AN INTERAGENCY MODEL FOR DESIGNING AND EVALUATING COMMUNITY, SOCIAL, AND REHABILITATION SERVICES

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This is to certify that the

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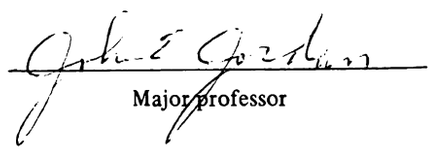

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ABSTRACT

AN INTERAGENCY MODEL FOR DESIGNING AND EVALUATING COMMUNITY, SOCIAL, AND REHABILITATION SERVICES

By

John B. Aycock

Statement of the Problem

A great deal of research, energies, and public monies have been invested over the years in developing effective rehabilitation programs for the mentally and emotionally handicapped and disabled. Much more remains to be accomplished. In these economic times community programs are finding public dollars in increasingly short supply, and the value of these dollars is constantly decreasing. Accordingly, there is an increasing necessity of developing programs which are both fiscally economical and accountable in terms of measurable results and responsiveness to specific client needs.

Community agencies and groups must, out of necessity, now collaborate in program planning, service delivery, and evaluation. Models must be developed which lend themselves to these tasks if the process is to be orderly, measurable, and replicable. Methodologies for collaboration must be reviewed and adopted. Instruments for measuring changes in attitude-behaviors must be utilized if prevention programs are to be justified. Rehabilitation programs must be defined and delivered with precisely defined behavioral objectives with the goal of producing socially competent persons.

If such demanding objectives are to be achieved, communities as well as clients must be carefully defined and described in terms of specific needs. Vaguely defined problems usually precede vaguely defined programs. Standard demographic surveys are a beginning, but must be followed by epidemiological surveys as presented in this work. Beyond that, communities and persons may be even more precisely defined for even clearer understanding of the community and its population. A Social Competency model is a giant step in such definition.

The sick-well dichotomy so prevalent in mental health programs may be replaced by keying in on the precise functional disabilities of a client, and rehabilitation activities may then be directed to those specific disabilities. The social skills of a person may then be emphasized, utilized, and supported during the time of rehabilitation.

Purpose of the Study

The purpose of the study was to develop a basis for a comprehensive plan for community-based mental health prevention and rehabilitation programs. This program includes:

1. Conceptualizing and organizing basic facets and elements of the overall task: A program plan and service delivery based on that plan will be as valid and usable as the initial task organization is reflective of the actual problems and the possible response to the problem. It is perhaps a truism to state that a program can hardly be expected to effectively respond to a vaguely defined

problem. Similarly, a well-defined problem can only be responded to effectively with a well-defined program. This response must include a framework within which the program activities can be effectively organized. A theory base for delivery of services in very carefully identified and measurable rehabilitative activities must then be adopted.

Initially, the basic task is to develop a reliable and usable "map" upon which problem definition, organization planning and theory, and finally, service delivery may proceed.

The organization of this thesis is based on the "mapping sentence" technique. This allows for the organization of the essential variables of the task in a logical framework. The mapping sentence allows for a multifaceted answer to the seemingly simplistic questions: "What is the problem?" and "How do we begin conceptualizing an adequate response?"

2. Organizing the needs of the consumer population: The mapping sentence approach identifies and organizes variables inherent in program planning. However, a method for careful identification of the client population must also be devised if the later-to-be developed response is to be relevant and specific to the client needs.

This identification of client need is presented through a standard survey approach, identifying data describing the incidence and prevalence of specific disabilities such as alcohol and drug use, mentally disabled, homicide and suicide rates, and retardation.

Further, a plan for more precise and useful definition of client needs is also projected within a "Social Competency" model. The theoretical explanation of this approach is discussed in the section of Community Response.

3. Organization of community resources: The technology for organizing an environment within which both problem definition and community rehabilitation may most effectively take place is provided with the theory of Interagency Collaboration. A collaborative environment among community agencies is essential for precise definition of problems as they exist in the community. Interagency Collaboration is also essential for precise and comprehensive design and delivery of both preventive and rehabilitative services.

Without such collaboration both gaps and overlaps in community services abound, planning remains haphazard and narrow, and rehabilitation is then more a matter of chance and luck as opposed to thoughtfulness and precision.

4. A comprehensive community response--prevention and rehabilitation: Within an established collaborative environment among the agencies of the community, the organization or concepts and technologies for prevention and rehabilitation programs can begin. The effectiveness of the "gatekeeper" approach to community prevention can be scientifically measured by Attitude-Behavior instruments. A "Social Rehabilitation" approach is used as a conceptual approach to the definition of rehabilitation problems and in the delivery of rehabilitation services. The theory of Social Competency, with its precise breakdown of effective and noneffective

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behaviors, is employed as a basis for a Social Rehabilitation program approach.

Consequently, methodologies to be reviewed are Interagency Collaboration, Attitude-Behavior Theory, and Social Competency.

Methodology

The methodology of the study emphasizes the need for the development and delivery of both prevention and rehabilitation programs in a community.

Prevention programs are essential to preclude the disablement of "vulnerable" persons in the community. Without such prevention programs, direct service programs become inundated with clients and the programs flounder. Prevention programs are directed to the "breakdown" process in individuals. Specific "gatekeeper" groups are identified who are trained to respond to client crises before such crises develop into serious disabilities.

Rehabilitation programs are also emphasized for those persons who, despite prevention programs, become socially disabled. The Social Competency approach is specifically helpful in delivering effective and accountable mental health rehabilitation services.

This double-barreled approach to community mental health rehabilitation becomes truly comprehensive when applied in a functional milieu of interagency collaboration. Duplication and gaps in service can be more clearly identified, agency roles become increasingly specific, and the community effort becomes more economical and orderly.

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Results

The survey directed to the incidence of drug and alcohol use and abuse portrayed the significant extent to which chemical substances were prevalent in an urban-rural community. A "vulnerable" population was thereby identified among persons who were nevertheless socially functional. Substance abuse was indicated across the community agencies, not only in the mental health drug client population. For instance, records of Juvenile Probation, Police, Jail, and Social Service departments, among others, all indicated the presence of drug and alcohol use among their client populations. Such use had already led to jail sentences, welfare support, and unemployment or underemployment. Additional usage increases could only result in the necessity of significantly increasing the scope of rehabilitation programs.

Specifically, the use of soft-drugs often in combinations, or poly-drug use, was portrayed. This substance use was not confined to the young, as indicated in the youth survey, but was also indicated in the household survey. The fact that adult use may be presumed to include drugs administered by prescription does not alter the fact that drug use, albeit legal, was prevalent in this adult population.

The Virginia Commonwealth Attorney's data indicated that while many of the clients were employed at the time of arrest, this employment was often in unskilled labor areas. This suggests the need for additional vocational training as one phase of rehabilitation for this population.

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Conclusions

When viewing a community in terms of social functioning, both "vulnerable" and disabled populations can and must be carefully identified. In order to produce effective rehabilitation programs the needs of these populations, social skill needs, independent living skill needs, and vocational needs, must be specifically identified and responded to in the prevention and rehabilitation programs.

In terms of the "vulnerable" population, trained "gatekeepers" can effectively assist the vulnerable population. Crisis intervention-based value clarification and decision-making are posed as effective antidotes to disorganization and initial levels of social dysfunction. By contacting the vulnerable population in times of crisis, gatekeepers can assist and support "hurting" citizens in their specific needs without referring them into traditional treatment programs. Admission into treatment programs is of itself often disruptive of client functioning in the community, leads to further breakdown in confidence levels, and fosters socialization to the treatment community as opposed to socialization to the real world, the community-at-large.

Where treatment is indicated because of severe social breakdown, the treatment is actually a carefully defined and customized rehabilitation directed to restoring social competency and functioning.

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AN INTERAGENCY MODEL FOR DESIGNING AND EVALUATING COMMUNITY, SOCIAL, AND REHABILITATION SERVICES

By

John B. Aycock

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
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Department of Counseling, Personnel Services,
and Educational Psychology

1976

"The test we say again and again, of any civilization is the measure of consideration and care which we give to our weakest members."

--Pearl S. Buck

DEDICATION

To Sharon, John, Tom, and Andy, my expert consultants in mental health rehabilitation; and Warren and Mary Frances, loyal cheerleaders.

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PREFACE

This study is one of a series of investigations spanning many years. Of special significance has been the monumental and prolific work of Dr. John E. Jordan in his development of the Jordan-Guttman Attitude-Behavior Scales. Dr. Zvi Feine and Dr. Mark Spivak, as Consultants to the City of Virginia Beach, have provided significant contributions in the areas of Interagency Collaboration and Social Competency.

The workshops and seminars on Social Competency sponsored by the Commonwealth of Virginia, Division of Mental Health Clinics and Centers, and the Bureau of Drug Rehabilitation, Dr. Thomas F. Updike, Director, provided the environment for translating Social Competency and Interagency Collaboration theories into programmatic terms.

The author, therefore, collaborated in many aspects although the data, results, integration of concepts, and comprehensive program conceptualization and implementation are those of the author.

I sincerely appreciate the efforts and assistance of my doctoral committee: Dr. John E. Jordan, Chairman, Dr. Thomas Gunnings, Professor James Howard and Dr. Alexander Cade. I am also grateful to my colleagues and classmates for their support, encouragement, and assistance, especially Dr. John Castro, Dr. Jay Lazier, and Dr. James Hightower.

CHAPTER I

INTRODUCTION

The Functional Person: Defining a Community

A human being may be defined in many ways. Height, weight, body, measurements, color of hair and eyes may all form the basis of description. A person may also be defined by life history, in terms of country or state of origin. Who his parents were, where they came from, how much money they made (or he made), and how they (or he) made their money, also aid in defining a human being.

Negatively, his crime file may be reviewed in the local police records, or in F.B.I. files. Personality deviations may be assessed by the administration of some instrument such as a Minnesota Multiphasic Personality Inventory. Medically, he may be described by his ulcers, heart condition, poor circulation, or hemorrhoids.

While all these descriptive elements may say something about the person, he is still described in parts, and most often in terms of what he cannot do, or at very best, by what he appears to be--his profile.

To describe the person as he is, in the manner and capacity of his human functioning, his human skills, is quite a more challenging enterprise. It is also more realistic.

This treatise looks at community symptomology with specific reference to drug and alcohol abuse. The conclusive emphasis

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is on a more individualized approach to client evaluation and collaborative community-based social rehabilitation.

The Functioning Community

As is true with individual clients, a community may be described in a number of perspectives. Census data may be used to describe the community in its citizens' numbers, their nation or state of origin, their ages, occupations, and incomes. The community may also be described in its financial assets, tax base, or number and type of industries, or in its political tendencies, affiliations, and philosophies. A community may also be defined by its number of new homes, its slums, its public institutions, its capacity to deliver its own public services, or by its payroll. More specific descriptive indicators may be added such as the incidence of disease, malnutrition, physical handicaps, mental regardation, drug abuse, and alcoholism.

All the above indicators tell something about a community, and taken collectively they may go far in portraying a community profile--an appearance of the community, its size, its shape, its symptoms. But these indicators hardly describe a community as it truly is--as its citizens function, and as its institutions relate to and respond to the specifically defined human need of its citizenry.

This work describes a community in profile, and suggests a metatheory for more meaningful community and citizen descriptions, in behavior-specific terms, in their functional capacity, in their

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social skills, and in their social relatedness to the community's human resources. This work also recommends an interagency rehabilitative community response to citizen needs.

Snapshots and Movies

Community profiles based on symptomology, like client profiles based on symptomology, serve as informative data bases for initial rehabilitative planning, but symptomology-based profiles are still-life pictures: snapshots of a client at a particular point in time. Such profiles do not provide the complete detailed picture of communities or clients upon which specific and measurable community responses and rehabilitative programs can be programed.

The community profile we want is not merely the snapshot type but rather a movie, in motion, constantly changing, developing, augmenting, acquiring, and specifically relating--relating to the community, relating to its human processes, and relating to citizens within its environment. This goes beyond a demographic profile, beyond what seems to be, and even beyond what a community perceives itself to be.

If time is the measure of that which changes, then man in his Social Skills is one unit measuring the quantity of change. It is this measuring unit--these Social Skills--by which man is measured to himself, and to others.

It has been said that mental health is the capacity of a person to pleasantly anticipate the next moment. If the definition is valid, then it insists that there be some founded hope on the

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part of the person that he can function adequately as a human being in that next moment. In its broad sense, this functioning capacity is termed "Social Skills."

Human social skills may be programed into three broad categories: Skills in Independent Living, Skills in Vocational Living, and Skills in Social Living. We begin to know the functional person when we begin to see him within these parameters.

Human Skills and Responsible Systems

Time, change, functioning are three key terms and concepts in knowing, assessing, and rehabilitating a human being. A fourth note --relating--must also be kept in the foreground of the picture. Birth, death, marriage, divorce, employment, all the key notes in a human life, encompass relationships. Every human theorist since Freud--Jung, Frankl, Sullivan, Horney, Adler, Perls, Rogers, to cite some of the more notable--has emphasized the critical element and functioning of relationships in human life processes. As Social Skills give man the breath to function, relationships give him the necessary space in which to flex his social muscles. Through the relationships which he forms, and strengthens, or terminates: man to a great extent describes his own environment.

It is almost trite to add that relationships are, however, always a two-way street--man reflecting upon himself (the "I-Me" of Mead, the "I-Thou" of Buber and Tillich), man interacting within the family and the social community, man interacting with the economic and industrial community.

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When the "I-Me" relationship breaks down, existential crises soon follow; when family and community relationships break down, marriage and community crises occur; when communications between the individual and the economic/industrial community break down, revolutions, peaceful or otherwise, are not far behind. Witness the existential crises on the campuses of the '50s, the riots of Watts and Detroit of the '60s, and the volcanic American and Russian revolutions of the less recent past.

Rehabilitative systems must then of necessity look keenly at man himself, but especially man in his Social Skills, and man in his social relationships. The skilled marriage counselor looks at the individual, but also at the marital relationship itself, as described by its capacities, its needs, its communication, and above all, its responsiveness.

The rehabilitation counselor also addresses the individual in his capacities, deficits, skills--but also in a perspective of the world into which the client returns--the ongoing relationship of the citizen with his community. Like marriage, this relationship also is one of resources and needs, asking and receiving, confronting and supporting. The citizen brings his skills and his needs--the community has its demands and resources--and its needs for the citizen's skills.

If this relationship between citizen and community is to be viable, or even sane, it must be the two-way street. The many facets of such a relationship must be somehow organized to be understood--

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and the rehabilitation program must be built in such an understandable, organized framework if it is to make sense at all.

There must be clear communication on both sides. There must be a meeting of needs, a quid pro quo, on both sides, or the very fiber of human life, of social life, breaks down at its base.

The task of relating to man as he is, is a challenge to the program planner and the counselor. For man functions, even with his handicaps and disabilities, as a unique social being. Rehabilitation programs and activities must be framed in an environment of customized variables identifying the ebbing and flowing, giving and getting, of personal, social and vocational activities and relationships. In this context, community agencies, or groups, are viewed as moral persons, as partners in relationships with individuals, communicating back and forth, giving and receiving, adapting, changing, growing.

For here it is posited that only within such a socialized community can true rehabilitation take place--a rehabilitation based on truth, openness, flexibility, and especially responsiveness. Growth then is a mutual process, from the individual, from the community and its rehabilitative units or agencies. The client grows in his social capacities and skills, the agencies grow in their responsiveness to individual need, in their sensitivity to clients, and in the strength that comes from thoughtful flexibility.

Rehabilitation is about persons first, and then about agencies. Rehabilitation must be individualized to personal need, and agencies must be organized within the many variables necessary

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to deliver their resources and services both sensitively and effectively.

This work addresses this two-fold objective of individualized rehabilitation, delivered in an environment of community-based and highly collaborative agencies.

A community profile will be offered, but beyond that, a plan for organized and individualized rehabilitation will also be projected. To attain this total objective, the following concepts and issues will be addressed.

1. The concept of prevention, including a definition and conceptual analysis of the phenomenon "social breakdown."

2. Concepts relevant to Social Rehabilitation, with specific regard to the theory of Social Competency.

3. The development of a community response to Social Breakdown based on Interagency Collaboration.

4. The initial diagnosis of a community using drugs and alcohol as symptoms of desocialized behavior.

5. Projection to a method of assessing a community in terms of social functioning and dysfunctioning.

CHAPTER II

REVIEW OF THE LITERATURE

The interagency collaboration approach to the issues of program utilization by clients, as outlined above, is pursued in this study. Such an approach could result in enhanced utilization and effectiveness of mental health rehabilitation programs. The development of a conceptual framework, which when effectively used would enhance interagency collaboration and thus program utilization, may turn out to be more successful than other methods such as "outreach" and reliance upon court referrals, which have in the past been the only methods of referral for rehabilitation programs. Also, a precise methodology for client rehabilitation, Social Competency, is the other crucial component of any mental health rehabilitation program, and is also included as an integral part of this study.

The conceptual framework should encompass a systems approach to collaboration because of the complex, continually changing, and interrelated nature of interorganizational relationships. Techniques most useful for enhancing the quantity and quality of contact aimed at improving collaboration should be explored. The "needs" of the individual community agency staff members must also be analyzed. It is posited that agency needs are in part reflected by the needs of individual staff members of that agency. Relevant concepts from

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these bodies of social science knowledge will be utilized in the study's conceptual framework and will be explained later in this chapter. Services to clients are not delivered in a vacuum. A systems and interorganizational perspective combined with the use of interpersonal techniques and the fulfillment of personal and organizational role needs of community agency staff members comprise the interagency collaboration conceptual framework of this study.

Comprehensive Community Rehabilitation in Interagency Collaboration

The development of responsive, measurable, and economic community-based rehabilitation programs is continually frustrated by two major factors:

1. The lack of communication, cooperation, and functional interaction among community agencies and groups responsible for rehabilitation program planning and implementation.
2. The lack of a sensible model and terminology on which to plan, deliver, and measure rehabilitation activities.

This effect is hardly surprising. Legislative acts proposing, authorizing, mandating, and funding community programs often result from political needs and political compromises as well as justified client needs and scientific program planning. Also, agencies tend to isolate turfs and define "kingdoms," confounding interagency cooperation and interaction. Ego needs of administrators, supervisors, and line workers also serve as reinforcers of territorial approaches.

Present international, national, and local economic factors demand more economical cooperative and measurable programs.

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Politicians and government administrators, presently "under the gun" in the Watergate aftermath, are demanding accountability measures and concrete results in community programs.

Three methodologies provide great promise as foundations for both cooperative and understandable programs: Interagency Collaboration, Social Competency, and Jordan-Guttman Facet Theory as instrumented in Attitude-Behavior scales.

These three systems may be melded into one functional model on which community rehabilitation programs can be based. Interagency Collaboration provides the rationale and guidelines for interagency communication, planning, funding, implementation, and evaluation. Social Competency is a methodology which can be used for identifying community rehabilitation problems, designing specific rehabilitative responses, in identifying gaps and overlaps in services, and measuring and tracking rehabilitation results. The Jordan-Guttman ABS scales provide a unique methodology for quantifying changes in clients', or trainees' attitude-behaviors.

In recent years mental health rehabilitation programs have been developed to meet the treatment needs of the mentally ill. These programs extend across agencies and services, including mental health, public health, social services, vocational rehabilitation, and many similar service groups in the private sector. These programs are usually comprised of a combination of major segments: outpatient, inpatient, consultation and education, alternatives to hospitalization, emergency services, and drug rehabilitation. These segments

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represent the best, albeit imperfect, answers our society has developed to date to respond to the problems of mental illness and addiction.

Such responses are still fragmented, often uncoordinated at the federal, state, and local levels. Funding sources remain varied. Treatment objectives often are unclear, effective prevention almost nonexistent. Programs are often underutilized, tracking systems usually ineffective if extant at all.

The major goal of a mental health rehabilitation program is to prevent the onset of the disability, or to rehabilitate mentally ill clients. To accomplish this, the program must secure a number of inputs and organize a number of variables, such as funding, staff, community support, clients, methodologies and theories, and administrative endorsements. These inputs and variables are interrelated and intergenerating. These are, in systems theory terms, necessary inputs to achieve an output--namely, the prevention or rehabilitation of mental disability.

Millions of federal, state, and local dollars have been poured into mental health programs and drug rehabilitation programs. Nevertheless, it is the opinion of Virginia's state-level mental health administrators that virtually all drug programs are underutilized in terms of the people who could benefit from such programs, and there is little evidence to suspect that this is not also true with state mental health programs in general.

Mental health centers and clinics remain "9 to 5" operations for the most part. Programs tend to be isolated from the mainstream

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of community agencies, offer traditional, if not archaic, "therapy" which is at best unmeasurable and at worst conceptually and programmatically disorganized.

The effects are predictable. One drug program in Virginia had only three percent (3%) of its clients "graduating" from its programs. One mental health center has had no meaningful systematic data recording or tracking system for the past five years in any of its program units. It is readily apparent that programs have had difficulty in successfully reaching and binding in clients and have had little means to explain or justify their activities. It comes as no surprise, then, that such program staffs relate poorly, if at all, to the other service agencies, and have little sense of perspective of how what is going on in their program relates to the broader community rehabilitative effort. Poor collaboration may explain low utilization of mental health programs in terms of low referrals, lack of proper client maintenance, and a consequent lack of respect for the program by the community at large.

Two major avenues are available then for analyzing the process of referral and maintenance of clients. On the one hand, the effectiveness of the treatment program itself can be questioned. The program's understanding of the community rehabilitation problem, its precisely defined response, the use of outreach approaches to the target population, the method of binding-in clients to the program, and the rehabilitation itself may all be ineffective. On the other hand, collaborative efforts of the programs with other community agencies may be poor or nonexistent. One component of

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community collaborative failure is that the quality of interagency collaboration may be lacking as well as the quantity. Or agencies may be interacting with poor agendas, weak methodologies, undefined central terminology, vaguely defined problems, and nonspecific program activities.

The crucial effects of intrastaff relationships upon clients' treatment was first clearly documented by Stanton and Schwartz (1949). They described the highly detrimental results of staff disagreement for hospitalized mental patients. Nevertheless, interagency staff relationships have not been carefully studied for their effects upon various aspects of client treatment such as appropriate referral and participation in treatment programs.

The concept of SSR (Social Systems' Relatedness) comes from systems theory and in this study calls for fulfilling the role behavior needs of other staff members and significant others in the community by a staff of a mental health rehabilitation program. It is hypothesized that such collaboration increases program utilization by increasing the number of referrals and the number of clients maintained in the program, and is more feasible in terms of amassing community resources, and control of program costs.

However, just referring clients into a program is not the final program goal. Clients are needed by a program, but there are also other program needs. For example, a program needs clients to whom it can adequately and responsibly respond in terms of treatment

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and rehabilitation. Therefore, the referrals must necessarily be thoughtfully considered in terms of clients' needs and the agencies' capacity to respond. Such referrals can only be made if clients' needs are accurately assessed, program operations are clearly defined to program staffs within the agency and throughout the community, and the agency is actually able and in fact does respond effectively to client needs.

Further, agencies who duplicate efforts, as agencies who do not respond to proven (or mandated) needs, will be in jeopardy fiscally and politically. Community programs, then, need clients, but they also need credibility. This credibility is enhanced by demonstrated program effectiveness, clear definition of agency roles, the fulfilling of political and fiscal needs by responsible definition of community needs, elimination of gaps and overlaps in services--all in an interorganizational collaborative community effort.

The interorganizational environment is the focus of this study because we are interested in the transfer of inputs and outputs across organizational boundaries. Thus, a promising perspective for improving interorganizational relationships is that of "open systems theory." It calls for a view of the organization and the environment in which it operates.

Within the context of a systems theory approach, the acquisition of referrals (input resource) can, for the most part, be seen as one part of an exchange relationship. According to Blau (1968) "the concept of exchange refers to voluntary social actions

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that are contingent on rewarding reactions from others and that cease when these respected reactions from others are not forthcoming."

Referrals, then, are exclusively seen as input resources to rehabilitation programs, and will not usually be generated by themselves in the normal course of business. Some exchange or reciprocity must take place between those individuals referring clients and the staff of a mental health program.

The extent to which the "needs" of other service agencies are met by the mental health administrators is a major determinant of the other community agencies initiating or continuing to engage in the referral of clients to the mental health program.

The conceptual framework of this study incorporates a social system approach which is termed Social System Relatedness (SSR), consisting of areas of SSR, techniques, and role behavior needs. This conceptual framework will be explicated below and can be used to analyze the interorganizational-oriented activities of agency administrators and staff members. SSR might also be used as an approach to altering agencies' collaborative behavior.

The following section deals with the open systems approach of this study. Included in this section is a review of the concepts and development of systems theory which is one major perspective assumed by the study.

Review of Open Systems Theory

A frequent objection to organizational research is that "the typical models of organizational theorizing concentrate upon

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principles of individual functioning as if these problems were independent of changes in the environment" (Katz and Kahn, 1966). The result is an emphasis on the concepts of production, efficiency, and internal stability in analyzing organizations. This is a closed system approach to organizational analysis because it concentrates on the internal operations of an organization. Recently, however, organizational researchers have viewed the organization in a new light, applying some of the principles of biology and physics in the process. This was the beginning of open systems thinking. Initially, this approach considered some of the biological aspects of organisms. An analogy was made between organisms and organizations. It involved the organism's symbiotic relationship with its environment. The analogy posited a tie between organism and environment, consisting of an exchange between them, an exchange that was necessary for the operation of both. In applying this analogy the organization does not exist in isolation but operates with close ties to its environment. For the organization, then, the environment is an essential factor underlying the system's models (Buckley, 1967).

The analogy of an organization as a mechanistic or organic model occurred at the beginning of systems thinking. As this school of thought has developed these approaches have been widely criticized. Thus, Buckley (1967) speaks of the mistake of equating the organization with an organism and not the entire species. The organization in this system should not be an organism, but the species, for if it were an organism, then the parts would cooperate and not compete in a struggle for survival (Buckley, 1967).

Physical systems also differ from social systems in their extent of purposiveness; therefore, the analogy to physical systems is thought to be erroneous. Social systems are more goal directed and as such have embodied in them the concept of feedback between the organization and the environment. This places a much larger burden on the input, throughput, and output of the system (Buckley, 1967).

Work in this area has given the field of organizational research the concept of "systems," usage of which is fashionable today. However, as Blegen (1968) points out, this is not to state that there exists one "system school"; although it does signify a general approach to the study of organizations, even if different aspects of those organizations are stressed.

The significance of this approach is stated by Emery and Trist:

> The environmental contexts in which organizations exist are themselves changing, at an increasing rate, and towards increasing complexity . . . . In a general way it may be said that to think in terms of systems seems the most appropriate conceptual response so far available when the phenomena under study at any level and in any domain display the character of being organized, and when understanding the nature of interdependencies constitutes the research task (Emery and Trist, 1965, p. 21).

Warren (1967) expands this notion of complexity and interdependency in the development of the concept of "density of events." He points out that as the density of events increases, such as when traffic increases to the point of needing a light, the chance of reaching stability by mutual adaptation and competition is reduced. As the density of events increases, the focus is on the occurrence

of interaction and its structure. Moreover, this higher density also results in new forms of interaction for different types of actors.

As the environment becomes increasingly more complex and as researchers focus in on the network of relationships to aid in understanding an organization's operation, the assumption of an open systems approach becomes more significant and almost unavoidable. This is because the area of interest is the relation between organizations; therefore, an approach that focuses on the nature of interaction among subunits will be more appropriate than a perspective that focuses on the subunits alone.

Thus open systems theory is a promising perspective or approach for use in analyzing interorganizational relationships. It is a major vantage point of this project. It has been called a "way of thinking and a way of analysis that accommodates knowledge from many sciences" (Janchill, 1969).

A system is a set or arrangement of parts related to form a whole, such that a change in one part causes a change in the whole. Blegan (1968) cites the definition of concept as "a set of objects together with the relationships between the objects and their attributes." The relationships "tie the system together" and the environment "is the set of all objects, a change in whose attributes affects the system and also those objects whose attributes are changed by the behavior of the system" (Blegan, 1968). To determine when an object is part of the environment, one draws a boundary around the phenomenon one is studying. Everything within the

boundary is the system, outside of it is the environment (Blegen, 1968). The perspective is to view both the system (the organization) and its environment--in short, an open systems approach. Dill uses the term "task environment," which is a more workable concept than boundary maintenance, because it compresses those inputs which bear potentially on goal setting and attainment (Dill, 1971).

The distinction between "open" and "closed" systems, as well as their respective approaches, relates to the interaction between systems and their environment. A system is open, generally, when an exchange occurs across the boundaries between system and environment. It is closed when no interchange occurs. Hence, with an open systems perspective, one is interested in the exchange and relation of system to environment. This can be stated in terms of "entropy." The closed system increases in entropy, or in other words, runs down, while the open system is negentropic or tends to decrease in entropy (Buckley, 1967). By extending this distinction between open and closed systems, we see that within a closed system approach one determines or has knowledge of cause and effect relationships from the results of action within the system. Furthermore, the actions all arise from within the system. With an open systems approach, however, the cause and effect relation is more difficult to determine because the consequences within the system might arise from actions outside the system, that is, actions in the environment. Causal actions could then extend throughout the system with varying degrees of effect (Thompson, 1967).

Herein lies the dependence of the system on the environment for energy. As Katz and Kahn (1966) point out, the organization is "continually dependent upon inputs from the environment." Moreover, "the inflow of materials and unit energy is not constant. The flow of energy is broken up into the stages of input, transformation or throughput, and output. With this perspective referrals can be conceptualized as an input resource, which is necessary for the continued existence of the organization. This implies a degree of openness of the organization to its environment.

In this process of energy transfer, only throughput involves a stage contained within the system itself; the others involve the system and some parts of its environment. Because of this energy transfer, there is the premise of constant flux for the organization, although it seeks stability. Rice (1963) says that a characteristic of an open system is that "it exerts forces to attain, and then to maintain, a steady state" (p. 184). In an effort to make the environment more predictable, organizations might engage in the investment of relationships with other organizations.

Systems theory at the same time tends to be very general and vague. In its focusing on the "organization-set" of the total system, a little precision is lost in attempting to have a broader view. Moreover, the very generality of systems theory means that the concept can be manipulated according to individual bias. Given these shortcomings and our realization of their existence, open systems theory nevertheless is a useful tool in any attempt to describe and view an organization's operation in its environment.

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In fact, it is essential, for any other approach which is focused entirely on a particular subunit would not provide a viable approach to interagency relationships.

From the systems perspective is derived a number of dimensions, described below, for viewing organizations. While systems theory is the vantage point, the dimensions indicate means of action to enhance agency effectiveness, and are the functional elements of the systems perspective.

A conceptual framework attempting to explain a large area of reality based on interagency collaboration runs the risk of being highly abstract and difficult to translate into reality. Such a conceptual framework may well be a prelude to further research in testing various elements of hypotheses of the framework.

Literature will be reviewed below. The focus of the initial review will be upon discovering useful concepts for effecting interagency collaboration. Such an applicable conceptual framework can incorporate only a small number of unified concepts at one time. In this way, empirical tests become possible. We are attempting in this study to glean from social science findings knowledge that can be used to improve comprehensive community planning and service delivery. An eclectic approach from various social science areas could be most useful. The conceptual framework for effecting interagency collaboration must at the same time use social science findings, deal with the realities of collaboration, and, if found to be effective, be communicable to practitioners. This collaboration among agencies is the necessary foundation for the rehabilitation process itself.

Below is a review and discussion of work done in the area of collaboration.

Coordination, Cooperation, and Collaboration

Those who work at providing mental health rehabilitative and social services are probably more aware than other professionals of the problems in planning and service delivery. Potentially effective programs remain underutilized by clients, gaps and overlaps of services are apparent and result in either a lack of essential services of competition between agencies. Moreover, community resources may be wasted when a comprehensive plan is not in operation.

As a result, community counselors have been concerned with issues regarding collaboration, cooperation, and coordination with other professionals and agencies to reduce the problems and improve the delivery of services.

The interest in this subject is reflected in the number of articles emphasizing the importance of collaboration. Yet most of the professional articles dealing with this subject simply survey the issues involved and emphasize the need for collaboration (Visotsky, 1966). Despite the vital practical implications for clients in enhancing effective collaboration between professionals and agencies, there has been a relative lack of integration of recent social science findings and actual experience on the community level to enhance collaboration.

Relatively little sophisticated conceptualizing of the various issues in collaboration as well as translating the social science

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knowledge we possess into practical planning and interventive frames of reference has been accomplished. Behavioral sciences have only in the last decade begun to relate to interorganizational behavior.

Articles by Parnicky, Anderson, Nakoa, Thomas (1961), Black and Case (1973), and Wolkon (1970) exemplify much of the social work literature on "coordination and cooperation." These particular articles deal with the securing of referrals as the focus of interagency cooperation. The articles generally point out the need for strengthening referral procedures, the need for cooperation, and cite obstacles preventing such cooperation. These articles, though, do not present a conceptual framework for achieving such cooperation. Moreover, the distinction between coordination, cooperation, and collaboration, is not usually clarified.

Reid (1969) sees coordination of services as an ideal state and carefully lists many of the reasons why this goal is so elusive. Rein (1970), on the other hand, points to the dangers of too much coordination, and he adds that confusion and competition between organizations may be all for the best--otherwise a client may be dependent upon one social worker or agency who will impose controls on what he considers deviant behavior on the part of the client. As Powell and Riley (1970) point out, the coordination, development, and integration of relevant services can place the community mental health agency "in a potentially competitive and threatening relationship to other agencies and private practitioners" (p. 120). On the other hand, Kahn (1973) points out that "efforts need to be integrated, interrelated policies coordinated. This goal does not

result simply from value orientation but the belief that increased collaboration will lead to a system with reduced overlap of services and therefore, increased efficiency" (p. 7). Much confusion, then, is to be found in the social science literature regarding the concept of coordination. Thompson (1967) outlines three methods for achieving coordination. These include:

1. Standardization--which involves establishing routines and rules to constrain the actions of an organization and thereby to make them consistent;

2. Planning--which creates a schedule for the interdependent units to govern their actions; and

3. Manual adjustment--or "feedback" in March and Simon's terms, which involves the transmission of new information while in action.

These three methods involve progressively more communication and decision and include real costs for the organization as a result of the coordination.

Kahn (1967) cites a number of methods for achieving coordination of policy and programs through:

1. The structuring of executive and administrative authority;

2. The formal administrative mechanisms at the level below the executive;

3. Interagency, interdepartmental, or interorganizational committees; and

4. Joint or unified service operations.

The ambiguity of the term coordination is well pointed out by Mott. In essence, it is the value which we attach to the term coordination and the ways in which it is secured. According to Mott (1970):

> Coordination is an ambiguous term that describes all organized behavior, for the efforts of individuals and groups are coordinated when their behavior is concerted in respect to some desired purpose or consequence. The term only takes on specific meaning in relation to the methods by which coordination is accomplished and the ends that they service (p. 55).

White (1968) points to cooperation including processes "often called collaboration, teamwork, multidiscipline approach or interagency integration." By whatever technical name, these processes imply individuals working together towards a shared objective.

The term "cooperation," according to Cohen (1969), may be conceptually analyzed among five types of cooperation: automatic, traditional, contractual, directed, and spontaneous.

Collaboration seems more appropriate as the frame of reference for this study than that of cooperation or coordination.

Although cooperation emphasizes association or working together for a mutual objective between groups, it says nothing about the relative position of the groups that are cooperating.

Coordination, on the other hand, is identical with "being carried out from above" and hints at a less than equal relationship between the partners. The term coordination can be conceived as bringing "into common action" various programs whose aims, skills, or beliefs are strikingly different (Stukes, 1965).

In comparison to cooperation and coordination, collaboration is usually associated with more equality and involvement among the partners in any particular undertaking. An exchange or reciprocal relationship will exist.

In focusing on the collaborative efforts made by one agency toward another the sphere of interest is the interorganizational environment and the relationships within that sphere. The concern then becomes relationships between organizations as reflected in the relationships between the administrators and staffs of different organizations. These relations assume importance since organizations cannot collaborate without both administrators and staffs of those agencies collaborating.

One way to look at interagency collaboration is through exchange theory. Exchange theory provides a means to conceptualize the collaborative process as a flow of goods between organizations. Exchange, as defined by Levine and White (1961), refers to "any voluntary activity between two organizations which has consequences, actual or anticipated, for the realization of their respective goals or objectives" (p. 583).

Gouldner (1970) criticizes the concept of exchange for its tendency to become "more and more one sided." To counterbalance this tendency, Gouldner prefers the concept of reciprocity which he finds "implies that <u>each</u> party receives something from the other in return for what he has given him." Gouldner maintains that people tend not only to receive, "but to reciprocate relationships" (Gouldner, 1970). For Thompson (1967), the result of a reciprocal relationship is a form on interdependence between organizations. It is a situation in which the outputs of one organization become the inputs of another; thus each organization involved is penetrated by another organization.

Another approach for understanding interorganizational relationships can be found in the literature dealing with obstacles or barriers in delivering human services.

Furman lists seven obstacles in the development of community mental health centers. His approach questions various professional values and practices as well as community beliefs. Furman's seven obstacles are listed below:

> The obstacles that we consider to be paramount for the next decade or so are the following: (1) the persisting illusion of "cure" as the standard goal, coupled with emphasis on a higher status for long-term or "open-end" psychotherapy, as well as depreciation of other methods; (2) rigid concepts of professionalization, interdisciplinary conflicts and lack of clarity about the boundaries of the field itself; (3) overestimation of public tolerance of the mentally ill; (4) postponement of evolutionary approaches due to a magical aura attached to the term CMHC itself; (5) the dominance or primary of research, resulting in overall selectivity of intake; (6) inappropriate training models in community mental health settings, leading to the same self-defeating result; and (7) abuse or distortion of the mental health consultation and referral processes (Furman, 1967, p. 757).

Rome (1966) extensively surveys barriers to the establishment of comprehensive community mental health centers. He cites a model for community action that is intended to circumvent organizational barriers. His behind-the-scenes attack on the decision-making power structure includes the following six steps:

(1) informing the executive committee of the Board of Health;
(2) conferring with leaders of the power structure;
(3) involving community professionals;
(4) stimulating citizen interest;
(5) securing support from leaders; and
(6) obtaining action from policymakers (Rome, 1966, p. 48).

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It is noted in the text that a deficiency in any of the areas of community planning--professional involvement, utilization of the existing power structure--will create a barrier to any attempt to reconcile overlapping and competing bureaucracies (Rome, 1966).

Borus (1971) speaks of eight obstacles which may lead to a prior antagonism between the private medical practitioner and the community mental health centers. These include (a) lack of feedback, (b) fear of receiving "dumped" clients, (c) lack of sensitivity to others, (d) differing modes of behavior and decision making, (e) different funding patterns, (f) fear of "snooping," (g) poor previous referral experience, and (h) fear of being put out of business. Borus goes on to list a series of strategies and techniques to counteract antagonism and effect collaboration.

Lastly, Dubey (1968) lists a series of socio-cultural factors which lead to resistance to technological change in traditional socities. The technological change may (a) not be approved by significant others, (b) be incompatible with their expected role behavior, (c) conflict with their value system, (d) not be related to their felt needs, and (e) bear a very wide impact upon their lives. The factors listed above are thought provoking in the complex area of human service delivery.

The obstacles or barriers approach to understanding inter-organizational relationships has its limitations. The literature presented above provides some helpful perspectives for viewing the problem and suggests some helpful strategies and techniques.

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In the following chapter, we shall expand upon the study's conceptual framework alluded to in this chapter, and begin to tie in the relationship of Interagency Collaboration, as a system, to service delivery in a Social Competency model.

Interorganizational Relationships

As was indicated in the sections on open systems theory and collaboration, one concern of this study is the organization, the environment, and the relationship between the two. Since we are interested in interagency collaboration and the flow of services across organizational boundaries, the concern becomes interorganizational relationships. Therefore, this section involves a discussion of the literature on interorganizational relationships and its use as a frame of reference for interagency collaboration.

