

JOINT LEGISLATIVE
AUDIT & REVIEW
COMMISSION

THE
VIRGINIA
GENERAL
ASSEMBLY

PROGRAM EVALUATION

VIRGINIA
DRUG ABUSE
CONTROL PROGRAMS

October 14, 1975

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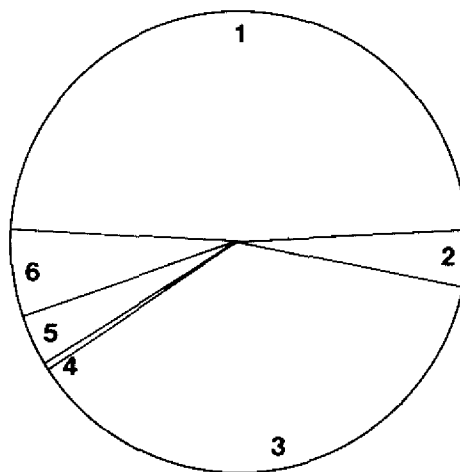
SUMMARY
VIRGINIA DRUG ABUSE CONTROL PROGRAMS

At one time, drug abuse was considered to be limited to a small subgroup of society and caused little public concern. In the late 1960's, however, drug use, including the abuse of legal as well as illegal substances, reached national crisis proportions involving nearly every segment of society. Large amounts of public resources were committed to the drug problem, and methods of treatment and control became subjects of intense public debate.

In Virginia drug abuse is a continuing problem. Law enforcement officials attribute increases in burglaries, prostitution, and other fund-raising crimes to the need to support a drug habit. Since 1970, approximately \$37 million in federal, State, and local funds have been expended on various drug abuse control activities. Of the estimated \$15 million spent in FY 1975, almost one-half was used for enforcement of drug laws, a third was used to treat abusers and less than one percent was used for education.

Despite the substantial expenditure of public funds, efforts to cope with drug problems have met with limited success. Four of the critical areas that adversely affect State programs require special mention at the outset and include: the organizational relationships in managing drug programs; the emphasis on marijuana control by the criminal justice system; the funding difficulties and marginal outcomes of narcotic treatment programs; and, the need for a more effective educational response to drug problems.

**ESTIMATED DISTRIBUTION OF FUNDS
FOR DRUG ABUSE PROGRAMS
1974-1975**



1 ENFORCEMENT	\$ 7,209,000	48.5%
2 CORRECTIONS	564,000	3.8%
3 TREATMENT	5,578,000	37.5%
4 EDUCATION	60,000	.4%
5 COORDINATION	531,000	3.6%
6 RESEARCH/OTHER	927,000	6.2%

Source: JLARC, July, 1975

Organization: Because Virginia reacted to increasing drug problems and initial federal policies by either creating new agencies or assigning responsibilities to existing agencies on a piece-meal basis, the drug abuse control effort has lacked coordination. As a result, the Commonwealth now has a complex structure of State, regional and local organizations involved in drug abuse control with overlapping and sometimes conflicting responsibilities.

Moreover, Virginia has been slow to respond to more recent federal initiatives to streamline organizational relationships and procedures that call for a single agency to plan, implement, and coordinate drug efforts. Although the Division of Drug Abuse Control (DDAC) is designated as the single state agency, it shares policy-making and grant review authority with the Virginia Drug Abuse Advisory Council (VDAAC), an organization comprised of the same agencies DDAC must attempt to coordinate. This relationship has resulted in a State plan and funding policies reflecting agency self-interests. Furthermore, it has jeopardized federal funding which is now approved only on a temporary basis pending required modification of the State's drug organization.

Additional problems of administration have resulted from the existence of separate organizations for dealing with alcohol and other drugs. Both programs have many common functions and needs including information gathering, planning, coordinating, and funding; and increasingly, treatment programs are aimed at both alcohol and drug abusers. Available resources could be more effectively and efficiently administered by combining drug and alcohol abuse management responsibilities under a single umbrella agency at the State level.

Marijuana: Another aspect of drug abuse control has been the pervasive impact of marijuana on the State's criminal justice system. Marijuana is a controlled substance subject to criminal penalties, and accounts for three-quarters of all local and State police drug arrests, and two-thirds of all court cases involving drugs. However, these enforcement efforts have not had a significant impact on the availability or use of marijuana. According to the Virginia Drug Abuse Survey, there are about 187,000 marijuana users and, of more importance, nine out of ten have never been arrested. Moreover, there is little evidence to indicate that the occasional use of marijuana poses a significant hazard to individual health and there are few social consequences associated with its use. It is reasonable to conclude that the money and manpower committed to control marijuana use greatly exceed its social cost or potential for individual harm.

Treatment: Programs for treatment of narcotic and other drug dependent persons are relatively new, but there are indications that only limited success can be expected from present efforts. Based on a review of outcomes of four representative treatment programs there is a clear need to improve program management and develop new treatment strategies. And, because of a new cost assumption policy adopted by the State's Council on Criminal Justice, the General Assembly may be asked to provide an additional (and unexpected) \$1.4 million in the 1976-78 biennium to fund treatment programs currently receiving federal grants from the Division of Justice and Crime Prevention (DJCP). At the same time, other funds will be used to start new programs.

Additional treatment programs should not be established until sources of funding have been clearly identified and ways to improve treatment outcomes have been more carefully defined.

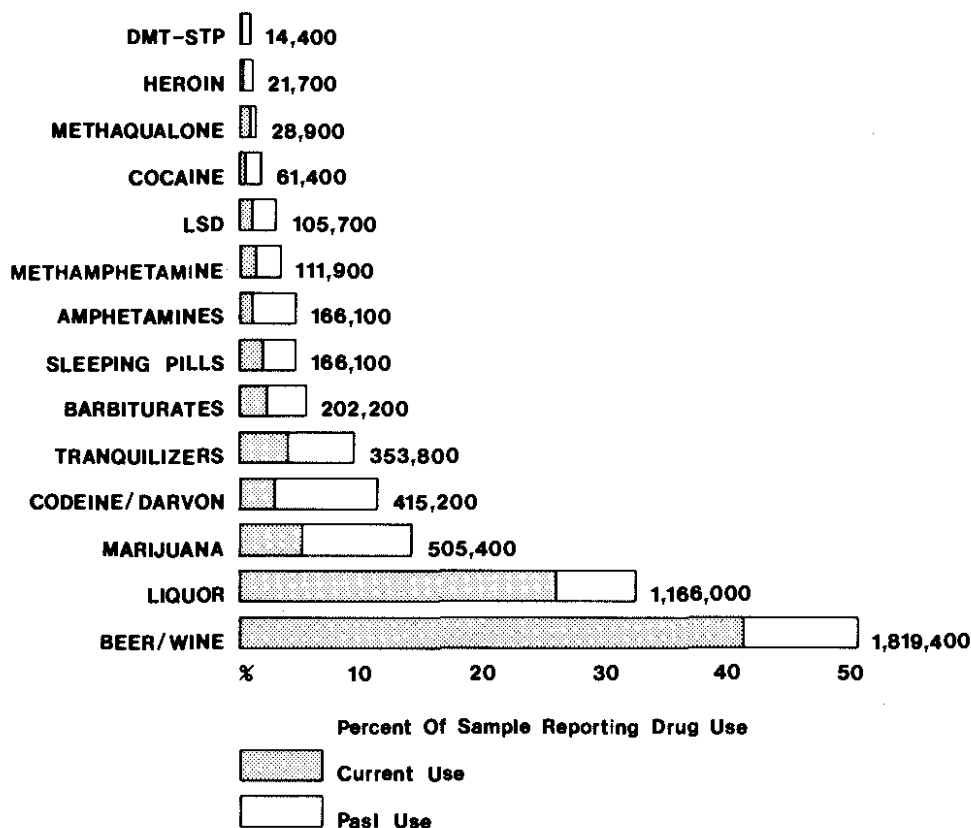
Education: Drug education has not reduced the level of drug use as originally expected. In fact, the current factual teaching approach may have contributed to increased experimentation with drugs. Newer teaching methods, including ones associated with improving decision-making skills, greater access to counseling services, and better communication of drug discovery policies should be encouraged. Finally, high priority should be given to teacher preparation through both collegiate and in-service training.

The balance of this summary has been prepared to highlight key facts, findings, and conclusions and is arranged according to the organization of the report. Page numbers are included in the text for easy reference and a detailed index of issues is incorporated as part of the summary.

VIRGINIA'S DRUG PROBLEM

The patterns of drug use in Virginia shown below follow that found in other states and encompass a wide range of drugs, both legal and illegal.

PATTERNS OF DRUG USE IN VIRGINIA



Note: Sample includes 2503 interviews, late summer and fall, 1973.
Numbers shown are the estimated total of past and current drug users in Virginia.

Source: Virginia Statewide Drug Abuse Survey: Summary Report, 1974.

The nature of drug abuse has been assessed by three indicators: (1) potential harm to the individual user; (2) social consequences; and (3) incidence and frequency of use (pp. 15-35).

Every indicator suggests that alcohol must be recognized as the State's most serious drug problem. It is the most widely used and abused drug with at least a half million regular or heavy consumers and an estimated 122,000 alcoholics. Alcohol is a central nervous system depressant that acts as a relaxant at moderate levels of consumption. Continued and excessive use produce intoxication and can lead to physical and psychological addiction. Extended heavy use can lead to neurological and intestinal damage. Alcohol is a major contributor to drug deaths and is frequently reported as the cause of a health crisis by hospital emergency rooms. It is the probable cause of between one-quarter and one-half of all highway fatalities, and accounts for about one-third of all commitments to city and county jails. Alcohol abuse is often associated with violent crimes (pp. 16, 22, 27, 28).

Narcotic usage continues to be a serious problem, and recent evidence suggests that the availability of heroin is increasing. Heroin is a highly addictive substance used for its euphoric effect. Other narcotics including opium, morphine, codeine, and methadone are also used to produce euphoria or reduce pain. Psychological and physical addiction both develop rapidly. Although there are only an estimated 3,000 to 5,000 regular users of heroin or other opiates, the cost to society and potential harm to the individual resulting from addiction are well documented and substantial (pp. 18, 25).

Abuse of prescription drugs, such as barbiturates and amphetamines, is the State's hidden drug problem. There may be as many as 33,000 persons illegally using prescription drugs. Although the impact of this form of abuse is not very well known, medical evidence suggests that the abuse of legally prescribed drugs can often be very dangerous and should be given greater public concern (pp. 16, 22).

Hallucinogens have no common medical use, but are consumed to produce mind-distorting experiences. While there are several natural and synthetic substances, LSD is the most well known. The psychedelic effects of LSD usually last from eight to twelve hours but recurring hallucinations have been known to occur up to a year after last use. Tolerance can develop and psychological dependence is possible. There are an estimated 1,400 regular users of hallucinogens.

Marijuana is the most widely used illegal drug, with an estimated 187,000 current users of which about 72,000 report regular use. Marijuana is a psychoactive drug used as a euphoriant to produce a state of intoxication, hilarity, and sociability. There are few social consequences associated with its moderate use even though long-term, heavy use can produce psychological dependence. Although marijuana is not a harmless drug, the weight of evidence demonstrates that its occasional or experimental use does not pose a significant hazard to individual health (pp. 30-34).

DRUG EDUCATION

Public concern about an ever growing drug problem in the schools

led to the initiation of a statewide program in 1970 to provide increased drug education, in-service training for teachers, and the integration of instruction on drugs and drug abuse as part of the health curriculum. HJR 15 (1971) placed emphasis on beginning instruction in the elementary schools and on education as a means of reducing drug use among students (p. 37).

Although 90% of Virginia's senior high school students have received drug education, there is substantial research evidence as well as agreement among students, teachers, and counselors that merely providing factual information about drugs will not prevent drug abuse. In fact, it may have led to increased experimental use of all drugs (p. 71).

Nearly two-thirds of all students responding to a JLARC survey stated that drug education had made them more aware of drugs and their effects but had not reduced the level of drug abuse in their school. Among those students identified as potential abusers (those whose friends already use drugs) nine out of ten believed drug education was not effective. The responses of this target group were significantly more negative than those of other students, indicating that the most important audience was not being reached. Significantly, the majority of students believe there is a need for some form of drug program in the schools (p. 62).

The State Department of Education and several local school divisions have begun to advocate a mental health approach to drug education, assuming that a better understanding of oneself can assist in developing alternative means to cope with life's problems without resorting to drugs. While it is unrealistic to expect that education alone can eliminate drug abuse, it is appropriate to provide students with the skills necessary to make responsible decisions regarding drugs. The small number of studies in this area indicates that mental health education may positively affect attitudes and behavior towards drug abuse. However, since widespread adoption of this approach would require an expanded and expensive teacher training effort, it is important that the potential effectiveness of such an effort in Virginia be determined through careful evaluation of pilot programs (pp. 58-60).

Teacher preparation is a major factor in the effectiveness of any educational approach. HJR 15 intended all teachers be sufficiently trained to teach drug education. A Department of Education survey of principals in 1974 showed that 79% of all current classroom teachers had not received drug training. A JLARC survey of health and physical education teachers, who are primarily responsible for drug education in the secondary schools, also found that a third lacked in-service training in drug abuse. Additionally, 30% of the elementary schools and 17% of the senior high schools do not have a single drug education specialist on their faculty. Any new approach to drug abuse will obviously require increased attention to teacher qualifications (pp. 43-46).

Most teachers responsible for secondary school drug education have received dual certification in health and physical education which had little emphasis on health aspects. The State Board of Education should encourage the separation of these disciplines by advising local divisions to hire separately trained graduates and by encouraging teachers to specialize in one of the two fields (pp. 42-48).

The State's schools also need to provide specialized drug training for counselors and counseling services for drug troubled students. In addition, there must be increased communication concerning school drug abuse control policies throughout the entire system (pp. 54-55).

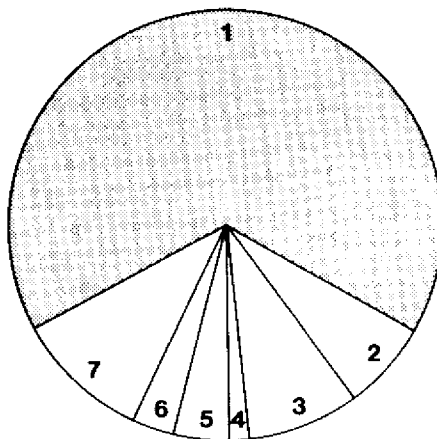
LAW ENFORCEMENT

Law enforcement has been the principal activity used by the Commonwealth in its battle against drugs. The State's enforcement efforts, however, are characterized by a lack of formalized coordination between police jurisdictions and a heavy emphasis on the arrest of marijuana users.

State and Local Police (pp. 77-87, 92-97)

Because most drug arrests were for marijuana violations and because almost all arrests were at the user level, the General Assembly adopted SJR 60 in 1972. It specified that law enforcement efforts should be directed toward persons engaged in the trafficking and abuse of those drugs which present the greatest danger and harm to both users and society (p. 74). State and local law enforcement agencies have not followed this direction. Instead, most resources are spent on the apprehension of drug users and the confiscation of small amounts of marijuana. During 1974, about three-quarters of all local and State police drug arrests were related to marijuana. State Police drug arrests for 1974 are shown below.

STATE POLICE DRUG CASES, 1974*



- 1 MARIJUANA 66.2%
- 2 NARCOTICS 6.8%
- 3 HALLUCINOGENS 8.4%
- 4 DEPRESSANTS 1.4%
- 5 STIMULANTS 4.2%
- 6 HASHISH 3.0%
- 7 OTHER 10.1%

*Includes only identified drugs

Source: Department of State Police

The amount of marijuana seized by the State Police for each arrest during the last half of 1974 was small--60% of all marijuana cases averaged less than one ounce each. There were only 29 heroin arrests averaging .1 ounce, 28 cocaine arrests averaging .06 ounce, and 34 arrests involving 46,383 amphetamine tablets (1 arrest, however, accounted for 44,500 tablets). Furthermore, only 2% of all arrests can be reasonably classified as involving major drug seizures (pp. 83-84).

Although the Department of State Police has well trained and experienced officers, there is considerable variation in the measurable level of drug enforcement activity throughout the State. The more rural areas encompassed by the Wytheville, Salem, and Appomattox field offices generally made fewer drug arrests, confiscated fewer drugs, had a greater percentage of marijuana arrests, and had the highest average cost for each arrest (p. 86). Evidently this variation is a result of allocating drug enforcement resources on the basis of existing uniformed division boundaries rather than on a specific plan to address priorities in drug control.

DSP needs to develop a prioritized drug enforcement plan in cooperation with Virginia's drug abuse planning agency to address the State's drug problem. In addition, DSP should consider a reorganization of its undercover activities and allocation of resources to provide greater flexibility in drug enforcement. Such action should consider allocation of resources to rely less on staffing field offices and providing increased funds for other types of drug enforcement activities including drug buy funds, development of local, State, and federal coordinative agreements and emphasis on major drug traffickers.

Cooperation and coordination between local, State, and federal agencies is a prerequisite to effective investigation of major drug dealers and illicit manufacturers. Interjurisdictional arrangements, however, are generally characterized as informal and based on personal relationships. A key element in effective statewide coordination of drug enforcement efforts is leadership. The Department of State Police as the primary drug enforcement agency should play an active leadership role in establishing statewide drug enforcement priorities and developing formalized interjurisdictional agreements (p. 96).

Reporting Drug Arrest Statistics (pp. 94-95)

JLARC found that some local police departments report arrests as the number of charges filed instead of the number of individuals arrested. This process inflates arrest statistics because many persons are charged with multiple offenses. Furthermore, some localities have reported drug charges to the FBI as part of the Uniform Crime Report, even though the reporting handbook clearly states this is an incorrect procedure.

With the recent changes in crime reporting, local enforcement agencies now submit their criminal statistics to the State Police instead of the FBI. JLARC feels this is an appropriate time to examine the entire crime reporting system, including both the State's role in coordinating, processing, and analyzing crime statistics, and the manner in which local enforcement agencies report data.

Alcoholic Beverage Control Board (pp. 87-88)

The enforcement division of the ABC Board has become increasingly involved with drug violations. Drug arrests have increased from 16% to 26% and alcohol arrests have decreased from 51% to 43% of total arrests. ABC agents may have become more involved with drugs because of revised alcohol regulations. On the other hand, because of close working relationships, requests from local police for assistance may constitute the bulk of the shift in arrests. In any event, the ABC Board should carefully review its enforcement activities to determine the appropriate level of its manpower needs.

Board of Pharmacy (pp. 88-89)

The Board of Pharmacy controls the legal manufacture, distribution, and dispensing of drugs in order to prevent their diversion and illegal use. The board licenses pharmacists, issues permits to pharmacies, promulgates regulations regarding controlled substances, conducts undercover shopping of pharmacies and medical practitioners, and inspects manufacturers and distributors. According to the federal drug enforcement agency, Virginia's Board of Pharmacy is one of the "top 10 state regulatory enforcement agencies in the nation." However, in view of the problem caused by the abuse of prescription drugs, and the high level of pharmacy thefts, the capabilities of the board should be strengthened by adding field personnel to conduct inspections and develop educational seminars dealing with pharmacy theft prevention.

ADJUDICATION OF DRUG OFFENDERS

The drug laws of Virginia have undergone considerable revision in recent years. The 1970 Drug Control Act amended many laws regulating the use of drugs including establishment of a drug schedule and reducing the penalty for marijuana from a felony to a misdemeanor. Then, in 1971, the General Assembly established a commission to study criminal drug sanctions and changes were enacted into law designed to provide harsh penalties for drug traffickers, but to be more lenient toward users (pp. 99-100). For the past several years, however, the courts have had to deal with an increasing number of minor drug cases. Thus, while local and State enforcement agencies continue to spend considerable time and resources apprehending users, particularly marijuana offenders, the courts in many instances are dealing leniently with all drug users--felons and misdemeanants. This indicates there are inconsistencies between police enforcement and court adjudication of the State's drug laws. Although provided with a variety of alternatives to deal more leniently with drug users, a lack of uniformity also exists among courts and within the same court in using available alternatives.

Court Cases and Variations in Dispositions (pp. 103-115)

Slightly over two-thirds of all drug cases appearing before the courts were for drug possession and only 10% were classified as distribution offenses. Furthermore, two-thirds of all offenses were for violation of the State's marijuana laws, and half of all cases were for possession of marijuana.

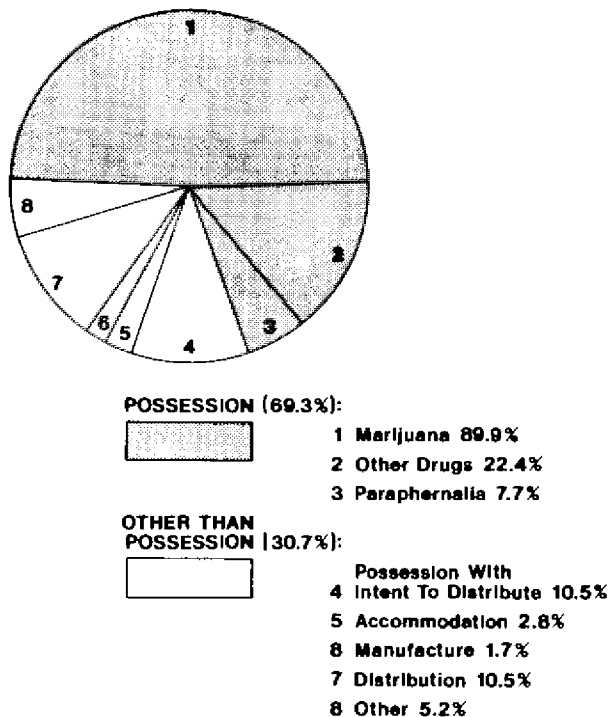
Distribution of court caseload for 1973 and 1974 is shown in the following illustration.

JLARC also found that more than half of all drug cases did not result in convictions. Of those persons who were found guilty and of those sentenced, 61% of the sentences were entirely suspended, and only 14% of all drug cases resulted in incarceration.

Deferred Judgments (pp. 115-130)

The deferred judgment statute permits a judge to dismiss a charge for first time drug possession after successful completion of a probationary period. The offender must have been found guilty. Although many courts are using this statute to deal with first offenders, especially in cases involving simple possession of marijuana, there are noticeable variations in its application. Of the courts that responded to a JLARC survey, approximately two-thirds reported that the statute was being used in first offender cases. Of this group, 79% estimated that it was applied in less than 25 cases. In those areas where the statute has been most frequently used--Northern Virginia, Newport News, Richmond, and Charlottesville--new burdens have been placed on probation officers to provide services to persons granted a deferred judgment. In at least one court, this has resulted in a recommendation not to use the statute. As a first step to insure consistent treatment of first offenders, the statute should be amended to more carefully prescribe the extent of judicial discretion when dealing with first time drug offenders. Also, to reduce

**DISTRIBUTION OF DRUG CASELOAD
BY OFFENSE
1973 - 1974**



Source: Department of State Police: CCRC case dispositions

the burden on the probation system, consideration should be given to placing first time marijuana offenders on unsupervised probation, unless there are compelling or unusual circumstances that warrant otherwise.

Regulation of Marijuana (pp. 30-34, 130-131)

Possession of marijuana has had a significant impact on the activities of law enforcement organizations, courts, and probation. Of the total drug caseload in 1974, about half consisted of simple possession of marijuana violations (p. 106). Although there is an unquestionable need to discourage the use of marijuana, it should be accomplished efficiently and in a manner more consistent with its social consequences and potential harm in relation to other drug abuse. Consideration should be given by the General Assembly to reducing the penalty for possession of small amounts of marijuana (less than one ounce) and substitution of a citation system with a fine. Currently six states and the District of Columbia have taken such action--Alaska, California, Colorado, Maine, Ohio, and Oregon. Reduced penalties have been endorsed by such national organizations as the American Bar Association, the governing board of the American Medical Association, Commissioners on Uniform State Laws, American Public Health Association, and the Council of Churches in addition to the National Commission on Marijuana and Drug Abuse (p. 33).

CORRECTIONS

When JLARC first initiated its review of drug programs in the correctional system they were best characterized as disjointed and lacking leadership and accountability. During the course of this review, however, the JLARC staff noticed a considerable improvement in the department's approach to drug abuse problems. The department is now providing access to treatment and counseling services to drug involved inmates in one institution, conducting drug education and training programs for correctional personnel, has acquired a pharmacist to administer a proposed central pharmacy and has instituted a urine surveillance program in several facilities to monitor illicit drug abuse.

Control of Drugs in Institutions (pp. 140-142)

An important part of the department's drug abuse control activity is the prevention of drug abuse among prisoners. This is accomplished in several ways among which are the control of prescription drugs and the monitoring of drug use. Prompted by indications that the department's procedures regulating the use and handling of prescription drugs was inadequate, JLARC requested the Board of Pharmacy to inspect selected adult institutions and field units. Extensive violations of the State's Drug Control Act were found including unlicensed pharmacies, inadequate procedures for handling and storing drugs, and unregistered nurses involved in prescribing and dispensing medication. Recently the department has hired a pharmacist to establish a central pharmacy in Richmond. Based on initial assessments, this action is viewed as a positive step to improve control over drugs in correctional facilities.

The use of involuntary urine screening can also be an effective way of both detecting and controlling illegal drug use. During September 1974, JLARC requested the department to conduct urine screening among a randomly selected sample of its prison population. Because of personnel changes within the department, JLARC was forced to abandon its request. Beginning in late 1974, however, urine surveillance was initiated at the department's four receiving centers--the State Penitentiary, Powhatan, the Women's Center, and Southampton. By July of this year, the department planned to have procedures for conducting urine screening at five work release centers (p. 142).

Drug Treatment (pp. 135-137)

In July 1974, the department established a drug specific treatment program at its James River Correctional Facility with a capacity of 25 in-patients and 40 out-patients. By April 1975, the program had accepted 10 in-patients while 25 of the out-patient slots were filled. One reason full capacity had not been achieved was the selection process--only highly motivated individuals were being accepted.

In addition to the drug specific program, the department also operates drug general programs (not necessarily aimed at the drug client but toward the emotional disorders of all clients) at the Southampton Correctional Center and the Correctional Center for Women. While the programs appear to be operating successfully, the department needs to conduct an extensive evaluation of these drug treatment programs to determine their effectiveness.

Probation and Parole Drug Teams (pp. 142-146)

The Division of Probation and Parole has used drug teams to provide specialized services to drug involved clients since 1971. Currently there are 11 teams, although a few exist in name only and do not perform the duties expected. The drug team concept has been beset by assorted organizational and administrative difficulties from its inception. The goals, guidelines, and procedures for the original teams were vague. Furthermore, caseloads were high and not composed entirely of drug dependent clients. Originally, an interdisciplinary approach consisting of a probation and parole officer and a vocational rehabilitation counselor was to be used. The agreement between the Departments of Vocational Rehabilitation (DVR) and Corrections has, however, encountered criticism regarding the guidelines under which probation officers and counselors were to operate. JLARC believes that the use of multi-disciplinary drug teams is a logical approach to dealing with the complex problems of drug and alcohol involved clients. The Division of Probation and Parole should expand the membership of the teams to include representatives from other State and local organizations involved in providing services to drug addicts and alcoholics. This is especially important since, under new federal guidelines, DVR may have to withdraw from active team participation.

Drug Training Program (pp.137-140)

In January 1974, the department began a program to provide a maximum of 20 hours of drug training to all personnel who have daily contact with

inmates, plus an additional four hours of instruction each year. The department began this program without requesting additional funds and it has been hampered throughout by a lack of resources. It was originally anticipated that training would be completed by April 1, 1975, however, only the Division of Probation and Parole met this deadline. The Division of Youth Services expects to have all personnel trained by October 1975. The Division of Adult Services had trained 1,375 persons by May 1975, and expects to complete the training by December.

Continued Need for Drug Programs (p. 147)

The drug programs of the department are only a first step in dealing with a sizable drug problem and need to be continually evaluated, improved and expanded where necessary. One major area of concern is the department's heavy reliance on DJCP funds for operating treatment and counseling programs. Because DJCP cannot continue to maintain these programs indefinitely, the department should develop a plan for assuming the costs of the Southampton, Women's Center, and James River Programs and to expand access to such programs. Due to the continuing nature of drug abuse problems among criminal offenders, there is little doubt that drug general and drug specific programs will be needed indefinitely. Greater efforts also need to be encouraged to control illicit drug use in institutions.

TREATMENT

Beginning in 1971 increasingly large sums of federal, State, and local funds have been applied to the State's drug treatment programs. Today, some type of program is available in all areas of the State except the most remote communities, and while not all programs are concerned strictly with drugs, they all represent a major source of help to which drug involved persons may turn.

Program Effectiveness (pp. 169-177)

It appears, however, that many treatment programs--those devoted exclusively to drugs--achieve only marginal success. JLARC carried out a special in-depth study of four of the State's largest treatment programs focusing on program accomplishments. Two principal issues were assessed--are drug abusers becoming gainfully employed, and are they remaining arrest free after leaving treatment? Although some measurable success was found in terms of clients remaining arrest free after leaving treatment, few if any appear to be earning even a subsistence wage (pp. 176-177). This finding seemed to be generally true for all programs regardless of the type of treatment provided.

A key factor contributing to these poor results may be the rapid attrition rate among clients. Few individuals stay in treatment long enough to receive the full extent of counseling services required. A second major problem is the development of employment opportunities. Although most clients come to treatment with some job skill, very few successfully remain employed subsequent to treatment. More attention needs to be given to provide adequate

job development and placement and find employers who will hire former addicts (p. 175). Marginal treatment results may also reflect the inability of treatment efforts to reach the hard core addict. Most clients have a long history of drug involvement often coupled with a criminal record.

These programs, however, are virtually the only means the Commonwealth has of rehabilitating drug dependent individuals. Special attention, therefore, needs to be given to finding ways of keeping clients in treatment longer or developing a new short term treatment methodology. Greater attention should also be placed on determining which individuals are most likely to benefit from treatment in order to most effectively utilize available facilities.

Program Management (pp.162-169)

Some treatment problems can be traced to the fact that all funding agencies have been too lax in their controls. Treatment programs are required to submit quarterly financial reports but to date only three programs have been audited, all within the past few months. Two programs, funded with drug monies, were found to be primarily involved in non-drug related activities during the course of this evaluation.

JLARC staff also found that client files are generally poorly maintained. There is no standardized intake form, and those that are used are not always completed and often lack periodic summaries of client progress. Clearly more control needs to be exerted (p. 163). All funding agencies should (1) adopt a comprehensive set of funding criteria, (2) audit a portion of all programs each year, and (3) regularly monitor and evaluate programs to determine which treatment elements are most effective. The Department of Mental Health and Mental Retardation (MHMR) in particular, should continue to exert leadership in evaluation of treatment program quality. DDAC also needs to continually examine the utilization and impact of treatment programs and although no such evaluations have been completed, DDAC has identified this as a major goal in the current State Plan. At least half of all existing programs are planned to be reviewed by June 1976, yet not more than \$25,000 has been budgeted for this purpose.

Licensing is another means of exercising control over programs, and DDAC is required under the Drug Abuse Office and Treatment Act to plan for the licensing and accreditation of treatment facilities. Responsibility for development of licensing standards rests with MHMR, and although preliminary standards have been developed and public hearings held as early as April, 1973, no programs have yet been licensed. The delay appears to be the result of a conflict over what should be included in the standards. As now written, licensing standards are overburdened with such technicalities as sewage disposal and storage requirements but fail to include many essential elements involved in establishing a minimum level of care such as counselor qualifications and hours of operation.

Confusion also exists in the definition of private facilities for licensing purposes because it is not clear whether programs funded through Chapter 10 Boards, a local health department, or some other arm of local government should be licensed. Furthermore, there may be conflicts with

statutory requirements which give authority to license methadone programs to the Department of Health. MHMR's authority to develop licensing standards needs to be carefully reviewed and ambiguous and overlapping responsibilities should be more clearly defined (p. 167).

In spite of these program deficiencies, Virginia has a much broader range of treatment methods than many other states which began funding programs much earlier. However, all areas of the State do not have equal access to the same types of treatment, nor has there been a systematic attempt to allocate resources to those regions with the greatest need. Richmond, for example, receives over half (57%) of all treatment funds, but has only 12% of the State's out-patient services. Additionally, few resources have been devoted to the treatment of poly-drug abusers. These deficiencies result from failure to establish and enforce priorities and planning in the allocation of drug treatment resources.

PLANNING AND FUNDING

Strong leadership is needed to end proliferation of drug abuse control efforts among State and local agencies and to develop and implement a coordinated statewide drug policy. Weaknesses in the present organization structure have resulted in lack of a definition of the drug problem, few specific priorities, and little control over funding drug programs.

The State Plan (pp.180-183)

The comprehensive State Plan adopted by VDAAC in April, 1975, contains several significant weaknesses. It fails to summarize or integrate existing drug related data (e.g., health crisis reports or drug arrests) into a realistic assessment of the drug abuse problem, and is unable to be used to evaluate the need for existing services, gaps in services, or strategies to provide new services.

An adequate information base (an area in which DDAC has sole authority) is essential for effective planning and management. It had been expected that the Statistical Tracking Retrieval Analysis and Planning (STRAP) information system, being developed by the Bureau of Educational Research of the University of Virginia for DDAC, would be ready for use in the 1975 plan. The client-oriented reporting component, however, is not yet operational, the drug incidence and prevalence surveys have methodological deficiencies, and there are gaps in the state agency information component. The STRAP system appears to have been much too ambitious an initial undertaking given DDAC's limited experience in management information system development and its weak administrative authority.

Grant Review (pp. 183-185)

Grant review is a mechanism for coordinating agency and program requests for State or federal funds and is a primary means of implementing the State Plan. It is, however, complicated by the split authority between VDAAC

and DDAC. The Virginia Drug Abuse Advisory Council has delegated its authority for reviewing grant requests to a grant review committee composed primarily of State agency representatives. While grant review should be a means of implementing priorities set forth in the State Plan, the lack of priorities and agency participation in review means that little coordination occurs and the grants awarded do not reflect a deliberate statement of priorities.

VDAAC and its grant review committee, as a result, have been largely ineffective in evaluating and controlling grant awards. In an effort to achieve consensus among committee members, nearly every grant proposal has been accepted as conforming to the State Plan. This is evidenced by the fact that of the 151 grant applications reviewed by the committee from July, 1972, through March, 1973, 150 were endorsed as being consistent with current State plans even though a plan did not exist until November, 1973.

Funding (pp. 190-192)

The ineffectiveness of the grant review process to control and evaluate spending has serious implications in Virginia where, despite substantial direct and indirect funding by State and local governments, a large proportion of the drug abuse effort is funded by federal money. All federal funding agencies have a policy of reducing their commitment to a program over time so that after a fixed number of years programs no longer receive full federal support and must turn to other funding sources for continuation. In the case of grants received from the National Institute of Drug Abuse (NIDA), this means that Virginia will have to increase funding of treatment programs by \$640,000 during the 1976-78 biennium if these programs are to continue at current capacity (p. 160).

Another federal funding source is through the Law Enforcement Assistance Administration (LEAA). Congress intended LEAA to be an innovator in the area of criminal justice. To accomplish this, LEAA allocates block grants to states to set up demonstration projects with the expectation that successful projects will be taken over by State or local governments. The Division of Justice and Crime Prevention and its policy-making body, the Council on Criminal Justice, administer these funds and originally provided four years of full funding, phased out in incremental steps over the next four years. The Council on Criminal Justice adopted (February, 1975) an accelerated cost assumption policy under which a program receives full funding for only three years, 50% the fourth year, and nothing the fifth. The policy was also made retroactive to July 1, 1973, with the result that it will have its greatest impact during the next biennium (p. 192).

The effect of this change in policy is to place a sudden burden on either State or local governments. JLARC has calculated that it will require approximately \$1,400,000 during the coming biennium to assume DJCP's declining share in drug programs. Moreover, DJCP funds will continue to be used to start additional programs which the State, along with local governments, may have to assume after another three years. The General Assembly should be fully informed of the future cost implication of these policies and a moratorium should be instituted on new programs until all fiscal impacts are clearly resolved.

New Sources of Support (pp. 160-163)

There are two new sources of funds that might be used to offset other declines. Congress recently enacted legislation under the Social Security Act (Title XX) that allows the State greater flexibility in the type of service it may provide under Department of Welfare programs. The Department of Welfare has about \$20 million of unused federal funds which may be applied to such services as drug and alcohol treatment. The department, however, has allotted only \$57,398 for these purposes. Given the rapid decline in DJCP grants for existing drug abuse control programs, JLARC suggests that consideration be given to using a somewhat greater share of these funds to assume drug treatment costs.

Another new source of support is through NIDA. DDAC has about \$380,000 in funds available under Section 409 of the Drug Abuse Office and Treatment Act for use in implementing the State Plan. It has allocated \$110,000 to State agencies and \$270,000 to localities. About two-thirds of the funds committed to local jurisdictions are planned for treatment programs. DDAC will also have an additional \$636,000 from NIDA available next year, some of which will be used to continue programs started this year and some to start new programs. JLARC recommends, however, that as great a part of these funds as possible be used to offset the declining funds available to ongoing programs instead of establishing new programs.

COMBINED AGENCY FOR ALCOHOL AND DRUGS

Initially, this evaluation was not designed to include problems of alcohol use because of its legal status. However, in nearly every aspect of coordination and planning, alcohol abuse could not be avoided, and careful attention was given to an efficient and effective means of organizing the State's response to both drug and alcohol problems.

In 1948, the Bureau of Alcohol Studies and Rehabilitation (BASR) was created as part of the Department of Health, and an in-patient treatment and research program operated by the department was established at the Medical College of Virginia. In 1972, the Department of Health (BASR) was designated as the single state agency for alcohol as prescribed under federal law. BASR is, therefore, responsible for developing and implementing a community based alcoholism plan, including the delivery of client services. Formula grant funds are available from the National Institute of Alcohol Abuse and Alcoholism for planning, implementing, operating, coordinating and evaluating projects concerned with alcohol abuse.

Of prime importance to both DDAC and BASR should be the preparation of a comprehensive plan, establishing goals, objectives, priorities, and needs in control of both legal and illegal drug abuse. JLARC's evaluation of the State drug abuse program has established the need for a strengthened organization. Lack of a single agency with clearly established responsibilities and commensurate authority has been responsible for many existing drug abuse shortcomings (pp. 192-195).

However, the pressing need to provide a carefully coordinated and efficient State response to all drug problems calls for combining the State's drug and alcohol planning functions. The General Assembly should consider establishing a single state agency responsible for planning, coordinating, and controlling all State alcohol and drug programs (pp. 195-198).

Regardless of whether such an agency is established, existing weaknesses in the State's organization for drug abuse control require, at a minimum, statutory changes regarding VDAAC and DDAC. It is imperative that there be only one agency with sufficient authority to coordinate the State's drug abuse control efforts. To that end, the implementation powers of VDAAC should be assigned to DDAC, and the council's role should be limited to consultation and advisement.

INDEX OF KEY ISSUES

ORGANIZATION OF DRUG ABUSE CONTROL	<u>PAGE REFERENCE</u>
Federal Role	
-initial response lacked direction, coordination.	2
State Effort	
-complex organization, overlapping responsibilities	6-11
-15 State agencies spent \$15 million in 74-75; \$37 million since 1970	4, A-1
Conflict in Roles--VDAAC and DDAC	
-federal law requires single state agency	11
-DDAC lacks necessary authority to carry out this responsibility	12
DEFINING THE DRUG PROBLEM	
Incidence, Social Cost, Potential Harm	
-alcohol most widely used and abused.	21, 25-30
-narcotics remain serious problem	21, 25-30
-abuse of legally prescribed drugs.	21, 25-30
Marijuana	
-not harmless, but not as great a hazard to individual or public health.	32-33
-marijuana use does not lead to harder drugs.	32
Elementary and Secondary Students	
-alcohol and marijuana a serious problem.	20-25
EDUCATION	
Teacher Preparation	
-separate certification needed for health and physical education.	42
In-Service Training	
-81% of elementary, and 75% secondary teachers lack awareness training	45
Factual Education Has Not Prevented Drug Abuse	
-may have increased experimentation at lower grades . . .	57-58
-not focused on potential drug abusers.	60-66
Mental Health Education	
-may be effective in teaching decision-making skills. . .	58-60

Lack of Coordinated Response	
-gaps in counseling services	49-52
-lack of statewide program for health services	55
-lack of uniform policies for drug discovery	54

LAW ENFORCEMENT

State Police Drug Arrests	
-70% of statewide arrests for marijuana.	80-81
-60% of marijuana cases involved less than 1 ounce	82
-lack of emphasis on traffickers and dangerous drugs	82
Undercover Operations	
-Appamattox, Salem, Wytheville field offices overstaffed	85-86
ABC Board	
-27% of total arrests for drugs.	87-88
Board of Pharmacy	
-pharmacy break-ins increasing	89
-additional field inspectors needed.	90
Local Law Enforcement	
-marijuana, hashish comprised 77% of arrests	92-94
-inflated arrest statistics.	94

COURTS

Disposition of Drug Cases	
-70% for possession; 63% marijuana-related	106
-possession cases handled more leniently	107
Conviction Rates	
-variations by judicial district	109
-conviction rate for possession of marijuana by 18-25 year olds, higher for those with no prior arrest record	110
Sentencing Patterns	
-extreme variations by district.	112-114
Deferred Judgment Statute	
-not uniformly applied to first offenders.	117-118
-impact on probation and parole.	122
-consider alternative methods of regulating marijuana.	131

CORRECTIONS

Drug Problems Within Institutions	
-expanded diagnostic, referral and treatment services needed	113-134
Dispensing of Prescription Drugs	
-Board of Pharmacy inspection results	140-142

Monitoring Drug Use	
-expanded urine screening program needed	142

TREATMENT FUNDING

Pattern of Funding	
-four agencies fund treatment programs.	149
-decline in federal support	159-160 191-192
Allocation of Funds	
-disproportionate level of funds to Richmond	156-158
-types of service not evenly distributed by region	159
New Sources of Revenue	
-Title XX, DDAC funding	160-162
-Drug overcharge funds	190-191
Management of Treatment Programs	
-lack of adequate client information	163
-insufficient program auditing	165
-lack of evaluation and monitoring	166
-licensing authority must be defined	166-167

TREATMENT EFFECTIVENESS

Client Turnover	
-only 20% remain one year	171-173
-need to reduce attrition rates	173
Program Results	
-25%-56% remained arrest-free	174
-less than 5% remain arrest-free and earn at least \$2,000 per year	176
-focus needed on job development and placement	175

PLANNING AND COORDINATION

Problems in Planning Process	
-lack of problem definition	180
-lack of priorities	183
Grant Review	
-members of VDAAC grant review committee approve their own grants	183
Management Information	
-deficiencies in incidence surveys	186-187
-gaps in State agency reporting	188-189
-local program data not adequate	188
Organization for Alcohol and Drug Abuse	
-need for combined agency for planning and coordination	192-195

FOREWORD

The Joint Legislative Audit and Review Commission became an operating arm of the Virginia General Assembly during 1974. Its primary function is to carry out operational and performance evaluations of State agencies and programs. Each study is designed to assess the extent to which legislative intent is being carried out as well as the effectiveness and efficiency of program activities. This evaluation of Virginia Drug Abuse Control programs is the second staff report prepared for the Commission.

Drug abuse control in the Commonwealth involves a host of federal, State and local agencies, each addressing only a part of the drug problem. For that reason, this study was designed to take a comprehensive view of all types of control functions ranging from education to law enforcement, adjudication and treatment. Special attention, however, was given to the organization of state level planning and coordination; and, this report highlights a number of important organizational concerns.

JLARC policy calls for efforts to keep agencies informed of the progress of our reviews at various stages of the evaluation process. Appropriate agencies are provided a preliminary draft report for comment as part of an extensive data validation process. Because so many agencies play a part in drug programs, the JLARC staff also held meetings with representatives of each organization and discussed functional sections at length. Many revisions were made to the initial draft as a result of those discussions. Some written comments were submitted and they have been included in the Appendix.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided by every agency contacted during this study. Special appreciation is extended to the State Board of Pharmacy for preparation of the audit reports concerning drug handling in correctional institutions and to the Virginia Employment Commission and the Central Criminal Records Exchange for the cooperation extended to complete the drug treatment outcome analysis.

October 14, 1975



Ray D. Pethtel
Director

TABLE OF CONTENTS

SUMMARY	S-1
INDEX OF KEY ISSUES	S-18
FOREWORD	i
I. HISTORY AND ORGANIZATION	
History of Drug Abuse Control	1
VDAAC and DDAC - A Conflict in Roles	11
II. AN OVERVIEW OF THE DRUG PROBLEM	
An Overview of the Drug Problem	15
Potential Harm to the Individual	16
Incidence and Intensity of Drug Use	19
Social Consequences of Drug Abuse	25
The Marijuana Issue	30
III. EDUCATION'S RESPONSE TO DRUG ABUSE	
The Drug Education Program	37
Teacher Preparation	42
Counseling Preparation	49
Policies and Procedures for Drug Discovery in the Schools	54
School Health Services	55
Evaluation of Drug Education	56
Attitudes Toward Drug Education in Virginia	60
Youth Involvement	67
IV. DRUG AND NARCOTICS ENFORCEMENT	
Drug and Narcotic Enforcement	74
Federal Enforcement	75
Virginia State Police	77
Other State Agencies	87
Local Law Enforcement	92
V. ADJUDICATION OF DRUG OFFENDERS	
Adjudication of Drug Offenders	99
Legislation	99
Alternatives to Imprisonment	100
Disposition of Drug Cases	103
Deferred Judgment Statute	115
VI. CORRECTIONS	
Corrections	133
Probation and Parole Drug Teams	142

VII. TREATMENT

Treatment	149
Patterns of Funding	155
Management	162
Program Utilization and Effectiveness	169

VIII. PLANNING AND COORDINATION AND CONTROL

Management of Drug Abuse Control	179
Planning	180
Grant Review: Plan Implementation	183
Information for Effective Planning	185
The Changing Pattern of Financial Support	190
Organization of Alcohol and Drug Abuse Programs	192
Creating a Combined Agency	195

END NOTES	199
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APPENDICES

Technical Appendix by Chapter	A-1
Agency Responses	A-67
JLARC Comments	A-109

HISTORY AND ORGANIZATION

In 1969 there were few State or local organizations directly involved in providing drug prevention or treatment services. Six years later, at least 14 State and several regional and local agencies play some part in the State's drug abuse control program. Most were assigned their responsibilities on a piecemeal basis as the federal government rapidly increased its financial commitment to drug abuse control. With each new federal initiative, a new State agency was created, or new responsibilities assigned to an existing agency. The proliferation of drug abuse control programs has resulted in a loosely structured State effort which does not have clear direction and definition despite the General Assembly's attempt to encourage setting priorities in each area of drug control.

Several important factors impact on Virginia's drug programs including: (1) the prominent role of the federal government in shaping the State's response; (2) a recent federal commitment to decrease drug funds and rely more heavily on the State to formulate policy; (3) the complex nature of Virginia's drug program organization characterized by overlapping agency responsibilities, and (4) the conflicting roles of the Virginia Drug Abuse Advisory Council and the Division of Drug Abuse Control.

This chapter reviews the Commonwealth's drug abuse control efforts from the perspectives of historical development, the federal effort, the State's effort, legislative direction, and organizational responsibility.

I. HISTORY OF DRUG ABUSE CONTROL

The federal government has been the principal architect of drug abuse treatment, enforcement, education, and planning programs. Both the executive and legislative branches have been instrumental over the years in creating special study commissions and developing legislation aimed at controlling the nation's drug abuse problem.

In 1962, the beginning of the modern day drug crisis, President Kennedy summoned a White House Conference in response to increasing drug traffic and abuse. While the conference was concerned with such issues as the scope of drug use and whether it was a federal or state problem it did not resolve them.¹ In 1963 the President's Advisory Commission on Narcotics and Drug Abuse, chaired by Judge E. Barrett Prettyman, issued 25 recommendations which served as the basis for subsequent federal actions. Another study commission in 1967, the President's Commission on Law Enforcement and Administration of Justice: Task Force on Narcotics and Drug Abuse, generally supported the recommendations of the Prettyman Commission including: The need for strengthened law enforcement efforts; adoption of state uniform drug control acts; and, enactment of laws which deal more fairly with less serious drug offenders. At the peak of the drug abuse problem in 1972 and 1973 the National Commission on Marijuana and Drug Abuse presented its findings and recommendations on the widespread use of marijuana and other drugs.²

Federal Legislation

The U. S. Congress has been at work for many years enacting legislation which forged national and state drug policies. As early as 1914 the Harrison Narcotics Act attempted to regulate the possession and sale of opiates. The Marijuana Tax Act of 1937 imposed an excise and transfer tax on marijuana, although it was struck down in 1969 by the Supreme Court because it violated individual rights. As a reaction to public concern over the spread of narcotic addiction among young persons, Congress passed the Boggs Act (1951) which increased penalties for all drug violations. This was the first time federal legislation combined marijuana and narcotic drugs, prescribing uniformly stiff penalties for both.³ In 1956 the Narcotic Control Drug Act made the penalties even stronger.

Since 1960 Congress has reacted to the most serious drug abuse problem in our nation's history. The Drug Abuse Control Amendments of 1965 established a Bureau of Drug Abuse Control within the Food and Drug Administration. Under a reorganization in 1968 this agency was combined with the Federal Bureau of Narcotics to form the Bureau of Narcotics and Dangerous Drugs.⁴ With the increasing number of persons being arrested and convicted of marijuana and narcotics possession and a confusion of penalties, Congress enacted the Comprehensive Drug Abuse Prevention and Control Act of 1970 which reformed criminal penalties for narcotics, dangerous drugs, and marijuana; expanded community assistance programs to include all types of drug dependent persons and drug abusers; and established educational and informational programs.⁵ The same year, the Drug Abuse Education Act was passed establishing a drug education program in the Department of Health, Education, and Welfare.⁶

In conjunction with the 1970 legislation, the National Conference of Commissioners on Uniform State Laws drafted a recommended state act known as the Uniform Controlled Substances Act designed to complement the new federal law. Standards and schedules were established to classify drugs according to their effects.⁷ The last major piece of legislation adopted by Congress was the Drug Abuse Office and Treatment Act of 1972. Its two major features were: to coordinate federal and state drug abuse efforts; and, to provide vast commitments of federal money to develop community-based treatment.

Federal Response to Need for Coordination

Until the early 1960's the drug problem was viewed primarily as a state and local matter. State policy was reflected almost exclusively by the Uniform Narcotic Drug Act, and in the activities of local police department vice squads. There were few state operated treatment programs, no drug education programs, no information programs, no drug abuse agencies, and there was no federal assistance.

By the mid-1960's state and local governments were totally unprepared to provide drug prevention, education, treatment, or training services. The federal government filled this gap and reacted to a growing drug problem by increasing expenditures from \$81.4 million in FY 1969 to \$745 million in FY 1975, an increase of 815%. As stated in the second report of the National Commission on Marijuana and Drug Abuse:

The federal government's initial response was for the most part reflexive. No overall plan of action was formulated; monies and attention were expended on a first come, first served basis. Finally, a program was patched together by setting up divisions within existing departments and agencies, and beefing up already existing programs. The result was that 13 federal agencies, in eight Departments, had piece-meal authority to provide the necessary funds and assistance to the states.

Because federal policy lacked direction and coherence, the funding of programs at state and local levels was a haphazard enterprise. Formula and block grants were distributed to the states without provisions for monitoring and evaluation.⁸

After several years without a coordinated national drug abuse policy, and after encouraging (by making available large sums of money) the widespread proliferation of state and local agencies involved in the provision of prevention and enforcement services, Congress created the Special Action Office for Drug Abuse Prevention (SAODAP) in 1972. This office was to simplify and coordinate the drug abuse activities of 13 federal agencies. SAODAP has been successful in eliminating much of the overlap and duplication that existed prior to its creation, and was phased out on June 30, 1975, with many of its coordinative functions being absorbed by the National Institute on Drug Abuse.⁹

There are four federal agencies that still effect Virginia's drug prevention and enforcement programs.

National Institute of Drug Abuse: NIDA had been a division of the National Institute of Mental Health in HEW. Under a 1973 reorganization, NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and NIMH were brought under one umbrella agency, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). NIDA's principal role as far as the Commonwealth is concerned, is to fund the one State agency designated as responsible for drug program administration and local treatment programs.

Law Enforcement Assistance Administration: LEAA was created in 1968 with passage of the Omnibus Crime Control and Safe Streets Act. It was set up to serve as a funding agency for projects that involve new methods to prevent or reduce crime, or that strengthen law enforcement activities at the community level. Programs related to drug addiction were specifically included. In Virginia, the Council on Criminal Justice and its administrative arm, the Division of Justice and Crime Prevention (DJCP), were established to administer these funds. Approximately one-tenth (about one million dollars) of DJCP's total annual budget is devoted to drug programs.

Drug Enforcement Administration: DEA was formed by President Nixon in 1973 and combines the Bureau of Narcotics and Dangerous Drugs, the Office of Drug Abuse Law Enforcement, the Office of National Narcotics Intelligence, and approximately 500 Customs Bureau officials. The primary responsibilities of DEA are drug traffic prevention, regulation of the legal manufacture of drugs and other controlled substances, and the provision of drug training programs for state and local police forces.

Office of Education: OE has played a relatively minor role in Virginia's drug education program. Under the Drug Abuse Education Act of 1970, the Office of Education provided assistance to the State Department of Education. There is some doubt whether the current federal administration will support the continuation of this program. OE has also provided mini-grants to local communities for drug education training.

Emerging National Trends

After half a decade of increasing involvement in drug abuse control programs, two major trends are emerging which indicate the federal government's desire to reduce its drug prevention commitment. These are:

- A decrease in federal drug abuse program funds; and
- Greater reliance on a single state agency to define the nature and extent of the drug problem and to disburse federal money to program operators.

Evidence to support the first trend is found in the federal drug abuse prevention discretionary budgets. The FY 1975 appropriations for drug abuse prevention were reduced by Congress and another reduction has been requested for FY 1976. Congress, however, increased the amount of money earmarked for drug law enforcement activities for FY 1975. In general, this signifies a congressional intention not to increase the number of available treatment program slots nationally, but to continue strong support of federal drug enforcement efforts.¹⁰

The second trend is the result of Section 409 of the Drug Abuse Office and Treatment Act of 1972. Section 409 provides funds through NIDA to be used by states to create a single state agency to develop drug abuse plans, and to implement them by funding approved drug programs. NIDA is currently providing 409 block grants to DDAC for this purpose.

STATE EFFORT IN DRUG ABUSE CONTROL

As the federal government was rapidly increasing its commitment to drug abuse prevention and treatment, the states were beginning to respond by spreading funds and responsibilities among existing agencies. Virginia was no exception. As with the federal initiative, however, insufficient attention was given to the critical need for defining the nature of the drug abuse problem, establishing realistic priorities, and coordinating the efforts of so many different agencies. As a result, Virginia is now faced with at least 14 agencies each acting independently but having overlapping concerns with drug control. Since these programs have developed without strong coordination and control, Virginia's response to the drug abuse problem can also be characterized as "patched and piece-meal" with corresponding inefficiencies and ineffectiveness.

While precise fiscal data are not available, JLARC estimates that the cost of supporting Virginia's drug abuse treatment, enforcement, and education programs was about \$15 million during 1974-75. This amount excludes costs associated with court proceedings, drug enforcement training, and classroom instruction in drug education. In terms of the impact on the general public, the annual direct cost of drug abuse is approximately \$3.25 per person. Figure 1 shows that nearly all program funds are used to support treatment or enforcement activities, while public expenditures for education and correctional programs comprise a relatively small percentage of drug abuse funds. These figures include federal (39.0%), State (28.7%), and local (32.3%) funds. (See Appendix I for funding by agency.)

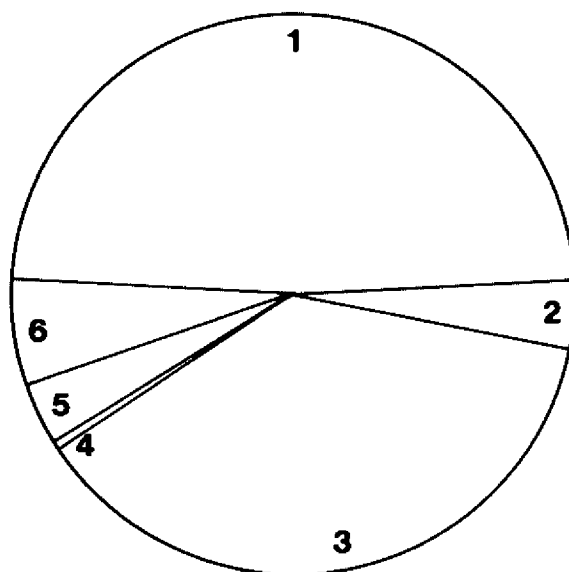
Legislative Action

The General Assembly during the past five years has expressed its views and attempted to encourage or establish priorities and give direction to drug abuse control programs, through legislation and resolution.

In 1970, the legislature enacted the Omnibus Drug Control Act, which tightened regulations controlling the sale of narcotics and controlled drugs, and established different schedules for controlled drugs based on their effects. Based on the recommendations of the Commission on Narcotics and Drug Laws, the 1972 session enacted reformed criminal sanctions for drug violations, reflecting a general nationwide trend at that time to impose stiff penalties for drug traffickers, and to be more lenient towards users, especially experimenters. This action was complemented, by resolution, when the General Assembly directed all law enforcement agencies to expend their major efforts on the most serious drugs and concentrate on drug traffickers.

