institute a warehousing system. Those who are close to the treatment of alcoholics tell me that they are not willing ever to write off the possibility of helping even the most hard-core chronic alcoholic. They cannot determine ahead of time who can be helped, or how long it will take. In their judgment, warehousing of alcoholics, regardless of how incalcitrant they may seem, is not medically warranted. And a warehousing operation is, in my opinion, clearly indefensible from a constitutional viewpoint.

The President's Commission on Crime in the District of Columbia squarely faced this problem, and came to the following conclusion:

> "For these unfortunate people, humanity demands that we stop treating them as criminals and provide voluntary supportive services and residential facilities so that they can survive in a decent manner."

This would require, of course, a complete overhaul of the present civil commitment system in the State of Georgia. And it should, in my opinion, begin immediately.

VI

The alcoholism movement has too long suffered, I believe, from a defeatist attitude. In the District of Columbia we have shown not only that the public will accept the Easter decision, but also that it will not tolerate a Government that refuses to help derelict alcoholics.

Today, in Atlanta, you are taking a major step forward. But a conference like this one is just the beginning. What we need now are man-to-man confrontations among public officials, without fanfare or publicity, in which practical solutions to pressing problems are worked out on a sensible basis.

If I have one message to leave with you today, I would urge you to start the job immediately.

Talk Presented By Peter Barton Hutt To The Atlanta Bar Association,

Atlanta, Georgia, March 16, 1967.

June 4, 1969

Mr. Raphael B. Levine, Director
Comprehensive Area Wide Health Planning
Community Council of the Atlanta Area, Inc.
1000 Glenn Building
120 Marietta Street, N. W.
Atlanta, Georgia 30303

Dear Dr. Levine:

Thank you for your letter outlining the organization and function of the Metropolitan Atlanta Council for Health.

As you know, the Fulton County Department of Health is the official agency for health matters affecting the City of Atlanta and, normally, programs involving health and health planning would be the responsibility of the County Health Department as far as the City of Atlanta is concerned. I understand, however, that the Comprehensive Area-wide Health Planning Program which will be carried on by the new Metropolitan Atlanta Council for Health will involve area responsibility for developing policy and all the broad aspects of health including environmental sanitation, water pollution, etc.

Since the City of Atlanta does have major responsibility for production and distribution of potable water and for collection and disposal of solid waste and also sewage treatment and disposal, I can understand why the City of Atlanta should have a representative on the Health Council. Since both the Sanitation Division and the Water Pollution Control Division fall within the area of responsibility of the Public Works Committee of the Board of Aldermen, I am asking Alderman G. Everett Millican, Chairman of this Committee, to represent the City on the Council.

Sincerely yours,

Ivan Allen, Jr.
Mayor

Council of Greater Atlanta

October 22, 1969

Mr. R.H. Phillips
President
Council of Greater Atlanta, Inc.
151 Spring Street, N.W.
Atlanta, Georgia 30303

Dear Bob:

Please excuse me from making any decisions concerning additional responsibilities at this time.

I will be glad to discuss the matter of the Council with you after the first of the year.

Gratefully,

Ivan Allen, Jr.
Mayor

IAJr:ja

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Mr. Richard Dolson
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Mr. Jerry Fields
Mr. Hilton Fuller
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Mr. R. Ellis Godshall
Dr. Marvin Goldstein
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Mr. C. D. LeBey
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Mr. Martin Libowsky
Mr. Seymour W. Liebmann
Mr. E. A. McGuire
Mr. Robert Martin
Mr. W. R. Massengale
Dr. Harmon D. Moore
Judge Sam Phillip McKenzie
Brig. Alfred J. Osborne
Mrs. Louis Regenstein, Jr.
Rev. James Scherer
Mr. Michael Sertich
Mr. L. M. Shadgett
Mr. Donally Smith
Dr. Horace Tate
Mr. Lyndon Wade
Mr. William Waronker
Mr. J. R. Wilson, Jr.
Mrs. P. Q. Yancey