The interorganizational field has only recently been recognized as a distinct area of study in the social sciences (Epstein and Rothman, 1971). Both Etzioni (1969) and Warren (1967) point to the growing literature on interorganizational relationships and to the need for research in this area.

The areas of health, welfare, and community organization are especially well suited for studying interorganizational relations. Most of the articles in the interorganizational field are in those three areas.

Vlasak and White (1970) explain the applicability of interorganizational relationships to the study of the health service delivery system:

> Any attempt at "rationalization" of the American health service delivery system must inevitably come up against the problems of recognizing interorganizational relationships and adapting, changing, or bringing them about. This necessity affects the most naive, exhortative, general coordination schemes as much as the more modest and realistic ones. While such problems are not limited to the health field, it is the field where problems of interorganizational relationships seem to be currently most widely noted, discussed, and occasionally even tackled on a large scale. Coordination, cooperation, comprehensiveness, planning--all of these and others are only slightly more specific, directional terms for the same generic phenomenon: They all speak of processes that by definition take place between and among, as well as within, organizations. Endeavors intended or actually undertaken under the banners of Regional Medical Planning or Comprehensive Health Planning can be seen as pure examples of interorganizational processes (Vlasek and White, 1970, p. 1).

Etzioni (1969) indicates that agencies cannot usually control the elements necessary or helpful to carrying out their operations, such as securing funding and clients. Indeed, Etzioni states that "the need for a sufficient number of clients, for example, is often more efficiently met through exchange with other organizations than through independent casefinding procedures" (p. 120).

The interorganizational field is closely tied to systems theory. Warren states:

> The concept of interorganizational field is based on the observation that the interaction between two organizations is affected, in part at least, by the nature of the organizational pattern or network within which they find themselves (Warren, 1967, p. 398).

Emery and Trist (1965) point to "those processes in the environment itself which are among the determining conditions of the exchanges" between the organization and elements in its environment. The additional concept of the causal texture of the environment at

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a social level of analysis is necessary, according to Emery and Trist. They add:

> With this addition, we may now state the following general proposition: that a comprehensive understanding or organizational behavior required some knowledge of each member of the following set, where L indicates some potentially lawful connection, and the suffix 1 refers to the organization and the suffix 2 to the environment:
>
> L 11, L 12
> L 21, L 22
>
> L 11 here refers to processes within the organization--the area of internal interdependencies; L 12 and L 21 to exchanges between the organization and its environment--the area of transactional interdependencies, from either direction, and L 22 to processes through which parts of the environment become related to each other--i.e., its causal texture--the area of interdependencies that belong within the environment itself (Emery and Trist, 1965, p. 28).

In a similar vein, Terreburry's (1971) thesis is "that the selective advantage of one intro- or interorganizational configuration over another cannot be assessed apart from understanding of the dynamics of the environment itself" (p. 70).

A systems approach is at the basis of the interorganizational field. Indeed, the quickly changing network, its complexities, and the interrelated nature of organizations indicates the necessity of a systems approach to the interorganizational field.

Literature reviews of the interorganization field, ranging from listings of articles to comprehensive critiques can be found in Warren (1967), Terreberry (1971), Turk (1960), Evan (1971), and Aiken and Hage (1968). White and Vlasak (1970) have presented us with a highly sophisticated collection of papers on interorganizational relationships in health. The papers represent the "state of the art" of the interorganization field. We shall present below the

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thrust of the major articles which comprise the interorganizational field. Some have conceptual frameworks and others, series of hypotheses.

In studying interorganizational relationships and understanding the elements of collaboration, Levine, Paul, and White (1963) advise those who study health and welfare agencies to study organizational factors which influence collaboration. They identified three organizational factors as determinants of interaction. These include:

1. The function of the agency and therefore the elements of inputs needed;
2. The access the organization has to elements outside itself or its relative dependence on the local environment; and
3. The degree to which domain concensus exists.

Gummer (1972) approaches interorganizational relations from a similar perspective as Levine, White, and Paul. His emphasis is on the use of systems theory in interorganizational relationships. By categorizing organizations in terms of the concentration of inputs, and the acceptance of claim to function (domain concensus), Gummer establishes a typology of organizations similar in a number of its main points to the framework of Levine, White, and Paul.

Hylton and Litwak, on the other hand, take a more "structural" view of interorganizational relationships and coordination. They stress that:

> Interorganizational analysis suggests two important facets of analysis which differ somewhat from intraorganizational analysis: (1) the operation of social behavior under

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> conditions of partial conflict and (2) the stress on factors which derive equally from all units of interaction rather than being differentially weighted by authority structure (Hylton and Litwak, 1962, p. 398).

Hylton and Litwak (1962) identify the coordinating agency, such as a community chest or social service exchange, as a mechanism whose "major purpose is to order behavior between two or more other formal organizations." The authors view this mechanism as "specialized coordination" (p. 399).

From this point of departure, Hylton and Litwak present their major hypothesis:

> Coordinating agencies will develop and continue in existence if formal organizations are partly interdependent; agencies are aware of this interdependence, and it can be defined in standardized units of action. What characterizes the three variables in this hypothesis (interdependence, awareness, and standardization of the units to be coordinated) is the extent to which they are tied to the organizations to be coordinated (Hylton and Litwak, 1962, p. 400).

The three concepts of interdependency, awareness, and standardization are used by the authors for analyzing interorganizational relationships and coordinating mechanisms.

Aiken and Hage (1968) relate an organization's interdependence with other organizations, or the impact of the environment, upon internal organization behavior. In the interorganizational frame of reference, the scarcity of resources is identified as the factor that forces organizations to engage in cooperative activities with other organizations, thus creating greater integration of the organizations in a community structure.

Assael (1969) also related functional interdependence to the scarcity of resources. The potential for conflict is high in

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situations of functional interdependence. Conflict may be positive when it leads to a more stabilized system, but destructive when there is lack of recognition of mutual objectives. Assael lists conditions for constructive conflict.

Turk (1973) utilizes an interorganizational level of analysis for studying the integrative significance of government and voluntary associations. He contends that:

> The establishment of formal relations among an important set of the community's organizations depends upon the community's capacity for such relationships and upon the need for them. Capacity is defined in terms of the community's overall organizational structure, measured here by two organizations' sources of integration: (1) the scale and diversification of municipal government, and (2) the extent to which voluntary associations are community-wide and uncontested (Turk, 1973, p. 37).

Turk generates two major hypotheses that are confirmed by his data. They are:

> Hypothesis 1. Formal relations in any broad class of local organizations will occur more frequently (a) the more diversified the municipal government and the larger its scale or (b) the less contested and the more community-wide the voluntary associations.
>
> Hypothesis 2. The correlation between the need for formal relations in any broad class of local organizations and the occurrence of such formal relations will be greater (a) the more diversified the municipal government and the larger its scale or (b) the less contested and the more community-wide the voluntary associations (Turk, 1973, pp. 42-43).

The authors cited below relate also to the individual in the framework of interorganizational relationships. Yuchtman and Seashore (1962) utilize a conceptual framework based on a systems approach. The framework views the distinctiveness of an organization as an identifiable social structure and its interdependence with the

environment. Organizational effectiveness is to be measured by success in securing scarce and valued resources.

A "bargaining position" is viewed as pointing to the more general capability of the organization as a resource-getting system. Specific goals are incorporated in this conceptualization in two ways: (a) as specifying means or strategies employed by members toward enhancing the bargaining position of the organization, and (b) as specifying personal goals of members of the organization. The better the bargaining position of the organization, the more capable it is of allowing the attainment of the personal goals of members (Yuchtman and Seashore, 1962).

Thompson (1962) developed a typology of output roles, all of which are boundary spanning roles linking organization and environment. The output roles are designed to arrange for the distribution of the organization's ultimate product or services. The output roles are defined in part by reciprocal roles of non-members. "Both member and non-member roles contain the expectation of closure or completion of interaction or bringing the relationships into a new phase." We feel that the concept of boundary spanning roles can also be used in viewing input transactions which are the focus of this study. Thompson has emphasized that within the organization's structure an individual worker's role may span the boundaries of the organization.

Evan (1971) utilizes the dynamic concept of "role-set" for analyzing role relationships. "A role-set consists of the complex of roles and role relationships that the occupant of a given status

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has by virtue of occupying that status." With role-set as a point of departure, Evan develops the concept of "organization-set." Instead of taking the individual as a unit of analysis, the unit will now be an organization or class of organizations. The interactions the organization has within its network are then traced. "The relations between the focal organization and its organization-set are conceived as mediated by: (a) the role-sets of its boundary personnel, (b) the flow of information, (c) the flow of products or services, and (d) the flow of personnel."

Evan's dimensions of organization sets is as follows:

1. Input vs. output organization sets;
2. Corporative vs. normative reference organization;
3. Size of the organization-set;
4. Concentration of input organizational resources;
5. Overlap in membership;
6. Overlap in goals and values; and
7. Boundary personnel (Evan, 1971).

In his notion of boundary personnel, Evan deals with the individual's role and behavior in an interorganizational context. We feel a stronger emphasis upon understanding an individual's role in an interorganizational relationship.

The major interorganizational studies discussed above for the most part are either too vague to indicate any definite course of action or deal with effecting collaboration and overcoming organizational obstacles to successful collaboration.

Reid (1970) believes the representative sample of inter-organizational theories he studied "offers us better descriptions than explanations of cooperation among organizations." Nevertheless, they make "us aware of the range of factors that may affect cooperation in giving us systematic ways of viewing them" (p. 99).

Seemingly, the interorganizational field is still in its infancy, being highly abstract and comprising conceptual frameworks, dimensions, and hypotheses which have not, for the most part, been empirically tested. Moreover, little has yet been translated into processes or practice for use in effecting interorganizational collaboration. The interorganizational perspective has influenced our own thinking and the development of some of this study's major foundation included in the conceptual framework. Much overlap exists between many of the studies presented above. Nevertheless, if we are to effect and enhance interagency collaboration in human services delivery, the individual will be the beneficiary of any form of effective interaction.

This study is interested in interstaff (including administrators) collaboration and the effect of collaboration on the acquisition of inputs, specifically the development of programs, elimination of gaps and overlaps, and efficient services. Reciprocal need fulfillment is an integral element in the collaborative process. To cite Piedmont (1968), "the failure to reciprocate leads to withdrawal of initiated communication" (p. 31).

Interorganizational programming demands a "quid pro quo." In this study, the "quid" might be fulfilling legislative mandates

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and the "quo" could relate to fulfilling the needs of the local governing bodies. The role behavior needs of agency representatives include personality makeup, the role of the staff member in the organization, and organization needs. The extent to which these "needs" are fulfilled will largely determine the completion and reinforcement of an exchange or reciprocal relationship. Need fulfillment then will be viewed in terms of the effects of the inputs into the organization. Lastly, a focus on the individual in the interorganizational context will emphasize personality and role behavior need fulfillment for enhancing interagency collaboration.

Personality and Role Behavior Needs

In previous sections we have discussed open systems theory, collaboration, and interorganizational relationships, however, we have not yet dealt with the individuals involved in collaboration. Each of these individuals besides having a role in the organization also has certain role behavior needs. The importance of these role behavior needs will be discussed below.

The development of the human resources school in the study of organizations is a dramatic change from the traditional "scientific management" emphasis. With the new approach, the behavior of the organization's member is determined not only by his role in the organization but also by his personality. Role is defined as "definite acts or complexes of customary ways of doing things organized about a particular problem or design to attain a given objective" (Inkeles, 1964, p. 66). Individuals may have comparable job descriptions

and yet may carry out their roles differently depending upon their own unique personalities. The role itself will be a major determinant of an individual's behavior in a work situation. However, because personality has some impact on the performance of a role, it is necessary to delineate the personality variables involved.

An individual develops a self-concept through interaction; he also develops a concept of others. Both concepts work to organize behavior. Behavior then represents an ongoing process which is the result of a transaction between the individual and others. It is posited that patterns of behavior are in response to and relfect a "need for that individual." The study of personality then focuses on the individual as a system of needs, feelings, aptitudes, skills, and defenses (Smelser and Smelser, 1970).

Murray defines needs as:

> A construct (a convenient fiction or hypothetical concept) which stands for a force . . . a force which organizes perception intellection, conation and action in such a way as to transform apperception in a certain direction, an existing, unsatisfying situation (Hall and Lindzey, 1970, p. 175).

Maslow (1970) constructed a need hierarchy for the work situation. He separated the needs structure of individuals into five categories: (1) physiological, (2) safety, (3) belonging, (4) self-actualization, and (5) esteem. The five needs categories can be divided into deficit and growth needs, of which self-actualization is the only growth need.

Bartow (1972) uses the concept of need to illustrate the idea that individuals participate in activities for a number of

reasons. In participation, there is an exchange that occurs and satisfies some individual's needs. As a result of the interaction, an actor will satisfy to an extent some of the needs of the other actors participating in the interaction.

Many studies have been conducted on personality and needs as influencing job performance. Aram, Morgan and Esbeck (1971) studied collaboration, needs satisfaction, and goal attainment. They hypothesized that collaboration and consensus in interpersonal relations would benefit both the individual and the organization. The results of the study indicated that individuals do benefit from collaboration and consensus; however, it did not confirm the hypothesis that organizations benefit from collaboration and consensus. Yet, team collaboration was not an obstacle to the organization's effectiveness.

The unit of analysis in Murray's conceptual efforts was the individual's needs (Hall and Lindzey, 1970). Since he was interested in human motivation, his framework incorporated twenty needs reflecting the complexity of human motives. Like Maslow, Murray employs the idea of prepotency. He suggests there is a hierarchy of needs which is constantly changing as needs are being satisfied according to their hierarchical ordering.

The delineation of the "needs" of individuals should have a direct bearing on program design and program directions. In this study we are interested in the needs of community citizens, the response by the community programs to these citizens, and the mutual fulfillment of both organizational and individual needs by

the response. Thus the concern of this study is the operational model that provides a map for interagency collaboration on the community level, a methodology designed for precise responses to client needs, and a conceptual approach to melding interagency collaboration with these specific rehabilitative responses (social competency).

In summary, this section of this chapter has emphasized the usefulness and interrelatedness of an approach for enhancing interagency collaboration which would use perspectives of systems theory, collaboration, interorganizational relationships, and an individual's role behavior needs.

In the following sections of this chapter we shall address Facet Theory and the theory of Social Competency in its recent development and in its implications in a community rehabilitative program.

Facet theory provides the theory base for measuring attitudes, and attitude changes. Facet theory also serves as a theory base for the design of social rehabilitation programs based on a Social Competency theory model. A review of Facet Theory is therefore critical for the purposes of this study.

The Guttman-Jordan Facet Theory

One of the perennial problems in mental health programming is the identification and utilization of theories and instruments useful in the evaluation of prevention programs.

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The Guttman-Jordan Facet Theory provides a conceptual, clinical, and instrumental base for measuring attitudes as a facet (in the broad sense) of behavior. Behavior change, not mere imparting of information, is postulated as the most essential goal of mental health prevention. Evaluation activities must measure such changes.

Because of its import and applicability for quantitatively measuring the effects of prevention programs, a review of the Guttman-Jordan Facet Theory is included as an integral part of this dissertation.

The quest of Guttman-Jordan's attitude facet theory (Guttman, 1959, 1970, 1971; Jordan, 1971a, 1971b) is to quantify the qualitative; to be able to construct a scale, an index, an instrument which will indeed be able to "measure" attitude-behaviors. Two of the most attractive traits of the Guttman-Jordan proposition are the rigor of its logic and the precision of its "ordering principle" in attempting to introduce the concept of semantic "structure" as a means of quantifying qualitative data (Foa and Turner, 1970).

Contrary to many other psychological researchers, Guttman-Jordan define an attitude as a "delimited totality of behavior with respect to something" (Guttman, 1950a, p. 51). Thus, they consider an attitude as a whole, a universe, a totality: composed of interdependent parts, which parts can be subdivided and rearranged in diverse a priori specified ways to represent the given whole.

It is this concept of a content universe or whole, and its parts of components as applied to attitude-behavior, that "allows"

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the researcher to be able to quantify qualitative data. Basic to facet theory, then, is the concept of set theory. The individual objects in a set are called elements or members of that set. All the possible combinations of elements derived from the diverse sets under consideration are called the set product or the Cartesian product (Elizur, 1970).

In facet analysis the set product is synonymous with the attitude-behavior universe which encompasses the combinations of all elements from the divers sets. In this sense, as a profile of elements across sets, facet theory attitude research is multivariate. It considers the many variables, aspects, qualities, or facets which combine to comprise the attitude-behavior universe.

Founded on the principles of set theory, there are two basic steps in facet design. The first step is the development of a rationale for the selection and specification of the basic sets called facets (e.g., aspects or qualitative variables of the attitude-behavior universe, as illustrated in Table 1). Each basic facet is composed of various elements.

The second step is the selection of sets of elements, combinations, or profiles which together form the Cartesian product of the facets of the total universe under consideration. These new sets, profiles, or combinations may be called attributes, subuniverses or subscales; which are divided into attitude-behavior levels by "degree of strength," or interpersonal intimacy (i.e., of subject-object interaction, as shown in Tables 1 and 2).

TABLE 1.--Facets Used to Determine Joint Struction[a] of an Attitude Universe.

(A) Referent	(B) Referent Behavior	(C) Actor	(D) Actor's Intergroup Behavior	(E) Domain of Actor's Behavior
a_1 others	b_1 belief	c_1 others	d_1 comparison	e_1 hypothetical
a_2 self	b_2 experience (overt behavior)	c_2 self (mine/my)	d_2 interaction	e_2 operational

[a]Joint struction is operationally defined as the ordered sets of the five facets from low to high (subscript 1's are low) across all five facets simultaneously.

TABLE 2.--Joint Level, Profile Composition, and Labels for Six Types of Attitude Struction.

Subscale Type-Level	No.[a]	Profile by Definitional[b] System	Profile by Notational System in Table 1	Attitude Level Descriptive Term
1	0	o b o c h	$a_1\ b_1\ c_1\ d_1\ e_1$	Societal stereotype
2	1	o b o i h	$a_1\ b_1\ c_1\ d_2\ e_1$	Societal norm
3	2	i b o i h	$a_2\ b_1\ c_1\ d_2\ e_1$	Personal moral evaluation
4	3	i b m i h	$a_2\ b_1\ c_2\ d_2\ e_1$	Personal hypothetical action
5	4	i e m i h	$a_2\ b_2\ c_2\ d_2\ e_1$	Personal feeling
6	5	i e m i p	$a_2\ b_2\ c_2\ d_2\ e_2$	Personal action

[a]Number of strong elements.

[b]Facet elements of Table 1: A = o (others) or i (self)
B = b (belief) or e (experience)
C = o (others) or m (mine/my)
D = c (comparison) or i (interaction)
E = h (hypothetical) or p (operational).

Although the five 2-element facets of Table 1 permit the generation of 32 combinations or profiles, it has been established (Maierle, 1969) that only 12 of these are logically and semantically consistent, psychologically relevant, and nonredundant. These 12 profiles group into six "levels of strength." Six of these profiles, one at each level of strength (Table 2), have been chosen for the attitude-behavior scales (ABS) and the research discussed herein. The rationale for the selection is extensively discussed elsewhere (Jordan, 1971a, 1971b).

Although the Guttman-Jordan paradigm as it is used in the ABS:IE is composed of five facets and six levels, Guttman (1959) originally employed only three facets (subject's behavior, referent and referent's intergroup behavior) and four levels (stereotype, norm, normal evaluation and hypothetical interaction). Jordan (1968) expanded the Guttman design by adding two facets (actor and domain of actor's behavior) and two levels (personal feeling and personal interaction) as shown in Table 3.

In his attempt to capture the multidimensionality of attitude-behavior in his facet analysis scaling, Guttman (1959) had stated: "To increase the predictability would require enriching the facet design, or placing these behaviors in a larger context" (p. 327). Convinced that the "conative dimension" and the "affective domain" of attitude-behavior were not being measured specifically in the four-level system, Jordan (1968) attempted to enrich the facet design and placed attitude-behavior in a larger context as shown in Table 4.

TABLE 3.--Comparison of Guttman and Jordan facet designations.

Facets[a] in Jordan Adaptation

TABLE 3.--Comparison of Guttman and Jordan facet designations.

Designation	Facets[a] in Jordan Adaptation				
	A	B	C	D	E
Jordan	Referent	Referent behavior	Actor	Actor's intergroup behavior	Domain of actor's behavior
	a_1 others	b_1 belief	c_1 others	d_1 comparison	e_1 hypothetical
	a_2 self (I)	b_2 experience (overt behavior)	c_2 self (mine/my)	d_2 interaction	e_2 operational
Guttman	-----	Subject's behavior	Referent	Referent's intergroup behavior	-----
	-----	b_1 belief	c_1 subject's group	d_1 comparative	-----
	-----	b_2 overt action	c_2 subject himself	d_2 interactive	-----

[a]Facet elements of Table 1:

A = o (others) or i (self)
B = b (belief) or e (experience)
C = o (others) or m (mine/my)
D = c (comparison) or i (interaction)
E = h (hypothetical) or p (operational)

TABLE 4.—*Five-facet six-level system of attitude verbalizations:*[a] levels, facet profiles, attitude-behavior dimension and definitional statements for twelve combinations.

TABLE 4.--Five-facet six-level system of attitude verbalizations:[a] levels, facet profiles, attitude-behavior dimension and definitional statements for twelve combinations.

Level	Facet Profile	A-B Dimension	No.[b]	Definitional Statement[c]		Descriptive Name[d]
1	o b o c h $a_1b_1c_1d_1e_1$	Cognitive	0	Others believe others' comparisons hypothetically	**	Societal stereotype (group assigned group status)
2	i b o c h			I believe others' comparisons hypothetically		Personally-assigned group status
	o b o i h $a_1b_1c_1d_2e_1$	Cognitive	1	Others believe others' interactions hypothetically	**	Societal norm
	o b m c h			Others believe my comparisons hypothetically		Group-assigned personal status
3	i b o i h $a_2b_1c_1d_2e_1$	Affective		I believe others' interactions hypothetically	**	Personal moral evaluations (perceived values)
	i b m c h		2	I believe my comparisons hypothetically		Self-concept (personally assigned personal status)
	o b m i h			Others believe my interactions hypothetically		Proclaimed laws (group (expectations)
	o e o i h			Others experience others' interactions hypothetically		Group identity (actual group feelings)
4	i b m i h $a_2b_1c_2d_2e_1$	Affective Conative	3	I believe my interactions hypothetically	**	Personal hypothetical action
	o e o i p			Others experience others' comparisons hypothetically		Actual group action
5	i e m i h $a_2b_2c_2d_2e_1$	Affective Conative	4	I experience my interactions (feelings) hypothetically	**	Personal feeling
6	i e m i p $a_2b_2c_2d_2e_2$	Conative	5	I experience my interactions (overt behavior) operationally	**	Personal action

** Combinations used in the ABS.

[a] Cf. Tables 1 and 2.

[b] No. = number of strong elements in level.

[c] Words in parentheses are part of redundant but consistent statements.

[d] Alternate names in parentheses indicate relationships of various level members.

Brodwin (1973) emphasizes Jordan's contribution to Guttman's attempt to measure the entire universe of attitude-behavior:

> His (Jordan's) theory, while including Guttman's four levels (cognitive and affective elements), extends Guttman into the realm of conative behavior. His two additional Levels, personal feeling (Level 5) and actual personal action (Level 6), extend the theory to 'real,' observable overt behavior. These levels are evaluating the subject's actual feelings and actions, instead of his perceived thoughts, beliefs and opinions (as measured in the first four Levels). They appear to be in the crucial Levels at which attitudinal change occurs (pp. 162-63).

Thus, the Guttman-Jordan five-facet, six-level design encompasses the three dimensions of attitude behavior: the cognitive (levels 1 and 2), the affective (levels 3, 4, and 5), and the conative (levels 4, 5, and 6).

Facet scaling, then, is basically a technique employing the theory of facet analysis: "a tool for the organization of ideas" (Foskett, 1963, p. 111). Foskett (1963) views Guttman's facet analysis as "the coordination of elements from sets which together add up to the whole content of research projects" (p. 111).

Although Guttman rejects factor analysis as a means for quantifying data, he considers factor analysis a "predecessor" to facet analysis. Guttman's primary aim is not to "factorize" the data, but to present a theory and a method of instrument or scale construction in which he "quantifies a class of attributes" by means of predetermined rules of classification. The effect is directed toward scaling the universe of attributes of the area under consideration such that it contains 'all' of the attributes under investigation.

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Guttman (1970) approaches the actual "quantifying of attributes" in facet theory by a procedure termed structioning. Structioning consists of providing a faceted definitional system (Figures 1 and 2) for a set R and is accomplished by mapping R into the Cartesian space of the facets (R = set of rules for classification).

This set of rules for classification is decided a priori but not without a rigorous, empirical, and logical rationale (i.e., a "theory"). Guttman (1973) states that a theory can be defined as:

> an hypothesis of a correspondence between a definitional system for a universe of observations and an aspect of the empirical structure of those observations, together with a rationale for such an hypothesis (p. 35).

Kim, Jordan and Horn (1974) elaborate that such a theory and methodology attempt to answer quantitative questions as:

> How are the variables under consideration distributed in the population? What are the laws of interrelationships between variables that produce this behavior? Are these laws generalizable to all individuals (p. 11)?

According to scale theory, ordering of the profiles also implies, as Guttman (1959) states, "a formal ordering of the specific categories of elements 'within' each facet" (p. 320). In attitude research this methodological approach allows a "known" sampling of appropriate items for the different attitude-levels or subscales (Table 2 and Figure 1) and also enables the prediction of relationships between the different substructures (profiles) of the attitude universe.

Joint struction (Guttman, 1970) is restricted to the "ordering" depicted in the five facets of Table 1. Structioning is


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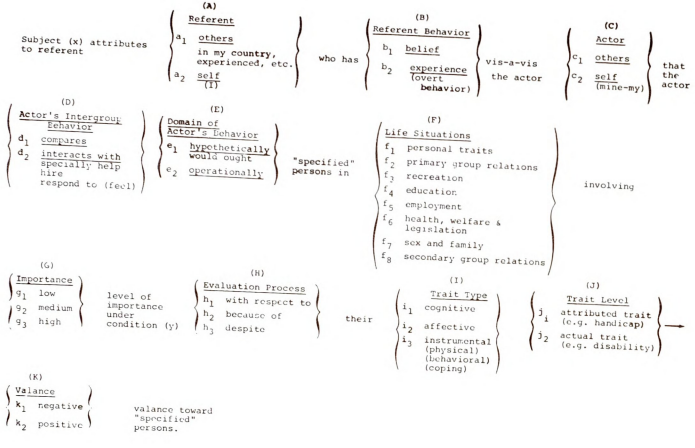

Figure 1.--A mapping sentence for the facet analysis of joint[a] and lateral[b] struction of attitudes toward specified[c] persons.

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[a]Facets A through E denote Joint Struction or level.

[b]Facets F through J denote attitude content or Lateral Struction.

[c]Any person or social group such as aged, blind, alcoholic, drug user, Negro, national, or ethnic group may be substituted for "specified" persons.

Subject (x) attributes to referent	(A) Referent		(B) Referent Behavior		(C) Actor			(D) Actor's Intergroup Behavior
	a_1 *others*		b_1 *belief*		c_1 *others*			d_1 *compares*
	a_2 *in my country*		b_2 *experience*		c_2 *self*			d_2 *contrasts*
	a_3 *experienced, etc.*	who has	*(overt*	vis-a-vis	*(mine/*	that the actor		*(favorably*
			behavior		*ingroup*			*unfavorably*
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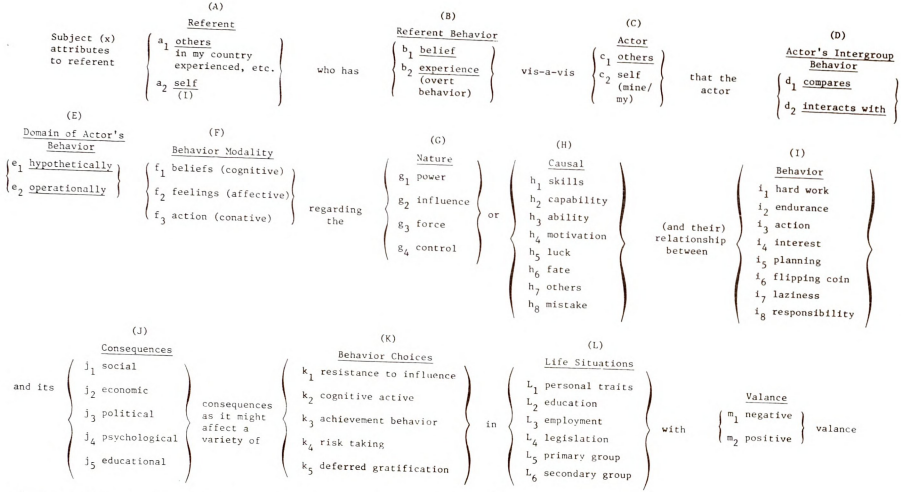

Figure 2.--Mapping sentence for the facet analysis of joint[a] and lateral[b] dimensions of attitude-behavior toward internal-external locus of control.

[a]Facets A through E denote joint structure.

[b]Facets F through L denote lateral structure.

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operationally defined as the ordered sets of the five facets of Table 1, from low (subscript "1") to high (subscript "2"), across all five facets simultaneously (Jordan, 1968, p. 76); leading to six levels of attitude-behavior strength. Low (subscript "1") represents a cognitive-other-passive orientation and high (subscript "2") represents an affective-self-action orientation (Kim et al., 1974, p. 6).

It is this quantitative rank ordering or joint struction, measuring the increasing strength of attitude-behavior from a "weak" cognitive-other-passive orientation to a "strong" affective-self-action orientation, that quantifies the qualitative data and lays the foundation for considering the multidimensional aspect of attitude-behavior.

The resulting six levels derived from the combinations of the facet-elements can thus be ordered from weakest to strongest, vis-à-vis object interaction; depending on the number of "strong" facet elements appearing in each level. Using this type of struction or ordering, Guttman-Jordan arrive at a multivariate attitude-behavior content universe which is "scaled" into six levels, each progressive level, from one to six, containing from zero to five "strong" facet-elements (Table 2).

The following analysis defines the joint struction or "ordering" rationale as applied by Guttman-Jordan to the facet-elements of Table 1:

> Facet A--the referent "other" (a_1) is weaker than the referent "self"-I (a_2) in being less personal.

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Facet B--"belief" (b_1) is weaker than "experience"-overt behavior (b_2) in being "passive" rather than "active."

Facet C--referring to the behavior of one's "self"-mine/my (c_2), rather than of "others" (c_1), is stronger in that it implies personal involvement.

Facet D--in behavioral terms, "comparison" (d_1) is weaker than "interaction" (d_2) since it does not imply social contact. A member of some identified group (i.e., the attitude object) is seen by the subject in comparison to members of some group--his own or another--without any necessary implication of interactions between S and the members of the other group.

Facet E--"hypothetical" behavior (e_1) is weaker than "operational" (e_2) in that it does not imply acting-out behavior (Kim et al., 1974, p. 6).

As is obvious, there is a rank order underlying the joint struction facet-elements in this design. Guttman refers to it as a progression from a weak to a strong form of subject's behavior vis-à-vis the attitude object. The more subscript "2" elements a profile contains the greater the strength of the attitude-behavior at that particular level. In summary, there is a progression through (Table 2) the subscale levels, "stereotype" (level 1) being the weakest, proceeding through to "personal interaction" (level 6), the strongest. Table 2 represents the special case in which all the facets are monotonic functions of the rank order specified in the ordering principle by the number of weak-strong elements of interpersonal interaction.

Jordan has attempted to establish also an ordering principle for the attitude item content itself so that it, too, could be "ordered" with some explicit a priori semantic meaning, rather than attempting to a posteriori evolve the meaning by some procedure such

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as factor analysis. Guttman calls this type of ordering "lateral struction" and the rationale Jordan (1971b) proposes considers three main principles in the selection of the item content (Figures 1 and 2) in an attitude-behavior scale.

1. Relevance of the content-area for the subject: Low-high. Is "situation y" relevant and/or important to the subject?

2. Ego involvement of subject: Cognitive-affective. Is the "attitude object in situation y" dealt with cognitively or affectively by the subject?

3. Social distance between subject and attitude-object: Distant-close. Is subject's "self" touched in situation y by the attitude object?

In other words, an item (variable) belongs to the universe of attitude items if and only if its domain asks about behavior in a cognitive, affective, instrumental modality toward an object; and its range is ordered from very positive to very negative toward that object. Therefore, attitude items toward a given object are not negatively correlated for usual populations.

Consistent with the above discussion of the weak-strong principle in the evaluation of facets A-E and attitude levels 1-6, a positive or stronger attitude in the lateral struction would be expressed by a subject who "agreed with or chose" items that dealt with the attitude object in "highly important situations that involved the 'self' of the S in close interpersonal action."

By combining the content ordering, or lateral struction, with the joint struction ordering of the six attitude-behavior levels, Jordan has developed several ABS type measures of attitude-behaviors toward varied "attitude objects" (Bray and Jordan, 1973;

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Dell, Orto, and Jordan, 1974; Hamersma, Paige, and Jordan, 1973; Harrelson, Jordan, and Horn, 1972; Jordan, 1974; Jordan and Brodwin, 1974). Although each ABS can be differentiated by its content and/or attitude object, the underlying joint struction/ordering provides the researcher a social psychological basis for predicting the structure of the empirical intercorrelation matrix of its six levels into a specific type of matrix: s simplex, as shown in Table 5.

This prediction was stated by Guttman (1959) as the contiguity hypothesis: "Subuniverses closer to each other in the semantic scale of their definitions will also be closer statistically" (p. 324). The contiguity hypothesis postulates that levels adjacent to one another will correlate to a stronger degree than will levels that are more distant from each other. In other words, "Societal norm" (level 2) will correlate more highly with a closer level, "Personal hypothetical action" (level 4) than it will with "Personal action" (level 6), a more distant level.

Nevertheless, Guttman (1959) does caution the researcher concerning the ordering principle:

> One cannot presume to predict the exact size of each correlation coefficient from knowledge only of the semantics of universe ABC, but we do propose to predict a pattern or structure for the relative sizes of the statistical coefficients from purely semantic considerations (p. 324).

Facet analysis provides a means of selecting items from an infinite sample of items that are representative of the particular dimensionality of the scale being constructed. That a rank order of subjects can be established for material that is qualitative in nature is especially significant. By means of a semantic facet

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TABLE 5.--A Simplex for Six Variables.

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2	.55	---				
3	.39	.45	---			
4	.27	.30	.70	---		
5	.24	.28	.62	.86	---	
6	.21	.24	.59	.82	.88	---
	1	2	3	4	5	6

analysis, qualitative data can be interpreted by quantitative means. The qualitative variable is given quantitative significance "such that each attribute in the universe of attributes is a simple function of that quantitative variable" (Guttman, 1950b, p. 88).

Jordan's recent summary (Kim et al., 1974) of the results he has obtained from the application of the multidimensional facet theory approach in numerous attitude-behavior studies serves as a résumé of the Guttman-Jordan attitude facet procedure. The importance of a facet-designed approach to attitude research, and the results obtained thereby can be considered under three aspects--(a) methodological, (b) theoretical, and (c) applied:

1. The facet-theory approach has proved a powerful tool in (a) defining research problems, (b) finding relationships within and among variables, (c) dealing with problems of relevancy, equivalency, and comparability in cross-cultural research, and (d) assisting in the analysis and interpretation of empirical data.

2. Certain aspects of attitude-behavior are cross-culturally invariate (i.e., the simplex-determined largely by structure of the object-subject relationship.

3. Certain aspects of attitude-behavior are object specific.

4. Certain aspects of attitude-behavior are situation specific (e.g., the same attitude object in different situations--that is, attitudes of Whites towards Blacks re: education vs. housing vs. jobs vs. etc.).

5. Certain aspects of attitude-behavior are culture specific (racial attitude-behaviors in New Zealand are quite similar in structure to those in the U.S. but more equalitarian in magnitude).

6. Certain aspects of attitude-behavior may be personality specific, as has been demonstrated in the authoritarian personality studies.

7. Knowledge per se about the attitude objects does not generally lead to attitude positiveness.

8. Amount of contact per se increases attitude intensity but not positiveness unless accompanied by (a) enjoyment of the contact and (b) perceived voluntariness of the contact. Mere exposure "is not" enough (Zajonc, 1968)!

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9. Attitude positiveness is related to a value-affective-contact base rather than a cognitive-knowledge one.

10. Attitude-behavior change must be approached multi-dimensionally: knowledge is more related to Stereotypic and Normative levels and contact, values, and enjoying factors are more related to the Actual Feeling and Action (acting-out) levels (p. 15).

Six Levels of Attitudes

The concept of Attitudes is broken down into six levels (Jordan, 1972) as noted below:

1. Societal stereotype
2. Societal norm
3. Personal-moral evaluation
4. Personal hypothetical action
5. Personal feeling
6. Personal action

Each of these levels represents a "delimited" or defined totality of behavior. Attitude is no longer a "psychic condition," but is actual behavior defined among six correlated levels, or delimited totalities of behavior. Behaviors are measured by "degrees of favorableness toward a specific object."

In commenting on the relationships of the six-level paradigm to predictiveness, Jordan (1972) notes:

> In the six-level paradigm in Tables 3-6, stereotypic attitudes are farthest removed from personal action and according to the contiguity hypothesis should be the least related to action type behavior. Thus, if an attitude scale is of the stereotypic nature (Level 1) it should be

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> expected that it should not predict personal action (Level 6). This turned out to be the case in most of our research: across cultures, across groups, across attitude objects, and across situations: (i.e., the same attitude object in different situations or contexts) (Jordan 1971a, p. 8).

The first five levels of the Attitude-Behavior Scales reflect the internal behavior of a person, not dissimilar to the internal processes of the "Disorganization" factor in Social Competency.

The notion is posed, then, of the utility and efficiency of ABS scales in identifying a "vulnerable" population previous to actual behavioral breakdown as defined by Antonovsky (1968, p. 9).

ABS scales also lend themselves to identifying change within individuals, or groups, that have undergone training/education programs direct to creating empathy, clarifying values, and increasing decision-making skills.

To illustrate the evaluation design, a comparative sketch may be of assistance here:

R	X	O
R		O

ABS Scales	Crisis Training
1. Stereotype	Opinion and information
2. Normative	Value clarification
3. Personal-moral	Value clarification
4. Hypothetical	Decision-making
5. Feeling (affective)	Empathy
6. Behavior	Decision-making (overt behavior)

Figure 3.--ABS Scales as Instruments in Evaluating Crisis Training.

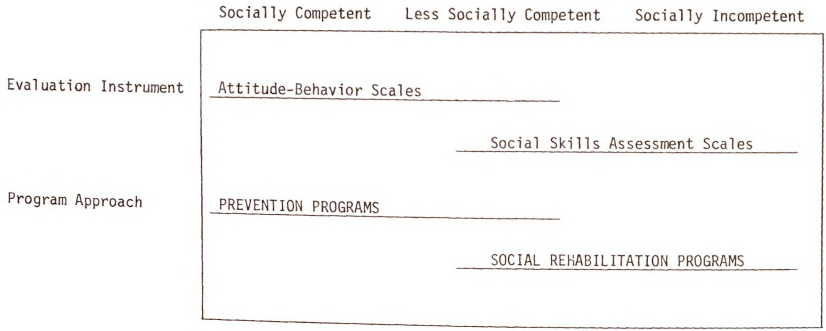

Figure 4.--Program Approaches and Evaluation Instruments.

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Social Rehabilitation and Evaluation

Program planning, as well as program evaluation, necessitates the collection of data describing program functioning. Specifically, demographic data, operating expenses, crisis training effectiveness data reflecting the impact of the prevention program on the community need to be collected, analyzed, stored and communicated.

Evaluation needs demand that program goals be clearly defined at the onset. Specific evaluation instruments and statistical tools must be identified. Data collection procedures must be specifically detailed and organized. Specific staff personnel must be identified to work with the evaluation procedure. Data recording sheets must be designed to accurately match needed data categories as described in the evaluation design.