In the area of education, the 1970 General Assembly, by resolution, encouraged local officials to intensify drug education in the schools. In 1971

Figure 1
**ESTIMATED DISTRIBUTION OF FUNDS
 FOR DRUG ABUSE PROGRAMS
 1974-1975**



1 ENFORCEMENT	\$ 7,209,000	48.5%
2 CORRECTIONS	564,000	3.8%
3 TREATMENT	5,578,000	37.5%
4 EDUCATION	60,000	.4%
5 COORDINATION	531,000	3.6%
6 RESEARCH/OTHER	927,000	6.2%

Source: JLARC, July, 1975

House Joint Resolution No. 15 directed that drug education be taught in elementary and secondary schools, that it be given priority in elementary schools, and that all teachers should receive adequate drug awareness training. In 1972, legislation was enacted requiring that drug instruction be provided by all public schools.

Also in 1972 and 1973 the General Assembly directed the former Department of Welfare and Institutions to study and develop a plan for the treatment of drug addicts within correctional facilities.

Finally, the General Assembly has assumed an active role in the review and study of drug abuse. The General Assembly authorized a Virginia Advisory Legislative Council study to determine the feasibility of combining drug and alcohol abuse control programs under one State agency. More recently, the Senate Committee on Rehabilitation and Social Services and the House Health, Welfare, and Institutions Committee hired two professional staff employees, under a grant from the Citizens Conference on State Legislatures, to assist the committee in studying Virginia's drug and alcohol abuse programs.

Executive Actions

During 1970, former Governor Holton created the Council on Narcotics and Drug Abuse Control. The council and its staff were given responsibility for (1) developing a comprehensive State drug abuse plan, (2) reviewing all grant applications, and (3) serving as a coordinating agency. The council engaged Touche Ross, Inc., a private consulting firm, to assist in establishing objectives, priorities, and direction for a comprehensive drug abuse control program. The report, issued in March 1971, outlined a commendable strategy for a comprehensive drug control plan, and contained several types of recommendations including:

- An approach to coordination of the State's drug agencies;
- Priorities or responsibilities for each major agency involved in treatment, law-enforcement, and education;
- Alternatives to incarceration for drug offenders;
- Combining alcohol and drug coordination efforts in one organization; and
- Developing systematic means to obtain drug use information and continuing evaluation of all programs.

Many of the initial recommendations contained in the report became the basis for subsequent action. However, several key concepts necessary for effective coordination were not adopted, especially the recommendation that alcoholism be included in the overall responsibilities of the Governor's Council on Narcotics and Drug Abuse Control.

In response to the need for an increased number of drug treatment slots and the availability of federal funds, the Council on Criminal Justice, the Department of Mental Health and Mental Retardation and the Department of Health began funding and encouraging the development of locally operated drug treatment programs.

In April of 1970, the State Board of Education passed a resolution encouraging local school officials to increase their efforts in drug education, and the following year the board directed all schools to include drug education as part of the health curriculum.

In 1970, the State Police were charged to expand and strengthen drug law enforcement in coordination with the Council on Narcotics and Drug Abuse Control. In 1971, DSP was authorized to establish a special unit to investigate drug trafficking. The Department of State Police, however, is not the only State law enforcement agency involved in drug investigations. In the early 1970's the Alcoholic Beverage Control Board (ABC), as part of its investigations of alcohol law, reported encountering an increased number of drug violations. In response, the ABC Board began increasing its efforts in the area of drug enforcement and began sending its agents to receive drug training.

During 1971, the Department of Vocational Rehabilitation (DVR) in cooperation with the former Department of Welfare and Institutions implemented a drug education specialist program at four correctional facilities to make inmates and institutional staff more aware of drug problems through education and training. (This program has since been discontinued.) Also, in response to an increased number of drug disabled individuals seeking vocational rehabilitation services, DVR placed drug counselors in its local offices throughout the State.

Later in 1973, the Division of Probation and Parole set about assessing the drug abuse problem among its clients. Drug teams were created in ten probation and parole districts consisting of specially identified drug officers and DVR counselors.

ORGANIZATION FOR DRUG ABUSE CONTROL

Figure 2 shows the many different federal, State, and local agencies involved in drug abuse control by functional relationships. It is clear from the figure that the State's drug abuse control effort is extremely complex with overlapping organizational responsibilities. A general description of State agencies participating in Virginia's drug effort is outlined by major functional areas in the following text and in the same order in which each function is discussed in this evaluation.

Education

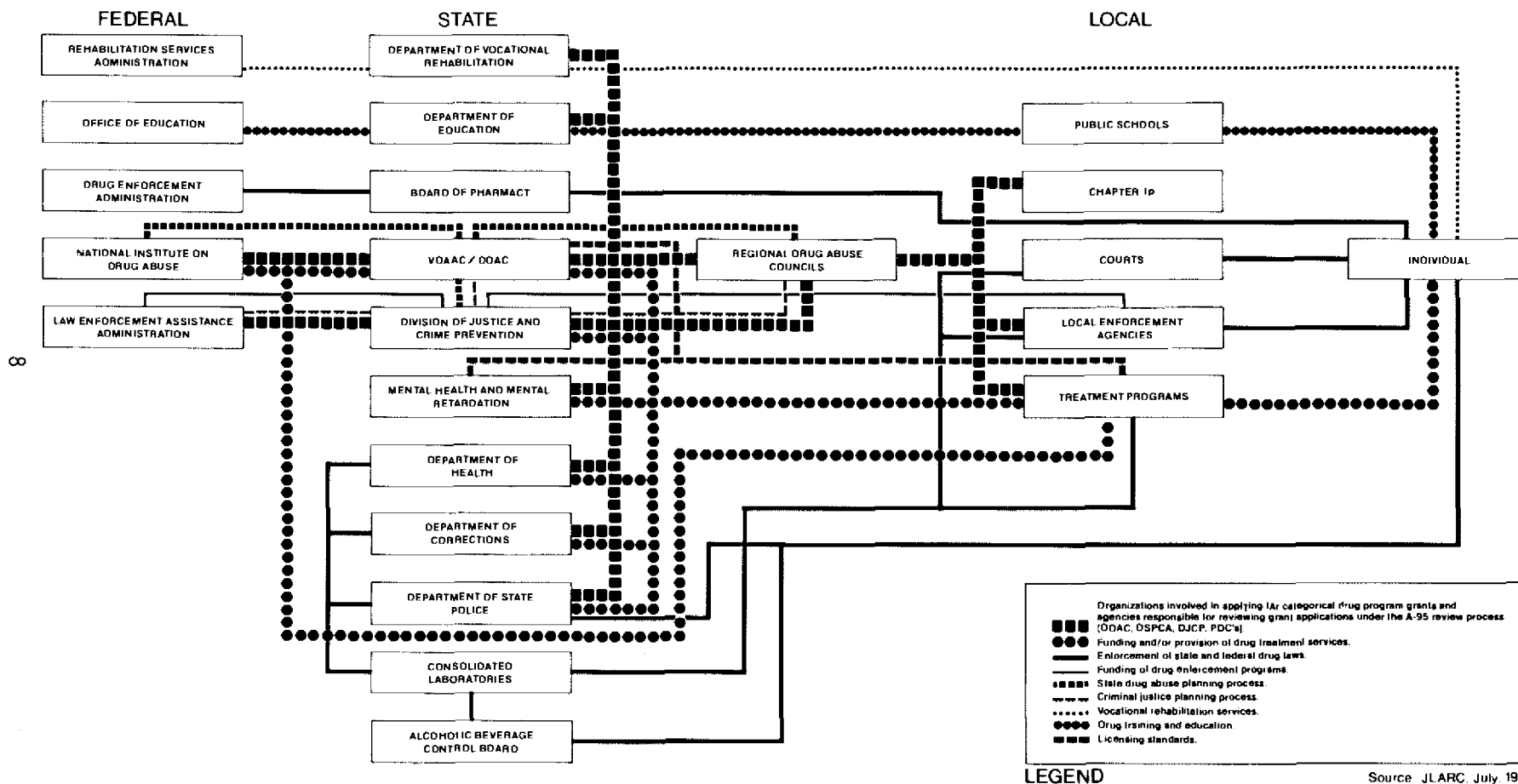
The General Assembly has mandated that instruction shall be given concerning drug abuse by the public schools as prescribed by the State Board of Education. The State Department of Education (SDE) has operated a drug education program since 1970, which has promoted the integration of drug information with the health curriculum. The department has conducted training workshops for teachers, counselors, and administrators, and has recently held conferences for school nurses and youth involvement programs.

The Virginia Community College System (VCCS) has become involved in drug education, offering courses in drug abuse as well as sponsoring regional in-service training programs. The state's colleges and universities provide teacher preparation programs for health and physical education, which may include drug education. These programs must be approved by the State Council of Higher Education.

Enforcement

The Board of Pharmacy is responsible for licensing all pharmacists, pharmacies, drug manufacturers, drug wholesalers, dealers in narcotics and other drugs subject to abuse, and physicians dispensing drugs. It is the only State agency with the power to routinely inspect and investigate individuals and organizations, and has the authority to revoke licenses or impose civil fines for violations of its regulations or the Drug Control Act.

Figure 2
**FUNCTIONAL RELATIONSHIPS OF
 DRUG ABUSE PROGRAMS**



Although not specifically assigned the task of narcotic investigation, the Enforcement Division of the Alcoholic Beverage Control Board (ABC) investigates the illegal sale, transportation, and possession of alcoholic beverages and related violations of the ABC Act. The ABC Board has, however, become increasingly involved in drug investigations during the past four years to the extent that during 1973-74, 27% of all ABC arrests were for drug violations other than alcohol.

The Department of State Police (DSP) is responsible for the enforcement of all criminal laws of the State. The department assists local police in the investigation of drug crimes. Currently, a drug task force, composed of 60 full-time troopers and investigators, is assigned to identify and curtail narcotics and dangerous drug trafficking largely by undercover activities.

The Division of Consolidated Laboratory Services of the health department conducts chemical analysis on all samples of suspected narcotics and dangerous drugs supplied to the laboratory by any police officer in the State. Its representatives testify as expert witnesses in criminal cases in which its services were utilized.

Corrections

Effective July 1, 1974 the corrections function of the Department of Welfare and Institutions was transferred to the Department of Corrections. The department not only provides facilities to incarcerate convicted drug violators but also is beginning to become involved in drug treatment, rehabilitation, and training programs.

A rehabilitation program for former drug abusers was begun as a cooperative effort of the Division of Probation and Parole Services and the Department of Vocational Rehabilitation. Two-man teams of parole officers and DVR counselors were given specialized training in the area of drug abuse. The teams work directly with individuals who have a history of drug abuse.

Treatment and Rehabilitation

The principal source of drug treatment services within the Department of Mental Health and Mental Retardation (MHMR) is the Bureau of Drug Rehabilitation Programs, established in 1972, which funds community-based treatment programs. In addition, MHMR is authorized to provide matching grants to localities for community-based mental health programs. State law permits the department to treat and rehabilitate drug addicts in State hospitals, and also permits local programs to provide services for persons with drug or alcohol abuse problems.

The Department of Health is responsible for licensing any public or private agency which uses methadone in the detoxification of drug addicts. The department may also fund methadone programs. The Bureau of Alcohol Studies and Rehabilitation plans and designs the statewide alcohol program, establishes and maintains 15 community-based alcoholism treatment centers, and administers an in-patient treatment facility at the Medical College of Virginia.

The Department of Vocational Rehabilitation (DVR) operates several drug programs in cooperation with other State agencies and community treatment programs. Drug addiction is considered a disability by the department, and drug addicts are eligible for vocational rehabilitation benefits. DVR has designated nine drug counselors to work primarily with drug and alcohol clients. With the assistance of a DJCP grant, the department placed five drug educational specialists in several correctional facilities in 1972 (the program was terminated in April, 1974). The eligibility requirements for rehabilitation services have recently been revised and DVR participation in drug programs is likely to change in the future.

Planning and Coordination

The Council on Criminal Justice and its administrative arm the Division of Justice and Crime Prevention (DJCP) is one of two state agencies that have planning and coordinating responsibilities related to drug abuse. DJCP has responsibility for developing a comprehensive plan for strengthening and improving law enforcement and administration of criminal justice and has always included drug abuse as part of its plan. To implement the plan DJCP receives federal monies from LEAA.

The agency which has official administrative responsibility for planning and coordinating the State's drug abuse effort is the Division of Drug Abuse Control (DDAC), of the Virginia Drug Abuse Advisory Council (VDAAC). The division is primarily responsible for developing the comprehensive State Plan for council approval, providing staff review of grant applications, coordinating agency programs, and disseminating public information.

Since FY 1973 the division has experienced a dramatic increase in appropriated funds, mostly from federal sources. This trend is expected to continue because of the federal government's desire to provide responsible state agencies with more policy and decision-making responsibilities (Table 1).

Table 1

FUNDS AVAILABLE FOR DDAC

<u>Source of Funds</u>	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>	<u>1975-76</u>
General Funds	\$ 43,005	\$ 46,630	\$ 206,320	\$ 212,680
Federal Funds	<u>129,015</u>	<u>133,890</u>	<u>3,201,735</u>	<u>3,383,950</u>
Total	\$172,020	\$180,520	\$3,408,055	\$3,596,630

Note: Excludes \$342,093 in DJCP funds awarded since 1972.

Source: Commonwealth of Virginia, *Budget July 1, 1974-June 30, 1976*, and Chapter 681, *An Act to Appropriate the Public Revenues*, approved April 8, 1974.

The Virginia Drug Abuse Advisory Council (VDAAC) consists of 27 members including representatives of 17 state agencies and 10 at-large members appointed by the Governor. The current chairman is the Secretary of Human Affairs and the Attorney General is vice-chairman. The executive director of VDAAC also serves as director of the division.

The council is authorized to investigate the drug abuse problem in the Commonwealth; survey the present resources for solving drug problems; and assess all social, economic, and psychological factors which contribute to drug abuse. The council, in cooperation with the Council on Criminal Justice, is directed to formulate a comprehensive plan to prevent and control drug abuse. VDAAC is also directed to review all applications for State and federal funds or services to be used in drug abuse control programs. Finally, the council serves as the planning and coordinating body for all drug abuse control programs.

According to division guidelines, regional Drug Abuse Control Councils (DACCs) are established to plan, coordinate, and provide technical assistance to local programs within their regions, as well as to review and comment on regional grant applications. Most of the regional DACCs are advisory councils or committees of a Planning District Commission.

There were 12 regional DACCs as of January 1, 1975--most of which appear to be well staffed. Funding patterns vary, with some regional DACCs receiving substantially greater local support than others. The most frequent funding pattern is 90% federal, 5% State, and 5% local. Total regional budgets for 1974-75 ranged from \$20,000 in the Newport News-Hampton area, to \$74,000 in the Norfolk area. Beginning with FY 1976, the regional organizations will probably be funded by DDAC with funds provided by Section 409 of the Drug Office and Treatment Act. DDAC is presently assessing the future role of the regional groups as part of the statewide planning process and the usefulness of maintaining 12 regional drug abuse councils.

VDAAC AND DDAC - A CONFLICT IN ROLES

According to the Drug Abuse Office and Treatment Act of 1972, (PL 92-255), any state desiring to receive drug grants must:

Designate or establish a single state agency as the sole agency for the preparation and administration of the plan, or for supervising the preparation and administration of the plan.

The law also specifies that a state advisory council is to be established to include representatives of "nongovernmental organizations or groups, and of public agencies concerned with the prevention and treatment of drug abuse and drug dependency." This council is to be only advisory and is to, "consult with the State agency in carrying out the plan."

Furthermore, according to federal regulations, the State Plan must contain documentary evidence of the designation or establishment of a single state agency. In this regard, Governor Holton designated DDAC as Virginia's single state agency in March 1973, and Virginia's plan notes that DDAC, "is

designated, as required in Public Law 92-255 and its regulations, as Virginia's single state agency for drug abuse control." Under Virginia law, however, the division which was created prior to passage of PL 92-255, was established to serve as the "administrative arm of the council."

Thus while DDAC is officially designated as the single state agency, it is actually the council which has the policy-making and priority setting authority to coordinate the State's drug abuse effort. VDAAC, however, is composed of the same agencies which are responsible for implementing drug abuse programs. As a result, these agencies have set their own priorities, often without adequate regard to either the State's limited resources or the nature of Virginia's drug abuse problem. This has resulted in a fragmented approach to drug abuse control with conflicting priorities, some in apparent contradiction to legislative intent.

The Attorney General concluded in a letter to the Director of DDAC, that "the Division of Drug Abuse Control, as the administrative arm of the Virginia Drug Abuse Advisory Council, has the necessary legal authority to carry out the requirements specified in the Drug Abuse Office and Treatment Act and the regulations promulgated thereunder." Compliance with federal law, however, requires VDAAC be relieved of its policy-making responsibilities. In fact, NIDA withheld approval of DDAC's 1973 plan, completed in November of that year, until assurances were provided by the Secretary of Human Affairs that appropriate legislative action would be introduced during the 1975 session of the General Assembly.

While draft legislation was submitted to NIDA and verbal approval regarding compliance was given by NIDA to DDAC shortly after the beginning of the 1975 General Assembly session, DDAC requested and received approval to delay introduction of the legislation until 1976.

The General Assembly, in the 1974 Appropriations Act, recognized there was a need to better coordinate drug program expenditures, and specified that,

*No State agency shall expend any public funds
for purposes of narcotic and drug abuse control
without the prior written approval of the Governor.*

This authority was delegated to DDAC by a memorandum in November, 1974, from the Secretary of Human Affairs, which outlined specific procedures to insure that the division would have the power to effectively coordinate drug programs. First, agency budget requests for drug activity are to be reviewed by DDAC and the Division of the Budget to insure they are in accordance with the State Plan. (This requirement has not been complied with to date. Furthermore, DDAC's State Plan must first be adopted by VDAAC before it can be used as an official planning document, further diluting DDAC's authority). Second, no grantor agency in the State may take final action on any drug abuse grant until it has been reviewed by DDAC.

The intention of the Secretary's memorandum was to provide DDAC with authority to coordinate all budget requests and grant applications with the State Plan as required by the Appropriations Act. It was because of this action

that NIDA was willing to grant temporary approval for the State to continue operating under current statute. The division, in May, 1975, drafted a letter to the Division of the Budget outlining procedures for implementing the Secretary's memorandum. However, no change has been made in the grant approval process.

Today, the division, although designated as Virginia's single state agency for drug abuse, still lacks the necessary authority to effectively carry out its responsibility.

CONCLUSION

The primary direction for drug abuse control has been provided by the federal government and the State has followed this initiative by spreading funds and responsibilities among existing agencies. As a result Virginia is faced with a complex drug abuse program organization. Additionally the federal government has now committed itself to reduce its support for drug abuse control and to give states increased responsibilities.

JLARC assigned its staff to this evaluation at this time because of the continuing and serious nature of drug abuse. The State's drug abuse control programs are in many instances five years old now and although much has been accomplished it is time to review their progress to see if they are adhering to legislative intent. Furthermore, this review is especially timely in view of increased public concern about drug abuse.

The balance of this report assesses Virginia's drug abuse problem and then examines the specific program areas of education, enforcement, and treatment. The report concludes with a critical assessment of planning, coordination, and control, and discusses organizational adjustments that should be considered to insure that drug abuse is addressed in the most effective manner in the future.

AN OVERVIEW OF THE DRUG PROBLEM

Although the Commonwealth has recognized the existence of continued and serious drug usage and responded with a high level of public expenditures, the State's drug problem has not been clearly defined. This chapter discusses a number of indicators that can be used to identify major drug problems and establish priorities for statewide drug abuse control activities in treatment, law enforcement, and education.

The State's drug problem is assessed from three viewpoints: (1) potential harm to the individual user; (2) social consequences or costs to the public resulting from abuse; and (3) incidence and frequency of use.

Based on current measures and information, alcohol must be recognized as the most widely used and abused drug in Virginia -- even though its use is legal. Marijuana, although an illicit drug, is the second most prevalent drug. Its use, however, has few demonstrated social costs -- such as drug related crimes, highway fatalities, or health crises -- and current research suggests that its occasional use does not present as great a health hazard as the abuse or use of many other commonly available substances.

Narcotics abuse remains a serious problem according to all measures, and may be on the increase as is the abuse of many legally prescribed drugs.

Finally among the school-age population, the use of all drugs including alcohol, has reached alarming proportions and the abuse of drugs by school aged persons should be given high public concern and attention.

11. AN OVERVIEW OF THE DRUG PROBLEM

The social use of drugs is not new to society, and some substances which are now commonly accepted were once viewed with moral outrage. In the United States, each generation seems to have had a drug subculture, which has often attracted a youth following. The Bohemian movement of the late 19th century was criticized for its use of alcohol and coffee, while many residents of Greenwich Village during the 1920's were viewed as outcasts for using alcohol and tobacco.¹¹ The development of a subculture during the 1960's was also associated with heavy use of drugs. And, because of improved medical technology, widespread use of patent prescription drugs for physical and psychological ills, and improved transportation, communication, and affluence, drug use became more prevalent at all levels of society.

The use of drugs in Virginia seems to have followed the national pattern. While there is no reason to assume that drug use is any more or less extensive than in other states there remains a serious and continuing problem which cannot be ignored. For example:

- At least 33,000 people can be identified as using prescription drugs for non-medical reasons;
- Drug usage among elementary and intermediate level school children is reported to be increasing;
- An estimated 40% of the State's senior high school students report that several or most of their friends "turn on" with drugs; and
- Over half of all convicted felons committed to the State's correctional institutions during 1974 had a known history of drug use or heavy drinking.

In an effort to address these problems the federal, State, and local governments have expended a minimum of \$37 million in the Commonwealth since 1970 for drug abuse control.

Defining the Problem

Despite the existence of continued and serious drug usage, and a high level of public expenditures, Virginia has not yet defined the problem that must be dealt with. In fact, the current State Plan for drug abuse control does not define either the term "drug abuse" or the nature of the Commonwealth's drug problem. In 1973, the National Commission on Marijuana and Drug Abuse decided that it was no longer functional to talk about "drug abuse" since the term had become a "code word for that drug use which is ... considered wrong." However, lack of definition, especially in a state without coordinated drug programs and in which there are numerous participating agencies can result in multiple definitions and either misdirected or conflicting program priorities. Thus, even though definition of the term may be controversial and may have highly emotional overtones, JLARC has defined drug abuse as:

The intentional use of any illicit or illegally obtained drug, or the non-medical use of any mood altering substance which has a harmful affect on an individual's capacity to function effectively.

To use this definition for working purposes further distinctions need to be made. Thus, drug abuse can be functionally defined to include:

- The use of any illegal drug such as heroin, marijuana, or cocaine;
- The excessive use of legally prescribed or legally available drugs or substances which are potentially harmful such as barbiturates, tranquilizers, amphetamines, or alcohol; or
- The use of prescription drugs for any reason other than the purpose prescribed.

Because drug abuse is generally clandestine, accurate information regarding its nature and extent is difficult to quantify. There are, however, several available indicators that, when used collectively, may provide a coherent overview of the drug problem and assist in developing drug control priorities. These include, (1) the potential harm to the individual, (2) the incidence and intensity of drug use among the general and school age populations, and (3) the social costs associated with drug abuse. It is important to note that priorities must be set based on a combination of these indicators. For example, the widespread use of a drug with little social consequence or potential harm to the individual (such as the occasional use of a tranquilizer to aid sleep) demands few public resources. On the other hand, any use of drugs that results in significant social consequences and holds great potential harm for the individual (such as heroin and methamphetamine) commands a high level of public concern.

POTENTIAL HARM TO THE INDIVIDUAL

The first aspect of drug use necessary to define the State's drug problem is the potentially harmful effects associated with abuse. This section reviews the major legal and illegal drugs in terms of their harmful effects and potential for addiction. Three important terms are used: tolerance, or the need to use increasing dosage levels to obtain the desired effect; psychological dependence; and physical dependence, or bio-chemical changes in the body which compel continued drug use. (See Appendix II for selected demographic characteristics of drug users and a detailed informational chart on each drug, reprinted from the Drug Enforcement Administration's publication, *Drugs of Abuse*.)

Depressants

Alcohol is the most widely used and by all indications the most widely abused drug in society. If used occasionally and in moderation, there are few undesirable side effects. The potential for harm, however, both mental and physical, makes this one of society's most dangerous drugs. The history of alcohol regulation, including its one-time national prohibition, is common knowledge but its medical effects are less widely understood.

Alcohol is a central nervous system depressant and at moderate consumption levels serves as a relaxant and increases sociability. Continued use can produce intoxication and tolerance, as well as psychological and physical addiction. The symptoms of alcohol use can range from drowsiness, belligerence, depression or euphoria to impairment of coordination and restricted reflexes; the effects of extended use can include serious malnutrition, neurological, and gastrointestinal damage. There are 148,500 regular or heavy users of liquor and 269,600 regular or heavy users of beer or wine. Of these, there are an estimated 122,000 alcoholics.¹²

Barbiturates such as phenobarbital and seconal are central nervous system depressants, medically prescribed to induce sleep or produce a calming effect. Drunkenness, similar to the effects of alcohol, can occur at higher dosage levels. Physical dependence does not usually occur at the clinical dosage level, although psychological dependence can develop at any level. Continued use of high dosages can result in tolerance and physical dependence. Withdrawal from addiction is considered more dangerous than for opiates and can include convulsions, deliriums, and psychosis, requiring close medical supervision. Barbiturates are extremely dangerous in combination with alcohol, often leading to accidental poisoning or death.

Non-Barbiturate Sedative/Hypnotics, including antihistamines, scopolamine, and various commercial sleeping pills, have substantially the same properties as barbiturates. Physical addiction only occurs at much higher than prescribed dosage levels. Withdrawal symptoms, however, are just as serious as with barbiturates. The sedative/hypnotics are used to induce drowsiness, sleep, and reduce nervous tension.

Tranquilizers: Minor tranquilizers such as librium, valium, and miltown, reduce anxiety and nervous tension. Physical dependence occurs at much higher than prescribed dosage levels, and withdrawal symptoms are similar to the barbiturates and sedative/hypnotics. Major tranquilizers, such as mellaril, serpasil, thorazine, and stelazine, are used in the clinical treatment of psychotics to reduce panic, fear, hostility, and agitation, while helping to regulate thinking and control disorganized behavior. On the other hand, they can cause impairment of the mental and physical skills required to perform coordinated tasks like driving.

Solvents and Inhalants include several highly volatile compounds which are extremely soluble in human tissue. These substances include:

Coal tar derivatives: Lacquers, paint thinners and removers, and quick drying glue and cement; kerosene and other petroleum products; lighter and cleaning fluids; and nail polish remover.

Freon gases: a group of halogenated hydrocarbons commonly used as aerosol and refrigerant gases.

Nitrous oxides: derivatives of nitric acid, some of which have anesthetic qualities.

Solvents and inhalants are depressants, similar to alcohol and barbiturates. At low levels of use they produce mood elevation, mild euphoria, sociability, and a lessening of inhibitions. Increased use can produce

dizziness, blurred vision, slurred speech, and impairment of motor coordination. Death from overdose can occur through respiratory or cardiac arrest. Any abuse of inhalants is dangerous because the dosage level cannot be controlled.

Stimulants

Methamphetamine (methadrine) is a potent central nervous system stimulant. It may be prescribed for the control of appetite, reduction of mild symptoms of mental depression, and to maintain blood pressure in anesthetized patients. The primary use of methamphetamine, however, is non-medical, by habitual high-dosage addicts who commonly inject it for its euphoric effect. Tolerance and psychological dependency occur; and continued abuse leads to psychosis, loss of memory or concentration, and violent behavior. The injection of methamphetamines is regarded by numerous authorities as the most dangerous of all drugs because of the severe consequences of its abuse.

Cocaine is an alkaloid contained in the leaves of the coca bush, grown largely in Bolivia, Peru, and Java. The white crystalline powder is usually sniffed (but can also be injected) to produce a stimulating effect and feelings of mental and physical prowess. No tolerance or physical dependence have been documented. Sustained use, however, can produce psychological dependence, hyperstimulation, convulsions, paranoia, and death. Cocaine was once used as an anesthetic: Freud prescribed it for the treatment of nervous conditions. Today cocaine has been replaced by other non-toxic local anesthetics for medical use.

Amphetamines including benzedrine and dexedrine, are stimulants which produce increased alertness, confidence, and a sense of well-being. Although physical dependence has not been demonstrated, continued use may lead to tolerance and psychological dependence, as well as psychotic reactions with paranoid delusions. Withdrawal symptoms include chronic fatigue.

Diet Pills include an amphetamine like substance, alone or in combination with a depressant. While the diet pills reduce appetite, the depressant counteracts any overstimulation which might occur. The effectiveness of diet pills for weight control is being questioned by many medical researchers.

Antidepressants have replaced amphetamines in the clinical treatment of depression. These substances can have undesirable side effects especially if used in combination with alcohol or other drugs. Tolerance and physical dependency have not yet been documented.

Narcotics

Heroin is a highly addictive white crystalline powder synthesized from morphine. It was first produced in 1898 as a non-addictive substitute for morphine or codeine but clinical experience proved that it was at least twice as powerful as morphine. Tolerance and physical dependence develop rapidly, and heroin addicts require increasingly greater amounts to satisfy their need.

Although a number of deaths due to heroin overdose have been reported, there is now some doubt whether death was specifically caused by heroin. It may be more technically correct to refer to these deaths as the result of an acute reaction to the injection of heroin by a person already drunk from alcohol or barbiturates.

Controlled narcotics other than heroin include both natural and synthetic narcotics such as opium, morphine and codeine, methadone, and meperidine (Demerol). Controlled narcotics produce euphoria and reduce pain. Tolerance, as well as psychological and physical dependence, all develop rapidly within a therapeutic range.

Non-controlled narcotics and prescription non-narcotic analgesics produce euphoria and reduce pain. These substances can lead to physical dependency, although not at normal therapeutic levels. The drug user is either required to register the purchase, as in the case of codeine-based cough syrups, or a prescription is required, as in the case of Darvon or Talwin.

Hallucinogens

There are several natural and synthetic psychodelic substances, such as psilocybin, mescaline, DMT, STP, and LSD which have no common medical use but are consumed to produce a mind-distorting experience.

LSD (D-lysergic acid diethylamide) is the most widely popularized hallucinogen and is a derivative of a fungus that grows on rye and other cereals. It was discovered accidentally in 1943, and is easily manufactured. The effects of LSD, including distortions of perception and hallucination, last from eight to twelve hours but recurring hallucinations without drug use have been reported up to a year later. Tolerance to LSD develops, and psychological dependence is possible.

Marijuana

Marijuana includes various preparations of cannabis sativa, a hemp plant which grows in mild climates throughout the world. The marijuana compound used as a drug is prepared by drying the leaves and flowering tops of the plant (containing the active ingredient tetrahydrocannabinol). Hashish is produced by drying the resin of the plant, which is richer in cannabinoids than the leaves and tops. Marijuana has been described as a "euphoriant" which produces a mild state of intoxication, hilarity and sociability. The great majority of marijuana users smoke the drug in cigarette form or in pipes. Because the State devotes considerable manpower and resources to suppress marijuana use, its history and known health effects are discussed in greater detail later in this chapter.

INCIDENCE AND INTENSITY OF DRUG USE

A second measure used to determine the nature of the drug problem is the frequency and extent of drug use. As a result of the lack of incidence

data during the 1960's, many states were encouraged by the federal government to conduct incidence and prevalence (I&P) studies to measure the scope of the problem. These studies have helped to determine:

- Number of users by type of drug,
- Frequency of drug use,
- Demographic characteristics of drug users,
- Attitudes towards drug use and related issues, and
- Location of serious drug abuse.

New York was one of the first states to complete an I&P study in June, 1971. Eleven other states carried out comparable studies by contracting with Resource Planning Corporation, a Washington, D.C. consulting firm, specializing in drug incidence survey research. Virginia elected to carry out its I&P study through a contract with the Bureau of Educational Research, University of Virginia, and because a different survey methodology was used, the results of the Virginia study cannot be compared with other states. Despite these differences, it appears that Virginia's drug problem is not substantially different from other states relative to its population.¹³

Number of Users by Type of Drug in Virginia

Figure 3 illustrates the pattern of drug use. Alcohol is by far the most widely used drug among the general population, and marijuana is the most widely used illegal drug, estimated to be used currently by just over five percent of the Commonwealth's population over age twelve.

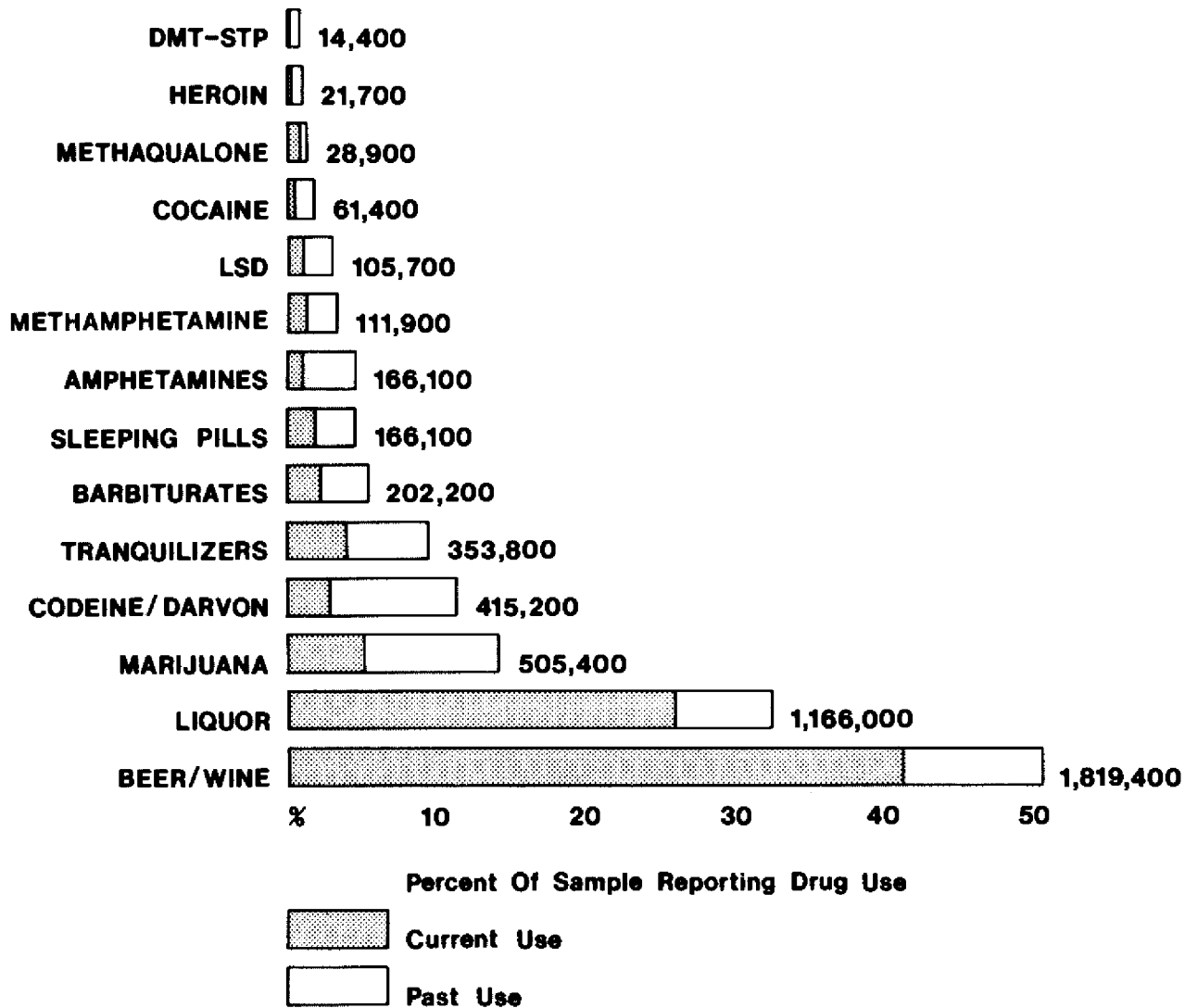
Because many of the other drugs shown have medical uses, a more specific indicator of potential abuse is the extent to which they are used for non-medical reasons. As detailed in Table 2, it is clear there is extensive abuse of prescription drugs including tranquilizers, codeine, barbiturates, and amphetamines.

While some drugs, such as alcohol or tranquilizers, may not constitute a serious hazard when taken occasionally, the heavy or regular use of such substances does constitute a potential for abuse. Table 2 shows that the heavy or regular use of beer, wine, liquor, and some prescription drugs also present a potential danger for abuse. In fact, the extent of abuse of prescription drugs, because of their ready availability may reach the level of regular use of marijuana. This is especially significant in view of the popular conception of drug abuse as largely confined to heroin and marijuana.

Drug Use Among Students

An important factor contributing to understanding the extent of Virginia's drug problem is the widespread and increasing use of drugs by elementary and secondary students. Two sources of information are used for this purpose. First, an annual survey of principals has been conducted by the State Department of Education since the 1970-71 school year. Second, JLARC's Drug Education Survey administered to 1,227 tenth, eleventh, and twelfth grade students in December, 1974 included a scale to assess drug incidence. (See Appendix III for discussion of survey methodology.)

Figure 3
PATTERNS OF DRUG USE
IN VIRGINIA



Note: Sample includes 2503 interviews, late summer and fall, 1973.
 Numbers shown are the estimated total of past and current drug users in Virginia.

Source: Virginia Statewide Drug Abuse Survey: Summary Report, 1974.

Table 2

ESTIMATED INCIDENCE OF DRUG USAGE
(Current Users)

Type of Drug	Number of Non-Medical Users	Number of Heavy or Regular Users
Non-Prescription Drugs ^a		
Beer, Wine	1,480,100	269,600
Liquor	956,700	148,500
Marijuana	187,700	72,100
Hallucinogens	21,700	1,400
Cocaine	10,800	1,400
Heroin-opiates	3,600	2,900
Prescription Drugs ^b		
Tranquilizers	33,200	57,700
Methamphetamine (Speed)	28,900	11,500
Methaqualone	18,100	2,900
Codeine-Darvon	17,300	27,400
Barbiturates	17,300	21,600
Sleeping Pills	18,000	10,100
Amphetamines	13,000	4,300

^aAll use of these drugs is non-medical.

^bRegular or heavy use of prescription drugs may include medical use.

Source: Virginia Division of Drug Abuse Control, *Virginia Statewide Drug Abuse Survey: Summary Report*, (Richmond, 1974).

Principals' Perceptions: Table 3 shows how principals perceive drug use by type of drug, categorized by elementary, intermediate, and senior high school. The use of both alcohol and marijuana has increased rapidly at all three levels during the three year period, while the use of heroin appears to have declined. Although there are no consistent trends for other drugs, there is widespread use of amphetamines and barbiturates with the most frequent use occurring in the senior high schools. Special concern, however, must be shown for the sharp increase in drug use at elementary and intermediate schools. In fact, the use of marijuana, amphetamines, and barbiturates in intermediate schools is beginning to reach the proportions found in senior high schools.

The departmental survey also requested principals to indicate the seriousness of the drug problem in their school, and the responses are summarized in Table 4. The number of senior high schools reporting "no problem" declined steadily during this period, while the number reporting a "serious" problem increased. A similar trend is evident at the intermediate level, but with a much sharper decrease in the number of principals reporting "no problem". This corresponds to the increase in alcohol and marijuana use noted earlier.

Table 3

PERCENT OF SCHOOLS REPORTING DRUG USE
(Principals' Perception, by Academic Year)

Type of Drug	Elementary			Intermediate			Senior High		
	1972	1973	1974	1972	1973	1974	1972	1973	1974
Alcohol	1%	4%	9%	22%	53%	62%	43%	76%	81%
Marijuana	2	6	7	34	74	91	52	93	94
Amphetamines	-	3	2	17	22	26	28	47	34
Barbiturates	-	2	2	19	26	21	23	38	28
Volatile Substances	1	5	4	11	25	19	5	15	5
Hallucinogens	-	-	-	6	7	4	11	11	7
Heroin	-	-	-	1	1	-	6	1	1

Note: A change of wording in the 1973-74 Principals' Survey may account for part of the increase in perceived drug use between 1973 and 1974.

Source: State Department of Education, Principals' Survey, years cited.

Table 4

SERIOUSNESS OF DRUG PROBLEM IN VIRGINIA'S PUBLIC SCHOOLS
(Principals' Perceptions, by Academic Year)

Seriousness	Elementary			Intermediate			Senior High		
	1972	1973	1974	1972	1973	1974	1972	1973	1974
No Problem	94%	89%	87%	33%	16%	4%	19%	8%	3%
Limited Experimental	6	10	13	48	56	88	42	36	76
Problem, Not Serious	0	1	-	17	25	-	29	43	-
Serious	0	0	0	3	3	8	10	13	21

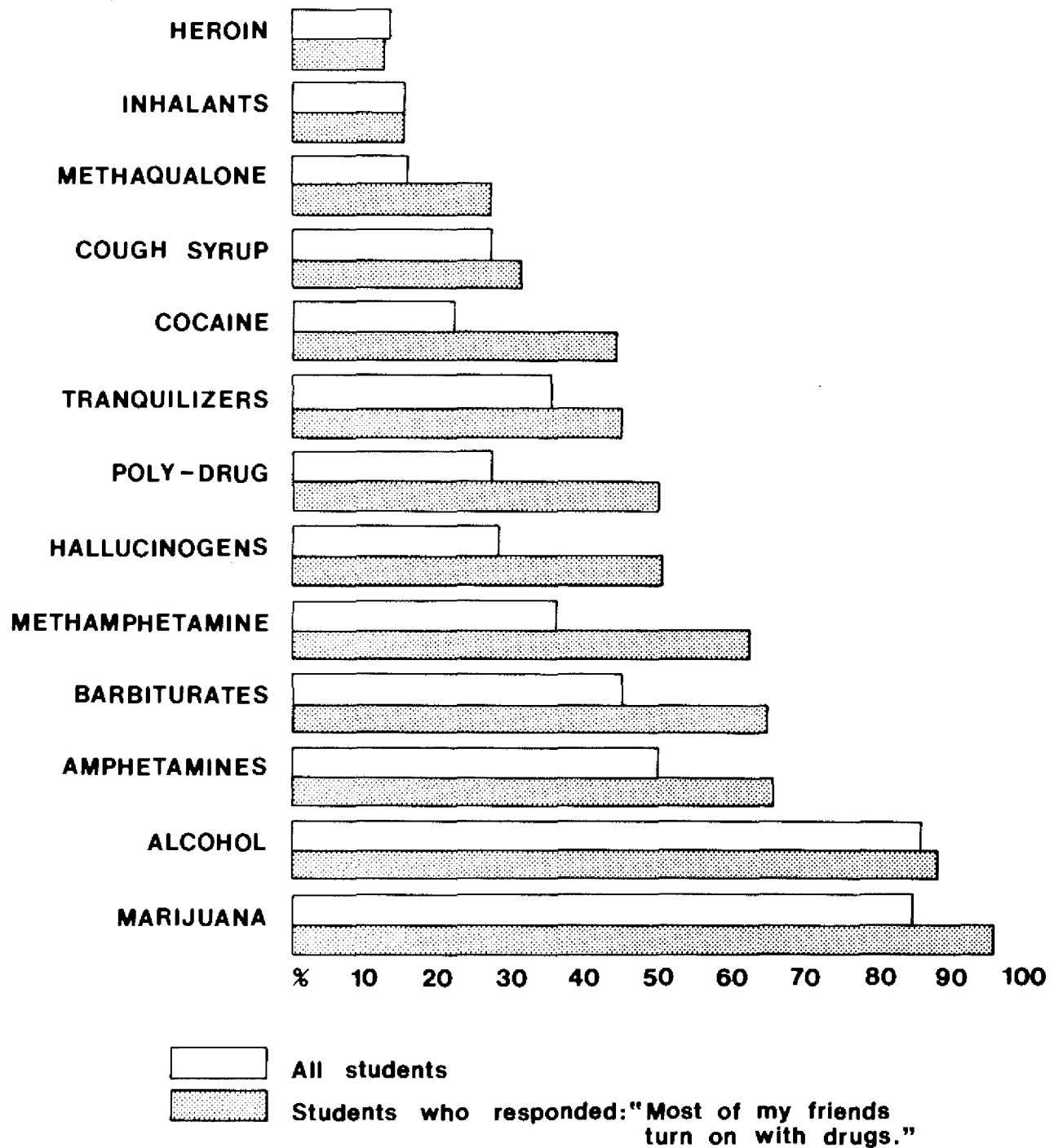
Note: Scale used in 1974 did not include "Problem, Not Serious."

Source: State Department of Education, Principals' Survey, years cited.

Student Perceptions: Students were asked in a JLARC survey how many of their friends "turned on with drugs," and over 40% responded that several or most of their friends did so. This is an important finding, because many studies have established a positive relationship between peer group and individual drug use, and these students are probably not only more aware of drug use but constitute a substantial group of potential drug abusers.

The JLARC incidence scale, when tabulated by levels of peer group drug use, showed that those students whose friends used drugs tended to see higher levels of use. The results of this analysis are illustrated for each drug in Figure 4. (It is important to recognize that Figure 4 does not represent incidence of drug use, rather the way in which students perceive its use.) The use of marijuana, amphetamines, barbiturates, methamphetamine,

Figure 4
**PERCENT OF STUDENTS REPORTING
 OCCASIONAL OR HABITUAL USE OF
 DRUGS IN THEIR SCHOOL**



Source: JLARC Student Survey, December, 1974.

poly-drug, hallucinogens, cocaine, and methaqualone is more widely reported within the context of the drug aware peer group than among the general student population.

Among students there is also a small but disturbing number of known addicts. Evidence of this is provided by the Department of Education's Principals' Survey. During 1972-73, 66 schools reported a total of 272 student addicts. Of the total schools, 53 were senior high schools, 12 intermediate schools, and one elementary school.

Student Attitudes: The JLARC survey also asked students to characterize the seriousness of drug use. Approximately three-fourths of the respondents reported that drug abuse in their school was "a problem, but not serious" and, moreover, tended to report experimental or occasional drug use. JLARC compared these perceptions of the seriousness of drug use with perceived frequency. This indicator, illustrated in Figure 5, shows that student perception of the seriousness of the problem depends on the type of drug and the level of use. The habitual use of any drug was viewed by students as a "serious problem," while the occasional use of alcohol and the experimental use of marijuana was not considered to be a problem. Alternatively, any type of heroin use was seen as "serious."¹⁴

Availability of Heroin

The number of drug samples tested by the Department of Health's Consolidated Laboratories not only partially reflects incidence, but the analysis of heroin is an indicator of supply and intensity of use. When heroin is plentiful its level of purity rises--when it is scarce, dealers reduce purity in an effort to increase supply.

Consolidated Laboratories reported that during early 1974 the purity of heroin samples was approximately 2% or less. At the same time supplies of white heroin from the Middle East decreased and brown Mexican heroin was found. This may have been the result of the Turkish ban on poppy production and a period of heroin scarcity. Beginning in the fall of 1974 the purity of heroin ranged between 2-5%; during the first quarter of 1975 Consolidated Laboratories reported purity between 5-7%; and the latest available information rates purity at 10%. Additionally, there has been an increase in the amount of white heroin.

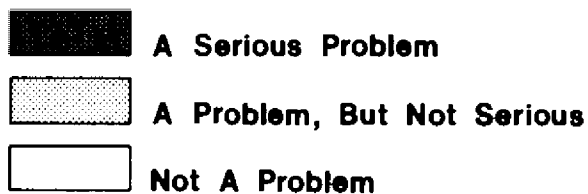
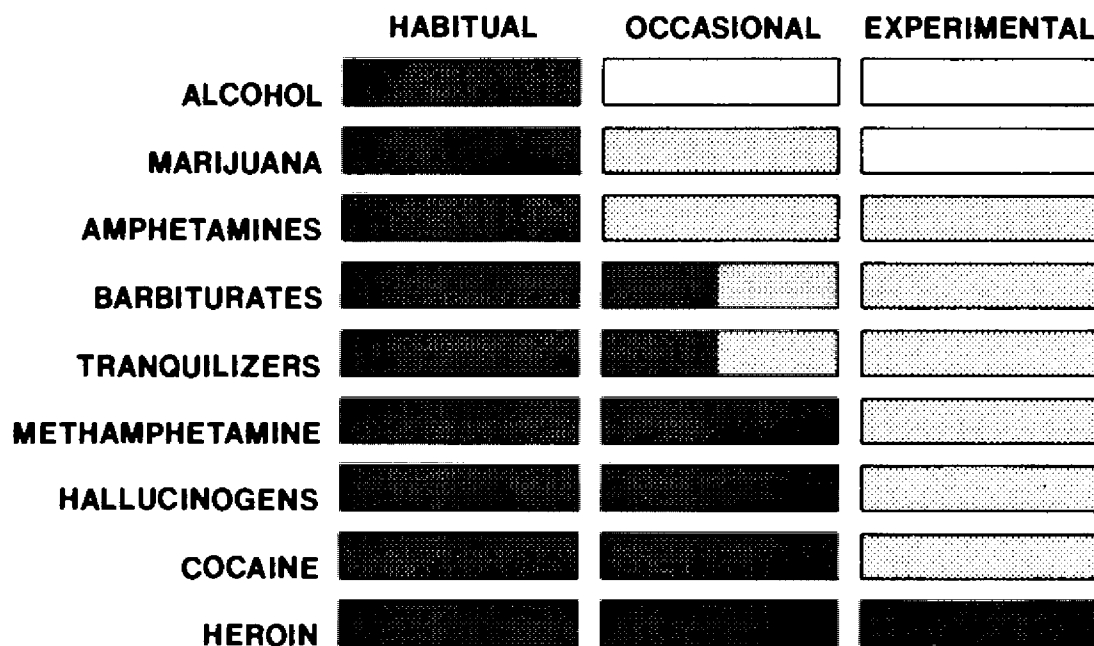
The total number of drug samples received for analysis has increased from 62,958 during July - September, 1974 to 88,482 during December - February, 1975. Of particular note, however, is that while total specimens increased by slightly more than a third, the number of heroin specimens more than doubled (417 to 931). These data suggest that both the availability and purity of heroin in Virginia is increasing, and that another "heroin epidemic" similar to the late sixties and early seventies might be possible in the near future.

SOCIAL CONSEQUENCES OF DRUG ABUSE

A final indicator that is useful to set public priorities in drug programs is the social cost of drug use which includes drug-related crimes and

Figure 5
**SERIOUSNESS OF THE DRUG PROBLEM
 BY LEVEL OF USE**

(A Profile of Student Opinion)



Source: JLARC Student Survey, December 1974.

deaths, health crisis reports, impaired driving, drug related highway fatalities, and convictions for drunk and disorderly conduct.

Crimes Against Persons or Property

Criminal behavior which endangers human life and property is conceded to be the social cost of greatest concern and several national studies have examined drug abuse from this perspective. There are no definitive statistics available to indicate the extent to which drug use causes crime in the Commonwealth. There is, however, a consensus among law enforcement officials interviewed by JLARC that the need for narcotic addicts to support their expensive habit has substantially contributed to increased burglaries, prostitution, and other fund-raising crimes. For example, the Richmond Bureau of Police estimated that the cost of crimes directly attributed to opiate dependency was \$2.3 million, during the 3 year period ending with 1973. According to the second report of the National Commission on Marijuana and Drug Abuse:

*The use of opiates in the United States, particularly heroin use, increases the probabilities that an individual will engage in acquisitive crimes or other criminal behaviors, most of which are directly related to supporting the drug habit. However, the available evidence indicates that users of opiates are significantly less likely to commit homicide, rape and assault than are the users of alcohol, amphetamines and barbiturates.*¹⁵

The report further indicates that a disproportionate share of heroin addicts had long histories of delinquent or criminal behavior prior to their being identified as drug users.

The 1972 Consumers Union Report *Licit and Illicit Drugs* concluded that alcohol was the single greatest contributor to criminal law enforcement problems. A number of studies cited in the report demonstrated that stabbings, beatings, and shootings, were causally related to alcohol.

*...one can say that there is a strong link between alcohol and homicide and that the presumption is that alcohol plays a causal role as one of the necessary and precipitating elements for violence. Such a role is in keeping with the most probable effects of alcohol as a depressant of inhibition control centers in the brain--leading to release of impulses.*¹⁶

The report also concluded that alcohol is often causally related to child abuse since in a high proportion of battered child incidents, resulting in hospitalization or death, the parent was found to be drunk.

Information on crimes committed by drug dependent persons is not usually available. One drug treatment diversion program in Richmond, Treatment Alternatives to Street Crimes (TASC), however, has for the past year been screening persons arrested and identifying themselves as drug dependent. TASC reports the types of crimes committed by persons it accepts. During the first year of operation, TASC accepted 246 clients having a total of 311 arrest charges. Nearly half of all charges represent fund-raising activities.

Drug Deaths

Deaths due to accidental drug overdose or drug dependency is another indicator of the types of drugs being abused. Suicides, in which drugs (usually barbiturates) were the cause of death, are excluded from this analysis since they represent a different type of drug problem than is commonly associated with drug control programs. The number of drug related deaths in Virginia, as shown in Table 5, increased from 13 in 1967 to a peak of 48 in 1972. Of the total 266 drug-related deaths between 1967 and 1974, two-thirds were white, and similarly two-thirds were male. Interestingly, eight out of ten narcotic deaths during this period were under 30 and the same proportion of alcohol, barbiturate, and tranquilizer deaths were over 30 years of age.

Table 5

DRUG RELATED DEATHS IN VIRGINIA, 1967-1974^a

Type of Drug	1967	'68	'69	'70	'71	'72	'73	'74
Heroin	2	8	5	13	12	10	6	1
Other Narcotics	1	2	-	6	8	6	7	17
Barbiturates and Narcotics	-	-	-	1	-	3	1	1
Alcohol and Other	4	3	12	13	14	9	14	6
Barbiturates	5	5	4	3	-	4	3	7
Tranquilizers	-	2	2	1	-	3	1	1
Methadone	-	-	2	1	5	11	1	-
Other Drugs	<u>1</u>	<u>1</u>	<u>3</u>	<u>2</u>	<u>7</u>	<u>2</u>	<u>2</u>	<u>2</u>
Total	13	21	28	40	46	48	35	35

^aExcludes children under six years, deaths associated with old age, and suicides.

Source: State Department of Health, Bureau of Vital Records and Health Statistics.

Drug deaths were concentrated in the major metropolitan areas and Richmond and Northern Virginia had a disproportionate number of drug deaths relative to their share of the State's population as shown below.

Table 6

PERCENTAGE OF DRUG DEATHS IN VIRGINIA 1967-1974

Region	% Population	% Drug Deaths
Richmond	11%	25%
Northern Virginia	19	26
Tidewater	21	23
All Other	<u>49</u>	<u>26</u>
Total	100%	100%

Source: State Department of Health, Bureau of Vital Records and Health Statistics.

Heroin deaths have declined since 1970, and only one was reported in 1974. The number of deaths caused by other narcotics, however, have increased so that total narcotic-related deaths have remained fairly constant. There have been three recent significant demographic trends -- a shift in narcotic deaths from non-whites to whites, an increase in deaths among persons under 30 and an increase in deaths outside the State's three major metropolitan areas (See Appendix 11).

Health Crisis Reports

Health crisis reports from hospital emergency rooms and other medical facilities present another facet of the social costs of drug abuse. Information from five regions was available for analysis and is shown in Table 7. Alcohol was the most frequently reported cause of a health crisis followed by poly-drug use. It is important to note that out of 1,328 reports, only one was attributed to marijuana, which is consistent with current research evidence regarding its potential hazard to health.

Table 7
HEALTH CRISIS REPORTS
1974

	<u>Number</u>	<u>Percent</u>
Alcohol	367	27.6
Poly-Drug (Combination of drugs)	265	20.0
Barbiturates	224	16.9
Narcotics (Opiates)	148	11.1
Amphetamines	14	1.1
LSD	14	1.1
Marijuana	1	-
Other or Unknown	<u>295</u>	<u>22.2</u>
Total	1,328	100.0

Note: Includes only those areas of the State submitting data on health crisis reports to DDAC for the 1975 State Plan for Drug Abuse Control.

Source: DDAC 1975 State Plan for Drug Abuse Control.

Other Social Costs

Highway Fatalities: The Department of State Police has estimated that 26% of all highway fatalities are attributable to drivers who are under the influence of alcohol. The Division of Highway Safety likewise reports that in 1974, 305 highway deaths (over 29% of all highway fatalities) were caused by drivers with a high blood alcohol level. This is probably a low estimate since it represents only those accidents in which the police officer could determine that alcohol was definitely involved. The Virginia Highway Research Council, meanwhile, estimates that alcohol contributes to half of all highway fatalities.

Driving Under the Influence of Intoxicants: A 1970 study sponsored by the Board of Medical Examiners reported that among 7,230 persons stopped by police for suspicion of driving while impaired, 84% showed blood alcohol levels of .15% or higher. Furthermore, convictions for driving under the influence of drugs or alcohol, as reported by the Division of Motor Vehicles, have more than doubled since 1970, as shown below.