Advisory Council
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Mr. James Dodd
Dr. Harry A. Fifield
Mr. William Frankel
Mr. Ralph H. Garrard
Gen. Alvan C. Gillem, ret.
Dr. William S. Jackson
Mr. Irving K. Kaler
Mr. Hugh Mercer
Rabbi Jacob Rothschild
Mr. C. L. Sneed
Gen. (Lt.) John L. Throckmorton
Mr. T. Clack Tucker
Mr. Robert B. Wallace, Jr.
Mr. Horace T. Ward

Executive Director
Lloyd R. Hoon

October 17, 1969

The Honorable Ivan Allen, Junior
Mayor of Atlanta
City Hall
Atlanta, Georgia 30303

Dear Mayor Allen:

As you know, you are the Honorary President of our Council. We regret your departure from the office of Mayor, but recognize and congratulate you for your wonderful accomplishments and contributions to this city as its Mayor.

We would hope your departure from that office might be our gain as we would like very much to have you as a member of the Council for 1970. The Council meets at a simple lunch four times a year with a good deal of the work done behind the scenes by key people and committees. We would be honored to have you as a member of our Council. We have some very enthusiastic people supporting it. Incidentally, Blanche Theabom is just joining us and will be a new member for next year. We are trying to make our Council more representative of major and important segments of our community.

Won't you let us have your acceptance? Again, thanks for the great job you have done for a great city.

Cordially yours,

Bob

R. H. Phillips, President

Copy to Mr. Lloyd R. Hoon

USO MEMBER AGENCIES
THE YOUNG MEN'S CHRISTIAN ASSOCIATION • THE NATIONAL CATHOLIC COMMUNITY SERVICE • THE NATIONAL JEWISH WELFARE BOARD
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RALPH WILLIAMS
1903-1960

TELEPHONE 522-2508
AREA CODE 404

January 20, 1970

Honorable Sam Massell
Mayor, City of Atlanta
68 Mitchell Street, S. W.
Atlanta, Georgia 30303

Dear Mayor Massell:

It gives me genuine pleasure to enclose a courtesy copy of the 1969 Directory of Community Services published by the Community Council of the Atlanta Area, Inc. We have been very pleased with the reception given this publication and trust that it will be of value to you.

Yesterday I chatted briefly with Dan Sweat about our community center in the hippie district and the work the Council is doing in the area of alcohol and drug abuse. A council was formed a short time ago composed of organizations concerned with the problem of alcohol and drug abuse. Because of the tremendous interest in this area, I understand that now approximately 150 organizations have expressed a desire to work through some sort of council. The Community Council has been providing staff assistance and guidance to the project. I told Dan that we would get up a summary of what has been done and the present proposed plan for continued coordinated effort on this problem.

I am aware of the many critical problems with which you are now concerned and I told Dan that we would be glad to sit down with both of you and discuss some of our activities at your convenience.

Best personal regards.

Sincerely,

Eugene T. Branch

ETB:js
Enclosure

cc: Mr. Dan Sweat

Community
Council of the
Atlanta
Area inc.

EUGENE T. BRANCH, Chairman
ELLIOTT GOLDSTEIN, Vice Chairman
A. B. PADGETT, Vice Chairman
MRS. THOMAS H. GIBSON, Secretary
RALPH A. BECK, Treasurer

DUANE W. BECK, Executive Director

ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE 577-2250

January 8, 1970

Mr. Dan E. Sweat, Jr.
Chief Administrator
Office of the Mayor
City Hall
Atlanta, Georgia 30303

Dear Mr. Sweat:

The Interagency Council on Alcohol and Drugs is composed of 150 public and private agency and organization representatives who are concerned and interested in the problem of alcoholism and drug abuse. It is chaired by Dr. James L. Goddard whose background in Public Health and Pure Foods and Drugs has lent immeasurable support and knowledge to the Council. The Interagency Council was established to carry on a program of education, coordinate existing services and stimulate the development of new ones.