Some program theories carry their own evaluation (e.g., theory of Social Competency). Other instruments are available which lend themselves to evaluation of the impact of prevention activities (e.g., attitude-behavior scales). Still other instruments are directed to the measurement of interagency relationships (e.g., Interagency Collaboration).

Organizing the Program Variables

Mapping sentences enhance evaluation as instruments for social rehabilitation concepts and variables and their respective relationships. Facet theory serves as a base or tool for two important elements of mental health behavior systems: attitude-behavior evaluation, and Social Competency (social skills) theory.

Facet theory also allows for specific evaluations of semantic statements as these statements are broken down or "facetized" in specific semantic elements. This unique approach provides the conceptual and instrumental base for a detailed organization of program behaviors not possible in the more traditional program organizational approaches. Above all, the use of mapping sentences organizes the program variables into a "research design" upon which both planning and evaluation may be based.

Analyzing Behavior in an Attitude-Behavior Context

Community-based social rehabilitation programs are usually funded with the supposition that one of the objectives of such programs is behavioral change from asocial or anti-social behavior to "socialized" behavior. Such behavior is ordinarily viewed as connative or muscular-skeletal behavior. The implications for similar changes in attitudes, values and feelings may often be only vaguely considered. It seems reasonable to assume that in at least some fashion a change in actual behavior implies client changes of attitudes, knowledge, thought processes, values, and feelings.

The assigned task, then, is to specify the levels of behavior which lend themselves to evaluation and, if necessary, redirection. The basic supposition is two-fold:

1. A client is behaving asocially or anti-socially and is in some significant way a threat to himself and/or the community; or

2. A client is in proximate liability or danger of becoming a threat to himself and/or society.

The term "threat" is used in a broad sense and may relate to any individual functioning outside the social systems and subsystems of the community and either interferes with community functioning or poses as a danger to his own functioning, or both.

If in this broad context community social rehabilitation programs are to address specific symptoms or grouping of symptoms of the "threatening" or "vulnerable" community, a frame of reference must be adopted which lends itself to the task of behavior change. Behavior needs to be addressed in its manifestations in intersocietal processes and interpersonal relationships. The theory of Social Competency as reviewed in this section provided a base from which to develop a rehabilitation process with a view toward the client's relationships to his environment, with specific implications for prevention as well as treatment.

Social Competency Perspective

Social Competency is a behavioral and community approach to health services delivery. It asks questions concerning the present social skills of clients, and the effectiveness of client functioning in a particular social situation. The client's ineffective (incompetent or unskilled) behaviors are evaluated and actions taken to expand the repertoire of social skills and options in behaviors of that individual within the range of client expectations and community norms. In this sense, it is a personal-social-community approach with the goal of enabling the individual to function more effectively within a community or community subgroup. Socialization of the

rehabilitatee must then be in terms of the community and the client himself, and not the agency or unit delivering the rehabilitation services.

Dr. Mark Spivak, of the Israel Institute of Applied Social Research, Jerusalem, Israel, has used the concept of competency to develop a program for the treatment and rehabilitation of mental illness (1974).

Attitude-Behavior Measurement in the Prevention and Rehabilitation Model

In evaluating behavior, the Guttman-Jordan (1971) attitude-behavior theory provides the evaluator with (a) a breakdown of attitude into six levels from the "stereotypic" or opinion level down to behavior itself; previous attitude-behavior studies with which to compare future local efforts; (b) a methodology allowing for a precise quantitative system of measure across and down the semantic statements of attitude.

Guttman defines attitude as a "delimited totality of behavior." Spivak addresses sanity-insanity in terms of Social Skills. Antonovsky describes "breakdown" as a concept and a process involving "choice" or "decision-making" in a definite behavioral context.

In examining the concepts, what immediately becomes evident is the conceptual link between the Jordan-Guttman attitude theory on the one hand and the Spivak Social Competency model on the other:

(A) Action Potential		(B) Action	(C) Type of SSR[a]	(D) Areas of SSR[a]
Knowledge (capacity) Liking (motivation) Doing (performance)	of, for	Developing Maintaining Utilizing	New Existing	Technologies (theories) Network linkages and roles Direct/prevention services

	(E) Role Behavior Needs		(F) Provider	(G) Evaluation
for fulfilling the	Autonomy (status) Power (control of destiny) Effectiveness (productivity) Relatedness (cooperative input) Funding (existence) Competence (internal quality) Political (endorsement) Control of information (perspective)	of	City Council City administration Public agencies Line staff Funding sources Taxpayers Private agencies Volunteers	Population description services Gaps in services Needs for services Methods of services Benefits of services Facilities needed Personnel needed Funding needed

	(H) Recipients		(I) Purpose		(J) Type	(K) Measurement	
of (for)	Clients Families of disabled Significant others Public agencies Community at large	for	Identifying Maintaining Developing Evaluating Reporting Funding Eliminating Absorbing	Social/ Rehabilitation Services:	Personal Social Vocational	High to Low	for disabled citizens

Figure 5.--Mapping Sentence for a System of Evaluation, Interagency Collaboration in Virginia Beach, Virginia. A proposal for accountable interagency collaboration for helping disabled persons to become tax-paying citizens.

[a]Social Systems Relatedness (care-giving in a cooperative, measurable community effort).

1. The systems are both programed on Facet theory (i.e., an orderly arrangement of multivariables on a lateral or semantic dimension);

2. Social Competency picks up where Attitude-Behavior theory ends (i.e., the sixth level of the Attitude-Behavior theory is noted as "Behavior," but reported or connative behavior); Social Functioning in Social Competency theory is reported, observed, and developed, or inculcated behavior.

Two instruments are available which could be most useful in assessing individuals and groups in pre- or post-training/education/prevention programs. One of these instruments is the Cognitive Style Assessment. The other is the Attitude-Behavior Scale (Jordan, 1972).

One significance of both these instruments is that both assess individuals or groups in dynamic terms (i.e., functional-attitudinal-meaning assessment styles or levels). The use of these instruments, along with a Social Competency (Spivak, 1974) assessment, should provide an insight into an individual which not only portrays his difficulties, but also suggests specific directions for rehabilitation.

The point is that the more traditional clinical-psychological-diagnostic approaches are not always very helpful in identifying population, subpopulation, or individual needs in target populations for prevention programs.

Attitude-Behavior Theory Development and Social Rehabilitation

When Facet theory is used in examining social attitude-behaviors, these behaviors are described and itemized "a priori." Evaluation or testing then is directed to the components of each attitude-behavior.

For present purposes, Guttman's definition of attitude as a "delimited totality of behavior with respect to something" will be accepted. In thus defining "attitude," Guttman went further than the more usual definition of attitude as a "predisposition to behavior," and included attitude as a unit of actual behavior (Nicholson, 1972).

Over the years a growing body of literature has become available relevant to Attitude-Behavior theory on the one hand, and the search for a paradigm for psychotherapy research on the other hand.

Both areas pose as potentially rich sources of knowledge for the improvement of community-based social rehabilitation programs.

Social Competency System as a Community Rehabilitative Response

In the past, mental illness was approached like physical illness; its symptoms were categorized, and individuals were diagnosed or labeled, treated (usually in large custodial institutions), and then pronounced "cured" accordingly. Unfortunately, however, cure usually has not resulted from this chain of events so successful in medicine. In fact, the entire physical illness approach to mental

health problems has not effectively dealt with this area which not only defies rigid categories or generalized curing remedies, but demands social-functioning based differential diagnoses which include a total perspective of physical, emotional, and social disabilities.

A new approach to mental illness conceptualized the observable side of mental illness as resulting from social disabilities or incompetencies. Treatment then is based on training the individual to operate effectively in a social sense.

The treatment effort focuses on the functional limitations, and the social skills, of the individual exhibited by his present behavior. Observing and describing the behavior of an individual is much more behaviorally specific than a diagnosis that applies a generalized label to the disorder, a label often more misleading than the specific behaviors themselves.

Because of the behavioral emphasis of this approach, a concern with the origin of a client's problem in terms of past experiences is minimal. The traditional psychiatric diagnosis, or whether a client had a good or a bad childhood, are not a primary concern. The central concern is the ability of the client to operate in a social situation with the necessary personal, social and vocational skills. The client's problem is described in terms of the incompetencies present and problem resolution or treatment occurs by the attainment of specific social skills. This is why the behavior of the client is so important. If he is skilled (competent), if he can function in society, then the description of the problem in terms of

the past is of no consequence. The client's ability to function is at issue and hence so are his behaviors.

This approach implies more for the rehabilitation agent than changing the behavior of the client. Altering behavior is not the only objective. The primary objective is increasing the options in behavior, the social skills, with which an individual can function in a community. In this way the client does not have to be condemned with a diagnostic label, or confined by his own incompetencies; rather, he can operate from a wider range of choices in his behavior. However, this does not mean that the client is to be resocialized to middle-class standards. What is offered the client is an opportunity to select his lifestyle from a position of strength rather than from an inability to cope in any other manner.

Definition of Social Competency

Items belong to the universe of competency development or rehabilitation if and only if the universe pertains to the development of (social instrumental) competencies, with respect to a current social norm of a society, and its range is ordered from very competent to very incompetent with respect to that norm. Social competency is a measure of an individual's skills in social interaction and articulation, while instrumental competency is a measure of that individual's ability to perform certain behavioral tasks. Both social and instrumental competencies relate to the set of various reactions exhibited by an individual within some social space.

The goal of rehabilitation then is to increase the variability of possible client behaviors (the functional options) so

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that the client may successfully cope with situations he will encounter in the community. A rehabilitation process should involve the teaching of and development of those social and/or instrumental competencies necessary for successful coping and functioning. In short, the idea is to increase the options of possible client behaviors. It can be seen from the goal of rehabilitation, as stated above, that certain assumptions are made by the social competency model. These assumptions are that:

1. Certain skills or behaviors are necessary to function in society. These competencies can be characterized as involving social or interactive skills and instrumental or task-related skills.

2. The goal of rehabilitation is to assess the needs of the individual in terms of social competencies (skills) and incompetencies and to inculcate those social and instrumental competencies or skills lacking in that individual. Since every individual will have different types and levels of social skills, individualized treatment plans are necessary.

3. As a result of the differential treatment plans, the program must be adaptable to each individual's needs.

4. Rehabilitation is directed to the return of the rehabilitatee to the community, and therefore the norms of the rehabilitation center must be congruent with those of the community of reentry.

The approach to treatment is based on the process of disorganization and desocialization. The socially incompetent

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behaviors exhibited by a client arise from these two processes. In a larger sense, through rehabilitation (the development of socially competent behavior), the individual is being reorganized and resocialized. The following section deals with the dual processes of disorganization and desocialization.

Disorganization and Desocialization

In describing the incompetent behaviors of clients of a program, the formulation established by Cameron and Magaret (1951) proves useful. They state that schizophrenic disorders evolve from and comprise a dynamic interaction between behavioral disorganization and desocialization. The incompetencies exhibited by a client stem from the processes of disorganization and desocialization.

Disorganization is "the disruption of a unified reaction, or system of reactions, and its replacement by behavior that is fragmentary, haphazard or chaotic." There are a number of conditions under which disorganization is likely to occur. These conditions include behavior frustration, behavior conflict, environmental change, preoccupation, emotional excitement, ineffectual role-taking, and situational complexity (Cameron and Magaret, 1951).

The conditions associated with disorganization refer not to skills or behaviors which are necessarily lost or forgotten but to a blockage in those behaviors appropriate for a specific situation.

Desocialization includes "a reduction in the social articulation of behavior, resulting from the partial or complete detachment of an individual from participation in the activities of the social community."

The conditions under which desocialization are likely to occur include:

> Social isolation, decline in social communication, loss of techniques of social validation, progressive loss of social skills through disuse, impairment of language behavior decrement of role-taking skills, nonconformity to the expectations and opinions of others, and emotional avoidance of human relationships (Cameron and Magaret, 1951).

The result of all desocialization is the impairment of social skills.

As can be inferred from the above, the dual processes of disorganization and desocialization are most closely related and are mutually reenforcing. They are, in addition, behavioral indicators of individual disabilities or incompetencies, and provide specific direction to the customized rehabilitative program.

It is important to note that all individuals will at some time experience disorganized and desocialized behavior. For example, from past experience people assume that they can pick up the telephone receiver, dial a number, and speak to the desired party. What sometimes happens, though, is a disruption of this standard behavior due to a breakdown in the telephone system. When this occurs the caller might push down the receiver buttons, shake the phone, shout, or slam the receiver down. This might be described as disorganized behavior. In instances of disorganized behavior, most individuals have others whom they can fall back on--friends or family, organizations to which they belong, and so on. These have been characterized by Antonovsky (1968) as "resistance resources" which can prevent social breakdown. For some individuals these resistance resources might not be sufficient to maintain or restore functioning, in which

case an additional resource would be a social service program. Moreover, although the program's goal is total rehabilitation, the need for or at least the possibility exists that the program may well continue even after "rehabilitation." As a result continued contact with the individual after he has left the program is of crucial importance for the maintenance of socially competent behaviors.

In the previous sections the conceptual framework of social competency has been briefly explicated. Now the question must be asked as to how the incompetent behaviors can be reversed. To do this we must look at the program itself, its results in terms of competencies developed, and the means initiated. This methodological framework will and must stem directly from the theoretical analysis of social competency.

Methodological Framework for Social Competency

The methodological framework of this approach is the means by which the social and/or instrumental competencies will be developed by the client. It is divided into four sections: the rehabilitation facility, treatment approach, treatment plan, and evaluation.

The rehabilitation facility is where direct treatment of the client occurs, and therefore it constitutes an environment for that client. In a true sense, any health service center, or other caregiving facility, can become a rehabilitative center, e.g., Social Service, Juvenile Probation, Mental Health. To achieve maximum benefit from any rehabilitation action, the environment of the facility should be structured in such a way as to promote socially

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competent behavior on the part of the clients. To do this, social structural control mechanisms and interactional control mechanisms must be an integral part of the program to treat incompetent (ineffective) behaviors resulting from disorganization and desocialization.

Social structural control mechanisms.--This refers primarily to programmatic decisions concerning the program's stance or structure in treatment. They include:

a. Integration: Solidarity or conflict may exist among clients and staff in a program. Overt and especially covert staff conflict can be highly destructive to clients. Positive and effective action among staff is necessary to form and carry out treatment plans for clients. An emphasis upon formal and informal communication is essential for the staff to implement the treatment plans in a unified and integrated manner.

b. Goal application: The rewards or restrictions of a program must be consistent with the expectations of the local community, or community subgroup. Moreover, it is crucial that the client see the relationship that his treatment plan and the rewards and restrictions of the program has with his overall rehabilitation goals. It may be best to form the treatment plan with the client. Considerable individual and group discussions with the client may be necessary to accomplish the above.

c. Instrumental role: This involves staff efforts to counteract the inadequate or unrealistic role-taking of clients in

the program. Staff will generally utilize noncomplex and repetitive roles for clients to counteract preoccupation. These roles may gradually become more complex, comprising a sequence of a number of repetitive acts. The instrumental role may take place in a secluded or highly social setting, depending on the tolerance level of the client. Yet the instrumental role does not entail social, but rather specific instrumental interaction with others.

d. Affective-expressive: This concerns the degree of environmental threat or permissiveness in the affective-emotional interchange that is permitted between clients and staff. The extent of tolerance by staff for various kinds of deviant behavior by clients as well as permissiveness for other kinds of behavior must be clearly delineated, articulated, and structured into the program.

e. Social role adequacy: This binds the client into the program in a meaningful way, and assigns roles to the client which are consistent with the expectancies placed upon him by the larger community. The program should have an array of socially meaningful roles for the client to fill which are consistent with those roles and skills useful to the client in the community. The client learns how to adequately fill progressively more complex social roles in accordance with his own needs and goals, which are also socially rewarding and fulfilling.

Interactional control mechanisms.--This refers to programmatic decisions concerning the ways to react to (or ignore) a client's deviant behavior. It is the approach taken with a client in

interaction but not necessarily the only means by which socially competent behavior is inculcated. The interactional control mechanisms include:

a. Social support: As the client expresses his fears and difficulties, the staff indicates to the client that he will obtain support as he is and that he is viewed by the staff as a worthwhile person. The staff provides flexible support for a client and his problems by intervening in his life space in order to facilitate maintenance in the program. Emotional supports are flexibly provided whether through individual or group interaction. Staff essentially gives the client the message "we like you for who you are."

b. Permissiveness for the expression of deviant tendencies: The client is told that he will not be rejected for his behavior. This may be qualified by exceptions such as physical violence to other clients and use or possession of drugs. The program's tolerance for deviance, as it is expressed in daily interaction with the client, must be greater than that of the larger community because of the desocialized status of the client. Staff should react permissively to instances of deviant behavior on the part of clients if his or other clients' well-being is not endangered.

c. Denial of reciprocity for deviant expectations: Despite the acceptance of the client's deviant behavior, the staff should indicate to the client that his behavior is not accepted as being optimal and that measures will be taken within the program to alter that behavior. On the other hand, the client is not punished, as

he expects, for his deviant behavior. The client may be told, "we like you, but not always what you do."

d. Conditional manipulation of rewards: Rather than use negative sanctions for altering deviant behavior, positive rewards in interaction with the client are to be used by staff to reinforce the client's positive behavior. Negative sanctions often reinforce those negative behaviors of the client. They also reinforce the client's own poor self image and add another failure experience to his collection. Positive rewards, though, must be consistent with the behavior exhibited by the client.

Overzealous praise by a staff member for an inconsequential act may only serve to scare the client. He will be well aware that his act does not merit such praise and he will be fearful of his new "successful" status since he well knows that he does not possess the commensurate skills. Positive sanctions should be related to the behavioral act itself and not to the worth or status of the client.

These mechanisms are of primary importance for the foundations of a program. They are, in a sense, its underpinnings. However, the actual treatment plan will not necessarily contain this information as it is specific only to the program and the programmatic approach taken toward the clients. The control mechanisms are not necessarily applied differentially to clients.

In a sense these control mechanisms can be thought of as the behaviors of the staff and the program through the staff. They are, in effect, the competencies of the program. Without the basic

foundation the success of the rehabilitation effort is likely to be reduced, since the socially competent actions taken are the vehicle through which change is effected in a client. The degree of change in the clients then will only result to the extent that the program is socially competent. It is hypothesized that the relationship works in the following manner.

		Competence of Client's Behaviors	
		High	Low
Competence of Staff	High	1	2
and			
Program Response	Low	3	4

Figure 6.--Social Competency Program Relationships.

If there is a high correlation between competence of the program and the clients, either a high program and client competence will correspond (Cell 1) or a low program and client competence will respond (Cell 4).

Program and Treatment

At this point, a discussion of the application of Social Competency theory to the rehabilitation process would be practical. The emphasis in the remainder of this section will therefore be on the practical application of social competency to program rehabilitation in a community.

The general program goal of social rehabilitation has been broken down into three subprograms. These subprograms are (a) independent living, (b) educational and vocational skills, and (c) social (family and group) behavior. Each of these subprograms is to add specificity to the areas that are to be involved in rehabilitation as well as to provide consistency to the social rehabilitation effort in the city.

Within the three subprograms the incompetencies and the competencies of the client must be determined and their relationship to the processes of disorganization and desocialization established. Not only will this process indicate something concerning the nature of the socially incompetent behaviors of the client, but the way they cluster or group themselves with all the incompetent behaviors exhibited can denote trends or threads of difficulties for that client. For example, after reviewing and evaluating a client's behavior, it might become apparent that he becomes disorganized when faced with situational complexity and emotional excitement.

Thus, identifying the disorganized and desocialized behaviors can provide information as to the pattern of the incompetent behaviors and the appropriate structuring of the rehabilitation actions.

After the client's socially incompetent behaviors (SIB) within the three programs are identified by the program staff primarily through elevation and observation of the client, the socially competent behaviors (SCB) to be taught can be determined. These SCB's are necessary for the itemization of the three subprograms

and hence the meta-goal of rehabilitation. The social competency actions might be called the activities of the program--what the client is to do in rehabilitation. A social competency action (SCA) is that activity necessary to bring about a particular SCB. Moreover, the social competency action must occur within a social competency unit (SCU). The SCU is the unit or part within a program where particular SCA's occur bringing about the desired SCB's. The social competency model calls for the delineation of SIB's, SCB's, SCA's, and SCU's for each individual.

For example, suppose there is a client who fails to keep scheduled appointments which is interfering with his ability to find employment (a subprogram item of choosing and obtaining educational and vocational placement). Incompetent behavior of this type may result from behavior conflict, preoccupation, decline in social communication, and ineffectual role-taking. The competent behavior or skill would be punctuality in terms of keeping appointments. The SCA might be something as simple as buying the client an alarm clock so that he will wake up in the morning, or it might require helping the client set up a time schedule of activities. The unit in the first case would be the purchasing department of the facility or in the latter instance a one-to-one counseling session. Tardiness can be the result of many factors other than the ones presented here. This example was used to illustrate the importance of being specific about the client's problems and the types of therapeutic actions to be utilized.

To illustrate what has been said thus far we will make use of a flow chart, as shown in Figure 7.

Many SCB's will cut across the three subprograms of treatment. They will most likely also cut across SCA's and SCU's. Because of this overlap, the treatment subprograms for that client must be clearly thought and priorities established.

To avoid complications in client evaluation, clinical decisions must be made when relating specific SIB's to a subprogram. For example, articulation may be an SIB which affects client functioning in both the Social and Vocational aspects of his life. The problem may also affect his self-image, or Independent Living. But a referral is necessary to only one SCA for rehabilitation, as is illustrated in Figure 8.

An added concept in the illustration is that the client may have been referred by a private physician to the public mental health facility for evaluation and treatment because the client is experiencing sleeplessness in the absence of any physical/neurological problem.

Mental health evaluation indicates significant worry by the client because his speech problems are causing a general lack of self-confidence, plus a marked inefficiency in his supervisory role at work. The client is referred to a Social Competence Activity, in this instance located at a local public school, conducted by the Department of Vocational Rehabilitation. The doctor remains throughout the primary therapist of record, and the client is referred back

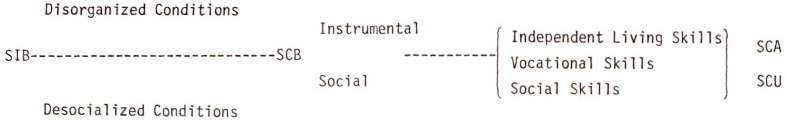

Figure 7.--Flow Chart: Socially Incompetent Behavior to Program.

	SIB	SCB	SCA	SCU	SCA
Ind. Living Skills	Poor articulation	Pronunciation, enunciation	Speech therapy	Adult education	Vocational Rehab.
Social Skills	Problem	Other skill	Training group	Seminar	Mental Health
Vocational Skills	Problem	Other skill	Training group	Seminar	Public Health
					Social Services

Figure 8.--Flow Chart: Organization of Response.

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to him upon completion of treatment. In effect, two key strategies are involved in comprehensive client evaluation:

1. The careful identification of client skills and disabilities; and

2. Careful referral to the specific unit and activity of rehabilitation; at the rehabilitative facility or elsewhere in the community.

By applying the approach of outlining the necessary SCA's, SCB's, and SCU's, it is possible to group them in terms of similarity of function. After grouping, the development of a treatment plan will be much simplified. That is, SCA's taken for one treatment goal can be applied to another goal, all of which can be accomplished within given units. In this way, the overlap and counterproductivity of various rehabilitation actions can be reduced.

The application of SIB's, SCB's, SCA's, and SCU's entails a high degree of specificity regarding the program's treatment and its purpose. To create and then use the social competency model requires that everything occurring in the rehabilitation process be clearly spelled out. The SIB's and SCB's state what behaviors or skills are inappropriate and need to be obtained. The goals of rehabilitation and treatment are then very certain and exact. The means by which the SCB's are learned are the SCA's and the SCA's occur within particular parts of the program or SCU's. This might be called Treatment By Objectives (TBO) similar to the management by objectives concept. With this approach the rehabilitator knows what he is attempting to accomplish and by what means.

However, this is not necessarily an easy model to apply although its clarity and effectiveness is great. It is a tremendous challenge to the program staff for they must have categorized all the SCA's and SCU's of the program in terms of the SCB's to be inculcated.

Therefore, the social competency model, to work properly, requires a thorough understanding of the rehabilitation process and precise and extensive evaluation concerning the program. Yet, it adds flexibility to the program in that the needs of the clients must continually be matched with the program's clinical actions. As a result, the program must remain open to change in terms of the treatment it offers. The necessity of the continuing program relevance to client needs demands continual client and program evaluation. It also requires a great deal of interagency effectiveness on the part of city department heads and private facility administrators. Application of the social competency model provides a framework by which a program can be evaluated on a basic treatment level. Its specificity enables a measure of effectiveness of specific program components.

Treatment Plan

In applying a treatment model of this kind, the rehabilitator must realize that the assessment of the client for his competent and incompetent behaviors is a continuous process. The measuring of success in achieving any rehabilitation goal is in the short and the long term. After each assessment, the competent and incompetent

behaviors of the client will alter and therefore so will the SCA's and SCU's for that client. Of course, with a model of this nature the treatment plan will be different for each client and a schedule appropriate to his needs and priorities will need to be established.

The specific program arrangements for establishment of a treatment plan will undoubtedly alter between programs; however, a general outline of this process has been created which might prove helpful.

To develop a treatment plan for a client, a team should be established consisting of at least two members of the treatment staff, the client, and significant others. After assessment of the client's behavior, a determination of the client's SIB's and the predominant disorganizing and desocializing conditions associated with the SIB's is made. The SIB's are then categorized according to the three treatment subgoals previously established. In conjunction with the conditions associated with the SIB's and the SIB's themselves, list all SCB's. Next list the SCA's for each SCB, and the SCU's that the program can provide and those that other community agencies can provide. Contact the community agencies that can have the needed SCU's for that client which the program does not offer. The total rehabilitation schedule, SIB's, SCB's, SCA's and SCU's must be clearly defined. A total rehabilitation schedule, including place, time, and transportation needs can then be easily devised.

The review of the literature has focused primarily on the theory of Interagency Collaboration, with briefer review of the related areas of Social Competency and Attitude-Behavior scaling.

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CHAPTER III

METHODOLOGY AND CONCEPTUAL APPROACHES

The introductory chapter of this study addressed the question, "Why is collaboration necessary?" The answer is contained in the general chapter theme: clients' socialization needs are most often too complicated to be effectively addressed by a single community agency.

The second chapter addressed the question of the "how" of interagency collaboration (i.e., a review of theories for effecting collaboration among agencies or community resources).

This chapter addresses the question, "What is there to collaborate about?" or the programmatic directions and content that both generate and comprise the community's responsive behavior to social dysfunction.

The most specific concept reviewed will be that of Prevention (i.e., the most effective response to social rehabilitation is to prevent dysfunction in the first place, or at least to arrest dysfunction in its earliest stages).

The other major response is that of a specific rehabilitative response for those clients who, for whatever reason, slip through the prevention efforts and become socially dysfunctional. This rehabilitative response was presented and discussed in terms of the theory of Social Competency in the previous chapter.

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Prevention Programs: Stemming the Tide

Within any community, some citizens are functional and some are not. In the latter group are persons disabled by one or another physical, neurological, educational, economical, or social handicap. The lines separating the various lines of disability are at times clear and at times blurred. Often enough a disabled person may fall within a number of disability areas. For example, a significant physical disability may render a person also socially and vocationally handicapped.

A social disability, in its broad sense, is any unfilled need within a person's immediate environment which renders the individual unable to provide for his personal, interpersonal, or vocational needs and precludes normal functioning as compared to prevalent and general norms of the immediate society or community. Any number of community agencies are prepared to respond to various categories and degrees of citizen need. However, community services are seldom if ever categorized and utilized as preventive resources, or resistance resources. Another way of saying this is that community agencies tend to view themselves and to be viewed as static and often isolated agencies that deliver rather narrowly defined direct treatment services with vaguely described goals and objectives.

In this study services are viewed as interrelated in an Interagency concept as described in the previous chapter. These close relationships among agencies are not ends in themselves, but means for more accountable and efficient service delivery. The

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vaguely defined goals and objectives alluded to above must be precisely defined if Interagency Collaboration is to be productive.

The Concept of "Prevention"

Discussing this concept of "prevention," Antonovsky (1968) suggests that the phenomenon we should be trying to prevent, both in the behavioral as well as the medical sciences, is "breakdown." In terms of social breakdown, he comments:

> It should . . . be obvious that there is an intimate relationship between the culture a person is socialized into, the social system in which he participates, and the resistance resources available to him. . . .
>
> Public health and preventive medicine have overwhelmingly been devoted to controlling the threats posed by the outer environment, moving close to people only in matters such as immunization. Even health educators have focused on equipping persons with specific, static responses to threats.
>
> It seems . . . that a new health profession is needed. The practitioner whose responsibility it is, working in the community, to augment the resistance resources of people prior to breakdown. Conceivably this could be the "community psychiatrist," the public health nurse or the medical social worker; but by and large this is not the job being done today by those professions. The training of such a professional would, of course, depend upon learning much more about breakdown and resistance resources than we know today.
>
> But what would such a person do? I can here only throw out a few general suggestions. He (or she) could identify the high-risk populations, primarily in terms of those with poor resistance resources, and not only for those confronted by much threat. He could not only provide information about existing facilities available to people to meet threat, but help uncover the resources which people have unknown to them. He could mobilize the resources of the many in a community who want to do for others but neither know who these others are nor how to go about doing such a good (pp. 12, 13).

Antonovsky (1968) calls for a searching for inner resources as well as community resources in a comprehensive prevention effort

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involving the total community. He also notes that much more is to be learned, which is really very similar to treatment programs, in which there is also much more to be learned.

Antonovsky's thoughtful comments suggest the obvious: Much more can be done with community programs than relegating the whole notion of prevention to the usual level hardly above "lip-service" that is sometimes found in the traditional mental health program.

Intervention: The Goal of Prevention

If the thesis is accepted that social dysfunction often either leads to or is a result of social skill deterioration, then the task of a prevention program is somewhat delimited. The goal of prevention then is to intervene in a person's lifestyle at a point in time, in a sensitive and effective manner, so that the social breakdown of an individual, or groups of individuals, may be precluded.

It should be noted that "mental health prevention" and "mental health education" are not synonymous terms or concepts. Drug education may be one phase or facet of drug prevention, but "drug education" may also have the effect of raising the incidence of drug abuse. Information is of itself no guarantee of prevention.

Objectives of Prevention Programs: The Concept of "Breakdown"

An individual may become dysfunctional for a variety of reasons--escape from pain (physical or psychic), social pressure, daring, excitement, peer pressure, striking out at authority, fear,

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and so on. Other variables such as rigidity, isolation, confusion, apathy, and indecision are also related to the onset and development of "desocialization" and "disorganization" behavior patterns that are both the cause and result of social breakdown.

Antonovsky (1968) notes that breakdown is not a one-dimensional concept, and the factor of "choice" or decision-making is often inherent in the breakdown process. Whatever else they may be designed to do (e.g., organize, coordinate, inform), prevention programs should be directed to the decision-making processes of vulnerable individuals in order to prevent social breakdown and support social functioning. Prevention programs should also be designed to enhance an individual's adaptability, effective ties to immediate resources, and ties between an individual and his community.

Again, a truly comprehensive rehabilitation program will be directed toward the prevention of social breakdown occurring in the first place, and the social rehabilitation of individuals who, despite community preventive efforts, break down socially.

"Breakdown" defined.--But perhaps more importantly, Antonovsky (1968) suggests that "breakdown" can be prevented, inasmuch as it is any state or condition which is described by the mapping sentence contained in Figure 9.

When breakdown is viewed as the failure to function in a critical social institution or set, the implication for the employment of internal and external resistance resources becomes even more evident.

		(A)		(B)
		Dysfunction		Debilitation
A condition	which is	Not at all / Mildly / Moderately / Severely	directly	Painful to the individual, and dysfunctional

(C)		(D)		(E)
Impairment		Intensity		Condition
Limits / Impairs	him/ her	Not at all / Minimally / Moderately / Severely	described by	1. Neither acute nor chronic 2. Mild chronic 3. Acute but not life threatening 4. Serious & chronic but not degenerative 5. Serious, chronic, degenerative, acute and life threatening

	(F)
	Social/Medical Response
and is responded to societally/ medically	Not at all / Observation only with active therapy

Figure 9.--A Mapping Sentence for "Breakdown."

Breakdown, then, doesn't just accidentally occur. Changes in life tasks, values, resources, tension intensity, and other personal and environmental factors all relate to social breakdown. Antonovsky (1968) states:

> At any given time, the individual is confronted with demands (one might well use terms like presses, problems, threats, stressors) placed upon him by his inner and outer environments. These demands upset equilibrium and create a state

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> of tension. Every individual has at his disposal what I would call resistance resources, by which I mean power which can be applied to resolve tension. Tension is inevitable for living human beings. It is, moreover, often deliberately and willfully brought into being; it is a state which can be gratifying and rewarding in two major ways. First, tension can be directly pleasurable; the sexual experience and the football match are only two of innumerable examples which could be given. Second, the experience of tension provides one with the values of any experience: adding to one's repertoire for future use.
>
> It is not, then, the imbalance which is pathogenic. It is, rather, the prolonged failure to restore equilibrium which leads to breakdown. When resistance resources are inadequate to meet the demand, to resolve the problem which has been posed, the organism breaks down (1968, pp. 1-2).

Some clients need to be referred into the health service system or a similar care-giving agency, but other clients may be effectively helped without formal entry into the system and thereby prevented from entry into the system. This rationale responds to the question, Why collaborate? The answer is to provide the earliest, most efficient, most accountable and most economical human services response to disabled persons. This is accomplished by identifying gaps and overlaps in services, identifying the various levels of resistance resources in the community, sensitizing administrators and staffs of their roles in developing community resistance resources, and developing precisely defined direct service delivery programs and referral processes. In effect, this means that community agencies are conceptualized, and actually function in a manner which intercepts, or intervenes with, clients before total social breakdown occurs. The role of the community agency as a resistance resource is an essential element in a community preventive approach. Conversely, in a community where little or no

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prevention occurs, direct care services expand enormously, waiting lists of clients develop and lengthen, budgets balloon, counselors grow weary and frustrated, staff turnover rates increase, goals and objectives blur, case notes and tracking systems become neglected, and accountability disappears. With respect to treatment, if community rehabilitation programs are to be effective, economical, and sensible, a strong prevention approach to social disability must be designed and implemented.

When agency administrators begin to work together, their energies may be appropriately directed to three tasks:

1. Communication and planning based on interagency collaboration;
2. The development of resistance resources; and
3. The development of organized and effective rehabilitation programs.

Developing a Public Health Approach

Prevention program development is centered around a few basic concepts. These basic concepts include:

1. Whenever possible, individuals in crisis can be more effectively assisted before their crisis develops to the point that they have to be referred into the mental health treatment system;

2. The many human resources of a community can be organized to react to individuals in emotional stress before that stress seriously interferes with community, vocational, and personal functioning;

3. Prevention programs can be developed on theory bases for implementation and evaluation;

4. The activities associated with prevention programs include activities directed to cognitive learning and personal growth, including sensitivity to feelings of self and others, identification of personal values and guidelines for resolution of value conflicts, ability to make decisions, adequate defense mechanisms, and sufficient personal flexibility;

5. The training of trainers is a critical factor in implementing a crisis intervention program with "community gatekeepers" or persons in critical positions in the community who have regular contact with large community groups (e.g., policemen, social workers, teachers, parks and recreational personnel, clergy, probation, etc.);

6. The training of gatekeepers emphasizes their sensitization to their roles as "resistance resources" (i.e., their capacity to intervene in a preventive response with clients and individuals who are becoming desocialized).

Prevention Programs: Developing a Training Effort

Activities associated with crisis training program delivery include:

1. Adaption, as necessary, of training curriculum emphasizing value clarification and decision-making;
2. Identification, employment and training of training staff;
3. Organization of target population for training;

4. Development of logistical steps for training, including time, place, training aids;

5. Identification of specific behaviors associated with prevention training;

6. Collection and interpretation of data;

7. Evaluation of prevention/training effectiveness;

8. Communication of data reflecting program effectiveness or deficits to program administration and responsible community and funding groups, agencies, and bodies; and

9. Adjustment of program curriculum and delivery in light of collected evaluation data, for improved program effectiveness.

Above all, evaluation data must be translated in concepts and language readily interpretable to the consumer, taxpayer, client, and staff. For unlike the treatment model, prevention programs have yet to fully enter into the free enterprise money market. Prevention models, as well as prevention curricula, are also relatively rare and not easily understood by professional or politician. All too often, "prevention" curricula turn out to be little more than educational or informational curricula. The program must be understood if it is to receive professional and political endorsement.

A Community Response to the Vulnerable Citizen

The organization of inner human resources and external community resources obviously dictates two broad areas of responsibility, both essential in effective prevention programs: the responsibility of the individual for the development of his human resources--resiliency, flexibility, sensitivity, insight, awareness, toughness,

or sound defenses; and the responsiblity of a community to actively respond to a threatened individual and assist him/her in dealing with the threat in a manner that portrays that this community value-responsibility has been truly institutionalized.

The above discussion identifies two main thrusts of a social rehabilitation program in a public health (preventive) model:

1. The adaption and implementation of a specific curriculum of crisis intervention aimed at developing empathy, value clarification, and decision-making processes. This approach is directed to the establishment of inner human resources;

2. The implementation of agency interaction processes within and between city departments and resource groups. This approach is directed to the coordination and development of community resources. This theory of Interagency Collaboration is included in a separate section of this study.

Relating Prevention with Rehabilitation

Regardless of how well this preventive approach is accomplished, needs of some citizens for direct services in a rehabilitative sense will always be present, although these numbers should be significantly reduced. When the need for direct services is indicated, such services should be provided as quickly as needs indicate, within a comprehensive community effort with gaps and overlaps deleted, and with client needs clearly defined and integrated in a precise treatment plan. This treatment plan, and rehabilitation

process, is most precisely defined within the context of a Social Competency model, and was discussed in the preceding chapter.

Organization of Concepts and Efforts

Some form and substance, then, begins to appear. Collaborating agencies must:

1. Identify agency needs and concerns, and develop a framework for communication around these needs;

2. Identify the incidence and prevalence of community disabilities (client needs), and develop preventive programs to reduce the incidence of social breakdown;

3. Develop a precise and effective community rehabilitation system which eliminates gaps and overlaps in services, responds to the needs of individual clients, and can be translated into trackable and measurable results; and

4. Develop, administer, analyze, and utilize a method for identifying specific social disabilities of community citizens in order to effect a community rehabilitation approach.

Defining the Vulnerable Population

In a real sense, every person is subject to social breakdown and in that sense every person may be broadly classed as "vulnerable." The usual formula declaring "out of a city of so-many-thousand, such-and-such a percentage of persons may be considered drug abusers or mentally ill" is only a beginning step in a specific identification of the population. Data must be useful in making programmatic

decisions concerning specific responses to vulnerable or disabled persons at specific age levels.

In determining vulnerability at adolescent, early and adult levels, such factors as "needed social skills," vocational needs, relationship needs, decision-making skill need, and value clarification needs all may be helpful guides to identifying "at risk" or vulnerable populations.

Specifically, the Virginia Beach Drug Abuse Survey gave some indications of use/abuse of drugs at specific age levels and with various substances of abuse. Definition of specific rehabilitation needs within such age groups may be made by more specific evaluation of the subjects prior to training or rehabilitation (i.e., the use of a social skills assessment instrument).

Primary, secondary, and tertiary prevention in the public health literature relates to the question of "what to" do in responding to community breakdown. Interagency Collaboration, Social Competency, and Facet theories provide methodological bases as a response to "how to" implement primary, secondary, and tertiary prevention approaches in the community. For background reading in the public health prevention model, the reader is especially referred to the important contributions of Hanlon (1974), and also to Wilbur (1963) and Burton and Smith (1975).

Conclusion

Chapter III has presented the methodology necessary to study the two specific areas of disability surrounding the use of drugs

and alcohol, but primarily from a conceptual framework rather than from an empirically data-based framework.