CONVICTIONS FOR DRIVING WHILE INTOXICATED

<u>Year</u>	<u>Alcohol</u>	<u>Drugs</u>
1970	8,710	1
1971	9,389	1
1972	11,703	8
1973	16,514	12
1974	17,800	35

Source: Division of Motor Vehicles.

Drunk and Disorderly Conduct: Drunkenness and drunk and disorderly conduct represents the single most frequent criminal offense as measured by commitments to county and city jails. For the years shown in the following display, these offenses represent approximately one-third of all local commitments.

COMMITMENTS FOR DRUNKENNESS, AND DRUNK AND DISORDERLY CONDUCT

<u>Year</u>	<u>City and County</u>	<u>% of Local Commitments</u>
1971	42,440	32%
1972	39,972	31%
1973	39,577	29%
1974	38,439	28%

Source: Department of Corrections, Bureau of Research and Reporting.

The above statistics clearly show that the abuse of alcohol must be considered to have substantial social costs with respect to public order and safety.

THE MARIJUANA ISSUE

Because of the extensive use of marijuana and the great amount of public resources being devoted to its control, it is important to take a close look at marijuana's history, use, and health effects.

The History of Marijuana

Marijuana's use dates back 5000 years to early Chinese and Indian cultures. Traders brought the plant westward to Persia and Arabia during the

fifth century A.D., and its medical use became widely accepted in Europe following the return of Napoleon's armies from Egypt. The Spaniards introduced the hemp plant (from which marijuana is derived) to the New World during the 16th century, and colonists brought hemp to Jamestown in 1611. By 1762 hemp was an important crop in the Southern economy. Hempculture was encouraged by the colonial Virginia government, and hemp is still used in the production of rope, twine, and textiles, while its seed is used as bird food.

Marijuana enjoyed widespread therapeutic use until 1937 when it was replaced by drugs that could be more precisely administered. American soldiers stationed in the Panama Canal Zone reportedly used marijuana as an intoxicant as early as 1916 but it was not used widely for recreational purposes until after the prohibition of alcohol. During Prohibition, marijuana was cheaper and often more easily obtained than alcohol, and marijuana "tea pads" opened in New York City. Sailors returning to New Orleans brought marijuana from Mexican ports, while imported Mexican laborers brought the drug to the far West.

The fact that marijuana became illegal following the end of Prohibition has been attributed largely to the efforts of the Federal Bureau of Narcotics, created in 1932 to take over the anti-narcotic activities of the former alcohol enforcement agency. An optional ban on marijuana was inserted in the 1935 Uniform Anti-Narcotics Act. By 1937, 46 of the 48 states had adopted the prohibition of marijuana. The ban was proposed because of highly publicized incidents in which violent crimes were reported to have been committed by persons who were high on marijuana. Many of these stories have since been discredited and there is no evidence that marijuana use by itself leads to criminal behavior.

The Marijuana Tax Act of 1937 prohibited the non-medical possession of marijuana and imposed a tax on physicians who prescribed the drug, as well as on pharmacists, growers, and importers. The Federal Bureau of Narcotics testified in favor of the Marijuana Tax Act, although no medical testimony was offered in support of the measure. However, representatives of the American Medical Association testified against the law, and an AMA resolution adopted that year supported the continued availability of marijuana for therapeutic use. (In 1969, the Act was declared to be contrary to provisions of the Constitution by the U.S. Supreme Court.) After 1937, the Federal Bureau of Narcotics continued its campaign against the use of marijuana, and soon many states specified that marijuana should have the same penalties as heroin; and as penalties for narcotics became more harsh, penalties for marijuana increased accordingly. In 1951 uniform federal penalties were adopted for use of both marijuana and narcotics. Strict legislation and harsh penalties, however, have not prevented its use. The National Commission on Marijuana and Drug Abuse estimated in 1972 that 24 million people had used marijuana.

The Marijuana User

According to the Virginia drug survey, 59% of the current marijuana users are male, and nearly all are under age 35. Most had completed high school, while three out of five had some college education. Almost half of the users were students, and another third reported skilled occupations. Nine

out of ten admitted users had never been arrested. The survey profile does not correspond to the typical person tried for drug violations in Virginia -- 86% male, 9% students, and 53% having previous arrests.

Of all past and current users most (60%) reported they began using marijuana out of curiosity or for recreation. One-half reported either experimental or rare use, while an additional 29% reported occasional use. Moreover, the largest number of respondents used the drug for only one to three months. When asked their reason for termination of use, only one out of ten past marijuana users cited legal concerns.

These data suggest that although marijuana usage is widespread among young, college-educated, and employed people, its use is neither frequent nor of long duration, and that the legal deterrent does not appear to be a significant factor motivating persons to discontinue marijuana use.

At one time, it was assumed that marijuana users "graduated" to heroin, because many addicts were found to have used marijuana. While many addicts had undoubtedly used marijuana, they had also used many other substances such as alcohol or tobacco as well, yet that did not constitute evidence of a cause-and-effect relationship. Today there is no evidence to suggest that marijuana use necessarily leads to the use of other drugs. A recent study by the Yale University Center for Survey Research found that although among users of harder drugs there was a progression from alcohol to marijuana to harder drugs, most alcohol and marijuana users did not progress to other drugs.

Similarly, there is no evidence to link the use of marijuana with crimes against persons or property. The 1972 *Report of the National Commission on Marijuana and Drug Abuse* found that neither the marijuana user nor the drug itself could be said to represent a danger to public safety or that it leads to acts of violence, juvenile delinquency, or aggressive behavior.

The Health Effects of Marijuana

The National Commission on Marijuana and Drug Abuse concluded in 1972 that marijuana, like any psychoactive drug, is potentially harmful, depending on the intensity, frequency, and duration of use. For the experimental or occasional user there is little proven danger of physical or psychological harm. The commission was most concerned with the long-term heavy user, who may develop psychological dependence on the drug, as well as specific behavioral changes.

In March, 1975, *Consumer Reports* published a review of current medical research on the health effects of marijuana use. The research evaluated clinical findings of possible brain damage, lowered body resistance to disease, birth defects and hereditary disease, lung damage, sterility, and impotence, and found that most of the earlier negative findings could not be verified by more extensive and controlled experiments. In some cases, for example, subjects were found to have used other drugs such as LSD or results were based on extremely high dosage levels administered to animals. In other cases the results simply could not be replicated.

A 1970 study of marijuana use in Jamaica found no physical or mental damage resulting from life-long, very heavy use of marijuana among a group of field workers. Although Jamaican marijuana (generally more potent than that found in Virginia) decreased the overall efficiency of field workers, it increased their social cohesiveness and their willingness to work long hours in the fields. When these heavy smokers were clinically examined, no physical abnormalities or evidence of psychological or brain damage was found. Furthermore, no difference in regularity of employment was found between smokers and non-smokers.¹⁷

Consumer Reports concluded that marijuana, like most other drugs, is not harmless. For example, it is very likely that heavy smoking (whether marijuana or tobacco) can damage lung cells. Long-term heavy use can also produce psychological dependency as well as possible behavioral changes. But, there is no conclusive evidence that moderate use of marijuana, like the moderate use of alcohol, poses a significant hazard to individual health.

Recent Approaches to Marijuana Regulation

In 1972, the National Commission on Marijuana and Drug Abuse recommended "...a social control policy, seeking to discourage marijuana use, while concentrating primarily on the prevention of heavy and very heavy use." While rejecting both total prohibition and outright legalization, the Commission recommended "... a decriminalization of possession of marijuana for personal consumption on both the State and federal levels." Marijuana would remain contraband subject to confiscation in public places, and a fine would be imposed for public use.

In addition, reduction of penalties for possession of small amounts of marijuana has been endorsed by a number of national organizations.¹⁸

- American Bar Association
- National Conference of Commissioners on Uniform State Laws
- National Advisory Commission on Criminal Justice Standards and Goals
- Governing Board of the American Medical Association
- American Public Health Association
- American Academy of Pediatrics
- National Education Association
- National Council of Churches
- B'nai B'rith

A different approach was recommended by the Consumers Union in *Licit and Illicit Drugs*. It recommended the repeal of all federal laws governing the production, distribution, possession, and use of marijuana. Furthermore, the Consumers Union recommended the legalization of marijuana, subject to appropriate regulations. This recommendation was not based on the belief that marijuana is harmless; but that "...an orderly system of legal distribution and licit use would have noticeable advantages for both users and non-users over the present marijuana black market."

Oregon was the first state to abolish criminal penalties for possession of one ounce or less of marijuana and to replace them with a maximum fine

of \$100. One year later, in October, 1974, a survey by the national Drug Abuse Council, Inc. of Washington, D.C. found that the incidence of marijuana use had not significantly increased. Of the nine percent of Oregon adults who currently use marijuana, 91% had used the drug prior to decriminalization. Lack of interest and health reasons were cited by those who had stopped. A positive effect of the Oregon statute was the increased priority given by police to crimes of violence and crimes against property. Furthermore, this action removed approximately one-third of the total number of cases awaiting trial in local courts. Following the Oregon experience, legislation proposing a reduction or elimination of criminal penalties for marijuana possession was introduced in 20 other states and the U.S. Congress. To date, Alaska, California, Colorado, Ohio, Maine, and the District of Columbia have reduced the penalty for the possession of small amounts of marijuana to a monetary fine.

Additionally, the Alaska Supreme Court ruled in May, 1975, that the possession of marijuana within the home was protected under a 1972 amendment to the Alaska Constitution, guaranteeing the right to privacy. Several other states have adopted similar amendments guaranteeing the right to privacy, including California, Illinois, Arizona, Hawaii, and South Carolina. Due process, as guaranteed under the 14th Amendment, has been expanded by several recent decisions of the United States Supreme Court to include the right to privacy within the home. The Alaska Court, however, devised an intermediate test for privacy, maintaining that the State had failed to demonstrate that the private use of marijuana was harmful, and that therefore its control constituted an improper invasion of privacy. Similar constructions of due process and the right to privacy may be possible in other states, including Virginia, in which case regulation of the private possession of marijuana might become a judicial rather than a legislative prerogative.

The lack of demonstrated social costs, as well as the absence of evidence demonstrating significant danger to public health, indicates that a review of Virginia's approach to the control of marijuana should be considered.

CONCLUSION

Because of the failure of any Virginia agency to adequately define the scope of the drug problem in Virginia, JLARC has reviewed a number of indicators which may be useful to establish legislative and administrative priorities for statewide drug efforts in planning, treatment, law enforcement, corrections, and education. It is evident that the nature of drug abuse is not static; therefore, indicators must be constantly updated and reviewed in order for planning and decision making to be based on the best available information.

Current information indicates that alcohol must be recognized as the most serious problem since it is the most widely used and abused drug in Virginia, with at least a half million regular or heavy users and 122,000 alcoholics. The high social costs of alcohol abuse are evident from the data presented on drug related deaths, impaired driving, highway fatalities, health crisis reports, and convictions for drunk and disorderly conduct. Additionally, the Virginia Bureau of Alcohol Studies and Rehabilitation estimates that alcoholics cost Virginia industry about \$338 million annually.

Narcotic abuse remains a serious problem, and recent evidence suggests that the availability and purity of heroin in Virginia is increasing. Although there are only 3,000 to 5,000 heavy or regular users of heroin or other opiates compared to 122,000 alcoholics, the social costs and potential harm resulting from narcotic addiction are more significant than this small number would indicate.

Abuse of prescription drugs is, perhaps, the hidden drug problem in the State. There are many individuals who are using prescription drugs illegally. Although the impact of this form of abuse is not very well known, medical evidence suggests that the abuse of legally prescribed drugs can be dangerous to the individual and should be given greater public attention.

Marijuana is the most widely used illegal drug, with an estimated 187,000 total users and 72,000 regular or heavy users. There are, however, few social consequences associated with its use, and the weight of clinical research suggests that moderate use of marijuana is no more hazardous to health than the use of many other commonly accepted substances. Although marijuana is not harmless, the social costs of marijuana and its potential health hazard indicate that its use does not pose as great a problem to society as the abuse of alcohol, narcotics, or prescription drugs.

Finally, among the school-age population, alcohol, marijuana, amphetamines and barbiturate use have reached alarming proportions. The use of these substances as well as the experimental use of any drug by under-aged persons should be assigned high public concern.

EDUCATION'S RESPONSE TO DRUG ABUSE

The primary goal of drug education in Virginia has been to provide students with factual information about the effects of drugs and drug abuse in order to prevent the abuse of drugs and other substances.

The response of the State Department of Education (SDE) and the local school divisions to the drug abuse problem extends beyond providing classroom instruction. At the State level, there has been an increased effort to upgrade the college preparation of health teachers, to integrate drug education with the health curriculum, and to provide in-service training for administrators, counselors, and teachers. Some deficiencies, however, still exist in these areas which adversely affect the quality of drug education. There appears to be a lack of professionally trained health education teachers as well as insufficient in-service training for counselors and classroom teachers. Furthermore, lack of uniform statewide policies and standards for drug discovery, guidance counseling, and health services has hindered implementation of an effective policy of drug abuse prevention.

Educators once believed that providing factual information about drugs would prevent drug abuse, but recent evaluations suggest that drug education may encourage the use of drugs, most noticeably marijuana, among younger students. As a result, the department and many local school divisions are now advocating a new approach to drug education, focusing on personal mental health and individual decision-making skills. The effectiveness of the department's efforts to implement a coordinated response to the drug problem should be carefully examined before a new mental health approach is undertaken.

This section reviews the efforts of the State Department of Education to fulfill legislative intent with respect to drug education and examines related efforts including counseling, school health services, and school drug policies. An important aspect of this review is a presentation of survey research by JLARC staff, based on random samples of high school students, health and physical education teachers, and guidance counselors.

111. THE DRUG EDUCATION PROGRAM

The abuse of alcohol, marijuana, and other substances by elementary and secondary students has become a serious issue of public concern. By 1974, 94% of senior high school principals and 91% of intermediate principals reported the use of marijuana by students who attend their schools, while 40% of senior high students recently reported that several or most of their friends turned on with drugs.

Virginia's drug education program is based upon the concern of the General Assembly that all students receive instruction in drugs and drug abuse, especially in the lower grades, and that all teachers be provided with a minimum level of drug training.

Legislative History

As concern for the drug problem mounted during the late 1960's, the Governor's Council on Narcotics and Drug Abuse Control (established in 1970) recommended that drug education be required as an integral part of health programs in public schools. House Joint Resolution No. 122 of March, 1970, and a resolution of the State Board of Education the following month encouraged local officials to intensify drug education programs and to take action to prevent drug experimentation and abuse.

The following year, House Joint Resolution No. 15 was introduced on behalf of the State Crime Commission, which was concerned with the haphazard manner in which drug education was being provided. The patrons of the resolution believed that objective information about drugs should be provided for all students and that education would reduce the level of drug abuse in the schools. The intent of the General Assembly was expressed on three important areas:

- That education on the dangers of narcotics and drug abuse be taught in elementary and secondary schools.
- That such education begin immediately in the primary grades and as soon as possible in all other grades; and,
- That all teachers in elementary and secondary schools receive sufficient training to conduct drug education.

The General Assembly did not intend that all teachers should become experts on drug abuse, but they should receive a minimum level of training to enhance their awareness of the problem. In addition, every school was expected to have at least one staff member with expertise in this field. With extensive training for teachers, drug education classes for all students, and an emphasis on the lower grades, it was generally agreed that the level of drug abuse in the schools would be reduced.

In response to this legislative mandate, the State Board of Education adopted the following regulations:

The elementary and secondary schools shall include in health education classes instruction in drugs and drug abuse beginning

with the 1971-72 school year. In addition, the elementary and secondary schools should incorporate without undue duplication instruction in drugs and drug abuse in other subjects such as civics, government, science, and home economics which have appropriate contributions to make to the overall drug education program.

In 1972, the original legislation requiring study of the "evil effects of alcohol and narcotics" (adopted in 1928) was amended to require that instruction concerning drugs and drug abuse be provided by the public schools as prescribed by the State Board of Education.

Federal assistance for the establishment of drug education programs was provided under the Education Profession Development Act of 1970. The three sections of this Act provided assistance for teacher training, drug education, and vocational rehabilitation training. Under the Drug Abuse Education Act of 1970, the Office of Education was authorized to provide drug education grants to state departments of education.

On September 21, 1974, the Alcohol and Drug Education Act was signed into law. The importance of the act is seen in its recognition of legal as well as illegal drugs, and its emphasis on drug abuse as a complex human behavior which is influenced by many forces. The purposes of the Act are to develop new curricula, to demonstrate model drug education programs, and to provide assistance for training. The Act encourages new directions in drug education, including an interdisciplinary school team approach, peer group counseling, and community programs for parents. Up to ten percent of the funds may be provided to a state department of education for assisting localities with programs for minorities, in-service training, and training for peer counselors. As of this writing, however, funds have not been made available under the Act.

Organization for Drug Education

The primary agencies involved in drug education have been the State Department of Education, the State's colleges and universities, and the local school divisions. According to the State Comprehensive Plan for Drug Abuse Control, the role of the State Department of Education is one of planning, coordinating, implementing, and evaluating the drug education program. A drug education coordinator, responsible to the Supervisor of Health and Physical Education, was employed on July 1, 1970, with federal funds to oversee the program. In December, 1972, a separate organizational unit for drug education was established with State funds. At that time a Supervisor of Drug Education was employed to replace the previous coordinator.

The State's educational institutions, including 14 teacher's colleges, have become involved in drug education through the preparation of health and physical education teachers and through cooperation with SDE to sponsor in-service training workshops. In addition, several colleges and universities now offer extension courses in drug abuse and related health issues.

The Virginia Community College System has recently become involved in drug education efforts. John Tyler Community College, for example, has

submitted a proposal for a certificate program to train paraprofessional drug counselors. Other community colleges have proposed training programs for local teachers, and several have drug-related courses in law enforcement, nursing, and mental health fields of study.

The Office of Education within HEW has provided mini-grants for training nine school or community-based teams from Virginia at Biscayne College in Miami, Florida. In the past, this effort has not been coordinated with SDE's efforts to develop a statewide training program.

At the local level, school divisions determine the content and overall direction of drug education, with technical assistance from SDE staff. Decisions regarding curriculum, materials, teacher selection, and salaries, as well as drug policies and procedures are made by local school divisions with the assistance of their health and physical education staff.

Program Expenditures

The Department of Education received a total of \$127,700 in federal grants from the Office of Education between 1970-1974 to implement a statewide drug training and education program. No federal funds were available in 1974-75. Appropriations for drug education were reduced after a federal moratorium on new drug education programs. The moratorium followed a recommendation contained in the Second Report of the Commission on Marijuana and Drug Abuse based on tentative research findings that drug education had, in fact, increased experimentation.

Since 1969-70, the Department of Education has reported expenditures for drug education of about \$294,000 as shown in Table 8.

Table 8

SDE EXPENDITURES FOR DRUG EDUCATION PROGRAMS

<u>Year</u>	<u>Federal Funds</u>	<u>State Funds</u>	<u>Total</u>
1969-70	N/A	N/A	\$67,940
1970-71	N/A	N/A	39,615
1971-72	\$48,202	---	48,262
1972-73	18,948	\$ 4,240	23,188
1973-74	36,260	18,795	55,055
1974-75	37,108	22,644	59,752
			<hr/>
			\$ 293,812

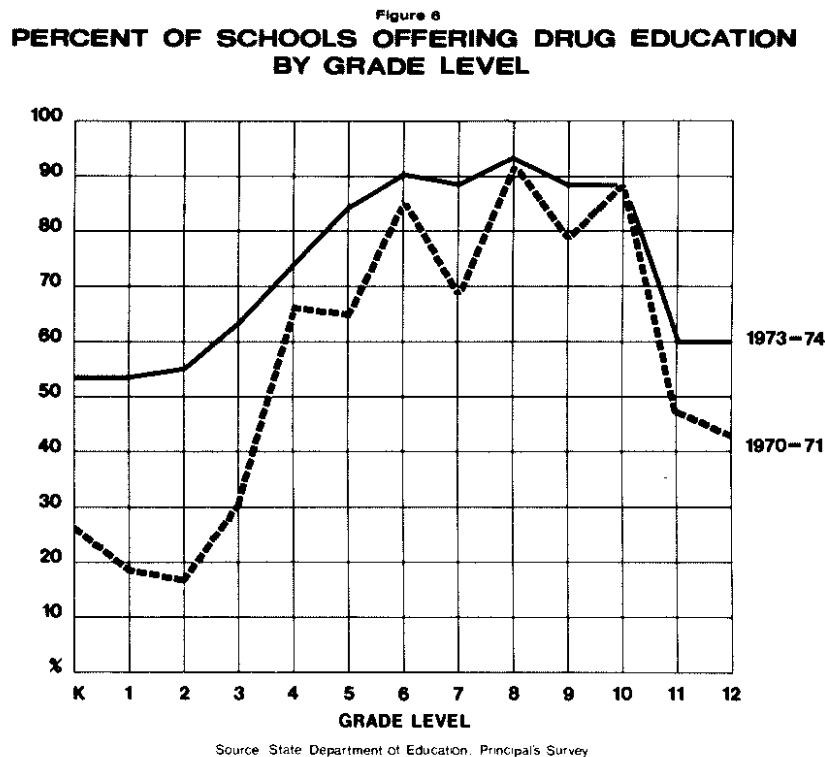
Source: State Department of Education, Division of Secondary Education.

Students Receiving Drug Education

The number and percentage of students who received drug education increased from 58% in 1971-72 to 71% in 1973-74, primarily in grades 1-4 and

9-12. Moreover, one of the most significant trends, illustrated by Figure 6, is the rapid increase in the percentage of schools offering drug education at the elementary grades. From 1970-71 to 1973-74, the percentage of schools teaching drug education in Kindergarten increased by 27%; in first grade, by 35%; in second grade, by 38%; and in third grade, by 31%. The percentage of schools offering drug education, however, has increased more than the percentage of students receiving drug education.

In general, progress has been made towards achieving the first two objectives of the General Assembly expressed in HJR 15. Data provided by the Department of Education indicate that nearly three-fourths of all students received some form of drug education during 1973-74, while 90% of the 10th, 11th and 12th grade students sampled by JLARC had received drug education in Virginia. Additionally, drug instruction has indeed increased most rapidly at the primary grade levels.



Integration of Drug and Health Curricula

The Department of Education has developed curriculum materials and guidelines for youth or community involvement and in-service training for use at the local level. "Drugs and Drug Abuse", a unit for health and physical education teachers, was distributed to every secondary school in the State during January, 1970.

In August, 1971, 38,000 copies of a revised *Health Education Curriculum Guide* were distributed to teachers in all grades. Principals

reported that during 1971-72, 71% of all schools used the health education guide. This increased to 86% in 1972-73 and 94% in 1973-74. (However, a survey conducted in January, 1975, by the Capital Area Comprehensive Health Planning Council in the Richmond area found that only 69% of all health teachers had a copy of the guide.) The guide includes materials on a variety of health and mental health related topics as well as an eighth grade unit on Drugs, Alcohol, and Tobacco. The goal of this unit is ... "to prevent the use and misuse of these harmful substances..." and the emphasis is to be placed on "...the harmful effects, both physical and psychological that alcohol, tobacco, and drugs may produce."

The specific objectives of the Health Guide relative to drugs are essentially informational. Drug education is intended to provide instruction in the following areas:

- History of the early use of drugs,
- The danger of drugs and narcotics,
- Factors leading to drug addiction,
- Facilities and methods for treating drug addiction,
- Legal controls on drugs,
- Virginia's laws concerning controlled drugs,
- Problems and effects of continued drug use, and
- Research relative to drug abuse.

According to the guide, instruction is effective if there is evidence that the pupil (1) understands the substance of what is taught, (2) avoids the use of drugs and other harmful substances, and (3) refuses to try or use illegal drugs. Clearly, the intent of the department's drug education program is to induce students not to use harmful or illegal drugs.

The extent to which drug education has been incorporated into the health curricula is shown in Table 9. Generally, the State's schools have been successful in meeting this legislative requirement, with 91% of all schools complying by 1973-74, compared with 69% three years earlier.

Table 9

PERCENTAGE OF SCHOOLS WITH DRUG EDUCATION
AS PART OF HEALTH CURRICULUM

<u>Type of School</u>	<u>1970-71</u>	<u>1971-72</u>	<u>1972-73</u>	<u>1973-74</u>
Elementary	62%	75%	81%	88%
Junior High	98	93	99	99
Senior High	83	82	96	96
Total	69%	78%	86%	91%

Source: State Department of Education, Principals' Survey, 1973-74 *Annual Report*.

TEACHER PREPARATION

A major factor in the success of any educational program is the quality of teaching staff. At the elementary level, a classroom teacher offers drug education, while in most intermediate and senior high schools a health and physical education teacher is assigned this function. However, the majority of both elementary and secondary teachers have not received drug awareness training, and correspondingly health and physical education teachers appear to lack adequate training.

Separation of Health and Physical Education

The State Board of Education plays a major role in the development of pre-service education by establishing minimum standards for certification of teachers. Prior to 1975, the department only certified teachers with a combined degree in health and physical education. This year, it is also possible for a teacher to be certified just for health or just for physical education. In 1977, the combined endorsement will receive a slight increase in its emphasis on health.

Most secondary drug education teachers, however, have already received the dual certification, which placed greater emphasis on physical education than on health. For example, three quarters of the health and physical education teachers surveyed by JLARC had no college credit in drug abuse or related problems. Moreover, 69% of recent graduates of health and physical education programs had no college course work in drug education. While teachers may have been exposed to information about drugs in health survey courses, this is not sufficient to conduct effective drug education at the secondary level. Clearly, teacher preparation programs under the combined endorsement have not met the State's need for drug education specialists.

Pre-service education for health and physical education teachers is beginning to undergo a major revision in Virginia. Two colleges have already submitted proposals to the State Council of Higher Education to establish health education as a degree program separate from physical education. This development represents a first step in the separation of these academic disciplines.

The certification question is both important and controversial. Many of the faculty affected at Virginia colleges and universities maintain that continuation of a combined endorsement will retard the development of health education specialists. The new combined endorsement for 1977, for instance, requires a 42-hour course of study, including 24 hours of physical education but only nine hours of health. Advocates of separating the two disciplines believe that the lack of preparation of physical education teachers in health areas has contributed to ineffective drug education. Health specialists are required, they contend, if the State is to implement a humanistic approach to drug and mental health education. Advocates of the combined endorsement respond that many smaller school divisions cannot afford to hire specialists in both areas. However, with the physical and psychological pressures of today's society, schools may not be able to afford not to hire separately trained professionals in health, as well as in physical education.

In practice, drug education in many schools was simply added to the existing responsibilities of physical education teachers and, apparently, many of these teachers would prefer not to teach it. In a survey of all health and physical education teachers conducted during January, 1975 by the Capital Area Health Planning Commission, three-fourths of the respondents preferred to concentrate on physical education and turn over health education to specialists in that field.

The Third Statewide Conference on Health Education in Virginia, sponsored by the Health Education Advisory Committee of the State Department of Health, was held in November, 1974. The conference recommended the complete separation of health and physical education at the intermediate and senior high levels and pointed out the need for a comprehensive health education program which would encompass such areas as drug abuse.

At the present time there are not enough professionally trained health educators to implement a comprehensive health education program, or to justify immediate elimination of the dual certification. The State Board of Education, however, should encourage local divisions to hire separately trained graduates. In addition, currently employed health and physical education teachers should be encouraged to specialize in one of the two fields through continuing education and in-service training. Within a reasonable period of time, the State Board of Education should provide for the complete separation of the two disciplines and separate certification.

In-Service Training

When the Department of Education began to develop its program in response to HJR 15, it was evident that large-scale, on-going teacher training would be required. During the early 1970's a primary training objective was to provide information about drugs to teachers who were unfamiliar with the subject. Early training programs included physicians, law enforcement personnel, and others who could provide background information. Training was to help teachers realize that they did not have to be experts on drug abuse, as well as provide them with a common base of information and other resources. The first phase of drug training encompassed the department's workshops in 1971 and 1972, the early training programs offered at the local division level, and the first graduate seminars at the university level.

A second phase of drug training is beginning to develop in a number of local school divisions. As teachers became more sophisticated in their knowledge of drugs, drug education coordinators believed there was less need for purely informational training and more emphasis should be placed on individual mental health, so that teachers might recognize and deal with the underlying causes of drug abuse. This type of training, however, is far short of being implemented across the State.

Training Objectives: A 1970 departmental publication set forth program objectives for drug education. A primary goal of the training program was to provide all teachers with some form of drug training by June, 1971. The objectives of the programs specified that upon completion of in-service training, teachers and others involved would be:

- Aware of the nature and extent of drug abuse;
- Able to identify the pharmacological, psychological, and sociological effects of drugs;
- More aware of the nature of the youth subculture, and able to communicate effectively with youth;
- Familiar with curricular materials; and
- Familiar with community services available for treatment and rehabilitation.

In September, 1972, the objectives of training were modified to reflect new areas of concern. In addition to the preceding objectives teachers and others were to become "more familiar with problem solving and humanistic approaches that may be used in helping people explore their attitudes toward drug use and abuse."

Training Workshops: During the summer of 1970 and 1971, the department sponsored a number of Drug Education Training Centers in cooperation with several State colleges. Department records indicate that in August, 1970, 168 persons attended four, two-week intensive workshops at Old Dominion University, Virginia Commonwealth University, Radford College, and Madison College.

In August, 1971, the department again sponsored eight, one-week intensive workshops, involving 450 people who were then to lead local awareness training sessions. Regional meetings were held at 15 locations throughout the State in November and December, 1972. The attendance included 7 superintendents, 403 guidance counselors, 300 principals and assistant principals, and 75 others, totaling 785 persons. Nearly every school jurisdiction was represented.

A Drug Education Workshop for Virginia Colleges, focusing on the need to prepare future teachers for health education was held in Charlottesville in May, 1973. In April and May, 1974, a model training program was carried out with representatives of treatment centers, regional DACC's, nurses, guidance counselors, administrators, and teachers. This session emphasized the need for cooperation between various community resources and received excellent feedback. The Department of Education sponsored a statewide conference in Richmond in December, 1974, on the role of the school nurse in drug education. During the Spring of 1975, another conference was held on youth involvement programs. While these activities represent a continuing State effort, corresponding local efforts are required if all teachers are to receive adequate training.

Extent of Training: A major State effort was mounted in 1970 and 1971 to provide intensive training for a select group of educators who would then return to their school divisions prepared to lead local awareness training sessions. Training, however, must be a continuing function of the educational system, because of constant turnover in teaching positions. The 1973 Comprehensive State Plan for Drug Abuse notes that 95% of all teachers had received local in-service awareness programs by 1971. While JLARC does not dispute

the accuracy of that figure as a measure for 1971, it is important to determine the extent of training in 1975, as well as its effectiveness.

Table 10 indicates that 75% of all schools now have at least one teacher with training in drug education. However, 17% of senior high schools (50 schools) and 30% of elementary schools (375 schools) still do not have anyone trained in drug education, indicating a need for continued training efforts.

Table 10

PERCENTAGE OF SCHOOLS REPORTING AT LEAST ONE TEACHER
WITH TRAINING IN DRUG EDUCATION

<u>Type of School</u>	<u>1972-73</u>	<u>1973-74</u>
Elementary	57%	70%
Intermediate	85	94
Senior High	<u>78</u>	<u>83</u>
Total	64%	75%

Source: State Department of Education, Principals' Survey, 1973-74 Annual Report.

Not only do many schools lack even one teacher with drug training, but only 21% of Virginia's classroom teachers had received drug awareness training as of 1973-74. Table 11 indicates that urban jurisdictions, where the drug problem has been most severe, have the lowest proportion of teachers with awareness training (14%), while rural jurisdictions have the highest (30%).

Table 11

EXTENT OF DRUG AWARENESS TRAINING AMONG VIRGINIA CLASSROOM TEACHERS

	<u>Elementary</u>		<u>Secondary</u>		<u>Total</u>	
	<u>All Teachers</u>	<u>% Trained</u>	<u>All Teachers</u>	<u>% Trained</u>	<u>All Teachers</u>	<u>% Trained</u>
Urban	16,448	11%	12,359	18%	28,807	14%
Suburban	6,301	23	4,738	28	11,039	25
Rural	9,551	30	6,981	35	16,532	32
Total	32,300	19%	24,078	25%	56,378	21%

Source: State Department of Education, 1974 Principals' Survey, 1973-74 Annual Report.

Some Department of Education officials believe that classroom teachers should have a full day of drug awareness training, however, the JLARC staff believes this is inadequate for health and physical education teachers who are responsible for teaching drug education. A JLARC survey of health and physical education teachers found that about one-third had not received any in-service drug training since 1970 (Table 12). Of the 24% that reported receiving 1-4 hours of State or local training, three-quarters of them also had no in-service training through college credit courses. Thus, after nearly five years following the adoption of House Joint Resolution No. 15, requiring all teachers receive sufficient training to conduct drug education, a majority of all classroom teachers have not received any in-service drug training and 49% of all health and physical education teachers either have not received any training or appear to be inadequately trained.

Table 12

EXTENT OF IN-SERVICE TRAINING AMONG
HEALTH AND PHYSICAL EDUCATION TEACHERS
(Hours of Training Since 1970)

	State or Local Hours				College Credit Hours		No In-Service Training Since 1970
	1-4	5-8	9-16	Over 16	1-3	Over 3	
Urban	25%	15%	17%	5%	16%	--%	27%
Suburban	17	14	8	6	24	8	58
Rural	25	14	14	5	21	10	26
Total	24%	15%	15%	5%	21%	7%	31%

Source: JLARC, Health and Physical Education Survey, December, 1974.

Effectiveness of Training: Alexandria sponsored an intensive program in 1973 for 84 classroom teachers, nine counselors, and seven administrators. Participants met three hours daily for three weeks, and received graduate credit for the course. Twenty-five hours of lecture-discussion covered pharmacology, the youth culture, motivations for using drugs, treatment programs, legal implications and classroom techniques. One session was a workshop on communication skills. Four other sessions were designed for small-group interaction, experiential learning and values clarification. The small group sessions were each led by a psychiatrist or psychologist with experience in drug abuse.

Pre and post-training surveys were administered to the participants, and the results indicate substantial increases in drug knowledge. Attitudes toward the educational process and feelings about youth tended to remain the same. In addition, respondents reacted favorably to a direct evaluation of the program; 87% of the teachers stated that the course will make them better teachers concerning drug use. Based on the training course data, the survey researchers suggest that those teachers with less traditional attitudes toward

the educational process and the youth culture be selected for training. In this way, the researchers conclude, students may find drug education more relevant and valuable.¹⁹

While the Alexandria evaluation found very positive responses to an intensive, three-week seminar training programs across the State differ in length, content and learning strategies. Even those programs sponsored by SDE varied in important respects. In order to obtain overall feedback from the recipients of drug training, JLARC surveyed 225 health and physical education teachers and 300 guidance counselors. The responses of counselors, which will be analyzed in the following section, indicated favorable reaction to the factual components of drug training. Training programs were not well received, however, with respect to providing the counseling skills needed to help students with problems.

Health teachers also tended to rate training programs higher in providing factual information and understanding the reasons for drug use, but lower on learning about community resources and helping students who have problems. Table 13 totals the responses of health and physical education teachers to an evaluation of drug training programs based on various departmental objectives.

The Department of Education was moderately successful in achieving its earlier 1970 objectives, such as providing factual information. However, it was rated less successful in the achievement of its 1972 objectives, which were more oriented towards humanistic and problem-solving approaches such as learning to help students with drug problems.

Health and physical education teachers were also asked for specific suggestions to improve in-service training. Of those who responded to this question, the most frequent suggestion (27%) was to provide more training programs. In addition, there should be required training for drug education teachers. The second most frequent suggestion was to provide better qualified personnel to direct training programs. Resource people should include those who have direct experience with drug abuse, and not just educators. Another group of respondents believed there should be greater emphasis on counseling individual students who have problems as well as greater emphasis on mental health strategies for the classroom. These attitudes are reflected in the comments below, selected as most typical of teachers who responded.

Teacher A:

Less emphasis should be placed on knowledge and more on relating to the individual - understanding themselves and helping them (students) make healthy decisions concerning drugs.

Teacher B:

We need an updating of our program...Much of our secondary curriculum is simple repetition of facts learned in earlier years. We need to concentrate more on the social, emotional, and legal aspects of drug use, and our program needs to be revised constantly.

Table 13

HEALTH AND PHYSICAL EDUCATION TEACHERS'
EVALUATION OF DRUG TRAINING PROGRAMS

Training Objectives	Not Helpful	Neutral	Helpful
Recognizing the basic classification of drugs and the symptoms of their abuse:	10%	32%	58%
Understanding the reasons for drug use among students:	14	24	61
Increasing your ability to communicate openly and honestly with students:	18	26	56
Learning to distinguish between drug experimentation, use, and abuse:	20	27	52
Learning more about local treatment programs and other community resources:	27	27	46
Learning to help students to better understand themselves, so that they can make their own decisions regarding the use of drugs:	17	30	53
Learning to help individual students who may have problems:	26	27	46
Learning how to involve students in the educational process:	17	34	44

Source: JLARC, Health and Physical Education Survey, December, 1974.

COUNSELING PREPARATION

Counseling programs are intended to provide assistance to students in developing educational and career plans, as well as providing help for students with personal problems. Even though most senior high schools now employ guidance counselors, JLARC believes there is a critical gap in the provision of helping services for drug troubled students. Not only do many students believe there is no adult in their school to whom they can turn for help with drug problems; but, high counselor caseloads and a significant gap in drug training suggest that counseling is not reaching those students who have drug-related problems, especially at the elementary and intermediate level.

Counseling Students Who Have Drug Problems

JLARC asked high school students to agree or disagree with the statement: "If I had a serious drug problem, there is someone in my school other than a student to whom I would turn for help." Almost half of the students (48%) disagreed with this statement, while 19% were unsure, and 33% agreed. In other words, half of all students believe they cannot receive help from their school. A very significant difference in the response was noted according to the level of peer group drug awareness. Figure 7 illustrates the point that students who are most aware of drugs and perhaps most in need of help (those who responded that several or most of their friends used drugs), are much less likely to feel there is someone to whom they can turn for help.

Although most senior high schools provide guidance counselors, almost one-fourth of intermediate and four-fifths of elementary schools do not. In addition, Table 14 shows that other types of assistance are limited. Only 15% of the senior high schools provided rap centers, and only 39% provided medical assistance.

The JLARC Survey of Counselors, as well as a recently published study of guidance and counseling by the University of Virginia, point out serious deficiencies in the provision of counseling services. The latter study, prepared by the University's Department of Counselor Education, recognizes the importance of both guidance and counseling to the personal development of each student. The report covers several issues, however, which have direct bearing on the effectiveness of counseling in helping students with drug problems.²⁰

Table 14

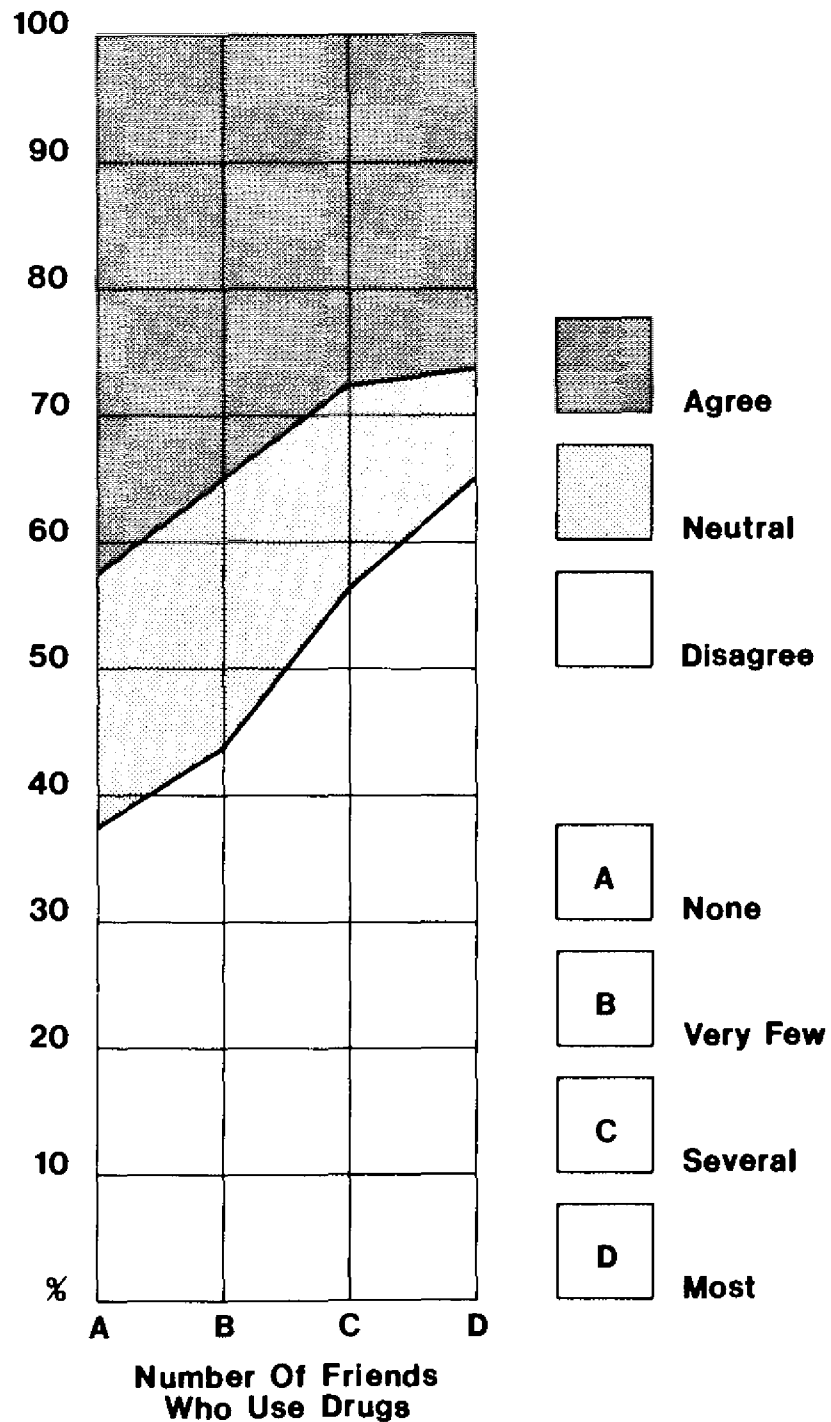
SERVICES AVAILABLE WITHIN THE SCHOOLS FOR "DRUG TROUBLED" STUDENTS

<u>Type of Service</u>	<u>Elementary</u>	<u>Intermediate</u>	<u>Senior</u>
Guidance Counselors	20.3%	76.8%	97.0%
Rap Centers	--	11.2	15.1
Medical Assistance	.2	34.5	39.2

Source: State Department of Education, Principals' Survey, 1973-74 *Annual Report*.

Figure 7

THERE IS SOMEONE TO WHOM I WOULD TURN FOR HELP



Source: JLARC Student Survey, December, 1974

Lack of Statewide Policies: The University of Virginia study noted there was no clear description of the guidance function, and that specific skills required for effective counseling were not included in the State's Standards of Quality requirements. The development and monitoring of such statewide policies and standards should be a critical role for SDE. Unfortunately the last guidebook in this field was published ten years ago, and makes no mention of drugs or drug-related problems. The SDE should update its policies and standards for counseling and prepare a manual for counselors which reflects current drug problems and priorities.

Organization and Coordination: SDE employs five Assistant Supervisors of Guidance to assist in the development and coordination of counseling programs. Poor organization and coordination of counseling programs at the local school level, however, was cited by the University of Virginia study as a major concern. Only three-fifths of the 1,178 counselors responding to a survey conducted for the study indicated that their division employed a system-wide counseling coordinator. The report suggests that for many divisions, an SDE supervisor provides the only coordination. Furthermore, the report explained that both State and local coordinators "...lacked policy power and ...were unable to provide the support necessary for an effective program. In many school systems, division-wide coordination and leadership is non-existent."

Lack of Elementary Counseling: The University of Virginia report noted an increasing interest in providing elementary school counselors, and recommended the SDE provide strong support for this trend. The JLARC Counselor Survey found that 76% of all respondents believe that counselors should be employed in elementary schools to provide early intervention for potential drug abusers, however, only one-fifth of all elementary schools had counselors in 1973-74. With the level of drug abuse increasing in the lower grades, counseling in the elementary and intermediate schools has become much more essential. Counseling services should be given greater attention by school divisions and the State Board of Education should consider mandating counseling services in elementary schools.

Counselor Caseloads: Although the Standards of Quality recommend that no counselor have a caseload of more than 350 students, JLARC's survey findings show that almost one-third of all counselors have caseloads exceeding this standard and about one in five have caseloads with 400 or more students.

Furthermore, most counselors apparently spend very little of their time actually counseling students about personal problems. Table 15 shows that the majority of counselors spent one-quarter or less of their time in personal counseling. (The University report recommended at least half of a counselor's time should be devoted to individual and group counseling.)

The Department of Education has not established a standard as to how much of a counselor's time should be spent in group or individual counseling, guidance, and other activities. However, one problem cited by the University study and reinforced by the JLARC Survey was the need for additional clerical staff. A majority (59%) of the counselors surveyed by JLARC believed that counselors in their school spent too much of their time doing clerical work, and not enough time working with students. Counselor caseloads should be no

Table 15

PERCENTAGE OF TIME DEVOTED TO COUNSELING

<u>Amount of Time</u>	<u>Percent of Counselors</u>
Less than 10%	22.3%
11-25	32.7
26-50	32.3
Over 50	12.7

Source: JLARC Counselor Survey, December, 1974.

greater than the Standards of Quality recommend and additional clerical support should be provided in order that counselors may concentrate on their professional responsibilities.

In-Service Training for Counselors

A large proportion of guidance counselors (84%) have at least a Master's Degree. In-service training, however, is cited by counselors as essential to effective job performance. This is particularly true in relation to counseling for drug-related problems. The University of Virginia report noted that the average age of counselors was 43 years, and over 98% had come to counseling from a classroom teaching background. Because of this type of background, in-service training is necessary to insure awareness of contemporary problems of students, including drug abuse.

Extent of Training: While almost one-fourth of all counselors have not received in-service training in drug abuse (Table 16), 20% of all counselors have received over eight hours of State or locally sponsored training, and

Table 16

EXTENT OF IN-SERVICE TRAINING AMONG COUNSELORS
(Hours of Training Since 1970)

	<u>State or Local Hours</u>				<u>College Credit Hours</u>		<u>No In-Service Training Since 1970</u>
	<u>1-4</u>	<u>5-8</u>	<u>9-16</u>	<u>Over 16</u>	<u>1-3</u>	<u>Over 3</u>	
Urban	30%	11%	25%	24%	12%	4%	21%
Suburban	17	15	22	7	5	5	26
Rural	29	15	17	8	16	2	21
Total	26%	12%	18%	12%	12%	4%	22%

Source: JLARC Counselor Survey, December, 1974.

16% have taken college courses as in-service training (some double counting exists). Of the 26% who reported 1-4 hours of training, however, 23% had

received no additional college training. Significantly, suburban school counselors were least likely to have received drug training. This gap in training for counselors must be addressed.

Effectiveness of Training: In order to evaluate the impact of training on job performance, the JLARC survey asked counselors to rate training programs on the basis of seven indicators summarized in Table 17.

Counselors rated training programs highest for providing factual information about drugs, and for understanding the reasons for drug use among students. Most significantly, however, was the response to the final indicator. A total of 44% believed that training had not helped them to learn new counseling techniques to help individual students with problems. Since this is a major function of counseling with respect to drug abuse, JLARC staff concludes that drug awareness training has not satisfied counselor needs.

Table 17

COUNSELORS' EVALUATION OF DRUG TRAINING PROGRAMS

Training Objectives	Not Helpful	Neutral	Helpful
Recognizing the basic classifications of drugs and the symptoms of their abuse:	7%	24%	52%
Understanding the reasons for drug use among youth:	16	26	49
Increasing your ability to communicate openly and honestly with students:	21	28	42
Learning to distinguish among drug experimentation, use, and abuse:	27	35	37
Learning more about treatment programs and other community resources:	21	27	45
Learning to help students better understand themselves, so that they are capable of making their own decisions:	31	28	38
Learning new counseling techniques to help individual students who may have problems:	44	26	39

Source: JLARC Counselor Survey, December, 1974.

Future Training Needs: The University of Virginia counseling study provides recommendations for both counselor education and in-service training. For counseling in general, training in group counseling techniques was one of the most frequently cited areas requiring more emphasis. Course work in the behavioral sciences, human relations training, and practicums in school

settings were suggested for college-level preparation. For practicing counselors, the two most important in-service training needs were skills for evaluation as well as skills for helping students solve problems.

The written suggestions supplied in the JLARC Counselor Survey were also analyzed for specific content. Almost one-third of the counselors wrote that the content of the training program should be improved. Group counseling techniques were listed as the most needed skill to be learned, while many counselors felt that the use of expert resource people, such as treatment specialists and drug counselors, as well as physicians, ex-addicts, and students should be involved. A smaller number of counselors suggested a need for more factual information which could help in identifying drug users, and further study in adolescent psychology to help understand the underlying causes of drug abuse.

Another group of responses suggested that the scope of training programs be expanded. This could be achieved through a requirement for in-service training, an annual update, and more training at both the regional and individual school level. A third group of responses centered around strategies for conducting the training program itself. Most frequently mentioned were small group sessions, T-groups, human relations training, field trips to treatment programs, school practicums, and fewer classroom lectures. The responses to this written question indicate that a sizeable proportion of counselors felt the current approaches to drug training need improved content, scope, or learning strategy.

POLICIES AND PROCEDURES FOR DRUG DISCOVERY IN THE SCHOOLS

The Department of Education has established a prototype policy for drug discovery in the public schools, and has outlined actions to take regarding drug problems by division superintendents, principals, teachers, school nurses, and counselors. The guidelines were approved by the State Board of Education in January, 1971. The department has also requested local school boards to adopt and publish policies governing the use, possession, and sale of drugs by students. Copies of local drug abuse policies were requested along with other information from the 22 school divisions that had designated a coordinator for health, drug or physical education as of August, 1974. Sixteen coordinators responded to the survey, and twelve supplied copies of their local policies. In reviewing these policies, a great deal of variation was found in the extent to which the State guidelines had been followed.

Although almost all school divisions may have some kind of policy or procedure for drug discovery, one or more principals in 52 counties and 13 cities reported (in the 1974 SDE Principals' Survey) that their division did not have a drug policy. Statewide, 16% of the elementary principals, 15% of the intermediate, and 22% of the senior high principals reported that their school division did not have a drug policy. Moreover, JLARC found that 40% of all health and physical education teachers noted that their school did not have a policy, or they were unaware of it. Although each individual school need not develop its own, it is expected that divisions should communicate all drug policies to their principals, and that principals should make teachers aware of them.

The comparison of selected local drug policies with the suggested State policy indicates that not all divisions are focusing attention on the critical roles of school personnel in helping students with drug problems. Some policies are entirely punitive in nature, and ignore the underlying causes of drug abuse. Furthermore, since only 60% of health and physical education teachers could report that their school had a drug policy, there is apparently a critical gap in communication between State guidelines and the individual teachers. The Department of Education should immediately take steps to insure that effective drug control policies are developed by each local school division, and that such policies are communicated to all staff.

SCHOOL HEALTH SERVICES

Local school boards have been empowered to employ school nurses as part of an effort to provide health services for students, including emergency drug services. (Virginia Code, 22-241 and 22-242). Responsibility for school health services, however, is diffused between local health departments and school divisions.

House Joint Resolution No. 46 adopted by the 1974 General Assembly directed the Departments of Education and Health to review the need for nursing services in public schools. According to a survey conducted for their report during July, 1974, only 55 school divisions (40%) provided school health services. In another 33 divisions, the local health department provided a part-time public health nurse. Responsibility for nursing services was divided in 22 divisions, while in another five, no one had responsibility for this function. Other major problems outlined by the report included:

- Lack of qualified medical resources available to many schools;
- Lack of uniformity in those school nursing programs administered by local school divisions; and
- Inconsistencies in health screening of school children across the State.

The report further indicated that school health needs in the area of drug abuse were not being met (the 1974 SDE Principals' Survey pointed out that medical assistance for drug-troubled students was available in only 35% of the intermediate and 39% of the senior high schools). Although drug abuse may not be the major priority for a school nursing program, there is clearly a need for further review in this area. Several local coordinators of school nurses have suggested that the nurse, given adequate training, could perform a valuable service in both health services and drug education. In addition, it was suggested that nurses may serve in a personal and more confidential drug advisory role for students.

There is a lack of clarity in the State legislation which does not specify departmental responsibility for the delivery of school health services. The Department of Health has established standards for Public Health Nurses, but where local school boards have nursing services, the board establishes standards. As a result, the level of school health service varies tremendously.

The fundamental problem, however, is the lack of a state-wide policy or program for the delivery of nursing services to students. As a result, emergency medical care for a drug crisis is not available in most schools, and a valuable source of drug education is not fully utilized. The Department of Education should be assigned responsibility for developing a comprehensive program of school health services.

EVALUATION OF DRUG EDUCATION

Many schools in the past have employed scare tactics to frighten students away from drugs. Much of the classroom information provided was distorted and exaggerated, and failed to recognize the underlying problems which cause drug abuse. Most educators now believe that scare tactics did not prevent, nor discourage, drug abuse.

In 1970, when the growing seriousness of the problem was becoming widely recognized, a new educational approach was undertaken. Stimulated by federal funding under the Drug Education Act of 1970, the Department of Education began to promote an informational approach to drugs. Rather than attempting to scare students, teachers were to be trained to present factual information about drugs and drug abuse. By emphasizing the pharmacological and legal effects of drugs, educators assumed students would learn that drug abuse is not worth the potential risks involved.

JLARC survey results indicate that merely providing factual information does not necessarily prevent drug abuse. While 64% of students surveyed believed that drug education had made them more aware of different types of drugs and their effects, an equal number responded that drug education had not reduced the level of drug abuse in their school. Among the target group of potential drug abusers, 90% believed it had not been effective. Other evaluation studies have also concluded that while factual information about drugs is important in a school's curriculum, it is often an irrelevant variable in affecting student behavior. There is also substantial evidence that a purely informational approach to drugs may either serve to encourage experimentation or to educate a more knowledgeable drug user.

Recently, several local school divisions and SDE have begun to advocate a broader mental health approach, stressing the need for understanding the causes of problems such as drug abuse. This approach assumes that an individual who gains a better understanding of himself and the reasons why he might use drugs can develop alternative means for coping with life's problems without drugs.

This educational approach is appealing because it recognizes that schools cannot simply prevent drug abuse by showing films or giving lectures. On the other hand, mental health education is virtually untested. Its goals and objectives are far from clearly defined, and few evaluation studies have assessed its impact on important behavioral objectives. The small number of studies which have been completed, however, indicate that mental health education may have positive effects on drug attitudes and behavior. Since widespread adoption of this approach would require a major curriculum development and teacher training effort, it is important that the potential effectiveness

of such an effort in Virginia be determined through careful evaluation of pilot programs.

The Factual Information Approach

Early prevention programs concentrated on providing factual information. According to the *Second Report of the National Commission on Marijuana and Drug Abuse*:

Much of the present effort to prevent drug use through information and education programs rests on the expectation that if everyone understood all the facts about prohibited drugs, very few would use them. The people and agencies designing the programs assume that the facts about illegal drugs, once they are fully known and considered, will point irrefutably towards abstinence.²¹

The first indication of the negative impact of informational drug education was reported in a 1969-70 study of eleven school districts in California. Each had recently implemented a drug education program, yet drug use did not decline in any district. In four of the districts, there was a significant increase in drug use. The study points out that drug education may not be immediately successful, but that its beneficial effects might be long-range. Furthermore, decline in drug use should not be the only criterion for evaluation, according to the report. Other success measures might include a slowing of the increase in drug use, a shift from hard to soft drugs, or an increase in decision-making skills.²²

A number of educational researchers have also questioned the ability of prevention programs to influence drug-using attitudes and behavior simply by presenting factual information. Dr. John Swisher, Director of the Addiction Prevention Laboratory at the Pennsylvania State University, has reported that the more students know about drugs, the more likely they are to favor their use. Dr. Swisher's research found that informational programs had actually increased drug experimentation because of more relaxed attitudes about the effects of drugs.²³

A recently completed study conducted by Yale University's Center for Survey Research suggests that a factual information approach to drug education, at least among younger students, may also encourage marijuana use. On the other hand, a slight reduction in alcohol and marijuana use was attributed to drug education among older students. In the short run, however, drug education did not affect the use of the most harmful drugs, such as heroin. The study was based on a sample of 13,500 junior and senior high school students in the New Haven area.²⁴

One possible explanation for the increased use of marijuana by younger students is their relatively conservative initial attitude toward marijuana. Teachers' attitudes towards marijuana were much more moderate; hence they had a liberalizing influence on younger students. However, student attitudes towards marijuana tend to become more liberal by senior high, so that teacher attitudes could be a moderating influence on older students.

The researchers note a progression from alcohol to marijuana to harder drugs, among those persons who were using harder drugs. However, the researchers also point out that most alcohol and marijuana users do not progress to harder drugs.²⁵

The Mental Health Approach

In response to negative evaluations of the informational approach, many educators are beginning to view drug abuse as one aspect of the individual's mental health. From this perspective a new approach to health education is emerging which emphasizes how people develop their values and make decisions affecting their personal and mental health. Interpersonal and group communication, sensitivity to the needs of others, and an open acceptance of human feelings and emotions are stressed in this approach. Mental health includes an awareness of how outside pressures generated by peer groups, family conflicts, and the mass media influence personal behavior.