At present there is a tremendous amount of public interest in drug abuse and many groups are eager to do something about it. There are now 4 proposals for Drug Treatment Centers which the Interagency Council is evaluating in order to make recommendations for implementation. These plans all require support from the city administration. Since the Council is composed of and has access to most of the drug specialists in the area the judgments it makes should be valid and objective. We will be glad to supply you with our findings and act as a clearing house for all drug treatment proposals. In this way we can be sure that the city gets the best kind of services and the kind it really needs.

Sincerely,

Duane W. Beck

Duane W. Beck
Executive Director

Copy to: Clarence L. Greene
Office of the Mayor

DWB:cfh

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Community Council of the Atlanta Area inc.

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ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE 577-2250

Sch 1/29

19 January, 1970

TO: Members of the Metropolitan Atlanta Council for Health

FROM: A. B. Padgett, Chairman pro tem

SUBJ: Meeting Notice

The annual meeting of MACHealth will be held 29 January 1970. Place of the meeting will be Room 409, 101 Marietta Street Building. Time will be 12:00 Noon.

Principal business of the meeting will be the election of officers for the year 1970. Persons elected will serve until the next annual meeting in January, 1971, or until their successors are qualified. Enclosed with this meeting notice is the report of the Nominating Committee. Persons have been nominated for each of the seven offices, and for a replacement on the Nominating Committee in case Dr. Wells is elected president. (The president serves, ex officio, on the Nominating Committee.)

The second page of the Nominating Committee report indicates the distribution of one-, two-, and three-year terms for persent members of the Council. This is to insure that one-third of the elected members of the Council are elected each year in the future. The selection for length of term was done by drawing numbers out of a hat, but assuring that specific groups (such as medical society members, health providers as a whole group, etc.) have a reasonable distribution of 1-, 2-, and 3-year terms.

With the possible exception of our first meeting last June, this is likely to be the most important meeting of MACHealth's history. Your attendance is urgently requested. If you cannot make it, be sure your alternate attends!

A. B. Padgett

A. B. Padgett, Chairman pro tem

ABP/RBL/la

P. S. I regret to have to tell you that, because of budgetary problems, we will be unable to hold our "getting to know you" meeting on 7 February. We shall try to schedule it for March.

ABP

REPORT OF THE NOMINATING COMMITTEE - JANUARY 1970

The Nominating Committee, consisting of Hon. L. H. Atherton, Rev. E. B. Broughton, Mr. A. B. Padgett, and Dr. R. E. Wells, present the following slate for consideration of the Metropolitan Atlanta Council for Health:

For President:	Dr. Robert E. Wells
For Vice President Council Function:	Mr. Lyndon A. Wade
For Vice President Liaison & PR:	Hon. Thomas M. Callaway, Jr.*
For Vice President Special Needs:	Rev. Ervin B. Broughton
For Vice President Project Review:	Dr. Luther Fortson
For Vice President Administration:	Mr. Gary Cutini
For Secretary:	Mrs. Loretta Barnes

*Has not signified acceptance of the nomination as of 19 January 1970.