However, Chapter IV does present detailed demographic data related to the disability areas of drugs and alcohol use from the Interagency Collaboration framework.

CHAPTER IV

RESULTS

Prevalence of Drug Abuse

For this study of the incidence and prevalence of drug abuse in Virginia Beach, two methods of collecting data were used. Whenever there were large groups from which data were to be obtained, as with physicians, a questionnaire form was developed and mailed to a sample of that group. The second procedure, followed with smaller groups of only a few members, as with the Juvenile Probation staff, was to conduct a personal interview with each member.

The mail-out questionnaires were similar in certain respects, particularly in regard to the first question, which concerned the prevalence of drug abuse. The directions stated, "Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with." The directions explained that "people you have come in contact with include not only friends, relatives, business and professional associates, and acquaintances, but also anyone you know who is using drugs."

Bar graphs were constructed to show differences among the different groups who were surveyed to portray the prevalence of the usage of each of the types of drugs. The groups which were surveyed were combined for purposes of this study into "The Professional

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Community" (attorneys, clergy, pharmacists, physicians, and professional service organizations), "The Business Community" (businesses which received mailout questionnaires, and those which were interviewed), and the "Households in Virginia Beach" section (results from a random sample of 1,000 households in Virginia Beach).

Figures 10-17 are graphs representing the percentage of respondents who thought usage of that particular drug was either "widespread" or "moderately widespread," two of the four possible responses to the question. "Widespread" meant: "Of the people with whom I have come in contact in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis." "Moderately widespread" differed because the estimated number of acquaintances taking this drug regularly was only 10 to 20 people.

Figure 10 illustrates the prevalence of marihuana and hashish usage. As many as 85.7% of the attorneys who responded thought marihuana and hashish were either widespread or moderately widespread. In other words, 64.3% were saying that they personally knew 20 or more people who used marihuana and/or hashish regularly, and another 21.4% knew 10 to 20 people who used these regularly. These percentages total to 85.7% of the attorneys who know 10 or more people who use these drugs regularly.

Eighty percent of the pharmacists and 70% of the clergy also thought that marihuana usage was either widespread or moderately widespread. At least 50% of all the respondents in the other surveys, physicians, service organizations, and businessess, all except

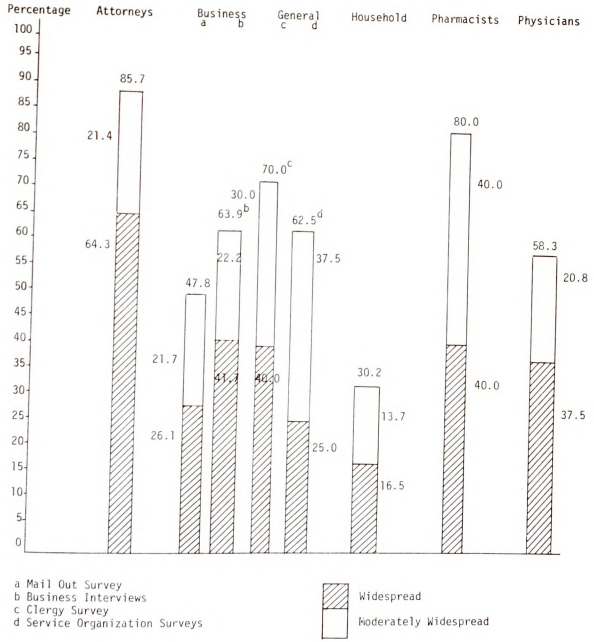

Figure 10.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Marihuana.

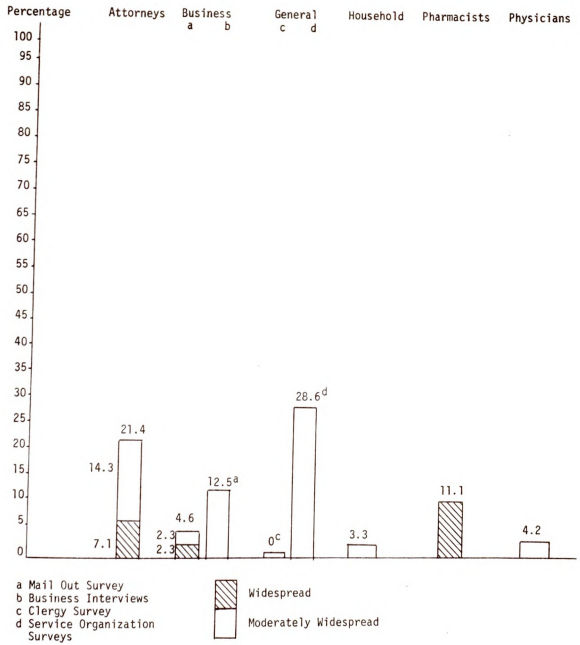

Figure 11.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Inhalants.

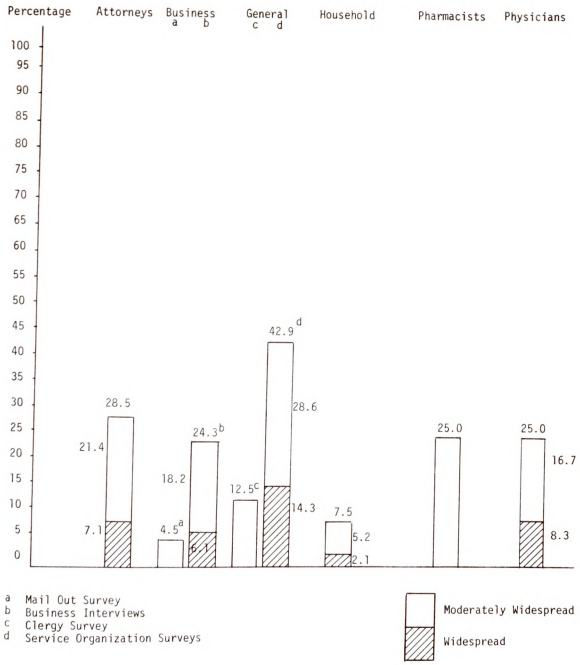

Figure 12.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Hallucinogens.

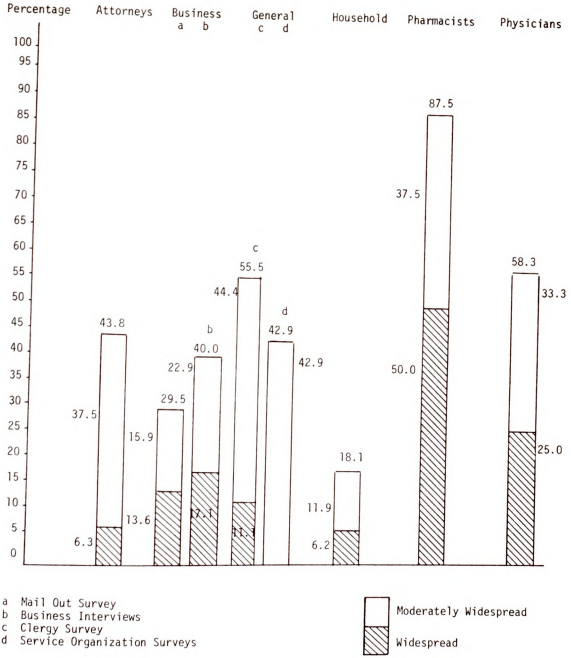

Figure 13.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Stimulants.

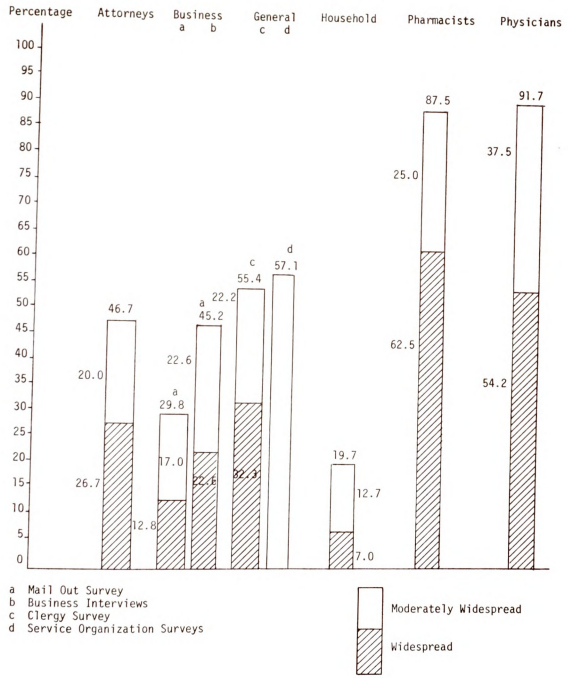

Figure 14.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Depressants.

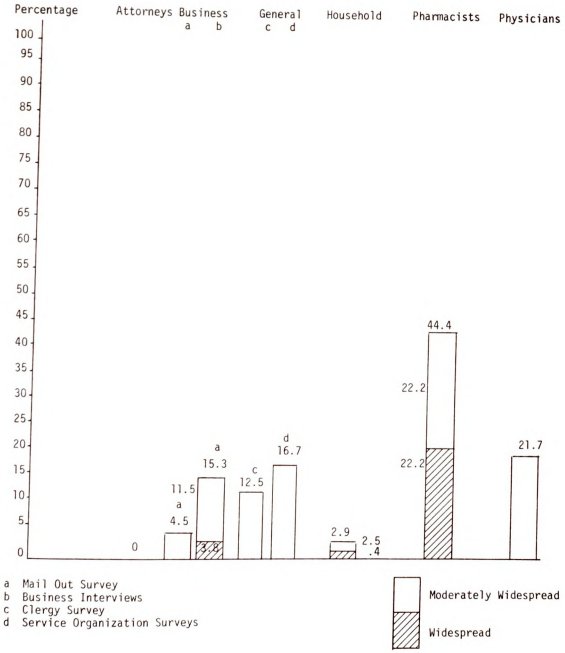

Figure 15.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Opiates.

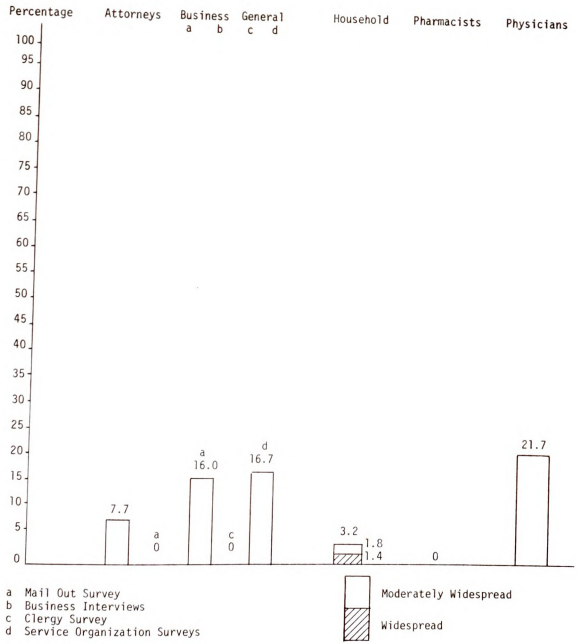

Figure 16.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Cocaine.

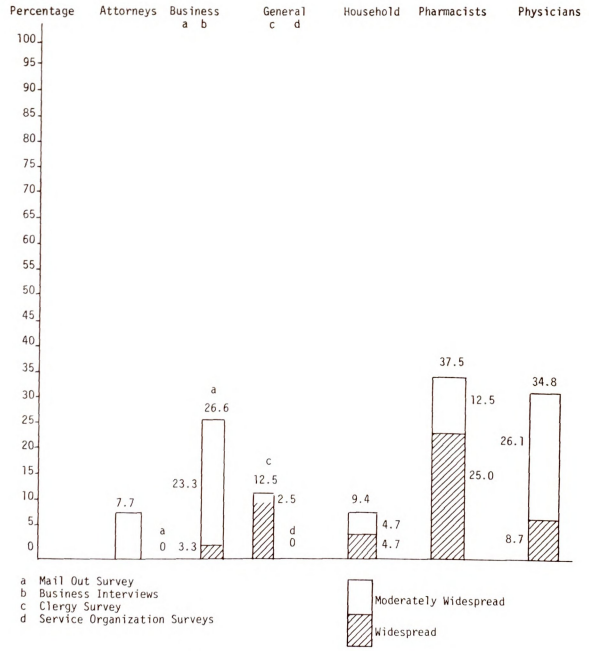

Figure 17.--Prevalence of Drug Abuse in Virginia Beach (Question 1): Methaqualone (Quaaludes, etc.).

households, stated that marihuana and hashish usage were either widespread or moderately widespread.

Of the respondents in the household survey, only 30% believed these drugs widespread or moderately widespread. There was quite a difference of opinion among those professionals and business people who work or practice daily in Virginia Beach and those who live there but may work elsewhere. In the Tidewater area, Virginia Beach is acknowledged to be a "bedroom" or commuter community where many people live but do not necessarily work. Tourism seems to be the major industry in Virginia Beach, and those not involved in providing services for tourists or residents might work elsewhere in Tidewater, particularly in Norfolk at the naval bases. The professional and business people surveyed in this study were the ones who work in Virginia Beach providing legal and medical services and operating department and food stores for the residents, as well as tourists. These professionals, whose work was more problem-oriented than the average resident, were more likely to encounter drug use. The results from the professional and business people seemed to generally agree on how widespread was the usage of each drug.

The persons who responded to the household survey seemed to consistently underestimate the drug abuse problem in Virginia Beach. As stated earlier, part of this might have been due to the large numbers who live in Virginia Beach but worked elsewhere, outside the city. Also, residents seemed to remain fairly isolated within their own housing developments in Virginia Beach. In some ways they remained out of contact with the areas beyond their own neighborhoods.

There could have been quite a flourishing drug problem, as the evidence seemed to indicate, without the residents of Virginia Beach ever quite realizing it. Although certain residents realize the problem with drugs, some residents may not have known what was going on concerning the "drug scene" because there had been, until the survey, a lack of data in this area.

The flow of drugs is very difficult to trace even in large cities with narcotic squads and federal agents. It was especially difficult to detect in a fairly urbanized area like Virginia Beach where so few people even knew the indicators of a drug abuse problem and often seemed to say that what they did not know would not hurt them. No city agencies except the police department had been collecting data on this subject. The information in this report often came from personal recollections and impressions. Since there were no data readily available to city officials, it was not surprising that residents of Virginia Beach, who relied on these city officials to inform them of potential problems like drug abuse, were so uninformed regarding the prevalence of drug abuse. A comparison of survey results from Virginia Beach business people and professionals with results from household questionnaires was necessary in order to detect this disparity of opinion concerning drug abuse. Figures 10-17 on the usage of the various drugs better illustrated the disparity of opinion between household respondents and business and professional people.

Less than 30% of the respondents seemed to think that use of inhalants (including glue and other vapors and volatile intoxicants)

was widespread or even moderately widespread (Figure 11). The person using inhalants was usually a young boy, 8 to 14 years of age, who sniffed "airplane glue" or gasoline or paint to "get high." This is a particularly dangerous form of drug abuse because repeated use can cause severe brain damage.

The professional service organizations, many of whom deal with young boys, like the Boy Scouts and YMCA, had the highest percentage of respondents who personally knew 10 or more people who used this drug regularly in the last 12 months. Many of the attorneys, businesses, and pharmacists also knew people who used inhalants regularly.

The service organizations also had the highest percentage of respondents who knew people taking hallucinogens, like LSD, mescaline, STP and other drugs (Figure 12). These are drugs that, like inhalants, were favored primarily by young people. Attorneys, pharmacists, physicians, and business people who were interviewed were all in close agreement on how widespread hallucinogen usage was.

The business people who were interviewed represented businesses which were located in areas where they were most likely to encounter drug abuse. They were specifically selected for this reason. In order to learn about the prevalence of drug abuse, it seemed best to question those businesses located in the Beach Borough or which would have young people primarily as customers, such as fast food diners, motels, and entertainment centers. These business people are usually in agreement with the professionals about the prevalence of these different drugs. They did not often

agree with the results from the random sample of businesses to whom questionnaires were mailed. Many of the businesses in this second sample were backyard mechanics and construction companies, but, as explained later, this type of sample of the business community was necessary in addition to the business interviews. At any rate, the businesses in the mail-out questionnaire sample and the household sample seemed most likely to underestimate the drug problem in Virginia Beach, as they did with the hallucinogens.

The use of stimulants seemed to be widespread according to pharmacists (Figure 13). Almost 88% of these professionals knew people taking stimulants; 50% of them knew 20 or more people using stimulants. In the course of their work, pharmacists apparently filled many prescriptions for stimulants including amphetamines, and various "pep pills" and diet pills.

Over 50% of the clergy and physicians believed that use of stimulants was widespread or moderately widespread. The attorneys, service organizations and businesses who were interviewed were in agreement as to how widespread usage of this type of drug was. Once again, the businesses in the mail-out survey and the households, particularly the households, greatly underestimated the use of this drug.

The same trends were noted for depressants as well (Figure 14). About 90% of the pharmacists and physicians believed that depressants (meaning the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers") were widespread or moderately widespread. Over 50% of these two professions thought

that depressants were widespread, meaning that they knew more than 20 people who took these drugs regularly. The people who took these sedatives and tranquilizers probably ranged from school children, taking drugs illegally for "kicks," to housewives and business executives who used the drugs to help them cope with anxiety, stress, and tension, to the elderly who may be overusing sedatives for many reasons.

Use of sedatives and tranquilizers was widespread and was probably pervasive throughout all levels of the community. Most of the other survey results were in agreement, from attorneys to clergy and service organizations. Only 20% of the household respondents, however, agreed that use of these drugs was either widespread or moderately widespread. Apparently, the use of depressants was not widely discussed by those who take them. In other words, people may be reluctant to discuss whether they were taking such mood-altering drugs as depressants and stimulants, because their use, particularly if prescribed by a doctor, is often associated with some very personal problem, such as anxiety or work pressures. Therefore, one may not have known what drugs his neighbors and friends took, but the doctors and pharmacists for the community knew, and they believe these mood-altering drugs were used quite widely in Virginia Beach.

Opiates, however, did not seem to be nearly so widely used according to most professionals and business people, with the exception of the pharmacists (Figure 15). Almost half of the pharmacists who responded stated that opiates were either moderately widespread or widespread. From 10% to 22% of the clergy, physicians, service

organizations, and business people interviewed agreed that regular opiate use was at least moderately widespread. Opiates were defined as including heroin, codeine, morphine, paragoric, and other opiate derivatives. For a community that was not reputed to have a hard drug problem, significant numbers of Virginia Beach professionals and business people knew 10 or more people who use opiates on a regular basis.

Although cocaine is a rare and very expensive street drug, from 16% to 22% of the business people interviewed, as well as the clergy and physicians, believed its use to have been at least moderately widespread (Figure 16). As might be expected, pharmacists had no knowledge of the use of this drug since it cannot be purchased in a pharmacy. About 8% of the attorneys had had some experience with users of the drug, a finding which concurs with data from the police department and Commonwealth Attorney's office concerning the number of arrests and convictions for use of this drug.

Quaaludes, one type of methaqualone, are believed to be rather widespread, more so than cocaine or the opiates, like heroin (Figure 17). About 35% of the pharmacists and physicians believed this drug to be widespread or moderately widespread. Quaalude is one brand name for methaqualone, which was available in most local pharmacies on prescription. It must be prescribed by a physician, so both groups of professionals were likely to know how widely it is used. Twenty-seven percent of those business people who were interviewed agreed that it was fairly widely used in

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Virginia Beach. As one professional close to the drug scene commented, "If Virginia Beach hasn't heard about Quaaludes, they will soon." Its use was quite widespread in metropolitan areas like Washington, D.C., and in the surrounding suburbs of Maryland and Virginia, according to the Washington Post's several feature articles in the spring of 1973. The use of Quaaludes and "Sopors," another name for methaqualone, is expected to spread to less urbanized areas, particularly along the Atlantic Seaboard and on the West coast.

The Professional Community

Methodology

In planning this study of the incidence and prevalence of drug abuse in Virginia Beach, surveying the professional community (including attorneys, clergy, pharmacists, physicians, as well as professional service organizations like Girl Scouts, Boy Scouts, Red Cross, etc.) seemed to be of primary importance. With a problem like drug abuse, it was important to survey not just one segment of the community, such as law enforcement officials or physicians, but to survey a wide spectrum of people who might have some information on the drug abuse problem. By carefully adding together all the pieces of information from the professional community, one should attain a valuable perspective of the drug scene.

In order to survey the "professional" community, as distinct from the "business" community or military bases, it was first necessary to list all those groups of people who in the course of their

work might come in contact with people using drugs. From that list was extracted those professions that had so many members to make personally interviewing each member an unwieldy, time-consuming, and costly task.

From the standpoint of response rate and completeness of answers, the personal interview was preferable and was used whenever possible during the study. For the larger samples, however, it was found to be most economical to mail questionnaires. This method also ensured some uniformity from one measurement situation to another by standardizing instructions, wording, and the order of questions.

For these professions with more than 15 or 20 members, such as medicine or law, special questionnaires were devised which would tap their knowledge of the drug abuse situation. Each profession differed somewhat in how it related to society and to those people taking drugs, so special questions were created to find out in what ways and how often in the course of their work these professionals encountered problems caused by drug abuse. Next careful pretests of each questionnaire were conducted.

Theoretically, the ideal sample for most surveys is the random sample (i.e., a certain percentage of each profession could have been chosen by randomly drawing their names from a hat). However, it was the opinion of one attorney that the most accurate information on the drug problem could be attained by surveying only those attorneys who deal with drug offenses on a fairly regular basis. Not all attorneys worked with drug abuse cases, and their

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answers or lack of them might have had a tendency to skew the results. So the logical course seemed to include using purposive or judgmental samples for some professions and universal samples (surveying all the organizations within a profession like all the pharmacies) for other professions (Selltiz et al., 1967).

The objective of a purposive or judgmental sample was to handpick the subjects to be included by using good jugment. For example, a local attorney was asked to choose, from a comprehensive list of all attorneys in Virginia Beach, those attorneys which have had some experience with drug cases. Then "Attorneys' Questionnaires" were mailed with cover letters and self-addressed, stamped envelopes to the 44 attorneys that he selected. Similarly, a comprehensive list of all physicians and their specialities was given to a person who was familiar with the medical aspects of drug abuse. As a result, specialties like radiology and plastic surgery were omitted from the sample since radiologists and plastic surgeons were less likely to have had encounters with persons abusing drugs. "Physicians' Questionnaires" were then mailed to 60 physicians who were considered likely to have encountered drug abuse cases. These physicians, who would be consulted for other medical reasons, might have detected the patients' abuse of drugs.

Since there were only about 25 pharmacies in Virginia Beach it seemed reasonable to survey each one. Therefore, a "Pharmacists' Questionnaire" was mailed to the chief pharmacist of each pharmacy.

A similar procedure was followed for the survey of clergymen. There were about 36 churches and synagogues of numerous

denominations in the Virginia Beach survey sample. "General Survey" questionnaires were mailed to the pastor, priest, or rabbi of each church or synagogue. The general survey form was created for the smaller samples. It was more general in format and did not ask questions that could be answered by only particular professions.

The general survey form was also mailed to certain professional service organizations, especially those connected with young people since they might have had some experience with drug abuse. The following organizations were included in the purposive sample: Boy Scouts, Girl Scouts, Young Men's Christian Association, Red Cross, Salvation Army, Association for Research and Enlightenment, Inc., Things Unlimited (the Friends School Thrift Shop), and the Young Women's Christian Association.

The rate of response, measured by percentage of questionnaires returned by mail for each individual sample, may not seem encouraging, as indicated in Table 6. Yet one of the foremost methodology textbooks in the field of sociology states, "When questionnaires are mailed to a random sample of the population, the proportion of returns is usually low, varying from about 10% to 50%" (Selltiz et al., 1967). In view of this statement, the mail-back return rates for the different surveys are within these boundaries and are quite good with respect to the physicians and service organizations as the table indicates.

Results

The purpose of constructing separate questionnaires for each of the different professions was to allow for questions

TABLE 6.--Response Rates of Professionals to the Mailed Questionnaires.

	Sample Size	Number of Mail-back Responses	Percentage Mail-back Responses
Attorneys	44	16	36.4
Clergymen	36	10	27.8
Pharmacists	24	11	45.8
Physicians	60	32	53.3
Professional service organizations	8	8	100.0

regarding drug abuse as specifically related to each of these professions. Some of the individual questions, therefore, differed from questionnaire to questionnaire and should be discussed separately, but some were quite similar and allowed for a degree of cross-comparison.

Initially, results from very similar or identical questions were compared across the different professions. The following question is the first of this type.

> Do you know of persons in Virginia Beach engaged in the abuse of drugs (excluding alcohol and tobacco)?

Table 7 seems to show that a rather high percentage of those professionals in a client-professional relationship know of persons engaged in the abuse of drugs, excluding pharmacists and service organizations.

Pharmacists were more likely to see people in customer-professional relationships as they filled prescriptions and, as one

TABLE 7.--Knowledge of Persons Engaged in Abuse of Drugs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	75.0%	70.0%	50.0%	68.0%	37.5%
No	12.5	20.0	30.0	20.0	37.5
No answer	12.5	10.0	20.0	12.0	25.0

pharmacist noted, are not often in a position to know the drug taking practices of others.

The responses from the service organizations were also likely to differ significantly from those of other professionals. The groups in the service organization sample were highly diverse, ranging from the youth organizations like Boy Scouts and Girl Scouts, to the Red Cross, and Salvation Army. The clients they served differed greatly in average age, education, economic background, and likelihood of exposure to various drugs, including alcohol.

Some organizations which had a predominantly young membership (from 8 years to 17 years) and with a clean-cut, "good guy" image may have attracted relatively few drug users as members. The professionals involved with these organizations may also have had very little experience with drug abuse and may have had difficulty spotting drug users.

On the other hand, an organization like the Salvation Army may have had considerable contact with middle-aged people, many of whom may have been alcoholics or frequent users of depressants and

stimulants. A social worker at the Salvation Army noted that she was seeing increasing numbers of hard drug users seeking treatment for their addictions at the different drug clinics. She viewed this trend optimistically as evidence that increasing proportions of the addict population were trying to become drug-free.

In considering results from these organizations, it must also be pointed out that often the client-professional ratio may have been as high as 20 or 30 to 1. In such situations it would be most difficult to ascertain whether or how many people were abusing drugs or which drugs are involved.

While the majority of the members of most professional groups knew of persons engaged in the abuse of drugs, very few members of any of the groups knew of persons engaged in the illegal sale of drugs, as indicated in Table 8. Attorneys seemed to be the exception, but these percentages may reflect those attorneys with clients who were accused of selling drugs.

Do you know of persons in Virginia Beach engaged in the illegal sale of drugs?

TABLE 8.--Knowledge of Persons Engaged in Sale of Drugs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	43.8%	10.0%	0.0%	16.0%	12.5%
No	37.5	70.0	70.0	72.0	75.0
No answer	18.8	20.0	30.0	12.0	12.5

The responses to the question in Table 9 indicate that although the professionals did not know actual persons involved in the illegal sale of drugs, the vast majority of each group believed that there was illegal drug trafficking in Virginia Beach. In other words, they believed there was illegal buying and selling of drugs in the community. These were professionals in daily contact with different segments of the community and who could supply invaluable information on the drug scene.

Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach?

TABLE 9.--Belief in Illegal Drug Trafficking (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	81.3%	100.0%	70.0%	88.0%	75.0%
No	0.0	0.0	0.0	0.0	0.0
No answer	18.8	0.0	30.0	12.0	25.0

It is interesting to note that while at least 70% of the respondents in each profession stated that they believed that there was illegal drug trafficking, there were absolutely no negative responses to this question. There was no one who would say that there was no illegal drug trade in Virginia Beach. The conclusion to be drawn from these statistics, therefore, is that from the viewpoint of the professional community, there was certainly a drug abuse problem in Virginia Beach.

The question in Table 10 is most important in ascertaining whether these professionals actually encountered cases of drug use in their daily work with their patients or clients. Of course, these figures vary by profession depending upon the professional's need to know this information in order to help his client or patient. The number of drug abuse cases practitioners within a profession are likely to observe depends upon their ability to spot a drug user. Many professionals have received no specific training in this area and may not know the indicators of drug abuse, such as dilated pupils, and so on. Therefore, there is the strong possibility of undercount in the results of such a question. If these professionals had been trained in detecting cases of drug abuse, these results would be much more accurate.

> How many persons do you see during an average month for non-drug reasons whom you suspect or have found to have drug problems? Under 18 years old ____ 18 years of age and older ___.

TABLE 10.--Persons You See Who Have Drug Problems (Professional Survey).

		Average	Range	No Answer
Under 18 Years of Age[a]				
Attorneys	N=16	3.31	0 to 10	3
Clergy	N=10	2.75	0 to 5	2
Physicians	N=25	5.39	0 to 15	11
Service org.	N= 8	2.60	0 to 10	3
18 Years of Age and Older[a]				
Attorneys	N=16	5.08	0 to 15	3
Clergy	N=10	4.17	1 to 11	4
Physicians	N=25	6.96	0 to 25	7
Service org.	N= 8	1.60	0 to 5	3

[a]Pharmacists were omitted since they did not really see people as either clients or patients.

The percentage of professionals preferring not to answer this question was fairly high, up to 44% of one sample. This is a question that was difficult to answer for two reasons. First, it required some review of records, and second, it suggested a question that many professionals may not have previously considered, "How many of my patients or clients were actually using drugs?" As the results indicate, some felt that none of their patients or clients were using drugs; others, especially attorneys and physicians, seemed to have many clients or patients who used drugs.

As stated earlier, the actual findings certainly represent only a fraction of persons who actually used drugs. The discrepancy was in the lack of training and experience some professionals have in detecting symptoms or drug use. The solution to this dilemma lies in education of the public, particularly the professional community, as to the causes, effects, and indicators of drug abuse. If people knew what to look for, the drug abusers would not be so indistinguishable from the rest of the population.

On one page of each questionnaire various programs were listed which advised or treated alcoholics and drug abusers in Virginia Beach. These programs were Alcoholics Anonymous, Alcohol Information Center, Broken Needles, Drug Information Center, Drug Outreach Center, and Martus, Inc. (no longer in operation). The question in Table 11 sought information on how well these programs responded to the drug abuse situation there.

From these results, one can conclude that the majority in each of these professions thought that these programs as a whole are

Do you think these programs can adequately handle the drug problem in Virginia Beach?

TABLE 11.--Adequacy of Drug Programs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Very well	0.0%	30.0%	20.0%	8.0%	0.0%
Fairly well	31.3	40.0	40.0	28.0	37.5
Not too well	43.8	20.0	10.0	32.0	25.0
Not at all	0.0	10.0	0.0	8.0	0.0
No answer	25.0	0.0	30.0	24.0	37.5

only handling the drug problem "fairly well" to "not too well." In not one profession did the majority of respondents think these programs were handling the drug abuse situation "very well." There was some consensus of opinion among these professional groups that these drug programs could have responded more effectively to the drug problem in Virginia Beach. The professionals were not asked to explain to what they attributed the inadequacy of these programs. The shortcomings may have been due to lack of funding, inadequate staff training, understaffing, misdirection of program objectives, or any number of other factors. A whole new survey would have been necessary in order to ascertain the problems with the treatment programs. The facts established thus far by this survey were that there was a significant drug problem in Virginia Beach and, in the public eye, the programs in operation could not adequately respond to the drug problem.

Are you aware of any drug abuse prevention programs in Virginia Beach or in this area?

TABLE 12.--Awareness of Drug Abuse Prevention Programs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	50.0%	70.0%	50.0%	68.0%	50.0%
No	25.0	30.0	20.0	16.0	0.0
No answer	25.0	0.0	30.0	16.0	50.0

At least half the respondents from each profession stated that they had heard of some drug abuse prevention programs in Virginia Beach. Many, however, had not heard of any prevention programs which pointed up the need for wider-spread publicity concerning drug abuse prevention programs.

Another factor which must be considered in looking at this data is whether the respondents understood the concept of a drug abuse prevention program, as distinguished from a drug abuse treatment program.

The answer to the question in Table 13 concerning the drug abuse prevention programs indicated that most professionals answering this question thought these programs were effective. Another obvious finding seemed to be a lack of willingness on the part of any of the professionals to answer "no," indicating the prevention programs were not effective. The majority of the professionals seemed to think that these programs were effective.

Do you think these (drug abuse prevention programs) are effective?

TABLE 13.--Effectiveness of Drug Prevention Programs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	50.0%	60.0%	30.0%	60.0%	37.5%
No	0.0	10.0	0.0	4.0	25.0
No answer	50.0	30.0	70.0	36.0	37.5

Opinion on the question in Table 14 seemed more or less divided as on the previous question concerning drug abuse prevention programs. Attorneys and pharmacists were somewhat in favor of more drug abuse prevention programs. Clergymen and physicians were overwhelmingly in favor of more drug abuse prevention programs.

Do you think more drug abuse prevention programs are needed?

TABLE 14.--Need for More Drug Prevention Programs (Professional Survey).

	Attorneys N=16	Clergy N=10	Pharm. N=10	Physicians N=25	Serv. Org. N=8
Yes	43.8%	60.0%	30.0%	64.0%	25.0%
No	12.5	10.0	10.0	12.0	25.0
No answer	43.8	30.0	60.0	24.0	50.0

The Business Community

Methodology

Surveying the Virginia Beach business community was accomplished in two steps, after the initial steps of constructing and pretesting the "Business Questionnaire" (see Appendix B). First, a random sample of the 5,746 businesses licensed with the Commissioner of Revenue was taken, yielding 312 businesses to whom "Business Questionnaires" were mailed. Of these 312 businesses, 61 responded by returning their questionnaires.

Second, to insure that a significant number of businesses who might have had some experience with drug abusers (i.e., snack bars, hamburger stands, motels, Beach Borough businesses, etc.) were sampled; Drug Focus Committee volunteers as well as staff members conducted personal interviews with selected businesses using the "Business Questionnaire" forms. Out of 95 attempts, 45 completed questionnaires resulted.

The results of the two samples were often substantially different and will be presented in separate tables and not combined.

Results

The results from Question 5 (Table 15) indicate that more of the businesses interviewed knew of persons involved in the abuse of drugs (48%) compared to 33% of the businesses in the mail-out sample.

This finding substantiated our reasons for conducting two surveys of the business community. To be more specific, the list

Do you know of persons in Virginia Beach engaged in the abuse of drugs (excluding alcohol and tobacco)?

TABLE 15.--Knowledge of Persons Abusing Drugs (Business Survey).

	Business Interview N=45	Mail-Out Business N=61
Yes	46.7%	31.1%
No	37.8	60.7
No answer	15.6	8.2

of businesses at the office of the Commissioner of Revenue was, on one hand, the most complete and up-to-date list; however, since it held the name of every licensed business, it tended to be heavily weighted with very small businesses, such as the backyard auto mechanic and the one- or two-person construction company. Therefore, it is important to consider the results of the business interviews.

While 16% of the businesses interviewed said they knew of persons in Virginia Beach engaged in the illegal sale of drugs, 20% preferred not to answer. This was a question which people who really knew something about the drug scene often preferred not to answer. One employee in a local business refused to answer because he said it was against the law to know something on this subject and not report it, that is, to withhold this information from the police.

These results compared interestingly to those from the mail-out business survey where only 9% stated that they knew persons illegally selling drugs. Ninety-one percent said that they did not know of persons engaged in the illegal sale of drugs.

High percentages of both business samples answered Question 7 affirmatively. Ninety-three percent of the mail-out businesses and 82% of the businesses interviewed believed there is illegal drug trafficking in Virginia Beach. In other words, in their opinion, without necessarily having direct knowledge, the majority of businesses in both surveys felt that there was illegal buying and selling of drugs in Virginia Beach. This question differed significantly from Questions 5 and 6 which concerned only people they actually knew.

The results from Question 8 indicated many businessmen in both samples have observed persons entering their businesses who appear to be involved in the abuse of drugs. Business managers in the interview sample gave more affirmative responses (36% compared to 51%).

The question concerning drug abuse by those frequenting Virginia Beach businesses was subject to underestimation by respondents. Often people in business indicated that they found it difficult to identify the physical symptoms of drug abuse with the usual exception of alcohol. As many stated during interviews or on questionnaires mailed in, they usually could not tell which drugs people were on or even whether they were taking drugs, except alcohol. Most of the businessmen interviewed stated that the drug causing them the most problems was alcohol, especially regarding their own employees.

In addition to being often unaware of the the physical effects of drug abuse, many business people stated that they simply did not have the time during most business days to observe whether their

customers were on drugs. Therefore, there seemed to be two factors affecting the accuracy of the business people's observations: their lack of knowledge or experience, and their lack of time. Thus, there could have been considerably more people on drugs than indicated by these statistics from business people.

Another possible source of undercount is the fact that 97% of the mailed-back questionnaires were answered by the business owners or by the manager-operators (69% of the business interviews were conducted with owners-managers). While it was necessary to address the questionnaires to someone in charge to insure a greater response rate, those in control of the businesses might not always be sufficiently attuned to the "drug scene" to accurately estimate actual numbers of people taking drugs. It might have been better to interview only workers, clerks, waiters, salespeople in the different businesses, but often these persons were transient and had not been with the business long enough to form opinions about the drug scene.

The responses to Question 10, which asked if existing alcohol and drug abuse programs could adequately handle the drug problem in Virginia Beach, were quite similar for both business samples. Question 10 concerned the following programs: Alcoholics Anonymous, Alcohol Information Center, Drug Information Center and Drug Outreach Center.

Only 5% of the business interviews and 10% of the mailed-in questionnaires stated that the programs were handling the drug problem "very well." While 33% of those in both samples felt that

the programs were doing "fairly well" at handling the drug problem, at least that many in each sample thought the programs were doing "not too well." Apparently, those responding to these questionnaires were not very enthusiastic about how well these programs were handling the drug abuse problem in Virginia Beach.

According to the results from Question 11, substantial numbers of business people were aware of drug abuse prevention programs in Virginia Beach or in this area. Only small percentages (27% of business interviews and 17% of the mailed-in questionnaires) thought that these programs were effective. Large numbers in each sample, however, seemed reluctant to judge their effectiveness and simply did not answer the question.

Substantial numbers in each sample (46% and 47%) felt that more drug abuse programs were needed. Only a very few people, less than 7% of either sample, believed that no additional programs were needed. Once again, at least 47% of each sample refused to answer this question, perhaps believing themselves not informed enough to answer.

It seemed evident that more information on the drug abuse problem was needed, from effects, to incidence, to treatment. Among people with opinions on the subject, the overwhelming majority felt that more drug abuse prevention programs were needed. Future objectives of the drug abuse programs should include education of the public concerning cause, effect, and treatment of drug abuse. Even though the public was much better informed at present than in

past years, the average person still seemed to know relatively little about this area of public concern.

Households in Virginia Beach

Methodology

In surveying the incidence and prevalence of drug abuse, a survey of Virginia Beach residents seemed essential. The study would not have been complete without an opinion survey of residents in order to compare their perceptions of the drug problem with those of the business and professional communities, as well as with law enforcement and court officials, and with public health and hospital spokespersons.

After studying various questionnaires on drug abuse administered in Virginia, New Jersey, California, and elsewhere in the country, a comprehensive questionnaire was formulated. The purpose of administering the questionnaire was two-fold: First, to inquire of the prevalence of drug use among acquaintances of the respondents, as did the questionnaires for the business and professional communities. Second, unlike the questionnaires for business and professional people, it was necessary to seek information about the respondent's personal drug use, as well as the demographic data concerning the respondent's age, sex, education, income, marital status, number of children, and occupation.

There was and is some question as to the reliability and validity of the self-reporting of drug use. One problem with using a self-reporting form would be that people might over- or under-report the types and amounts of drugs that they were using. Thus

far, drug abuse researchers have devised no method of studying the occurrence of under-reporting in self-report questionnaires. They have studied the occurrence of over-reporting and have found in several studies that the percentage who exaggerate their use of drugs or who report using fictitious drugs is quite small. With the acknowledged exception of adequately studying under-reporting, Paul C. Whitehead and Reginald G. Smart (1974) make the following statement: "The evidence supports what has been an assumption on the part of many researchers in this area: there is reason to have confidence in the validity and reliability of self-reports of drug abuse" (p. 3).