Mental health education involves many other issues besides drug abuse, and requires newer teaching strategies that actively involve students in the learning process. Although it is believed that this will discourage students from experimenting with drugs as a means of solving their problems, the goal should not be simply to prevent drug use. Such an assumption would be as misleading as the earlier assumption that people who knew the facts about drugs would refuse to use them. Instead, the goal of mental health education should be to enable students to make responsible decisions concerning their lifestyles in the face of the many conflicting pressures in today's society.

North Carolina has implemented such an approach, and in its publication, *Life Skills for Health: Focus on Mental Health*, the North Carolina Department of Public Instruction explains:

Traditionally, we have assumed that health problems could be alleviated by more and better health knowledge. While health knowledge is certainly important, we now recognize that people often take risks with their health in their desire to meet other needs that are important to them. Therefore, the emphasis of health education should be to enable children to develop the skills to meet their own needs in healthy ways...²⁶

The North Carolina curriculum is not intended to turn the teacher into a counselor. Rather, its purpose is to prevent problems, rather than cure them, by enabling children to learn the skills necessary to cope with everyday life situations. According to health education specialists within the North Carolina Department of Public Instruction, the initial reactions of both teachers and students have been very favorable.

Evaluation of Mental Health Education

There have been very few evaluations of mental health education, but those which have been completed suggest this approach can be effective in influencing attitudes and changing behavior. Mental Health education is more

difficult to implement, however, as it is based on a learning model which is different from the traditional lecture format of most classrooms. One particular strategy uses values clarification, a process of identifying, questioning, and discussing one's values on a particular topic in a group setting. Values clarification was first introduced in California, and was favorably evaluated in 1971. The frequency of drug use was found to be lower among an experimental group using values clarification.²⁷

Keystone Central School District: Dr. Swisher of the Addictions Prevention Laboratory, recently completed an evaluation of the Keystone Central School District's Drug Education Program in Pennsylvania, in which several different educational approaches were pilot tested, and results were evaluated using a pre and post-test design. The researchers concluded the structured mental health curriculum was more effective for elementary grades in regard to drug attitudes than the values clarification strategy. One advantage cited was that the structured mental health materials were more easily used by the teachers.

At the secondary level, however, the values clarification approach led to a significant reduction in personal drug use, suggesting that "...individuals with clarified values may choose not to use drugs even though their personal attitudes are not particularly conservative." The report concluded with the observation that the mental health curriculum appeared to be more effective at the elementary level, while values clarification was more effective at the high school level.²⁸

New York City's SPARK Program: An important evaluation of a comprehensive drug abuse prevention program in New York City was completed in September, 1974. The School Prevention of Addiction through Rehabilitation and Knowledge (SPARK) Program, begun during the 1971-72 school year, was shown to positively affect four behavioral dimensions. These included drug-related incidents, acting-out incidents, absences from school, and average grades.

Recognizing that schools cannot simply teach students to avoid drugs, SPARK relies on group interaction. Groups of ten or fewer students, who have been referred to or sought out by the program, meet at least once a week with an adult from the SPARK staff. Individual and small group counseling techniques are utilized to help the students deal constructively with personal and peer group problems. The SPARK program management and the individual school teams are involved in a variety of other activities, including training students for group leadership roles, making home visits, and developing parent workshops and parent/child sessions. In addition, SPARK teams are involved in curriculum development and in-service awareness training for teachers.²⁹

Dade County's PRIDE Program: In Miami Beach and Dade County, Florida, an extensive peer counseling program has been developed and evaluated. Professional Resources in Drug Education (PRIDE) employs 70 peer counseling specialists to serve all secondary schools. These persons are involved in a number of related activities, including:

- Training students as peer counselors in areas such as effective learning techniques and positive alternatives to drug abuse;

- Parent communication programs, including values clarification and decision-making techniques for parents; and
- Disseminating drug information in the form of written hand-outs and homework assignments, rather than devoting class time to lectures.

The 1972-73 program was evaluated using a pre and post-test, control group experimental design. Students completed questionnaires on both knowledge and drug-related attitudes. According to the evaluation report, students involved in the PRIDE program at both the elementary and secondary levels showed significant gains in both knowledge and attitudes, when compared with the control group. The evaluation report states that:

Much of the present school curriculum has little significant impact on drug abuse because the focus has always been on drug content rather than on the individuals own (intrinsic) values and attitudes interwoven in the whole syndrome of drug use, abuse, and addiction.³⁰

ATTITUDES TOWARD DRUG EDUCATION IN VIRGINIA

Under contract with the Department of Education, Virginia Polytechnic Institute and State University undertook an evaluation study of drug education in six Virginia communities during 1972 and 1973. The results, released in late 1974, demonstrate very little improvement in either drug knowledge or attitudes, for both experimental and control groups.

Three curricula were evaluated, two of which were considered experimental in nature: a commercially available "Creative" program and a locally developed "Roanoke" program. Within each school division using one of the experimental programs, a third or control group of students was taught using the State Department of Education's outline for drug education. All students received a drug knowledge test and an attitude inventory before and after instruction.

The "Creative" and "Roanoke" groups fared no better on either the achievement or attitudinal instruments than the control group with the SDE health curriculum. The VPI & SU study concluded that the specific content of the drug education program itself may not be as significant a variable as teacher training and qualifications, physical conditions surrounding instruction, and student motivation.³¹

Student Evaluation of Drug Education

Taking into account the information already available in this area, JLARC staff has concluded that further survey research should focus on the consumers of drug education--the students--to ask them how effective they feel it has been. In order to determine student opinion, JLARC selected a random sample of 1,200 tenth, eleventh, and twelfth grade students to receive drug education questionnaires.

From these surveys, JLARC staff has determined that drug education, as presently taught in Virginia, has increased the level of student awareness about drugs, but has not been effective in reducing the level of drug use. Furthermore, drug education is not likely to influence its principal target group--those students who are most likely to use drugs--unless the current educational approach is altered.

Student opinions on specific issues relative to their teachers and materials were divided, with some students rating classroom experiences positively and others negatively. Table 18 summarizes the students' evaluation of their most recent class in drug education. While only 26% of the students did not believe the teacher really cared about drug use, students were evenly divided on whether the teacher knew a lot about drugs. Also while students tended to disagree that textbooks were relevant, they were inclined to believe that films were. Students generally agreed that the teacher talked about both legal and illegal drugs, that drug education had made them more aware of the different kinds of drugs and their effects, that the teacher listened to students, and that all students should receive drug education. This finding indicates strong student support for the concept of drug education in Virginia.

Several students commented that drug education had helped to reduce hard drug use, but may have increased the use of marijuana. For example, students commented that:

Student A: It has made people aware of the real danger of hard drugs. However, when trying to find the evils of marijuana their arguments break down and they make themselves look much more foolish than if they left it alone.

Student B: It has reduced usage to a certain extent. Hard drugs particularly. But many people at least try marijuana just to see what it's like. Alcohol is by far the biggest problem.

Student C: In some areas, especially marijuana, it has helped to increase its use by advertising its less serious effects on the body. It has, however, deterred the use of hard drugs and pills very much.

Student D: The class may have encouraged more kids to use it, because many teenagers are curious, and when someone preaches against something they do it just for fun.

Student E: People have become more aware of the factual effects of drugs through the drug education. But too much drug education may raise one's curiosity to try drugs.

Evaluation by Potential Drug Users: Although many students did react favorably to their drug education classes, it appears that the most critical target group--those students whose peers already use drugs--reacted negatively. In addition, a number of students suggested that the ones for whom drug education was intended and for whom it is most important may not have been listening by commenting that:

Table 18
STUDENT EVALUATION OF DRUG EDUCATION CLASSES

Evaluation Component	Disagree	Neutral	Agree
The teacher seemed to really care whether or not the students used drugs:	26%	31%	43%
The teacher seemed to know a lot about drugs:	37	27	36
The teacher was really good at getting us to talk about the reasons why people use drugs:	39	25	37
The textbooks seemed to be relevant to the drug problems of today:	49	26	25
The films we saw were relevant to the drug problems of today:	30	24	46
The teacher talked about both legal and illegal drugs:	19	20	62
The teacher believed that students should make their own decisions about whether or not to use drugs:	37	23	40
Drug education has made me more aware of different kinds of drugs and their effects:	20	17	64
The teacher listened to us as much as we listened to the teacher:	31	23	46
I think drug education is a good thing for all students to have:	9	13	79

Source: JLARC Student Survey, December, 1974.

Student F: The people that it concerned paid no attention to the class. People that are on drugs don't listen to anyone but their friends who are also on drugs.

Student G: Only a few listened and the ones who did were the ones who didn't take drugs in the first place.

Student H: The teacher just gave us the information, tested us, and that was it. The students are going to try it anyway and they won't listen to the teacher. There was no genuine interest or concern shown on the part of the teacher.

A significant difference was noted in the specific indicators of drug education according to the level of peer group drug use. For example, about half of those with no peer drug usage responded that their teacher was knowledgeable about drugs, however, less than a third of those with high peer drug use rated their teacher's knowledge of drugs favorably (Figure 8).

Those students whose peers tend to be more involved in drugs may also be more knowledgeable about drugs themselves (or think they are) and less likely to view their teacher as a source of expertise. The same trend was noted in the evaluation of drug films (Figure 9). Those students with higher peer drug use were less likely to believe that drug films were relevant.

Those students whose friends used drugs were also less likely to believe that the teachers encouraged their classes to discuss the reasons for using drugs or that teachers listened to their students. Again, many of those with high peer group drug usage were turned off by the drug classes.

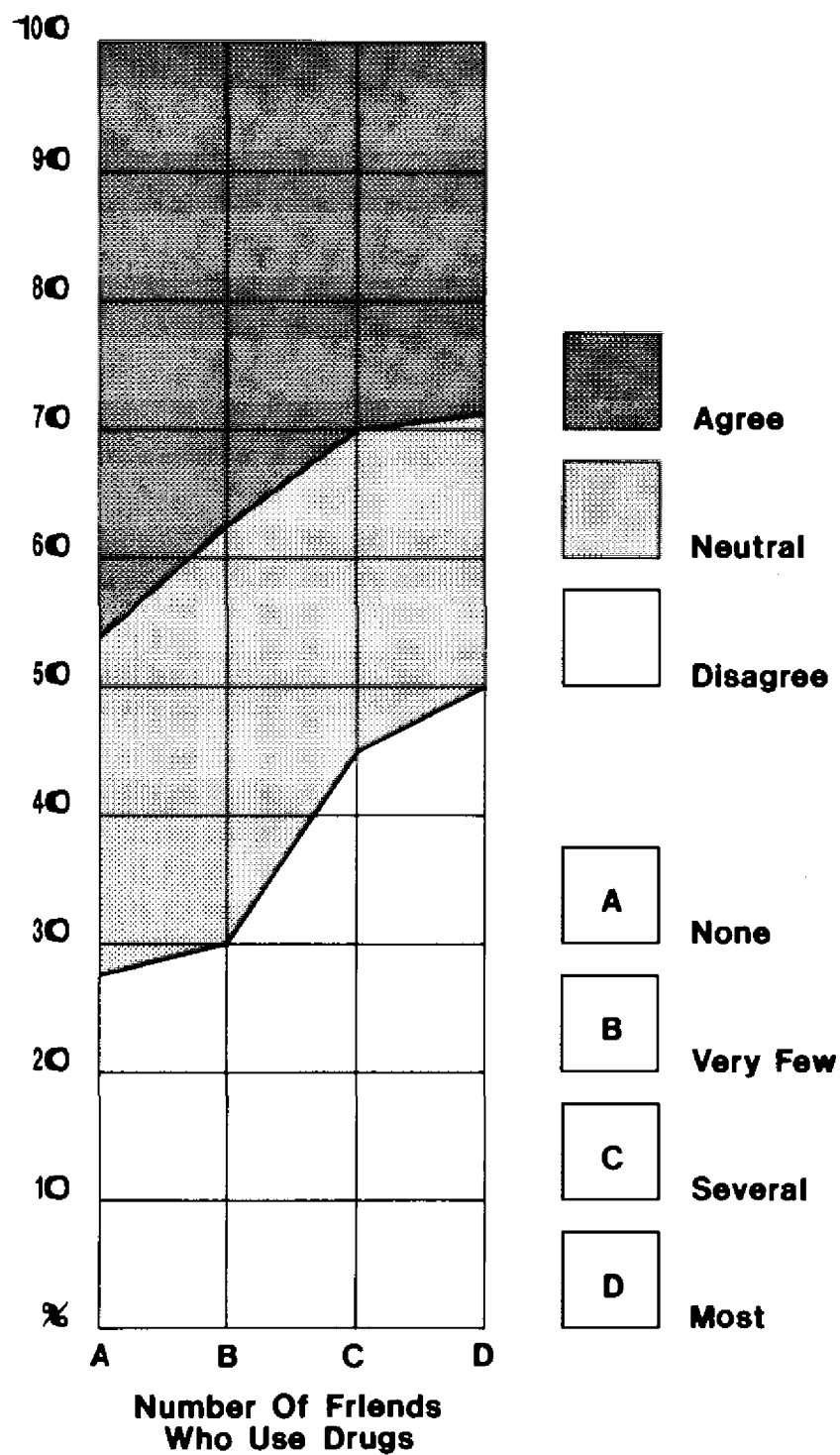
Not only were the ratings of drug education classes and materials highly correlated with peer drug use, but the impact of the classes varied along the same dimension. Of those whose friends were most likely to use drugs, only 46% felt that drug education had made them more aware of drugs. As far as the impact of drug education, nine out of ten felt that it had not reduced the level of drug abuse in their school. This finding is dramatically displayed in Figure 10.

The responses to the JLARC survey are significant when viewed in relation to other research findings. It has been shown that drug education programs can easily increase the level of cognitive knowledge, yet numerous studies have also shown the difficulties in influencing attitudes or changing behavior. Further evaluation is required to assess the long-term impact of drug education.

Teacher Evaluation of Drug Education

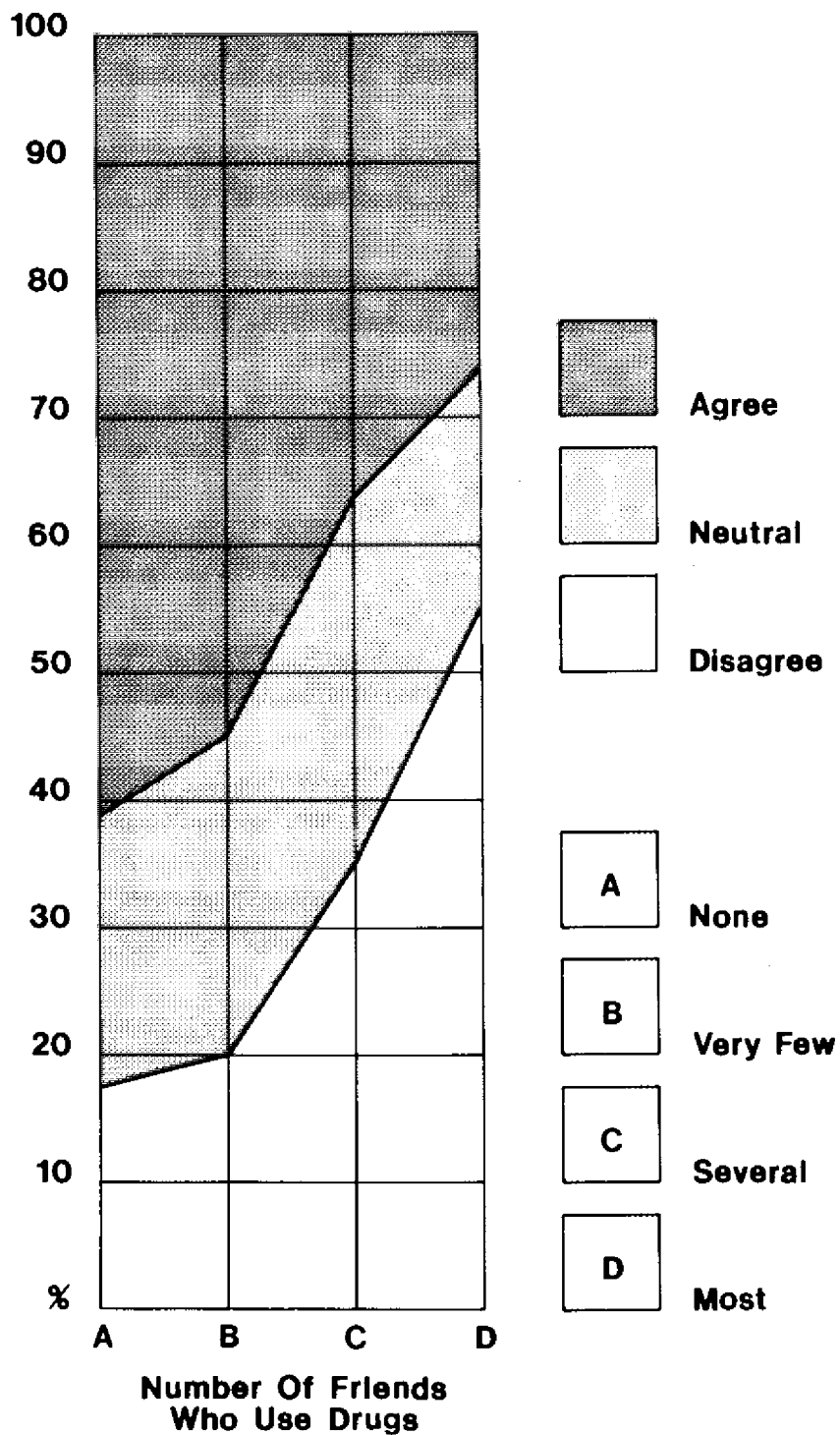
The JLARC survey of health and physical education teachers tended to reinforce the conclusions of the student survey. Only 18% of the respondents believed that "providing factual information about the harmful effects of drug abuse will prevent students from using drugs." Although three-quarters of the teachers believed that drug education had made students more aware of the facts about drugs, only 21% believed this had helped to reduce the level of drug

Figure 8
THE TEACHER SEEMED TO KNOW
A LOT ABOUT DRUGS



Source: JLARC Student Survey, December, 1974.

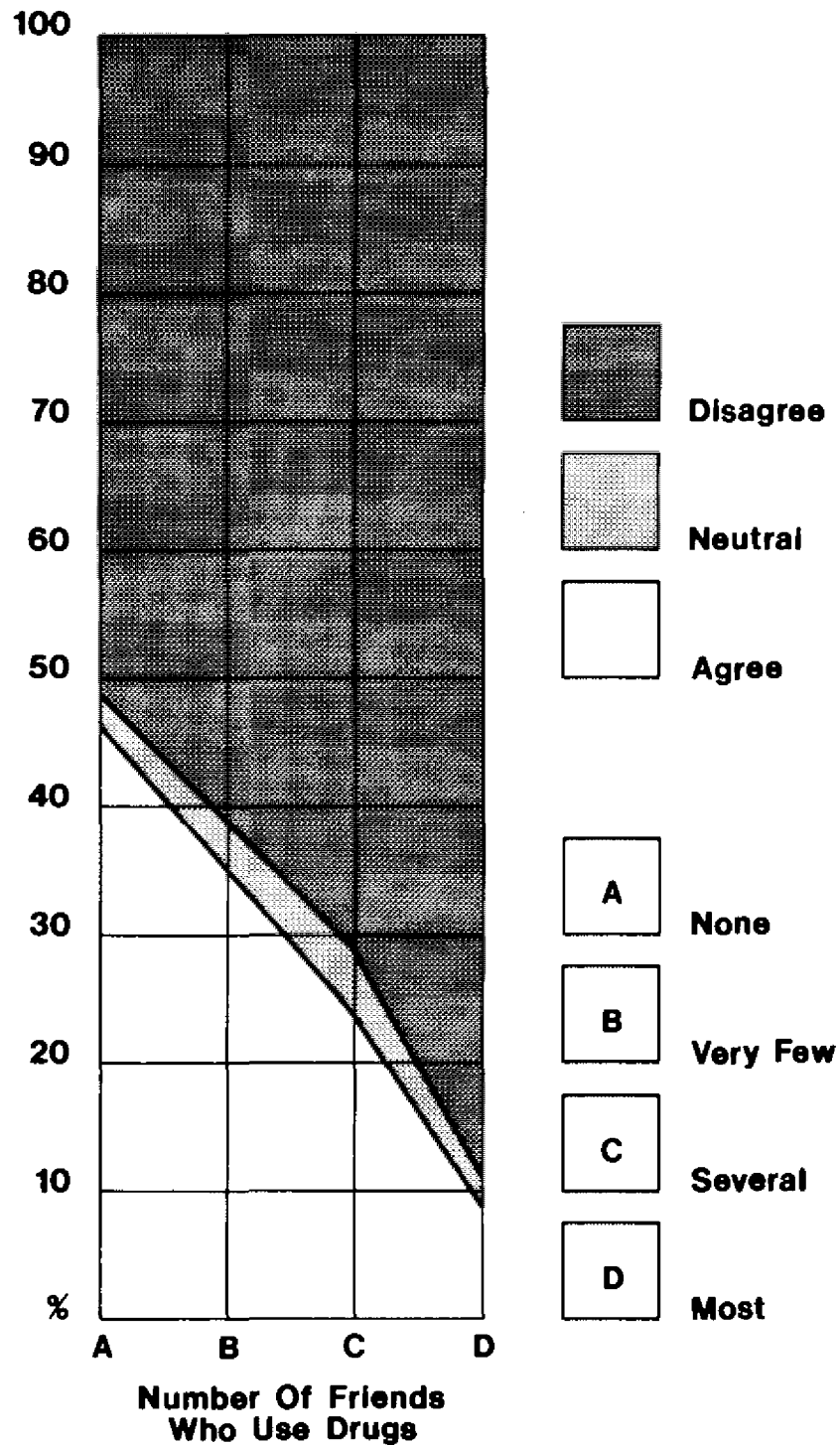
Figure 9
**THE FILMS WE SAW WERE RELEVANT
 TO THE DRUG PROBLEM**



Source: JLARC Student Survey, December, 1974

Figure 10

HAS DRUG EDUCATION REDUCED THE LEVEL OF DRUG ABUSE IN YOUR SCHOOL?



Source: JLARC Student Survey, December, 1974.

experimentation, and only 37% believed that drug education had reduced the level of serious drug problems in their school. Large city and suburban county respondents were even less likely to believe that drug education had been effective.

On the other hand, the teachers overwhelmingly agreed that a more humanistic approach was needed, and 85% agreed with the statement:

In order to be more effective in the future, drug education should concentrate on helping students to understand themselves, their emotions, and their own motivations for using drugs.

Along with this approach, 82% of the teachers believed that group discussions are more effective than lectures. However, they tended to view their present role as one of presenting factual information to prevent drug use. Over 60% believed that the main goal of drug education is to reduce the incidence of drug use, and over half (54%) believed that their main goal as a teacher was to provide information to the students. Many teachers do not believe that this approach has been effective. This feeling among health and physical education teachers was strongly supported by the JLARC Counselor Survey, which found that only 14% of the guidance counselors believed drug education had reduced the level of drug abuse in their school.

Educational Objectives: JLARC asked teachers to rank several possible objectives for their school's effort in dealing with drug abuse. These objectives were ranked on the basis of how many teachers felt they should be important or extremely important in their school's program. The priority ranking in Table 19 indicates that providing factual information is only a medium priority for most health teachers, while helping students learn more about themselves has top priority.

Class Size: Health and physical education teachers believe that their school should do more than simply provide factual information in order to deal effectively with drug abuse. However, the size of drug classes may be prohibiting the introduction of newer teaching strategies. The 1974 Statewide Conference on Health Education included a Task Force Report calling attention to "The urgent need to reduce class size from 40-50 per class, to 20-30 pupils as in English, history and other classes".

The survey of health and physical education teachers conducted by the Capital Area Health Planning Council discovered that a major problem is the lack of permanently assigned classrooms for health education. Many teachers reported that their classes were held in gymnasiums, locker rooms, auditoriums, or cafeterias. These locations suggest large class sizes and traditional lectures, which have been shown to be the least effective in preventing drug abuse.

YOUTH INVOLVEMENT

A number of school divisions in Virginia have recently initiated youth involvement programs using high school students as group leaders for

Table 19

HEALTH AND PHYSICAL EDUCATION TEACHERS' RANKING OF GOALS
FOR DRUG EDUCATION

<u>Program Objective</u>	<u>Positive Response^a</u>
<u>Higher Priority</u>	
Helping students to learn more about themselves, so that they can make their own decisions regarding the use of drugs:	83%
Providing counseling services for individual students with problems:	83
Helping students to explore positive alternatives to drug use:	80
<u>Medium Priority</u>	
Exploring the reasons why people use both legal and illegal drugs:	76
Providing factual information about drugs:	75
Developing interpersonal and group communication skills:	71
<u>Lower Priority</u>	
Warning students about the dangers of drug abuse:	66
Involving students in drug abuse curriculum development and evaluation:	65
Working directly with parents to help alleviate family problems:	65
Referring students with problems to local community services:	64
Distinguishing between drug experimentation use, and abuse:	62

^aSum of percentages responding 4 or 5 on a 5-point rating scale: 1 (not at all important) to 5 (extremely important).

Source: JLARC, Health and Physical Education Survey, December, 1974.

elementary school classes. Most of the programs are termed SODA, Student Organization for Developing Attitudes. Local SODA coordinators stress the importance of peer group influence in supporting drug education, and believe that carefully selected and trained high school juniors and seniors can serve as positive role models for younger children.

Although originally seen as a drug abuse prevention tool, many of the student programs in Virginia have since moved away from an emphasis on drugs toward a broader concern for life values and attitudes. If questions about drugs are raised by the elementary classes, the SODA volunteers are prepared to discuss them, but in most cases the students do not plan specific lectures on the subject. Many of the programs have established goals similar to that of the Roanoke program: "To aid students...in the development of independent, self-supporting attitudes with emphasis on decision-making, communication, and personal and social awareness."

New SODA members are selected by previous participants and in some cases by the staff of their high school. Students receive approximately 30 hours of training in group counseling, the typical problems of 10 to 12 year olds, drug awareness, and class planning techniques. Teams consisting of one boy and one girl are assigned to an elementary school which feeds students into their high school. The older students can then be seen as experts on the problems of moving from elementary to junior high school.

One major factor influencing the success of SODA programs has been the attitude of the elementary school teacher whose classroom the SODA team visits. While the support of school boards, superintendents, and principals has been excellent, in some cases the lack of teacher support has been a problem. In divisions with new programs, only those teachers who express an interest have SODA visits, and those who may be most in need of a SODA team may not be interested. Several SODA coordinators feel there is a need for more direct communication with classroom teachers, many of whom are unfamiliar with the open style of a SODA team.

Evaluation of SODA

No systematic evaluation of the impact of SODA on younger students' attitudes or behavior has yet been completed. However, a major study of Roanoke's SODA will be completed in mid-1975, which will include pre and post-test results for an experimental (SODA) and control (non-SODA) group.

The Waynesboro Mental Health Association administered an attitudinal survey to 3,500 students in 1972 as part of an overall SODA evaluation. The most significant finding of this study was that elementary and intermediate school children have not yet developed "...clear cut decisions about philosophies concerning (their) fellow man, parentally held values, or peer values". The report concludes that values oriented education could have a significant positive impact for this age level.³²

Alexandria has evaluated its efforts to establish Social Environmental Education (SEE), another SODA type program, initially set up as a summer

pilot course in 1973. The results indicated that all students in the course increased their awareness of drugs and related issues. In addition, teacher observations and student feedback showed increased decision-making, communication, and group leadership skills. During the following year SEE teams visited eighth grade classrooms in Alexandria and their evaluation showed positive responses from students.³³

The major drawback in the SODA evaluations to date is their preoccupation with the mechanics of program implementation. Planning, organization, responsibility in class, and communication are important variables, and their measurement has provided insight into program performance. Unanswered by these reports, however, is the impact SODA has had on the attitudes and values of younger students (especially drug use). The Roanoke evaluation should provide preliminary answers to these questions.

SODA appears to be one means of recognizing and dealing with the underlying causes of drug abuse. The continued development of SODA programs at the local level is an important objective. In addition, SDE should review the effectiveness of SODA through objective evaluation, and use the findings as one aspect of developing a mental health education model for the future.

Other Forms of Youth Involvement

The Department of Education has unnecessarily limited the scope of student involvement in drug education by defining SODA as the youth involvement program. There are many ways in which young people can become involved in the educational process, and SODA should be viewed as only one form. In an area such as drug abuse, it is surprising that 49% of the intermediate and 56% of the senior high school principals report no student involvement:

Table 20

PERCENTAGE OF SCHOOLS REPORTING YOUTH INVOLVEMENT

<u>Type of School</u>	<u>1971-72</u>	<u>1972-73</u>	<u>1973-74</u>
Elementary	32%	29%	35%
Intermediate	48	43	51
Senior High	<u>39</u>	<u>49</u>	<u>44</u>
Total	35%	32%	39%

Source: State Department of Education, Principals' Survey, 1973-74
Annual Report.

A recent departmental publication, *Virginia's Resource Guide for Drug Education* includes "Suggested Guidelines for Youth Involvement," and discusses the SODA program. Aside from this, the department should more actively promote other forms of student involvement, particularly rap centers, curriculum evaluation, and student participation in the review of drug policies and procedures.

CONCLUSION

Drug education in Virginia has resulted in an overall increase in student awareness of drugs, particularly with respect to the dangers of hard narcotics. There is substantial evidence, however, that drug education has not been successful in its primary goal: to prevent the use and misuse of drugs and other harmful substances. This is made all too clear by the increasing level of drug abuse by students attending Virginia's public schools, especially at the lower grade levels. Yet, it is unrealistic to expect that drug education alone can stop drug use. It may be more appropriate to provide students with the skills to make their own responsible decisions.

Nationwide, evaluation studies suggest that drug education, especially at the lower grades, may have contributed to the increase in experimental use of marijuana, alcohol, and other substances. These results are backed by evaluation research, as well as student and faculty opinion, in Virginia. Only 21% of teachers surveyed by JLARC believed that education had reduced the level of experimentation, while only 37% believed that it had reduced the level of serious drug problems in their schools. Moreover, only 28% of the students, and 14% of the counselors believed that drug education had reduced the level of drug abuse. As students have expressed strong support for the concept of drug education, such negative results suggest fundamental weaknesses in the State's educational effort which must now be addressed.

Lack of Emphasis on Health Education

Drug education in Virginia has not been as effective as it might have been, due to a lack of teacher preparation. Drug education has been taught in the elementary schools by classroom teachers, four-fifths of whom did not have special training in drug education as of 1973-74.

At the secondary level, drug education has been taught by health and physical education teachers, whose college preparatory background was heavily oriented to physical education, rather than the social or psychological issues involved in health-related areas such as drug abuse. Moreover, of all health and physical education teachers, 31% reported no in-service training in drug abuse, and another 18% appear to be inadequately trained. The lack of teacher preparation in this field suggests that most school divisions do not have a comprehensive health education program.

There are indications that class size and physical surroundings for drug education have not been conducive to effective learning. A survey in the Richmond area found that many classes were held in gymnasiums, locker rooms, auditoriums, and cafeterias. Not only does this suggest a traditional lecture format, but it also implies a low priority on health education. The first step in upgrading drug education in Virginia should be for the State to place increased emphasis on health education.

The Need for a New Educational Approach

Factual information concerning drugs and drug abuse is essential for responsible decision making in today's society. A more comprehensive approach

to health and mental health education and counseling will be required, however, if the schools wish to deal directly with the problems leading to drug abuse.

A review of research findings and the experience of other states indicates that a broader, decision-making approach, in the context of a comprehensive health education and counseling program, can have a positive influence on younger students. Unfortunately, the capabilities of many school divisions to implement mental health education programs are limited. Most divisions do not have a coordinator for health education and although a brief unit on mental health is included in the State's curriculum, a more comprehensive mental health guide is needed to implement this approach. Most teachers have not received in-service training in drug abuse and a major effort would be required to provide training in new mental health approaches.

At this time, the State should encourage the development of pilot programs in this field, to determine whether this would be an effective strategy for dealing with the underlying causes of drug abuse. An objective evaluation of SODA programs should be an important component of this effort.

Focus on Specific Target Groups

Drug education has not addressed the problems of students who are most likely to be using drugs. Many of these persons are habitual users of alcohol and marijuana, as well as experimental or occasional users of stimulants, depressants, hallucinogens, and other drugs. The State's health curriculum guide has not reflected a concern for the problems and motivations of these students, and they appear to have been alienated by the traditional classroom format.

In addition, counseling services for these students appear to be severely limited, particularly at the elementary level. Not only does a significantly higher proportion of the target group feel there is no adult in their school to whom they can turn for help, but counselors report that in-service training has not provided them with sufficient skills to help students who have problems. Moreover, with 40% of health and physical education teachers unaware of a drug control policy in their school, there is a critical gap in policy development and communication, such that many schools may not be able to respond effectively to drug incidents on school property.

While SDE responded to the drug crisis by developing a comprehensive health curriculum with an expanded unit on drugs and drug abuse, many local school divisions responded by adding a unit on drugs and drug abuse to their physical education program. The evidence suggests that this approach has not been successful.

While SDE has developed a useful planning tool through its annual Principals' Survey, neither the department nor DDAC has used the information to define existing gaps in teacher preparation, training, counseling, or health services. There is a lack of up-to-date policies and standards for counseling, as well as insufficient coordination of counseling programs at both the State and division levels. There is no statewide program to provide health services

for students, and emergency drug services are lacking. Finally, the implementation of standard drug abuse control policies and procedures has not been effectively monitored by the department. If these problems are not addressed, a new educational approach is not likely to be effective.

DRUG AND NARCOTICS ENFORCEMENT

Law enforcement is one of the principal methods used by the Commonwealth in its battle against drugs. The General Assembly sought to establish priorities by directing in SJR 60 that law enforcement efforts emphasize persons engaged in the trafficking and the abuse of those drugs which present the greatest danger and harm to both users and society. State and local enforcement agencies, however, have not established priorities in drug enforcement. Instead, according to available indicators, they have continued to expend most resources on the apprehension of users, especially marijuana violators. For example, during 1974, approximately three-fourths of all local and State Police drug arrests were related to marijuana.

The amount of drugs confiscated by the State Police for the last six months of 1974 for each case involved small quantities--60% of all marijuana cases involved less than one ounce. There were 29 heroin arrests averaging .1 ounce each, 28 cocaine arrests averaging .06 ounces each, and 34 arrests involving 46,383 amphetamine tablets (1 arrest accounted for 44,500 pills). Only 2% of all arrests can be considered major drug seizures--and not one was for heroin.

The State Police are both well trained and experienced, but there is considerable variation in the measurable level of enforcement activity throughout the State. The more rural areas encompassing the Wytheville, Salem, and Appomattox field offices generally make fewer drug arrests, confiscate fewer drugs, have a greater percentage of marijuana arrests, and have the highest average cost per arrest. Evidently this is a result of allocating drug enforcement resources more on the basis of existing uniformed division boundaries than on a specific plan to address priorities or needs in drug control. A drug enforcement plan stating priorities is required to comply with legislative intent.

This chapter examines the achievements of federal, State, and local law enforcement agencies in attempting to reduce the Commonwealth's drug problem. The principal issues related to drug law enforcement are: (1) the extent to which law enforcement agencies have established priorities consistent with SJR 60; (2) the manpower needs to enforce the State's drug laws; (3) the amount of drug training received by State and local police; (4) the extent of cooperation and coordination among enforcement agencies; (5) the accuracy of reporting drug arrest statistics at the local level; and (6) the need for drug buy money.

IV. DRUG AND NARCOTICS ENFORCEMENT

Law enforcement has been the principal method of combatting the drug abuse problem in Virginia. Since the enactment of the Harrison Narcotic Drug Act in 1914, substantial public funds have been used to enforce drug and narcotic laws, but not even the infusion of additional federal funds and the vigorous law enforcement campaign of the federal government has appreciably stemmed the continued use of illegal drugs.

The purpose of the State's drug enforcement program is to reduce the supply of and the demand for illegal drugs. This is to be accomplished by (1) forcing distributors out of business and seizing narcotic supplies, (2) discouraging users through the risk of criminal punishment, and (3) emphasizing in both cases the most dangerous drugs. This purpose was clearly stated in Senate Joint Resolution No. 60, March, 1972. At that time, the General Assembly sought to establish priorities for drug law enforcement. The resolution noted that although law enforcement agencies have the responsibility to enforce all laws, they lack the resources to completely eliminate trafficking and abuse of illegal drugs. It further pointed out that the majority of drug arrests were for marijuana violations; that with few exceptions nearly all drug arrests involved users or minor distributors and did not affect major traffickers; that there was a trend toward leniency for drug users and harsh penalties for distributors; and that heroin addiction is a major cause of crime with its distribution closely linked to organized crime. In concluding SJR 60, the General Assembly directed the State Police and all other law enforcement agencies in the Commonwealth to:

...expend their major efforts in the investigation of individuals who are engaged in the trafficking and the abuse of the drugs which present the most danger and harm to both the user and society as a whole.

Thus, while not condoning the use of any illegal drug, the General Assembly instructed enforcement agencies to direct their limited resources toward the investigation of large distributors of drugs and the most dangerous drugs, particularly heroin in an effort to reduce its availability. JLARC staff found no evidence that warrants changing the priorities established in 1972 by the General Assembly.

In the past few years, increasing drug arrests and convictions have been matched by increased appropriations and expenditures. Federal and State appropriations used by State agencies for drug abuse enforcement are shown in Table 21.

Expenditure estimates for local enforcement and the judicial system are not available; however, the annual budget for maintaining the local law enforcement system was estimated to be approximately \$66 million in 1971-72. Additionally, assuming that local drug arrest expenditures are similar to State arrests, JLARC estimates the cost of local drug enforcement during 1974-75 was about \$4.8 million. (See calculation in Table 30 of this chapter.) In 1970, there were only 40 officers estimated to be involved in full-time drug enforcement activities; this increased to about 300 full-time officers in 1974.

Table 21

FUNDS AVAILABLE FOR DRUG ABUSE CONTROL ENFORCEMENT PROGRAMS

<u>AGENCY</u>	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>	<u>1975-76</u>
State Police				
State Funds	\$858,315	\$862,155	\$1,023,355	\$1,041,500
Federal Funds	<u>54,935</u>	<u>66,460</u>	<u>---</u>	<u>---</u>
Total	\$913,250	\$928,615	\$1,023,355	\$1,041,500
Alcoholic Beverage Control Board				
State Funds ^a	\$122,660	\$206,050	\$ 239,235	\$ 238,010
Board of Pharmacy				
State Funds	\$206,145	\$206,050	\$ 239,020	\$ 240,720

^aEstimated by JLARC based on percentage of drug arrests.

Source: Commonwealth of Virginia, *Budget, 1974-76*, and Department of State Police.

FEDERAL ENFORCEMENT

At the federal level, the Drug Enforcement Administration (DEA) and the Law Enforcement Assistance Administration (LEAA) conduct programs and activities which heavily influence the character of the State's drug enforcement.

Drug Enforcement Administration

DEA's major enforcement efforts focus on the source and distribution of illicit drugs rather than on the arrest of abusers. DEA believes its agents should devote approximately 70 - 80% of their time investigating heroin and cocaine; 20 - 30% on other dangerous drugs; and not more than 15% on marijuana and hashish. In the latter case, DEA officials report they are primarily interested in supplies of one ton or more. However, DEA admits that about 30% of its drug arrests involve marijuana (Table 22). There are six DEA agents in the Norfolk district office responsible for conducting drug enforcement activities throughout the State except Northern Virginia which is assigned to the DEA office located in the District of Columbia.

Federal drug enforcement emphasis in Virginia has been to assist State and local police in the prevention of illegal drugs from reaching the community. This is accomplished through (1) the investigation and apprehension of drug traffickers, usually with the help of State and local police, (2) providing buy money, under certain circumstances, to local enforcement agencies involved in undercover work, and (3) encouraging and actively participating in the formation of regional or metropolitan drug enforcement task forces.

Table 22

DEA DRUG CHARGES AND SEIZURES IN VIRGINIA
July 1, 1974 to October 1, 1974

<u>Type of Drug</u>	<u>Number of Charges Filed</u>	<u>Approximate Amount Seized</u>
Heroin or Cocaine	14	.75 lb.
Marijuana and Hashish	16	8103.00 lb.
Methamphetamines	9	1.75 lbs. and 142,000 pills
Other Non-Narcotic Drugs	5	.25 lb.

Source: Drug Enforcement Administration, Baltimore Regional Office,
October, 1974.

DEA arrest data for three months in 1974 are presented in Table 22. Of the 44 charges filed against drug offenders, only four were directly related to possession of a drug. Most of the charges were concerned with conspiracy to sell, distribute, or manufacture controlled substances. About one-third of all charges involved marijuana or hashish, while about another third consisted of heroin or cocaine.

Another responsibility of the DEA is regulation of drug manufacturers and distributors under the Controlled Substances Act of 1970. Manufacturers, wholesalers, doctors, and pharmacists, who manufacture, distribute, prescribe, or dispense controlled drugs must register annually with the DEA and are subject to periodic inspections. This activity has been carried out in close cooperation with the Virginia Board of Pharmacy.

The DEA has the authority to deny a license to manufacturers, but not physicians, or pharmacists, and must therefore rely on the states for regulation and inspection of these professionals. During FY 1974, DEA performed 39 compliance investigations of distributors, pharmacies, physicians, and researchers in Virginia. There were no audits or investigations conducted of manufacturers because of an agreement between the Board of Pharmacy and DEA that allows the Board to perform this function.

Law Enforcement Assistance Administration

Since 1969 LEAA has allocated approximately \$436,000 to State and local agencies for drug enforcement purposes. These funds have been used primarily for surveillance equipment, buy money, officer training, and salaries to a limited extent.

One feature of LEAA grants is the availability of money to purchase drugs for use as evidence against drug suppliers or pushers. In the past as much as 50% of the grant could be used to purchase drugs as evidence. This was subsequently reduced to 33% and later to 15%. Recently, however, the amount of the grant that may be used to buy drugs has increased to 30 - 40%.

Another source of buy money has been the DEA which on occasion has provided buy money to local police agencies. Local officers, however, feel they cannot depend on DEA as a source of buy money.

The availability of buy money is an important element in the investigation and apprehension of large drug dealers. Increased cooperation between local, State, and federal enforcement agencies is needed to insure adequate funds are available for this purpose.

VIRGINIA STATE POLICE

The Department of State Police (DSP) receives its authority from Title 52-8 of the Code of Virginia which states that, "The Superintendent of State Police, his several assistants and police officers appointed by him are vested with the powers of a sheriff for the purpose of enforcing all criminal laws of this State...". Executive Order Number Four issued by former Governor Linwood Holton in 1970 directed the State Police to expand and strengthen the department's enforcement of drug and narcotic laws. Furthermore, Section 52-8.1 directs the department's Division of Investigation, to which drug enforcement has been administratively assigned, to conduct criminal investigations whenever requested to by the Attorney General, or any sheriff, local chief of police, Commonwealth's Attorney, or grand jury. The number of such requests for drug related assistance is shown in the Appendix.

DSP administers its uniformed patrol operations through six divisions and its investigative activities through the Division of Investigation in Richmond. The Division of Investigation assigns officers to each of the six State Police divisions, as shown on the following map, for either undercover drug enforcement or other criminal enforcement activities.

For the 1974-76 biennium, DSP has available \$47,752,305, of which \$2,064,855, or about 4%, is used exclusively to enforce drug laws. Table 23 illustrates the funds available to DSP for drug law enforcement since 1970-71. It should be noted that many drug arrests are also made by uniformed troopers and therefore, the funds used for drug control are understated below.

Table 23

FUNDS AVAILABLE FOR DSP ENFORCEMENT OF DRUG LAWS

<u>Year</u>	<u>State Funds</u>	<u>Federal Funds</u>	<u>Total</u>
1970-71	\$ 181,205	\$ - - -	\$ 181,205
1971-72	839,795	5,000	844,795
1972-73	858,315	54,935	913,250
1973-74	862,155	66,460	928,615
1974-75	1,023,355	- - -	1,023,355
1975-76	<u>1,041,500</u>	<u>- - -</u>	<u>1,041,500</u>
Total	\$ 4,806,325	\$126,395	\$4,932,720

Source: Department of State Police.

All State Police officers receive a 22-week basic course and must attend an annual one-week in-service training session. Included in the basic course are 31 hours of drug awareness and enforcement training covering such subject areas as Virginia's drug problem, identification of drugs, and investigative procedures. Police assigned to the narcotics enforcement unit generally receive an additional 40 hours of drug training. Much of this training, however, is a repeat of the 31-hour course taught as part of basic training.

Drug Arrests

To determine the extent to which DSP has directed its efforts toward the more dangerous drugs as instructed by the General Assembly, JLARC examined drug cases over a four-year period. Although DSP drug cases have remained fairly constant, only increasing from 2,553 in 1971 to 2,688 in 1974, a significant growth has occurred in the percentage of marijuana arrests (Figure 11).

Additionally, a comparison of marijuana arrests with all drug cases for the past four years shows a direct relationship between month-to-month variation, and the increase or decrease in marijuana cases. Thus, if total cases increase, it is principally because of an increase in marijuana arrests.

Evidently, SJR 60 has not brought about any significant shift in DSP policies and priorities related to the investigation of the most harmful and dangerous drugs since two-thirds of all DSP cases during 1974 involved marijuana, while only about 7% were for narcotics including cocaine (3%). Furthermore, marijuana investigations and arrests continued to increase and the percentage of narcotic arrests in fact decreased after passage of SJR 60 in 1972.

In order to make comparisons among regions, JLARC examined drug arrests for the last half of 1974 by field office. About 70% of all DSP cases throughout the state involved marijuana. Three field offices exceeded that average by large margins--Wytheville with 80%, Appomattox with 78%, and Salem with 76%--while Culpeper had the lowest percentage of marijuana arrests (56%) and high rates of hallucinogen and stimulant arrests, consistent with the major drug problem as identified by local law enforcement agencies in Northern Virginia. Opiate cases ranged from none in Wytheville to 8% in Chesapeake (Table 24).





Amount of Drugs Seized

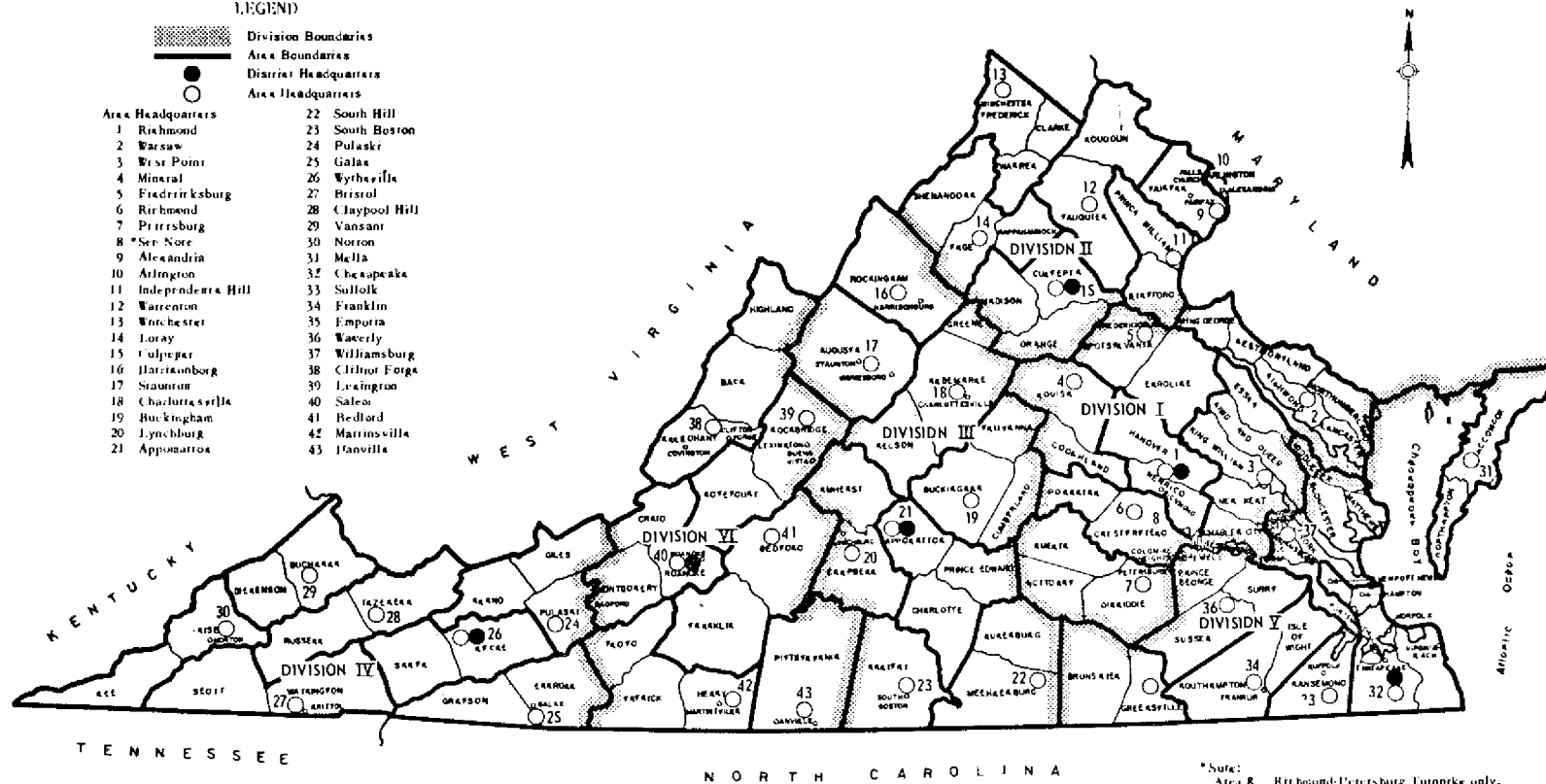
One of the objectives of both SJR 60 and DSP is to emphasize the investigation and apprehension of major drug dealers. One measure of whether this objective has been met is the amount of drugs confiscated. While major drug traffickers do not necessarily possess large amounts of drugs, large drug seizures do indicate the arrest of major dealers.

Table 25 shows that DSP confiscated a total of 251 pounds of marijuana, 2.5 pounds of hashish, 46,383 tablets of amphetamines, and 4,209 pills of hallucinogens during the last half of 1974. Most of the drugs were seized in the Chesapeake and Richmond areas. During this period little heroin,

VIRGINIA DEPARTMENT OF STATE POLICE

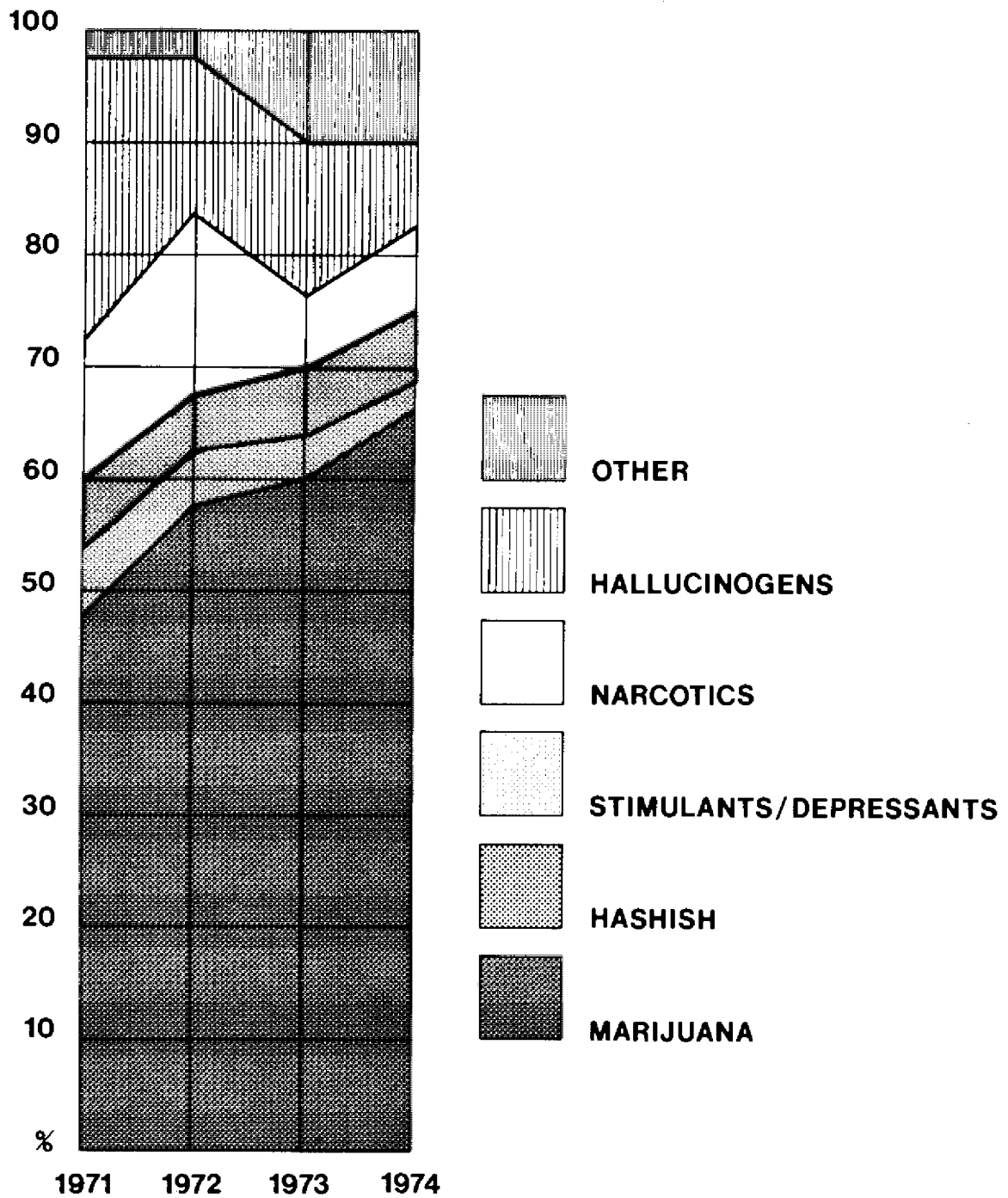
LEGEND

	Division Boundaries
	Area Boundaries
	District Headquarters
	Area Headquarters
Area Headquarters	
1 Richmond	22 South Hill
2 Warsaw	23 South Boston
3 West Point	24 Pulaski
4 Mineral	25 Galax
5 Fredericksburg	26 Wytheville
6 Richmond	27 Bristol
7 Petersburg	28 Claypool Hill
8 *See Note	29 Vansant
9 Alexandria	30 Norton
10 Arlington	31 Mella
11 Independence Hill	32 Chesapeake
12 Warrenton	33 Suffolk
13 Winchester	34 Franklin
14 Lora	35 Emporia
15 *See Note	36 Waverly
16 Harrisonburg	37 Williamsburg
17 Staunton	38 Clinton Forge
18 Charlottesville	39 Lexington
19 Buckingham	40 Salem
20 Lynchburg	41 Bedford
21 Appomattox	42 Martinsville
	43 Hanville



*Note:
Area R Richmond-Petersburg Turnpike only.
Headquarters in Richmond area 6.

Figure 11
STATE POLICE DRUG ARRESTS
1971 - 1974



Source: Department of State Police.

Table 24

DSP DRUG CASES BY FIELD OFFICE AND TYPE OF DRUG
July - December, 1974

Type of Drug	Chesa- peake	Richmond	Culpeper	Wythe- ville	Appo- mattox	Salem	Total
Marijuana	67.9%	72.2%	56.0%	80.4%	78.4%	76.1%	70.5%
Opiates	8.0	1.0	6.4	---	2.7	5.2	3.2
Cocaine	2.1	3.0	1.0	---	1.0	6.7	3.6
Hashish	4.3	3.5	3.7	---	2.2	3.0	3.3
Stimulants	3.2	2.5	9.2	3.6	4.5	1.5	3.9
Depressants	---	0.5	---	1.8	1.5	---	.5
Hallucinogens	10.8	3.0	15.6	8.9	0.7	4.5	7.4
Other	<u>3.7</u>	<u>14.3</u>	<u>8.1</u>	<u>5.3</u>	<u>9.0</u>	<u>3.0</u>	<u>7.6</u>
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Notes: Excludes unidentified drugs.

Source: Department of State Police.

Table 25

AMOUNT SEIZED FOR DSP DRUG CASES BY
FIELD OFFICE AND TYPE OF DRUG
July - December, 1974

Type of Drug	Chesa- peake	Richmond	Culpeper	Wythe- ville	Appo- mattox	Salem	Total (Units)
Marijuana	149.2	51.6	16.0	1.7	8.6	24.0	251.1 (lbs)
Hashish	.8	.8	.3	---	.6	*	2.5 (lbs)
Heroin	*	.1	*	---	---	*	.2 (lbs)
Cocaine	.5	.8	*	---	.1	.2	1.7 (lbs)
Stimulants	1,288	514	44,518	49	12	2	46,383 (pills)
Depressants	---	12	---	5	53	---	70 (pills)
Hallucinogens	4,115	21	NA	26	2	45	4,209 (pills)
Other no consistent unit of measure						

*less than .1 pounds.