MUNICIPALITIES	Clayton	Cobb	DeKalb	Douglas	Fulton	Gwinnett	Wh.	Non-Wh.	Attend.	1	2	3	
- Marietta		x									X		
Breen - Decatur			x									X	
- Forest Park					x					X			
PROVIDERS													
Fortson - Cobb Med		x					x				X		
McLendon - Atl. Med.					x			x			x		
Vinton - Dekalb Med			x				x			x			
Wells - Fulton Med					x		x					x	
Miller - Ga. Psychiat.		X					x		N	X			H
Gulley - No. Ga. Dent					x			x			x		
Hamby - No. Dist. Dent					x		x			x			
Cantrell - Fulton P.H.D.					x		x					x	
Vinson - DeKalb P.H.D.			x				x				x		
Burge - Atl. Hosp. Dist					x		x				X		
Pinkston - Grady Hosp					x		x					x	
Richardson - Emory Med Sch			x				x		N	x			
Lane - Ga. State H. Sci.					x		x					x	
Lott - 5th Dist Nurs					x		x					x	H
Beck - Ga. Heart Assoc					x		x					x	
McFall - Am. Soc. H. Assocs					x		x			x			
Wade - Nat Assoc Soc Work					x			x			x		H
Jockers - Med. Tech. Soc					x		x				x		H
Robinson - Grady (semi-skil)					x			x		x			H
Cutini - Health Ins.			x				x				x		H
POOR & NEAR POOR													
Gardner - Atl EOA					x			x		x			
Freeman - Atl EOA					x			x	new		x		
Mooney - Atl EOA					x		x					x	
Glenn - Clayton EOA	x							x			x		
Souder - Clayton EOA	x							x		x			
Sanders-DeKalb-Rockdale EOA			x					x	new			x	H
Broughton - Gwinnett EOA						x		x		x			H
Johnson - MOdel Cities					x		x					x	
Lovett - Model Cities					x			x		x			
Cofer - Grant Park PTA					x		x				x		H
Hawthorne PTA		x							N	x			H
Griffin - So. Douglas PTA				x			x					x	H
Mathews - Nat. Welf Rights					x			x	N		x		H
Barnes - Southside Comp H.					x			x			x		H
Griggs - Tenants United FF					x			x				x	H
Marshall - Atl NAACP					x			x		x			H
Kimpson - Atl Urban League					x			x				x	H
BUSINESS & LABOR													
Fuller - Atl. C of C of C's					x		x			X			
Wright - Atl Labor Counc					x		x					x	

Community Council of the Atlanta Area inc.

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EUGENE T. BRANCH, Chairman of the Board of Directors
DUANE W. BECK, Executive Director ALENE F. UHRY, Editor

1000 GLENN BUILDING, 120 MARIETTA STREET, N.W. ATLANTA, GEORGIA 30303 TELEPHONE 577-2250

January, 1970

SPECIAL EDITION

LOOKING AHEAD

Eugene Branch, Chairman of the Community Council's Board of Directors, has carefully reviewed our activities of the year just ended, and now looks ahead to 1970.

We believe Communique readers will be interested in the following program Mr. Branch envisions:

The beginning of a new year is a good time for an organization to pause long enough to consider where it is in the achievement of its goals and where it is going.

Since others are due the credit, I think it not immodest of me to say that I believe the Council did a good job in 1969. However, rather than dwell on the 1969 activities, it would seem more helpful to mention some of the activities which will be given priority in 1970. In addition to the normal and on-going activities of the Social Research Center and Permanent Conference, the following illustrate the activities which will be given emphasis in 1970:

1. Community Coordinated Child Care (4-C)

The 4-C program is a federal program designed to develop a coordinated program to provide services to children--and thus make better use of the community's funds and resources in providing such services. Atlanta was named a pilot community and the Council was named the delegate agency. A Steering Committee composed of parents, representatives of day care agencies and organizations has been elected and is at work. Much of our staff time will be devoted to this activity. This is an outgrowth of our Child Development Project.

2. Day Care Action Subcommittee

The very fine work of this Subcommittee will be continued in 1970. Its function is to stimulate interest in day care and help develop new day care resources. In 1969 the Subcommittee published a Day Care Manual which provides a step-by-step guide to those interested in planning and developing a day care center. The response has been so enthusiastic that we are swamped with requests by church groups and others for technical assistance. This important activity also arose out of our Child Development Project.

3. Coordination of Services and Planning

One of the most important on-going activities of the Council is that of bringing together planning and service agencies in an effort to provide coordination of planning and services. The existing funds and resources for dealing with our urgent urban problems are extremely limited and all agencies have an obligation to jointly plan and coordinate their activities in dealing with the problems which are their major ooncern. Space does not permit an adequate description of the Council's work activities in coordination but periodic reports will be given in Communique.