First, an extensive pretest of the questionnaire was undertaken in the community with the help of members of the Drug Focus Committee. The questionnaire was then revised and pretested on a smaller sample once again. Then after another and final revision, the survey was reviewed once more and printed for distribution. Questionnaires with cover letters and self-addressed, stamped envelopes were then mailed to the 1,000 households in the sample.

The sample consisted of 1,000 households randomly selected from the Virginia Beach City Directory. Although this directory may not have seemed to be the ideal universe or population of addresses from which to select the sample, it was the only source available for Virginia Beach. The city planning office for Virginia Beach did not have a comprehensive up-to-date list of addresses for Virginia Beach, nor did the local Chamber of Commerce. Therefore,

the City Directory was found to be the most complete and up-to-date source of addresses for Virginia Beach.

From the sample of 1,000 questionnaires mailed to various homes and apartments, 11 were returned by the post office for having insufficient addresses and 270 were filled out and returned by respondents. This resulted in a response rate of 27% for this survey, which is within the limits of expectations as defined by Selltiz et al. (1967).

Perhaps the response might have been higher if questions concerning personal drug use and personal information such as education, income, and occupation had been omitted. But these questions seemed important from the standpoint of obtaining a profile of the community. This profile could then be compared with other surveys (The Virginian-Pilot/Ledger Star City Profiles, August 1973, and 1970 census data) to see how closely the samples matched. This information will be discussed at a later point in this section.

Information of these personal characteristics is also essential in order to perform "descriptive cross-tabulations" (Layarsfeld, Pasanolla, and Rosenberg, 1972). By recording the data concerning each adult in the survey onto individual McBee cards, it was possible to obtain descriptive, statistical profiles on the users of different drugs. These tabulations should indicate the role of demographic characteristics, such as age, sex, and income in drug use.

Results

Drug use is fairly widespread in Virginia Beach, according to Table 16. All types of drugs from tobacco and alcohol, to

TABLE 16.--Reported Experience With Drug Use by Adults (in percentages), N = 465.

Drug	N	Total	Minimal Use	Regular Use
Tobacco, cigarets	194	41.9	6.6	35.3
Alcohol	404	86.8	57.6	29.2
Over-the-counter drugs, all types	428	92.0	--	--
Prescription tranquilizers, sedatives	47	10.1	6.2	3.9
Prescription stimulants	3	0.6	0.0	0.6
Prescription, other-opiates	37	8.0	6.9	1.1
Marihuana	31	6.7	5.8	0.9
Inhalants, glue, etc.	0	0.0	0.0	0.0
Hallucinogens	2	0.4	0.4	0.0
Stimulants[a]	10	2.2	2.2	0.0
Depressants[a]	29	6.2	6.0	0.2
Opiates, heroin, etc.	5	1.1	1.1	0.0
Cocaine	2	0.4	0.4	0.0
Methaqualone	2	0.0	0.0	0.0
Other	0	0.0	0.0	0.0

[a]Nonmedical use only.

legitimate nonprescription drugs such as Bufferin and Anacin ("over-the-counter" drugs) and prescription psychoactive drugs, to illicit drugs such as marihuana, LSD, and heroin were included in this first table. As was noted in the second report of the National Commission on Marihuana and Drug Abuse (1973), "Although the use of illicit drugs tends to arouse the greatest public clamor and concern, it is, with the exception of marihuana use, a relatively uncommon occurrence when measured against other types of drug experience" (p. 63).

Use of certain drugs, especially alcohol, and "over-the-counter" drugs, was quite widespread in Virginia Beach. While almost 90% of the residents drank alcoholic beverages at least occasionally, only 30% used them regularly (meaning at least once a week or daily).

Among respondents admitting to smoking cigarets, 35% smoked at least half a package or more a day. Only about 7% reported minimal use, that is, smoking less than half a package a day. The implication here was that very few people smoked only a few cigarets daily. Smoking at all seemed to lead to smoking at least a half pack a day.

"Over-the-counter" drugs are remedies for headache, insomnia, nervous tension, etc., that can be purchased in most drugstores. Specifically mentioned in the questionnaire were Tylenol, Bufferin, Aspirin, Anacin, Quiet World, Compoz, Sleepeze, No Doz, Vivarin, and Be Bright. No tabulation of frequency of usage was made due to the nature of these drugs, except to note that at least 92% of the

population of Virginia Beach used one or more of these drugs at least occasionally.

Prescription psychoactive drugs (tranquilizers, stimulants, etc.) seemed to be fairly widely used with 18.7% of the population reporting at least minimal use. The usage of illicit drugs, such as marihuana, hallucinogens, and opiates seemed to be used to a much lesser extent or at least their use was not reported with any regularity. Of course, the use of these drugs is against the law, and this consideration might have caused extensive under-reporting, as noted elsewhere in this study. There were two possible alternatives: users of these drugs may not have returned their questionnaires just because questions concerning illicit drug use were present, or they may have mailed their questionnaires but denied taking these drugs.

For these questions concerning personal drug use, the research case was broadened to include the husband or wife of the respondent. The questionnaire form included space for the respondents to answer the questions on personal drug use for other members of their families as well. Of course, this approach offered the possibility of some error in that drug use may be occasionally disguised or hidden even from other members of the family, and the respondent may not have known the types of drugs his spouse used nor the extent. For example, a housewife may not have wanted her husband to know that she took tranquilizers.

The advantage of this method was evident in the near doubling of sample size. This enabled subtle trends to be more easily

recognized and analyzed, and methodologically this procedure had sound precedents (Riley, 1963).

For the remainder of the questions on the household survey, mostly concerning opinions and attitudes, the research case remained the actual respondent who completed the questionnaire. The sample size for these questions was 261; nevertheless, for questions on personal drug use, the sample size was 465.

The contents of Table 17 describe users of various "legal" drugs using certain demographic characteristics such as age, sex, etc. About the same proportion of males and females in the sample were likely to be cigaret smokers. On the other hand, about 13% more males than females drank alcoholic beverages at least occasionally; however, more female than male respondents reported using prescription drugs.

Extent of drug use differed by age to any great degree only with respect to alcohol. At least some minimal use of alcohol was highest among those who are 30 to 49 years of age (90%), and lowest among those who are 50 years of age and older (76.3%). Apparently, use of alcohol, at least on an occasional basis, was not quite as widespread among those over 50 years of age as it was among those who are under 50.

Level of education did not seem to be a significant variable, except regarding those with less than a high school education. Among these people, only about 7% of the total sample, fewer seemed to smoke, drink, or take prescription or over-the-counter drugs than those with more education.

TABLE 17.--Demographic Characteristics by Percent of Users of Cigarets, Alcohol, and Legal Drugs (N = 465).

Demographic Data	N	Cigarets	Alcohol	Over-Counter Drugs	Prescrip. Drugs
Sex					
Male	227	41.9	93.4	92.5	11.9
Female	226	41.6	80.5	93.0	21.2
No answer	12	41.7	83.3	66.7	25.0
Age					
18-29	136	39.0	86.0	94.9	19.1
30-49	252	43.7	90.0	92.5	14.7
50 +	59	40.7	76.3	94.9	18.6
No answer	18	38.9	83.3	55.6	22.2
Education					
< High school	31	38.7	71.0	90.3	13.0
High school grad.	147	49.0	87.8	94.6	14.3
Some coll. or tech.	259	37.1	87.3	92.7	17.8
No answer	28	50.0	96.4	75.0	25.0
Marital Status					
Never married	18	50.0	83.3	83.3	27.8
Married	415	40.5	86.7	94.0	15.4
Widowed, sep., div.	18	61.1	94.4	83.3	27.8
No answer	14	42.9	85.7	57.1	28.6
Family Income					
< $10,000	86	43.0	81.4	94.2	24.4
$10,000-$15,000	139	41.7	82.0	95.7	16.5
$15,000-$20,000	122	45.9	93.4	92.6	13.9
$20,000 +	101	34.7	89.1	90.0	12.9
No answer	17	47.0	94.1	58.8	23.5

There seemed to be great differences in extent of drug use when cross-tabulated by marital status. A much larger percentage of those who were widowed, separated, or divorced smoked cigarets and/or drank alcoholic beverages. More unmarried respondents also smoked cigarets than married ones, but married respondents were more likely to take over-the-counter drugs, while more unmarried and more of those who were widowed, separated, or divorced took prescription drugs.

Cigaret smoking seemed to be more widepsread among those whose annual income was less than $20,000 per year, but alcohol was more widely used among those who had incomes of $15,000 or more per year. Use of all types of legal psychoactive drugs, whether over-the-counter or prescription, seemed to decline as the income rose. Perhaps these statistics indicate a trend toward substituting alcohol use for psychoactive drugs to lessen such symptoms as nervous tension and insomnia among the higher income respondents.

According to Table 18, which gives the demographic characteristics of the different types of alcohol users, more females than males never used alcohol or used it only minimally. More males used one or more types of alcohol (beer, wine, or other alcohol) regularly, meaning at least weekly or daily.

Regular use of alcohol was more characteristic of those over 30 years of age. Those respondents under 30 were more likely to use alcohol occasionally rather than regularly. Almost one-quarter of those over 50 never used alcohol at all while slightly over a quarter of this age group used alcohol regularly.

TABLE 18.--Alcoholic Beverage Consumption Related to Demographic Characteristics (in percentages), N = 465.

Demographic Data	N	Never Use Alcohol	Minimal Use of Alcohol	Regular Use of Alcohol	Total
Sex					
Male	227	10.1	54.6	35.2	99.9
Female	226	15.9	61.5	22.6	100.0
No answer	12	16.7	41.7	41.7	100.0
Age					
18-29	136	14.0	63.2	22.8	100.0
30-49	252	9.9	58.3	31.7	99.9
50 +	59	23.7	47.5	28.8	100.0
No answer	18	16.7	38.9	44.4	100.0
Education					
< High school	31	29.0	51.6	19.4	100.0
High school grad.	147	17.7	62.6	19.7	100.0
Some coll. or tech.	259	9.7	56.4	34.0	100.1
No answer	28	3.6	50.0	46.4	100.0
Marital Status					
Never married	18	16.7	38.9	44.4	100.0
Married	415	13.3	59.3	27.5	100.1
Widowed, sep., div.	18	5.6	55.6	38.9	100.1
No answer	14	14.3	35.7	50.0	100.0
Family Income					
< $10,000	86	18.6	62.8	18.6	100.0
$10,000-$15,000	139	18.0	56.8	25.2	100.0
$15,000-$20,000	122	6.6	60.7	32.8	100.1
$20,000 +	101	10.9	54.5	34.7	100.1
No answer	17	5.9	35.3	58.9	100.1

Education seemed to be a key variable in studying alcohol use patterns. Many more of those respondents with at least some college or technical training (34%) were using alcohol regularly while only 10% of these respondents reported never using alcohol. Those with less education seemed more likely to report never using any type of alcohol or using it only minimally.

There were also important distinctions in alcohol use according to marital status with those who were unmarried and those who were widowed, separated or divorced being much more numerous among the regular users of alcohol. Almost 95% of those who were no longer married, or married but separated, used alcohol at least occasionally, indicating perhaps some use of alcohol as a possible escape.

Regular use of alcohol seemed to rise along with the income, according to Table 18. About the same proportion (60%) of all income groups reported minimal use of some type or types of alcohol, with those who reported never using alcohol having incomes of less than $15,000 per year.

The most significant findings occur if one considers how the proportions of each income group that used alcohol regularly rose as the amount of the annual income increased. Only 18.6% of those with incomes of less than $10,000 per year used alcohol regularly, but of those respondents earning $20,000 or more per year, 34.7% used alcohol regularly. So regular use of alcohol seems to be more prevalent among those with higher incomes. Perhaps drinking

was only for social purposes, but perhaps it was also used in some cases for release of tensions and relaxation in a competitive world.

Table 19 gives some insight into the characteristics of those respondents who used different types of illicit drugs. For example, respondents who reported using only marihuana (no other illicit drugs) at least minimally seem to be predominantly young, under 30 years of age, to have had some college or technical training, and to be spread across the economic spectrum. Slightly more female than males used marihuana only.

Almost two times as many females as male respondents reported illicit use of soft drugs (not including marihuana). The majority (numerically) of the soft drug users were 30 to 49 years of age and, in numbers, almost as many graduated from high school as went on to college or technical training. By far the majority were married and clustered in the $10,000 to $20,000 income range.

The number of respondents admitting to use of hard drugs only, heroin or some other opiate derivative or cocaine, was so small as to make demographic analysis statistically hazardous.

Those respondents who claimed to use more than one type of illicit drug, from marihuana to hard drugs, tended to be predominantly male, mainly young, of all different educational and income backgrounds, and all were married.

Table 20 attempts to investigate "poly-drug" use, which means using more than one type of drug, whether it be alcohol, over-the-counter drugs, prescription drugs, or illicit drugs. The tabulations were performed, and the table was created to see if

TABLE 19.--Demographic Characteristics of Adult Illicit Drug Users (in percentages), N = 62.

Demographic Data	N	Mari. Only	Soft Drugs No Mari.	Hard Drugs Only	Combi-nation	Total
Sex						
Male	26	34.6	26.9	11.5	26.9	99.9
Female	36	36.1	52.7	2.8	8.3	99.9
No answer	0	0.0	0.0	0.0	0.0	0.0
Age						
18-29	33	51.5	27.3	0.0	21.2	100.0
30-49	26	19.2	53.8	15.4	11.5	99.9
50 +	3	0.0	100.0	0.0	0.0	0.0
No answer	0					
Education						
< High school	7	42.9	14.3	0.0	42.9	100.1
High school grad.	14	14.3	71.4	0.0	14.3	100.0
Some coll. or tech.	37	43.2	37.8	8.1	10.8	99.9
No answer	4	25.0	25.0	25.0	25.0	100.0
Marital Status						
Never married	4	75.0	25.0	0.0	0.0	100.0
Married	54	33.3	40.7	7.4	18.5	99.9
Widowed, sep., div.	4	25.0	75.0	0.0	0.0	100.0
No answer	0					
Family Income						
< $10,000	14	50.0	35.7	7.1	7.1	99.9
$10,000-$15,000	18	16.7	61.1	11.1	11.1	100.0
$15,000-$20,000	13	15.4	61.5	0.0	23.1	100.0
$20,000 +	13	69.2	15.4	7.7	7.7	100.0
No answer	4	25.0	0.0	0.0	75.0	100.0

TABLE 20.--Incidence of Poly-Drug Use (N = 62).

Drug Type	Mari. Only	Soft Drugs Only (No Mari.)	Hard Drugs Only	Comb. Only
1. No other drug/alcohol	0	0	0	0
2. Alcohol only	2	0	0	1
3. Over-counter drugs only	0	2	0	0
4. Prescription drugs only	0	0	0	0
5. Over-counter drugs and alcohol (no prescrip.)	16	17	3	9
6. Combination of some/all	22	26	4	10

there were individuals in the survey who might be users of one illicit drug only such as marihuana or if all users of illicit drugs used some legal drugs as well, perhaps in conjunction.

The results in Table 20 show that no respondents who used an illicit drug used only that drug; they were all "poly-drug" users. Almost all these illicit drug users reported using alcohol as well as some type of over-the-counter drug (see line 5). Line 6 would be the total of the separate types of drugs used plus those respondents who used all three: over-the-counter drugs, prescription drugs, alcohol, as well as the illicit drug at the top of the column. As Table 20 indicates, "poly-drug" use seemed to be the pattern in Virginia Beach.

The results from the question on personal drug use could be generalized to the population of Virginia Beach because of the sampling techniques that were used. A random sample of the population

TABLE 21.--Use of Prescription, Nonprescription, Legal, and Illegal Drugs.

User type	Percent
Marihuana and/or hashish	6.7
Inhalants (like glue, paint, and gasoline)	0.0
Hallucinogens (LSD, mescaline, etc.)	0.4
Stimulants (amphetamines, diet pills, etc.)	2.8
Depressants (tranquilizers, sedatives, etc.)	16.3
Opiates (heroin, morphine, etc.)	9.1
Cocaine	0.4
Methaqualone (Quaaludes, "Sopors")	0.0

of Virginia Beach was carefully drawn (see the discussion of sampling methods earlier in this section) enabling us to generalize from the findings of the survey to the population of this city at large. There was, however, the possibility of a significant amount of under-reporting of personal drug use in a survey of this nature, as noted later in the report. The household statistics indicated personal drug use in Virginia Beach was not as widespread as the results from the survey of professionals (like physicians, pharmacists, and attorneys) and of business people indicated. The results on personal drug use provided minimum figures and should be read "at least 6.7% of the population of Virginia Beach use marihuana. . . ."[1] These

[1]The official population estimate for Virginia Beach from the Department of City Planning, as of October 1, 1974, was 225,000. Unofficial estimates are as high as 235,000 in 1976.

statistics include use of prescription and nonprescription, legal and illicit drugs.

Almost 7% of the respondents stated that they used marihuana. One-seventh of these used it daily or at least once a week. In comparing these results with those from Question 1 (Figures 10-17) concerning the prevalence of drug abuse, it seemed possible that people were under-reporting their use of marihuana. In other words, 30.2% of the respondents stated that they had come in contact with ten or more people in the last twelve months who used marihuana on a regular basis (compared with an average of 67.3% of the respondents in the sample of professionals and 55.9% in the sample of business people). It seemed unusual that 30% of the respondents would have acquaintances who used marihuana regularly, but only 7% of the respondents admitted using marihuana.

Part of the under-reporting may have occurred because smoking marihuana, hashish, and THC was illegal. In spite of the anonymous nature of the questionnaire, people may have been too afraid of arrest and legal entanglement to give a full and honest report of their drug use. Also, some drug use may have occurred without the knowledge of one's husband or wife, or parents in some cases. There was also the possibility to under-report frequency of use for all these drugs, to check "occasionally" instead of "once a week" or "daily," especially when the drugs were not only illegal but could also have dangerous effects and side effects, as could hallucinogens and opiates.

The use of depressants and stimulants may also have been under-reported. All drugs, except tobacco and alcohol, were grouped together in this one question including those that could be obtained legally with a doctor's prescription but taken illicitly (for example, using another family member's prescription for tranquilizers), to those that could be purchased legally but taken illegally (for example, inhalants like gasoline and paint) and including those drugs which are both illegal to buy and to consume (such as hallucinogens and cocaine). Some under-reporting may have occurred because many people did not want to admit, perhaps even to themselves, that they were taking mood-altering drugs, ones that could have become drugs of abuse.

The frequency of taking these drugs may also have been underestimated. It was probably easier to check "occasionally" than to remember exactly how often one took a certain drug. The large majority of respondents stated that they took these drugs only occasionally.

The question analyzed in Table 22 concerned the availability of various drugs in Virginia Beach. Since the question excluded those drugs which were available by prescriptions for medical reasons, it therefore referred to those drugs which had to be obtained illegally. The majority of respondents answered that they would not know how difficult it is to obtain the drugs. Surprisingly high percentages of respondents, however, seemed to know how difficult it would be to obtain most of these drugs illegally and perhaps this was one of the important findings. That people actually knew how

If you wanted to obtain any of the following drugs in Virginia Beach, how difficult would it be to do so (exclude drugs obtained by prescription for medical reasons)?

TABLE 22.--Household Survey for Availability of Drugs (excluding medically prescribed drugs), N = 261.

Drug Type	I Wouldn't Know How Difficult It Is to Obtain Them	Very Difficult	Somewhat Difficult	Not at All Difficult	No Answer
Marihuana (including hashish, THC-synthetics)	58.6%	0.0%	5.7%	33.3%	2.3%
Inhalants (glue and other vapors or volatile intoxicants)	53.6	1.5	2.3	37.9	4.6
Hallucinogens (LSD, mescaline, STP and similar drugs)	69.0	2.3	13.8	10.3	4.6
Stimulants (amphetamines, meth-amphetamines, pep pills)	60.2	0.7	12.3	23.8	16.5
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")	56.3	0.7	11.5	28.4	3.1
Opiates (heroin, codeine, morphine, paregoric, and other opiate derivatives) (N=251)	68.6	10.3	11.9	5.4	3.8
Methaqualone (Quaalude, etc.)	76.6	4.2	7.7	5.7	1.9
Other	8.8	1.1	0.4	1.1	88.5

easily illegal drugs can be obtained in Virginia Beach is of great significance.

The next important finding seemed to be that such large numbers of the respondents thought that most of the drugs were "not at all difficult" to obtain in Virginia Beach. About one-third of the respondents thought marihuana, inhalants, stimulants, and depressants were not at all difficult to buy illegally. Fewer (about 10%) believed that hallucinogens were easily obtainable, while only about 5% felt that opiates and methaqualone could be obtained easily.

No one thought that marihuana was very difficult to buy, and only one or two percent thought that inhalants, hallucinogens, stimulants, and depressants were very difficult to buy. The concensus of opinion seems to be that all these illegal drugs are available and are fairly easy to obtain in Virginia Beach.

This finding coincided with results from a question that was asked on the business and professional surveys, "Check those drugs which you think residents of Virginia Beach buy in and/or outside Virginia Beach. Check both if appropriate." The vast majority of the respondents checked both "in and outside of Virginia Beach" for all the drugs. Slightly fewer checked that opiates could be bought inside Virginia Beach. In other words, not quite as large a majority of professional and business people were unsure that heroin could be obtained in Virginia Beach, but large numbers of others felt that all the other drugs could be bought in Virginia Beach.

One question on the household survey was designed to learn why people decided not to abuse drugs. As Table 23 indicates, the great majority of respondents answered they "never had any desire to abuse drugs" when asked the question:

If you do not presently abuse drugs, which one of the following has most influenced your decision not to abuse drugs?

TABLE 23.--Results from Household Survey on Question 9: Factors[a] Most Affecting Decision Not to Abuse Drugs (N = 261).

Total Responses	Percent of All Responses	Factor Affecting Decision
13	3.3	What your parents told you about drugs
3	0.8	What your brothers and sisters told you about drugs
11	2.8	What your friends told you about drugs
30	7.7	The information you got in school or in drug abuse education classes
78	20.1	The information you got from television, books, or newspapers
5	1.3	The information you got from your family doctor
6	1.5	The information you got from your minister, priest, or rabbi
187	48.1	I just never had any desire to abuse drugs
48	12.3	Other
8	2.1	None of the above
389	100.0	Totals

[a]Total responses exceed number of respondents because frequently respondents checked more than one reason for not abusing drugs.

As stated earlier, most people did not abuse drugs primarily because they never had any desire to do so. The second most popular reason was the information on drugs that people got from television, books, or newspapers. Many people noted under "Other" reasons that their occupations, as nurses, policemen, pharmacists, kept them from abusing drugs because they knew the potential for harm. In this category, some respondents also noted that friends of acquaintances had bad trips on drugs or suffered other damaging side effects and this possibility had prevented them from ever experimenting with drugs. About 8% of the respondents stated that the information they got in school or in drug abuse education classes kept them from trying drugs. Since most of the respondents were in their twenties or older, many had not been exposed to drug education classes in school, so the percentages in this category were rather low.

The answers to the question in Table 24 helped evaluate how well the respondents in the household survey thought that alcohol and drug information treatment programs were handling the drug problem in Virginia Beach. The programs which the question concerns are Alcoholics Anonymous, Alcohol Information Center, Drug Information Center, and Drug Outreach Center.

Only about 7% of the household survey respondents thought the drug and alcohol information and treatment programs responded to the drug problem in Virginia Beach "very well." The majority thought the programs responded only "fairly well" or "not too well." The results are quite similar to those from the professional and business communities; most people felt that, for whatever reasons,

How well do you think these programs [Alcoholics Anonymous, Alcohol Information Center, Drug Information Center, and Drug Outreach Center] respond to the drug problem in Virginia Beach?

TABLE 24.--Household Survey of Adequacy of Treatment Programs: Question 12.

Response	Total Respondents	Percent
Very well	17	6.5
Fairly well	94	36.0
Not too well	70	26.8
Not at all	6	2.3
No answer	74	28.4
Total	261	100.0

the programs were simply not adequately responding to the drug problem.

Household Demographic Data

The sample of 261 households contained in this survey is very similar to the sample of 366 households in the Virginian-Pilot/ Ledger-Star City Profiles sample in terms of age, sex, marital status, and so forth. Both samples are relatively similar to the results from the 1970 U.S. Census of Population and Housing for Virginia Beach. Of course, the area has grown from a population of 172,106 in 1970 to the present 231,000 (± 500), a population increase of about

11,778 per year.[1] The increase of one-third could have significantly altered the population composition since 1970.

The demographic data on the 261 households was obtained from the questions at the end of the household questionnaire. The questions concerned age, marital status, number of children living at home, last year of school completed, family income, area of residence in Virginia Beach, and occupation.

Although the census offered no data on age, the figures from this sample of households are quite similar to those from the Virginian-Pilot/Ledger Star sample as indicated in Table 25. One of the purposes of these questions on age, sex, etc., was to check the sampling procedures to see if the sampling techniques produced a random sample that was similar to the Virginia Beach population at large. Since there was such a similarity, it became possible to generalize from the sample to the population at large.

For the question concerning sex of the respondents, there was no comparable data from the Virginian-Pilot/Ledger-Star survey or from the 1970 census. It seemed important for the accuracy of the survey that the sex composition of the respondents be similar to the population in general. In other words, the respondents should have numbered about 50% male and 50% female, which they did. About 47.9% were male and 46.0% were female, with 6.1% of the respondents not answering the question.

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[1]These figures are from the Office of City Planning of Virginia Beach and represent population projections as of October 1, 1975.

TABLE 25.--Household Survey: Age of Respondents.

Age	Drug Abuse Survey N = 261	Virginian-Pilot/ Ledger-Star Survey N = 366
Under 29	30.0%	31%
30 - 49	51.0	51
50 +	13.8	19
No answer	5.4	--
Total	100.0%	101%

The respondents in this survey were primarily married and living with their marital partners (Table 26). The Virginian-Pilot/ Ledger-Star survey had no data on this subject, but one assumes that the statistics on marital status resemble the Virginia Beach population rather closely. Of course, the predominantly young age of most of the sample (77.1% were 22 to 49 years of age) means that the number of widowed will probably be low. Virginia Beach is also a predominantly young community, made up of married couples, usually with children.

Table 27 from the drug abuse survey gives the percentages with one, two, three, four or more children and those with no children. These statistics were not comparable to the Virginian-Pilot/ Ledger-Star survey data nor to census data. There is the possibility, moreover, that slightly more families with no children or with only one child were represented in this sample. Perhaps these families had more time to respond to lengthy surveys of this type.

TABLE 26.--Marital Status of Respondents (N = 261).

Status	Percent
Never married	6.9
Married	80.1
Widowed, separated, divorced	8.0
No answer	5.0
Total	100.0

TABLE 27.--Number of Children Per Family of Respondent (N = 261).

Children	Percent
0	31.8
1	23.0
2	18.8
3	10.0
4 +	10.3
No answer	6.1
Total	100.0

Educational attainment (Table 28) can be compared from this drug abuse survey and the Virginian-Pilot/Ledger-Star survey. There were some differences, but most of these could be accounted for by chance. There were also some differences in categories; for example, the Virginian-Pilot/Ledger-Star survey had no category for "technical training."

TABLE 28.--Education of Respondents.

Level of Education	Drug Abuse Survey N = 261	Virginian-Pilot/ Ledger-Star Survey N = 366
0 - 7	0.0%	5%
8th	0.4	3
Some high school	5.7	15
High school graduate	29.1	37
Some college	22.5	19
College graduate	14.6	16
Post-graduate	16.8	4
Technical	4.7	--
No answer	5.7	2
Total	99.5%	101%

The data on income (Table 29) for Virginia Beach was comparable for drug abuse survey data, Virginian-Pilot/Ledger-Star data, and 1970 census data. Incomes in Virginia Beach have undoubtedly increased in the five years since the 1970 census. It is also important to remember that the current average income for the nation

TABLE 29.--Income of Respondents.

Income	Drug Abuse Survey N = 261	Virginian-Pilot/ Ledger-Star Survey N = 366	1970 Census
Under $5,000	1.1%	8%	15%
$5,000-$10,000	17.6	27	33
$10,000-$15,000	29.1	27	29
$15,000 and over	46.4	24	23
No answer	5.8	14	--
Total	100.0%	100%	100%

is about $12,000, and the Virginia Beach average was also probably higher than the national average. In the directions for the drug abuse survey, it was stressed that respondents were to combine the incomes of husband and wife, perhaps raising the number in the $15,000 or more category, as evident in Table 29.

The respondents in the drug abuse survey were primarily located (Table 30) in the major population centers of Virginia Beach: the Beach Borough, Lynnhaven, London Bridge, Hilltop, Bayside, and Kempsville. The distribution of the same was in accord with population figures on these areas.

Survey of Youth of Virginia Beach

Methodology

One of the more important segments of the population of Virginia Beach is the youth population. This is the population where drug abuse often causes the most public concern. This is also the

TABLE 30.--Respondents' Area of Residence Within Virginia Beach.

Zip Code	Area	Number	Percent
23450	Mail Handling Annex	0	0.0
23451	Main Post Office, Beach Borough	41	15.7
23452	Lynnhaven Station	61	23.4
23453	London Bridge Station	0	0.0
23454	London Bridge Station, Hilltop	33	12.6
23455	Bayside, Naval Amphibious Base	41	15.7
23456	Princess Anne Station, Pungo	5	1.9
23457	Back Bay	0	0.0
23458	Main Post Office, Beach Borough	0	0.0
23459	Fort Story	0	0.0
23460	Naval Air Station, Oceana	0	0.0
23461	Dam Neck Naval Base	0	0.0
23462	Kempsville Area, Witchduck Annex	62	23.8
No answer		17	6.5
Other zip code		1	.4
Total		261	100.0%

polulation where drug abuse often causes the most public concern. This is also a population which is vulnerable to the abuse of psychoactive drugs as well as alcohol.

The most efficient way to survey this population was to contact the Virginia Beach School Board to gain permission, assistance, and support in administering questionnaires to a sample of the junior high and high school students. A proposal outlining the projected survey was submitted to school officials who reviewed the proposal and informed the principals and assistant principals of the ten junior and senior high schools of the upcoming survey.

The questionnaire to be used was created by Dr. John D. Swisher and Dr. John J. Horan of Pennsylvania State University. Dr. Swisher was contacted and gave permission to use the "Drug Education Evaluation Scale" as the survey instrument.

The school principals all designated assistants to select the individual classes to which the questionnaires were to be administered. An effort was made to stratify the sample by age, to get a somewhat even breakdown.

The ideal situation would have been a simple random sample with the total population of young people from 14 to 18 years of age in Virginia Beach as the universe. However, a more realistic research model had to be adopted considering limitations in staff size, circumstances, and budget.

The school principals and their assistants chose the classes to be surveyed and asked the teachers' help in administering the anonymous questionnaire. The students were assured that the

identities of themselves, their classes and their schools would remain anonymous. They were only asked to write their ages on their individual questionnaires. The questionnaires were then collected from all the participating classes in all ten junior high and senior high schools and shuffled together to prevent identification.

Results

Tables 31-41 give the results of the youth survey. Table 31 gives an overview of the drug use patterns of youths from 14 through 18 years of age. Some explanation of this Table 31 is essential, since it is in the form of a work table. In other words, much information that might have taken three or four tables to present is presented on one large table.

The percentage of the youth sample using each drug is presented on the right-hand side of the double column under the appropriate frequency heading. For drug program implementation purposes, projections were made from the percentages of the youth sample using drugs to the total population of young people in Virginia Beach who are 14 to 18 years of age. These projection figures appear on the left-hand side of the double column.

Table 31 would read "36.9% of the youths in the sample never used cigarets. A projection of this figure of the total youth population of 21,182[1] of Virginia Beach would mean that 7,818 young people never smoked cigarets." The other figures can be read similarly.

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[1]This figure was obtained from the Department of City Planning, City of Virginia Beach.

TABLE 31.--Results of Youth Survey: 14-18 Year Olds (21,182 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=512)	7,818.28	36.91	3,103.16	14.65	993.44	4.69	1,241.27	5.86	1,241.27	5.86	620.63	2.93	1,323.88	6.25	4,840.09	22.85
Alcohol (N=514)	4,410.09	20.82	1,978.40	9.34	1,071.81	5.06	3,956.80	18.68	5,028.61	23.74	4,162.26	19.65	370.69	1.75	205.47	.97
Marihuana (N=488)	11,980.54	56.56	997.67	4.71	1,823.77	8.61	1,084.52	5.12	2,084.31	9.84	1,866.13	8.81	910.83	4.30	434.23	2.05
Hashish (N=505)	17,030.33	80.40	838.81	3.96	461.77	2.18	881.17	4.16	1,635.25	7.72	252.07	1.19	0.00	0.00	84.73	.40
Hallucin. (N=495)	18,917.64	89.31	855.75	4.04	470.24	2.22	512.60	2.42	341.03	1.61	42.36	.20	0.00	0.00	42.36	.20
Stim. (N=501)	18,053.42	85.23	1,438.26	6.79	423.64	2.00	590.98	2.79	508.37	2.40	127.09	.60	0.00	0.00	42.36	.20
Depress. (N=509)	18,644.40	88.02	1,122.65	5.30	624.87	2.95	499.90	2.36	207.58	.98	42.36	.20	0.00	0.00	42.36	.20
Heroin (N=507)	20,597.38	97.24	417.29	1.97	124.97	.59	0.00	0.00	42.36	.20	0.00	0.00	0.00	0.00	0.00	0.00
Cocaine (N=511)	19,813.64	93.54	497.73	2.35	165.22	.78	207.58	.98	372.80	1.76	42.36	.20	0.00	0.00	82.61	.39
Other (N=472)	20,239.40	95.55	313.49	1.48	224.53	1.06	224.53	1.06	180.46	.85	0.00	0.00	0.00	0.00	0.00	0.00

TABLE 32.--Results of Youth Survey: Age 14 (4,744 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=102)	1,722.1	36.3	834.9	17.6	417.5	8.8	327.3	6.9	417.5	8.8	137.6	2.9	327.3	6.9	559.8	11.0
Alcohol (N=102)	1,442.2	30.4	512.4	10.8	370.0	7.8	977.3	20.6	977.3	20.6	417.5	8.8	42.7	0.9	0.0	0.0
Marihuana (N=100)	3,131.04	66.0	237.2	5.0	47.44	1.0	379.5	8.0	284.6	6.0	427.0	9.0	142.3	3.0	94.9	2.0
Hashish (N=101)	436.9	92.1	0.0	0.0	47.44	1.0	0.0	0.0	232.5	4.9	47.44	1.0	0.0	0.0	47.4	1.0
Hallucin. (N=101)	4,506.8	95.0	94.9	2.0	0.0	0.0	47.4	1.0	47.4	1.0	47.4	1.0	0.0	0.0	0.0	0.0
Stim. (N=102)	4,374.0	92.2	94.9	2.0	94.9	2.0	47.4	1.0	94.9	2.0	47.4	1.0	0.0	0.0	0.0	0.0
Depress. (N=101)	4,459.4	94.0	90.1	1.9	90.1	1.9	42.7	0.9	42.7	0.9	0.0	0.0	0.0	0.0	0.0	0.0
Curare (N=101)	4,696.6	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin (N=101)	4,696.6	99.0	47.4	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine (N=101)	4,554.2	96.0	94.9	1.9	0.0	0.0	0.0	0.0	90.1	1.9	0.0	0.0	0.0	0.0	0.0	0.0
Other (N=86)	4,634.8	97.7	56.9	1.2	56.9	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

TABLE 33.--Results of Youth Survey: Age 15 (4,503 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=124)	1,454.5	32.3	761.0	16.9	396.3	8.8	364.7	8.1	292.7	6.5	144.1	3.2	252.2	5.6	833.1	18.5
Alcohol (N=123)	1,170.8	26.0	441.3	9.8	220.6	4.9	914.1	20.3	1,206.8	26.8	477.3	10.6	72.0	1.6	0.0	0.0
Marihuana (N=124)	2,976.5	66.1	180.1	4.0	180.1	4.0	232.2	5.6	508.8	11.3	292.7	6.5	72.0	1.6	36.0	0.8
Hashish (N=122)	3,985.2	88.5	148.6	3.3	72.0	1.6	148.6	3.3	112.6	2.5	36.1	0.8	0.0	0.0	0.0	0.0
Hallucin. (N=124)	4,250.8	94.4	108.1	2.4	72.0	1.6	0.0	0.0	72.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0
Stim. (N=124)	3,994.2	88.7	292.7	6.5	36.0	0.8	108.1	2.4	36.0	0.8	36.0	0.8	0.0	0.0	0.0	0.0
Depress. (N=124)	4,111.2	91.3	216.1	4.8	36.0	0.8	108.1	2.4	36.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0
Curare (N=124)	4,503.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin (N=124)	4,394.9	97.6	36.0	0.8	0.0	0.0	36.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	36.0	0.8
Cocaine (N=122)	4,318.4	95.9	72.0	1.6	0.0	0.0	36.0	0.8	36.0	0.8	0.0	0.0	0.0	0.0	36.0	0.8
Other (N=108)	4,426.5	36.0	36.0	0.8	0.0	0.0	0.0	0.0	36.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0

TABLE 34.--Results of Youth Survey: Age 16 (4,175 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=131)	1,624.1	38.9	571.8	13.7	129.4	3.1	158.7	3.8	192.1	4.6	62.6	1.5	288.1	6.9	1,148.1	27.0
Alcohol (N=133)	597.0	14.3	534.4	12.8	250.5	6.0	659.7	15.8	1,160.7	27.8	814.1	19.5	125.2	3.0	33.4	0.8
Marihuana (N=133)	2,229.5	53.4	346.5	8.3	501.0	12.0	33.4	0.8	563.6	13.5	283.9	6.8	150.3	3.6	62.6	1.5
Hashish (N=130)	3,532.1	84.6	158.7	3.8	96.0	2.3	158.7	3.8	158.7	3.8	62.6	1.5	0.0	0.0	0.0	0.0
Hallucin. (N=131)	3,857.7	92.4	96.0	2.3	129.4	3.1	62.6	1.5	33.4	0.8	0.0	0.0	0.0	0.0	0.0	0.0
Stim. (N=132)	3,699.1	88.6	158.7	3.8	125.3	3.0	125.3	3.0	33.4	0.8	33.4	0.8	0.0	0.0	0.0	0.0
Depress. (N=132)	3,828.5	91.7	158.7	3.8	96.0	2.3	62.6	1.5	33.4	0.8	0.0	0.0	0.0	0.0	0.0	0.0
Curare (N=132)	4,175.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin (N=132)	4,141.6	99.2	0.0	0.0	0.0	0.0	0.0	0.0	33.4	0.8	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine (N=132)	3,920.3	93.9	947.7	2.3	33.4	0.8	125.3	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other (N=122)	3,728.3	97.6	33.4	0.8	33.4	0.8	33.4	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

TABLE 35.--Results of Youth Survey: Age 17 (3,891 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=140)	1,334.6	34.3	470.8	12.1	54.5	1.4	27.6	7.1	54.5	1.4	112.8	2.9	249.0	6.4	1,334.6	34.9
Alcohol (N=142)	412.5	10.6	272.4	7.0	190.7	4.9	684.8	17.6	957.2	24.6	1,206.2	31.0	108.9	2.8	57.5	1.4
Marihuana (N=140)	1,529.2	39.3	194.6	5.0	249.0	6.4	194.6	5.0	661.5	17.0	610.9	15.7	276.3	7.1	167.3	4.39
Hashish (N=139)	2,350.2	60.4	334.6	8.6	167.3	4.3	420.2	10.8	556.4	14.3	54.5	1.4	0.0	0.0	0.0	0.0
Hallucin. (N=140)	3,112.8	80.0	221.8	5.7	194.6	5.0	194.6	5.0	108.9	2.9	54.5	1.4	0.0	0.0	0.0	0.0
Stim. (N=140)	2,836.5	72.9	38.9	1.0	108.9	2.9	544.7	14.0	544.7	9.2	0.0	0.0	0.0	0.0	0.0	0.0
Depress. (N=140)	3,000.0	77.1	334.6	8.6	249.0	6.4	194.6	5.0	112.8	2.9	0.0	0.0	0.0	0.0	0.0	0.0
Curare (N=136)	3,778.2	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin (N=140)	3,758.7	96.6	167.3	1.3	81.7	2.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine (N=140)	3,225.6	82.9	194.6	5.0	194.6	5.0	163.4	4.2	81.7	2.1	0.0	0.0	0.0	0.0	27.2	0.7
Other (N=120)	3,665.3	94.2	97.3	2.5	66.1	1.7	66.1	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

TABLE 36.--Results of Youth Survey: Age 18 (3,869 total population).