NA - No figures in pills available.

Note: Figures in pounds excludes minor seizures that were reported in pills, tablets, capsules, or packets. Conversely figures represented in pills excludes some minor seizures reported in grams.

Source: Department of State Police.

cocaine, or barbiturates were seized. Based on this measure, it is evident that DSP has not intercepted large quantities of drugs, especially heroin or cocaine, and that few of these more harmful drugs are being found in the three western, and more rural, areas of the State.

It is also evident that most drugs are seized in a very small number of arrests (Table 26). For example, twelve marijuana arrests account for two-thirds of the marijuana seized. Sixty percent of all marijuana cases involved possession of less than one ounce. At the same time there were no large busts of heroin, hashish, or barbiturates, indicating that DSP is probably not having much success in apprehending traffickers of more dangerous drugs. During this six month period, DSP reports that about half of all arrests involved distributors and manufacturers and a summary report of charges by field office prepared by DSP is contained in the Appendix. An analysis of court dispositions reported in a subsequent chapter shows, however, that a much smaller proportion of court cases are reported as distribution offenses. Apparently many of the original charges are reduced to a lesser offense.

Table 26

DSP DRUG CASES BY AMOUNT SEIZED
July - December, 1974

Type of Drug	Small Seizures		Large Seizures		Total Cases
	Cases	Amount	Cases	Amount	
Marijuana	581	82.7 lbs.	12	See below	593
Hashish	28	2.4 lbs.	- - -	none - - -	28
Heroin	29	.2 lbs.	- - -	none - - -	29
Cocaine	27	1.1 lbs.	1	.6	28
Amphetamines	33	1,883 pills	1	44,500 pills	34
Barbiturates	4	70 pills	- - -	none - - -	4
LSD/Phencyclidine	60	620 pills	2	3,549 pills	62
Total	762		16		778
	(98%)		(2%)		(100%)

LARGE MARIJUANA SEIZURES

Norfolk	56.1 lbs.	Page Co.	4.8 lbs.
Newport News	47.5 lbs.	Newport News	4.8 lbs.
Henrico Co.	12.1 lbs.	Norfolk	4.6 lbs.
Henrico Co.	11.0 lbs.	Dinwiddie Co.	3.5 lbs.
Norfolk	10.1 lbs.	Winchester	3.5 lbs.
Newport News	7.7 lbs.	Henrico Co.	2.7 lbs.

Note: DSP made 12 other large marijuana seizures during the first half of 1974 totaling 566 pounds.

Source: Department of State Police.

Based on available information, it appears that DSP has not apprehended drug traffickers of the more dangerous drugs, and that arrests for distribution have been at the user or user/distributor level, especially in the three western field offices.

Undercover Drug Activities

Since the drug enforcement unit is assigned to the Investigative Division of the Department of State Police, JLARC reviewed the division's undercover operations. There are 60 officers (12 investigators and 48 troopers) permanently assigned to the six field offices for undercover drug investigation. Each field office has two investigators who act in an administrative and supervisory capacity. Additionally, six to eleven troopers are temporarily assigned as undercover agents for a period of time ranging from 12 to 15 months. JLARC staff reviewed the undercover operations for the period July 1, through December 31, 1974. During this time a total of 84 officers (61 troopers and 23 investigators) were assigned for all or part of this period to the narcotics unit. The average age of the 61 troopers was 29.2 years and they had spent an average of 5.5 years on the force (Table 27). The Wytheville and Salem field offices had the highest average age and Wytheville had the most experienced officers in terms of years with the State Police. The average length of assignment to the narcotics unit was 12.5 months--Chesapeake had the highest average (19.5 months) while Culpeper's was the lowest with only 6.4 months.

Table 27

DSP OFFICERS ASSIGNED TO NARCOTICS AS OF DECEMBER 31, 1974 Age and Experience

<u>Field Office</u>	<u>Average Age</u>	<u>Years on Force</u>	<u>Months Assigned to Narcotics</u>
Chesapeake	28.6	4.4	19.5
Richmond	29.9	6.9	16.3
Culpeper	26.5	3.8	6.4
Appomattox	28.7	4.4	14.6
Salem	31.6	6.8	12.9
Wytheville	<u>32.1</u>	<u>8.2</u>	<u>16.0</u>
Statewide Average	29.2	5.5	12.5

Note: Excludes investigators in each field office.

Source: Department of State Police.

JLARC staff also reviewed the education and training of drug officers (troopers and investigators) and found that nearly half had some college education and a full third had more than one year. Even though additional drug training is often given before assignment to the undercover force, two-thirds (55 officers) had the special narcotic training. Of those 55 officers, 36

(69%) received the training the same year they were assigned to drugs (Table 28). Although drug training does not deal extensively with procedures for undercover operations, the narcotics seminar does include such topics as:

- The drug problem
- Effects of drugs and related laws
- Drug language
- Use of informers and drug buys
- Demonstration of investigative procedures

Orientation to undercover work is carried out largely by on-the-job training and assignment to another undercover agent for a period of time.

Table 28

EDUCATION AND TRAINING OF DSP OFFICERS
ASSIGNED TO NARCOTICS

<u>Field Office</u>	<u>Some College Education</u>	<u>Narcotics Seminar</u>
Chesapeake	44%	71%
Richmond	25	50
Culpeper	50	50
Appomattox	56	69
Salem	20	90
Wytheville	<u>60</u>	<u>50</u>
Statewide Average	44%	62%

Source: Department of State Police.

Officer Activities

JLARC staff also requested information on the amount of time and money spent by agents on different types of activities. Data were collected on 33 troopers who were assigned to undercover activities for a six-month period, and it was found that 90% of their time was spent on investigative drug activity.

All undercover agents spent a total of \$110,260 during the last six months of 1974: \$37,633 for drug buys, \$12,828 for informants; and \$59,799 on personal expenses such as food, clothing, and equipment (Table 29). The amount of funds spent for drug buys and informants composed a third or less of the total expenditures of the Salem (33%), Appomattox (24%), and Wytheville (19%) field officers. Compared to the three western field offices, Chesapeake, Richmond, and Culpepper spent considerably more money for informants and drug buys, perhaps reflecting the greater availability of drugs in these regions.

While reviewing the expense statements of the undercover agents, JLARC discovered variations among field offices in the way funds are spent.

Table 29

EXPENSES OF DSP DRUG UNDERCOVER AGENTS
July - December, 1974

<u>Field Office</u>	<u>Percent of Total</u>			<u>Total</u>
	<u>Drugs</u>	<u>Informants</u>	<u>Personal Expenses</u>	
Chesapeake	44%	21%	35%	\$29,033
Richmond	45	9	46	26,997
Culpeper	34	9	57	18,138
Appomattox	18	6	76	14,882
Salem	26	7	67	11,488
Wytheville	<u>8</u>	<u>11</u>	<u>81</u>	<u>9,722</u>
Total	34%	12%	54%	\$110,260

Source: Department of State Police.

Undercover agents in the three western offices tend to spend more time and money on food, beverages, and entertainment. As indicated in Table 29, Salem, Appomattox, and Wytheville apply an unusually large share of their drug investigation funds to personal expenses of undercover agents.

Using average annual salaries and man-years worked in each field office, JLARC staff estimates the total cost of DSP drug investigations, excluding administrative overhead, was \$463,308 for the last half of 1974 (Table 30). Comparing costs and arrests by field office shows a wide range of costs for each arrest.

Table 30

COST OF DSP DRUG INVESTIGATIONS
July - December, 1974

<u>Field Office</u>	<u>Man-Years</u>	<u>Total Expenditures</u>	<u>Persons Arrested</u>	<u>Cost/Arrest</u>
Chesapeake	5.8	\$ 92,647	422	\$219.54
Richmond	6.6	103,346	270	382.76
Culpeper	5.0	72,498	152	476.96
Salem	3.7	55,888	74	755.24
Wytheville	4.6	64,143	83	772.81
Appamattox	<u>5.2</u>	<u>74,786</u>	<u>81</u>	<u>923.28</u>
Total	30.9	\$463,308	1,082	\$428.20

Includes all State Police drug arrests, both uniformed troopers and undercover agents.

Source: Department of State Police.

There were 1,082 persons arrested on drug charges during July - December, 1974, including uniformed troopers and undercover agents. Thirty-nine percent of the arrests were by the Chesapeake field office and another 25% occurred in Richmond. Salem and Wytheville accounted for only 15% combined.

Also indicative of the greater enforcement activity in the Richmond and Chesapeake field offices are the number of drug buys per man-month (Table 31). Chesapeake had 3.4 and Richmond 2.02 drug buys per month, while Appomattox and Wytheville each had less than one. Using the direct cost of DSP drug enforcement activity, the average statewide cost per drug arrest was \$428. Chesapeake had the lowest average cost, \$219, while Appomattox, Wytheville, and Salem had the highest, \$923, \$773, and \$755 respectively. DSP reports, however, that the cost of all enforcement activity is greater in rural communities. (It should be noted that these average costs could be higher if drug arrests made by uniformed troopers are subtracted from the total. A review of Chesterfield County District and Circuit Court files revealed that between 50% to 75% of all DSP drug arrests for 1974 were made by uniformed troopers. A large percentage of these arrests involved hitch-hikers in possession of illegal drugs.)

Table 31

DSP DRUG BUYS BY FIELD OFFICE
July - December, 1974

<u>Field Office</u>	<u>Number of Buys</u>	<u>Man- Months</u>	<u>Buys/ Man-Months</u>	<u>\$ For Buys</u>	<u>Cost/ Buy</u>
Chesapeake	236	69.5	3.40	\$12,561	\$53.22
Richmond	159	78.7	2.02	12,264	77.13
Culpeper	100	60.5	1.65	6,284	62.84
Salem	51	44.0	1.16	2,980	58.40
Appomattox	62	62.5	.99	2,679	43.21
Wytheville	40	54.8	.73	836	20.90
Total	648	370.0	1.75	\$37,604	\$58.03

Source: Department of State Police.

DSP made 648 drug buys during the last six months of 1974, at an average \$58 a buy. Richmond had the highest cost, \$77, an indication of either larger amounts or more dangerous drugs, while Wytheville had the lowest, \$21 (an indication that most drug buys are for marijuana which costs an average of \$20 an ounce) (Table 31).

Clearly a considerable amount of time is spent investigating and arresting users and persons in possession of small amounts of marijuana. Only a few marijuana arrests involved relatively large amounts. Likewise, there were no large busts of heroin, hashish, or barbiturates, and nearly all of the amphetamines seized were taken in one arrest. Furthermore, because of the wide variation in costs and arrests among the six field offices, JLARC staff

believes that the department has allocated too much of its drug enforcement resources to its western offices. It is difficult to see the need for 25 full-time drug investigators in the three western field offices, and DSP should reduce its manpower commitments in these areas.

The department also should give consideration to making selective staff reductions or reassignments in its other regions. In Chesapeake, for example, of the 10 officers assigned to narcotics for at least five of the last six months of 1974, three have made no drug buys and two others have made two buys each. The other five troopers accounted for 89% of all drug buys made during the six months.

DSP must, of course, enforce violations of State law when discovered and respond to requests for assistance from local communities. However, compliance with these requirements should not preclude DSP from establishing drug enforcement priorities consistent with SJR 60. Based on this information made available during the course of this evaluation, it is reasonable to conclude that drug enforcement efforts are not based on a prioritized plan. Such a plan should be prepared by DSP based on the State's drug problem in cooperation with the drug control planning agency.

In addition, DSP should reevaluate the need to permanently assign undercover officers in each uniformed division. A smaller, centralized drug investigative unit might be more effective and efficient in directing attention and resources on major drug dealers throughout the State.

OTHER STATE AGENCIES INVOLVED IN DRUG ENFORCEMENT

In addition to the drug enforcement activities of the State Police, the Alcoholic Beverage Control Board (ABC), Board of Pharmacy, and Consolidated Laboratory also contribute to drug abuse control at the State level.

Alcoholic Beverage Control Board

Although not specifically mandated to investigate narcotic abuses, the enforcement division of the Alcoholic Beverage Control Board has become increasingly involved in the enforcement of drug laws. While ABC agents are empowered to enforce all criminal law, their primary function is to investigate violations of the State's ABC laws and regulations.

The activities of the division are supported entirely by revenues derived from licensing fees. There are 54 investigators assigned to four regions in the State--Tidewater (11), Eastern (15), Central (13), and Western (15). Two investigators are full-time undercover agents. Nearly all of the ABC agents have received special DEA drug training in addition to required training received at the Tidewater Police Academy.

During interviews with division personnel, it was noted that persons who use drugs are often involved in alcohol violations resulting in ABC agents encountering an increasing number of drug violations as part of their normal

activities. Contact with drugs, however, has increased to the point that they not only make a significant contribution to the agency's workload, but drug arrests have increased at the expense of alcohol arrests (Table 32).

Table 32

ABC PARTICIPATION IN ARRESTS

Types of Arrests	1972-73		1973-74		1974-75	
	Number	Percent	Number	Percent	Number	Percent
Drug	838	16.2%	1,336	26.9%	1,344	25.6%
Alcohol	2,628	50.9	2,048	41.2	2,229	42.5
Other	1,695	32.9	1,578	31.9	1,670	31.9
Total	5,161	100.0%	4,962	100.0%	5,243	100.0%

Source: ABC Board, Division of Enforcement, *Annual Report of Activities*.

Drug arrests increased from 16% to 26% of total arrests, while alcohol arrests decreased from 51% to 43% between 1972-73 and 1974-75. These statistics represent arrests that the board's agents have participated in, not cases handed over to other law enforcement agencies. It was estimated by the board that most arrests are made in cooperation with local police and a few are made in cooperation with the State Police.

ABC agents generally work closely with local police in all their activities and depend on local police for intelligence data. In some cases, because of close relationships, ABC agents almost seem to be part of the local force. For example, in Hampton, ABC agents work closely with the city police department and regularly take part in drug busts at the Hampton Coliseum. In Gloucester County, ABC investigators recently cooperated with the sheriff's office in seizing and destroying 150 pounds of marijuana. In a Richmond case, an ABC agent was offered marijuana in a local restaurant. After purchasing six cigarettes, he turned the evidence over to city detectives who made arrests several days later. On the other hand, there are few working relationships between the ABC agents and the Department of State Police, and is there little formal coordination of drug activities.

It is possible that because of revised ABC regulations, ABC agents have become involved with more drug violations because of reduced ABC violations. On the other hand, requests for assistance may constitute the bulk of the reason for the shift in arrests. In any event, the ABC Board should carefully review the activities of their agents to determine the appropriate level of ABC alcohol enforcement needs.

Board of Pharmacy

A less visible State agency involved in drug regulation and enforcement activity is the Board of Pharmacy, which is chiefly responsible for

regulating the manufacturing and dispensing of prescription drugs through (1) the formulation of rules and regulations, (2) the performance of audits and inspections, (3) the issuance of licenses and permits, and (4) undercover shopping of pharmacies and medical practitioners.

A substantial portion of the board's FY 1974-75 budget of \$239,000 was allocated to the support and maintenance of six field inspectors, one supervisory inspector, and one auditor. Each inspector is a pharmacist, and they are assigned to offices in Norfolk (2), Richmond (2), Arlington (2), and Western Virginia (1).

The board is authorized to establish rules and regulations consistent with existing State laws but the core of its enforcement and regulation activities includes the audit and inspection of manufacturers, distributors, pharmacies, and medical practitioners. Violations are reported to the Board of Pharmacy for action; however, violations by medical practitioners are referred to the appropriate medical licensing board.

During FY 1973-74, the board conducted 1,506 inspections and 138 audits averaging about one inspection of each drug distributor, wholesaler, or dispenser each year. At JLARC's request, the Board of Pharmacy carried out audits of drug control procedures at 11 State correctional institutions. Results of these reviews have been reported to the Department of Corrections and the Attorney General and are summarized in a subsequent chapter on correctional activities.

Also, during 1973-74, 187 doctors and pharmacists were investigated for alleged drug violations, including addiction and indiscriminate prescribing and dispensing. Of these, 71 reports were turned over to the the Board of Medicine for review and appropriate action; four physicians and four pharmacists were committed to treatment for drug addiction, and seven Controlled Substances Registration Certificates were revoked.

A third major activity involves the annual issuance of licenses, permits, and certificates to qualified manufacturers, distributors, prescribers, and dispensers of drugs as shown below:

	<u>Number</u>
Controlled Substances Registration Certificates	8,700
Pharmacist Licenses	3,318
Community and Hospital Pharmacy Permits	1,082
Manufacture and Wholesaling Permits	76

This regulatory mechanism is designed to control the legal manufacture, distribution, prescribing, and dispensing of drugs to prevent their diversion to illegal use. An emerging problem throughout the State, however, is the number of thefts of community pharmacies. Nationally there were 5,400

thefts during FY 1973, and 7,700 during FY 1974, an increase of 43%. Information supplied by the board of the number of pharmacy break-ins in Virginia is presented below.

<u>Period</u>	<u>Number of Break-Ins</u>	<u>Amount Stolen (Dosage Units)</u>	
		<u>Stimulants</u>	<u>Depressants</u>
July 1, 1972 to March 23, 1973	NA	119,470	66,855
July 1, 1974 to February 5, 1975	109	119,126	95,828

These figures indicate that the volume of drugs stolen from pharmacies increased. However, the board staff believes that pharmacy thefts have stabilized in recent months because of new alarm systems installed at community pharmacies.

The Board of Pharmacy apparently performs its job aggressively and with commendable results. DEA officials reported to JLARC that Virginia's Board of Pharmacy is one of the "top ten state regulatory enforcement agencies in the Nation," and, in fact, DEA does not assign compliance officers to its Norfolk Regional Office because of the board's effective inspection and auditing program.

In light of the sizable problem of abuse of legally prescribed drugs in Virginia, JLARC recommends that the functions of the Board of Pharmacy be strengthened by additional field inspectors and development of educational seminars across the State in cooperation with appropriate State and local agencies dealing with pharmacy theft prevention.

Consolidated Laboratory

The Division of Consolidated Laboratories Services of the State Health Department supports law enforcement agencies by conducting chemical analysis on all samples of suspected narcotic and dangerous drugs supplied by police officers throughout the State, and by testifying as expert witnesses in criminal cases in which their services were utilized. The division also conducts analysis of urine specimens submitted by drug treatment centers and State agencies to determine whether an individual has recently taken drugs. The division will also assist any Virginia law enforcement agency that wishes to conduct raids on illicit chemical conversion laboratories or in other enforcement situations where the services of a skilled chemist are required.

For FY 1975, the division had available \$541,796 of which about one-third was from federal sources.

Over half of the laboratory's caseload consists of driving under the influence and city police cases (Table 33). Also, nearly three quarters of their work involves drug related offenses--50% drug possession or trafficking and 27% related to driving under the influence of an intoxicant. JLARC staff requested data on drug samples received during September and October, 1974.

A total of 1,745 samples were received, of which more than two-thirds were marijuana as shown in Table 34.

Table 33
CONSOLIDATED LABORATORIES CASES BY SOURCE
1973-74

<u>Agency</u>	<u>Number</u>	<u>Percent</u>
City Police	5,895	26.6%
State Police	2,066	9.3
County Police	1,901	8.6
Town Police	663	3.0
Sheriffs	931	4.2
Medical Examiner	3,427	15.4
Courts ^a	5,991	27.0
ABC	122	.6
Other	<u>1,182</u>	<u>5.3</u>
Total	22,178 ^b	100.0%

^aDriving under the influence of an intoxicant.

^b10,000 identified drug cases.

Source: Consolidated Laboratory, Bureau of Forensic Science.

Table 34
DRUG SAMPLES ANALYZED BY CONSOLIDATED LABORATORIES
September - October, 1974

	<u>Number</u>	<u>Percent</u>
Narcotics	107	6.1%
Marijuana/Hashish	1,185	67.9
Stimulants	24	1.4
Depressants	34	1.9
Hallucinogens	87	5.0
Non-controlled	21	1.2
Other	91	5.2
Two or More Drugs	<u>196</u>	<u>11.3</u>
Total	1,745	100.0%

Source: Consolidated Laboratory, Bureau of Forensic Science.

During fiscal years 1973-74 and 1974-75, the Consolidated Laboratories received \$129,695 from DJCP to conduct urine analysis of specimens submitted by the Department of Corrections, Probation and Parole, Department of Health (Methadone Clinics), and the Division of Vocational Rehabilitation. The purpose of the program is to provide information necessary in monitoring the

progress of drug clients and inmates which in turn enhances effective treatment and counseling.

By September, 1974, several drug treatment centers were making extensive use of the service, but State agencies were not. Of the 10,393 urine samples submitted for analysis from January through September, 1974, 3,052 were sent by Project Jump Street in Richmond (Methadone Clinic). The bulk of the remaining samples were from Fairfax Drug Center, Hampton Roads Drug Center, and Portsmouth Methadone Clinic.

LOCAL LAW ENFORCEMENT

Local enforcement agencies bear the chief responsibility of enforcing the State's narcotic and drug laws at the community level. During the past four years police departments and sheriffs have responded to the drug problem by devoting more resources to drug investigations, training programs, and drug buy funds. Because of the fluid nature of narcotic trafficking across jurisdictional boundaries, especially in metropolitan areas, cooperative agreements between urban, suburban, and rural communities have become a prerequisite to effective drug investigation and surveillance. But even with the additional focus on drug enforcement in Virginia, the illicit use of drugs has been shown to have increased dramatically since 1971.

Drug Arrests

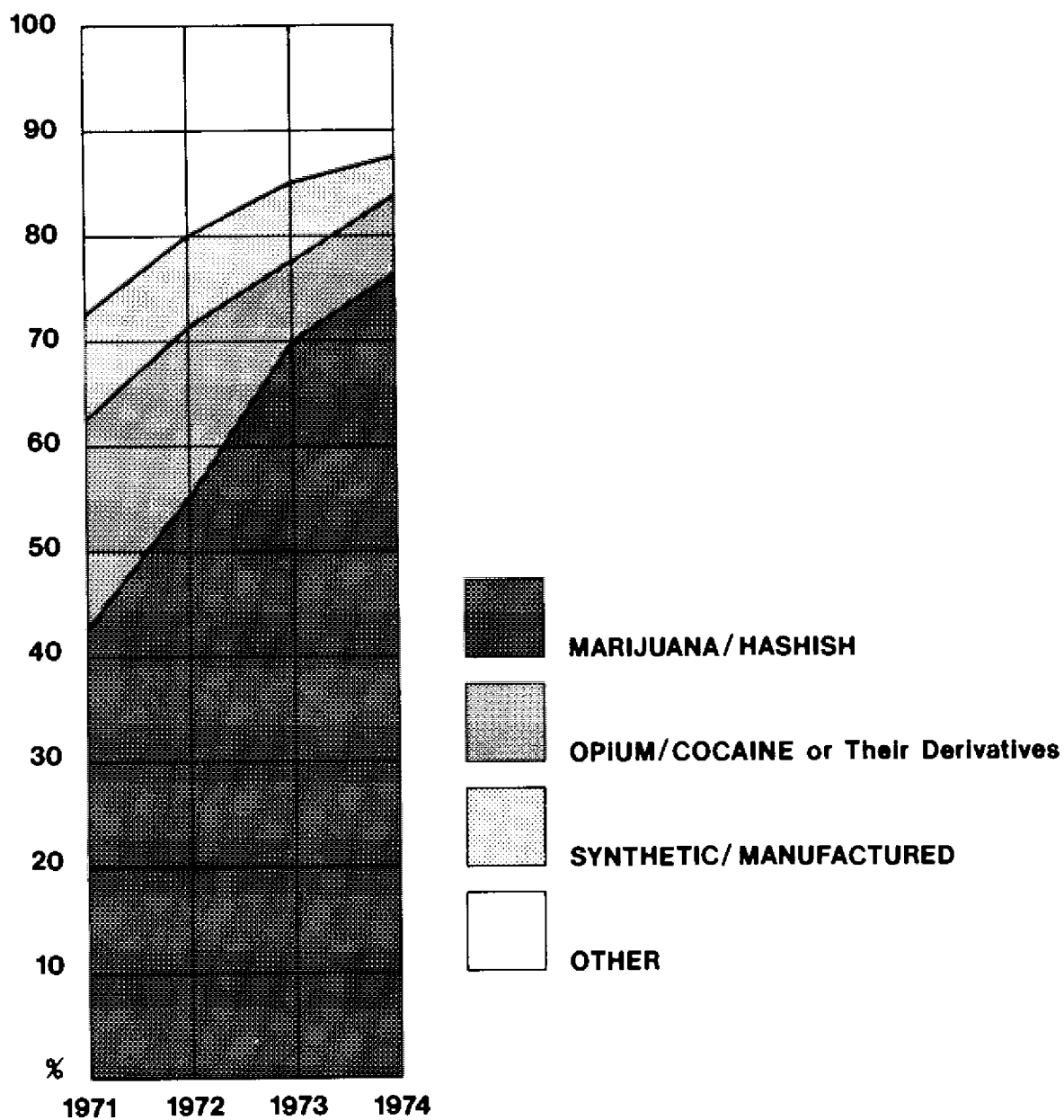
Information on the total number of drug arrests made annually in Virginia is not available. Neither DJCP nor DDAC monitor the drug enforcement arrest activities of State and local agencies. This is a serious weakness in the State's planning process which needs to be quickly corrected in view of the large sums of federal, State, and local money used to enforce drug laws.

To assess the extent of local drug enforcement, JLARC surveyed 22 local police departments (five counties and 17 cities) regarding local drug arrests. A total of 9,383 drug arrests were reported for 1974, an increase of 121% from 1971 (Table 35). Based on the FBI's uniform crime statistics, JLARC estimates these arrests represented about 80% of all local drug arrest activity in 1974 and there were about 11,700 local drug arrests during 1974 (See Appendix for details).

Even though there has been a dramatic increase in the number of arrests since 1971, Figure 12 clearly demonstrates the increase is attributable to marijuana. Marijuana and hashish arrests comprised 77% of all local drug arrests in 1974; opium and cocaine arrests, however, have declined since 1971, from 20% to 7%. It is difficult to determine conclusively whether these trends are the result of a declining narcotics problem or local emphasis on an easier drug "bust"--the marijuana user. Nevertheless, based on discussions with local law enforcement officials and other available evidence such as court dispositions, JLARC concludes that nearly all the increase in drug arrests is attributable to marijuana users rather than traffickers and dealers.

Figure 12

LOCAL POLICE DRUG ARRESTS 1971 - 1974



Source: Local Police Departments

Table 35

DRUG ARRESTS REPORTED BY SELECTED LOCAL ENFORCEMENT AGENCIES

<u>Type of Drug</u>	<u>1971</u>		<u>1972</u>		<u>1973</u>		<u>1974</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
Marijuana and Hashish	1,815	43%	3,095	55%	5,503	69%	7,188	77%
Opium and Cocaine	839	20	920	16	744	9	700	7
Synthetic ^a	377	9	500	9	542	7	343	4
Other Drugs	<u>1,214</u>	<u>28</u>	<u>1,160</u>	<u>20</u>	<u>1,153</u>	<u>15</u>	<u>1,152</u>	<u>12</u>
Total	4,245	100%	5,675	100%	7,942	100%	9,383	100%

^aStimulants/depressants, LSD, and prescription drugs.

Source: JLARC Survey of local law enforcement agencies.

Reporting Drug Arrest Statistics

When JLARC first requested drug arrest data from local police departments in late 1974, it was assumed this data would represent the number of persons arrested. In several instances, however, local police departments reported the number of charges filed, which inflates arrest statistics because many persons are charged with multiple offenses. In the words of one local enforcement official, "I would not be surprised that all police departments in the State use charges instead of persons too, because it beefs up the figures for budget purposes". For example, there are many occasions when a person is arrested for possession of marijuana and paraphernalia, resulting in two charges.

Furthermore, some localities have been inadvertently passing along drug charges to the FBI as part of the Uniform Crime Report, even though the reporting handbook clearly states this is an incorrect procedure. Newport News, for example, reported charges as arrests until 1973 when a consultant informed the department of the discrepancy.

The City of Richmond is currently reporting drug charges instead of the number of persons arrested. A representative of the vice-division supported JLARC's finding by stating that the division has been compiling drug arrest data by charges for some time, and he believed other divisions within the department were doing the same. The City has also been submitting these statistics to the FBI as part of its annual crime report. One area in which inaccurate crime reporting will impact is DJCP's target allocation formula, which will set limits for planning purposes on the amount of funds DJCP allocates to each region. The Council on Criminal Justice may, of course, fund regions in excess of the formula. Planning district commissions will be

required, however, to establish priorities for criminal justice programs within the limits of their regional allocation.

With the recent changes in crime reporting, local enforcement agencies now submit their criminal statistics to the State Police instead of the FBI. JLARC staff feels that this is an appropriate time for the Department of State Police to examine the entire crime reporting system in Virginia, including both the State's role in coordinating, processing, and analyzing crime statistics, and the manner in which local enforcement agencies report data.

Local Police Training

In-service training programs, designed to make local law enforcement officers more aware of narcotic and dangerous drug abuse have evolved concurrently with the increase in drug and drug related crimes. The following discussion presents a general overview of drug enforcement training programs available to local law enforcement agencies.

Minimum Drug Training Standards: In 1968, the General Assembly established the Law Enforcement Officers Training Standards Commission to coordinate and establish minimum standards for police training across the State. (Changed to Criminal Justice Officers Training and Standards Commission, CJOTSC, in 1974.) The Commission established a minimum of four hours of training in narcotics and dangerous drugs as part of the 204-hour compulsory in-service training program for all law enforcement officers in Virginia. The objective of the drug unit is to enable the officer to understand:

...the acceptable methods of police action that may be required in cases of suspected narcotics or dangerous drug violations.

The course outline for the narcotics unit covers such diverse subjects as federal and State narcotics laws, identification of drugs, case initiation and development, handling of specimens, paraphernalia, users and pushers, and presentation in courts.

Training Schools: Officers are trained at 31 regional schools approved by the CJOTSC. The scope, content, and duration of training programs at these schools vary in accordance with the training needs of local enforcement agencies. The largest jurisdictions tend to require more than the minimum amount of training required under CJOTSC standards. For example, Roanoke has a 10-week, Norfolk a 12-week, and Richmond a 16-week basic course. Similarly, the number of training hours devoted to narcotics and dangerous drugs varies: Richmond and Alexandria offer 24 hours of drug enforcement training while Danville provides the minimal four hours.

JLARC surveyed local enforcement agencies and found that 90% of city and county police departments require officers to participate in a drug training unit of four hours or more. This closely corresponds with the results of a 1973 DJCP study which found 88% of these agencies having in-service training in narcotics and dangerous drugs and meets the requirement of State law.

While the State may establish the requirements for training as well as minimum guidelines for course content and training objectives, implementation is left to local police officials and appears to be based on a philosophy of local control. Because funds to pay instructors, trainers, and administrators are limited, some local, State, and federal cooperative relationships have developed. The DEA training program is popular among city and county police departments, while many police agencies participate in regionally or locally sponsored programs. There are, however, some local police departments that provide their own basic drug enforcement training, such as Richmond and Norfolk, but rely on the DEA to offer advanced drug training. Nearly all of the police departments that reported having narcotic squads receive additional specialized drug enforcement training beyond that offered as part of their basic training curriculum.

Cooperation and Coordination

Cooperation and coordination between local, State, and federal agencies is a prerequisite to effective drug enforcement. Because illegal trafficking of narcotics and dangerous drugs is not confined to any one jurisdiction, but spills over into adjoining urban, suburban, and rural communities, the General Assembly enacted legislation in 1972 that permits local law enforcement agencies to enter into interjurisdictional agreements to allow police officers to cross local boundaries in order to enforce drug laws.

The Virginia State Crime Commission stated in its report, *Organized Crime Detection Task Force*, of December, 1971, that, "Efforts to enforce the drug laws are generally fragmented with a low degree of cooperation and coordination at the local level, at the local to State level, and at the State to State level." JLARC staff examined the progress of local and State police agencies in improving intergovernmental coordination of drug surveillance and investigations since the publication of the Commission's study, and the results are shown in Table 36. Based on JLARC interviews with local police officers, there appears to be some improvement in the coordination of drug enforcement activities, as evidenced by the signing of interjurisdictional agreements and the creation of narcotics strike forces in the Lynchburg metropolitan area and in the LENOWISCO planning district. However, in the Richmond area, as well as in most other areas of the State, the primary means of drugs enforcement coordination remains informal and based on personal relationships. Because State and local priorities are lacking, there is little current need to formally coordinate drug enforcement activities among federal, State, and local police agencies. Informal arrangements, however, can lead to program inefficiencies and ineffectiveness, as already pointed out in this Chapter.

Effective coordination of statewide drug enforcement efforts requires strong leadership at the State level. The Department of State Police as the primary drug enforcement agency should play an active role in establishing statewide drug enforcement priorities and provide leadership in developing mechanisms for improving drug investigation and apprehension activities with local police departments and the federal government.

Table 36

LOCAL DRUG ENFORCEMENT
COORDINATION AND COOPERATION 1971-1975

AREA	1971 MEANS OF COORDINATION ^a	1975 MEANS OF COORDINATION
<u>Roanoke</u> - Roanoke, Vinton, Salem, and Botetourt and Roanoke Counties.	Informal and based on personal relationships.	Informal and based on personal relationships; reliance on DEA for large drug buys.
<u>Northern Virginia</u> - Alexandria, Fairfax City, Falls Church, Vienna and Arlington, and Fairfax, Loudoun, and Prince William Counties.	Exchange of Information with Washington, D.C. Metropolitan Police Department and police departments in Maryland; metropolitan enforcement group (MEG) being organized.	Informal and based on personal relationships; MEG not organized; two DEA agents work with local governments in area, January, 1975; Section 15.1-131 in effect.
<u>Richmond</u> - Richmond, and Chesterfield Hanover, and Henrico Counties.	Organization of a Regional Narcotics Strike Force in progress.	Informal and based on personal relationships.
<u>Petersburg</u> - Petersburg, Hopewell, and Colonial Heights, and Prince George County.	Metropolitan enforcement group was operational--Area Drug Task Force.	Area Drug Task Force (Inactive since early 1973).
<u>Tidewater</u> - Norfolk, Portsmouth, Virginia Beach, and Chesapeake.	Informal and based on personal relationships.	Task force established in January, 1975 composed of DEA agents, State Police, Norfolk, Portsmouth, Virginia Beach, and Chesapeake. This was terminated September, 1975 due to insufficient funds. Section 15.1-131 in effect.
<u>Newport News</u> -Newport News, Hampton.	Informal and based on personal relationships.	Informal and based on personal relationships; Newport News considering Section 15.1-131.

^aAs stated in *Report of the Organized Crime Detection Task Force*, December, 1971.

Note: Interjurisdictional narcotic strike forces are also operational in the LENOWISCO planning district and Lynchburg metropolitan area.

Source: Based on JLARC Staff Interviews, January 1975.

CONCLUSION

State and local law enforcement agencies expend considerable resources on the apprehension of drug users and the confiscation of marijuana. (Although data on total arrests indicate only a small portion of the population that admits to abuse of drugs are being arrested.) Approximately 77% of all local drug arrests and 71% of all State Police drug arrests were for marijuana and hashish. At the same time, only 2% of all State Police drug arrests involved large quantities of drugs (75% were for marijuana), one indication that few arrests involve drug dealers or major traffickers. The State law enforcement agencies have not followed the direction provided by the General Assembly to emphasize drug trafficking and the more serious drugs.

A more specific directive may be required to guide the State Police in establishing priorities and conducting undercover drug operations. DSP should be directed to develop a drug enforcement plan which establishes priorities to address the State's drug problem in cooperation with Virginia's drug abuse planning agency. Furthermore, DSP should consider a reorganization of undercover activities to provide greater flexibility in drug enforcement. Such action should consider selective reallocation of resources to rely less on staffing field offices and increasing funds available for other types of drug enforcement activities, including drug buy funds and development of local, State, and federal drug control coordinative agreements.

ADJUDICATION OF DRUG OFFENDERS

The drug laws of Virginia have undergone considerable revision in recent years. The 1970 Drug Control Act amended many laws regulating the use of drugs. Then, in 1971, the General Assembly established a commission to study the criminal sanctions and many recommendations were enacted into law by the 1972 session designed to provide harsher penalties for drug traffickers, and to be more lenient toward users. For the past several years, however, the courts have had to deal with an increasing number of drug cases.

This chapter discusses Virginia's court system, focusing on conviction rates for drug offenses, variations in sentencing among judicial districts, and use of the deferred judgment statute. Emerging from this discussion are two important points: first, while local and State enforcement agencies continue to spend considerable time and resources apprehending users of drugs, particularly marijuana, the courts in many instances are dealing leniently with all drug users--felons and misdemeanants. Thus, there are inconsistencies between police enforcement and adjudication of the State's drug laws. Second, although provided with a variety of alternatives to deal more leniently with drug users, a lack of uniformity exists among courts and within the same court in using these alternatives.

Although many courts are using the deferred judgment statute to deal with first offenders, especially in cases involving simple possession of marijuana, there are noticeable variations in its application. In those areas where the statute has been most frequently used--Northern Virginia, Newport News, Richmond, and Charlottesville--a burden has been placed on probation officers to provide services to persons granted a deferred judgment. In at least one court, this burden has resulted in a recommendation not to use the statute. It seems consistent with legislative intent that the statute be amended to more carefully prescribe the extent of judicial discretion when dealing with first time drug offenders. To reduce a considerable part of the burden on the probation system, consideration should be given to placing first time marijuana offenders on unsupervised probation, unless circumstances warrant otherwise.

Possession of marijuana has had a significant impact on the activities of law enforcement organizations, courts, and probation. Of the total drug arrests in 1974, 70% or more involved marijuana offenses; and about half of the courts' drug caseload consists of simple possession of marijuana cases. Although the JLARC staff believes there is an unquestionable need to impose penalties for the possession of marijuana in Virginia, they should be more consistent with its social consequences and potential harm in relation to other drug use. Consideration should be given to reducing criminal penalties for possession of small amounts of marijuana by use of a citation system and monetary fine.

V. ADJUDICATION OF DRUG OFFENDERS

The elements of criminal justice comprise a large and highly inter-related system, and the increased number of drug related arrests, especially for marijuana, have created additional burdens for the courts, jails and correctional facilities, and probation and parole activities. Each has had to develop new ways of handling the ever growing drug problem along with their existing workloads and capabilities.

With respect to drug and narcotic offenders, the goal of Virginia's courts is to: provide violators of drug laws with prompt and equitable justice under the law; and assist, whenever possible, in the rehabilitation and social reintegration of persons who have committed drug offenses.

There are a number of State participants involved in the processing and sentencing of drug offenders including the Supreme Court, circuit courts, general district courts, juvenile and domestic relations courts, and commonwealth attorneys. However, financial data are not available to measure the extent of their involvement. During fiscal year 1974, the cost of operating the court system in Virginia was approximately \$18 million, of which a portion was used to adjudicate some 18,000 adult and juvenile drug cases.

LEGISLATION

The Commonwealth's legal framework for controlling the use of narcotics and dangerous drugs is composed of the Virginia Drug Control Act and Controlled Paraphernalia Act.

Drug Control Act

The 1970 Virginia Drug Control Act was the State's first major step in revising its drug laws. Many of the laws passed prior to this date for regulating and controlling the use of drugs were amended, including reducing the penalty for simple possession of marijuana from a felony to a misdemeanor offense.

Following the passage of the Virginia Drug Control Act, the 1971 session of the General Assembly created the Commission on Narcotic and Drug Laws (CNDL) to "concern itself primarily with the criminal sanctions outlined in the narcotic and drug laws, the penalties imposed, and all other legal and law enforcement aspects of these laws."³⁴ The commission's final recommendations included major modifications to both the regulatory provisions and criminal sanctions portion of the 1970 Act.

Based on the recommendations of the CNDL, amendments were enacted by the 1972 General Assembly emphasizing tighter regulation of legitimate, manufacture, sale, and distribution of narcotics and controlled drugs. This was done in order to substantially conform to the Uniform Controlled Substances Act, drafted by the National Conference of Commissioners on Uniform State Laws which was designed to complement the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

There are six schedules for classifying drugs, as outlined under section 54-524.84:1 of the Code of Virginia. The federal government and State Board of Pharmacy may designate, delete, or reschedule all controlled substances enumerated in these schedules. Prohibited acts and penalties related to each of the six schedules are presented in Appendix V. One of the actions of the 1972 General Assembly was to classify marijuana as a Schedule I drug. Although it is a Schedule I drug, a possession offense is punishable under the criminal sanctions provided for possession of Schedule III drugs--a fine of not more than \$1,000 and/or confinement in jail not exceeding 12 months. Distribution of marijuana, however, is considered a felony and punishable as a Schedule I drug. When the penalties for marijuana were reduced, however, hashish was not excluded from the harsher Schedule I penalties and hashish possession remains 1-10 years and/or not more than a \$5,000 fine. Legislation to correct this inconsistency was introduced during the 1974 legislative session but failed to pass. It is clear that legislation is needed to make the penalties for marijuana and hashish more consistent.

Also, a number of laws were adopted amending the criminal sanctions portion of the 1970 Act including the deferred judgment statute.

Controlled Paraphernalia Act

The Controlled Paraphernalia Act became effective in July, 1971. The purpose of the Act is to regulate the possession and distribution of paraphernalia used to illegally administer, manufacture, distribute, or dispense any controlled drug. It is a misdemeanor for any person or persons to possess or distribute controlled paraphernalia such as hypodermic syringes for illegal purposes.

ALTERNATIVES TO IMPRISONMENT

The Commission on Narcotic and Drug Laws was guided in its efforts to amend the State's drug laws by the legislative actions of other states, reflecting a nationwide dissatisfaction with existing criminal sanctions. There seemed to be a trend in most states to provide stiff penalties for distributors of drugs but to be more lenient toward users. Especially young experimenters. The Commission stated:

*The State's responsibility goes much further than prohibiting the illegal use of drugs; it must assist parents and guardians in protecting these young people from temptation of drug experimentation and use, and it must assume responsibility towards addicts--to get them off the streets, to treat them and to get them away from crime. Surely the imposition of a felony conviction for one indiscretion of a young boy or girl is not an acceptable solution if such youth is not a commercial distributor.*³⁵

The 1972 General Assembly enacted into law the recommendations of the study commission. These laws, augmented by more recent ones, comprise the State's alternatives to imprisonment for drug offenders. The addition of federal and State financial support of drug treatment programs, designed to

complement these alternatives, has provided further incentives to the courts to help persons involved with drugs.

The Accommodation Clause

Prior to 1972, a person who was convicted of gratuitously passing a marijuana cigarette to another was guilty of the same type of offense and subject to the same penalty as a large scale pusher.

With the passage of section 54-524.101:1 of the Code of Virginia, the 1972 General Assembly distinguished between a person who distributes drugs for profit and one who distributes such drugs as an accommodation. A person who is convicted of being a commercial distributor or pusher of Schedule I, II, or III drugs is subject to five to forty years in a State penal facility. A gratuitous distributor would receive a lesser sentence: one to ten years in jail, or at the discretion of the jury or court, the person could be found guilty of only a misdemeanor.

Courts throughout the State, especially those in the larger metropolitan areas are making use of the accommodation clause. The JLARC survey of CCRE court disposition reports revealed that about 3% of all drug cases were for accommodation offenses, resulting in a high conviction rate (69%) compared to other types of drug offenses.

Deferred Judgment Statute

Section 54-524.101:3 of the Code of Virginia, also enacted in 1972, was an effort to reform the criminal sanctions portion of the Drug Control Act. The deferred judgment statute allows the court to place a first time offender on probation who has either pleaded guilty to or been found guilty of simple possession of a controlled substance. Further proceedings are deferred pending the individual's successful completion of probation, at which time the court dismisses the charges. An evaluation of this alternative is presented later in this report.

Suspended Sentences

The court may suspend the sentence of anyone found guilty of violating any law concerning the use of controlled substances under section 54-524.101:4. The court may, however, require an individual to agree to periodic medical examinations for the purpose of ascertaining the person's use or dependency on drugs. The State pays the cost of the medical examinations. The judge may also prescribe additional conditions, such as participation in a treatment program to aid in the offender's rehabilitation. This section of the Code has been used by the courts to divert drug dependent felons or misdemeanants to local treatment programs.

Commitment to Treatment Facilities

Another alternative available to the courts is commitment to a

licensed or supervised facility of the State Mental Health and Mental Retardation Board (section 54-524.12 Code of Virginia). A person who has been found guilty of a drug offense and is in need of treatment for the use of drugs, may be committed to an institution if the person first consents and secondly if the receiving institution agrees to accept the person for treatment. Confinement under such commitment is treated as confinement in a penal institution. Upon presentation of a certified statement from the Commissioner of Mental Health and Mental Retardation that the person has successfully responded to treatment, the judge or court may release the individual prior to the termination of the sentence. To date, only two persons have been committed under this section of the Code.

Commitment to Mental Institutions

In addition to the criminal sanctions portion of the Drug Control Act, another section of the Code that may be increasingly used by the courts to divert drug dependent clients away from incarceration is Title 37.1, which allows for civil commitment of drug addicts to State mental institutions. An amendment passed by the 1971 General Assembly redefined a "mentally ill person" to include a "drug addict". Consequently, any person with a serious drug problem is now eligible to receive treatment services from State-supported mental health hospitals.

The Department of Mental Health and Mental Retardation, however, has said that civil certification of persons with a primary diagnosis of drug addiction is not a common occurrence.

Nolle Prosequi (Nol-Pros)

Nol-Pros, or no prosecution, may be used at the discretion of the court and the commonwealth's attorney. When used, it is applied primarily to first-time drug offenders, if the charge is possession of marijuana and a decision has been made not to prosecute. This alternative has been popular in northern and southeastern Virginia courts as a means of disposing of marijuana cases. Slightly more than 25% of the cases analyzed by JLARC were nol-prossed.

Other Alternatives

Two Richmond-based programs have been established recently to assist the courts in rehabilitating and counseling the drug offender.

TASC: The City of Richmond's Treatment Alternatives to Street Crime is one of 25 such programs in the nation. It is funded by LEAA and NIDA and administered by the City Department of Public Health. Major goals of TASC are: (1) to decrease the incidence of drug related crimes with its inherent cost to the community; (2) to interrupt the drug-driven cycle of street crime and jail, by providing the possibility of treatment for drug-addicted arrestees; and (3) to decrease the problems in jail facilities resulting from arrestees who are experiencing severe drug problems such as withdrawal. TASC relies on local programs for providing treatment to arrestees who have severe drug addiction problems.

TASC accepted its first client in July, 1974, one year after being formally established. The delay resulted from misunderstandings between TASC and representatives of the criminal justice system regarding the program's purpose and operations. These misunderstandings were eventually overcome and at the present time, TASC's monthly intake is approximately 15 to 25 persons, mostly arrestees awaiting trial. TASC also receives referrals from community treatment centers, attorneys, and self-referrals.

A person who is arrested must first volunteer for TASC's services and have a drug problem. Some arrestees without drug problems volunteer because they believe the court will be more lenient in imposing a sentence if they are found guilty. To eliminate this possibility TASC requires volunteers to submit to a counselor interview and a urinalysis immediately following arrest. TASC provides the judiciary and prosecutor with a diagnosis of the arrestee's drug addiction, an evaluation of his social competence, and a prognosis of his success in treatment. It is often the responsibility of the judiciary to decide how the court will intervene on behalf of the offender.

During the period July, 1974, to April, 1975, 647 arrestees were interviewed or screened, of which 285 expressed an interest in or volunteered for TASC. TASC admitted 211 clients to the program.

TASC has not been operational long enough to permit an adequate assessment of its effectiveness. The results of this program effort should be carefully evaluated in the coming months so as to determine the possibility of applying this diversionary model in other localities throughout the State. Thus far, a major accomplishment of TASC has been to bring various segments of the criminal justice system and community treatment programs together in a unified effort to deal with the drug problems of arrestees.

OAR: Offender Aid and Restoration of Richmond, Inc., initiated a privately funded program in April, 1975, aimed at providing probationary services to misdemeanor drug offenders placed on probation as a result of a deferred judgment. Approximately 60 volunteers were each assigned one offender to supervise. Another 20 volunteers are supposed to conduct background investigations on persons eligible for a deferred judgment. This program is officially referred to as the Volunteers in Misdemeanant Probation and is the first to use volunteers in Virginia's adult probation system. It has been estimated that the per capita cost will be approximately \$337 per year.

DISPOSITION OF DRUG CASES

JLARC was interested in evaluating the extent to which courts were prosecuting drug offenders and utilizing the available alternatives to incarceration. However, under existing local and State court recordkeeping practices it was impossible to determine the number of arrests, court caseload, case disposition, and type of sentence imposed for drug violations (including diversion to treatment programs). An LEAA financed project is currently underway to develop a uniform docket form to keep track of general district court statistics. A data system now exists for the circuit courts which includes general data on the number of cases commenced, number of cases on the docket, and number of cases disposed of during the year. Accurate and up-to-date

court data are essential to monitoring the efficiency and effectiveness of the criminal justice system. To date, DJCP staff assigned to drug program activities have devoted very little attention to compiling statistics on drug offenders. JLARC believes that DJCP spends a considerable amount of time serving as a conduit for LEAA drug enforcement grants without an adequate knowledge of the criminal justice system as it relates to drug offenders. DJCP, with the assistance of DDAC, should develop a system of monitoring and evaluating the handling of drug offenders from the time of arrest to case disposition.

Due to the absence of court information the JLARC staff relied on the Central Criminal Records Exchange (CCRE) of the Department of State Police as a primary source of court disposition data. The clerk of each court of record and court not of record is required by law to submit a report to the CCRE of any dismissal, nol-pros, acquittal, or conviction of, or failure of a grand jury to return a true bill against any person charged with a drug offense. JLARC staff manually coded 1,958 separate drug charges and dispositions received by the CCRE during the months of September, October, and November, 1974. Because of the time between action by the courts and when the reports are submitted to the CCRE, 66% of the cases were disposed of during the period January through June, 1974; 93% of the cases covered the period January, 1973, to November, 1974.

Although some of the reports lacked certain items of information, overall, JLARC is confident that the analysis of the CCRE data provides a fair assessment of court disposition of drug cases in Virginia. The reader is cautioned of the possible limitations associated with the use of these data since it relies on court reporting practices.

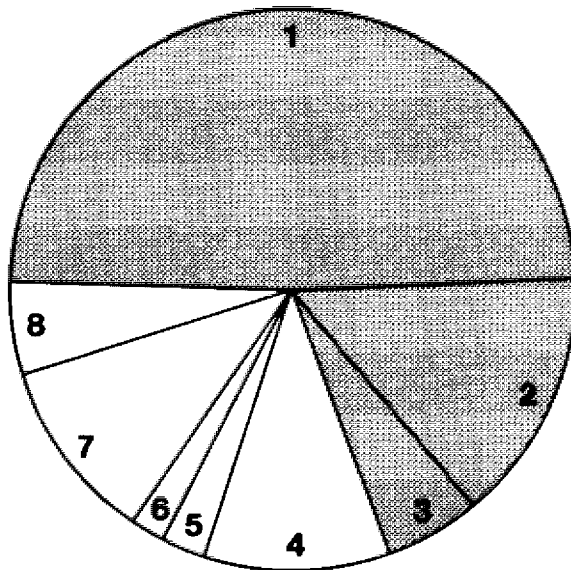
Cases Reported

The courts not of record bear the largest responsibility for trying drug cases and, therefore, it is not surprising that 83% of the charges were prosecuted at the general district court level, mostly in the major population centers of the State. JLARC estimates that there were about 18,000 drug cases processed by the court system in 1974, broken down by level of court as follows: (1) general district - 12,000; (2) juvenile and domestic relations - 3,600; and (3) circuit - 2,400.

Approximately 62% of the cases were for misdemeanor drug violations, and a large number of the felony arrests were reduced to a misdemeanor charge, accounting for the 83% disposition rate at the general district court level.

Table 37 indicates more than two-thirds of the cases were a result of persons being arrested for illegal possession of controlled drugs, and only one-fourth for trafficking related offenses. Corresponding somewhat closely with the arrest data presented in the enforcement section, 63% of all cases were for violation of the State's marijuana laws. Of the 1,358 possession cases, 70% were marijuana related, a clear indication of State and local drug enforcement operational priorities. Figure 13 graphically presents the distribution of charges by drug offense.³⁶

Figure 13
**DISTRIBUTION OF DRUG CASELOAD
 BY OFFENSE**
 1973 - 1974



POSSESSION (69.3%):



- 1 Marijuana 69.9%**
- 2 Other Drugs 22.4%**
- 3 Paraphernalia 7.7%**

OTHER THAN POSSESSION (30.7%):



- Possession With**
- 4 Intent To Distribute 10.5%**
- 5 Accommodation 2.8%**
- 6 Manufacture 1.7%**
- 7 Distribution 10.5%**
- 8 Other 5.2%**

Source: Department of State Police, CCRE case dispositions.

Table 37

DRUG CASES BY TYPE OF DRUG AND OFFENSE
1973-1974

<u>Type of Offense</u>	<u>Marijuana</u>	<u>All Others</u>	<u>Total</u>
<u>Possession</u>	<u>949</u> (49%)	<u>409</u> (21%) ^a	<u>1,358</u> (70%)
<u>Trafficking Related</u>	<u>282</u> (14%)	<u>216</u> (11%)	<u>498</u> (25%)
Accommodation	32	23	55
Possession With Intent	118	87	205
Distribution	101	104	205
Manufacture	31	2	33
<u>Unknown</u>	<u>4</u> ^b	<u>98</u> (5%)	<u>102</u> (5%)
<u>Total</u>	<u>1,235</u> (63%)	<u>723</u> (37%)	<u>1,958</u> (100%)

^a Includes 105 cases of possession of paraphernalia.

^b Less than .1%.

Source: Department of State Police, CCRC Case Dispositions.

Profile of Drug Offenders

There were 1,553 persons responsible for the 1,958 drug cases, or about 1.26 charges per person. This indicates that most arrests are for one offense, primarily possession of marijuana.

Persons appearing in court were primarily white (83%), males (86%), between the ages of 18 to 25 (73%), employed in blue collar type occupations (45%), with a previous record of arrest (53%). Students (9%) and white collar workers (8%) were a relatively small percentage of drug violators. Military personnel comprised 11% of the caseload.

Dispositions and Conviction Rates

Table 38 presents a summary of the dispositions of the 1,958 drug cases surveyed by JLARC. Of this number, only 47% of the cases resulted in convictions (fine, jail, fine and jail, probation, or reduced sentence). Overall, persons charged with a marijuana violation are more likely to be convicted than those who commit other types of drug offenses. Furthermore, fine and jail sentences are more prevalent among marijuana violators.

Looking at rates for different offenses (Table 39), it appears that local enforcement officials and commonwealth's attorneys are significantly more effective at obtaining convictions for accommodation and distribution offenses

Table 38

COURT DISPOSITION OF DRUG CASES
1973-1974

<u>Disposition</u>	<u>Total Cases</u> ^a	<u>Marijuana Cases</u>	<u>All Other Cases</u>
Not Guilty	1.5%	1.1%	2.2%
Dismissed	16.8	19.4	12.3
Nol-Pros	25.2	21.1	32.1
Deferred Judgment	.9	1.0	.8
Fine	6.3	7.1	5.0
Jail	12.0	9.0	17.2
Fine and Jail	24.4	30.7	13.7
Probation	2.2	1.9	2.6
Reduced	2.0	2.4	1.4
Other or Unknown	<u>8.7</u>	<u>6.3</u>	<u>12.7</u>
Total	100.0%	100.0%	100.0%

^a 1,958 cases were surveyed.

Source: Department of State Police, CCRE Case Dispositions.

Table 39

CONVICTION RATES BY TYPE OF OFFENSE
1973-1974

<u>Offense</u>	<u>Total Cases</u>	<u>Conviction Rate</u>
Accommodation	55	69.1%
Distribution	205	57.1
Possession With Intent to Distribute	205	48.3
Possession	1,253	45.8
Paraphernalia Act	105	34.3
Manufacture	33	18.2

Note: Includes cases receiving a fine, jail sentence, fine and jail sentence, probation, or reduced charge.

Source: Department of State Police, CCRE Case Disposition.

than for manufacture violations. However, over half of the possession offenses, including paraphernalia act violations, did not result in convictions.

Another way of looking at conviction rates is to compare the percent of convictions by various types of drug offenses (Table 40). Although the number of cases varies considerably by drug offenses, convictions for LSD,

Table 40
CONVICTION RATES BY TYPE OF DRUG AND OFFENSE
1973-1974

Type of Drug	Offense					
	Possession	Possession With Intent	Distribution	Accommodation	Manufacture	Average
Marijuana	50.2% (949)	55.9% (118)	56.5% (101)	71.8% (32)	19.4% (31)	51.0%
Heroin	40.0 (40)	46.7 (15)	40.0 (10)	75.0 (8)	--- ---	45.2
LSD	30.0 (40)	40.0 (20)	48.0 (25)	25.0 (4)	--- ---	37.1
Hashish	27.3 (44)	--- ---	100.0 (9)	--- ---	--- ---	35.1
Amphetamines	28.6 (28)	25.0 (4)	100.0 (2)	100.0 (1)	--- ---	34.4
Cocaine	15.8 (19)	75.0 (4)	50.0 (4)	50.0 (2)	--- ---	29.9

AVERAGE CONVICTION RATE = 46.9%

Note: Number in parentheses represents the number of cases reviewed.