4. Emergency Assistance

Every effort to identify the most urgent problems in our five-county area has resulted in high priority being given to the need for developing more resources for emergency assistance. There are many aspects of the problem. An Emergency Assistance Committee has been organized and has begun to function. It has determined to work first on developing resources to deal with the problems arising out of evictions. Hundreds of families are evicted each year and there is no organized program to help the evicted families with such needs as storage space for furniture, temporary shelter, food etc.

5. Other Special Activities

(a) Welfare Committee. Practically everyone agrees that our entire welfare program must be overhauled. A Welfare Committee is studying various income maintenance programs, including the Administration's Family Assistance Act, and will make periodic reports.

(b) Advisory Committee for Information and Referral. This Committee was formed to assist in the improvement of information and referral service in the metropolitan Atlanta area and to devise means for improving services to meet the most urgent needs identified by such service. Among other things, this Committee will help focus attention on the most serious unmet needs in our area.

(c) Fourteenth Street Multi-Purpose Center. The Council has leased a house on Juniper Street to be used as a community center for the Fourteenth Street area. It is functioning and has been well-received. The focus will be on a voluntary medical clinic, a counseling center and a twenty-four hour information and referral service. This facility is being operated at the present time entirely by volunteers. The Center can meet a great need and we'll keep you up to date on its activities in Communique.

(d) Interagency Council on Alcohol and Drugs. This Council is simply a "coming together" of established agencies concerned with problems related to the use of alcohol and drugs. It provides a means by which such agencies can work together. The Council has divided itself into the following five Task Forces: Resources and Existing Facilities and Services, Education, Treatment and Counseling, Speakers Bureau, and Legal Aspects and Legislation. You've received some information on this important and interesting activity and more will be forthcoming.

(e) Expanded Public Information Service. We have improved our methods of getting valuable information to the general public and will give greater emphasis to this activity. The information gathered by our Research Center and through our various programs, if properly and attractively passed on to the general public, will provide our area with a better informed citizenry. This greater understanding of our problems will in time result in an improvement in services and funds to meet the problems.

The above are simply illustrative of the variety of activities in which the Council is engaged. The Child Development Project revealed the need for further work on such problems as retardation of children, the need for twenty-four hour child care, learning difficulties etc.

Volunteer Atlanta

The Council is a sponsor of Volunteer Atlanta and will continue to assist this project. As you may recall, Volunteer Atlanta was brought about largely by the Council and is sponsored by the Council, the Atlanta Chamber of Commerce, the Atlanta Junior League, the Community Chest, and E.O.A. Its object is to recruit, train and place volunteers in public and private agencies throughout the five-county area. We think this can be one of the most important projects begun in the Atlanta area during recent years.

Assistance to Groups

The Council is receiving an ever increasing number of requests for technical assistance from agencies, neighborhood groups, and civic organizations. Agencies are requesting assistance in reviewing their programs; neighborhoods are seeking assistance in the drafting of proposals for resident-determined programs; and civic organizations are asking for suggestions as to the type of programs in which they might be effectively involved Thus, technical assistance to neighborhood groups and direct service agencies is becoming a major role of the Council. We think this role should be emphasized and that means must be devised to adequately provide such assistance. The Council is basically a collection of staff, accumulated information and experience, and skill, and whenever its assistance can make agencies, neighborhood groups, churches and civic organizations more effective in their work, we add to the funds and resources being put to effective use in our community. This type of assistance is one of the most important functions the Council can perform.

Program Development

During the early part of 1970, we expect to organize a Program Development Committee for the Council. This Committee will be made up of Board members and individuals who are not on the Board. Its function will be to provide a means for continually reviewing the work activities of the Council and assisting in the establishment of priority for its programs. The Council is a social planning organization which can be an important resource in the community only if it retains its vitality and flexibility. If the Council had become rigid in devising its programs, its people and resources would not have been available to engage in some of the activities described above which maintain a balance between continuity in those activities which look to long range improvement and flexibility sufficient to give the community the benefit of the skill and information available through the Council's resources. The Program Development Committee will provide a means for retaining the Council's vitality and balance in its work activities.