Drug	Never Used		Used Before 1/1/73 But Not Now		Used Since 1/1/73 But Not Now		Once/Twice a Year		Once/Twice a Month		Once/Twice a Week		Once/Twice a Day		Often Each Day	
	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%	Proj.	%
Cigarets (N=86)	1,613.4	41.7	584.2	15.1	42.6	1.1	89.0	2.3	313.4	8.1	135.4	3.5	181.8	4.7	901.5	23.2
Alcohol (N=86)	719.6	18.6	224.4	5.8	131.4	3.4	630.6	16.3	766.1	19.8	1,303.9	33.7	46.4	1.2	46.4	1.2
Marihuana (N=84)	1,613.4	41.7	321.1	8.3	460.4	11.9	232.1	6.0	321.2	8.3	692.6	17.9	185.7	4.8	46.4	1.2
Hashish (N=84)	2,901.75	75.0	139.3	3.6	92.6	2.4	274.7	7.1	460.4	11.9	0.0	0.0	0.0	0.0	0.0	0.0
Hallucin. (N=84)	3,451.1	88.0	139.3	3.6	46.4	1.2	232.1	6.0	46.4	1.2	0.0	0.0	0.0	0.0	0.0	0.0
Stim. (N=85)	3,048.8	78.8	363.7	9.4	135.4	3.5	275.0	7.1	46.4	1.2	0.0	0.0	0.0	0.0	0.0	0.0
Depress. (N=85)	3,277.0	84.7	274.7	7.1	92.9	2.4	135.4	3.5	46.4	1.2	46.4	1.2	0.0	0.0	0.0	0.0
Curare (N=84)	3,869.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heroin (N=85)	3,822.6	98.8	46.4	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine (N=84)	3,636.9	94.0	46.4	1.2	92.9	2.4	46.4	1.2	46.4	1.2	0.0	0.0	0.0	0.0	0.0	0.0
Other (N=71)	3,102.9	97.6	46.4	1.2	46.4	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

TABLE 37.--Youth Survey: Poly-Drug Use, Age 14 (N = 102).

Drugs Only: 5		Used to Use Alcohol: 1
1. Presently smoke tobacco	4	regular
2. Marihuana	2	regular
	2	minimal
3. Depressants	0	
4. Hashish	0	
5. Stimulants	1	1-2 times/mo.
Alcohol Only: 31		
Presently smoke tobacco	9	minimal
	3	regular
Drugs and Alcohol: 22		
Drinking presently	14	minimal
		8 mari. minimal 2 regular
		3 mari. 1-2 times/wk; hash 1-2 times/yr.
		1 mari. & hash 1-2 times/wk.
	8	regular
		2 mari. regular 2 minimal
		1 mari. & hash daily; hallu. 1-2 times/wk.; & coc. 1-2 times/mo.
		1 mari. daily; stim. 1-2 times/wk.
		1 mari. daily; hash, depr. & heroin 1-2 times/mo.
		1 mari. daily; hash, hallu. & stim. 1-2 times/mo.
Nonusers:	26	never drank
		4 use cigarets regularly
		3 used cigarets before 1/73
		2 used cigarets since 1/73
	18	used to drink, but no longer drink
		15 used no other drugs ever
		3 used to use marihuana
		1 used to use hashish
		1 used to use glue

TABLE 38.--Youth Survey: Poly-Drug Use, Age 15 (N = 124).

Drugs Only: 4		Used to Use Alcohol: 3
1. Presently smoke tobacco	2	regular
2. Marihuana	2	regular
	2	minimal
3. Depressants	0	
4. Hashish	0	
Alcohol Only: 42		
Presently smoke tobacco	7	minimal
	8	regular
Drugs and Alcohol: 32		
Drinking presently	21	minimal
	1	mari. daily, hash & stim. 1-2 times/wk; hallu. 1-2 times/mo.; depr. 1-2 times/yr.
	8	mari. minimal, 1-2 times/wk.
	2	mari. daily
	2	mari. 1-2 times/wk.; hash 1-2 times/yr.
	1	mari. & hash 1-2 times/mo.
	1	mari. 1-2 times/mo.; hash 1-2 times/yr.
	1	depr. 1-2 times/yr.
	11	regular
	1	mari. regularly
	7	mari. minimal
	1	mari. 1-2 times/mo.; heroin & coc. daily
	1	stim. & coc. 1-2 times/mo.
	1	mari. 1-2 times/wk.; hash 1-2 times/mo.
	1	depr. & stim. 1-2 times/yr.; solvents 1-2 times/mo.
Nonusers:	32	never drank
	3	cig. before 1/73
	1	cig. since 1/73
	8	using cig. only--6 minimal, 2 regular
	1	mari. minimal
	1	used to use hallu. & stim.
	15	used to drink, but no longer drink
	4	no other drugs ever
	3	cig. only, min., 4 regular
	2	mari. 1-2 times/wk.
	1	mari. 1-2 times/yr.
	3	used to use mari.
	2	used to use hash & stim. & depr.
	1	used to use hallu.
	1	used to use stim.
	4	used to smoke cig.

TABLE 39.--Youth Survey: Poly-Drug Use, Age 16 (N = 133).

Drugs Only: 5		Used to Use Alcohol: 5
1. Presently smoke tobacco	3	regular
2. Marihuana	1	1-2 times/yr.
	1	1-2 times/mo.
	1	1-2 times/wk.
	1	1-2 times/day
3. Stimulant	1	1-2 times/yr.
4. Hashish	1	1-2 times/mo.
	1	1-2 times/wk.
5. Poly-drugs	1	mari. 1-2 times/day; hash 1-2 times/wk.; hallu., stim., heroin, cocaine 1-2 times/mo.; codeine 1-2 times/yr.
Alcohol Only: 54		
Presently smoke tobacco	5	minimal
	22	regular
Drugs and Alcohol: 33		
Drinking presently	17	minimal
		9 mari. 1-2 times/mo.
		2 mari. 1-2 times/mo.; hash 1-2 times/yr.
		1 mari. 1-2 times/wk.
		1 mari. 1-2 times/wk.; hash 1-2 times/yr.
		1 mari. 1-2 times/da.; hash 1-2 times/mo.
		1 mari. 1-2 times/wk.; hallu. 1-2 times/yr.
		1 mari. 1-2 times/wk.; hash 1-2 times/mo.
		1 mari. 1-2 times/wk.; stim. 1-2 times/yr.
	16	regular
		4 mari. regular
		5 mari. minimal
		1 hash 1-2 times/wk.; stim., depr. 1-2 times/yr.
		1 cocaine 1-2 times/mo.
		1 mari. & hash minimal
		2 mari. regular; hash minimal
		1 mari. daily; hash 1-2 times/mo.; hallu. 1-2 times/yr.; stim. 1-2 times/wk.; depr. & coc. 1-2 times/mo.
		1 mari. daily; stim. & depr. 1-2 times/yr.; coc. 1-2 times/mo.
Nonusers:	21	never drank
		2 used to use cigarets
		1 used to use stimulants
	20	used to drink, but no longer drink
		3 smoke cigarets regularly
		6 used to smoke cigarets
		5 used to use marihuana
		1 used to use marihuana, hash. & stimulants

TABLE 40.--Youth Survey: Poly-Drug Use, Age 17 (N = 142).

Drugs Only: 7			Used to use Alcohol: 5
1. Presently smoke tobacco	3	regular	
2. Marihuana	1	daily	
	6	minimal	
3. Depressants	0		
4. Hashish	3	minimal	
5. Cocaine	1	1-2 times/mo.	
Alcohol Only: 43			
Presently smoke tobacco	4	minimal	
	11	regular	
Drugs and Alcohol: 64			
Drinking presently	24	minimal	
		11 mari. regular	13 minimal
		1 hash 1-2 times/wk.	
		10 hash minimal	
		1 hallu. regular	2 minimal
		10 stim. minimal	
		4 depr. minimal	
		2 cocaine minimal	
	40	regular	
		27 mari. regular	12 minimal
		1 hash regular	22 minimal
		1 hallu. regular	9 minimal
		10 stim. minimal	
		7 depr. minimal	
		6 cocaine minimal	
Nonusers:	16	never drank	
		20 no other drugs ever	
		2 use cigarets regularly	
		1 uses cigarets minimally	
		2 used to use hallu., stim., depr.	
		1 used to use cigarets	
	9	used to drink, but no longer drink	
		6 used no other drugs ever	
		3 use cigarets regularly	
		2 used to use cigarets	
		3 used to use marihuana	
		1 used to use hash. and stim.	
		1 used to use hash., stim., hallu., depr., heroin & cocaine	

TABLE 41.--Youth Survey: Poly-Drug Use, Age 18 (N = 86).

Drugs Only: 3		Used to Use Alcohol: 1
1. Presently smoke tobacco	2	regular
2. Marihuana	1	1-2 times/yr.
	1	1-2 times/day
3. Depressants	1	1-2 times/mo.
4. Hashish	1	1-2 times/yr.
Alcohol Only: 33		
Presently smoke tobacco	9	minimal
	11	regular
Drugs and Alcohol: 29		
Drinking presently	7	minimal
		2 mari. 1-2 times/yr.
		2 mari. 1-2 times/mo.
		1 mari. & hash 1-2 times/mo.
		1 mari. 1-2 times/wk; hash 1-2 times/mo.; stim. 1-2 times/yr.
		1 mari. 1-2 times/wk; hash 1-2 times/mo.; hallu. & stim. 1-2 times/yr.
	22	regular
		5 mari. regular
		3 mari. 1-2 times/mo.
		1 hash 1-2 times/mo.; mari. 1-2 times/wk.; hall., stim., depr. coc. 1-2 times/yr.
		1 hall. 1-2 times/mo.; hash 1-2 times/yr.; mari. 1-2 times/wk.; stim. & depr. 1-2 times/yr.
		1 stim. 1-2 times/yr.; mari. 1-2 times/wk.
		1 depr. 1-2 times/wk.
		1 mari. 1-2 times/day; hash, hallu., stim., depr. 1-2 times/yr.
		1 mari. 1-2 times/wk.; hash & coc. 1-2 times/mo.
		1 mari. 1-2 times/wk.; hash 1-2 times/mo.; hallu. 1-2 times/yr.
		1 mari. 1-2 times/day; hash 1-2 times/mo.; hallu. 1-2 times/yr.
		1 mari. daily; hash 1-2 times/yr.
		2 mari. 1-2 times/wk.; hash 1-2 times/yr.
		1 mari. 1-2 times wk.; hash 1-2 times/mo.
		1 mari. & hash 1-2 times/mo.
		1 mari. daily; hash & stim. 1-2 times/mo.
Nonusers:	12	never drank
		1 used to use cigarets
		1 used to use stimulants & depressants
	7	used to drink, but no longer drink
		1 used no other drugs ever
		1 uses cigarets regularly
		3 used to use cigarets
		3 used to use marihuana
		1 used to use stimulants

The next double column indicates that 14.7% of the youth population surveyed smoked cigarets before January 1, 1973, but do not smoke now. Projected figures to the population indicate that approximately 3,100 young people from 14 to 18 used to smoke but no longer do.

The percentage of young people smoking (Table 31) was a strikingly high 43.8%. Of course, some of these young people smoke somewhat infrequently; however, almost one-third of those surveyed smoked daily, with a quarter of the sample smoking "often each day."

Tables 32-36 indicate that smoking daily increased evenly along with age from 14 to 17, but at age 18 there was a noticeable drop in the percentage who smoke daily. Perhaps this finding that smoking daily was so widespread should not be surprising when viewed with the fact that 41.9% of the adults sampled in the household survey also smoked. This compares with 38% of adults and 17% of youths who reported smoking in the nationwide survey conducted and published by the National Commission on Marihuana and Drug Abuse (1973, p. 46).

Alcohol consumption was also quite high, with 64.8% of the youths aged 14 to 18 reporting alcohol use at least once or twice a year. Most of them were occasional users with about 3% using alcohol daily.

As with smoking, use of alcohol rapidly increased with age up to 18 when over a third of the sample admitted using alcohol at least "once or twice per week." The second report of the National Commission on Marihuana and Drug Abuse (1973) made the following statement concerning alcohol consumption and age, "With regard to

age, use begins its steep climb during the middle teens, reaches its high point (66%) in the 22-25 year age group and gradually levels off thereafter. . ." (p. 47).

The use of marihuana among Virginia Beach youths from 14 to 18 years of age as reported in Table 31 was quite prevalent. Of the 512 youths in the sample, 43.4% reported having ever used marihuana; 13.3% of the sample no longer used marihuana but 30.1% or nearly one-third of the sample reported using marihuana at least once or twice per year. Daily use was reported by 6.3% of the sample. Regular use of marihuana was particularly prevalent among those 17 and 18 years of age.

Hashish was not as widely used as marihuana. It was most popular with 17 year olds. Hallucinogens seemed to have been more widely used in the past than at present. About 4.4% of the sample reported current use, while 6.3% report having used hallucinogens in the past but no longer. Hallucinogen use was highest among 17 and 18 year olds (about 8%), according to Tables 35 and 36, but no one in the sample reported using them daily.

Stimulants also were once more widely used than at present. About 9% of the sample reported using stimulants in the past but no longer, while 6% reported present use. However, current stimulant use still was rather high among those who are 17 years of age.

Seventeen year olds also seemed to be the ones most likely to be currently using depressants (7.9%) compared to 3.7% for the sample as a whole and 5.9% for the 18 year olds. Once again, use of these soft drugs increased with age up to 18 years.

Current heroin use was quite minimal and seems to have been mostly used in the past by 17 and 18 year olds. The picture for cocaine was quite different, with 3.3% of the sample admitting to its current use; some even used it daily.

The youth survey indicated that drug use, particularly of soft drugs (hallucinogens, stimulants, and depressants) was much higher in the past but significant numbers of young people still used these drugs fairly regularly (about 5% to 10%). Hard drugs have never been too widely used in Virginia Beach but were used more in the past than currently.

Marihuana use was quite widespread, but the most widely used and abused drug is alcohol. There was still a soft drug problem in Virginia Beach which had been compounded by increased use of alcohol, resulting in a poly-drug problem of considerable proportions, as Tables 37-41 indicate.

Increased police attention to drug sales as well as public concern with the drug problem and the resulting drug education programs in the ten junior and senior high schools may have all effected a decrease in the numbers of young people using drugs. However, much more needs to be done, particularly with prevention programs.

Department of Social Services

Methodology

The Department of Social Services was considered to be a prime source of data about drug abuse, especially as it affected their clients. The department, however, had no "hard" data

concerning drug abuse readily available. It was therefore necessary to create a "Drug Abuse Data Sheet" to be completed by a sample of caseworkers. One-fourth the total of 60 caseworkers were selected by their supervisors to complete the "Data Sheet." They were instructed to go through their files to collect information on their clients who used drugs. The information obtained provided the data for a profile of those Social Service clients who used drugs, but the number of clients in this sample by no means equaled the total of all Social Service clients who used drugs.

Results

Data from the Virginia Beach Department of Social Services indicate that all caseworkers in the sample had some clients who were using drugs. The number of clients who were using drugs ranged from 1 to 20, and the average was 7.5 per caseworker, totaling 105 clients in all. To be more precise, Table 42 indicates the number of clients using drugs that most caseworkers had.

TABLE 42.--Results of Social Service Survey of Drug Use in Virginia Beach.

Number of Clients on Drugs	Number of Caseworkers Having Clients on Drugs
1 - 4	5
5 - 9	5
10 - 14	1
15 - 20	3

About 30% of the clients using drugs were 21 years of age or younger. It is interesting to note, however, that among those clients using drugs, the majority (44%) of those whose ages were known were 30 years of age or over. Of course, many of those over 30 primarily abused alcohol. Table 43 gives more precise information on ages of clients using drugs.

TABLE 43.--Age of Social Service Clients Using Drugs in Virginia Beach.

Age of Clients	Clients in Age Range	
	Number	Percent
10 - 14	3	2.9
15 - 17	17	16.2
18 - 21	11	10.5
22 - 29	10	9.5
30 - 49	32	30.5
50 +	14	13.3
Age unknown	18	17.1
Total	105	100.0

About two-thirds of Social Services clients using drugs were either never married or widowed, separated, or divorced (Table 44). About 23% were married, with husband or wife present, as Table 44 shows. It seems that the majority of drug users among the clients of Social Services were not currently married.

TABLE 44.--Marital Status of Social Services Clients Using Drugs in Virginia Beach.

Marital Status	Number	Percent
Never married	31	29.5
Married, spouse present	24	22.9
Widowed, separated, or divorced	32	30.5
Marital status unknown	18	17.1
Total	105	100.1

The fairly high percentage of never married (30%) may reflect the 30% of the sample who were 21 years of age or younger. The fact that the numbers of those widowed, separated, or divorced outnumbered those who were married with husband or wife present might indicate greater marital instability for those using drugs.

As indicated in Table 45, the percentage of drug-using clients with no dependents (38%) perhaps reflects the high percentage of clients who have never married (30%). This area of data was one where caseworkers often lacked information, as the fairly high percentage in the "number unknown" category indicates.

Although the education level (Table 46) was not known for almost half (47%) of the drug-abusing population, most of those where the educational level was known were not high school graduates. Thirty-five percent of the clients had less than 12 years of schooling, a finding which is probably due to the young age of a third of the clients who used drugs.

TABLE 45.--Number of Dependents of Drug-Using Clients in Virginia Beach.

Number of Dependents	Clients	
	Number	Percentage
0	40	38.1
1	6	5.7
2	9	8.6
3	6	5.7
4 +	8	7.6
Number unknown	36	34.3
Total	105	100.0

TABLE 46.--Education Levels of Drug-Using Clients in Virginia Beach.

Education	Clients	
	Number	Percentage
Less than high school	1	1.0
Some high school	36	34.3
High school graduate	13	12.4
Technical school	0	0.0
Some college	6	5.7
College graduage	0	0.0
Graduate or professional school	0	0.0
Education unknown	49	46.7
Total	105	100.1

If a table were to be constructed for only those 56 clients whose educational level is known, the results would appear as in Table 47. Results from the City Profiles survey conducted by the Virginian-Pilot/Ledger-Star are given for Virginia Beach for purposes of comparison.

TABLE 47.--Education Levels of Social Service Clients Compared to the Virginian-Pilot/Ledger-Star Survey of Virginia Beach Residents (in percentages).

Education	Social Services Clients	Virginia Beach Residents[a]
Less than high school	1.8%	8.0%
Some high school	64.3	15.0
High school graduate	23.2	37.0
Technical school	0.0	(omitted)
Some college	10.7	19.0
College graduate	0.0	16.0
Graduate or professional school	0.0	4.0
Education unknown	(omitted)	1.0
Refused	(omitted)	1.0
Total	100.0	101.0

[a]As surveyed by Virginian-Pilot/Ledger-Star.

Those clients of Social Services who used drugs fell far below the educational levels attained by Virginia Beach residents, as reported by the Virginian-Pilot/Ledger-Star survey.

Table 48 indicates the areas where some of the Social Service clients who used drugs actually lived in Virginia Beach. This information, however, was not available for the majority of clients using drugs.

TABLE 48.--Virginia Beach Residence of Social Service Clients Using Drugs.

Zip Code	Area	Number	Percent
23450	Mail Handling Annex	0	0.0
23451	Main Post Office, Beach Borough	5	4.8
23452	Lynnhaven Station	9	8.6
23453	London Bridge Station	0	0.0
23454	London Bridge Station, Hilltop	2	1.9
23455	Bayside Area, Naval Amphibious Base	5	4.8
23456	Princess Anne Station, Pungo	1	1.0
23457	Back Bay	0	0.0
23458	Main Post Office, Beach Borough	0	0.0
23459	Fort Story	0	0.0
23460	Naval Air Station Oceana	0	0.0
23461	Dam Neck Navy Base	0	0.0
23462	Kempsville Area, Witchduck Annex	1	1.0
	Elsewhere in Tidewater	3	2.9
	Unknown	79	75.2
	Total	105	100.2

The majority (55%) of Social Service clients who used drugs had lived in Virginia Beach at least five years (Table 49.) Another 20% had lived in Virginia Beach from one to five years. Very few (11%) of clients on drugs had lived in Virginia Beach one year or less.

TABLE 49.--Length of Residence in Virginia Beach of Social Service Clients Using Drugs.

Length of Residence	Clients	
	Number	Percent
30 days	1	1.0
1-6 months	4	3.8
6-12 months	6	5.7
1-5 years	21	20.0
5 years +	58	55.2
Unknown	15	14.3
Total	105	100.0

Fifty-three percent of the Social Service clients who were on drugs were unemployed (Table 50). Only 14% were employed at the time, as Table 50 indicates.

Among those Social Service clients who listed an occupation or trade (Table 51), whether or not they were employed during 1973, 30% were unskilled laborers. Unfortunately, the occupation or trade of 40% of the clients was unknown. Only 3% were skilled laborers.

TABLE 50.--Employment Status of Social Service Clients Who Used Drugs.

Employment Status	Clients	
	Number	Percent
Employed	15	14.3
Unemployed	56	53.3
Other	2	1.9
Unknown	32	30.5
Total	105	100.0

TABLE 51.--Occupation or Trade of Social Service Clients Who Used Drugs.

Occupation Type	Clients	
	Number	Percent
Skilled	3	2.9
Unskilled	31	29.5
Business person	9	8.6
Public servant	0	0.0
Professional	0	0.0
Student	7	6.7
Housewife	11	10.5
Retired	2	1.9
Unknown	42	40.0
Total	105	100.1

Twelve (or 11%) of the 105 Social Service clients who used drugs had prior arrests for drug abuse. Seventy-five percent of the arrests were for abuse of alcohol, 17% were for possession of drugs other than alcohol, and 8% were for possession of drug paraphernalia.

The Department of Social Service clients who used drugs used primarily alcohol (36.2% of 105 clients) or were poly-drug users (22.9%) meaning that they used several drugs in combination. Of the 38 clients who used only alcohol, about 61% were 30 to 49 years of age with most of the others, 24%, being 50 years of age or older. Only about 16% of those using only alcohol were under 30 years of age. Many of the poly-drug users combined alcohol with other drugs, such as marihuana or depressants.

About 16% of the 105 clients used marihuana only, and most of these (94%) were under 30 years of age; none were 50 years of age or older. Marihuana was often used by the poly-drug users along with other drugs.

It is interesting to note that the majority or 62.5% of the poly-drug users were under 29 years of age (Table 52). The trend seems to be for the clients over 30 who were classified as using drugs to use only alcohol. Those under 30 were primarily poly-drug users who experiment with different drugs from marihuana to stimulants and depressants to even opiates. Relatively few, if any, of the clients used stimulants or depressants. As expected, those clients using inhalants were in the 10 to 17 years of age group. Very few people beyond these ages (Tables 52 and 53) were using inhalants.

TABLE 52.--Department of Social Services Clients in Virginia Beach Using Drugs, By Age (percentages).

Type of Substance	N	Age							
		Under 10	10-14	15-17	18-21	22-29	30-49	50+	Total
Alcohol	38	2.6%	0.0%	5.3%	2.6%	5.3%	60.5%	23.7%	100.0%
Marihuana (including hashish, THC-synthetics)	17	0.0	5.9	58.8	17.6	11.8	5.9	0.0	100.0
Inhalants (glue & other vapors or volatile intoxicants)	3	0.0	66.7	33.3	0.0	0.0	0.0	0.0	100.0
Hallucinogens (LSD, mescaline, STP & similar drugs)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Stimulants (amphetamines, methamphetamines, pep pills)	1	0.0	100.0	0.0	0.0	0.0	0.0	0.0	100.0
Depressants (the range of sedative anti-anxiety agents from barbiturates to "minor tranquilizers")	5	0.0	0.0	20.0	40.0	40.0	0.0	0.0	100.0
Opiates (heroin, codeine, morphine, paregoric, & other opiate derivatives)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Methaqualone (Quaalude, etc.)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Poly-drugs	24	0.0	0.0	25.0	20.8	16.7	25.0	12.5	100.0
Don't know	17								

TABLE 53.--Department of Social Services Clients in Virginia Beach Who Are Poly-Drug Users.

Type of Substance	N	Age						
		Under 10	10-14	15-17	18-21	22-29	30-49	50+
Alcohol & marihuana	3					2	1	
Alcohol & depressants	4						3	1
Marihuana, hallucinogens, stimulants, depressants	2			1		1		
Stimulants & depressants	2						1	1
Alcohol, marihuana, hallucinogens, stimulants, depressants, opiates	1					1		
Hallucinogens, stimulants, depressants	3			3				
Hallucinogens & stimulants	3				3			
Alcohol, stimulants, depressants	2						1	1
Marihuana & stimulants	1			1				
Marihuana & depressants	1				1			
Marihuana & hallucinogens	1			1				
Marihuana, hallucinogens, stimulants	1				1			

Drug Outreach Center

The most recent report from the Drug Outreach Center, 2022 Atlantic Avenue, Virginia Beach, Virginia, indicates (see Tables 54-56):

1. Slightly more males than females come in for counseling.

2. Almost 80% are returning rather than new clients seeking services for the first time.

3. The mean age is 23.3, but almost 40% are under 20 years of age.

4. The main problems for which clients went to Outreach were drugs, severe emotional problems, family problems, money, and job problems. The clients most often heard about Outreach by word of mouth and through advertisements. To a lesser extent, the clients were referred by the Hotline and various social agencies.

5. Most of the Hotline calls received concerned physical problems and, to a lesser extent, social and drug problems. About two-thirds of the callers were female.

6. Most calls were made on Saturdays with the rest of the calls about evenly divided among the other days of the week. The majority of the calls were brief, under five minutes.

7. The drug most often called about was marihuana (including hashish and THC), second was barbiturates, then alcohol, tranquilizers, and LSD and psychedelics. These findings closely resemble the drug use patterns discovered in the household survey data and the Department of Social Service data.

TABLE 54.--Outreach Center Counseling Data for Virginia Beach.

Caseload	Nov.	Dec.	Jan.	Feb.	Total	% of Total	Jul.-Oct. Total	% of Total
Total visits	101	89	192	122	504		173	
Sex								
Male	52	41	108	66	267	53.0%	77	46.3%
Female	49	48	84	56	237	47.0	77	46.3
Referral								
New	42	19	43	33	137	27.1	93	53.8
Return	59	70	149	89	367	79.9	80	46.2
Age[a]								
Under 16	10	2	6	10	28	5.6	26	15.0
16 - 20	34	37	64	37	172	33.8	72	41.7
21 - 25	30	26	61	38	158	31.4	43	24.9
26 - 30	13	8	34	25	80	15.9	15	8.7
Over 30	14	16	27	12	69	13.3	17	9.7
Problem								
Drugs	48	42	79	49	218			
Family	36	42	57	26	161			
Marital	13	8	15	7	43			
Sexual	6	13	10	7	36			
Romantic	7	3	11	9	30			
School	19	12	9	11	51			
Peer	10	18	25	14	67			
Military	11	6	11	11	39			
Legal	5	14	44	21	84			
Job	11	19	58	23	111			
Monetary	16	14	57	25	112			
Severe emotional	23	40	82	34	179			
Total	205	231	458	237	1,131			
Referred by								
Medical clinic	5	3	1	4	13	2.6%		
Hotline	24	25	42	12	103	20.7		
Drug Ed./Prev.	0	0	0	0	0	0.0		
Advertising	17	19	55	46	137	27.4		
Word of mouth	34	22	61	46	163	32.7		
Social agencies	17	20	32	14	83	16.6		
					499			

[a]Mean age, 23.3.

TABLE 55.--Outreach Hotline Data Summary for Virginia Beach.

Total calls	697	
Hang-ups	207	30%
Difference	490	70%
Time of Calls		
0900 - 1900	303	43%
1900 - 2000	56	8%
2000 - 2100	89	13%
2100 - 2200	68	10%
2200 - 2300	54	8%
2300 - 2400	57	8%
2400 - 0100	35	5%
0100 - 0900	35	5%
Reason for Calling		
Drug	135	27%
Social	135	27%
Physical	180	36%
Sex	98	14%
Sex of Caller		
Male	162	33%
Female	328	67%
Day of Call		
Sunday	92	13%
Monday	69	10%
Tuesday	101	14%
Wednesday	76	11%
Thursday	89	13%
Friday	96	14%
Saturday	174	25%
Length of Call (minutes)		
Under 5	213	46%
5 - 10	147	31%
11 - 15	44	10%
16 - 20	12	3%
21 - 30	25	5%
31 - 45	9	2%
46 - 60	8	2%
Over 60	7	1%

TABLE 56.--Outreach Center Hotline Data Summary for Virginia Beach: Reason for Calling (Detail).

1. Drug Problems	
Information	64
Now using	47
OD/poisoning	7
Withdrawal	7
Bad trip	3
Needs treatment	7
	135
2. Social/Personal Problems	
Romantic boy/girl	32
Family	48
Draft/military	4
Runaway	17
School	5
Employment	12
Money	5
Housing/crashpad	8
Social skills	15
	135
3. Physical/Mental/Legal	
Suicide	22
Arrest	5
Laws/legal advice	17
Loneliness/depression	62
Physical symptoms	42
Needs referral	32
	180
4. Outreach Center	
Clinic hours	46
Services available	80
	126

Drugs Involved	
THC/marihuana/hash	30
Heroin/narcotics	16
Barbiturates	23
Amphetamines	14
Other CNS stimulants	6
Tranquilizers	19
Other CNS depressants	17
Cocaine	10
LSD/psychedelics	18
Glue/inhalants	6
Alcohol	20
Referrals to	
Doctor/dentist	24
Psychiatrist	8
Hospital	14
Health Dept.	21
Planned Parenthood	6
Outreach Center	209
Drug program	7
Family/friends/clergy	32
Social services	10
Atlantic Mental Hyg.	6
Legal Aid	6
Police	7
In therapy now	6
Under physician's care	5
Other agency	34
Problem solved	68
Will call back	66
Chronic caller	33
Silent call	20
Other	20
No solution	16

8. The great majority of all Hotline referrals were to the Drug Outreach Center, but some callers were referred to other agencies or to family, friends, or clergy.

Juvenile Probation Department

Data furnished by the Juvenile Probation Department of Virginia Beach generally pointed to the poly-drug style of drug use. Patterns of use by clients were generally erratic.

Whereas alcohol and marihuana were the chief drugs used, 31.5% of the drug users used drugs other than alcohol and/or marihuana.

Some counselors noted that drug users in their caseloads viewed street-drug use in much the same perspective as adult alcohol users view their drinking: it only becomes a "problem," or drug "abuse," if it leads to social, legal, or physiological/psychological problems. In other words, drug use is not a problem unless one gets "busted," overdosed, or not able to function in a usual social pattern.

There seems to be an increase of, or return to, alcohol use for a "high"--probably because it is less difficult to obtain, and has less severe penalties connected with its use.

Some instances of alcohol use as a way of covering other drug "highs" were noted. In other words, if a juvenile comes home "stoned" or "high," there might be less parental "hassle" if the user smells of alcohol than if other drug use is suspected by the parent. This suggests that sometimes it's all right to sneak a drink, but not all right to smoke a joint or pop a pill.

In reviewing the data extracted from one counseling caseload for the previous year, the following statements seem particularly relevant in regard to the incidence of drug use by that population:

1. Of the 54 clients, 16.7% were arrested for drug violations, but 83.3% were actually using drugs illegally (45 out of the total of 54 cases).

2. In the 15-17 year old age bracket, 91.4% were using drugs, and 73.3% of the 18-21 year old bracket were drug users. The subpopulation of 10-14 years old was too small (N = 4) to consider seriously.

3. Of the total population, 66.7% had a junior high school education. Of this group, 77.8% were drug users. If #1 and #2 are combined into a grouping of "nongraduates of high school," 82.7% were drug users.

4. Most of the 54 clients were residents of Virginia Beach five years or more (44: 81.4%). Of this group, 84.1% were drug users.

5. Of the clients, 48.1% were employed, but 90.9% were listed as "unskilled" under "occupation." Only 18.5% were students, but 50% of these (5) were drug users.

6. In regard to poly-drug use:

   a. 55.6% of the total population were poly-drug users;

   b. 66.1% of the drug-using population were poly-drug users;

   c. 61.4% used only alcohol and/or marihuana;

d. Poly-drug users averaged 4.25 drugs per person;

e. Excluding alcohol and marihuana users in the poly-drug use category (13), the poly-drug users averaged 4.6 drugs per person;

f. Drugs used most often in the 15-17 year age bracket:

(1) Alcohol	36.6%
(2) Marihuana	24.4%
(3) LSD	11.0%
(4) Barbiturates	9.8%
(5) Amphetamines	9.8%
(6) Opium	7.3%
(7) Alcohol and marihuana	60.9%
(8) Amphetamines, barbiturates, LSD, opium	37.9%

g. Drugs used in order by poly-drug users:

(1) Alcohol	21.9%
(2) Marihuana	18.7%
(3) Amphetamines	15.6%
(4) Barbiturates and opiates	12.5%
(5) LSD and inhalants	9.4%

In collecting the data, each of the caseworkers in the Juvenile Probation Department was interviewed concerning clients involved in drug use.

A detailed breakdown of one of the caseloads produced the following results (Tables 57-59):

Number of clients during 12 months: 54

Arrested specifically for drug violations: 9 (16.7%)

Drugs used by those arrested: Alcohol, marihuana, hashish, LSD, amphetamines, barbiturates, glue, prescription drugs without prescription.

Caseloads were assigned randomly to the counselors. The counselors agreed that the caseload described was truly random and representative of the client population at the Juvenile Probation Department.

TABLE 57.--One Juvenile Probation Caseload Illustrating Drug Use in Virginia

Age	Total	Total Using Drugs	% of Each Group Using Drugs
10 years	0	0	0.0%
10 - 14	4 (7.4%)	2 (4.4%)	50.0
15 - 17	35 (64.8%)	32 (71.1%)	91.4
18 - 21	15 (27.8%)	11 (24.4%)	73.3
Total	54 (100.0%)	45 (100.0%)	83.3

TABLE 58.--Drug and Poly-Drug Use by Individual Juvenile Probation Clients in Virginia Beach.

Type of Substance	No. of Clients	Percent Using Drugs
Marihuana only	1	1.8%
Alcohol only	13	24.1
Alcohol and marihuana	13	24.1
Alcohol, marihuana, opiates	2	3.7
Alcohol, marihuana, amphetamines, depressants, LSD, opiates	7	12.9
Alcohol, marihuana, amphetamines	2	3.7
Alcohol, marihuana, inhalants, amphetamines, barbiturates, LSD	1	1.8
Alcohol, marihuana, amphetamines, barbiturates, opiates	2	3.7
Alcohol, marihuana, inhalants, LSD	1	1.9
Alcohol, marihuana, amphetamines, barbiturates	1	1.9
Marihuana, inhalants, amphetamines, barbiturates, LSD, opiates	1	1.9
No known drug use	5	9.2
Unknown	5	9.2
Total	54	99.9%
Poly-drug users (total population) N=30		55.6%
Poly-drug users (drug-using population) N=30		68.1%
Poly-drug users (drug-using population excluding alcohol and marihuana)		31.5%

TABLE 59.--Juvenile Probation Caseload by Demographic Statistics and Drug Use in Virginia Beach.

Demographic Data	Total		Total Using Drugs		Using Drugs Each Category
	No.	%	No.	%	%
Education					
Junior high sch. (8-9)	36	66.7	28	62.2	77.8
Some high sch. (10-12)	16	29.6	15	33.3	93.8
High school graduate	1	1.8	1	2.2	100.0
Education unknown	1	1.8	1	1.8	100.0
Total	54	99.9	45	99.5	83.3
Length of Residence					
Less than 30 days	1	1.8	0	0.0	0.0
1-6 months	0	0.0	0	0.0	0.0
6-12 months	1	1.8	1	2.2	100.0
1-5 years	8	14.8	7	15.6	87.5
5 + years	44	81.5	37	82.2	84.1
Total	54	99.9	45	100.0	83.3
Employed					
Yes	26	48.1	22	48.9	84.6
No	17	31.5	13	28.9	76.5
Other	11	20.4	10	22.2	90.0
Total	54	100.0	45	100.0	83.3

Table 59.--Continued.

Demographic Data	Total		Total Using Drugs		Using Drugs Each Category
	No.	%	No.	%	%
Occupation					
Professional	0	0.0	0	0.0	0.0
Skilled	0	0.0	0	0.0	0.0
Unskilled	44	81.5	40	88.9	90.9
Student	10	18.5	5	11.1	50.0
Total	54	100.0	45	100.0	83.3

Drugs Used by Ages

Age	Alcohol	Marih.	Inhal.	LSD	Amphet.	Barb.	Opium
10-14 (N=2)	2 (4.8%)	2 (6.5%)	0 (0.0%)	0 (0.0%)	1 (9.1%)	0 (0.0%)	0 (0.0%)
15-17 (N=32)	30 (71.4%)	20 (64.5%)	1 (50.0%)	9 (81.8%)	8 (72.7%)	8 (80.0%)	6 (60.0%)
18-21 (N=11)	10 (23.8%)	9 (29.0%)	1 (50.0%)	2 (18.2%)	2 (18.1%)	2 (20.0%)	4 (40.0%)
Totals	42 (100%)	31 (100%)	2 (100%)	11 (100%)	11 (99.9%)	10 (100%)	10 (100%)

Drugs Most Used in 15-17 Year Age Bracket

Alcohol	36.5%	Barbiturates	9.8%
Marihuana	24.4%	Opium	9.8%
LSD	11.0%	Inhalants	1.2%
Amphetamines	9.8%		

Prior Arrests for Drug Use

Of the fifty-four (54) clients, nine (9) had formerly been arrested for illegal drug use (17.7%).

City of Virginia Beach Adult Probation Department

An interview was conducted with the drug officer for adult probation, one of four probation officers. This probation officer stressed that the following comments were only opinions based on personal observations and did not necessarily reflect the opinions of the other officers of the department.

From 95% to 98% of the 75 clients of this probation officer had been arrested on drug charges or drug-related offenses. At least 50% of the clients of the other three probation officers had been arrested on such charges.

An example of a drug charge would be possession of marihuana or possession of heroin with intent to distribute. A drug-related offense might be strong-arm robbery that was committed while under the influence of one or more drugs, including alcohol. Another example of a drug-related charge might be statutory burglary with the intent to take and resell items to support a drug habit.

Many of the narcotic drugs in Virginia Beach were not of very good quality and tended to be very expensive, according to this source. A cap of heroin costing $2 to $3 in the District of Columbia could be as much as $12 in Norfolk. Although most people who wanted to buy heroin used Norfolk sources, the drug could also be bought in Virginia Beach.

The officer said the illegal drug which is primarily used in Virginia Beach is marihuana, and it is often used with various types of alcohol (beer, wine, bourbon, etc.) for a better high. Thus, poly-drug use seemed to be popular. It was observed that

during the 1960s, a person might be hooked on heroin or one other single drug. In the '70s, local authorities are seeing people addicted to multiple drugs.