Source: Department of State Police, CCRE Case Dispositions.

hashish, amphetamine, and cocaine violations are generally significantly below the average conviction rate (47%) for all drug cases sampled by JLARC. The conviction rate for marijuana is slightly above average and heroin cases are about average.

When specific types of drug offenses are analyzed, conviction rates for possession with intent to distribute, distribution of marijuana, and accommodation sales are significantly above average. However, the rate for possession of heroin, LSD, hashish, amphetamines, cocaine, and distribution of heroin, all felony offenses, are below average.

Based on the findings presented in Table 40, there are variations in the way courts deal with drug offenders. Most important, it seems that possession offenders are handled in a more lenient manner by the courts, as indicated by the fact that more than half of the cases do not result in convictions. Furthermore, possession cases involving felony offenses have a lower rate of conviction than misdemeanor drug violations--possession of marijuana. Attorneys and judges have indicated that insufficient evidence to prosecute and "plea bargaining" are partially responsible for the large number of dismissed and nol-prossed cases found by JLARC. Also, several courts are using (or have used) nol-pros as an alternate means of dealing with simple possession offenders, including violations of the paraphernalia act. Thus, it appears that the high priority given to apprehending users by law enforcement agencies is inconsistent with the handling of possession cases by the court system. Consideration should be given to modifying Virginia's laws pertaining to the possession of small amounts of marijuana in order to provide for a more efficient and effective utilization of existing court resources.

Variations in Conviction Rates by Judicial District

JLARC used the CCRE disposition data to determine if there were any major differences in conviction rates among the State's larger judicial districts. Table 41 shows that there were significant variations for all drug cases among the districts surveyed. Norfolk, Newport News, and Arlington varied considerably from the overall system average of 47%.

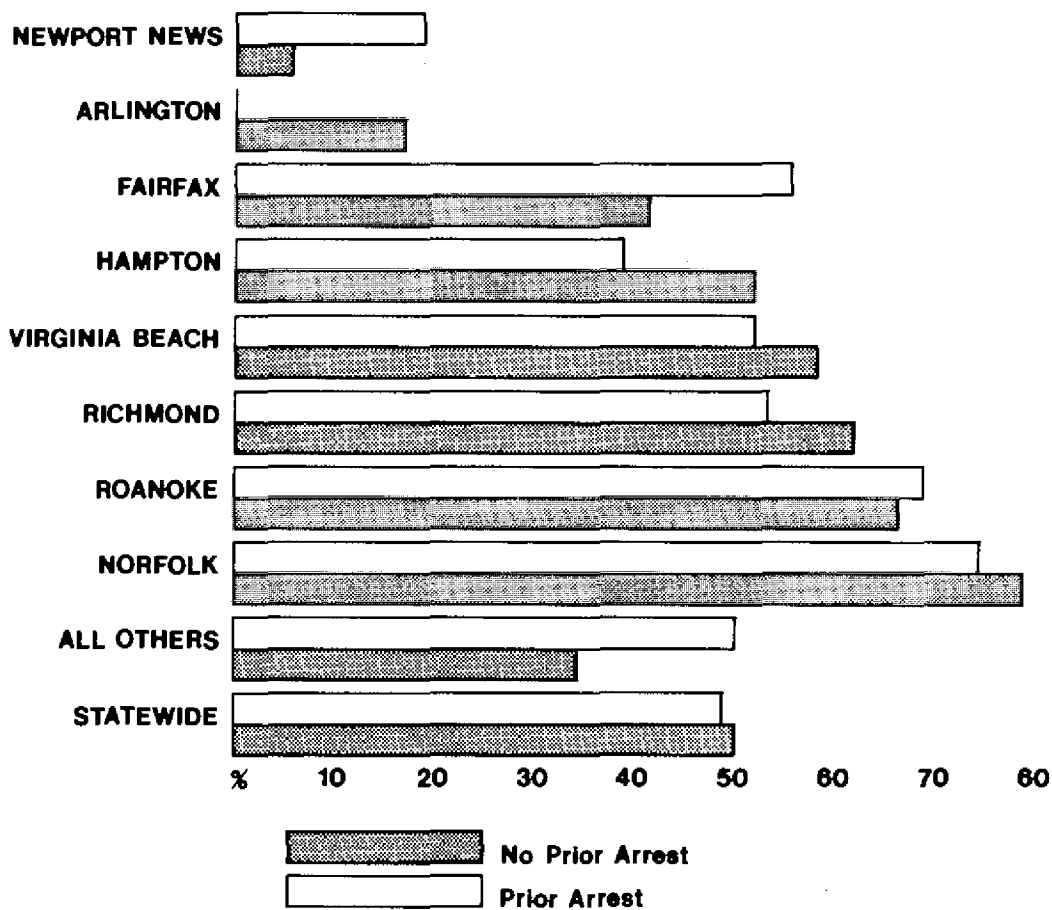
Further analysis revealed there were also significant variations in the conviction rates for cases related to possession of marijuana, involving persons 18 to 25 years old, with or without a prior record of arrest. Once again, Norfolk had the highest rate of conviction, with Arlington and Newport News having the lowest rates (Figure 14).

It was expected that conviction rates would be higher for those persons with a prior arrest record, than for those without any prior encounters with the law. Available data, however, do not support this argument. In five of the eight judicial districts, the rate for persons with no prior record of arrest was higher than for those with a history of arrest. It is clear that justice is not administered uniformly in cases involving first offenders.

Sentences

The final step in adjudication is the imposition of sentence by the

Figure 14
**CONVICTION RATE FOR POSSESSION OF MARIJUANA,
 PERSONS 18-25 YEARS OLD,
 BY JUDICIAL DISTRICT
 1973-1974**



Source: Department of State Police, CCRE case dispositions.

Table 41

CONVICTION RATES FOR DRUG CASES
BY SELECTED JUDICIAL DISTRICTS
1973-1974

<u>Judicial District</u>	<u>Conviction Rates</u>
Norfolk	65.9%
Richmond	50.8
Fairfax	49.0
Roanoke	49.0
Virginia Beach	45.8
Hampton	42.6
Newport News	18.5
Arlington	16.4
All Other Districts	47.5
System Average	46.9
N=1,958 Cases.	

Source: Department of State Police, CCRE Case Dispositions.

court. While about half of all cases resulted in a conviction, three-fourths of those convicted received either a jail and fine, or jail sentence only. Slightly more than half of those receiving a jail sentence were given 90 days or less (Table 42). Of the convicted cases, 61% were entirely suspended while only 14% resulted in incarceration (Table 43).

Table 42

LENGTH OF JAIL SENTENCE RECEIVED
1973-1974

<u>Length of Sentence</u>	<u>Number of Cases</u>	<u>Percent</u>
1 to 30 Days	188	26.4%
31 to 60 Days	40	5.6
61 to 90 Days	147	20.6
6 Months	80	11.2
1 Year	154	21.6
2 to 4 Years	35	4.9
More than 4 Years	62	8.7
Unknown	<u>7</u>	<u>1.0</u>
Total	713	100.0%

Source: Department of State Police, CCRE Case Dispositions.

Table 43
SUSPENDED SENTENCES
1973-1974

<u>Suspensions</u>	<u>Number of Cases</u>	<u>Percent</u>
Entire Sentence		
Suspended	437	61.3%
Portion of Sentence		
Suspended	82	11.5
Portion of Fine and		
Sentence Suspended	7	1.0
Sentence Not Suspended	<u>187</u>	<u>26.2</u>
Total	713	100.0%

Source: Department of State Police, CCRE Case Dispositions.

Some types of drug charges are more likely than others to result in suspended sentences. Overall, manufacture, possession, and possession with intent to distribute had the highest suspension rates. Fewer sentences for distribution and accommodation were suspended, indicating the courts' preference for imposing harsher penalties when persons were found guilty of drug trafficking related offenses.

Fines are usually imposed in cases involving less serious drug violations, such as possession of marijuana. JLARC found that nearly all of the fines levied by the courts were \$300 or less, and three-fourths were for possession offenses. Most fines were imposed in conjunction with a short, suspended jail sentence for drug violations involving the use of marijuana. Appendix V contains a detailed presentation of suspensions and fines related to drug charges.

Sentencing Variations

While laws should not be arbitrary and should be flexible to allow for the individual circumstances surrounding a case, it is often argued that too much latitude results in unequal justice.

All members of the society including the law violators must be encouraged by whatever means the people will accept to respect and observe the law. Perhaps next to non-enforcement the factor which contributes most to disrespect for law is the disparate or even whimsical inspection of sanctions.³⁷

To provide an indicator of the extent of sentencing variations among the judicial districts, JLARC focused on cases involving illegal possession of marijuana, committed by a person 18 to 25 years old, with no prior record of arrest. Due to the narrow scope of this analysis only four judicial districts were selected, Virginia Beach, Norfolk, Hampton, and Richmond.

Supporting the findings presented earlier in this chapter on conviction rates, there were radical variations in the types of sentences imposed for the same crime, as indicated in Figure 15. Richmond and Virginia Beach courts impose a higher percentage of jail and fine sentences than Norfolk, Hampton, and the other judicial districts across the State.

It should be noted that courts began using the deferred judgment statute more frequently after January 1, 1974. Since the CCRE does not usually receive disposition reports from the court clerks on deferred judgment cases until after the person has successfully completed his period of probation, (4 to 12 months), the JLARC sample did not adequately reflect the recent use of this statute by the courts in cases involving first offenders. (Therefore, use of the deferred judgment statute will be discussed in another part of this chapter.)

Time Required for Case Disposition

A person arrested for a drug violation has a right to a speedy trial. A major concern of judges, prosecuting attorneys, and defense attorneys in recent years has been the length of time required to bring a person to trial after he has been arrested and indicted for a criminal offense.

Table 44 indicates that over half of the marijuana cases and 46% of the other drug cases were disposed of within two months from the date of arrest. The National Advisory Commission on Criminal Justice Standards and Goals, recommends an ideal period from arrest to trial of not more than 60 days for a felony prosecution and 30 days for a misdemeanor. Based on these standards, Virginia's court system could use some improvement in expediting the disposition of drug cases.

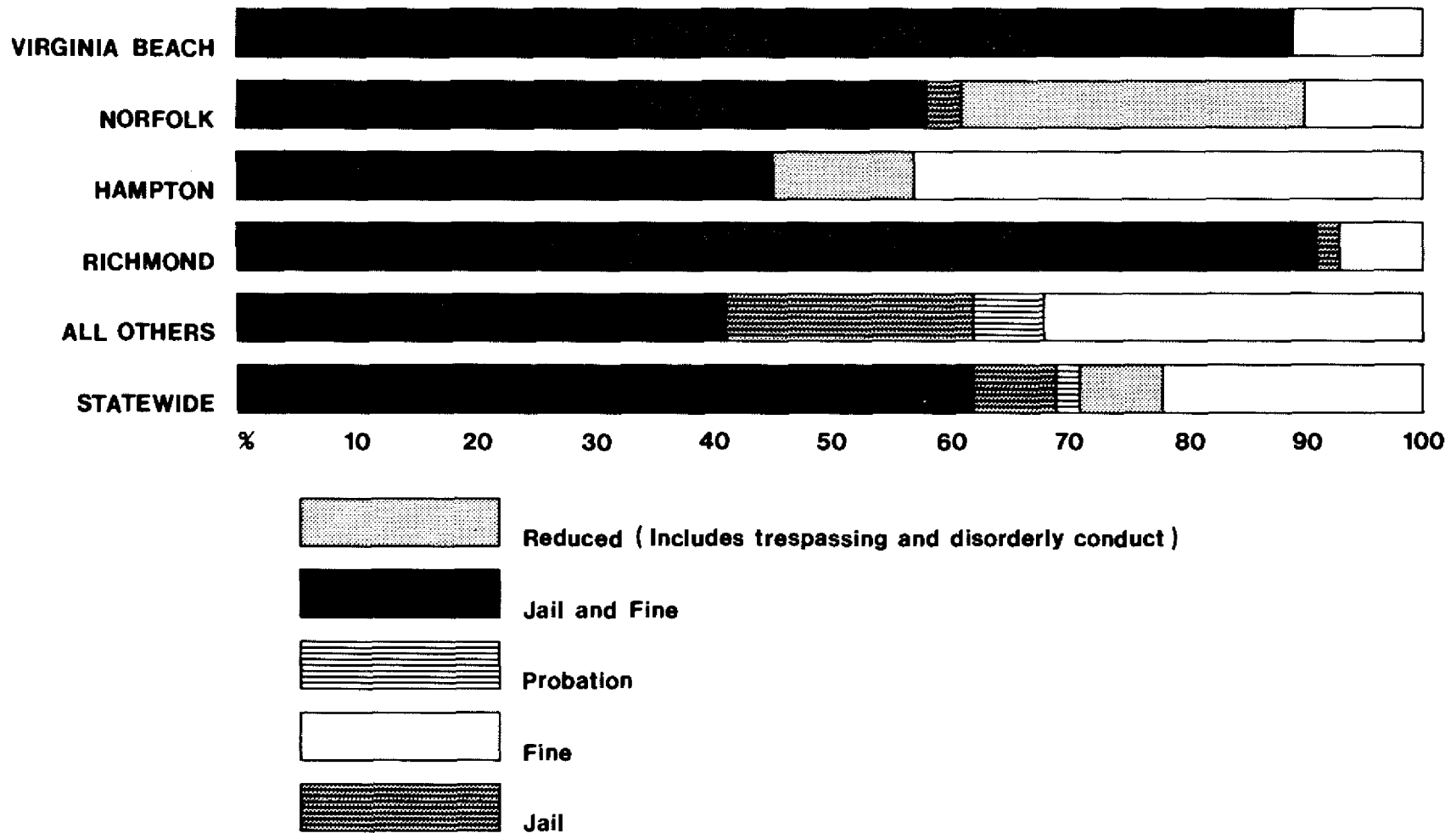
Table 44

TIME REQUIRED TO DISPOSE OF DRUG CASES FROM DATE OF ARREST 1973-1974

<u>Length of Time</u>	<u>Number of Persons</u>	<u>Marijuana</u>		<u>Other Drugs</u>	
		<u>Cases</u>	<u>%</u>	<u>Cases</u>	<u>%</u>
30 Days or Less	481	367	34%	114	25%
60 Days	315	218	20	97	21
90 Days	151	102	9	49	11
120 Days	93	69	6	24	5
150 Days	42	27	3	15	3
180 Days	39	25	2	14	3
More than 180 Days	174	119	11	55	12
Unknown	<u>258</u>	<u>169</u>	<u>15</u>	<u>89</u>	<u>20</u>
Total	1,553	1,096	100%	457	100%

Source: Department of State Police, CCRE Disposition Data.

Figure 15
**TYPE OF SENTENCE IMPOSED FOR POSSESSION OF MARIJUANA,
 18-25 YEARS OLD, NO PRIOR RECORD OF ARREST,
 BY SELECTED JUDICIAL DISTRICTS
 1973-1974**



Source: Department of State Police, CCRE case dispositions.

Court System - Summary

Reflecting the dramatic rise in drug arrests over the past four years, the court system has had to process an ever-increasing number of drug cases. About two-thirds of all drug cases involve possession offenses, mostly marijuana. Drug trafficking related violations account for one-fourth of the cases; however, only 10% of all drug cases sampled by JLARC were found to be for distribution offenses. (This latter finding conflicts with State Police statements which indicate that about half of all their drug cases involve distribution.)

Although law enforcement agencies spend a great deal of time and effort apprehending users, possession cases seem to be disposed of in a lenient manner by the court system, since over half of all possession cases do not result in convictions. It seems that the high priority accorded drug users by law enforcement agencies is incompatible with the actions of the court system.

Based on JLARC's CCRE sample, the drug laws of the Commonwealth are not administered in an equitable and uniform manner, as evidenced by variations in conviction rates and sentencing patterns among different courts for similar types of drug offenses. Statewide, when compared to a person who has had a prior arrest record, a first offender is just as likely, or more than likely, to be convicted of a simple possession of marijuana violation. Also, first offenders are dealt with more severely in some courts than others.

The increasing number of drug arrests and the widespread use of marijuana indicates that enforcement agencies, courts, and the laws of the Commonwealth have not effectively reduced the level of illegal drug use by the public.

Figure 16 provides a graphic presentation of the disposition of drug cases surveyed by JLARC.

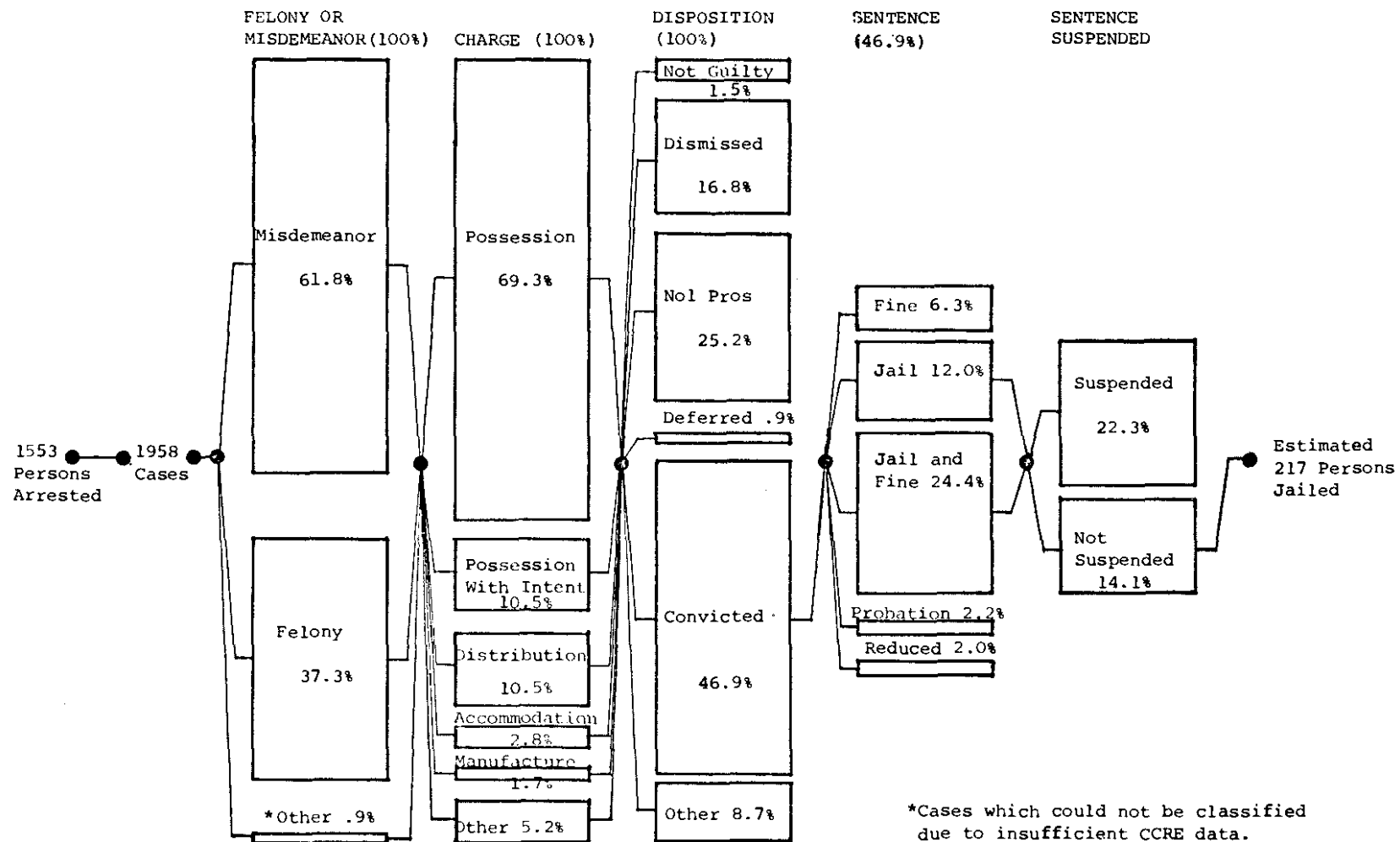
DEFERRED JUDGMENT STATUTE

Because of the recent use of the deferred judgment statute by Virginia's courts, and the failure of the CCRE data to adequately reflect this use, JLARC examined several different aspects of the deferred judgment statute, identifying issues associated with its use by the courts and ensuing effects on the probation and parole system. The analysis was based on three key issues: (1) Is the statute being used by the courts? (2) Is it being used consistently in all first offender cases? and (3) Are there any unusual problems associated with its use?

Legislative Intent

One of the recommendations of the 1971 Commission on Narcotics and Drug Laws, based on the belief that society should be more lenient towards users, was the conditional discharge provision, or deferred judgment statute. The commission stated:

Figure 16
DISPOSITION OF ADULT DRUG CASES
1973 - 1974



Source: Department of State Police, CCRE Case dispositions.

Since many simple possession offenders are either casual users or experimenters who would be unlikely to commit the offense again after their first encounter with the law, this provision gives the court an added flexibility in dealing with this type of offender. If the offender fulfills all of the terms and conditions of his probation, his record would remain clear and the stigma of a criminal prosecution would not follow him in later life. ³⁸

Following the recommendations of the Commission, the 1972 General Assembly enacted the deferred judgment statute.

It should be pointed out that this section of the Code is concerned with dismissing the proceedings against a person, and not with expunging a person's record of arrest, as some persons have been led to believe. The statute is intended to divert persons from the criminal process before they fall into a pattern of criminal activity by combining the incentive of a fresh start with the threat of renewed prosecution. The CNDL felt that this statute would apply only once to any person.

In summary, there are four key provisions of the deferred judgment statute:

- No prior record of a drug conviction under any State or federal statute, or drug arrest under the deferred judgment statute.
- Placement of the person on probation for a specified period of time.
- Dismissal of the charges against the person without adjudication of guilt after successfully fulfilling the terms and conditions of probation.
- Reporting the results of the case to the Central Criminal Records Exchange to be used in subsequent proceedings for the purposes of applying the statute.

Use by the Courts

In order to determine the extent to which the deferred judgment statute was being used by the courts, a questionnaire was mailed in November, 1974, to each clerk representing courts of record and courts not of record. Sixty-five percent, or 194 court clerks, responded to the survey.

Nearly two-thirds of the clerks reported that the statute was being used in drug cases involving first offenders (Table 45). Of this group, 79% estimated that it was applied in 25 cases or less. As anticipated, the courts not of record (general district) are making extensive use of the statute because of their jurisdiction over misdemeanors; four courts used the statute 200 or more times during the 16-month period from July, 1973, to November, 1974. Surprisingly, at the circuit court level, where there is original jurisdiction over all indictments for felonies, 44% of the respondents indicated the statute

was being used. Since the circuit courts have appellate jurisdiction, it appears that appeals from the general district courts, as well as reduced charges in the circuit courts, are responsible for the statute's use.

Table 45

USE OF DEFERRED JUDGMENT STATUTE
(July 1, 1973 to November, 1974)

<u>Court</u>	<u>Yes</u>	<u>No</u>
Circuit	34 (44%)	43 (56%)
General District	34 (72%)	13 (28%)
General, Juvenile and Domestic Relations	30 (79%)	8 (21%)
Juvenile and Domestic Relations	22 (69%)	10 (31%)
TOTAL	120 (62%)	74 (38%)

Source: JLARC Survey of Courts, November, 1974.

Type of First Offenders

A substantial number of the clerks representing courts who used the statute reported it was being used in cases involving first offense marijuana violations. These results correspond with the large number of marijuana arrests and court cases at the local level. It appears that the deferred judgment statute has provided the courts with an alternate means of dealing with simple possession offenders who are either casual or experimental users of marijuana.

Background Information on the Client

Before granting a deferred judgment, the general district court seeks background information on the offender, including prior offenses. Through interviews with court clerks and commonwealth's attorneys it was learned that there have been difficulties in obtaining sufficient background information on persons arrested for a misdemeanor drug offense and eligible for deferred judgment. As one assistant commonwealth's attorney stated, "The deferred judgment statute is being abused by the courts. Judgments are being cranked out without a thorough record check of the individual's past drug arrest history." A clerk of the general district court said, "Unfortunately, some defendants do not hesitate in giving misleading information as to a prior drug record under oath. A false statement, of course, can result in perjury, but if a defendant knew a probation report would be made he would be more candid with the court."

The JLARC survey of the courts revealed that 38% of the general district court respondents had a problem obtaining sufficient background information on clients; 13% of the general, juvenile and domestic relations courts reported having problems (Table 46). Of the courts which were

Table 46
PROBLEM OBTAINING SUFFICIENT BACKGROUND INFORMATION ON CLIENTS

<u>Court</u>	<u>Yes</u>	<u>No</u>	<u>No Response</u>	<u>Total</u>
General District	13 (38%)	21 (62%)	---	34 (100%)
Juvenile and Domestic Relations	4 (13%)	24 (80%)	2 (7%)	30 (100%)
TOTAL	17 (27%)	45 (70%)	2 (3%)	64 (100%)

Source: JLARC Survey of Courts, November, 1974.

experiencing difficulties in procuring background information, 10 admitted that some persons were granted a deferred judgment even though they had a prior drug conviction.

In Virginia, probation and parole officers are not required to provide pre-sentence investigations to district courts. There are, however, district probation and parole offices which do provide limited supportive services to general district court judges who grant deferred judgments and place persons on supervised probation. This is entirely dependent on office caseload and the approval of the chief circuit court judge. For example, there have been instances when circuit court judges have requested lower court judges not to use the statute because it interferes with the regular duties of the probation and parole officers, which include supervision of circuit court probationers and preparation of pre-sentence investigation reports on felons.

Because the general district courts lack the necessary services of a probation and parole officer, court clerks were asked if probation and parole officers should prepare a record check before a judge grants a deferred judgment. Seventy percent of the respondents believed a record check should be made, and of these, 65% believed that probation and parole officers should be assigned to district court judges to perform this function (Table 47).

Table 47
SHOULD PROBATION AND PAROLE OFFICERS PREPARE A RECORD CHECK
BEFORE A JUDGE GRANTS A DEFERRED JUDGMENT?

<u>Courts</u>	<u>Yes</u>	<u>No</u>	<u>No Response</u>	<u>Total</u>
General District	22 (65%)	11 (32%)	1 (3%)	34 (100%)
General, Juvenile and Domestic Relations	23 (79%)	5 (17%)	1 (4%)	29 (100%)
TOTAL	45 (71%)	16 (25%)	2 (4%)	63 (100%)

Source: JLARC Survey of Courts, November, 1974.

There seems to be a prevailing feeling among the general district courts that probationary services should be provided to lower courts, not only for the purpose of performing record checks on persons eligible for deferred judgment, but also for all serious misdemeanor cases.

The following statement generally reflects the attitude of the survey respondents toward probation and parole services for deferred judgment cases:

Ideally, it would be worthwhile to have an investigation and supervision in every deferred judgment case but it would greatly overload the present probation staff. If the staff were enlarged, then the probation officers' review and supervision would be quite worthwhile.

Variations in Interpretation and Use

On the surface it would seem that deferred judgments would be used in all drug cases involving first offenders, especially those involving possession of marijuana. Interviews, survey results, probation and parole caseload data, and arrest data, however, indicate variation in the type of probation given a person. Some judges believe that all persons should be placed on supervised probation, while others feel that unsupervised probation is an adequate way of handling these cases. It seems that an alternative form of supervision or counseling may be necessary for those clients with serious drug or social problems.

The JLARC survey attempted to determine whether all judges in a court uniformly applied the statute in cases involving marijuana possession. Of the 120 courts using the statute, 63% reported having more than one judge hearing drug cases. Table 48 indicates that, overall, in records with more than one judge, all judges uniformly apply the statute to cases involving first time marijuana offenders, especially at the juvenile and domestic relations court level.

Table 48

USE OF THE STATUTE IN COURTS WITH MORE THAN ONE JUDGE

<u>Courts</u>	<u>Yes</u>	<u>No</u>	<u>NO Response</u>	<u>Total</u>
Circuit	21 (81%)	1 (4%)	4 (15%)	26 (100%)
General District	10 (67%)	5 (33%)	---	15 (100%)
General, Juvenile and Domestic Relation	17 (85%)	3 (15%)	---	20 (100%)
Juvenile and Domestic Relations	14 (93%)	1 (7%)	---	15 (100%)
TOTAL	62 (82%)	10 (13%)	4 (5%)	76 (100%)

Source: JLARC Survey of Courts, November, 1974.

Problems with Administration

When asked whether the court was experiencing any unusual problems administering the statute, an overwhelming number (94%) of respondents said that they were not. Several clerks of court which were not making use of the statute indicated that the main reason was anticipated administrative problems. A typical response to the JLARC survey was:

The statute has not been used in _____ because of administrative problems with an already overcrowded docket and an overworked probation and parole staff.

Anticipated administrative problems have dictated the statute's non-use.

Overall, however, the administration of the statute does not seem to be creating any serious problems in the court system other than the additional paperwork needed to continue a case for a period of time before final disposition.

Central Criminal Records Exchange Form

Under section 19.1-19.3 (b) of the Code of Virginia, the clerk of each court of record and court not of record is required to report to the Central Criminal Records Exchange (CCRE) any dismissal, nol-pros, acquittal, conviction, or failure of a jury to return a true bill as to any person charged with an offense. A clerk is also responsible for reporting any actions taken by the court with regard to a deferred judgment case.

When the statute was first implemented, court clerks were confused as to which court order should be reported to the CCRE. For example, any person granted a deferred judgment is brought before the judge twice, once for deferral and once for dismissal. The JLARC survey revealed that the circuit courts and general district courts are still confused as to the proper procedure for reporting. Twenty-one percent of the respondents reported that they do not notify the CCRE of either the deferral or dismissal. Sixteen percent of the courts indicated that they file both the deferral and dismissal orders with the CCRE (Table 49).

If the confusion over the filing of reports with the CCRE continues, there may be abuse of the "one time only" provision embodied in the deferred judgment statute. In the words of one district court clerk:

As there is only one CCRE filed in each case the Court has space available for indication of final disposition only, and therefore, deferred dispositions are not filed until the probationary period is ended. The requirement of a probation report on those defendants returning for final disposition should be considered for future cases. An overlap can occur when a defendant is charged within a short period of time in separate localities and received first offender on each charge and neither will show on the CCRE printout until each is ended.

Table 49

COURT INFORMATION SENT TO THE
CENTRAL CRIMINAL RECORDS EXCHANGE

<u>Information Sent</u>	<u>Circuit Courts</u>	<u>General District Courts</u>	<u>TOTAL</u>
CCRE does not receive any information on deferred judgments from our office.	9 (27%)	5 (15%)	14 (21%)
CCRE is notified immediately after a judge grants a deferred judgment.	9 (27%)	4 (12%)	13 (19%)
CCRE is notified of the final disposition (a dismissal) after the person fulfills the terms and conditions of his probation.	11 (32%)	19 (56%)	30 (44%)
CCRE is notified of both the deferred judgment and final disposition (dismissal).	<u>5 (14%)</u>	<u>6 (17%)</u>	<u>11 (16%)</u>
TOTAL	34 (100%)	34 (100%)	68 (100%)

Source: JLARC Survey of Courts, November, 1974.

The CCRE is the only reliable source of statewide arrest and disposition data that can be utilized by local law enforcement agencies, courts, and probation and parole districts to determine whether a person is eligible for a deferred judgment. Some minor modifications to the CCRE form may be necessary to accommodate both the deferral and final disposition orders inherent in the court administration of these cases.

Impact on Probation and Parole System

In order to determine the impact of the deferred judgment statute on the probation and parole system, a brief survey questionnaire, similar to the one mailed to the court clerks, was sent to each of the 21 probation and parole district chiefs in the State. Twenty districts responded, indicating that since July 1, 1973, 1,338 adults were placed on probation because of the deferred judgment statute. Of these 937 were classified as being on active status in November, 1974. Nearly all of the active, and most of the inactive, cases released from probation during this period were for violation of the Commonwealth's marijuana laws. Assuming that the average period of probation is six months and the cost of providing probationary services to the client is \$200 per year, the Division of Probation and Parole Services has spent over \$134,000 on deferred judgment cases.³⁹

Fourteen respondents reported that the number of deferred judgment probation cases has been increasing relative to their office's overall total caseload. In 10 of the districts, it was reported that the courts were granting more deferrals in November, 1974, than six months ago, and 14 districts expected the courts to make greater use of the statute in the future.

Manpower Needs

Perhaps the most significant impact on the probation and parole system has been the increased demand on the officer's time to supervise and administer deferred judgment cases. Four district offices reported they had requested, or received additional probation and parole officers to supervise these cases. During the past year, the large number of caseloads in three districts, Richmond, Newport News, and Charlottesville have required an officer exclusively assigned to deferred judgment cases (Table 50).

Table 50

CASELOAD OF OFFICERS EXCLUSIVELY ASSIGNED DEFERRED JUDGMENT CASES

<u>District</u>	<u>Officer Caseload</u>
Newport News	236
Charlottesville	90
Richmond	75

Source: JLARC Survey of Probation and Parole
Districts, November, 1974.

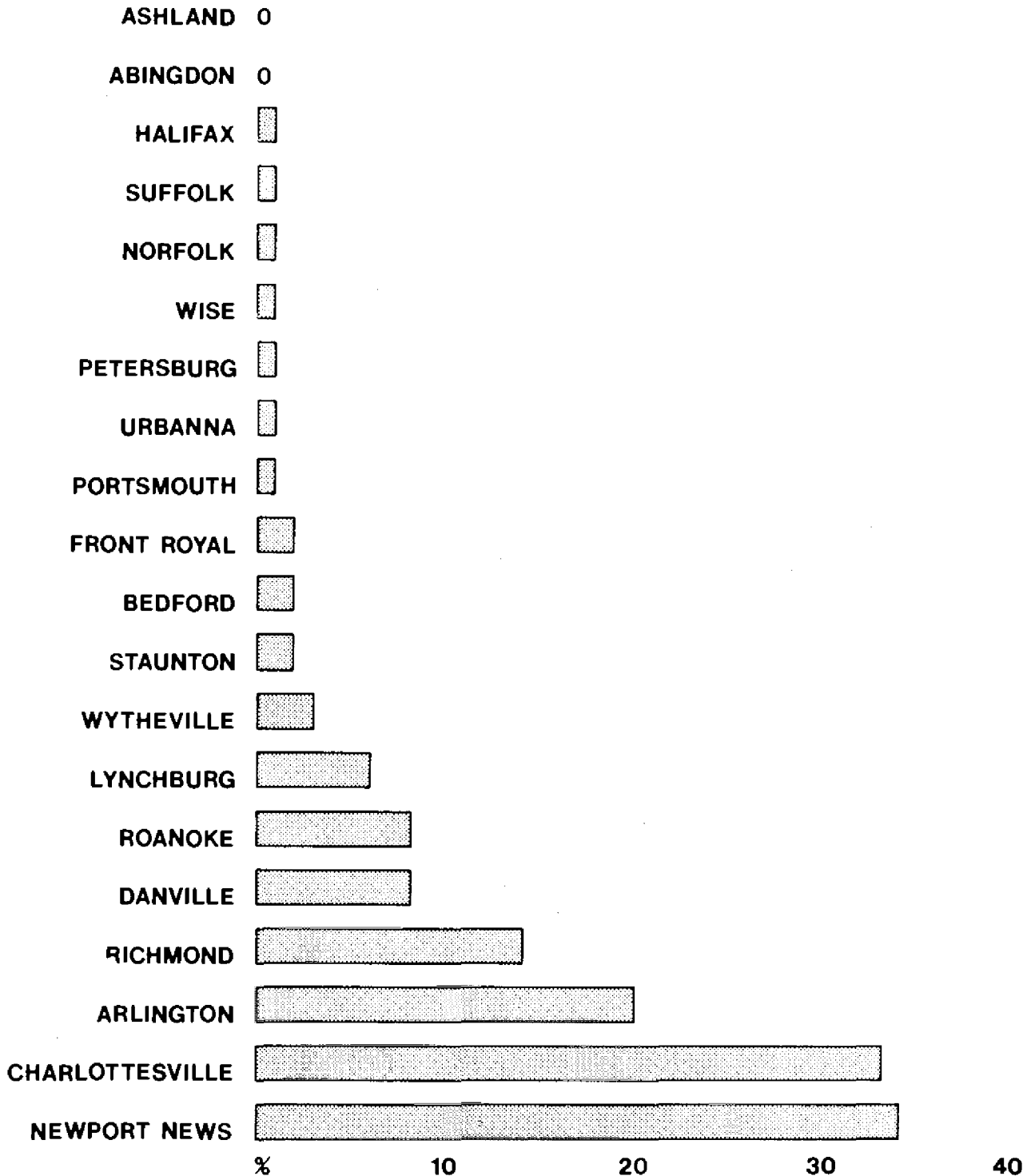
While the probation caseload varied from none in Ashland and Abington to 242 in Arlington, Newport News had the highest average number of cases per officer--19.7, Charlottesville had the next highest with 19 cases per officer, followed by Arlington with 10.5 (Table 51).

Deferred judgment cases have had the greatest impact in Newport News, Charlottesville, Arlington, and Richmond as indicated by Figure 17. Thirty-four percent of the Newport News caseload consists of deferred judgment clients. JLARC assumes that the primary reason for the low conviction rates in Newport News and Arlington is extensive court use of the deferred judgment statute.

During the period July to October, 1974, 23 new officers were assigned to district offices across the State. Of this total, 17 were placed in districts where the deferred judgment caseload comprised 6% or more of the total caseload. Since a district's total caseload is an important consideration in determining the need for additional officers, it appears that the recent rise in deferred judgment cases has been used by the division as a justification for additional probation and parole officers. If the courts increase their use of the statute and place more persons on supervised probation, as anticipated by the district offices, additional officers will be required.

Figure 17

DEFERRED JUDGMENTS AS PERCENT OF TOTAL PROBATION / PAROLE CASELOAD, BY DISTRICT OFFICE



Source: JLARC Survey of Probation and Parole District Offices, November 1974

Table 51

NUMBER OF ACTIVE DEFERRED JUDGMENT PROBATION
CASES PER OFFICER BY DISTRICT

<u>District</u>	<u>Number of Officers</u>	<u>Number of Deferred Judgment Cases</u>	<u>Average Number of Cases per Officer</u>
Richmond	23	191	8.3
Norfolk	20	5	.3
Portsmouth	13	8	.6
Accomack	---	---	---
Urbanna	2	1	.5
Suffolk	6	2	.3
Petersburg	7	4	.6
Halifax	3	1	.3
Charlottesville	5	90	18.0
Arlington	23	242	10.5
Front Royal	7	7	1.0
Staunton	8	10	1.3
Lynchburg	7	23	3.3
Danville	5	29	5.8
Roanoke	15	69	4.6
Wytheville	6	14	2.3
Abingdon	4	---	---
Wise	2	1	.5
Newport News	12	236	19.7
Bedford	3	4	1.3
Ashland	2	---	---
TOTAL	173	937	5.4

Source: JLARC Survey of Probation and Parole Districts, November, 1974.

Amount of Supervision Needed

There seems to be a feeling among officers that, overall, a person placed on a deferred judgment supervised probation usually requires less attention than the client who is on parole or a convicted felon. Nearly all deferred judgment cases are misdemeanors. One respondent stated "in many cases, supervision is not necessary and a record check at the end of the time would be sufficient." The judges in lower court have said that full supervision is not necessary and we devote more time to the more serious felony cases. Although there exists a general belief that deferred judgment cases require less supervisory time, 15 respondents reported a need to place persons on supervised probation. Sixteen of the 21 districts indicated that they provide an equal amount of supervisory time to deferred judgment cases as compared to other active probation and parole cases; Richmond and Newport News reported that they devoted less time to these cases.

It should be noted that there are courts in the State which are placing deferred judgment cases on unsupervised probation. Several of these

courts are located in the Tidewater area. Also, Richmond courts are diverting some probation cases to Offender Aid and Restoration for supervision and counseling services.

When asked whether many persons granted a deferred judgment receive any type of treatment for drug abuse, 14 respondents indicated that they did not. Since most cases represent marijuana violators, this is not surprising. This response appears to correspond with the general belief that most deferred judgment cases require less supervisory time than other types of cases.

Revocation Rate

As already pointed out, the intent of the deferred judgment statute is to deal more leniently with simple possession offenders who commit their first drug violation. It is assumed that because they are casual users or experimenters, they are unlikely to commit the offense again after their first encounter with the law.

Of the approximately 1,338 persons placed on supervised probation between July 1, 1973, and November, 1974, only 3.3% (45 persons) violated the terms and conditions of their probation. The normal probation violation rate is about 18%

A Case Study: Richmond

Extensive research into the use of deferred prosecutions has been conducted for the Richmond area which includes the Henrico County General District Court, Richmond City General District Court, and the Henrico and Richmond City Circuit Courts. The juvenile court was not included in the case study.

Variations in Use: Tables 52 and 53 show the number of times a deferred judgment was granted by the district and circuit court judges at the general district court level in Henrico County and the City of Richmond. Of all district court judges, Judge B was the only one consistently using the statute in first offender cases. Although some other judges hear an equal number of first offender cases, they are hesitant to use the statute.

In Henrico County, where the probation and parole records indicate the statute was first used at the general district court level, only five deferred judgments were granted for the twenty-month period ending September, 1974. Probation and parole officers have stated that because district court judges were beginning to request probation and parole officers to conduct pre-sentence investigations and record checks on persons eligible for a deferred judgment, the Henrico circuit judges instructed the lower court judges not to use the statute. Since probation and parole officers are assigned only to circuit court judges, it was felt that record checks conducted for the lower court judges would impede the regular duties of District 1 probation officers. Consequently, the Henrico general district court judges curtailed their use of the statute.

Table 52

DEFERRED JUDGMENTS GRANTED: RICHMOND AND HENRICO DISTRICT JUDGES

MONTH/YEAR	Richmond District Judges					Henrico District Judges			
	A	B	C	D	E	F	G	H	Total
January to December, 1973	--	--	--	--	--	--	--	5	5
January, 1974	--	--	--	--	--	--	--	--	--
February	--	3	--	--	--	--	--	--	3
March	5	22	--	--	--	--	--	--	27
April	5	21	--	--	4	--	--	--	30
May	--	20	--	--	--	--	--	--	20
June	--	23	--	--	--	--	--	--	23
July	2	19	--	--	1	--	--	--	22
August	--	6	--	--	--	--	--	--	6
September	--	8	--	--	--	--	--	--	8
TOTAL	12	122	--	--	5	--	--	5	144

Source: District One, Probation and Parole.

Table 53

DEFERRED JUDGMENTS GRANTED: RICHMOND AND HENRICO CIRCUIT JUDGES

MONTH/YEAR	Richmond Circuit Judges					Henrico Circuit Judges			
	J	K	L	M	N	P	Q	R	Total
January to December, 1973	21	--	7	14	--	1	2	1	46
January, 1974	2	--	--	4	--	--	--	--	6
February	4	--	--	2	--	--	--	--	6
March	--	--	--	9	--	--	--	--	9
April	2	--	1	6	--	--	--	2	11
May	--	--	--	--	--	--	--	--	--
June	1	--	1	1	--	--	--	--	3
July	3	--	--	6	--	--	--	--	9
August	--	--	--	--	--	--	1	--	1
September	--	--	--	--	--	--	--	--	--
TOTAL	33	--	9	42	--	1	3	3	91

Source: District One, Probation and Parole, and Order Book, Richmond Circuit Court, Division I.

Although the statute went into effect in 1972, one judge in the Richmond area did not become aware of its existence until early 1974. A lawyer appeared in court asking the judge to grant a deferred judgement to his

client, charged with a marijuana offense. The judge admitted that he was not aware of such a statute, prompting the lawyer to leave the courtroom and return with a copy of the Code. The lawyer then proceeded to read the statute to the judge.

At the circuit level, Richmond city judges also vary in their use of the statute. In Division I, judges J, L, and M applied the statute to 84 cases; however, the two circuit court judges serving Division II have not made use of deferred judgment and continue to impose fines and/or suspended jail sentences in cases involving simple possession of marijuana.

For a period July 1, 1973, to June 30, 1974, the Richmond Circuit Court, Division I, issued 75 deferred judgments--the average length of probation was six months. A breakdown of the type of drug offenders receiving deferred judgments is presented as shown below.

DEFERRED JUDGMENTS GRANTED IN RICHMOND CIRCUIT COURT,
DIVISION I, BY TYPE OF DRUG OFFENDERS
(July 1, 1973 to June 30, 1974)

<u>Type</u>	<u>Number</u>	<u>Appealed from</u> <u>Lower Court</u>	
Marijuana or Hashish Possession	70	60	(86%)
Marijuana Distribution (Accommodation)	1	--	
Noxious Chemical Substance	2	2	
Cocaine Possession	2	--	
	<u>75</u>	<u>62</u>	(83%)

Source: Order Book, Richmond Circuit Court, Division I.

Deferred judgments were granted to 83% of the persons who appealed their decisions from the lower court. Of all deferred judgments, 93% involved possession of marijuana or hashish, of which 86% were the result of appeals from lower courts. It appears that the hard-line attitude taken by lower court judges who refuse to take advantage of the deferred judgment statute has resulted in placing an increasing burden on the circuit court to hear appeals for minor drug violations.

Reporting to CCRE: The clerk of the District Court, Division I, reports the case disposition to the CCRE after the person has successfully completed his probation. The clerk of the Circuit Court, Division I, Criminal Division, notifies CCRE of both the deferral and the dismissal. By providing CCRE with two separate notifications, the clerk believes other courts and law enforcement agencies throughout the State can better prevent persons from abusing the "one time only" provision embodied in the statute.

Impact on Probation and Parole: On several occasions district court judges have requested the local probation and parole office to send an officer to court on the day drug cases are heard. This allows a judge to personally

inform the probation and parole office of the individuals granted a deferred judgment that day. A Richmond judge initiated such a procedure in his court after learning that several of his deferred judgment probationers never reported to the District I probation and parole office for supervision as they were instructed to do by the court.

Another important point related to the absence of probation and parole officer support at the district court level is the lack of pre-trial information on persons eligible for a deferred judgment. The District I probation and parole office reported that one judge granted deferred judgments to several persons who had a prior record of drug arrest and conviction.

The most direct effect of judges using the deferred judgment statute in Richmond has been the increase in total caseload for the District I office. As of November, 1974, the District I office was carrying 191 active deferred judgment cases. Because of this increased caseload, the office is burdened with an added amount of paperwork, something the officers would like to avoid. Deferred judgment cases tend to exaggerate the drug problem within the District I office, since they account for 30 to 40% of the total drug caseload.

Deferred Judgment - Summary

A number of courts appear to be using the deferred judgment statute as a means of dealing with first offenders, primarily persons who have violated the State's marijuana possession laws. Probation and parole data indicate that the statute has been most frequently used in the courts of Northern Virginia, Newport News, Richmond, and Charlottesville and the revocation rate is low--3.3%.

Based on JLARC's analysis of CCRE data, court survey results, and probation and parole records, it can be concluded that as a group judges are not consistently using the statute in cases involving first offenders. Some inconsistency can be attributed to different philosophies in dealing with offenders or a reluctance to impose additional workload on an already over-worked probation and parole system. If the statute were applied in all first offender cases, and these cases were placed on supervisory probation, the courts would likely have a difficult, if not impossible, time administering and supervising clients. However, it does not seem reasonable to deny a first offender use of the deferred judgment statute for these reasons, since the intent of the General Assembly was to deal more leniently with persons who have committed their first drug offense. To reduce the inconsistency of the statute's use among judges, JLARC recommends that the law be amended to more carefully prescribe the extent of judicial discretion when dealing with first offenders. To reduce the burden on the probation and parole system, consideration should be given to placing first time marijuana offenders on unsupervised probation, unless unusual circumstances warrant otherwise.

Consistent application of the statute has also been adversely affected by several unexpected procedural problems including the lack of pre-trial information on defendants and inadequate notification of CCRE by the courts of deferred judgment cases. These problems have resulted in some offenders being improperly granted a deferred judgment, violating the one time only provision of the statute. JLARC believes that it would not be economically

feasible for the probation and parole districts to perform pre-trial investigation reports on all offenders eligible for a deferred judgment. Therefore, CCRE forms should be modified to accommodate both orders associated with a deferred judgment case, the deferral and the final dismissal, and local police departments and the CCRE should be responsible for supplying the courts with accurate information on offenders.

The deferred judgment statute was recommended by the Commission on Narcotic and Drug Laws and enacted by the General Assembly to give the court added flexibility in dealing with simple possession offenders, who would be unlikely to commit the offense after their first encounter with the law. JLARC found the deferred judgment statute being used primarily as an alternative to dealing with marijuana violators. Clearly, the unnecessary burden now being placed on the courts and probation and parole system and the intent of the General Assembly can be easily achieved if the laws regulating the use of marijuana are made more consistent with its social costs and potential harm to the individual.

CONCLUSION

Since 1970, the General Assembly has revised the State drug laws by enacting progressive legislation aimed at regulating the legitimate manufacture and sale of drugs and by reforming the criminal sanctions, emphasizing leniency toward the user and stiffer penalties for distributors.

Although it is the intent of the legislature to be lenient toward users, Virginia's criminal justice organizations have devoted substantially more time, effort and public resources toward the apprehension and prosecution of drug users than traffickers. Of those persons apprehended, less than half of the cases result in convictions, and only 14% are incarcerated. The actions of the courts appear to be inconsistent with the heavy emphasis given to apprehending drug users by law enforcement agencies.

Marijuana has had a significant impact on the activities of law enforcement agencies, courts, and probation and parole. Of the total drug arrests in 1974, 70% or more involved marijuana violations; and about 63% of the court's drug caseload consists of marijuana offenses. The deferred judgment statute is being used by many courts as a means of dealing with first offenders primarily marijuana violators. Noticeable variations exist, however, among and within courts in the use of the statute; therefore, it is recommended that consideration be given to amending the statute in order to limit the extent of judges' discretionary powers. Furthermore, in order to alleviate the burden on the probation system, first-time marijuana offenders should not be placed on supervised probation except under unusual circumstances.

Despite aggressive pursuit of some 188,000 users of marijuana in Virginia, the criminal justice system has not effectively curbed the availability of small amounts of marijuana. The burden currently being placed on the courts can be greatly reduced if Virginia's laws are changed to conform more closely with the potential harm and social costs associated with marijuana

use. Such a modification in the law would also require enforcement agencies to reassess their priorities relative to the legislative intent of Senate Joint Resolution No. 60.

There is a need to impose penalties for the possession of marijuana in the Commonwealth in order to discourage its use. To achieve this objective at a reasonable cost to taxpayers, however, consideration should be given to reducing the criminal penalties for possession of less than one ounce of marijuana and substitution of a citation system with a fine. To date, six states--Alaska, Maine, California, Colorado, Oregon, and Ohio have reduced penalties for possession of small amounts of marijuana, and 20 other states are considering similar or identical changes in their laws.

The intent of the General Assembly is to deal severely with drug traffickers and distributors, therefore, it is also recommended that any new laws carefully define the nature of distribution and trafficking of marijuana and maintain stiff penalties for these violations.

CORRECTIONS

Although the Department of Corrections has made some progress in developing programs to control drug use among its inmate population, there remains a serious drug problem within correctional institutions. Efforts should be directed toward expanding diagnostic, referral, and treatment services for drug dependent persons. Furthermore, JLARC found serious deficiencies in the control of prescription drugs in violation of State and federal laws. Prompt attention is required to insure that pharmacy services are provided each institution and adequate procedures are established for the handling, dispensing, and storage of prescription drugs. In addition, adequate monitoring devices should be used to detect illegal drug use within the institutions.

The creation of probation and parole multi-disciplinary drug teams is a positive approach to dealing with the complex problems of drug and alcohol involved clients. The Division of Probation and Parole Services should expand the drug teams to include representatives from other State and local organizations.

This chapter reviews the department's efforts in providing drug training to its employees, the development of drug treatment programs, methods for discovering drug use within institutions, handling of prescription drugs, and establishment of probation and parole drug teams.

VI. CORRECTIONS

The correctional system has a vital role to play in the effective treatment of drug dependent persons at both the State and federal levels. Virginia's correctional system has recently experienced a series of organizational realignments and personnel changes. Effective July 1, 1974, the Department of Corrections, previously part of the Department of Welfare and Institutions, was created and now includes the Board of Corrections, the Probation and Parole Board, the Division of Youth Services, the Division of Adult Services, and the Division of Probation and Parole Services.

The rising increase in drug abuse has significantly impacted on department activities. While there were 1,303 juveniles under the department's care as of June 30, 1973, the lack of statewide drug statistics on youthful offenders prevented an analysis of the extent and nature of drug abuse within juvenile institutions. Available information concerning adult inmates indicates a serious drug problem exists in the Commonwealth's penal institutions. For example, a total of 2,061 felons were committed to the State's correctional system during 1973-74; approximately half had a known history of drug use or heavy drinking (Table 54).

Table 54

DRINKING AND DRUG USE HABITS OF FELONS COMMITTED
TO THE STATE'S CORRECTIONAL FACILITIES
(1973-1974)

<u>Habits</u>	<u>Number</u>	<u>Percent</u>
Heavy Drinking	268	13.0%
Occasional Drinking	645	31.3
Drug Use	449	21.8
Drug Use and Heavy or Occasional Drinking	343	16.6
No Drinking or Drug Habits	200	9.7
Unknown	<u>156</u>	<u>7.6</u>
Total	2,061	100.0%

Source: Department of Corrections.

Among misdemeanants committed to the state penal system during 1973-74, 15% had been convicted for either violating drug laws, drunk and disorderly conduct, or driving under the influence of intoxicants (Table 55).

In an attempt to control and counteract the influence of drugs on the prison population, the department instituted a drug education and training program for its employees, developed a drug treatment program at its James River Correctional Center, hired additional counselors at Southampton and the Correctional Center for Women, and employed a pharmacist to operate a central pharmacy in Richmond. These efforts, while commendable, still need to be

supplemented to effectively cope with the drug problem in the penal institutions. The department, however, has only 25 in-patient and 40 out-patient treatment slots, and lacks personnel and procedures to control the availability and misuse of drugs within its institutions.

Table 55

MISDEMEANANTS CONFINED TO THE STATE'S
CORRECTIONAL FACILITIES
(1973-74)

<u>Type of Offense</u>	<u>Number</u>	<u>Percent</u>
Violation of Drug Laws	55	3.4
Drunk and Disorderly Conduct	137	8.6
Driving Under Influence of Intoxicants	42	2.6
Other Offenses	<u>1,369</u>	<u>85.4</u>
Total	<u>1,603</u>	<u>100.0</u>

Source: Department of Corrections.

Table 56 shows the funds allocated for drug treatment and training programs operated by the department. In addition, the department has used nearly 80,000 manhours for drug training programs and is establishing a central pharmacy to regulate and dispense prescription drugs to prisoners.

Table 56

FUNDS AVAILABLE FOR DRUG TREATMENT PROGRAMS
DEPARTMENT OF CORRECTIONS

<u>Source</u>	<u>July 1973 to June 1974</u>	<u>July 1974 to September 1975</u>	<u>October 1975 to September 1976</u>
DDAC	---	\$ 64,357	---
DJCP	\$100,000	\$245,655	\$220,000
State	<u>\$ 33,333</u>	<u>\$ 29,694</u>	<u>\$ 24,443</u>
Total	<u>\$133,333</u>	<u>\$339,706</u>	<u>\$244,443</u>

Note: Excludes probation and parole drug team expenditures.

Source: Division of Drug Abuse Control, and Division of Justice and Crime Prevention.

IMPLEMENTATION OF HOUSE DOCUMENT NUMBER NINE

The magnitude of the combined drug and alcohol problem within State correctional institutions, prompted the 1972 General Assembly to adopt House

Joint Resolution No. 66 "directing the Department of Welfare and Institutions to conduct a study and develop a plan for the treatment of drug addicts accused of violations of the drug laws."

The plan was to include:

- The scope of drug abuse problems;
- The requirements for treatment and rehabilitation services;
- Provisions for the security of prisoners;
- The Constitutional requirements for a speedy trial and necessity of not impeding the process of justice; and
- Ways to make maximum use of all available treatment and rehabilitation facilities, both public and private, which now exist or may be developed in the future.

House Joint Resolution No. 216 of the 1973 General Assembly directed the department to continue the study, expanding its scope to include all elements of the State and local corrections system, and both juvenile and adult drug offenders. In November, 1973, the department reported the findings and recommendations of its two-year study effort (House Document No. 9).

Drug Treatment

One of the recommendations of the department was to establish a drug treatment program at a major correctional facility. This recommendation led to the establishment of the James River Correctional Center Drug Specific Program in July, 1974. Drug specific programs are oriented toward treating the drug and/or alcohol abuser, usually on an in-patient basis within a therapeutic community setting and offering a wide range of treatment services. The James River program has a capacity of 25 in-patients and 40 out-patients. Treatment personnel use multiple modalities to treat drug clients.

The objective of the treatment program as stated in the original grant proposal is "to reduce recidivism and drug usage of participants to a statistically significant degree with an ideal objective of more than 80% of the residents remaining drug-free following participation and recidivating at less than 20%." Participants must be within 18 to 24 months of parole eligibility, have a history of drug abuse, and apply for admission to the program.

DDAC supplied the initial funds for employment, training, development of staff, and remodeling the facility. Actual implementation of the program was funded by DJCP for the period October 1974 to September 1975. Funding for this program is shown in Table 57.