Obviously there is a great deal to be done to make our five-county area a better place in which to live. I think it equally obvious that there is a great deal with which to do the job if we plan and work together with imagination, enthusiasm and a sense of urgency. So let's roll up our sleeves and see what we can accomplish together in 1970.

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The 4-C program is a federal program designed to develop a coordinated program to provide services to children--and thus make better use of the community's funds and resources in providing such services. Atlanta was named a pilot community and the Council was named the delegate agency. A Steering Committee composed of parents, representatives of day care agencies and organizations has been elected and is at work. Much of our staff time will be devoted to this activity. This is an outgrowth of our Child Development Project.

2. Day Care Action Subcommittee

The very fine work of this Subcommittee will be continued in 1970. Its function is to stimulate interest in day care and help develop new day care resources. In 1969 the Subcommittee published a Day Care Manual which provides a step-by-step guide to those interested in planning and developing a day care center. The response has been so enthusiastic that we are swamped with requests by church groups and others for technical assistance. This important activity also arose out of our Child Development Project.

3. Coordination of Services and Planning

One of the most important on-going activities of the Council is that of bringing together planning and service agencies in an effort to provide coordination of planning and services. The existing funds and resources for dealing with our urgent urban problems are extremely limited and all agencies have an obligation to jointly plan and coordinate their activities in dealing with the problems which are their major ooncern. Space does not permit an adequate description of the Council's work activities in coordination but periodic reports will be given in Communique.

4. Emergency Assistance

Every effort to identify the most urgent problems in our five-county area has resulted in high priority being given to the need for developing more resources for emergency assistance. There are many aspects of the problem. An Emergency Assistance Committee has been organized and has begun to function. It has determined to work first on developing resources to deal with the problems arising out of evictions. Hundreds of families are evicted each year and there is no organized program to help the evicted families with such needs as storage space for furniture, temporary shelter, food etc.

5. Other Special Activities

(a) Welfare Committee. Practically everyone agrees that our entire welfare program must be overhauled. A Welfare Committee is studying various income maintenance programs, including the Administration's Family Assistance Act, and will make periodic reports.

(b) Advisory Committee for Information and Referral. This Committee was formed to assist in the improvement of information and referral service in the metropolitan Atlanta area and to devise means for improving services to meet the most urgent needs identified by such service. Among other things, this Committee will help focus attention on the most serious unmet needs in our area.

(c) Fourteenth Street Multi-Purpose Center. The Council has leased a house on Juniper Street to be used as a community center for the Fourteenth Street area. It is functioning and has been well-received. The focus will be on a voluntary medical clinic, a counseling center and a twenty-four hour information and referral service. This facility is being operated at the present time entirely by volunteers. The Center can meet a great need and we'll keep you up to date on its activities in Communique.

(d) Interagency Council on Alcohol and Drugs. This Council is simply a "coming together" of established agencies concerned with problems related to the use of alcohol and drugs. It provides a means by which such agencies can work together. The Council has divided itself into the following five Task Forces: Resources and Existing Facilities and Services, Education, Treatment and Counseling, Speakers Bureau, and Legal Aspects and Legislation. You've received some information on this important and interesting activity and more will be forthcoming.

(e) Expanded Public Information Service. We have improved our methods of getting valuable information to the general public and will give greater emphasis to this activity. The information gathered by our Research Center and through our various programs, if properly and attractively passed on to the general public, will provide our area with a better informed citizenry. This greater understanding of our problems will in time result in an improvement in services and funds to meet the problems.

The above are simply illustrative of the variety of activities in which the Council is engaged. The Child Development Project revealed the need for further work on such problems as retardation of children, the need for twenty-four hour child care, learning difficulties etc.