The opinion was offered that laws and court action have had little effect on current drug usage. This source did state, however, that the drug laws passed in 1972 did slow the supply of pharmaceutical drugs to the street scene. She noted that prior to 1972, 75% of all pills, tablets, capsules and so forth were pharmaceutical in nature; that is, these items were either blackmarketed or stolen directly from pharmaceutical companies or from the home medicine chest. Since 1972, doctors are no longer as willing to prescribe tranquilizers and amphetamines as they were a few years ago. Recent government regulations have placed restrictions on refillable prescriptions. Most of the mood-altering drugs are now labeled "nonrefillable" and can only be obtained a second time by a doctor's written request. Even with these precautions, however, it was noted that amphetamines and tranquilizers were still quite available on the streets of Virginia Beach. These drugs fit in with the new pattern of poly-drug use.

Frequency of drug use has also changed. "Tripping is a weekend thing," this source said, "while people may use pot every night, they won't trip every night." For one thing, acid (LSD) is expensive. The probation officer stated that use of hallucinogens, like LSD, peaked around 1970 and has since leveled off but not decreased. Cocaine and hashish were used, for instance, by many servicemen, more so than by the general population, because

servicemen have better access to these "imported" drugs. Quaaludes, a brand name for methaqualone, are used somewhat in Virginia Beach, but the rate of use is not as high as in D.C. and New York. The general public seemed still basically unaware of Quaaludes.

In any discussion of drug abuse, alcohol must be mentioned. This source in adult probation stressed that the average alcoholic was more secretive than the young drug abuser who may be on an "honesty trip." An alcoholic was much less likely to admit that he has a "drug problem." The party-oriented culture seemed to encourage alcohol use and abuse. The fact that alcohol was legal had partially kept people from realizing its potential for abuse and addiction. Young people who have grown up seeing their parents drink and seeing people drink on television and in the movies are as likely to drink and overuse alcohol as their parents, but they usually are less covert about it.

The generations over 40 years of age have been particularly successful in covering up alcohol use. This fact led the probation officer to say that apparently only 5% to 8% of their 300 cases in Adult Probation are admitted alcohol problems, but if more were to admit the problem, the number could be as high as 50%.

Part of the basis for the drug problem locally is that the public is so uneducated concerning drugs despite various attempts by many agencies to correct this situation. It is a problem that the general population, as well as many authorities, prefer not to deal with, nor even to recognize. Unfortunately, those persons who are

in the best positions to help the drug abuser will tend to punish rather than help.

City of Virginia Beach Jail

In interviews with 50 inmates of Virginia Beach City Jail, some 25 indicated that their incarceration was due directly or indirectly to drug problems. The majority indicated problems with soft drugs, but some exhibited "tracks" which they attributed to the use of needles for injecting heroin.

The City Jail administration had not developed a precise data gathering system relevant to inmates with drug problems. The Sheriff did indicate his interest in the development of such a system in the future.

The discovery that some 50% of the inmates have drug or drug-related problems has prompted discussions between the Mental Health professionals and the Sheriff over the possibility of introducing a jail drug rehabiliation program to reduce recidivism within the jail population, and provide counseling and follow-up services for the jail inmates.

Commonwealth Attorney's Office

The cases compiled were from a randomly selected group of cases in the Commonwealth Attorney's office (Table 60).

Allowances should be made for the fact that the "drug scene" in the city was an ever changing one. Hence, while the instances of abuse or use of one drug or another may change, the demographic data surrounding drug users may not change, or may not

TABLE 60.--Demographic Description of 94 Cases of Drug Offenders as Handled by the Commonwealth Attorney's Office in Virginia Beach.

Demographic Data	Number	Percent
Place of Birth		
In state	17	18.1%
Out of state	42	44.7
No information	35	37.2
Place of Residence		
Virginia Beach	65	69.1
Virginia	13	13.8
Out of state	11	11.7
No information	5	5.3
Marital Status		
Single	66	70.2
Married	12	12.8
Widowed/separated/divorced	6	6.4
No information	10	10.6
Number of Dependents[a]		
Never married	0	0.0
Married	14	1.2[b]
Widowed/separated/divorced	4	0.7[b]
No information	76	0.0
Employed		
Yes	45	47.9
No	9	9.6
Occasionally	5	5.3
No information	35	37.2
Age		
All cases N=92		21.5[b]
Hash and marihuana N=58		21.2[b]
Other drug offenders N=34		22.0[b]

[a]There were 14 dependents for the 12 married drug offenders, averaging 1.2 dependents per married offender.

[b]Average.

Table 60.--Continued.

Demographic Data	Number	Percent
Education (highest grade attained)		
6 - 8	10	10.6%
9 - 11	19	20.2
12	22	23.4
13 +	4	4.3
No information	39	41.5
Occupation		
Unskilled	36	38.3
Skilled	13	13.8
Student	9	9.6
Business	7	7.4
Public servant	3	3.2
Professional	2	2.1
Housewife	1	1.1
No information	23	24.5
Number of marihuana offenses only	41	
Number of multi-drug offenses	24	
Drugs Involved in Convictions (N=94)		
Marihuana	58	
Hashish	28	
Heroin	6	
Cocaine	5	
LSD	20	
Darvon	1	
Procaine	1	
Amphetamines	2	
Barbiturates	5	
Glue	1	
Demerol	1	
Opium	1	
Antihistamine	1	
Phenobarbital	1	
Mescaline	1	

change as rapidly as the preference for one drug or another or specific combinations of drugs.

The data obtained from the Commonwealth Attorney's office did contain some information which seemed to cast serious doubt on some rather well-established myths:

MYTH #1: MOST DRUG USERS COME FROM THE TOURIST POPULATION.

Whereas most drug offenders in this study sample were in fact born out of state (71.2%), most were actual residents at the time of their arrest (73%).

MYTH #2: MOST DRUG USERS ARE UNEDUCATED.

The average educational level (grade completed) of the drug offender in the sample was 11.6. Those arrested for hashish and marihuana offenses averaged 12.7 years of education. Those arrested for other drug offenses averaged only 11.1 years of education. Forty-six percent were at least high school graduates. Only one had completed four years of college.

MYTH #3: MOST DRUG USERS ARE UNEMPLOYED "HIPPIES," "BEACH BUMS," ETC.

Data was available in the employment category for only 59 of the 94 cases reviewed. Of these 59, 45 were employed at the time of their arrest (76%). It is interesting to note, however, that most of those who were employed were designated as unskilled in their occupational categories. The "unskilled" category was particularly high (53%) among those arrested for hashish and marihuana violations. Forty-eight percent (48%) of persons using drugs other than marihuana and hashish were in the "unskilled" labor category. Students

fell more often in the "other drug offenders" category as did those persons engaged in business. This would not necessarily mean that "other drug offenders" were not also using marihuana or hashish.

The implication seems to be that the marihuana and/or hashish offender was more often employed in an unskilled occupation, as was also true with other drug offenders. Skilled workers were more likely to appear as marihuana and/or hashish offenders, and students and those engaged in business were more likely to appear as "other drug offenders" (22.0%).

In terms of types of drugs cited in the convictions, 41 were convicted for marihuana only (44.7%), and 24 were arrested for poly-drug offenses (25.5%). LSD was cited 20 times (21.3%).

Finally, a special note should be made of the fact that the above data reflect what the individuals were actually arrested and convicted for possessing, using, distributing, or selling. They do not reflect the actual individual use of drugs by those individuals, as do the data provided by the Juvenile Probation Department included in another section of this report.

Department of Public Safety,
Police Division

Aside from a substantial increase in persons arrested and charges placed in August of 1972, there was little overall change in the "drug scene" as described in the police reports. With the exception of the August statistics mentioned above, the number of persons charged per month in 1972 was 44.8 as opposed to the slightly higher 45.8 for 1973. Numbers of charges placed in 1972 (53.0) per

month dropped to 52.1 in 1973. High increases in arrests in a particular month are often due to the result of a large "drug bust" in that month.

Marihuana leads all other drugs with regard to arrests for distribution, possession with the intent to distribute, and possession. This is probably due to the small narcotics section of the police force. A reliable source in the police department noted that although "everything" was available on the streets, the small size of the staff made detection and arrests for drugs other than marihuana and hashish difficult at best.

The same source also noted that in 1973 there was a notable rise in the availability of cocaine, and a similar rise in the use of barbiturates and the use of alcohol along with other street drugs. The comments about the availability of cocaine were substantiated by federal law enforcement authorities familiar with the Tidewater area, and by "street people" in Virginia Beach.

Statistical information shows an increase in the total arrests for 1974. By comparison, in 1973, the narcotic squad and the uniformed division placed 625 charges against 523 people. In 1974, 1,485 charges were placed against 1,063 people.

Police officials indicate that in Virginia Beach drug abusers included not only the addict who daily injected the amount of heroin his body craved but with the housewife who daily abused prescription pills, the businessman who got himself "up" with amphetamines before a meeting and came "down" at the end of the day with a couple of drinks, the juvenile who had been "turned on" by an older brother or

sister and the young adults who felt the need to prove themselves "in" by experimenting with marihuana and other hallucinogenic drugs, such as LSD, mescaline, or hashish.

In 1974, there was a slight increase in the use of heroin and LSD; however, marihuana still carries the "fame" of being the most popular drug of abuse in the city.

As in the past, credit was officially given the uniformed patrolmen for their assistance and information supplied on suspected drug trafficking. Police sources claimed the most successful weapon against the drug pusher was the use of uniformed patrolmen working as undercover agents and living in the midst of the drug culture.

Police also benefited from the close contact and cooperation of the Virginia State Police, federal agencies, and officers from neighboring cities.

Tables 61-62 and the following reflect a detailed breakdown of the total charges for 1974: (a) total number of charges placed--1974: 1,485; (b) total number of persons arrested--1974: 1,063.

The Drug Enforcement Administration, a division of the U.S. Justice Department, noted that narcotics "busts" from January 1974 to June 1975 in the Tidewater area had increased the street price of heroin because it was more difficult to obtain than formerly. The street price of heroin was roughly equivalent to the street price of cocaine. Given this rough equivalence in price between cocaine and heroin, a significant number of drug users could be expected to choose cocaine since it could be expected to be less addictive and produce a stronger "rush" than heroin.

TABLE 61.--Total Charges and Drugs Involved: 1974, Virginia Beach.

Charge/Drug Involved	Number	Total Charges
Distribution (Sale)		55
Depressants	2	
Stimulants	2	
Marihuana	38	
Hashish	1	
LSD	3	
PCP	8	
Opium-opiates	1	
Possession with Intent to Distribute		161
Depressants	8	
Stimulants	11	
Marihuana	113	
Hashish	7	
LSD	9	
Cocaine	7	
Heroin	1	
Mescaline	3	
PCP	2	
Possession		1,137
Depressants	54	
Stimulants	52	
Marihuana	881	
Hashish	58	
LSD	45	
Cocaine	12	
Heroin	20	
Mescaline	4	
PCP	8	
Dangerous Drugs	3	
Miscellaneous Charges		132
Prescription w/o script	23	
Paraphernalia	35	
Inhaling noxious chemicals	4	
Conspiracy to sell or buy	3	
Manufacture (marihuana)	66	
Dangerous drug	1	
Total Cases for Each Drug Category		
Depressants	64	
Stimulants	65	
Marihuana	1,032	
Hashish	66	
LSD	57	
Cocaine	19	
Heroin	21	
Mescaline	7	
PCP	18	

TABLE 62.--Monthly Breakdown of Drug Charges and Persons Arrested in 1974, Virginia Beach.

Month	Persons	Charges
January	68	88
February	50	60
March	56	64
April	63	80
May	100	135
June	148	204
July	143	197
August	135	197
September	95	136
October	83	125
November	74	128
December	48	71

The foregoing may be at least a partial explanation of various and consistent reports of the increased use of cocaine in Virginia Beach, with some lessening of heroin use and addiction. Comments from a local narcotics officer were also consistent with the above. Reliable sources placed the quality of street heroin generally from 1% to 4%, or "very poor."

The heroin sources are usually the Middle East, through Europe. Cocaine supplies come to the United States to a great extent from South America, police officials noted.

TABLE 63.--Annual Drug Arrests, January through December, 1975, Virginia Beach.

Total Persons Arrested:	857/919[a]	Sale Charges	
Total Charges Placed:	1,186	Poss. with intent	174
		Possession	863
		Other	95
		Sale/distribution	54
Charges Involving:			
Depressants	36	Prescrip. w/o script	15
Stimulants	34	Prescrip. forgery	8
Marihuana (Invest. only--4)	846	Paraphernalia (Invest. only--1)	24
Hashish	59	Inhale nox. chemicals	7
Cocaine	32	Conpsiracy to sell (LSD--1)	6
LSD	44	Manufacture	36
Heroin	9	Dispense narcotics	1
Mescaline	5	Hash oil	1
Opium	4	Controlled drug	1
THC	3	Drug rip-off G.L.	3
Peyote	1	Preludin	3
PCP	5	Amilenitrate	3

[a]The first figure (857) is without PA; the second figure (919) is with PA.

TABLE 64.--Types of Drugs and Drug Charges, January-December, 1975, Virginia Beach.

Drug Involved	Sale/ Distrib.	Poss. W/I to Sell	Possess.	Other
Depressants	2	6	28	
Stimulants	4	10	20	
Marihuana/keif	32	118	696	
Keif				
Hashish	6	7	46	
Cocaine	1	6	25	
LSD	4	12	28	
Heroin		2	7	
Mescaline		3	2	
Opium		1	3	
THC		1	2	
Peyote			1	
PCP	2	3		
Prescription w/o script	2	2	1	10
Prescription forgery				8
Paraphernalia				24
Inhaling noxious chemicals				7
Conspiracy to sell or buy				6
Manufacture				36
Dispense narcotics				1
Hash oil			1	
Controlled drug	1			
Drug rip-off G.L.				3
Preludin		3		
Amilenitrate			3	

CHAPTER V

CONCLUSIONS, IMPLICATIONS FOR FURTHER RESEARCH, AND RECOMMENDATIONS

Conclusions

In essence, drug abuse has little if anything to do with legalities. Rather, drug abuse has to do with the upsetting of chemical and psychological balances within the human system which, in turn, can cause malfunction of various parts of the human system, if not the total human system.

Sometimes this happens by accident, as in the case of the infant who unknowingly ingests poison. Or in the case of the person who unknowingly has diabetes and unwittingly strays from the required diet. Often enough, though, the imbalance is deliberately caused, not as a primary intention but allowed as a secondary effect in attempting to alternate moods and natural feelings.

Legally, such mood-altering is sometimes allowed (e.g., when a physician prescribes a specific drug or combination of drugs, for a specific time, and for specific purposes). Sometimes such prescriptions contain mood-altering agents. And sometimes this is the primary intention of the prescriber as well as the patient. Other times the mood alteration is simply a tolerated side effect.

People of varied cultures have engaged in drug use for centuries. In present day society, tobacco, caffeine, tea, and

alcohol are among the more commonly used "legal" drugs. Then there are the common pain relievers and tension relaxants found on the store counters. Also, some commonly known and easily available foods are used on occasion to cause one or another mind- or mood-altering effect.

The motivation behind such instances and practices of drug use may be as varied as the individuals themselves who participate in such practices. Peer group pressure, the delight of pseudo-adult experimentation, curiosity, fun, relief from pain (physical or psychic), escape from boredom, and the seeking out of the specific effects of a given drug are all among reasons given by drug users. Psychological habit and physical addiction also form cues for drug use.

Many difficulties surround attempts for solving, or even confronting, the problem of drug abuse. Community values and group attitudes influence local and state authorities in their approach to extracting guiding principles and legislating sound laws which both protect individual freedom on the one hand, while protecting the individual and society from undue harm on the other hand.

Fear, ignorance, as well as first-hand knowledge of the possible harmful effects of drugs witnessed or experienced by some individuals all contribute to the emotionality which often surrounds community efforts and individual attempts to successfully master the problem.

In spite of all that has been said or written about drugs during the recent past, drugs are still "good press." The subject

readily lends itself to shallow editorializing, easy verse, and simplistic solutions. Because so much is yet unknown in many aspects of drug abuse, everyone can still become an expert. The subject is the ground for prophets, healers, magicians, soothsayers, do-gooders, and cynics. But withal, the phenomena of drug abuse, drug use, and drug dependency go unchecked.

Some progress has been made, especially in the days since drug addiction became widespread outside the ghetto, the inner-city. But the total solution is not yet here, and may be long in coming, if it ever arrives at all.

The problem embraces many facets of the community: the medical community, the legal community, law enforcement aspects, religious values, economics, and mental health, to mention a few. Some contend that it would scarcely be a problem were there not such strict laws surrounding drug use. Others would advocate even stricter laws, harsher penalties. Execution of the drug user, and especially, the pusher, would be another approach. And the distance between these extremes is sufficiently extensive to allow for innumerable sound and unsound recommendations and attempts for problem resolution.

Solutions offered are generally in response to the question, Why is drug use "bad"? Treatment and prevention programs accordingly become based on principles of law enforcement, medical technology, religion, or psychology.

But other questions must be confronted. Questions elicited by the even greater questions surrounding such factors as violent and self-destructive behavior, pain tolerances in individuals, the

cue-response factors at work in the personality of the addicted and dependent, influence of values and attitudes on personal and social functioning, factors influencing decision-making, the subjects of escape, risk, emotional excitement, to name a few.

The community that seriously attempts to cure all its addicts or heal all its alcoholics may indeed be respected for the nobleness of its cause. It should also be prepared to pay a price in the expenditure of its taxes that may prove such attempts as impossible as they are noble. In spite of continued and sometimes all too evident shortcomings, drug programs (including alcohol programs) are more effective today than before. There are exceptions, but much has been learned. At least we know that laws alone will not solve the problem, nor will the courts, nor the police, nor the psychologists or psychiatrists or counselors, and not even the ex-addicts themselves. Nor will dollars alone provide the solution.

However, programs which do mobilize community and personal resources in highly motivated, persistent (even stubborn) efforts do have a chance for success--success for the individual and success for the community. Balanced community programs--stressing prevention along with treatment--which offer options to the citizens and which contain flexibility in their approaches probably stand the best chances of success. Programs utilizing personnel strong in their convictions and constant in their dedication--personable in their approach, and courageous in their constant evaluation and reexamination of their goals, objectives, and progress. Programs which are simple, uncomplicated in their delivery, but highly professional in their programming not only can, but must be designed and implemented.

Programs which are unbalanced in their approach, paying heed only to treatment while ignoring the rapid strides which have been made in the area of prevention, will in the future as in the past continue to be "finger-in-the-dike" approaches to containment of the problems of drug use, abuse, and addiction.

In regard to program planning, one serious question presents itself: After all the "problems" have been identified, how many clients actually want treatment services?

And further, what services presently exist which could respond to client needs? Publicly funded services should be responsible, economical, and effective. Hopefully, they will also offer treatment options not otherwise available. And just as important, they should include prevention approaches affecting the total community population. Treatment programs without prevention programs are about as effective as trying to control diseases such as smallpox, typhoid, and polio, for instance, without innoculation programs. We learned this long ago in public health. We may yet be a few billion taxpayer dollars away from learning it in mental health.

Admittedly, prevention programs are not usually very flashy. They're not "good print." The good prevention programs are basically highly technical and demand hard work and scientific bases in planning, delivery, and evaluation. Politically, they don't score many points and turn off impulsive seekers of the immediate treatment miracles.

But the prevention approach may well provide the sane and solid ground which produces the most effective results for the time, effort, and monies invested.

This study focused on the problem of interagency collaboration as a means for examining the needs of clients and designing an appropriate rehabilitative response to those needs.

The data from the two areas of drug and alcohol were used to illustrate the necessity of a theoretical or conceptual approach to community rehabilitation based on interagency collaboration.

The data indicate that many clients of the agencies and groups studied deal with the similar problems of drugs and alcohol.

It must be reasonably presumed that had the study been broader, the similarity of disability areas across agencies and groups would have been even more pronounced.

Implications for Future Study

The demographic data presented in the study implicate the validity of the interagency collaboration method. The data on drug and alcohol use specifically indicate the intertwining of the many agencies and groups in the community, and the necessity of developing operating procedures for interagency collaboration in order to:

1. Identify vulnerable populations (e.g., by patient origin studies);
2. Present a comprehensive response to client needs;
3. Identify and respond to gaps and overlaps in services;
4. Provide a sound base for economical and responsible rehabilitation services in the community;
5. Base all the above on a content of theory as a structure for program planning, implementation, and evaluation.

6. Provide a framework within which rehabilitation administrators on the local, state, national, and international level may orderly communicate regarding common concepts, problems, and data.

The underlying motivation for this study has been the urgency to combine academic research and scientific technologies with pragmatic program planning in the community. An educated community administrator cannot ignore scientific theories or methodologies. But neither can he or she ignore the daily urgency to deliver services to clients as swiftly and economically as possible.

The community administrator walks a tightrope between the rigors and rules of scientific research and the necessity of alleviating the hurts of thousands within the community for whom any assistance or program, even the mediocre, would be welcomed. The administrators of community programs cannot concern themselves only with academic research. But neither can they ignore academic research. Programs which are not scientifically based too easily serve only the egos and personal needs of the administrators rather than the needs of the community. Such programs tend to lose community credibility because they lack validity, accountability and reliability.

The practical implications in terms of this study are that such methodologies as Facet theory and Interagency Collaboration need to be even further adapted to community programming needs, and service delivery models such as Social Competency need to be further tested by the rules and strategies of traditional scientific inquiry.

Another way of posing the problem is: How do we, on one hand, put to work for purposes of community programming such theories as Facet Design and Interagency Collaboration, and conversely, how do we attach scientific credibility to such rehabilitation methods as Social Competency and Crisis Intervention techniques?

If the day of isolated and individualized scientific research (one man or woman sitting alone in a corner of the library working on a single project) has passed, the same is true of community planning and programming. The rehabilitation counselor needs the English major to assist in a careful expression of multi-faceted concepts, the data analyst who can provide proven expertise in the compilation and analysis of data extracted from many technological sources and designs, the clinician who can discern applicability of scientific conclusions for the counseling setting, the politically astute who can estimate the viability of the program in terms of community relevance and concern, the business management expert who can determine both costs and benefits for the community leadership, and the philosopher who can lend both perspective and meaning to the whole frantic endeavor.

Hence, the doctoral student who would aspire to jobs calling for skills in program development at the community level may well attend to the development of multi-discipline skills not to be found in the texts of Campbell and Stanley or Carl Rogers. Or, to paraphrase an old truism, acquiring a diploma is only the initial step in the quest for useful skills in community programming

and the development of scientific and pragmatic rehabilitation services.

Recommendations

The use of the Interagency Collaboration model in gathering the data on drug and alcohol use in the community used data of a demographic nature only.

Specific studies using the Interagency Collaboration model should be developed with appropriate instruments (e.g., based on social competency), representative samples, and analysis procedures which further test the utility of the Interagency Collaboration model as an effective approach to comprehensive preventive and rehabilitation services. Such studies have already begun in the state of Virginia. The implications are that programming will be more scientific, and rehabilitation activities will be more effective and replicable.

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APPENDICES

APPENDIX A

SOCIAL COMPETENCY THEORY:

SAMPLE TREATMENT DIAGRAMS

APPENDIX A

SOCIAL COMPETENCY THEORY:
SAMPLE TREATMENT DIAGRAMS

Based upon the work done by the Training and Implementation subgroups which have been meeting in Roanoke and in Blacksburg, and upon information obtained at the Richmond Social Competency Workshop in October, 1974, there have been identified two kinds of treatment process flow diagrams. The following pages contain revised copies of these diagrams as they are presently understood, explanations of the various stages of the diagrams, and forms that have been developed in association with the processes represented. Not all of this material is completely reality-tested; therefore, feedback based upon the experiences of others would be highly desirable.

The first diagram ("Treatment Plan Process") represents the formal, over-all process of client "diagnosis," treatment plan writing, and client reevaluation that goes on from the time the client enters the program until his/her discharge. The end products of this process are the determination of treatment goals and SCB's, and the client's assignment to the appropriate treatment units.

The second diagram represents more of the thinking process that is used by the counselor at any given time within the treatment process. It is much more specific in its consideration of the client's behaviors and the situations surrounding those behaviors. The

end product is the determination of the specific clinical actions that the counselor uses to respond to the client's incompetent behaviors.

1. Intake Process (Screening and Intake)

The following usually occurs during the intake process:

a. The question "What is the presenting problem?" (i.e., What is the immediate cause of the person coming to the program?) is answered.

b. Background information is gathered about the prospective client (social history).

c. The prospective client's own perceptions of his/her problems are discussed.

d. The perceptions of the problem by significant others in the lifespace of the prospective client are discussed.

e. The prospective client's expectations of what can be gained from participation in the program are discussed.

Based upon this information, the intake worker decides whether or not the program can meet any of the needs of this individual. If so, the person can be admitted as a client in the rehabilitation program. If not, a referral is made to another, more appropriate agency.

From the results of this process, an initial list of SIB's can be drawn up for the admitted client. If available, an evaluative questionnaire can be given to gain more information on the client, and to obtain baseline data which can be used in later client evaluations.

2. Information Gathering

Immediately after admission, the client is assigned to a generally-oriented SCU. The purpose of this is to place the individual in situations in which his/her behaviors can be directly observed. A more comprehensive list of SIB's can be drawn up based upon these observations. Also, the SCB's that the client performs should be noted.

3. Induction

Once a reliable list of SIB's is obtained from steps 1 and 2, patterns or trends will often appear which will enable the counselor to induce some of the SCD's (i.e., deficits, or lack of skills) that the client possesses.

4. Determination of SCG's

Determination of the SIB's and SCD's leads to the identification of the goals (SCG's) that the program can design for the client in order to correct the deficits or incompetent behaviors. These goals are written as generalizations of what the client needs to do to obtain a greater degree of social competence.

5. Determination of SCB's

The next step is to determine what socially competent behaviors the client must perform in order to accomplish the treatment goals. The SCB's are written more specifically than the SCG's, and are written in measurable, behavioral terms.

6. Determination of SCA's

List SCA's which are required in order to inculcate the previously-mentioned SCB's. Both actions contained within the program and those contained within other resources in the community should be listed.

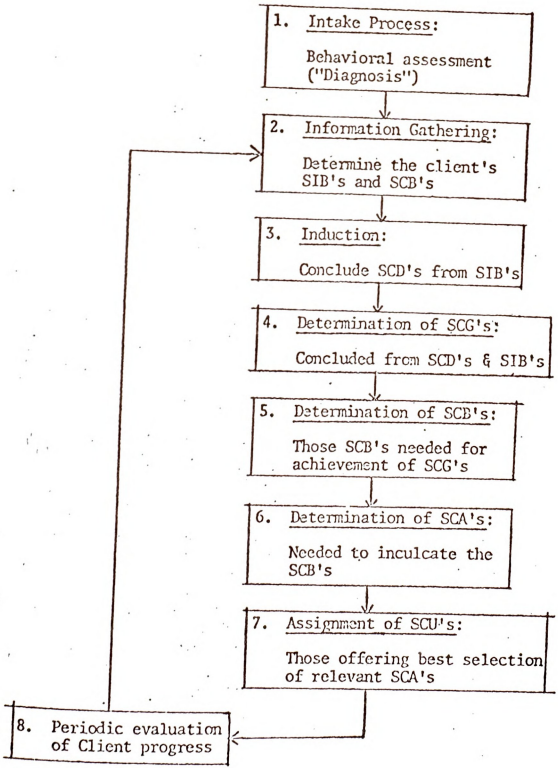
7. Assignment to SCU's

Once the required SCA's are identified, then the counselor can consult the program catalogue, and determine which of the SCU's available within the program would be most appropriate for the client.

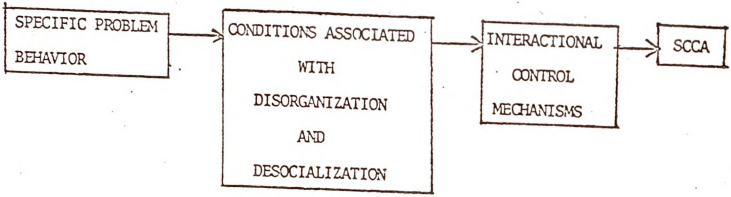
8. Evaluation of Client Progress

Periodic evaluation should be made to assess the effectiveness of the treatment plan and the change in the adequacy and appropriateness of client behaviors. The entire process, beginning with the assessment of SIB's, should be done on a regular basis. In addition, the questionnaire given in the intake procedure can be readministered periodically, in order to gain a continuous data base and aid with the further assessment of behavioral competence.

TREATMENT PLAN PROCESS



CLINICAL ACTIONS PROCESS



CLINICAL ACTIONS FORM

Specific Problem Behavior	Conditions of Disorganization and Desocialization	Deviant Expectations	SCCA			
			Support	Permissive-ness	Nonrecip-rocation	Conditional Manipulation of Rewards

APPENDIX B

SURVEY FORMS

APPENDIX B

SURVEY FORMS

SURVEY OF PHYSICIANS IN VIRGINIA BEACH

Please state your name and the address of your office in the following spaces. Due to the small size of this sample, it will be necessary to send out follow-up questionnaires to those physicians who do not respond to the first questionnaire. It is for this purpose only that we ask your name. Please write your name and the address of your office on this page. We will separate this page from the rest of the survey and discard it when all the surveys have been returned. Your answers will be held strictly confidential.

Your name _____

Office Address _____

Area of specialization within the field of medicine _____

1. In this survey, we are trying to ascertain facts about drug abuse, not merely opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. These "people you have come in contact with" include not only patients, friends, relatives and acquaintances but also people you have passed in the stores or streets, people you think may have been using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Degree of Use: Widespread	Moderately Widespread	Not Very Widespread	Hardly ever Used by Anyone
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (Amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")				
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Quaaludes				
Other, specify:				

KEY

WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis.

MODERATELY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 10 to 20 use this drug regularly.

NOT VERY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 5 to 10 use this drug regularly.

HARDLY EVER USED BY ANYONE–
Of the people whom I have come in contact with in the past 12 months, I would estimate that less than 5 use this drug regularly.

DRUGS	2. Check the age categories which you think primarily uses each type of drug: 10-14	15-17	18-21	22-29	30-49	50 & over	3. Check those drugs which you think residents of Virginia Beach buy in and/or outside of Virginia Beach. Check both if appropriate: Buy in Va. Beach	Buy outside Va. Beach	4. Please estimate how many patients you see during the average summer month and then during an average non-summer month where the following drugs are either the primary cause or a contributing factor in consulting you as a physician. Under 18 years: Ave. summer mo.	Under 18 years: Ave. non-summer mo.	18 years & over: Ave. summer mo.	18 years & over: Ave. non-summer mo.
Tobacco												
Alcohol												
Marihuana (including Hashish, THC-synthetics)												
Inhalants (glue & other vapors or volatile intoxicants)												
Hallucinogens (LSD, mescaline, STP & similar drugs)												
Stimulants (Amphetamines, methamphetamines, pep pills)												
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")												
Opiates (Heroin, codeine, morphine, paragoric, & other opiate derivatives)												
Cocaine												
Quaaludes												
Other, specify												

5. Please place the approximate number of patients that you see during an average summer month and average non-summer month who use the following non-prescription drugs on a regular basis. List any additional drugs that people may be abusing.

NON- PRESCRIPTION DRUGS	Number who use these drugs: Ave. summer month	Ave. non-summer month	Check the age categories which you think primarily use each type of drug: 10 to 14	15 to 17	18 to 21	22 to 29	30 to 49	50 and over	
For Headaches: Tylenol									
Bufferin									
Aspirin									
Anacin									
Other,									
For Sleep: Quiet World									
Compoz									
Sleepeze									
Other,									
To Wake Up: No Doz									
Vivarin									
Be Bright									
Other,									
Other:									

6. Please estimate the number of patients you see during the average summer month _____ and the average non-summer month _____.

7. Do you know of persons in Virginia Beach engaged in the abuse of drugs (excluding alcohol and tobacco)? ____ Yes ____ No. Estimate of number _____. Predominate age group _____.

8. Do you know of persons in Virginia Beach engaged in the illegal sale of drugs? ____ Yes ____ No. Estimate of number _____. Predominate age group _____.

9. Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach? ____ Yes ____ No. Estimate of number of such persons ____.

10. How many patients do you see during an average month for non-drug reasons whom you suspect or have found to have drug problems? Under 18 years old ____. 18 years old and over ____.

11.

PROGRAM	Check those programs with which you are familiar	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other, specify							

12. Do you think these programs can adequately handle the drug problem in Virginia Beach? ____ Very well ____ Fairly well ____ Not too well ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

13. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes ____ No. Which ones? _____

_____

Do you think these are effective? ____ Yes ____ No.

Do you think more drug abuse prevention programs are needed?

____ Yes ____ No. What kinds? _____

_____

14. Here is a list of alternatives for drug abuse treatment. Read the following descriptions of the different types of treatment before answering the questions.

Physician or private clinic—Go to a doctor for care and proper guidance.

Local General Hospital— enter this type of a hospital for treatment.

Local Psychiatric Hospital—enter this type of a hospital for treatment.

State Psychiatric Hospital—enter this type of a hospital for treatment.

Methadone program—enter a methadone program to stop use of heroin.

Traditional church—go to minister of a conventional church for guidance.

Live-in therapeutic community—join a group of other drug users living at a psychological counseling center.

Non-conventional religious organization—join an uncoventional religious group in order to develop spiritual strength.

Hotline or referral center—talk to a community referral agency to find out what facilities can best help.

Friends—talk with people you trust to find out what they think is best.

Professional psychotherapy—consult with a psychologist or psychiatrist.

Out-patient counselling center—visit a community counselling center regularly.

Legal restraint—jail or correctional institution.

None—no treatment alternative is recommended.

Other—some other alternative not mentaioned here is preferable.

Don't know—I really can't say with what I know now about the problem.

14. (See the previous page for instructions.)

(A.) Where would you refer someone who was addicted to heroin or one of the other opium derivatives (codeine, morphine, paragoric, etc.)? Please check one or more of the following alternatives in Column A.

(B.) Where would you refer someone who was misusing some other drug (hallucinogens, stimulants, depressants, etc.)? Please check one or more of the following alternatives in Column B.

	(A.)	(B.)
Physician or private clinic		
Local General Hospital		
Local Psychiatric Hospital		
State Psychiatric Hospital		
Methadone Program		
Traditional church		
Live-in therapeutic community		
Non-conventional religious organization		
Hotline or referral center		
Friends		
Professional psychotherapy		
Out-patient counselling center		
Legal restraint		
None		
Other, specify		
Don't know		

Comments _____

_____

_____

SURVEY OF ATTORNEYS IN VIRGINIA BEACH

Please state your name and the address of your office in the following spaces. Due to the small size of this sample, it will be necessary to send out follow-up questionnaires to those attorneys who do not respond to the first questionnaire. It is for this purpose only that we ask your name. Please write your name and the address of your office on this page. We will separate this page from the rest of the survey and discard it when all the surveys have been returned. Your answers will be held strictly confidential.

Your name _____

Office Address _____

1. In this survey, we are trying to ascertain facts about drug abuse, not merely opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. The "people you have come in contact with" include not only clients, friends, relatives and acquaintances but also people you have passed in the stores or streets, people you think may have been using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Degree of Use: Widespread	Moderately Widespread	Not very Widespread	Hardly ever Used by Anyone
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (Amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")				
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Quaaludes				
Other, specify				

KEY

WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis.

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Of the people whom I have come in contact with in the past 12 months, I would estimate that about 5 to 10 use this drug regularly.

HARDLY EVER USED BY ANYONE-
Of the people whom I have come in contact with in the past 12 months, I would estimate that less than 5 use this drug regularly.

DRUGS	2. Check the age categories which you think primarily uses each type of drug: 10-14	15-17	18-21	22-29	30-49	50 & over	3. Check those drugs which you think residents of Virginia Beach buy in and/or outside of Virginia Beach. Check both if appropriate: Buy in Va. Beach	Buy outside Va. Beach	4. Next to the appropriate drug, place the approximate number of times in average month that you, as an attorney in Va. Beach are consulted for problems related to the abuse of that drug: Under 18 years: Ave. summer mo.	Under 18 years: Ave. non-summer mo.	18 years & over: Ave. summer mo.	18 years & over: Ave. non-summer mo.
Tobacco												
Alcohol												
Marihuana (including Hashish, THC-synthetics)												
Inhalants (glue & other vapors or volatile intoxicants)												
Hallucinogens (LSD, mescaline, STP & similar drugs)												
Stimulants (Amphetamines, methamphetamines, pep pills)												
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")												
Opiates (Heroin, codeine, morphine, paragoric, & other opiate derivatives)												
Cocaine												
Quaaludes												
Other, specify												

5. During an average month, do you counsel young people, between the ages of 12 and 21, who come to you for advice but who were not as yet in trouble? (Counseling directly related to the drug problem) ____ Yes ____ No
Estimate of the number you have talked with during the last 12 months _____.

6. Do you know of persons in Virginia Beach engaged in the abuse of drugs? (excluding alcohol and tobacco) Yes ____ No ____. Estimate of number _____. Predominate age group _____.

7. Do you know of persons in Virginia Beach engaged in the illegal sale of drugs? ____ Yes ____ No. Estimate of number ____ Predominate age group _____.

8. Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach? ____ Yes ____ No.
Estimate of the number of such persons _____.

9. How many clients do you see during an average month for non-drug reasons whom you suspect or have found to have drug problems? Under 18 years old _____ 18 years of age and older _____.

10.

PROGRAMS	Check those programs with which you are familiar	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other,							

11. Do you think these programs can adequately handle the drug problem in Virginia Beach? ____ Very well ____ Fairly well ____ Not too well ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

12. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes ____ No. Which ones? _____

_____

Do you think these are effective? ____ Yes ____ No.

Do you think more drug abuse prevention programs are needed?

____ Yes ____ No. What kinds? _____

_____

13. Here is a list of alternatives for drug abuse treatment. Read the following descriptions of the different types of treatment before answering the questions.

Physician or private clinic—Go to a doctor for care and proper guidance.

Local General Hospital— enter this type of a hospital for treatment.

Local Psychiatric Hospital—enter this type of a hospital for treatment.

State Psychiatric Hospital—enter this type of a hospital for treatment.

Methadone program—enter a methadone program to stop use of heroin.

Traditional church—go to minister of a conventional church for guidance.

Live-in therapeutic community—join a group of other drug users living at a psychological counseling center.

Non-conventional religious organization—join an unconventional religious group in order to develop spiritual strength.

Hotline or referral center—talk to a community referral agency to find out what facilities can best help.

Friends—talk with people you trust to find out what they think is best.

Professional psychotherapy—consult with a psychologist or psychiatrist.

Out-patient counselling center—visit a community counselling center regularly.

Legal restraint—jail or correctional institution.

None—no treatment alternative is recommended.

Other—some other alternative not mentaioned here is preferable.

Don't know—I really can't say with what I know now about the problem.

SURVEY OF PHARMACISTS IN VIRGINIA BEACH

Please state your name and the address of your business in the following spaces. Due to the small size of this sample, it will be necessary to send out follow-up questionnaires to those pharmacists who do not respond to the first questionnaire. It is for this purpose only that we ask your name. Please write your name and the address of your business on this page. We will separate this page from the rest of the survey and discard it when all the surveys have been returned. Your answers will be held strictly confidential.

Your name _____

Address _____

Please describe the location of your pharmacy. Is it in a ____ hospital, ____ doctor's building, ____ part of a business ("drug store"), ____ other, please specify _____.

1. In this survey, we are trying to ascertain facts about drug abuse, not merely opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. These "people you have come in contact with" include not only customers, friends, relatives and acquaintances but also people you have passed in the stores or streets, people you think may have been using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Degree of Use: Widespread	Moderately Widespread	Not very Widespread	Hardly ever Used by Anyone
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")				
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Quaaludes				
Other, specify _____				

KEY

WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis.

MODERATELY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 10 - 20 use this drug regularly.

NOT VERY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 5 - 10 use this drug regularly.

HARDLY EVER USED BY ANYONE–
Of the people whom I have come in contact with in the past 12 months, I would estimate that less than 5 use this drug regularly.