As of April, 1975, the program had accepted only 10 in-patient residents, and only 25 of the 40 out-patient slots had been filled. The program director reported that inmates were initially hesitant to volunteer. The

Table 57

FUNDS AVAILABLE FOR DRUG SPECIFIC PROGRAMS

<u>Source</u>	<u>July 1974 to September 1975</u>	<u>October 1975 to September 1976</u>
DDAC	\$ 40,072	--
DJCP	55,655	\$ 60,000
State	<u>6,183</u>	<u>6,666</u>
Total	\$101,910	\$ 66,666

Source: Division of Justice and Crime Prevention.

selection process was identifies as a reason for vacant slots since only highly motivated inmates with a sincere interest in the treatment and counseling services were accepted.

An important aspect of the grant proposal was a research design for evaluating program success. Implementation of this evaluation tool has also been slow, and may eventually be discontinued because of the shortage of qualified personnel. The evaluation design is important but the grant proposal failed to include adequate resources to carry it out.

During the last few months, training sessions have been held to acquaint individuals outside the correctional system with the treatment techniques. This type of activity appears to be an improper use of time since it was not included in the original objectives of the project. The merits of the program should be clearly established by evaluation before training persons outside the correctional system. Since such an evaluation has not been conducted, it is impossible to judge whether the program has been successful at meeting the intended objectives.

Drug General Programs: While the department has been slow to develop drug specific treatment programs, drug general programs have been operating at the Southampton Correctional Center and the Correctional Center for Women. These programs are not specifically directed at the drug client, but toward the personality and emotional disorders of all clients. For example, the goal of the Southampton program initiated in July, 1973, is "to create an atmosphere in which inmates are motivated to further understand themselves and to actively participate in their own personal, social, educational, and vocational development."

At both the Southampton Center and Women's Center there are a large number of inmates with drug abuse and alcohol problems. An estimated 35% to 65% of Southampton's population has a drug use problem and 60% of the inmates at the Women's Center are serving time for drug or drug related offenses. The drug general programs employ additional rehabilitation counselors and psychologists to reduce the average caseloads.

The Southampton and Women's Center programs are coordinated and administered by counselor supervisors with little direct control exercised by

the central office in Richmond. Treatment teams consisting of correctional officers, DVR counselors, correctional counselors, and school teachers are responsible for managing a client's case. The Division of Justice and Crime Prevention is the primary source of funds as indicated in Table 58.

Table 58

FUNDS AVAILABLE FOR DRUG GENERAL PROGRAMS

<u>Source</u>	<u>July 1973 to June 1974</u>	<u>July 1974 to September 1975</u>	<u>October 1975 to September 1976</u>
DJCP	\$100,000	\$190,000	\$160,000
State	<u>33,333</u>	<u>21,111</u>	<u>17,777</u>
Total	\$133,333	\$211,111	\$177,777

Source: Division of Justice and Crime Prevention.

A major focus of the Southampton and Women's Center counseling programs is the use of behavior modification. Based on a client's performance a system of rewards is established, involving higher levels of privileges and responsibilities. Prior to this program the Department of Welfare and Institutions lacked any means, short of punishment, in dealing with clients who had drug or alcohol problems. It appears the Southampton program has been instrumental in identifying and treating drug abusers, improving coordination of programs and resources aimed at rehabilitating drug abusers, and training of institutional staff. In the near future, the department should conduct an extensive evaluation of these programs and determine their effectiveness in reducing or discouraging drug and alcohol use among clients. This evaluation could serve as the basis for deciding whether the department should assume the total cost of the programs when DJCP funds are eventually terminated, or expand the existing programs.

Education and Training

The continuing drug and alcohol problems within the State's correctional system have generated a need for education and training programs for all personnel. Department of Welfare and Institution surveys of correctional personnel validated the need for drug training and education. Respondents had been given general drug knowledge inventories which examined their understanding of nomenclature, effects, and types of narcotics and drugs. Results showed a low level of drug knowledge among institutional staff. This was also found to be true at those institutions where the Department of Vocational Rehabilitation education specialists had conducted drug training sessions. The Department of Corrections concluded in House Document No. 9 that because of the "apparent ineffectiveness of drug education efforts to date it is necessary to plan for both initial and follow-up drug education programs."

This led the department to launch an ambitious training program in January, 1974, aimed at providing a maximum of 20 hours of instruction to all personnel who have daily contact with inmates plus an additional four hours of

classes each year to update this basic training. As part of the departmental reorganization, the Bureau of Staff Organization and Development was created with the intention of coordinating and supervising all education and training activities including each divisional training section and the jails training section. In late 1974, however, it was decided that the bureau would serve as functional staff to the director of the department. Consequently, each division is responsible for implementing its portion of the drug training and education program, resulting in a decentralized approach to training with the bureau acting as a central coordinator and monitor.

After the 20-hour training program was recommended in House Document No. 9, the Department of Welfare and Institutions established an interdepartmental planning committee in February, 1974, to develop a plan for providing drug education and training. By August, 1974, a Task Force appointed by the committee completed plans for a program to train 40 drug trainers. It was planned that these trainers would train a core group at each institution. The 40 trainers, plus the institutional core groups, were to train all correctional personnel in the adult institutions, local jails, youth institutions, and probation and parole district offices by April 1, 1975. This plan was later abandoned and it is now the responsibility of the 40 trainers to train all personnel within the correctional system. These trainers participated in a four-day training workshop held in September, 1974, dealing with the preparation of a Basic Drug Education Program for Corrections personnel to be used to satisfy the 20-hour drug and alcohol training objective incorporated in House Document No. 9.

During the latter part of December, 1974, the department issued an exemption ruling--any person who has taken 20 hours of drug awareness training within the last 24 months, and passes the post-test examination with a 75% grade or better may be exempted from the training and education program. It is not known how many correctional personnel have qualified for this exemption.

Resources: The Division of Drug Abuse Control provided start-up funds amounting to about \$17,000 to develop the 20-hour basic training program. The Department of Corrections has committed many man-hours and funds for travel, lodging, and meals. It is estimated that approximately 30,000 man-hours will be spent in the classroom to train 4,000 correctional personnel. Assuming an average annual salary of \$6,000 per year, a conservative estimate of the cost of this program just for salaries is \$230,000. If the cost of meals, lodging, travel, printing, and time expended in program development are added the total State expenditures for the program could exceed \$300,000. However, during the 1974 session of the General Assembly, the Department of Welfare and Institutions did not request funding for this program and each division must rely on existing training budgets.

Program Results: Poor planning and a lack of adequate resources have beset the program from the start. It was originally anticipated that every person in the correctional system who had daily contact with inmates would receive training by April 1, 1975. Estimates of the number of persons who were to participate ranged between 4,000 to 5,000, depending on staff turnover and participation of local jail personnel. Only the Division of Probation and Parole Services successfully met the deadline. The Division of Youth Services expects to have all personnel trained by October, 1975. Because of its complexity and size, the Division of Adult Services has had the most difficulty in

training employees (the division had trained 1,375 persons as of May, 1975). The remaining employees are expected to be trained by December 31, 1976.

An apparent lack of communication among department staff and DDAC, resulted in a general, although false, belief that the drug education and training program was mandated by House Joint Resolution No. 216. In a report presented to DDAC in January 1974, it was stated that the department had a schedule for implementing "specific recommendations contained within HJR 216." In July, 1974, a department memorandum said, "It has been mandated by House Bill 216 that all Department of Corrections personnel having daily contact with clients must receive a minimum of 20 hours of training before April 1, 1975, with four hours follow-up training each year following." As late as December 1974, a divisional financial report remarked that "While the General Assembly mandated that the Department of Corrections comply with House Bill 216, it failed to appropriate any funds to cover the cost of compliance." This division was not aware that the department did not request funds for the drug education and training program.

Although the program has been marked with periodic lapses in coordination and communication, the department, especially the Division of Probation and Parole Services, has responded favorably. However, the divisions are adamant about not surrendering their training responsibilities to the Bureau of Staff Organization and Development.

Thus far, some of the more productive aspects of the program have been:

- An increased awareness on the part of correctional officials of the drug and alcohol problems among inmates and corresponding lack of employee training to begin addressing these problems.
- A basic drug education curriculum for correctional personnel has been developed as a guide for implementing education and training programs in each of the divisions and jails sections.
- The drug education curriculum has become a permanent part of the basic training program for all custodial personnel conducted at the Adult Services Training Center.
- A pre and post-test instrument has been developed to evaluate the program's effectiveness.

Research

The third major area of recommendations included in House Document No. 9 dealt with research. In October, 1975, the Department received a discretionary grant from LEAA to establish a program development and evaluation capability. The grant included funds for 3 program evaluation specialists and 2 program development specialists. These specialists will be assigned to all department programs, including drug programs.

As previously discussed, the Bureau of Research and Planning is conducting an evaluation of the drug training and education program. Evaluation

of DJCP funded programs are usually performed by personnel participating directly in the implementation of these programs.

DRUG CONTROL

Just as important as providing inmates with treatment and rehabilitation opportunities is the prevention of drug abuse among prisoners. JLARC's motivation to examine this aspect of the adult correctional system was prompted by indications that department policies and procedures regulating the use of prescription drugs were inadequate. JLARC was also interested in determining the extent of illegal drug use among clients, including both prescription and narcotic drugs.

Dispensing of Prescription Drugs

At the time of JLARC's initial review of this area in late 1974, each of the major adult institutions purchased bulk supplies of drugs through the Department of Purchases and Supply. Prescription drug needs of the 30 field units were satisfied whenever possible, by the State Penitentiary and local pharmacies. The department, however, did not have licensed pharmacists or approved pharmacies for dispensing drugs to inmates, in violation of State and federal law.

Since JLARC initiated its study of the department's handling of prescription drugs, a pharmacist has been employed to develop a set of procedures and guidelines for establishing a central pharmacy in Richmond.

Because of the decentralized methods used to purchase bulk drugs, it is difficult to accurately assess the extent of the department's involvement in dispensing prescription drugs. The storekeeper at the State Penitentiary, however, stated that approximately \$10,000 to \$12,000 worth of Schedule III through VI drugs are maintained in the storeroom. The average monthly State Penitentiary budget for drugs is estimated to be \$10,000 at wholesale prices.

Violations of State Drug Control Act: In order to determine whether the department was in compliance with the State Drug Control Act, JLARC asked the Board of Pharmacy to perform inspections of selected adult institutions and field units. The board responded favorably to JLARC's request and conducted inspections, in some cases with the assistance of JLARC staff, of the correctional facilities. (The board's response and general findings are included in Appendix VI.)

As indicated in Table 59, the board found widespread violations of the State's Drug Control Act including:

- Dispensing of drugs by persons other than a pharmacist or licensed physician,
- Unlicensed pharmacies,
- Poor recordkeeping, and

Table 59

BOARD OF PHARMACY INSPECTION RESULTS

<u>Institution Inspected</u>	Licensed Pharmacist Not Available	No Pharmacy Permit	Inadequate Records for Controlled Drugs	Mislabeling
State Penitentiary	X	X	X	X
Industrial Center for Women	X	X	X	X
Pocahontas Correctional Unit	X	X	X	X
Botetourt Correctional Unit				
Chesterfield Pre-Release	X	X		X
Chesapeake Correctional Unit	X	X	X	
St. Brides	X	X	X	X
Wise Correctional Unit	X	X	X	X
Haynesville Correctional Unit			X	X
New Kent Correctional Unit	X	X		X
Carolina Correctional Unit			X	X

X = Violation of 1970 Drug Control Act.

Source: Board of Pharmacy Inspection Reports.

- Mislabeling and misbranding of drugs.

The board also found inadequate procedures for handling and storage of prescription drugs at the institutions, and unregistered nurses involved in the practice of medicine including medical diagnosis, and the prescription and dispensing of medication.

Copies of the inspection reports were sent by the board to representatives of the department and Attorney General's office, and the department has taken steps to remedy some of the violations. In addition to the board's inspections, the Drug Enforcement Administration (DEA) conducted site visits at several juvenile institutions in mid-1974 and discovered similar violations of federal laws.

The department's lack of control of prescription drugs has resulted in thefts from the penitentiary drug storeroom, accumulation of drugs for illegal use and sale, and misuse of prescription pads by inmates. The recent acquisition of a pharmacist, and plans to establish a central pharmacy in Richmond will, hopefully, improve control over the use and abuse of prescription drugs within correctional institutions.

Monitoring Drug Use in Institutions

Involuntary urine screening can be an effective way of preventing or detecting illegal drug use within institutions. During September of 1974 JLARC requested the department conduct a sample urine screen of prisoners at selected adult institutions, to ascertain the extent of drug misuse. An unexpected change in personnel within the Division of Adult Services, however, forced JLARC to abandon its request.

At the time of JLARC's request, the department was not conducting urine screens of prisoners as originally intended under a 1974 DJCP grant awarded to Consolidated Laboratory, which provides free urinalysis services to the Department of Corrections. Beginning in late 1974, however, the department initiated urine screen surveillance at its four receiving centers, State Penitentiary, Powhatan, Women's Center, and Southampton.

By July 1, 1975, the department will have established urine screening surveillance guidelines and procedures for personnel at five work release centers including Chesterfield Pre-Release, Woodbridge, Pulaski, Southampton, and Roanoke. Results of urine screens will be used to determine a prisoner's continued participation in the work release program. These programs need to be expanded to cover all institutions.

PROBATION AND PAROLE DRUG TEAMS

With the recent increase in drug arrests and convictions, a demand has been created for the provision of specialized services to drug involved probationers and parolees. The Department of Corrections, Division of Probation and Parole Services, through its 23 district offices (there were 21 when JLARC initiated its study), provides these services. The division's involvement in drug abuse programs came soon after the recommendations of the Touche

Ross report, which suggested the establishment of multi-disciplinary teams to work with drug dependent or drug related probation and parole cases.

Following the recommendations of the Touche Ross report, surveys of the 21 probation and parole districts were conducted during 1972 and 1973. These surveys indicated an urgent need for addressing the drug and alcohol problems of the clients. Approximately 50% of the total number of clients supervised in 1973 had a history of drug abuse. The majority of these clients were male and under the age of 25. More recent statistics provided by the division, indicate 6,000 cases, or about 60% of the total probation and parole caseload, have used drugs.

House Document No. 9, the Department of Correction's plan of action for institutional drug treatment, education, and training programs within the correctional system, recognizes the need for providing "active re-entry and follow-up services in the community for released drug and alcohol abusers in cooperation with the Probation and Parole Board and licensed treatment programs".⁴⁰

A probation and parole staff paper states:

*The positive results of traditional supervision of dependent probationers and parolees have proved minimal and there has been little in the way of coordination between traditional correctional programs and treatment programs utilized by drug dependent probationers and parolees upon being probated or paroled. The drug team concept provides an opportunity for concentrated, coordinated treatment and control plans geared to the rehabilitative needs of each drug dependent client.*⁴¹

Salaries and other costs used for operating the drug teams are included in Table 60.

Table 60

DIVISION OF PROBATION AND PAROLE DRUG TEAM PROGRAM BUDGET

<u>Year</u>	<u>Amount</u>
1973-74	\$146,116
1974-75	224,138
1975-76	235,713

Source: Department of Corrections, Division of Probation and Parole.

It should be noted that these figures include the salaries and overhead costs involved with the maintenance of the drug team coordinator, and the original 10 drug officers and their team activities. The budget excludes 19 additional officers who are assigned exclusively to drug and alcohol clients, but are maintained within existing district office resources. The costs associated with maintaining the additional officers and the recent rise in deferred

judgment probation cases, therefore, have definitely had a major financial impact on the probation and parole system beyond the amounts presented in Table 60.

Organization

In mid-1972, meetings were held between the central office staff and selected field offices concerning the appointment of drug officers and implementation of a drug team component in 9 probation and parole districts (later expanded to 13). At the same time, the division and DVR were studying the possibility of organizing drug teams composed of DVR counselors and probation officers. An agreement was signed by both parties in March, 1973, outlining the responsibilities of probation and parole officers and DVR counselors assigned to drug teams.

Once a drug team is organized a probation and parole screening committee and drug client information system are established as supportive mechanisms to assist the team in processing drug involved clients. The purpose of the screening committee is "to evaluate each prospective probationer or parolee as to his drug problem (type and extent) to determine if such an individual is amenable to the rehabilitation programs offered." Usually, the screening committee is composed of a probation and parole drug officer, DVR counselor, and supportive community services including therapeutic community, out-patient drug treatment program, planning district commission, and other related agency representatives.

Major activities of a drug team are multi-dimensional in scope, ranging from pre-sentence investigations for the courts to the preparation of placement plans for the Parole Board. Other activities performed by officers and DVR counselors include: (1) client screening and referral, (2) client counseling and supervision, (3) vocational assessment, (4) urinalysis surveillance, (5) training of probation and parole personnel, and (6) data collection and analysis.

Since mid-1972, the drug teams have been beleaguered with an assortment of organizational and administrative difficulties. A concerted effort is now being made by the division to correct some of these problems and modify the drug team component within the 13 probation and parole districts. Although all teams are established, a few exist in name only and are not performing all the duties initially expected.

JLARC discussions with drug team members in November 1974 revealed that drug officer caseloads were excessive and not entirely composed of drug involved clients. Screening committees were organized in five districts. Also, district chiefs vary in their attitudes toward the concept, some believing that there was no reason to treat drug involved clients any differently than other probationers and parolees.

Generally speaking, the goals, guidelines, and procedures of the original drug team program were vague and ambiguous. Clear and concise definitions of a drug team and screening committee and descriptions of the roles and responsibilities of team members, district office administrators, and central office administrators were lacking.

The cooperative agreement between the Probation and Parole Board and the Department of Vocational Rehabilitation, establishing a teamwork approach for treating drug dependent probationers and parolees, has encountered criticism from both agencies. Probation and parole officers feel that DVR counselors are too slow in delivering services to their clients; and some counselors are not participating on the drug teams, especially in the more rural probation and parole districts where there are no designated DVR drug counselors. DVR contends that counselors are providing the best possible services they can under the existing conditions, which involve a great deal of paperwork required by the federal government. Also, DVR feels that there are basic philosophical differences between the two agencies, which add to the problem--DVR is treatment and counseling oriented while probation and parole personnel are concerned primarily with enforcement and control.

It seems the basic problem between the division and DVR is lack of communication at all levels of program management and implementation. At the central office level, the drug team program guidelines and cooperative agreement guidelines are not clear, leaving many administrative questions unanswered as to how DVR and the division are to interact in implementing the drug team concept. Drug officers of several teams feel the team is composed of probation and parole officers only, while others believe the drug team is not operative unless DVR counselors actively participate as originally outlined in the cooperative agreement. The drug team concept and the roles and responsibilities of the central offices are in need of further clarification.

At the district level, drug officers and DVR counselors are unsure as to their respective roles and responsibilities. One DVR counselor was never told by his local office supervisor that the cooperative agreement was in effect. This counselor worked a period of time before being notified by the DVR central office that the agreement existed. In the five areas of the State having DVR drug counselors, there seems to be a good relationship between the probation and parole drug officers and counselors. However, some districts have better officer/counselor relationships than others, and this may be a result of individual personalities.

In those districts where there are established drug teams but no DVR drug counselors, several drug officers feel DVR is responsible for the drug team's failure. However, these counselors have normal caseloads (which are usually high) and have little or no training in the area of counseling drug or alcohol dependent probationers and parolees. If a counselor is not officially designated as a drug counselor he is not governed by the same guidelines pertaining to a drug counselor. Therefore, the counselor's caseload is a mixture of all types of rehabilitation cases, including drug and alcohol clients.

Due to recent modifications in client eligibility criteria brought about by the federal Rehabilitation Act of 1973, fewer drug clients will be served by DVR since drug addiction is not considered a severe handicap. Furthermore, DVR is eliminating its drug counselor positions. As a result, the drug team composed of probation officers and DVR drug counselors will no longer exist as originally conceived.

JLARC believes the concept of multi-disciplinary teams working with drug and alcohol probation and parole cases is good. However, every effort should be made by the division to develop a clearly defined set of guidelines and responsibilities for operating, maintaining, and evaluating the drug team program. The team concept should be expanded to include representatives of other State and local agencies interested in meeting the needs of probationers and parolees with drug and alcohol problems. Elimination of DVR drug counselors as members of the drug teams is disappointing in light of the critical need to provide vocational rehabilitation counseling services to drug and alcohol clients. The division, with the assistance of DVR, should explore alternative ways of providing drug and alcohol clients with suitable vocational rehabilitation counseling services.

CONCLUSION

When JLARC first initiated its evaluation of the correctional system in August, 1974, the department's drug program could be characterized as disjointed, and lacking centralized leadership and accountability. Since the beginning of 1975, however, JLARC staff has noticed an improvement in the management of the department's approach to drug abuse programs. The department is now providing drug involved inmates access to treatment and counseling services, conducting drug education and training programs for correctional personnel, has acquired a pharmacist, and has instituted a urine surveillance program.

Several deficiencies, however, still exist which must be corrected. The department needs to (1) establish positive controls for the handling, storage, and dispensing of prescription drugs, (2) provide pharmacy service to each institution, and (3) expand its urine surveillance program to cover all institutions.

One area of concern is the department's heavy reliance on DJCP funds for operating treatment and counseling programs. Because DJCP cannot continue to maintain these programs for an indefinite period of time, the department should develop a plan for assuming the costs of the Southampton, Women's Center, and James River programs. Due to the continuing nature of the drug abuse problem among criminal offenders, there seems to be little doubt that the drug general and specific programs will be needed indefinitely. Because the imprisoned drug user is already provided lodging and meals by the State, a voluntary drug treatment and counseling program (for all drugs including alcohol) appears to be a wise utilization of the prisoner's time and public resources.

The drug team programs have been more successful in some districts than others. Established teams, like the Richmond District 1 drug team, are recommending individually prescribed treatment and control plans and devoting increased supervisory and counseling time to drug and alcohol clients. Officers and counselors trained in the problems and needs of drug clients are assigned the responsibility of supervising these difficult cases.

Another result of this program has been an improvement in the referral of probationers and parolees who have drug abuse problems to local drug

treatment programs. Prior to the establishment of screening committees, persons on probation and parole were often referred to programs without regard for which treatment modality would best suit their needs. The drug teams are experts trained in the problems and needs of drug dependent probationers and parolees, and can recommend referral to a treatment program which best satisfies the client's background and drug abuse history.

A less tangible output of the program has been an improvement in cooperation and coordination among probation and parole personnel, treatment program staff, DVR counselors, and members of the criminal justice system. Some people feel that the drug teams serve as a vital link between the criminal justice system and community treatment programs, particularly in the larger metropolitan areas of the State.

TREATMENT

This Chapter assesses the State's current drug treatment effort, the extent and nature of the services offered, types of clients being served, and program effectiveness. Much of the Chapter centers on the involvement of DJCP, MHMR, and the Department of Health as well as federal funding of locally-based drug treatment programs. Several key issues are discussed including licensing of drug programs, the extent to which programs are monitored, the need for more coordination, and the decline in federal funds.

The results of an extensive JLARC assessment of four treatment programs is discussed in detail and indicates that treatment outcomes may not be achieving two common expectations--a return to productive employment and removal from criminal activity--for the addict. Few individuals who leave treatment earn even a subsistence wage, although some individuals have remained arrest free. One reason for this finding may be that few addicts stay in treatment long enough for counseling to have much impact. Another may be that funding agencies have simply been too lax in their control over programs or there has not been sufficient systematic monitoring and evaluation. Or it may also be true that some drug addicts can, with sufficient motivation, be rehabilitated and some can not. The State needs to address these issues carefully and objectively before it commits more of its scarce resources to treatment.

VII. TREATMENT

Large amounts of federal and State dollars have been applied to the nation's drug abuse problem in the past few years including the establishment of many treatment facilities. Nationwide, the number of federally funded treatment facilities grew from 24 in 1970 to over 900 in 1974.⁴² This rapid growth, coupled with a shortage of qualified treatment personnel and lack of adequate planning, resulted in the establishment of some marginal programs. Virginia followed this national trend and is now faced with its attendant problems. Figure 18 shows the growth in federal, State, and local funds provided for treatment over the last few years in the Commonwealth.

Today, some type of program is available in all areas of the State, except the most remote communities. Not all of these programs, however, are drug specific (concerned only with drug problems) nor are they all funded with public monies. Private facilities, crisis intervention centers, State mental institutions, local community mental health centers as well as various specialized programs (veterans hospitals, military bases, and prisons) all represent major outside resources to which a person with a drug problem can turn. However, the State's primary treatment focus lies in 28 publicly funded programs located mainly in the urban areas of the State. (See Appendix VII for list of programs.)

FUNDING DRUG TREATMENT PROGRAMS

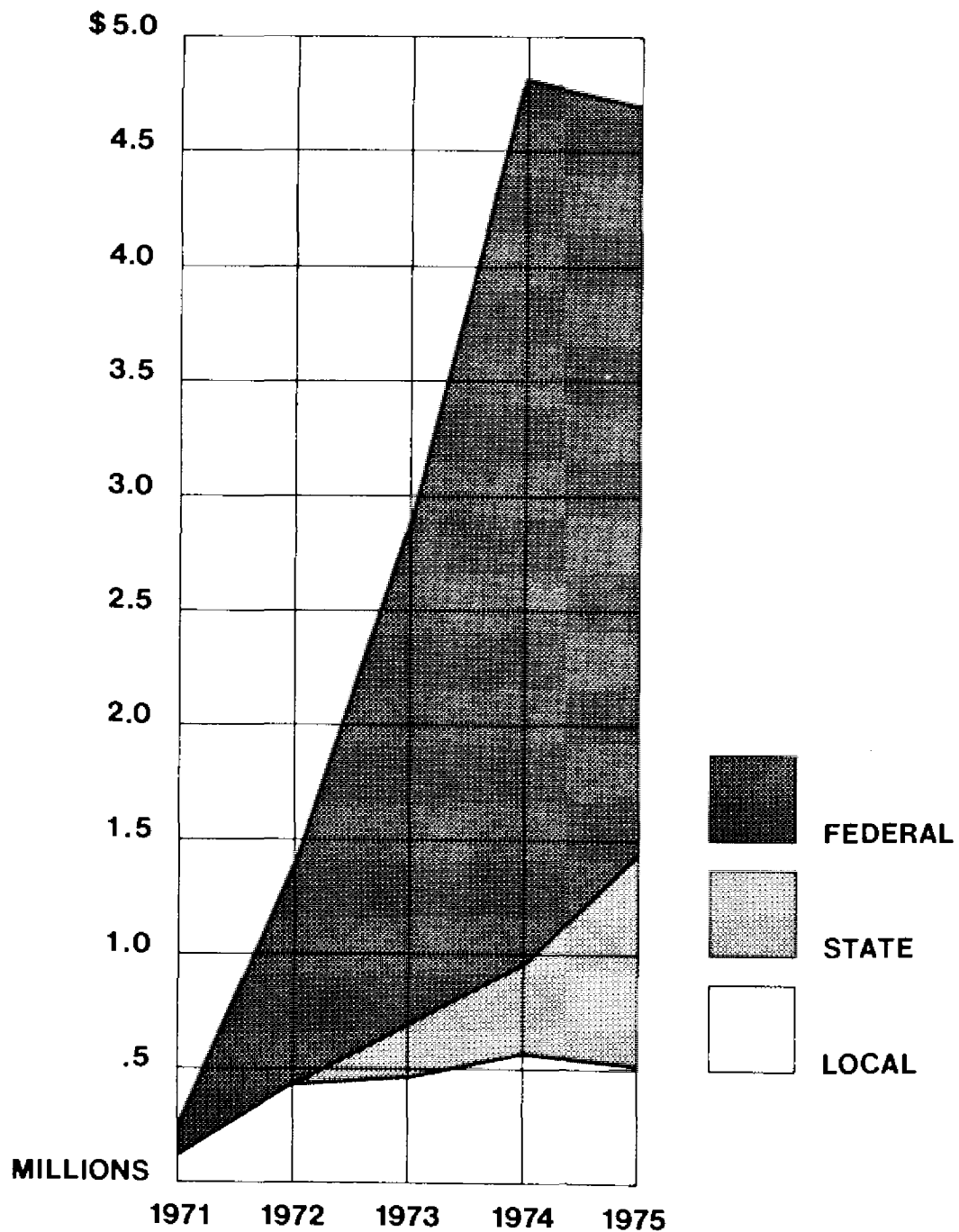
There are four principal agencies involved in funding drug treatment programs: The Council on Criminal Justice and the Division of Justice and Crime Prevention, the Department of Mental Health and Mental Retardation, the Department of Health, and at the federal level the National Institute for Drug Abuse. In addition, the Department of Vocational Rehabilitation provides important adjunct services by providing job training to qualified clients. Unlike the other four agencies, DVR is not involved with the funding of actual drug treatment programs. The approximate amount of funds available from each principal funding source for drug treatment programs in FY 1974-75 is listed below, and a discussion of each agency and DVR follows.

NIDA	\$3,160,000
DJCP	750,000
MHMR	500,000
Department of Health	<u>350,000</u>
Total	\$4,760,000

National Institute for Drug Abuse

Many of the first drug treatment programs in the Commonwealth were funded by NIDA, and while the State now has a major commitment the federal

Figure 18
**GROWTH IN DRUG TREATMENT FUNDS
1971 - 1975**



Source: JLARC, July, 1975

government is still the primary funding source. Currently, NIDA helps fund 10 treatment programs in Virginia, amounting to \$3,160,000 during FY 1975. In addition to providing funds, NIDA also provides technical assistance and training for local programs.

One of NIDA's most important responsibilities is to oversee the CODAP system--an information system designed by the federal government to provide key information about the utilization of local treatment programs. As will be explained later, there have been numerous problems in the implementation of this system at both the State and federal level.

Division of Justice and Crime Prevention

As part of the federal response to the burgeoning drug abuse problems, Congress allowed drug treatment programs to be funded under the Omnibus Crime Control and Safe Streets Act passed in 1968. In Virginia, the Council on Criminal Justice and its administrative arm, DJCP were created to administer these funds and now, have approximately \$750,000 available for drug treatment programs which represents a substantial portion of the State's treatment effort. Presently, 18 of the State's 28 drug treatment programs receive funds from DJCP.

Department of Health

Prior to 1972, the Department of Health's responsibility for the treatment of drug addicts was limited to its Bureau of Alcohol Studies. Following the recommendations by the Touche Ross study that MHMR be provided the major responsibility for drug treatment, the 1972 General Assembly removed that authority from the Bureau of Alcohol Studies, while granting to the department the more limited responsibility of licensing the use of methadone. (Methadone is a drug used in the treatment of opiate addiction. A brief description of this and other types of drug treatment is provided in Table 61.) To carry out these duties, the department established the Bureau of Methadone Treatment and Rehabilitation with a pharmacist to administer the program.

The bureau performs three key functions: (1) establishment of rules and regulations for methadone treatment programs; (2) funding of methadone programs; and (3) technical assistance. In addition, the bureau registers and monitors approximately 50 hospitals which use methadone. There are five methadone programs in Virginia. Table 62 shows appropriations and expenditures for the bureau since its inception.

Department of Mental Health and Mental Retardation

The Code of Virginia specifies that the "mentally ill" is, any person "who is afflicted with mental deficiency or mental retardation or is a drug addict or inebriate." This gives the department the authority to treat drug addicts through its existing mental health facilities, including 12 state hospitals and all local Chapter 10 programs funded under the Community Mental

Table 61

TYPES OF TREATMENT

Methadone maintenance:	Used strictly for opiate addiction, and relies on the use of methadone, a synthetic narcotic, to inhibit the effects of heroin. At maintenance levels the addict is no longer forced to support his habit, and can lead a more normal productive life. Originally used as a legal substitute for heroin, early programs freely dispensed the drug with little or no accompanying therapy. Stricter FDA regulations have since provided tighter controls and methadone is accepted as a viable treatment for hard-core heroin addicts.
Therapeutic communities:	Live-in residential centers patterned after a California program (Synanon) developed during the late 1960's, and designed to remove the drug abuser from his street environment by placing him in a social environment made up of other addicts where he is daily confronted with his negative life style and drug dependency. The original concept relied heavily on confrontation, deprecation, and denunciation to achieve its effects. Although a more clinical approach has developed, the condemnation technique is often still present to varying degrees. The original Synanon program emphasized a closed community and discouraged residents from leaving the program. Later modifications placed more emphasis on returning residents to society. A year of residence, however, is not uncommon for most therapeutic communities.
Drug-free outpatient therapy:	The most widely used modality, is a catchall for any type of counseling therapy given on an out-patient (non-residential) basis. There are almost as many techniques as programs and counselors: Rogerian, transactional analysis, primal scream, behavior modification, or any other approach currently in vogue. Generally provides on-going counseling either on a one-to-one or group basis.
Crisis intervention programs and drop-in centers:	Described as the first line of defense in drug treatment. They provide the drug dependent individual a place to turn for help. Such programs act primarily as a referral or a short term counseling program. They also tend to treat individuals whose drug dependency is less severe than the other types of programs.
Hotlines:	An important part of crisis intervention centers. They provide a ready means for drug dependent persons to take the first step in seeking help. Many hotlines are funded by local civic groups and their telephone number is widely publicized. They serve as an important link in the treatment delivery system between the client and treatment programs. They also provide an important preventative service in that many individuals will turn to a hotline for help before becoming too heavily involved with drugs.

Health and Mental Retardation Services Act. In 1972, the General Assembly expanded this responsibility by establishing the Bureau of Drug Rehabilitation programs to assess the problem of drug addiction and fund community based treatment programs.

Table 62

DEPARTMENT OF HEALTH APPROPRIATIONS
AND EXPENDITURES FOR DRUG TREATMENT

<u>Fiscal Year</u>	<u>Appropriations</u>	<u>Expenditures</u>	<u>Grants to Programs</u>
1972-73	\$250,000	\$ 72,400 ^a	\$ 67,737
1973-74	\$375,500	\$230,170	\$196,483
1974-75	\$375,500	\$244,000 ^b	\$216,000
1975-76	\$375,500	---	---

^a\$25,000 additional monies were transferred to DDAC for developing STRAP.

^bEstimated based on expenditures as of March 31, 1975.

Source: *Appropriations Act 1972-74, 1974-76*, Department of Accounts, and Department of Health.

The bureau performs the same type functions as the Bureau of Methadone Treatment and Rehabilitation in the Department of Health except it has fewer regulatory functions and is more involved in program initiation.

Table 63 shows appropriations and expenditures for the bureau since 1972. The bureau funds 19 of the State's 28 treatment programs.

Table 63

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
APPROPRIATIONS AND EXPENDITURES FOR DRUG TREATMENT ^a

<u>Fiscal Year</u>	<u>Appropriations</u>	<u>Amount of Appropriations Spent</u>
1972-73	\$100,000	\$ 75,000 ^b
1973-74	\$500,000	\$330,365
1974-75	\$500,000	\$429,695 ^c
1975-76	\$500,000	---

^aExcludes approximately \$50,000 administrative expenses.

^b\$25,000 additional monies were transferred to DDAC for developing STRAP.

^cAs of May 23, 1975.

Source: *Appropriations Act 1972-74, 1974-76*, Department of Accounts, and Department of Mental Health and Mental Retardation.

Department of Vocational Rehabilitation

Another important source of treatment support has been provided by DVR. Assistance is provided physically, mentally, and emotionally handicapped persons to become gainfully employed.

Drug addiction received initial recognition as a legitimate vocational handicap in July, 1974, after enactment of the Federal Rehabilitation Act of 1973. Previously, many DVR counselors classified drug dependent clients as having a "behavioral disorder" and a symptom of drug abuse rather than a drug addiction disability. Over the last two years there has been a noticeable increase in the number of drug-disabled individuals seeking vocational rehabilitation assistance. To better serve this type of client, the department formally instituted a drug counselor program as originally recommended by the Touche Ross Report. The primary purpose of the program is to provide vocational rehabilitation services required to prepare the drug-disabled client for a useful and productive life, including suitable employment. Financial support comes from the State and the federal Rehabilitation Services Administration. Eighty percent of the funds are provided from federal sources and the remaining 20% comes from the State (Table 64).

Table 64

DRUG COUNSELOR PROGRAM FUNDS

	<u>1973-74</u>	<u>1974-75</u>	<u>1975-76</u>
Federal	\$173,744	\$360,000	\$400,000
State	<u>43,433</u>	<u>90,000</u>	<u>100,000</u>
Total	\$217,177	\$450,000	\$500,000

Source: Department of Vocational Rehabilitation.

When the program was implemented in 1972, there were five DVR drug counselors throughout the State: Alexandria, Richmond, Roanoke, Norfolk, and Portsmouth. In 1974, four additional counselors were hired and assigned to offices in Annandale, Richmond, Southwestern State Hospital, and Western State Hospital. These counselors also devote a portion of their time to counseling persons with alcohol problems.

JLARC surveyed the drug counselors by phone in November, 1974, and found high caseloads, particularly in the Richmond and Annandale areas (Table 65). Later, additional counselors were placed in these two areas to lessen the caseload burden. More recently, however, new eligibility standards have been issued in accordance with the Rehabilitation Act of 1973, which will limit the eligibility of drug dependent persons. The special drug counselor positions are currently in the process of being phased out. It is recommended that an alternate source of funds be found to continue vocational rehabilitation services to drug and alcohol clients in the Richmond, Roanoke, Norfolk, and Arlington areas of the State.

Table 65

DVR DRUG COUNSELOR CASELOADS

<u>Counselor Locations</u>	<u>Caseload</u>
Norfolk	70 to 80
Richmond	140
Portsmouth	69
Roanoke	108
Annandale	150

Source: JLARC staff telephone survey of drug counselors, November, 1974.

PATTERNS OF FUNDING

The four principal funding agencies (DJCP, MHMR, Health, and NIDA) fund programs through grants made to individual treatment programs. Grants are made on a year-to-year basis and require the amount of the grant to be matched with some form of local resource. The match may be in the form of cash, services, free office space, or other "in-kind" donation. The exact amount of the local match and the type of resource that may be used varies from each funding agency and is shown in Table 66.

Table 66

MATCH REQUIREMENTS FOR FUNDING AGENCIES

<u>Agency</u>	<u>Maximum Agency will Contribute</u>	<u>Minimum Match Required</u>	<u>Nature of Match Allowed</u>
CCJ/DJCP	90%	10%	5% local cash/5% State dollars from general fund
Health	75%	25%	local cash or in-kind
MHMR	75%	25%	local cash or in-kind
NIDA ^a	90%-70%	10%-30%	State or local cash, or in-kind

^aThe exact amount of match depends on the year of funding and location.

Source: Compiled by JLARC, 1975.

These funding requirements are complicated by the fact that most programs receive funds from more than one source. This has been done in an effort to reduce reliance on any one source of federal dollars. There are also a variety of ways in which programs may receive funds. A few receive funds directly from the funding source, while most funds are channeled through some arm of local government.

Chapter 10 Mental Health Services Board

The Bureau of Drug Rehabilitation Programs in MHMR attempts to fund programs through local Chapter 10 Boards in accordance with the original recommendations made by the Touche Ross Report. Chapter 10 Boards come under the Community Mental Health and Mental Retardation Services Act and are set up to coordinate and develop a comprehensive system of community mental health services at the local level. The objective is to bring the various mental health related programs under the same umbrella, thus avoiding duplication of services and encouraging integration. Twelve of the State's 28 drug programs are under the Chapter 10 system. The remainder are either located in areas without a developed Chapter 10 Board or funded by agencies other than MHMR.

None of the other funding agencies have adopted a policy similar to MHMR's. As a result many programs funded by these agencies do not come under a Chapter 10 Board unless MHMR also funds the program. In the case of DJCP, according to LEAA regulations, programs must be funded through a unit of local government and under these same regulations Chapter 10 Boards cannot constitute such units. (DJCP's programs may still come under a Chapter 10 Board, if they are first sponsored by some other unit of local government.)

Similarly, three of the State's five methadone programs are funded through local health departments rather than Chapter 10. However, one city, Alexandria, has created a special citizens coordinating committee to insure that its local health department's methadone program is effectively linked to two drug-free out-patient programs and the city's alcohol services. As for NIDA, only three of its 10 programs are under the Chapter 10 system.

While not all areas of the State have well developed Chapter 10 systems capable of administering drug programs, a more consistent policy appears to be needed. DDAC, as the official State agency responsible for coordination, should use its policy-making authority to insure a more uniform approach is taken by all the funding agencies in regard to the Chapter 10 system.

In so doing, DDAC should seek the broadest participation possible on the part of localities. Local match requirements often result in geographic restrictions being placed by localities on whom a program can serve. As a specialized type of service, drug programs should serve regional populations and not just residents of one locality as is sometimes the case. Here too, DDAC, as the official State agency responsible for coordination, should help insure such restrictions are kept to a minimum.

Allocation of Funds

DDAC's organizational problems have resulted in weak coordination of drug programs at the State level. This is especially critical for treatment because VDAAC, not DDAC, has the authority to review all grants. As a result, no statewide priorities have been set in the area of treatment. Instead, this responsibility and the allocation of funds have been left to the funding agencies which have not established effective priorities either.

Individually, the funding agencies have channeled most of their funds to the urban areas where the problem is greatest. On an overall basis, however, there has been no systematic attempt to insure that regions are funded on an equitable basis. The result has been large disparities between regions, both in the total amount of funds received and in the types of services funded. Furthermore, at the regional level, the needs being met are left up to the idiosyncrasies of each individual program, which may not accurately reflect the needs of the community.

In the case of the federal government, a definite priority exists to treat the heroin abuser. As of 1975, about 70% of the patients in all federally funded treatment programs were being treated for opiate abuse. Similarly, most of the monies NIDA commits to Virginia go to programs designed for the same purpose. There is, however, a large non-opiate problem and insufficient emphasis is being placed on treating this type of drug abuser.

Funding Priorities - Regional Distribution: The earliest programs in the State were funded solely by either DJCP or NIDA. Between FY 1972 and 1973, the Bureau of Methadone Treatment and Rehabilitation and the Bureau of Drug Rehabilitation were created and the number of programs in the Commonwealth nearly doubled. Table 67 identifies the number of programs established each year in various areas of the State since FY 1971.

Not all of the 28 drug programs listed in Table 67 are oriented entirely towards treatment nor are they all directed exclusively at drug abusers. A few serve as information sources and some (crisis intervention centers) are aimed at the general drug-using age group.

Table 67

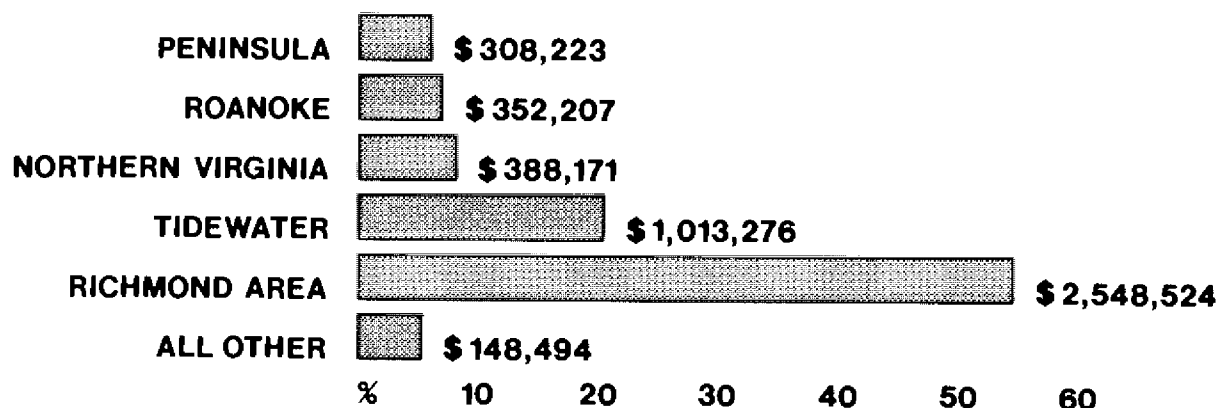
GROWTH OF PROGRAMS BY GEOGRAPHIC AREA

<u>Fiscal Year</u>	<u>Virginia</u>	<u>Richmond Area</u>	<u>Tide- water</u>	<u>Penin- sula</u>	<u>Roanoke</u>	<u>All Other</u>	<u>Total</u>
1971	-	1	-	-	1	-	2
1972	4	3	1	-	-	-	8
1973	-	-	2	3	-	3	8
1974	-	3	2	1	-	2	8
1975	-	-	-	-	-	2	2
Total	4	7	5	4	1	7	28

Source: National Institute of Drug Abuse, Department of Health, Department of Mental Health and Mental Retardation, and Division of Justice and Crime Prevention.

Figure 19 shows the amount of funds actually allocated to each of the major urban areas in the State in FY 1975. Most of the funds were committed to the Richmond area, which has the best mix of programs including a methadone program, a poly-drug detoxification unit (the only one in the State), a special adolescent facility, an LEAA sponsored criminal referral system, as well as the State's largest multimodality drug treatment program.

Figure 19
**AMOUNT OF DRUG TREATMENT GRANTS
GOING TO DIFFERENT REGIONS
OF THE STATE
1974-1975**



Source: JLARC, July, 1975

The amount of funds pouring into Richmond is disproportionate relative to its share of the State's population or the number of drug deaths (Table 68). Conversely, Tidewater, and Northern Virginia both receive less than their share of funds.

Table 68

DISTRIBUTION OF TREATMENT DOLLARS
RELATIVE TO REGIONAL POPULATION
AND DRUG DEATHS

<u>Region</u>	<u>Treatment Dollars</u>	<u>Population</u>	<u>Drug Deaths</u>
Northern Virginia	8%	19%	23%
Richmond Area	54	11	25
Tidewater	22	15	16
Peninsula	6	6	6
Roanoke Area	7	5	5
All Other	3	44	25

Source: National Institute of Drug Abuse, Department of Health, Department of Mental Health and Mental Retardation, and Division of Justice and Crime Prevention.

Funding Priorities - Treatment Modalities: The State has approximately 2,200 treatment slots (number of clients that can be treated at any one time). Thirty-five percent of these slots are methadone; 45% are out-patient and 21% are in-patient. This is a much broader range of treatment programs than

exists in many other states which began funding drug programs earlier than Virginia. Many states overcommitted themselves to the use of methadone and now have too few programs devoted to serving clients on an out-patient, drug-free basis.

The majority of slots is distributed equitably among the three largest urban areas of the State (Northern Virginia, Richmond, and Tidewater) with some of the remaining being concentrated in the Peninsula (Newport News-Hampton) and Roanoke areas. This has occurred in spite of the disparities in funding because not all funds are used entirely for treatment and because some programs have higher administrative costs than others, particularly those in the Richmond area (Table 69).

Table 69

GEOGRAPHIC DISTRIBUTION OF TREATMENT
SLOTS BY TYPE OF MODALITY

Region	Methadone		Out-Patient		In-Patient		Total	
	No.	%	No.	%	No.	%	No.	%
Northern Virginia	105	13.8	280	28.1	185	40.9	570	26.0
Richmond	294	38.7	124	12.4	184	40.6	602	27.4
Tidewater	241	31.7	259	26.0	35	7.7	521 ^a	23.7
Peninsula	120	15.8	60	6.0	25	5.5	205	9.3
Roanoke	---	---	160	16.0	24	5.3	184	8.4
Other	---	---	115	11.5	---	---	115	5.2
Total	760	100.0	998	100.0	453	100.0	2,197	100.0

^aThe total number of slots for each modality is 14 more than shown because 14 slots are assigned to both methadone and in-patient in one program.

Source: Division of Drug Abuse Control.

The types of services offered within each region, however, are not as evenly distributed. For instance, Northern Virginia has 26% of all treatment slots, 41% of the in-patient slots, and only 14% of the methadone slots. In contrast, 70% of the State's methadone slots are concentrated in the Richmond and Tidewater areas. Richmond, however, has only 12% of the available out-patient slots while Tidewater has only 8% of the in-patient slots. With the exception of the exclusive use of out-patient services in the less urbanized areas, there appears to be little justification for the way treatment slots have been allocated, further indicating the need for more coordination in the allocation of State and federal resources.

Impact of Declining Federal Support

Both DJCP and NIDA have policies of reducing their funding commitment to programs over time. NIDA funds four programs--one under a three-year non-poverty grant, the others under eight-year poverty grants--amounting to \$1,265,031. The amount of federal dollars NIDA will continue to contribute to

these programs depends on the type of grant and how long the program has been funded. The grants place an increasing demand on the programs to find more State and local dollars to meet an increasing match requirement each year. There is, moreover, no guarantee that NIDA will continue to fund these programs once the grant has expired.

Because most drug treatment programs throughout the country have not been able to fill all of their authorized treatment slots, and because of the decline in the overall heroin problem, NIDA is currently reassessing its funding policies and has adopted a general policy of either maintaining its current funding level or beginning to cut back. Table 70 below shows the amount of State funds needed to replace federal funds over the next three bienniums. The figures take into account both the cost of the declining federal share as well as the total costs of the program once the grant has expired. It is projected that Virginia may have to increase its funding by as much as \$2.7 million by the 1980-82 biennium.

Table 70
IMPACT OF DECLINING NIDA MONEY

<u>Biennium</u>	<u>State or Local Dollars Needed</u>
1976-78	\$ 641,491
1978-80	650,886
1980-82	<u>2,686,349</u>
Total	\$3,978,726

Source: National Institute of Drug Abuse.

A similar situation exists in the case of DJCP funds except the effect will be more immediate. Until this year, DJCP has been operating under an eight-year cost assumption policy. As with NIDA, programs funded with these monies will have to find other sources of funds to assume an increasing share of their costs. Recently, however, the Council on Criminal Justice, DJCP's policy-making body, accelerated this to a four-year policy, under which many of the 18 drug programs funded by DJCP will begin losing 50% of their funds on July, 1976. By July, 1977, the localities, or the State, will have to assume the total burden of many of these programs if they are to continue. JLARC estimates that \$1,100,000 will be needed in the next biennium to offset the impact of DJCP's new cost assumption policy in drug treatment alone. In combination with NIDA's declining share, the total cost of offsetting reduced federal support could exceed \$1,700,000 during 1976-78. Because these policies have a potential adverse impact on the entire State drug abuse effort, a more detailed discussion is provided in the final chapter.

New Sources of Revenues

There are two sources of additional funds that promise some relief: the Department of Welfare and other NIDA funds.

Department of Welfare Title XX Funds: Last January Congress enacted new legislation under the Social Security Act (Title XX) to allow State welfare departments greater flexibility in the types of services they may provide. The law permits the states to make major changes in existing social service programs and to define service priorities. Under this legislation the Department of Welfare may contract with local drug programs for counseling services.

While the law does not provide additional funds, it does allow the Commonwealth to use approximately \$20,000,000 of unused federal funds. Drug programs could use some of the money they receive from the Department of Health, MHMR, or local governments as a match for these unused funds. For every \$25 the program could provide, the federal government, through the Department of Welfare, would contribute \$75.

The exact implementation requirements have yet to be finalized by the department. As required by federal regulations, a state plan setting forth the proposed use of these funds was made available for public comments for a period of 45 days during July and August of this year. The plan will be finalized and adopted for implementation by October 1, 1975. The proposed plan provides only \$57,398 (of the \$20,000,000 available) for drug and alcohol counseling of 3,165 welfare clients, or only \$18.14 each. Given the possible decline in federal drug monies this seems to be an especially serious oversight.

JLARC surveyed all local welfare boards in the fall of 1974. From among the 38 city and 95 county boards surveyed, 116 (87%) replied. Of those that responded to the question, "To what extent do you believe drugs have added to the welfare problem?", 74% felt that drugs did not increase the problem while 18% believed that they did. A surprising number of the boards voluntarily listed alcohol as a problem among their clients. The majority of those who indicated a problem were from the large urban areas. Although 74% believed drugs have not affected their caseload, 35% did believe drugs to be a definite problem in their community, while another 8% believed them to be a serious problem (Table 71). These findings suggest that drugs are a definite though specialized part of the welfare problem and warrant serious reconsideration by the Department of Welfare for a larger share of available funds.

Table 71

NUMBER OF LOCAL WELFARE BOARDS INDICATING
DRUGS HAVE ADDED TO CASELOADS

	<u>Number</u>	<u>Percent</u>
Yes	17	18%
No	71	74
Don't Know	8	8
No Response	<u>20</u>	<u>---</u>
Total	116	100%

Source: JLARC survey of local welfare departments,
September, 1974.

DDAC's 409 Funds: The other new source of drug treatment money comes from section 409 of the Drug Abuse Office and Treatment Act of 1972. DDAC has about \$380,000 in federal 409 funds for use during fiscal 1974-75 to implement their State Plan. Approximately \$110,000 is to be allocated to State agencies for various drug related activities while \$270,000 is planned for localities. It is expected that about two-thirds of the funds being committed to the localities will go to treatment programs.

In allocating these funds DDAC has set the following priorities:

- (1) Essential programs that need emergency funds to continue in operation;
- (2) Geographical areas which presently have no State or federal drug program funding and can document their needs;
- (3) Programs where funding will enhance the utilization of existing resources; and
- (4) The expansion of existing programs in areas that currently have federal or State drug program funding and/or new programs in areas that currently have federal or State drug program funding.

These monies were to be awarded in early June, 1975, and it was expected that most of the treatment funds would go to start new programs in medium-sized cities that have no drug specific program.

DDAC will also have \$636,000 available in 409 funds for the next fiscal year; about a third will probably be used to help fund regional DACCs that will be experiencing cutbacks under DJCP's new cost assumption policy. Moreover, about half of the remaining funds will be required to continue programs being started with this year's funds. The remainder will be used to either start new programs or help support other existing treatment programs affected by DJCP's revised policy.

JLARC recommends that DDAC adopt a policy of using these funds to offset part of the \$1,700,000 decline in DJCP and NIDA grant money and specifically recommends that these funds not be used to start more new programs. Otherwise, under DDAC's sliding scale policy, the Commonwealth will be faced with yet another group of programs requiring additional State and local support if they are to continue.

MANAGEMENT

The State's treatment delivery system suffers from several key management weaknesses created by the proliferation of funding sources, problems in coordination, and lack of funding agency control over treatment programs. Program management at the local level is more reflective of the director's management capabilities than efficient State administration. A good example of this is the quality of patient records.

Patient Records

During the course of its review JLARC found that standardized intake forms had not been developed for use in obtaining basic client information. Although the different forms being used sometimes contained similar items, completion of these items was often inconsistent. In some instances, JLARC found client files to be a wastebasket of information, while in other cases the files were neatly arranged but incomplete. Deficiencies found during the review of client files include:

- No explanation for a client termination,
- No continuity between entries in case notes,
- Dates missing on entries making it difficult to trace client progress, and
- No periodic summary of client progress.

It is recognized that record keeping is time consuming, but accurate records are essential to effective treatment services.

Lack of Adequate Client Information: The federal government has developed a comprehensive client information system called Client Oriented Data Acquisition Process (CODAP), to satisfy basic data needs at the national and local program levels. All federally funded treatment programs are required to participate in the system, and one of DDAC's first initiatives was to require State-funded programs to complete CODAP forms as well.

DDAC has encountered repeated setbacks in its attempt to implement the system. Part of the problem is technical, involving the computer program NIDA designed to process the data. However, DDAC has been lax in checking for inconsistencies in the system, and in instructing the treatment programs on how to complete the forms. While the division reviews and corrects the forms for errors, it only performed its first audit in April, 1975, to check on the accuracy of the information being reported. Programs, meanwhile, have been completing CODAP forms since the third quarter of 1973 with no visible results and DDAC does not expect to have the system operational until January, 1976.

CODAP is important because it will provide much of the output information (e.g. number of clients served, number refused, number treated, number split, and basic demographics) needed to effectively monitor treatment programs. Without CODAP the programs, as well as the State, lack necessary information on program utilization for policy decisions.

CODAP, however, has some shortcomings. It fails to take into consideration such important factors as frequency of client contact (a client coming once a month is counted the same as one coming twice a week), number of prior admissions, length of time between admissions, or the client's chance for success. On a statewide basis, CODAP will serve a useful purpose and should be pursued by DDAC. But, because CODAP lacks some essential program information, the funding agencies should supplement CODAP with more detailed client information.

Efforts to Maintain Program Quality

All treatment agencies have suffered from lack of staff. There is only one grants coordinator at NIDA, one at DJCP, one at Health, and two at MHMR to administer over \$4,000,000 in grants to 28 drug treatment programs scattered throughout the State. In addition, the coordinators at NIDA and DJCP have several other grants to administer. At DJCP, however, there are at least support services (fiscal personnel, a computer monitoring system, etc.) which provide assistance. In Health the problem is not severe since there are only five programs to monitor. In MHMR, however, the problem is acute with 19 programs to oversee, although the situation should improve: One of two positions vacant for over two years has recently been filled while two others were recently created through special grants.

In the past, all funding agencies have failed to exercise adequate control over programs. This is evidenced in several ways: Types of programs funded; extent to which funds have been monitored; and the degree to which programs have been evaluated. The latter is particularly important in that it relates directly to the key question of how well programs are succeeding in rehabilitating drug abusers.

Types of Programs Funded: JLARC found wide variation in the types of programs funded. Although some flexibility may be necessary and even advantageous, two instances were found where drug monies were being used for non-drug related activities. While such instances are not believed to be common, they are indicative of the need for funding agencies to be more selective in funding programs.