Volunteer Atlanta

The Council is a sponsor of Volunteer Atlanta and will continue to assist this project. As you may recall, Volunteer Atlanta was brought about largely by the Council and is sponsored by the Council, the Atlanta Chamber of Commerce, the Atlanta Junior League, the Community Chest, and E.O.A. Its object is to recruit, train and place volunteers in public and private agencies throughout the five-county area. We think this can be one of the most important projects begun in the Atlanta area during recent years.

Assistance to Groups

The Council is receiving an ever increasing number of requests for technical assistance from agencies, neighborhood groups, and civic organizations. Agencies are requesting assistance in reviewing their programs; neighborhoods are seeking assistance in the drafting of proposals for resident-determined programs; and civic organizations are asking for suggestions as to the type of programs in which they might be effectively involved Thus, technical assistance to neighborhood groups and direct service agencies is becoming a major role of the Council. We think this role should be emphasized and that means must be devised to adequately provide such assistance. The Council is basically a collection of staff, accumulated information and experience, and skill, and whenever its assistance can make agencies, neighborhood groups, churches and civic organizations more effective in their work, we add to the funds and resources being put to effective use in our community. This type of assistance is one of the most important functions the Council can perform.

Program Development

During the early part of 1970, we expect to organize a Program Development Committee for the Council. This Committee will be made up of Board members and individuals who are not on the Board. Its function will be to provide a means for continually reviewing the work activities of the Council and assisting in the establishment of priority for its programs. The Council is a social planning organization which can be an important resource in the community only if it retains its vitality and flexibility. If the Council had become rigid in devising its programs, its people and resources would not have been available to engage in some of the activities described above which maintain a balance between continuity in those activities which look to long range improvement and flexibility sufficient to give the community the benefit of the skill and information available through the Council's resources. The Program Development Committee will provide a means for retaining the Council's vitality and balance in its work activities.

Obviously there is a great deal to be done to make our five-county area a better place in which to live. I think it equally obvious that there is a great deal with which to do the job if we plan and work together with imagination, enthusiasm and a sense of urgency. So let's roll up our sleeves and see what we can accomplish together in 1970.

EUGENE T. BRANCH, Chairman of the Board of Directors
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file
discussed with AB Padgett 2-4-70
No ans necessary
DS

ONE THOUSAND GLENN BUILDING, 120 MARIETTA ST., N. W. ATLANTA, GEORGIA 30303 TELEPHONE

6 November 1969

The Honorable Sam Massell, Jr.
40 Pryor Street, S. W.
Atlanta, Georgia

Dear Mr. Massell:

We would like to add our congratulations to the many you have been receiving, on your election. We should also like to add our pledge of support and cooperation in your efforts to keep Atlanta a great and evolving city.

As you know, the Community Council of the Atlanta Area has had an organizational grant from the Department of Health, Education, and Welfare to bring into being a new agency for "comprehensive areawide health planning" for the six-county metropolitan area. The basic work is largely complete. A 52-member "Metropolitan Atlanta Council for Health" has been established, a detailed proposal for a five-year work program has been prepared and submitted, and an organizational structure for carrying out comprehensive health planning has been created.

However, a number of new and rather bold departures from tradition have been made, in an effort to implement, fully, the vision of Public Law 89-749, the "Partnership for Health" act. These involve, in particular, an enhanced role for MACLOG in coordinating health planning with other major planning activities, and real and meaningful participation in planning and decision-making by poor and black citizens of the community.

Your guidance and help in both these areas are urgently needed. It is not an exaggeration to say that two or three decisions by you, now, can have an extremely important impact, not only on the success of health planning in this metropolitan area, but also on race relations in all aspects of community life, and even on the threatened "abolish Atlanta" movement. Howard Atherton is giving his full backing to the proposals we would like to place before you.