DRUGS	2. Check the age categories which you think primarily uses each type of drug: 10-14	15-17	18-21	22-29	30-49	50 & over	3. Check those drugs which you think residents of Virginia Beach buy in and/or outside of Virginia Beach. Check both if appropriate: Buy in Va. Beach	Buy outside Va. Beach
Tobacco								
Alcohol								
Marihuana (including Hashish, THC-synthetics)								
Inhalants (glue & other vapors or volatile intoxicants)								
Hallucinogens (LSD, mescaline, STP & similar drugs)								
Stimulants (amphetamines, methamphetamines, pep pills)								
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")								
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)								
Cocaine								
Quaaludes								
Other _____								

4. What is the approximate number of prescriptions filled during an average summer month? _____ During an average non-summer month? _____

5. Do you believe that items such as smoking accessories which are sold in your pharmacy, are being used for any form of drug abuse? ___ Yes ___ No. Check which ones of the following: ___ Pipes ___ Lighter fluid ___ Cigarette papers ___ Others, specify _____.

6. Try to estimate the number of the following drugs sold by your pharmacy during an average summer and non-summer month. List any additional drugs that people may be abusing.

NON-PRESCRIPTION DRUGS	Number who use these drugs: Ave. summer month	Ave. non-summer month	Check the age categories which you think primarily use each type of drug: 10 to 14	15 to 17	18 to 21	22 to 29	30 to 49	50 & over
For Headaches: Tylenol								
Bufferin								
Aspirin								
Anacin								
Other,								
_____								
For Sleep: Quiet World								
Compoz								
Sleepeze								
Other,								
_____								
To Wake Up: No Doz								
Vivarin								
Be Bright								
Other,								
_____								
Other: _____								
_____								

DRUGS	7. Of all the prescriptions filled during an average summer month, what percentage would you estimate were for: Average Summer Month %	Of all the prescriptions filled during an average Non-summer month, what percentage would you estimate were for: Average Non-summer Month %	8. In the last 12 months have certain types of drugs been stolen? (Please check)
Tranquilizers			
Barbiturates			
Morphine			
Codeine			
Paragoric			
Meperidine			
Amphetamines			

9. Do you think that the drugs were stolen for private use or for illegal sale? _____ Private use _____ Sale.

10. If you believe that you have noticed instances of abuse of drugs in the above categories, how many prescriptions would you say were involved? _____.

11. Do you know of persons in Virginia Beach engaged in the abuse of drugs (excluding alcohol and tobacco)? ____ Yes ____ No. Estimate of number _____ Predominate age group _____.

12. Do you know of persons in Virginia Beach engaged in the illegal sale of drugs? ____ Yes ____ No. Estimate of number ____ Predominate age group _____.

13. Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach? ____ Yes ____ No. Estimate of the number _____ Predominate age group _____.

14. Have you observed persons who frequent or who enter your business occasionally, who appeared to be involved in the abuse of drugs? ____ Yes ____ No. Please state the number during the average summer month _____. Please state the number during the average non-summer month _____.

15. Number the following age categories (1 through 3, 1 being the most likely, etc.) according to how likely each is to take drugs they don't need.
____ under 22, ____ 22 to 29, ____ 30 to 49, ____ 50 and over.

16.

PROGRAM	Check those programs with which you are familiar	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other, (Specify)							

17. Do you think these programs can adequately handle the drug problem in Virginia Beach? ____ Very well ____ Fairly well ____ Not too well ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

18. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes ____ No. Which ones? _____

_____

Do you think these are effective? ____ Yes ____ No.

Do you think more drug abuse prevention programs are needed?

____ Yes ____ No. What kinds? _____

_____

19. Here is a list of alternatives for drug abuse treatment. Read the following descriptions of the different types of treatment before answering the questions.

Physician or private clinic—Go to a doctor for care and proper guidance.

Local General Hospital— enter this type of a hospital for treatment.

Local Psychiatric Hospital—enter this type of a hospital for treatment.

State Psychiatric Hospital—enter this type of a hospital for treatment.

Methadone program—enter a methadone program to stop use of heroin.

Traditional church—go to minister of a conventional church for guidance.

Live-in therapeutic community—join a group of other drug users living at a psychological counseling center.

Non-conventional religious organization—join an unconventional religious group in order to develop spiritual strength.

Hotline or referral center—talk to a community referral agency to find out what facilities can best help.

Friends—talk with people you trust to find out what they think is best.

Professional psychotherapy—consult with a psychologist or psychiatrist.

Out-patient counselling center—visit a community counselling center regularly.

Legal restraint—jail or correctional institution.

None—no treatment alternative is recommended.

Other—some other alternative not mentaioned here is preferable.

Don't know—I really can't say with what I know now about the problem.

(A.) Where would you refer someone who was addicted to heroin or one of the other opium derivatives (codeine, morphine, paragoric, etc.)? Please check one or more of the following alternatives in Column A.

(B.) Where would you refer someone who was misusing some other drug (hallucinogens, stimulants, depressants, etc.)? Please check one or more of the following alternatives in Column B.

	(A.)	(B.)
Physician or private clinic		
Local General Hospital		
Local Psychiatric Hospital		
State Psychiatric Hospital		
Metnadone Program		
Traditional church		
Live-in therapeutic community		
Non-conventional religious organization		
Hotline or referral center		
Friends		
Professional psychotherapy		
Out-patient counselling center		
Legal restraint		
None		
Other, specify		
Don't know		

Comments _____

SURVEY OF BUSINESSES IN VIRGINIA BEACH

Please check one or more:

Type of business:

_____ motel, hotel
_____ restaurant, snack shop, cafe, bar
_____ store or shop: grocery, supermarket, drug store, hardware, clothing store, head shop, etc.
_____ entertainment center: theater, amusement park, discotheque, etc.
_____ building contractors, construction business, etc.
_____ other, specify _____

Size of business:

_____ Business valued at less than $10,000
_____ Business valued at $10,000 to $25,000
_____ Business valued at $25,000 to $100,000
_____ Business valued at $100,000 to $500,000
_____ Business valued at $500,000 to $1,000,000
_____ Business valued at $1,000,000 and over
_____ Don't know
_____ Other, explain _____

Location of business: Please write in the zip code of your business address to give its approximate location:

_____

Your position in the business:

_____ Owner
_____ Manager-operator
_____ Worker: waiter, clerk, etc.
_____ Other, explain _____

1. In this survey, we are trying to ascertain facts about drug abuse, not merely opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. These "people you have come in contact with" include not only customers, friends, relatives and acquaintances but also people you have passed in the stores or streets, people you think may have been using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Degree of Use: Widespread	Moderately Widespread	Not Very Widespread	Hardly ever Used by Anyone
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (Amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")				
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Quaaludes				
Other, specify _____				

KEY

WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis.

MODERATELY WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 10 to 20 use this drug regularly.

NOT VERY WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 5 to 10 use this drug regularly.

HARDLY EVER USED BY ANYONE-
Of the people whom I have come in contact with in the past 12 months, I would estimate that less than 5 use this drug regularly.

DRUGS	2. Check the age categories which you think primarily uses each type of drug: 10-14	15-17	18-21	22-29	30-49	50 & over	3. Check those drugs which you think residents of Virginia Beach buy in and/or outside of Virginia Beach. Check both if appropriate: Buy in Va. Beach	Buy outside Va. Beach	4. Place a check beside those drugs whose abuse may have caused you or your business specific trouble in the past. Explain at the bottom of the page if you like.
Tobacco									
Alcohol									
Marihuana (including Hashish, THC-synthetics)									
Inhalants (glue & other vapors or volatile intoxicants)									
Hallucinogens (LSD, mescaline, STP & similar drugs)									
Stimulants (Amphetamines, methamphetamines, pep pills)									
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")									
Opiates (Heroin, codeine, morphine, paragoric, & other opiate derivatives)									
Cocaine									
Quaaludes									
Other, specify									

Explanation: _____

5. Do you know of persons in Virginia Beach engaged in the abuse of drugs? (excluding alcohol and tobacco) ____ Yes ____ No. Estimate of number _____. Predominate age group _____.

6. Do you know of persons in Virginia Beach engaged in the illegal sale of drugs? ____ Yes ____ No. Estimate of number _____. Predominate age group _____.

7. Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach? ____ Yes ____ No. Estimate of number of such persons _____.

8. Have you observed persons who frequent or who enter your business occasionally, who appeared to be involved in the abuse of drugs? ____ Yes ____ No. Please state the number during an average summer month _____. Please state the number during an average non-summer month _____.

9.

PROGRAM	Check those programs with which you are familiar	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other, (specify)							

10. Do you think these programs can adequately handle the drug problem in Virginia Beach? ____ Very well ____ Fairly well ____ Not too well ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

11. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes ____ No. Which ones? _____

_____

Do you think these are effective? ____ Yes ____ No.

Do you think more drug abuse prevention programs are needed?

____ Yes ____ No. What kinds? _____

_____

12. Here is a list of alternatives for drug abuse treatment. Read the following descriptions of the different types of treatment before answering the questions.

Physician or private clinic—Go to a doctor for care and proper guidance.

Local General Hospital— enter this type of a hospital for treatment.

Local Psychiatric Hospital—enter this type of a hospital for treatment.

State Psychiatric Hospital—enter this type of a hospital for treatment.

Methadone program—enter a methadone program to stop use of heroin.

Traditional church—go to minister of a conventional church for guidance.

Live-in therapeutic community—join a group of other drug users living at a psychological counseling center.

Non-conventional religious organization—join an uncoventional religious group in order to develop spiritual strength.

Hotline or referral center—talk to a community referral agency to find out what facilities can best help.

Friends—talk with people you trust to find out what they think is best.

Professional psychotherapy—consult with a psychologist or psychiatrist.

Out-patient counselling center—visit a community counselling center regularly.

Legal restraint—jail or correctional institution.

None—no treatment alternative is recommended.

Other—some other alternative not mentaioned here is preferable.

Don't know—I really can't say with what I know now about the problem.

12. (See the previous page for instructions.)

(A.) Where would you refer someone who was addicted to heroin or one of the other opium derivatives (codeine, morphine, paragoric, etc.)? Please check one or more of the following alternatives in Column A.

(B.) Where would you refer someone who was misusing some other drug (hallucinogens, stimulants, depressants, etc.)? Please check one or more of the following alternatives in Column B.

	(A.)	(B.)
Physician or private clinic		
Local General Hospital		
Local Psychiatric Hospital		
State Psychiatric Hospital		
Methadone Program		
Traditional church		
Live-in therapeutic community		
Non-conventional religious organization		
Hotline or referral center		
Friends		
Professional psychotherapy		
Out-patient counselling center		
Legal restraint		
None		
Other, specify		
Don't know		

Comments _____

VIRGINIA BEACH DRUG ABUSE SURVEY

1. In this survey, we are trying to ascertain facts about drug abuse, not merely opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. The "people you have come in contact with" include not only clients, friends, relatives and acquaintances but also people you have passed in the stores or streets, people you think may have been using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Degree of Use: Widespread	Moderately Widespread	Not Very Widespread	Hardly ever Used by Anyone
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (Amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")				
Opiates (heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Quaaludes				
Other, specify				

KEY

WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 20 or more use this drug on a regular basis.

MODERATELY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 10 to 20 use this drug regularly.

NOT VERY WIDESPREAD–
Of the people whom I have come in contact with in the past 12 months, I would estimate that about 5 to 10 use this drug regularly.

HARDLY EVER USED BY ANYONE–
Of the people whom I have come in contact with in the past 12 months, I would estimate that less than 5 use this drug regularly.

DRUGS	2. Check the age categories which you think primarily uses each type of drug: 10-14	15-17	18-21	22-29	30-49	50 & over	3. Check those drugs which you think residents of Virginia Beach buy in and/or outside of Virginia Beach. Check both if appropriate: Buy in Va. Beach	Buy outside Va. Beach	4. Next to the appropriate drug, place the approximate number of times in an average month that you encounter problems related to the abuse of that drug. Under 18 years: Ave. summer mo.	Ave. non-sum. mo.	18 years & over: Ave. summer mo.	Ave. non-summer mo.
Tobacco												
Alcohol												
Marihuana (including Hashish, THC-synthetics)												
Inhalants (glue & other vapors or volatile intoxicants)												
Hallucinogens (LSD, mescaline, STP & similar drugs)												
Stimulants (Amphetamines, methamphetamines, pep pills)												
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")												
Opiates (Heroin, codeine, morphine, paragoric, & other opiate derivatives)												
Cocaine												
Quaaludes												
Other, specify												

5. During an average month, do you counsel young people, between the ages of 12 and 21, who come to you for advice but who were not as yet in trouble? (Counseling directly related to the drug problem) ____ Yes ____ No Estimate of the number you have talked with during the last 12 months _____.

6. Do you know of persons in Virginia Beach engaged in the abuse of drugs? (excluding alcohol and tobacco) Yes ____ No ____. Estimate of number _____. Predominate age group _____.

7. Do you know of persons in Virginia Beach engaged in the illegal sale of drugs? ____ Yes ____ No. Estimate of number ____ Predominate age group _____.

8. Without necessarily having direct knowledge, do you believe that there is illegal drug trafficking in Virginia Beach? ____ Yes ____ No. Estimate of the number of such persons _____.

9. How many persons do you see during an average month for non-drug reasons whom you suspect or have found to have drug problems? Under 18 years old _____ 18 years of age and older _____.

10.

PROGRAMS	Check those programs with which you are familiar	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other,							

11. Do you think these programs can adequately handle the drug problem in Virginia Beach? ____ Very Well ____ Fairly well ____ Not too well ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

_____

12. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes ____ No. Which ones? _____

_____

_____

Do you think these are effective? ____ Yes ____ No.

Do you think more drug abuse prevention programs are needed?

____ Yes ____ No. What kinds? _____

_____

_____

_____

13. If you have any specific information concerning drug abuse in Virginia Beach which you think might be useful to this survey, would you please relate it in the following space. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

14. (A) Where would you refer someone who was addicted to heroin or one of the other opium derivatives (codeine, morphine, paragoric, etc.)? Please check one or more of the following alternatives in Column A.

(B) Where would you refer someone who was misusing some other drug hallucinogens, stimulants, depressants, etc.)? Please check one or more of the following alternatives in Column B.

	A	B
Physician or private clinic		
Local General Hospital		
Local Psychiatric Hospital		
State Psychiatric Hospital		
Methadone program (enter a methadone program to stop using heroin)		
Traditional church (go to minister of conventional church for guidance)		
Live-in therapeutic community (join a group of other drug users living at a psychological counseling center)		
Non-conventional religious organization (develop spiritual strength by joining an unconventional religious group)		
Hotline or referral center (find out what facilities can best help)		
Friends (talk with people you trust)		
Professional psychotherapy (visit a psychologist or psychiatrist)		
Out-patient counselling center (visit a community counselling center regularly)		
Legal restraint (jail or correctional institution)		
None (no treatment alternative is recommended)		
Other (some other alternative not mentioned here is preferable)		
Don't Know (I really don't know much about the problem)		

Comments _____

SURVEY OF HOUSEHOLDS IN VIRGINIA BEACH

DO NOT WRITE YOUR NAME OR ADDRESS ON THIS QUESTIONNAIRE!

The City of Virginia Beach is conducting a comprehensive study of drug abuse in order to plan future drug abuse centers and drug education programs. Therefore, it is necessary to ask questions about personal drug use. These questions concern legal use of medically prescribed drugs as well as illegal drug use. Remember the survey is anonymous. No one can ever contact you concerning your answers.

1. In this survey, we are trying to ascertain facts about drug abuse, rather than opinions. That is why the following questions are asked about people you have actually come in contact with, not about the population at large. These "people you have come in contact with" include not only friends, relatives, business and professional associates, and acquaintances but also anyone you know who is using drugs.

Below are listed several categories of drugs. We would like you to check how widely you think these drugs are being used by people you have come in contact with.

DRUGS	Widespread	Moderately Widespread	Not very Widespread	Hardly ever used by anyone	Never Used
Marihuana (including Hashish, THC-synthetics)					
Inhalants (glue & other vapors or volatile intoxicants)					
Hallucinogens (LSD, mescaline, STP & similar drugs)					
Stimulants (Amphetamines, methamphetamines, pep pills)					
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")					
Opiates (Heroin, codeine, morphine, paragoric & other opiate derivatives)					
Cocaine					
Methaqualone (Quaalude, etc.)					
Other, specify _____					

KEY

WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months I would estimate that about 20 or more use this drug on a regular basis.

MODERATELY WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months I would estimate that about 10-20 use this drug regularly.

NOT VERY WIDESPREAD-
Of the people whom I have come in contact with in the past 12 months I would estimate that about 5-10 use this drug regularly.

HARDLY EVER USED BY ANYONE-
Of the people whom I have come in contact with in the past 12 months I would estimate that less than 5 use this drug regularly.

NEVER USED-
Of the people whom I have come in contact with in the past 12 months I would estimate that no one was using this drug regularly.

2. Do you and/or your spouse and/or others in your family take any of the following non-prescription drugs?	HUSBAND: No	Yes, Occasionally	Yes, At least once a week	Yes, daily	Don't Know	Not applicable	WIFE: No	Yes, occasionally	Yes, At least once a week	Yes, daily	Don't Know	Not applicable	OTHER FAMILY MEMBER: (Please specify) No	Yes, occasionally	Yes, At least once a week	Yes, daily	Don't Know	Not applicable	OTHER FAMILY MEMBER: (Please specify) No	Yes, occasionally	Yes, At least once a week	Yes, daily	Don't Know	Not Applicable
For Headaches:																								
Tylenol																								
Bufferin																								
Aspirin																								
Other:																								
For Sleep:																								
Quiet World																								
Compoz																								
Sleepeze																								
Other:																								
To Wake Up:																								
No Doz																								
Vivarin																								
Be Bright																								
Other:																								
Other: (specify)																								

3. Please list any drugs and/or medicine that your doctors have prescribed for you and your spouse within the past year and place a check by how frequently you take them.

DRUGS	Never	Yes, Occasionally	Yes, once a week	Yes, daily	Don't know	Not Applicable
Husband:						
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
Wife:						
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
Other member of family (Please specify): _____						
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
Other member of family (Please specify): _____						
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____
_____	____	____	____	____	____	____

4. Please place a check in the correct column. Do you and/or your spouse and/or others in your family smoke cigarettes?

	No	Yes, less than ½ pkg./day	Yes, ½-1 pkg. a day	Yes, more than 1 pkg./day	Don't Know	Not Applicable
Husband:	____	____	____	____	____	____
Wife:	____	____	____	____	____	____
Other family member (Please specify): _____						
	____	____	____	____	____	____
Other family member (Please specify): _____						
	____	____	____	____	____	____

5. Do you and/or your spouse and/or others in your family drink alcoholic beverages?

	No	Yes, occasionally	Yes, once a week	Yes, Daily	Don't Know	Not Applicable
HUSBAND:						
Beer	____	____	____	____	____	____
Wine	____	____	____	____	____	____
Other alcoholic beverages (whiskey, etc.)	____	____	____	____	____	____
WIFE:						
Beer	____	____	____	____	____	____
Wine	____	____	____	____	____	____
Other alcoholic beverages (whiskey, etc.)	____	____	____	____	____	____
OTHER FAMILY MEMBER (Please specify): _____						
Beer	____	____	____	____	____	____
Wine	____	____	____	____	____	____
Other alcoholic beverages (whiskey, etc.)	____	____	____	____	____	____
OTHER FAMILY MEMBER (Please specify): _____						
Beer	____	____	____	____	____	____
Wine	____	____	____	____	____	____
Other alcoholic beverages (whiskey, etc.)	____	____	____	____	____	____

6. Would you estimate how many persons in Virginia Beach might be engaged in the illegal sale of drugs. Estimate of number _____ Predominate age group _____.

7. Do you, your spouse, or any other member of your family use any of the following drugs?

DRUGS:	HUSBAND: No	Yes, occasionally	Yes, at least once a week	Yes, daily	Don't know	Not applicable	WIFE: No	Yes, occasionally	Yes, at least once a week	Yes, daily	Don't know	Not applicable	OTHER FAMILY MEMBER: (Please specify) No	Yes, occasionally	Yes, at least once a week	Yes, daily	Don't know	Not applicable	OTHER FAMILY MEMBER: (Please specify) No	Yes, occasionally	Yes, at least once a week	Yes, daily	Don't know	Not applicable
Marihuana (including Hashish, THC-synthetics)																								
Inhalants (glue & other vapors or volatile intoxicants)																								
Hallucinogens (LSD, mescaline, STP & similar drugs)																								
Stimulants (amphetamines, methamphetamines, pep pills)																								
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")																								
Opiates (heroin, codeine, morphine, paregoric, & other opiate derivatives)																								
Cocaine																								
Methaqualone (Quaalude etc)																								
Other, specify: _____																								
_____																								
_____																								

8. If you wanted to obtain any of the following drugs in Virginia Beach, how difficult would it be to do so? (Exclude drugs obtained by prescription for medical reasons.)

	I WOULDN'T KNOW HOW DIFFICULT IT IS TO OBTAIN THEM	VERY DIFFICULT	SOMEWHAT DIFFICULT	NOT AT ALL DIFFICULT
Marihuana (including Hashish, THC-synthetics)				
Inhalants (glue & other vapors or volatile intoxicants)				
Hallucinogens (LSD, mescaline, STP & similar drugs)				
Stimulants (amphetamines, methamphetamines, pep pills)				
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers"				
Opiates (Heroin, codeine, morphine, paragoric, & other opiate derivatives)				
Cocaine				
Methaqualone (Quaalude, etc)				
Other, Specify				

9. If you do not presently abuse drugs, which one of the following has most influenced your decision "not to abuse drugs." Please check.

_____ What your parents told you about drugs

_____ What your brothers and sisters told you about drugs

_____ What your friends told you about drugs

_____ The information you got in school or in drug abuse education classes

_____ The information you got from television, books, or newspapers

_____ The information you got from your family doctor

_____ The information you got from your minister, priest or rabbi

_____ I just never had any desire to abuse drugs.

_____ Other, specify _____

_____ None of the above.

10. Please check the age categories which you think primarily uses each type of the following drugs:

AGES	Tobacco	Alcohol	Marihuana (including Hashish, THC-synthetics)	Inhalants (glue & other vapors or volatile intoxicants)	Hallucinogens (LSD, mescaline, STP & similar drugs)	Stimulants (amphetamines, methamphetamines, pep pills)	Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")	Opiates (heroin, codeine, morphine, paragoric & other opiate derivatives)	Cocaine	Methaqualone (Qualudes, etc)	Other, specify
Under 10											
10 to 14											
15 to 17											
18 to 21											
22 to 29											
30 to 49											
50 and over											

11. PROGRAM	Check those programs which you have heard of	Check those programs which you have not heard of	From which of the following sources did you hear about each of these programs? Media	Friends	School	Other, Specify	Check those programs you feel should be expanded
Alcoholics Anonymous							
Alcohol Information Center							
Broken Needles							
Drug Information Center							
Drug Outreach Center							
Martus, Inc.							
Other, Specify _____							

12. How well do you think these programs respond to the drug problem in Virginia Beach? ____ Very well, ____ Fairly well, ____ Not too well, ____ Not at all. If not, what kinds of additional programs do you think should be established? Please explain _____

_____

_____

_____

13. Are you aware of any drug abuse prevention programs in Virginia Beach or in this area? ____ Yes. ____ No. Which ones? _____

_____

_____

14. If you are presently a student in a Virginia Beach high school, do you know whether your school has a drug abuse education program? ____ Yes ____ No. If yes, how effective is it? ____ Very effective, ____ Fairly effective, ____ Not very effective, ____ Not at all effective. If there is no drug abuse education program, do you think one is needed? ____ Yes ____ No. If yes, what kind, describe _____

_____

_____

_____

_____

15. (A) Where would you refer someone who was addicted to heroin or one of the other opium derivatives (codeine, morphine, paragoric, etc.)? Please check one or more of the following alternatives in Column A.

(B) Where would you refer someone who was misusing some other drug hallucinogens, stimulants, depressants, etc.)? Please check one or more of the following alternatives in Column B.

	A	B
Physician or private clinic		
Local General Hospital		
Local Psychiatric Hospital		
State Psychiatric Hospital		
Methadone program (enter a methadone program to stop using heroin)		
Traditional church (go to minister of conventional church for guidance)		
Live-in therapeutic community (join a group of other drug users living at a psychological counseling center)		
Non-conventional religious organization (develop spiritual strength by joining an unconventional religious group)		
Hotline or referral center (find out what facilities can best help)		
Friends (talk with people you trust)		
Professional psychotherapy (visit a psychologist or psychiatrist)		
Out-patient counselling center (visit a community counselling center regularly)		
Legal restraint (jail or correctional institution)		
None (no treatment alternative is recommended)		
Other (some other alternative not mentioned here is preferable)		
Don't Know (I really don't know much about the problem)		

Comments _____

For this survey to be meaningful, it is necessary to ask certain questions concerning population characteristics. In order to describe who is using which drugs, we must ask the following questions. They will help determine where in Virginia Beach to locate drug abuse centers and drug education programs. Remember, the survey is anonymous. No one can ever contact you concerning your answers.

Please fill in the following spaces as accurately as you can. All answers are completely confidential.

1. Age: ____ 2. Sex: ____ Male ____ Female

3. Marital Status: ____ Never married, ____ Widowed, separated, divorced
____ Married

4. Ages of children living at home ____, ____, ____, ____.

5. Last year of school completed: 1 2 3 4 5 6 Elementary 7 8 9 Junior High 10 11 12 High School

1 2 3 4 College 1 2 3 4 5 + Graduate or Professional School 1 2 3 + Technical or Vocational School

If you are presently in school, what grade or year are you in? _____

6. Family income: (Please check the category which roughly approximates your income or the combined income of you and your husband or wife if you are married. If you are living with your parents, check their approximate combined incomes)

____ Below $5,000 a year
____ $5,000 to $10,000 a year
____ $10,000 to $15,000 a year
____ $15,000 to $20,000
____ $20,000 to $30,000
____ $30,000 and above a year

7. Residence: It is important for purposes of the survey to determine the approximate area in which you live. Please write your zip code in the following space. Remember this is an anonymous questionnaire. _____

8. Occupation:

	Type of business or profession or trade	Position in it (or rate or rank if military)
Yours:	_____	_____
Your husband's or wife's:	_____	_____
If you live with your parents:		
Your father's occupation:	_____	_____
Your mother's occupation:	_____	_____

YOUTH DRUG USE SCALE

We would like your help in a survey sponsored by the Virginia Beach Mental Health-Mental Retardation Services Board. Many other people in this city are helping us in this survey by answering questionnaires such as you have before you.

This is a survey of drug use and abuse in Virginia Beach. About 1000 persons are participating in this part of the survey. The survey is designed so that no school or person can be identified in the results. The questionnaires from all the different classes and schools will be mixed up together as soon as they are collected. We assure you that there is no way that any person can be identified.

The purpose of all this is to help plan future drug programs in the city. We are asking you to help us with this, but you don't have to. Filling out the questionnaire is completely voluntary.

DIRECTIONS: Below you will find a list of products. Some people have not had any contact with these products at all. Other people have had considerable contact with each product. Use the following code to describe the frequency of your contacts with these products.

A. I have never used this product.
B. I have used this product BEFORE January 1, 1973, but do not use it now.
C. I have used this product SINCE January 1, 1973, but do not use it now.
D. I use this product about once or twice a year.
E. I use this product about once or twice a month.
F. I use this product about once or twice a week.
G. I use this product about once or twice a day.
H. I use this product often each day.

Circle only one choice for each question.

	Never used	Used before Jan.1, 1973	Used since Jan.1,1973	Once or twice per year	Once or twice per month	Once or twice per week	Once or twice per day	Often each day
1. Cigarettes	A	B	C	D	E	F	G	H
2. Alcohol (beer, wine, mixed drinks)	A	B	C	D	E	F	G	H
3. Marihuana (pot, grass)	A	B	C	D	E	F	G	H
4. Hashish (hash)	A	B	C	D	E	F	G	H
5. Hallucinogens (LSD, peyote, mescaline)	A	B	C	D	E	F	G	H
6. Stimulants without prescriptions (pep pills, uppers, speed)	A	B	C	D	E	F	G	H
7. Depressants without prescriptions	A	B	C	D	E	F	G	H
8. Curare (coolies)	A	B	C	D	E	F	G	H
9. Heroin or other opiates	A	B	C	D	E	F	G	H
10. Cocaine	A	B	C	D	E	F	G	H
11. Any other similar products without prescriptions? If so, what:	A	B	C	D	E	F	G	H

Please fill in your age here_____.

SOCIAL SERVICES DRUG ABUSE SURVEY (Page 1 of 2)

	TOTAL NO. OF CLIENTS	TOTAL NO. CLIENTS WHO WERE USING DRUGS
AGE:		
Less than 10		
10 - 14		
15 - 17		
18 - 21		
22 - 29		
30 - 49		
50 +		
MARITAL STATUS:		
Never married		
Married		
Wid., Sep., Div.		
NO. OF DEPENDENTS: (If not accounted for elsewhere in this survey)		
0		
1		
2		
3		
4+		
EDUCATION: (Highest grade attained)		
Some High School		
High School Graduate		
Technical School		
Some College		
College Graduate		
Graduate or Professional		
AREA OF RESIDENCE: (Zip Code or Neighborhood)		

	TOTAL NO. OF CLIENTS	TOTAL NO. OF CLIENTS WHO WERE USING DRUGS
LENGTH OF RESIDENCE:		
Less than 30 days		
1 - 6 months		
6 - 12 months		
1 - 5 years		
5 years or more		
WHETHER EMPLOYED WHEN CLIENT CONSULTED SOCIAL SERVICES:		
Employed		
Unemployed		
Other		
OCCUPATION OR TRADE: (whether employed during 1973 or not)		
Unskilled		
Businessperson		
Public Servant		
Professional		
Student		
Housewife		
Retired		

How many in your case load had prior arrests for drug abuse? _____

For what drugs? _____

SOCIAL SERVICES DRUG ABUSE SURVEY (Page 2 of 2)

If a person is using more than one type of drug, check each drug he uses. But fill in only the actual no. of clients at the top of each age category.

	# Of Clients <10				# of Clients 10-14				# of Clients 15-17				# of Clients 18-21				# of Clients 22-29				# of Clients 30-49				# of Clients 50+			
	Daily	Semi-weekly	Weekly	Monthly	Other	Daily	Semi-weekly	Weekly	Monthly	Other	Daily	Semi-weekly	Weekly	Monthly	Other	Daily	Semi-weekly	Weekly	Monthly	Other	Daily	Semi-weekly	Weekly	Monthly	Other	Daily	Semi-weekly	Weekly	Monthly	Other
Alcohol																													
Marihuana (including Hashish, THC-synthetics)																													
Inhalants (glue & other vapors or volatile intoxicants)																													
Hallucinogens (LSD, mescaline, STP & similar drugs)																													
Stimulants (Amphetamines, methamphetamines, pep pills)																													
Depressants (the range of sedative anti-anxiety agents ranging from barbiturates to "minor tranquilizers")																													
Opiates (heroin, codeine, morphine, paregoric, & other opiate derivatives																													
Cocaine																													
Quaaludes																													
Other, specify																													

APPENDIX C

SUGGESTIONS FOR OPERATIONALIZING THE MODEL

APPENDIX C

SUGGESTIONS FOR OPERATIONALIZING

THE MODEL

Overview Project Planning

A collaborative community response to "breakdown" or "crisis" involves both conceptualization and cooperative planning. To promote both conceptualization and planning, human service leaders may be organized, initially informally, into a task force to brainstorm the basic "who," "what," "where," "why," and "how" that goes into any program development activity. This task force may not be all-inclusive at the onset. Three or four departments may initiate the informal task identification, and other departments and groups joining the effort as the project needs, objectives, relationships, and communication are gradually clarified.

The schema is offered as one model of a basic initiation of a "Resistance Resources Development" on a municipal level. Four human services department heads meet (A) to clarify the basic problem, translate and delimit the more global concepts, and identify already existing collaborative community activities. This group also identifies theories and methodologies that may serve as bases for project development.

Major local data sources for problem identification are also noted (B^1). In this instance, the City Planning Department is cited

as an assist in identifying community demographic data. The Touche Ross report of the local Public Health Department focuses on the more serious community problems relating to general illness, communicable diseases, homicide, and suicide (B^2).

A larger working group of community resource leaders is noted in part C of the diagram. This is a more operationally-oriented group, developing specific procedures for translating the concepts of the A group into practical terms. The study group unit also provides an organizational mechanism for a broader agency input into a truly collaborative effort of service delivery, without unduly increasing the numbers of the primary planning team (A). Meetings of the two respective groups are more easily planned and consequently tend to be shorter in time spent at each meeting--which is another way of saying that the task perspectives are more clearly identified, and participants can more easily "stick to the subject" at the meetings.

Another advantage of the two-group approach: agency heads (and community representatives) who are more interested in (or feel more urgently inclined to) practical, as opposed to conceptual activities, are spared the conceptual side of program development, and tend to find their involvement and input a more enjoyable experience and the reverse is also true. But participation in one group in no way precludes participation in the other group. On-going interagency projects (or projects in advanced stages of planning) are noted (D).

The 24 hour Emergency Services planning (D^1) consumes massive amounts of planning time among the agencies, as well as considerable coordination with city management and funding sources. The program is already practically operational.

Plans for a day-care center for the elderly are in the final stages (D^2). A community response to alcohol abuse is presently being implemented.

The Humanistic Engineered Learning Program (H.E.L.P.) Classroom is a viable example of interagency collaboration delivering crisis assistance to students experiencing significant behavioral-adjustment problems to preclude referrals to state institutions and decrease school drop-out rates. Social and vocational skills are taught in a short-term behavior-modification approach in a small classroom environment.

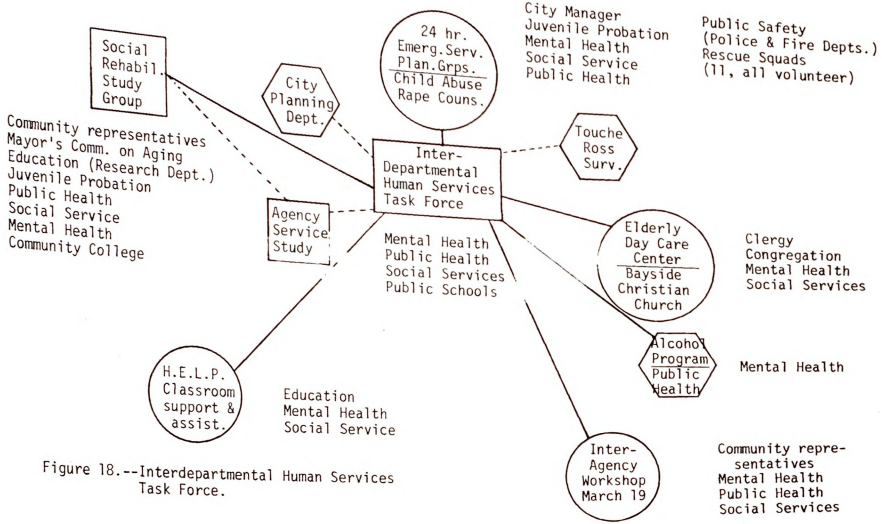

Figure 18.--Interdepartmental Human Services Task Force.

Community Resources Organized Into the Social Competency Model

If the community at large is viewed as an entity, a meta-agency, or even a large residence inhabited by the community residents--then the individual service agency or group in the community can be viewed as SCU's--Social Competing Units. In other words, the theory of Social Competency may be conceptually, and operationally, applied to the municipal human services delivery system.

If each agency is viewed as an SCU, then each program segment is viewed as an SCA--a Social Competency Activity--and the specific rehabilitative actions are SCB's--Social Competency Behaviors, or Skill Training Behaviors.

Any meaningful community assessment, or agency evaluation, should include a comparison of the Social Skill Training (specific rehabilitative activities) offered by the Agency and the identified needed SIB's (Socially Incompetent Behaviors--or needed skills) of the clients seeking assistance from that agency.

Two instruments are needed for such a comparison/evaluation: (1) an Agency Program Skills Evaluation Chart, and (2) a Client Skills Assessment Scale.

The Agency Program Skills Evaluation Chart is administered by:

1. The agency administrator/director filling out columns 1, 2, 3, 4, and 5;

2. The agency unit heads (supervisors, coordinators) filling out columns 6 and 7, and

3. The agency line staff filling out column 7.

The Skills Assessment Scale is also a response to Column 8 of the Agency Social Skills Evaluations Sheet. The scale is administered to clients of the specific agencies, the results are tabulated, significant SIB's (Socially Incompetent Behaviors) recorded in Column 8 of the Agency Social Skills Sheet, and the match or mis-match is then surveyed.

Beginning a Community Agency Assessment

A working group or agency heads can begin their assessment of which agencies provide what skill training may begin with the use of a scale similar to Figure 19. The uses of such scales are many, including identifying specific social skill training available in the community, which agencies provide this training, and which units of the agencies provide these services. The lack of specific skill training units may also be determined by the use of this scale model.

Client Skills Assessment Scale

A community assessment is one approach to identifying services presently available in the community as well as possible gaps in services. But determining the relevance of such services is yet another task. For example, a community may have within its agencies many social skill training agencies and units delivering training in many social skills. But are these skills the specific skills needed by the community citizenry, or especially by the clients of the agencies, individually and collectively?

1 Skill Training Agency/ Center	2 Objectives	3 Agency Training Group	4 Goals	5 Skill Training Unit	6 Skill Training Group	7 Socially Competent Behavior	8 Socially Incompetent Behavior
Juvenile Proba-tion	1. Assist Juv. persons who have come in (are about to) come in con-flict with the law.	1. Diversion Programs	1. Successful diversion from the juvenile court for youth. 2. Elimination of the deten-tion & commit-ment of status offender. 3. Reduction of recidivism among status offenders. 4. Reduction of juv. status offenders. 5. Reduction of Probation Officers caseloads.	1. Family Counseling	1. Intake 2. Crisis Counseling 3. Family Counseling Group	1. Identify family prob-lems: source and kind. 2. Improve Com-munications 3. Identify Com-munity re-sources. 4. Identify per-sonal problems 5. Develop problem solving skills.	1. School Truancy 2. Inability to com-municate with parents and children 3. Confusion in identifying family problems. 4. Confusion in identifying and solving personal problems.

Figure 19.--Agency Social Skills Evaluation Chart.

A survey of the specific abilities and disabilities of representative (randomly selective) clients of each agency may provide this important information.

Mean scores in the disability areas may be registered in a scale suggested in Figure 20, and the results compared to columns 7 and 8 in Figure 19. Relevance or irrelevance to client needs may then be ascertained to a reasonable degree of accuracy.

Places of residence, ages, item scores, as well as agencies providing specific skill training activity can be recorded on a chart as displayed in easily constructed charts. The controlling variable is the specific social disability, or socially incompetent behavior. This approach may be helpful in planning geographic locations of specifically designed social skill units or agencies.

A basic client treatment plan is contained in Appendix A. Writing across the page, beginning at the left with each social disability noted in the Skills Assessment Scale, the competent behavior training needed by the client, and where this training may be obtained, is entered as the counselor writes toward the right on the page.

It is important to note that the treatment plan may be rewritten as often as client needs indicate (daily, if necessary, especially in a residential facility).

Changing Clients--Changing Systems

Throughout the model, the emphasis remains on community and agency responsiveness to individual need--a responsiveness in

Social Disability	Mean Score	Needed Social Skills Trng.	Zip Codes	Mean Age	1. Mean Dev. 2. St.Dev. 3. Range	Agency Group Prov. Service	Gaps in Skill Training
			51 54 57 60 52 55 58 62 53 56 59 Other		1. 2. 3.		

Figure 20.-- Description of Disabilities and Resources.

specific skill training to needs defined in socially competent terms. Agency evaluation can then take place in terms of responsiveness to individuals. And individual expectancies can be verbalized in very precise behavioral terms.

Communication to funding sources and governmental bodies is enhanced because the concept of "cure" is translated into terms of socially functioning citizens. Agency needs can be more easily identified in terms mutually understood among the agencies. And agencies' collaboration is both a necessity and an outcome of the community approach to rehabilitation.

Much has yet to be done, in theory and in practice. But a beginning has been made. Communities can respond to citizens in need and people and communities can be "diagnosed" in "people terms," in their needs and in their success in social living.