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If at all possible, we would like to see you for about 45 minutes some time during the next ten days to fill you in on the details. You may recall that one of us (RBL) at your September 17th talk to the Emory-Grady Family Planning Clinic staff brought up the question of planning versus crisis-meeting. Your answer stressed the importance of planning to prevent crises. We believe this is such an opportunity.

Sincerely yours,

A. B. Padgett

A. B. Padgett, Chairman pro tem,
Metropolitan Atlanta Council
for Health

Raphael B. Levine

Raphael B. Levine, Director
Comprehensive Areawide Health
Planning

Encl: statement on comprehensive areawide
health planning
newsletters (Nos. 1 and 6)

February, 1969

COMPREHENSIVE AREAWIDE HEALTH PLANNING

In 1966, the United States Congress enacted Public Law 89-749, the "Partnership for Health" act. Under this law, the States, and through them, areas within the States, must assume responsibility for comprehensive health planning. The Congress declared that "fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts. and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources--national, State , and local--to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts".

The Atlanta metropolitan area was the first in Georgia to apply for and receive an "organizational grant" for the purpose of defining and developing an organization which will be capable of doing comprehensive health planning and obtaining community participation and support in the planning effort. This grant, from the U. S. Public Health Service, through the Georgia Office of Comprehensive Health Planning, supports the Community Council of the Atlanta Area in the professional and organizational effort necessary to instigate such an organization. Dr. Raphael B. Levine, of the Lockheed-Georgia Company Systems Sciences Research Laboratory, has been named Director of the Comprehensive Areawide Health Planning, to accomplish these organizational objectives.

The term "comprehensive" means that every aspect of the health picture in the five-county metropolitan area must be taken into account in the planning process. This includes not only the treatment of illness and injury, but their prevention, and the compensation for any lasting effects which they may leave. Thus, in addition to the manifold activities of medical and paramedical personnel in the variety of health treatment facilities, planning must consider environmental controls of the air, water, soil, food, disease vectors, housing codes and construction, waste disposal, etc. It must consider needs for the training of health personnel, for the improvement of manpower and facilities utilization, and for the access to health care. It includes the fields of mental health, dental health, and rehabilitation. It must be concerned with the means of paying for preventive measures and for health care.

The term "planning" means, first, that problem areas and potential problem areas in the entire field must be identified,and their magnitudes assessed. The trends of the problems must also be assessed, and projected for future years. Technical and organizational bottlenecks must be identified, and "planned around". Second, the community's resources in meeting its health needs must be equally carefully identified and projected, in terms of professional and subprofessional skills, facilities, and financial resources.

Third, since a considerable amount of planning is already being done for a number of projects, hospital authorities, counties, and municipalities, which affects the community's health picture, ways must be found to make maximum use of this capability, and coordinate it into a community-wide comprehensive planning effort. Finally, planning must preserve and encourage the highest level of professional competence in the entire health system, and must make use of the insights of all concerned in the community health system.

The overall task of putting together such an organization is thus seen to be a problem in "systems" analysis and development. Since the total resources of the community are likely to remain smaller than the demands which an ideal health system will place on the resources, rational and just methods of assigning priorities to the various needs must be developed. A cost-benefit analysis is essential to any such decision process, and, considering the literally hundreds of specific health needs in the community, it is likely that the cost-benefit model must rather soon make use of modern computer techniques.

The Partnership for Health law requires that such planning be done with people rather than for people. Therefore, maximum participation of health "consumers", health professionals, governmental units and agencies, and other community organizations is a necessity. The law is telling the States and communities that they will be given increasing responsibility and power to determine their own best health interests, and that the current Federal practice of funding health-related projects through specific project-type grants (such as for specific facilities and specific disease processes) will phase into a system of "block" grants to the states for use as local emphasis requires. Eventually, only communities which have organized themselves for comprehensive health planning may be eligible to receive Federal support.

The current Atlanta area project is a pioneering effort. No other communities in the country have progressed far enough along these lines to provide patterns as to what we should do (or avoid). We have an opportunity to be of service not only to our own community, but to others as well.