The Virginia Beach Comprehensive Drug Program was found to be extensively involved in running a medical clinic. A random sample of 100 client files revealed that 78% of its caseload involves medical cases. Most were for family planning, while drug cases represented only 10% of the program's caseload. The program maintains that the clinic acts as a drawing card for persons with drug problems. However, close examination of drug cases revealed that almost no one had come to the medical clinic before seeking counseling. Also, the City of Virginia Beach already has a family planning clinic in its Public Health Department suggesting that much of this program's effort may be duplicating existing services. This, however, may be indicative of a gap in the State's health services, in that some young people who would not seek medical help through other, more conventional means, will come to this type of clinic.

The program is funded jointly by DJCP and MHMR and receives a total of about \$60,000 from both sources. The DJCP grants coordinator apparently has attempted to find other sources of funds for this program without success. DJCP, however, does set aside funds for juvenile delinquency programs which would appear a more appropriate source for funding this type service.

Another instance of drug monies being used to fund non-drug activities is the Adolescent Clinic in Richmond--a specialized program at the Medical College of Virginia (MCV). The program has an in-patient and out-patient facility and occupies one wing of MCV hospital. A visit to the clinic in October, 1974, revealed 14 patients in the ward. Some had very serious medical

problems (e.g. sicklecell anemia, leukemia, and kidney failure), but there were no drug-related cases. The goal of the clinic is to bring a special approach to helping adolescents with any type of serious problem. This program is also funded by DJCP and MHMR with some indirect support from MCV. Because the program appears to be performing a commendable service, the General Assembly should consider funding it directly through MCV. DJCP and MHMR, however, should either terminate funding or find more appropriate funding sources for this and other similar programs.

Though the monies involved are not substantial in relation to the State's total treatment effort, it is not surprising that these situations exist. Only NIDA has a comprehensive set of standards for awarding grants. While all State funding agencies have some funding criteria, the Department of Health has developed the most detailed set of regulations. Health's regulations, however, are focused mainly on the many important health aspects of regulating the administration of methadone and neglect many key areas involving the adequacy of counseling. DJCP's criteria, based on guidelines set by the National Advisory Commission on Criminal Justice Standards and Goals, have not yet been approved by DJCP's Council on Criminal Justice, and MHMR guidelines are too limited. All State funding agencies should take immediate steps to adopt more comprehensive funding criteria patterned after those used by NIDA.

On-Going Auditing Activities: All agencies require programs to submit quarterly financial reports, which are the principal means of monitoring each treatment program's expenditures. While such reports are desirable and necessary, few financial audits have been done to check whether the amounts reported are accurate. Neither NIDA nor the Department of Health have ever audited any of their programs. DJCP has audited only one program while MHMR has audited two, all within the past few months.

The problem appears to be one of priorities. Until recently, NIDA had not set aside any money for auditing. In the case of Health and MHMR, drug programs are considered relatively small in relation to other programs and are given a low priority. At DJCP primary emphasis is placed on periodic site visits to the programs (monitoring) and on reviews of the quarterly financial reports, and auditing receives a low priority. DJCP's audit division has only five staff members; one supervisor, three accountants, and one assistant. Over the past few years DJCP has issued over 3,000 grants including about 50 for drug treatment, too many for this limited staff to handle. Current plans are to include only two treatment programs in this year's audits, only one of which is of any significance. Furthermore, grants now being audited at DJCP are ones dating back to 1972.

More rigid fiscal controls need to be imposed by all the funding agencies. Reviews of quarterly financial reports, while important, are not sufficient without periodic audits to insure their accuracy. While frequent audits of each program are not mandatory, some minimum standards should be developed. (DJCP's guideline is at least 25% of the programs and 50% of the total dollars awarded.) Given the overlap that often occurs in funding programs, it may be necessary for DDAC to coordinate one auditing schedule for all State funding agencies.

Extent of Monitoring and Evaluation: While all funding agencies maintain frequent contact with their programs, only two have a formal policy for conducting periodic assessments, the Department of Health and DJCP. The Department of Health evaluates its methadone programs at least once each year. In addition, the State's methadone programs come under the purview of the Food and Drug Administration. Each year the FDA spends one week evaluating each program's compliance with all FDA regulations regarding methadone; it is not an evaluation of program effectiveness.

DJCP monitors programs at periodic intervals with most drug treatment programs being reviewed twice yearly. Occasionally DJCP has done programmatic evaluations by contract with consultants. The consultants follow a prescribed procedure specified by DJCP and usually provide an objective overview of the program.

Over the last several months MHMR has been working with DJCP in developing a more thorough approach utilizing a team concept. The team draws together personnel from the different funding agencies, DDAC, the regional DACC, DVR, and other appropriate local personnel. The evaluation includes a review of client records, interviews with past and present clients, as well as outside agency personnel. Only four such evaluations have been completed, but the bureau plans to evaluate each program at least once a biennium.

The focus of the team evaluation is on the quality of care and operation of the program. It is appropriate that MHMR assume the leadership role in developing this approach, however, the State also needs to look at program utilization and its impact. This type of evaluation and its importance in setting priorities is a more appropriate role for DDAC.

Under an Attorney General's opinion of August, 1973, DDAC has the authority to conduct program evaluations. The State Plan identifies as the major goal the development of "a system to evaluate treatment and intervention programs and to evaluate 50% of the treatment programs by June 30, 1976." This is an ambitious undertaking yet only \$15,000-\$25,000 has been budgeted for next year.

DDAC also has monies available for non-recurring projects resulting from a Commonwealth lawsuit against several drug manufacturers on charges of price fixing. DDAC set evaluation as its top priority in using these funds, and some of these monies should be used to develop an evaluation system.

Licensing

One of the principal means of exercising control is through licensing. DDAC is required under the Drug Abuse Office and Treatment Act of 1972 to plan for "licensing or accreditation of facilities in which treatment and rehabilitation programs are conducted for persons with drug and other drug dependence problems." Responsibility for such licensing currently rests with MHMR. MHMR has legislative authority to license all private drug treatment facilities in the State (all those not operated by an agency of federal, State, or local government).

Preliminary standards have been developed by MHMR and public hearings were held as early as April, 1973. The last public hearings were held in November, 1974, and many objections were raised. The problem appears to be whether the standards should be directed at programmatic elements (number of clients per counselor, qualification of counselors, or hours of operation) or the suitability of the facilities (health and safety requirements, or building and fire codes). Further modifications in the standards have been made, and the Attorney General's Office has ruled that the changes warrant another public hearing.

The standards appear to be overly burdened with technicalities while failing to include many essential elements involved in establishing a minimum level of care. For example, the standards provide for sewage disposal but fail to require periodic reviews of each client's progress; they require the grounds to be kept clean, yet lack provisions for client follow-up. Moreover, the standards fail to establish specific penalties for lack of compliance nor do they provide the programs with a mechanism for seeking exemptions except through judicial redress. Many of the present provisions, if implemented, would divert resources from the direct functions of treatment to support activities.

In addition, a number of problems related to weaknesses in the legislation still remain. For example, the law defines "private facility" as any facility or institution not operated by an agency of federal, State, or local government. It is not clear whether a program funded through, but not operated by, a Chapter 10 Board, a local health department, or some other arm of local government should be classified as a private facility. Furthermore, the latest standards include such quasi-treatment programs as drop-in centers, outreach programs, and hotlines. This seems to go beyond legislative intent of licensing facilities that provide "care or treatment" of drug dependent persons. The law is also not clear regarding MHMR's licensing authority over methadone programs. Another section of the Code assigns this responsibility to the Department of Health. MHMR's authority to license drug programs should be reviewed to identify those areas that appear to be ambiguous and overlapping and clearly define the licensing authority to be retained.

Licensing is important not only because it is a federal requirement, but because it could be a factor in securing additional monies for treatment. Health insurance plans now extend coverage to include counseling services. Licensing may become a criteria to determine legitimate treatment and counselor qualifications could become a key factor.

Professional versus Paraprofessionals: The shortage in qualified personnel that grew out of the rapid influx of State and federal dollars forced many drug treatment programs to rely heavily on the use of paraprofessionals: Individuals who either lack a degree in one of the helping sciences or who have previously been involved in drugs. Many of these individuals have extensive knowledge of the "drug scene" and often can better relate to the drug dependent individual than a professional. At the same time many of these individuals lack professional training and counseling skills.

DDAC has as one of its goals in this year's State Plan the development of standards for drug treatment workers including paraprofessionals. In

developing the standards the division has a grant from NIDA to conduct a study of the manpower needs and training in the area of treatment. DDAC's original intent was to include actual certification of drug treatment workers along with the standards. However, VDAAC objected and it now appears that DDAC will only develop standards. The need for certification, however, still exists, and when considering licensing legislation, the General Assembly should also consider the inclusion of drug worker certifications.

Accreditation: The purpose of licensing is to set minimum standards for all drug treatment programs. Plans are also underway to develop accreditation standards at the national level. Unlike licensing, accreditation represents an optimal, not minimal, level of care. Furthermore, adherence to accreditation standards would be optional, not required as with licensing. Implementation of the standards would be made by a national health organization. Standards have been formulated and are now waiting approval by NIDA. As with licensing, accreditation can have important implications for third-party payments.

Special Efforts to Upgrade Programs

For the past two years the Bureau of Drug Rehabilitation Programs in MHMR has been involved in two special projects to upgrade program services. One, the Interagency Collaboration Project, focuses on program interaction with local community service agencies. The purpose of the project is to find ways of increasing the number of referrals from other local agencies. These referrals are an important form of outreach and can help bring the program in touch with many individuals who might otherwise not receive help.

Early phases of the project emphasized the type of interaction yielding the most referrals. An in-depth study report of five treatment programs was issued in October, 1974. Subsequent efforts have been directed at using these findings to increase referrals in other programs. A series of workshops were held over the last six months to acquaint treatment personnel with the findings of the report. The project has been funded entirely by DJCP and includes positions for two full-time professionals.

The second project (Social Competency Project), is more directly involved in upgrading the quality of care and is intended to help counselors identify specific objectives that can be achieved in treating a drug-dependent individual. The project is based on a model developed by Dr. Marc Spivak of Israel's Modom Shalom Mental Health Clinic, and consultant to the project under a DJCP grant.

The model provides counselors with a framework for analyzing complex types of social behavior frequently seen in drug dependent individuals, and forces counselors to carefully examine client needs, and ways to meet these needs. Social competency provides a means to unify many divergent approaches used by counselors in a pragmatic way while leaving the counselors free to select their own clinical approach. In addition, social competency could become a useful tool in evaluation (success can be measured in terms of specific behavior changes). Unfortunately efforts to implement the system have been hampered by a shortage of personnel.

While the bureau's workshops have provided the impetus to get the project going, many of the real initiatives have come from individuals in the programs. Significant progress has been made in adopting the model only when directors become involved. The bureau has applied to DDAC for 409 funds to hire another administrator and conduct further training. Despite these problems, social competency represents a significant step in upgrading the State's drug treatment delivery system, and the bureau should be commended for its efforts in this area.

Summary

JLARC found serious shortcomings in the controls exercised over drug treatment programs. While some commendable efforts have been made to upgrade the quality of care being delivered to drug dependent individuals, a key question must now be raised as to how effective the State's treatment effort has been. The next section addresses this question with an in-depth look at four of the State's largest treatment programs.

PROGRAM UTILIZATION AND EFFECTIVENESS

JLARC conducted a special in-depth study of four treatment programs focusing on program accomplishments from society's point of view--are drug abusers becoming gainfully employed, and are they remaining arrest free? Just as important, though not evaluated, is the mental health point of view that any addiction is an individual problem.

The programs selected for study represent each of the major urban areas of the State as well as the three major types of treatment: Drug free out-patient, methadone maintenance, and therapeutic community. Two of the four programs are methadone; the other two are large programs offering both a therapeutic community and out-patient services. JLARC studied the therapeutic community in each of these two programs as well as one out-patient service. The programs reviewed were some of the largest in the State and represent about 12% of the State's treatment capacity. A short description of each program is provided in Table 72.

JLARC sampled about 100 clients from each program, gleaned as much information as possible from the client records. Information on each client's background, history of drug usage, as well as information about contact with the program was recorded. In particular, information pertaining to the number of admissions, length of stay each time plus status at each discharge, were all noted. The sample consisted of all clients who had been seen by the program since it first began through June 30, 1974. Clients seen after that date were considered likely to either still be in treatment or to be out for too short a time to be evaluated.

To evaluate performance, JLARC compared the data on each client's experience in treatment with his subsequent arrest record and employment status. Arrest information on each client was made available through the Central Criminal Records Exchange operated by the State Police. Employment data covering the last quarter of 1973 and all of 1974 were obtained through

Table 72

DESCRIPTION OF TREATMENT PROGRAMS STUDIED BY JLARC

Program A is a methadone maintenance program that is funded by DJCP and the Department of Health. It has a static capacity to serve about 120 clients. Most of its clients are single, black males with no steady employment. The program has been in operation only since Spring of 1973 and is the newest of the programs selected. Almost all of this program's clients are hard-core heroin addicts.

Program B is also a methadone maintenance program except it has been in operation since late 1971, and has a static capacity to serve about 100 clients. Most of its clients are white but like Program A most are male with no steady employment. The program is funded by DJCP and the Department of Health. This program also primarily treats the hard-core heroin addict.

Program C is one of the oldest and largest treatment programs in the State. It is funded in large part by NIDA with some additional support from MHMR. Program C is a multimodality program with five separate sites. JLARC studied only the in-patient, therapeutic community, component of this program. This component alone accounts for roughly 100 of the 220 treatment slots for which this program is funded. This program's therapeutic community is oriented primarily toward the heroin addict.

Program D is also a multimodality program, only somewhat smaller than Program C. This program is funded for over 200 treatment slots with funds from NIDA, DJCP, and MHMR. JLARC studied both the out-patient (the largest component) as well as the therapeutic community component of this program. Unlike the other three programs this program is more oriented to the poly-drug user than the hard core heroin addict.

the Virginia Employment Commission. Careful precautions were taken throughout the study to preserve client confidentiality (See Appendix VII).

The results of the study indicate that many individuals (25-50%) remain arrest free after leaving treatment, but that only a few appear to be earning even a subsistence wage. This seemed to be generally true for all programs regardless of the type of treatment provided. This suggests that the State's drug treatment effort may, at best, be having a very limited impact. A key factor related to this is the fact that client turnover was found to be high; only a limited number of clients stay long enough to receive extensive counseling.

Client Turnover

The program data indicate that no more than 20% of the clients seeking treatment stay 12 months or more, and only 20%-40% stay a minimum of six months. The greatest attrition appears to occur within the first few months. One program loses over half of its patients in the first two months (over 15% either never stay long enough to receive counseling or are never even admitted). The other three programs lose 15%-40% of their patients in the first two months (Figure 20).

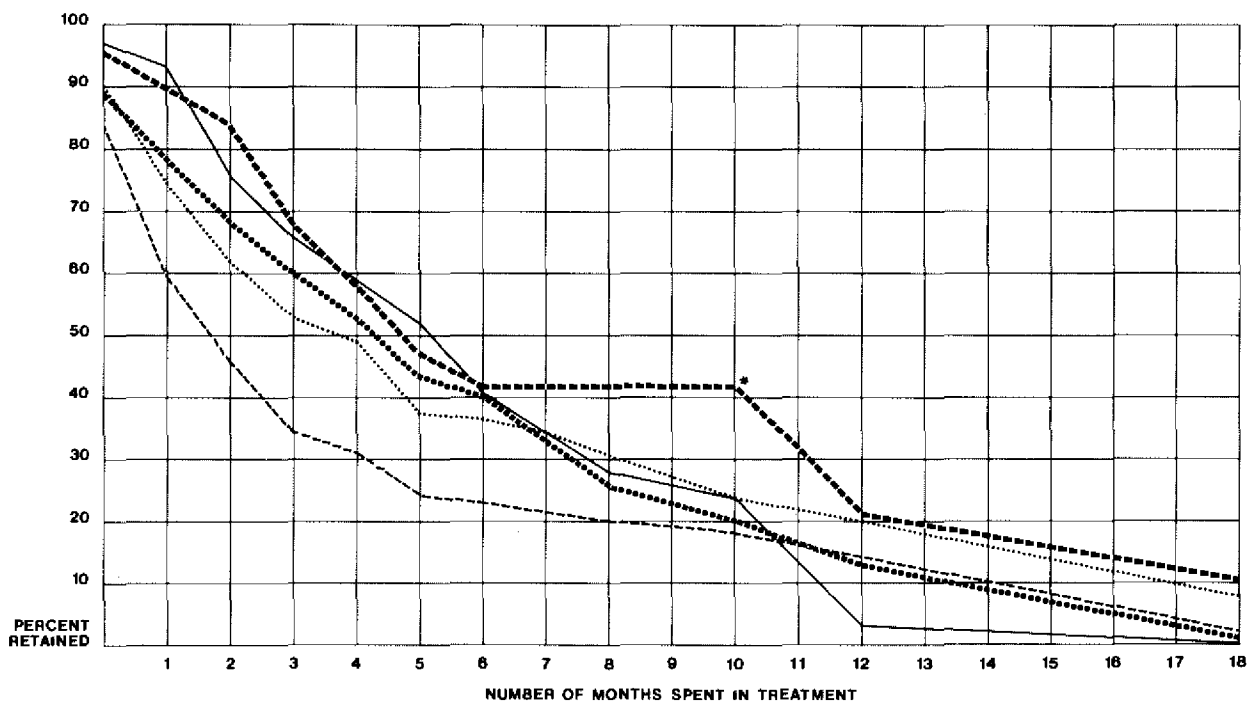
JLARC also found that 20%-30% of the clients sampled have attempted treatment more than once. A review was made to determine whether those who stayed only a short time had either been in treatment before (and perhaps were only coming back for temporary help) or were likely to return later for a more extended stay. The results indicated this was not the case. Generally, the clients who stayed the longest on any one admission were the ones most likely to stay the longest on either prior or subsequent admissions. There was evidence that retention rates have actually decreased. JLARC compared the length of stay of more recently admitted clients to those admitted earlier and found that in three of the five modalities fewer clients stayed longer than before (See Appendix VII).

Retention is a fundamental problem of treatment because both methadone maintenance programs and therapeutic communities are designed for long-term treatment. If only a limited number of clients stay the required length of time then only a few are receiving the kind of treatment these programs were designed to deliver. In the case of methadone, JLARC found only 13% reached a level of maintenance in one program and 27% in the other. Some of those who had reached maintenance in each of the programs were still in treatment (Table 73).

In the case of out-patient care the problem is less important since treatment is delivered on a short-term basis. However, even in this instance there still appears to be a problem. Twenty percent of the patients in this program stayed only two months or less--not long enough to expect counseling to have had much impact.

At the present time most programs are operating at or near capacity. Approximately 15%-35% of capacity is being used by patients who never stay long enough to receive treatment and who never return for further help. This

Figure 20
RATE OF ATTRITION FOR TREATMENT PROGRAMS



METHADONE:

- A
- B

THERAPEUTIC COMMUNITY:

- C
- D

OUT PATIENT:

- O'

*A small number of cases in this modality account for this aberration.
Source: JLARC Client Follow-up Study

Table 73

EXTENT OF MAINTENANCE REACHED
IN METHADONE PROGRAMS

	Program A	Program B
Maintenance level achieved ^a	13%	27%
Still in treatment	(8%)	(9%)
Out of treatment	(5%)	(18%)
Maintenance level <u>not</u> achieved	62	59
Never given methadone	15	3
No data available from files ^b	<u>10</u>	<u>11</u>
	100%	100%
Base: Total Clients Sampled.	99	107

^aMaintenance was defined as a constant dosage of
(± 20 mg) for at least five months.

^bMost of the clients for which there were no data came to the program for
only a few days, not long enough for maintenance to be achieved.

Source: JLARC client follow-up study, April, 1975.

problem is not being adequately addressed by either the programs or the funding agencies and represents a waste of State resources. DDAC should contract with the Department of Mental Health and Mental Retardation's Bureau of Drug Rehabilitation to perform a comprehensive study to identify the type of clients that leave and either find a way to retain them in treatment or screen them out. The study should also explore whether the right type of client is being treated by the right kind of program. For instance, individuals who leave a methadone program may be better suited to a therapeutic community. If this is the case some kind of central screening mechanism may be needed in each region to see that clients get matched with the right program.

Another area that should be examined is whether court referrals help to keep patients in treatment. JLARC found tentative evidence that the element of coercion in a court referral might act to keep clients in the program. Solutions to these problems will become more critical as federal dollars continue to shrink, and the State is required to assume an increasing share of the cost of treatment.

Program Effectiveness

Remaining in treatment is no guarantee that clients will be rehabilitated. An analysis of individuals who have received counseling and who are

now out of treatment shows that very few are presently arrest free and employed. This seemed to be generally true regardless of the type of treatment received or how long the individual remained in the program. These data suggest that the drug programs are, at best, having a very limited success in rehabilitating the drug-dependent individual.

Such results, though discouraging, should not be totally unexpected. Three of the programs studied deal primarily with hard-core heroin addicts. The fourth deals mainly with the serious poly-drug user. All are confronted with attempting to rehabilitate individuals who usually have long histories of drug use and criminal activity. With the exception of Program B, only 10%-15% of the clients seen have had no prior arrests (Program B tends to treat more women which may account for the fact that a higher proportion of clients from this program have no prior arrests). The rest either have confirmed arrest histories or have admitted prior arrests when they entered treatment (Table 74).

Table 74

ARREST HISTORY OF CLIENTS STUDIED
IN CLIENT FOLLOW-UP STUDY

Arrest Status Prior to Treatment	Methadone		Therapeutic Community		Out-Patient
	Program A	Program B	Program C	Program D	Program D
<u>No arrests</u>	<u>10%</u>	<u>28%^a</u>	<u>12%</u>	<u>14%</u>	<u>12%</u>
<u>Arrested</u>	<u>54%</u>	<u>34%</u>	<u>63%</u>	<u>59%</u>	<u>56%</u>
Average number of arrests per person	4.5	2.3	2.9	3.0	3.0
<u>Arrest Status Unknown^b</u>	<u>36%</u>	<u>38%</u>	<u>25%</u>	<u>36%</u>	<u>32%</u>
Base: All clients sampled who received counseling and are now out of treatment.	58	71	65	14	25

^aThis program serves more women which may account for the higher arrest-free figure.

^bThe majority of those lacking arrest data indicated prior criminal records in their client files.

Note: More detailed figures concerning arrests are available in Appendix VII.

Source: JLARC client follow-up study, April, 1975.

Many of the arrests are not necessarily limited to drugs. Forty to fifty percent involve fund raising crimes like shoplifting and larceny which may be related to the individual's drug habit. On the other hand, drug addiction may only be a symptom of an individual's criminal involvement and not the cause. It is important to recognize that programs like these, despite their apparent lack of effectiveness, are virtually the only means available for helping these people.

Table 75 shows the arrest and employment status of all those who received counseling and subsequently left their programs. As the table shows, a substantial number of clients in each program (25-56%) have remained arrest free since leaving treatment. It is apparent, however, that few arrest-free persons have also been able to support themselves. At most, only one or two individuals sampled in each program were found to be currently earning over \$501 per quarter. Separate analyses of earlier quarters revealed similar low rates of employment suggesting that the recent economic recession did not account for these findings.

There was evidence that those who remained arrest free were the ones who, prior to treatment, had the fewest arrests (Table 76). The fact that such individuals are now arrest free may be due as much to their prior lack of criminal involvement as to their subsequent contact with the program. However, even these individuals averaged two or three arrests per person, often for felonies. Furthermore, the individuals who remained arrest free also tended to stay in treatment somewhat longer (much longer in the case of Program B) than those who later were arrested. It may be that those having the most criminal involvement are simply the most difficult to rehabilitate. If true, such individuals may best be treated after they come in contact with the criminal justice system and not on a volunteer basis. If this is the case the State needs to do more to provide treatment programs within its correctional institutions.

The results of the JLARC study indicate that programs are limited in both their ability to retain clients in treatment and in their ability to substantially assist drug dependent persons to become productive, law-abiding citizens. A key problem in this regard appears to be employment. The fact that only a few individuals in each program were able to earn a decent income after having had counseling, suggests that more needs to be done to prepare clients for employment and assist in job development and placement. The latter may well prove to be the more fruitful of the two. JLARC found that 55%-75% of the clients being treated already had job skills. It may be that the stigma of having been a drug addict coupled with a past record of criminal offenses is preventing many rehabilitated drug abusers from being employed. Given the broad nature of the problem, DDAC should consider establishing a job clearinghouse for all drug programs. Such a clearinghouse is now being operated by one of the programs in the Richmond area. In addition, the programs and their respective funding agencies should focus more of their attention on providing clients with the necessary skills to find and keep a steady job.

At the same time, it should be understood that this problem may only be symptomatic of an inability of the programs to successfully reach the hard-core addict. Special attention should be given to rehabilitating such individuals and if further efforts prove fruitless, screening out those individuals least likely to benefit from treatment should be considered as a public alternative.

Table 75

ARREST AND EMPLOYMENT STATUS OF CLIENTS
HAVING GONE THROUGH TREATMENT

<u>Arrest Status Since Leaving Treatment</u>	<u>Methadone^C</u>		<u>Therapeutic Community</u>		<u>Out-Patient</u>
	<u>Program A</u>	<u>Program B</u>	<u>Program C</u>	<u>Program D</u>	<u>Program D</u>
<u>Arrest Free</u>	<u>31%</u>	<u>25%</u>	<u>32%</u>	<u>43%</u>	<u>56%</u>
<u>Employment status of those arrest free:</u>					
<i>Currently earning at least \$501/quarter</i>	3%	1%	---	---	4%
<i>Currently earning less than \$501/quarter</i>	---	---	---	---	8%
<i>Worked some time during last five quarters since leaving treat- ment but not now employed</i>	3%	4%	6%	14%	---
<i>Did not work in any of last five quarters since leaving treatment</i>	12%	14%	18%	29%	24%
<i>Employment status unknown ^a</i>	13%	6%	8%	---	20%
<u>Not Arrest free</u>	<u>33%</u>	<u>37%</u>	<u>43%</u>	<u>21%</u>	<u>12%</u>
<u>Arrest Status Unknown ^b</u>	<u>36%</u>	<u>38%</u>	<u>25%</u>	<u>36%</u>	<u>32%</u>
Base: All clients sampled who received counseling and are now out of treatment.	58	71	65	14	25

^aNo social security number available or not out of treatment long enough to adequately evaluate.

^bThe employment status of this group of clients was comparable to those who remained arrest free.

^cSince one of the goals of methadone is to help individuals stay employed while on maintenance, JLARC did an identical analysis for those few individuals sampled who were still in treatment. The results of this analysis indicated no clients were arrest free and employed in Program A and only 4 out of 13 individuals in Program B.

Source: JLARC client follow-up study, April, 1975.

Table 76

COMPARISONS IN ARREST STATUS AND AVERAGE LENGTH OF
TIME IN TREATMENT BETWEEN CLIENTS WHO REMAINED
ARREST FREE VERSUS THOSE SUBSEQUENTLY ARRESTED

Arrest Status after Leaving Treatment	Methadone		Therapeutic Community		Out-Patient
	Program A	Program B	Program C	Program D	Program D
<u>Average Number of Arrests Per Person Prior to Entering Treatment</u>					
Arrest Free	3.1	2.0	2.3	*	2.7
Not Arrest Free	6.0	2.5	3.2	*	4.0
<u>Average Length of Time Spent in Treatment--Months</u>					
Arrest Free	6.5	11.7	8.8	*	5.8
Not Arrest Free	5.6	6.8	6.6	*	4.9

*Too few cases.

Base: All clients sampled who received counseling and are now out of treatment.

Source: JLARC client follow-up study, April, 1975.

CONCLUSION

The State's drug treatment effort is clearly not satisfying what the public--and the General Assembly--expects. Few individuals enter treatment and leave as productive, law-abiding citizens. This may be due to the fact that the drug addict is hard to rehabilitate. Most have had a long history of drug involvement coupled with a criminal record. However, it is also true that the State's drug treatment effort has rapidly evolved without adequate controls. This was evidenced in several ways: Two programs were found to be heavily involved in non-drug activities; only three treatment programs had ever been audited; patient records were poorly maintained; and little had been done to systematically monitor and evaluate programs. There was, moreover, inequities in how funds for treatment had been distributed. Some regions had received more than their share of funds, others less. Similarly, not all regions had access to a full range of treatment services. DDAC, as the official coordinating agency, needs to insure a more equitable distribution of drug monies.

In addition, more has to be done to insure better management at the local level. In particular, the funding agencies will have to exert more control over the programs than they have in the past. All funding agencies should (1) adopt a comprehensive set of funding criteria, (2) audit a set number of programs each year, and (3) do more to determine through better monitoring and evaluation what treatment is most effective. In this regard special efforts need to be made for either keeping clients in treatment longer or developing new, more effective, short term methods of treatment. MHMR,

especially should continue to exert its leadership in this area. Until these steps are taken no new programs should be started.

The latter will be especially critical in light of the fact that NIDA and DJCP are preparing to turn their programs over for State and local funding, and in the case of DJCP, start new program efforts. Furthermore, DDAC as a conduit of federal 409 funds, is now embarking on an identical course. These policies are the result of federal mandates which the State cannot realistically ignore. However, the State can alter the way in which these mandates are carried out. For instance, DJCP's Council on Criminal Justice can adopt a different, more flexible, cost assumption policy. DDAC can set aside more of its 409 monies for evaluation and curtail further funding of new drug treatment programs. Furthermore, to offset any remaining decline in federal funds a larger share of the Department of Welfare's Title XX monies can be allocated for drug and alcohol counseling than is now proposed.

If, after these steps are taken the State still finds treatment to be only marginally effective, thought should be given to reducing the State's commitment to this area.

PLANNING COORDINATION AND CONTROL

A lack of coordination and direction, overlapping organizational responsibilities, and conflicts in authority, have resulted from the proliferation of drug abuse control efforts among State agencies. A definition of the drug problem has not been developed, and priorities have not been established among competing interests. The Comprehensive State Plan, published by VDAAC, reflects this weakness.

JLARC suggests that the existing State agencies involved in planning and coordinating alcohol and drug abuse control programs be combined to form an independent umbrella agency responsible for both alcohol and drugs and to provide a clear sense of direction and focus.

A key issue now facing the State is the decreasing financial commitment of the federal government to drug abuse control efforts, as well as the cost assumption policies of NIDA, DDAC, and the Council on Criminal Justice (DJCP's policy-making body). These two factors will require the State to assume an additional responsibility for several million dollars in treatment funding if programs are to be maintained at their current level. JLARC recommends that the Council on Criminal Justice and its administrative staff (DJCP) be required to make a full accounting of the implications of the cost assumption policy for drugs as well as for all other categories, and that careful consideration be given to the implications of these policies.

This chapter will examine the following key issues related to inter-agency coordination, cooperation, and planning: (1) the funding of drug programs; (2) the grant application and review process; (3) the planning process; (4) the conflicts in the roles of VDAAC and DDAC; and (5) the integration of alcohol and drug abuse coordination and planning.

MANAGEMENT OF DRUG ABUSE CONTROL

JLARC has analyzed several available indicators of the Commonwealth's drug problem and found the abuse of alcohol, narcotics, and prescription drugs warrant high public concern. Available resources have not been applied to the State's drug problem in an efficient and effective manner. There are serious weaknesses in the drug abuse control activities of education, law enforcement, courts, and treatment. A primary reason for these deficiencies is that key management functions, necessary to maintain adequate control of limited public resources, are not being properly executed nor is there a common direction in drug abuse efforts.

As discussed in Chapter 1, the Governor's executive order creating the Council on Narcotics and Drug Abuse Control established its membership and duties in regard to research, planning, coordination, and public information. In addition, the Secretary of Administration was directed to establish an executive agency to serve as the administrative arm of the council. By legislative action, the Virginia Drug Abuse Advisory Council (VDAAC) and the Division of Drug Abuse Control (DDAC) were created in 1972. Regional drug abuse advisory councils were also established to provide regional input to the statewide planning process and coordinate local drug abuse efforts.

There is generally a lack of effective planning and funding coordination for drug abuse programs created by conflicts in the authority and responsibilities of VDAAC and DDAC. The division was established as the "administrative arm of the council" yet later designated to serve as the single state agency (SSA) for drug coordination. The council and the division share the responsibility to formulate a state plan, while the authority to review and comment on all grant applications, as well as "promote, develop, establish, coordinate, and conduct unified programs and activities to accomplish the objectives (of the plan)" are exclusively reserved for the council. The council, therefore, is Virginia's policy-making body for drug abuse control; however, seated on the council are the same agencies charged with policy implementation. This conflict in roles and powers is illustrated by Figure 21, which shows the existing responsibilities of federal, State, and local agencies for the functions defined below.

- | | |
|-------------------|--|
| (1) Planning: | Development of policies, plans, priorities, and procedures for future action. |
| (2) Coordination: | Integration of on-going activities in order to implement policies, plans, and priorities. |
| (3) Controlling: | Monitoring performance through the establishment of regulations, licensing standards, financial auditing, or program evaluation. |
| (4) Funding: | Allocation and distribution of State and federal grants. |
| (5) Operating: | Direct contact with clients. |

It is clear that organization for drug abuse control is plagued by overlapping authorities and responsibilities, particularly between DDAC and VDAAC.

PLANNING

Effective regional and statewide planning is essential to successful drug abuse control programs. However, the State Plan lacks adequate information, and its failure to link planning with implementation through the grant review process is a serious weakness.

Soon after its organization, the former Council on Narcotics and Drug Abuse Control engaged Touche Ross, Inc. to develop a strategy for a comprehensive drug abuse control program. The report issued in March, 1971, was a major step toward developing a state program and contained several key concepts necessary for effective coordination. The report, however, did not address the conflict in the role of members of the Council on Narcotics and Drug Abuse Control with their role as operating program advocates.

Virginia's first plan was not published until November, 1973. The plan was reasonably well prepared in comparison with other state plans available for review. Its major fault was an inability to establish realistic priorities among competing programs. The second plan, adopted in 1975, also has several weaknesses which prevent its use as an effective management tool. First, the plan fails to define the changing nature of the drug abuse problem at either the State or regional level. Most importantly, there is no link between (1) the definition of the problem, (2) the need for services, (3) gaps in existing services, and (4) strategies for providing or continuing existing services to meet identified needs.

Lack of Problem Definition

The 1975 plan does not summarize or integrate data on health crisis reports, drug-related deaths, drug arrests, or drug abuse in the public schools into a realistic assessment of the nature of the problem. Although the regional DACC's were to provide data to document the nature and extent of drug abuse in their planning districts, the submissions varied in content and format making statewide comparisons difficult.

A brief perspective on the State's drug problem obtained from the statewide drug abuse survey is included at the end of the 1975 plan, but it is not integrated with other sections of the document. In addition, there are deficiencies in the methodology used in the drug survey, affecting the validity of statewide incidence projections. Moreover, the incidence data are not clearly summarized as a basis for establishing program objectives. The drug-related data presented are contained in separately bound appendices without analysis or summary. The gaps in data submitted by the regional DACCs, as well as weaknesses in its analysis, point out the need for improved management information. With regional DACCs now operational in each major metropolitan area, this lack of regional analysis is a critical weakness of the planning process.

Figure 21

ORGANIZATIONAL ENVIRONMENT OF DRUG ABUSE CONTROL

	TREATMENT	ENFORCEMENT	EDUCATION	
FEDERAL				
SAODAP	1 2 3			
NIDA	1 2 3 4			
LEAA	1 2 3 4	1 2 3 4		
DEA		3 5		
OE			1 4 5	
STATE				
VDAAC	1 2 3 4	1 4	1 4	
DDAC	1 2	1	1	
DJCP	1 2 3 4	1 2 3 4	4	
DSPCA	2	2	2	
MHMR	3 4 5			
Health	3 4			
DVR	5			
CJOTSC		3		
DSP		5		
ABC		5		
Pharmacy		3 5		
Consolidated Labs		3 5		
Corrections	5	5		
SDE			1 3 5	
VCCS			5	
Colleges			5	
SCHEV			2 3	
REGIONAL				
Regional DACC	1 2	1	1	
Chapter 10 Boards	2 3 4			
LOCAL				
Chapter 10 Boards	2 3 4			
Treatment Programs	5			
Police		5		
Courts		5		
School Divisions			5	

ACTIVITIES:

- 1 Planning**
- 2 Coordinating**
- 3 Controlling**
- 4 Funding**
- 5 Operating**

Source: JLARC, 1975

SAODAP	Special Action Office for Drug Abuse Prevention
NIDA	National Institute on Drug Abuse
LEAA	Law Enforcement Assistance Administration
DEA	Drug Enforcement Administration
OE	Office of Education
VDAAC	Virginia Drug Abuse Advisory Council
DDAC	Division of Drug Abuse Control
DJCP	Division of Justice and Crime Prevention
DSPCA	Division of State Planning and Community Affairs
MHMR	Mental Health and Mental Retardation
DVR	Division of Vocational Rehabilitation
CJOTSC	Criminal Justice Officers Training and Standards Commission
DSP	Department of State Police
ABC	Alcoholic Beverage Control Board
SDE	State Department of Education
VCCS	Virginia Community College System
SCHEV	State Council for Higher Education in Virginia
DACC	Drug Abuse Control Council

Lack of Priorities

The major priority emerging from the 1975 plan appears to be the continuation of existing programs, with little attention given to gaps in service delivery or performance. Moreover, the major focus of the planning document is the establishment of a planning process, without adequate consideration for defining the problems to be addressed by that process.

Although a formal procedure is outlined to establish priorities, the plan states that low priority programs supported by local or State agencies may continue to be funded. In other words, DDAC has relinquished its authority to plan and coordinate, and State agencies such as MHMR, DJCP, Health, State Police, and Education continue to play a major and independent policy-making role. Furthermore, where priorities are established they represent agency priorities and do not reflect DDAC's assessment of need. For example, top priority in law enforcement was maintenance of the State Police current manpower level of 60 full-time investigators. No analysis was made of need and DDAC accepted the request without comment even though there is substantial reason to question enforcement priorities and results.

GRANT REVIEW: PLAN IMPLEMENTATION

The grant review process is the primary means of coordinating agency requests for State or federal drug abuse funds. Agency requests for funds must follow the procedures outlined in Circular A-95 (of the federal Office of Management and Budget), as well as Section 9-124 of the Code of Virginia.

Grant Review

The Virginia Drug Abuse Advisory Council has delegated its authority for reviewing grant requests to a ten member Grant Review Committee (GRC) composed primarily of State agency representatives directly involved in implementing drug abuse programs and who are the major recipients of grant monies. For example, six of the ten members have a major organizational interest in grant approvals. These members represent the departments of: Health, Mental Health, Corrections, State Police, Vocational Rehabilitation, and DJCP. In addition, a representative of DDAC has not always been a voting member of the Grant Review Committee although this oversight has been corrected. The purpose of the committee is:

To review and comment upon all applications for federal or State funds or services, loans, grants-in-aid, or matching funds or services which are to be used in connection with any drug abuse control program. The Grant Review Committee will review applications in accordance with plans, policies, and procedures adopted by the Council and additional guidelines established by the Committee. *Its review and comments will be considered the official review and comments of the full Council provided that the Executive Director may at his discretion refer the Committee's review to the Executive Committee of the Council for revision or confirmation. Actions taken by the Executive Committee will be considered final in such instances. (emphasis added.)*

Of 151 grant applications reviewed between July, 1972, and March, 1975, 150 were endorsed by the Grant Review Committee as being consistent with current plans even though the first State plan was not adopted until November, 1973. While the grant review process may have improved interagency communication, it has not provided the in-depth analysis needed to insure that public funds are expended in a carefully planned fashion.

Federal A-95 Process: The A-95 review system was established in 1969 by the Federal Office of Management and Budget (OMB) to provide an opportunity for achieving greater interjurisdictional and intergovernmental coordination of federally assisted projects. Federal agencies administering certain grant programs are required to obtain the comments of designated clearinghouses prior to initiating the application process.

The Division of State Planning and Community Affairs and the 22 state planning district commissions were designated to serve as Virginia's State and regional clearinghouses. The clearinghouse insures all concerned agencies are brought together at the beginning of the grant application process before applicants have spent considerable effort on developing the application. After the applicant has had time to resolve clearinghouse objections, if any, the final application is prepared and submitted to the federal agency which considers the material and informs the clearinghouse of its actions.

State Drug Review Process: With the increasing number of State and local agencies participating in drug programs, the General Assembly in 1972 enacted legislation aimed at providing VDAAC with central review authority on all applications for State and federal drug abuse funds. Applicants requesting drug abuse program assistance must submit their final applications to VDAAC for review and comment before it is forwarded to the appropriate federal or State funding agency. In contrast, federal drug laws, require DDAC (as the designated single state agency) to review and comment on all federal grant applications to NIDA. Therefore, under the various review processes some drug grants may be reviewed by at least three State and one regional agency (Division of State Planning, VDAAC, DDAC, and the Planning District Commissions).

Problems with Grant Coordination

Grant coordinators of the Division of State Planning indicate that as of 1974 DDAC was not responding to requests for comments on preliminary drug grant applications. DDAC, on the other hand, reported to JLARC staff that an informal agreement existed with DSPCA under which DDAC would review only the completed grant applications. DDAC contended that sufficient information was not available to merit a staff evaluation of preliminary applications, and that many preliminary statements are often not received until after the final grant has been approved. This past May, DDAC and DSPCA formally agreed that DDAC could exercise an option under the A-95 review process to continue its practice of not commenting on the preliminary drug grant applications. JLARC staff believe that DDAC should review and comment on all preliminary, as well as final, grant applications.

DDAC staff review comments and recommendations have not always been acceptable to the Grant Review Committee and some have been deleted from the

final application. Of course, there is no assurance that the grant applicant or the federal funding agency will implement the recommendations of the committee. Thus far, the Grant Review Committee, has probably had its greatest impact on State agency requests because of the certification requirement of the Division of the Budget. All State agencies requesting State or federal assistance must first receive the approval of VDAAC's grant review committee indicating that the proposed grant is consistent with the drug abuse plan.

DJCP has played, until now, a major role in financing drug abuse treatment programs. Under Section 9-124 of the Code of Virginia the Grant Review Committee is responsible for reviewing DJCP drug grants. However, in most instances, DJCP has approved grants without taking action on the comments of either the committee or DDAC.

The large number of grants received annually places a substantial burden on the staff and members of the Grant Review Committee who meet on the average of twice a month. Most grants are received during the months of May, June, and July. At times, the committee has numerous grants to process within a 30-day period, often resulting in a cursory review of the application. In December, 1973, a timetable was established for receiving applicants' grants two months in advance of the review date, but there has not been any noticeable change in the submission process.

Another issue associated with the grant review is the failure of federal and State agencies to consistently notify DDAC of grant awards and changes in program expenditures. Federal agencies are supposed to notify DDAC when a grantee's request for funds has been approved. Federal agencies, however, have been "sloppy" in processing and handling notification forms, thus, leaving DDAC unaware of the actual amount of money awarded each program. Additionally, State agencies such as MHMR and the Department of Health have not reported the amount of unexpended funds carried over at the end of each grant period, so that DDAC is also unaware of the total amount of funds available.

Based on JLARC's evaluation of the VDAAC grant review process, it can be concluded:

- DDAC lacks the necessary authority to conduct in-depth project evaluations;
- Comments and recommendations of the Grant Review Committee have often not been implemented by applicants or federal agencies;
- Federal and State agencies are negligent in reporting final grant awards to DDAC and VDAAC; and
- VDAAC and its grant review committee, because of organizational self interest, cannot be objective in carrying out their grant review functions.

INFORMATION FOR EFFECTIVE PLANNING

An essential prerequisite to planning is adequate information. DDAC is responsible for coordinating the implementation of a drug abuse management

information system--Statistical Tracking Retrieval Analysis and Planning (STRAP). Developed by the Bureau of Educational Research, University of Virginia, STRAP is to provide timely and relevant information for improved planning and decision-making. There are three major components: Incidence and Prevalence (I&P) surveys, a State agency information system, and a client-oriented reporting process for treatment programs (CODAP). A management information system such as STRAP is essential. JLARC, however, has found (1) deficiencies in the State's I&P survey, (2) a State agency reporting system with serious gaps in needed information, and (3) a local program management information system which will not be operational until at least January, 1976. It had been expected that each component of STRAP would be fully operational in time to prepare the 1975 plan.

In September, 1972, the Executive Committee of VDAAC accepted a bid for STRAP from the Bureau of Educational Research, University of Virginia, and the \$142,000 contract was signed in January, 1973. An additional \$30,125 was provided for CODAP following modifications made by NIDA. Another \$3,000 per month including staff salaries and supplies since early 1974 is required to maintain the system on-line by DDAC. The STRAP system was probably too unrealistic an undertaking in view of the required cooperation of numerous State agencies and too ambitious in design by the Bureau of Educational Research. At this point, it is important that the weaknesses of the STRAP system be addressed, and DDAC should take appropriate steps to correct them without delay.

Incidence and Prevalence Survey

The first component of STRAP is a statewide incidence and prevalence survey. Conducted in late 1973 by the Bureau of Educational Research, the I&P survey is the only source of information used in the State Plan to define the drug problem. An over-representation of young people and women may have introduced significant sample biases, and projections of heroin use may not be as accurate as implied in the plan.

Over-sampling of Young People: A random sample of 2,504 Virginians was selected and interviewed. The interviewers were instructed to choose the youngest person over age 12 in each household. This selection process is contrary to standard I&P survey procedures which require that the individual interviewed in each household be selected at random. This error in methodology resulted in a significant sample bias by including a higher proportion of younger persons than in the general population. As indicated in Table 77, young people and females are over-represented in the sample which makes the plan's projections of drug usage questionable. The Bureau of Educational Research noted this problem in its report to DDAC and stated that a supplemental report would be submitted to account for the effects of sample bias. To date this report has not been submitted.

Projection of Heroin Use: The STRAP survey must also be used with caution in projecting the incidence of less common drugs such as heroin, due to the small number of respondents reporting heroin use. In a sample of 2,504 only 14 persons reported past or present use of heroin and only 2 persons reported regular use. Based on this sample, 21,700 heroin users, including 3,600 regular users, were projected in the State's over age 12 population.

Table 77

STRAP SAMPLE DISTRIBUTION COMPARED TO POPULATION DISTRIBUTION

<u>Age Group and Sex</u>	<u>Actual^a</u>	<u>STRAP</u>	<u>Difference</u>
Under 19	17.6%	23.5%	+ 5.9%
19-25	12.3	15.0	+ 2.7
Over 25	65.0	54.0	-11.0
Male	49.4	39.6	- 9.8
Female	50.6	60.4	+10.2

^aU.S. Census of Population, 1970 (Virginia).

Note: Percentages may not add to 100% because STRAP Survey excluded persons 12 or under.

Source: DDAC, *Virginia Statewide Drug Abuse Survey, 1974*.

The more precise one makes a projection of incidence the less confidence there can be in its accuracy. For example, acceptance of a 95% confidence level results in a $\pm 3\%$ standard error. Translated into an estimate of heroin use this indicates that the actual number of past and present heroin users falls within a range of 12,400 to 31,000. For regular users of heroin, JLARC calculated a $\pm .05\%$ standard error which means that the actual number of regular heroin users is between 1,600 and 5,500. This range indicates substantial caution should be used in allocating State resources based solely on the STRAP survey data.

Delays in Student and Military Surveys: As part of STRAP a student survey was to have been completed, but its administration was delayed during the course of this evaluation, after JLARC staff pointed out an apparent deficiency in sample selection. Rather than selecting a random sample of students, the bureau proposed a longitudinal study based on a sample of 14,000 students selected for a previous study (in 1969) by surveying 2,000 of the 10,000 students who could be located. The primary objective of the STRAP student survey, however, was to provide data on the extent and nature of current drug use among students, as a baseline for future studies. Unfortunately, the bureau's proposed sample would have eliminated those students who have moved into Virginia since 1969, thereby introducing a potential bias in the projections and making repetition of the survey in future years invalid.

DDAC requested the bureau to review the sampling procedures, yet the 1969 sample was used. The survey instrument was not mailed until April, 1975, and because follow-up procedures were not coordinated with the schools in advance, a number of local divisions refused to cooperate. This attempt to turn a planning survey into an academically oriented study based on an out-of-date sample has resulted in the waste of a useful tool for measuring current student drug use. Finally, preliminary results from a third survey of military personnel, to have been submitted by August, 1974, were not received by DDAC until April, 1975.

State Agency Reporting System

A second major component of STRAP is the compilation of specific data from 11 different State agencies. This information is essential for monitoring the changing nature of the drug abuse problem, and its impact on workload. While all agencies were supposed to have been on-line by February, 1974, only 6 agencies were actually reporting the required information as of May, 1975. Table 78 shows the participating STRAP agencies and the kind of data to be supplied. The agency data system is not fully operational for several reasons: Inadequate study of data requirements by the Bureau of Educational Research; insufficient attention to contract requirements for implementing the system by DDAC; and insufficient leadership by VDAAC.

Local Program Information

Information from the various local programs will be collected and analyzed through an Integrated Drug Abuse Reporting Process (IDARP) consisting of three parts (1) Client Oriented Data Acquisition Process (CODAP), (2) Drug Abuse Prevention Resource Unit (DAPRU), and (3) Financial Management System (FMIS). The DAPRU is designed to serve as a directory of all drug abuse resources and facilities, beginning with treatment and rehabilitation programs in 1975, and encompassing any additional resources by July 1, 1976. FMIS is also expected to be operational by mid-1976 and is to include comprehensive fiscal information on drug programs such as grant identification, program expenditures, source of payments, and unit costs.

Local program information through CODAP is particularly important for treatment, rehabilitation, and planning, and includes the total number of clients admitted, progress through treatment, status at discharge, and other demographic data. Although treatment programs have been submitting data on the required CODAP forms since the third quarter of 1973, the CODAP system at the State level is not functioning and DDAC does not expect to have the system operational until early 1976.

NIDA contracted with Resource Planning Corporation (RPC) for the design of computer software to process the treatment program data. The computer language used, however, was not compatible with that used by Virginia. As a result, implementation has required lengthy negotiations among DDAC, RPC, University of Virginia, and the State Division of Automated Data Processing (ADP). In the meantime, the treatment programs continue to complete the CODAP forms (a requirement for federal funding) even though they cannot be used for the information system.

While the federal agency must bear a principal part of the responsibility for delays in the CODAP system, there have been problems at the State level as well. Not only was training in the use of CODAP data forms which was provided by DDAC for program personnel inadequate, there has not been sufficient quality control. As a result, CODAP does not accurately reflect the existing client load in treatment programs, and is not adequate for planning purposes.

Table 78

STATUS OF STRAP AGENCY INFORMATION REPORTING
(As of May 15, 1975)

Agency (Department)	Reporting as of	Type of Information
Epidemiology (Health)	4-74	Incidence of Hepatitis
Vital Statistics (Health)	4-74	Drug overdoses
Consolidated Laboratories (Health)	NR	Drug analysis reports
State Police	4-74	Drug arrests with demographics; Does not include drug type or quantity.
Division of Vocational Rehabilitation	4-75	Drug client demographics
Virginia Employment Commission	4-75	Drug client demographics (also reported from 1-74 through 6-74)
Probation & Parole (Corrections)	NR	Pilot study in 3 districts (Richmond, Charlottesville, Newport News). Includes client demographics, as well as criminal, parole, drug, and treatment history.
Youth Services (Corrections)	NR	Dept. of Corrections loses authority to collect data on juvenile court cases as of 6-30-75. No data available after that date.
Adult Services (Corrections)	NR	Client demographics
Board of Pharmacy	NR	Agreed to provide data if DDAC paid for collection. As of 5-15-75 pharmacy had not submitted costs. Data will not include drug thefts and pharmacy break-ins.
Department of Welfare	NR	Client demographics

NR - Not reporting as of May 15, 1975

Source: Division of Drug Abuse Control.

THE CHANGING PATTERN OF FINANCIAL SUPPORT

A sizeable portion of the State's drug abuse effort is supported by federal funds. NIDA contributes about \$4 million annually to the State, used primarily as support for treatment. In addition, there is approximately \$1 million in LEAA funds that DJCP and its policy-making body, the Council on Criminal Justice, allocate for drug-related programs. These funds as well as new sources of funds are important in the changing pattern of financial support to the state drug program.

National Institute of Drug Abuse

There are two sources of NIDA funds. First, Section 409 of the 1972 Drug Abuse Office and Treatment Act is intended to be used by single state agencies. Second, Section 410 of the same act provides direct grants to local treatment programs.

Section 409: These funds are used for administrative costs and the preparation of a state plan. Additional 409 funds can be used in implementing portions of the plan at the discretion of the SSA. In Virginia, 409 funds have been limited primarily to the preparation of the State Plan and DDAC's administrative expenses. During 1974-75, however, an additional \$380,000 was available for grants that DDAC felt contributed to the State Plan. These grants are now in the process of being awarded. Approximately \$110,000 is expected to be allocated to State agencies with the remainder granted to localities. For 1975-76, there will be over \$636,000 available, and about half will be used to continue programs started this year. Part of the balance will probably be used to establish new programs.

Section 410: Funds provided under Section 410 amounted to about \$4 million in FY 1975 most of which were used either to fund treatment programs or to support research. Two methods are used to distribute 410 monies--direct grants and statewide service contracts through the SSA. In the future, NIDA intends to rely more heavily on funding programs through SSA service contracts. NIDA has taken the first step in this direction by funding Rubicon (a Richmond-based treatment program) through DDAC.

Division of Justice and Crime Prevention

DJCP provides funds allocated to the State by LEAA under the Omnibus Crime Control and Safe Streets Act of 1968. Between 1969 and 1974, DJCP provided a total of \$5.2 million in federal grants for drug abuse control as shown in Table 79. This represents about a tenth of DJCP's total block grant award.

Drug Overcharge Funds

The State also has \$700,000 available from a suit brought by the Commonwealth against several drug manufacturers on charges of price fixing. These funds remain after consumers were reimbursed for over-priced drugs. The court directed that these funds should be spent on non-recurring drug projects.

Table 79

DJCP GRANTS FOR DRUG ABUSE CONTROL

<u>Year Awarded</u>	<u>Grant to Programs</u>	<u>Grants to VDAAC</u>	<u>Total Grants for Drugs</u>	<u>% of DJCP Funds Allocated to Drugs</u>
1969	\$ 4,150	\$ 10,025	\$ 14,175	2.5%
1970	500,670	70,973	571,643	13.7
1971	753,773	38,352	792,125	9.8
1972	1,049,038	164,187	1,213,225	11.6
1973	994,933	138,906	1,133,839	9.3
1974	<u>1,436,000</u>	<u>39,000</u>	<u>1,475,000</u>	<u>12.1</u>
Total	\$4,738,564	\$461,443	\$5,200,007	10.7%

Source: Division of Justice and Crime Prevention.

VDAAC has established priorities for use of these funds: (1) evaluation, (2) prevention, (3) treatment, and (4) research. Half of the total amount will be available during 1975-76 and the remainder has been reserved for 1976-77. Grants will be awarded beginning October, 1975.

Declining Federal Support

Although DJCP and NIDA fund a large portion of the State's programs, their funding commitments are transitory and not always dependable. Both agencies have a policy of reducing their support to individual programs over time. This means that for a program to continue at its current level it must eventually seek additional funds from either the State or local government.

NIDA's Sliding Scale Policy: In the case of NIDA there are four types of grants made to localities: Three-year poverty and non-poverty grants, and eight-year poverty and non-poverty grants. The amount of federal funds decreases over time and the amount of local or State match requirement increases. NIDA has not decided whether current grants will be renewed as they expire. Similarly, DDAC also uses a sliding scale policy. Programs are funded for four years with the amount of State or local match increasing from an initial 10% to a total of 75%.

DJCP's Cost Assumption Policy: When Congress first passed the Omnibus Crime Control Act it intended LEAA to be an innovator, thus grants were designed to fund demonstration projects which would be continued by State or local governments. Until recently, DJCP's policy has been to provide four years of full funding phased out in incremental steps over another four years.

The Council on Criminal Justice and DJCP, however, overextended themselves with their eight year cost assumption policy, and as a result were not able to maintain funding levels of existing programs. To correct the situation, the Council on Criminal Justice, in February, 1975, adopted an accelerated cost assumption policy under which a program will receive full

funding for the first three years and conclude at 50% the fourth year. The situation was further compounded by a reduction in LEAA funds from \$10.6 million to \$9.1 million. This policy was made retroactive to July 1, 1973, and will have its first fiscal impact during the 1976-78 biennium as shown in the analysis below.

COMPARISON OF DJCP'S CHANGE IN COST ASSUMPTION POLICIES

	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>	<u>1975-76</u>	<u>1976-77</u>	<u>1977-78</u>	<u>1978-79</u>	<u>1979-80</u>
Original Policy	100%	100%	100%	100%	80%	60%	40%	20%
New Policy	---	100%	100%	100%	50%	---	---	---

The effect of this change is to place a large burden on State and local governments. JLARC has calculated that it will cost about \$1,400,000 in the 1976-78 biennium to assume DJCP's declining share in drug programs. This policy will enable the Council on Criminal Justice to start additional programs which State and local governments will presumably have to assume after another three years. It is important to note that the exact nature of the policy was not required under federal regulations and the Council on Criminal Justice could have lessened the fiscal impact for the next biennium.

ORGANIZATION OF ALCOHOL AND DRUG ABUSE PROGRAMS

Initially, this JLARC evaluation was not designed to include problems of alcohol use because of its legal status. However, in most coordination, planning, and focus aspects, alcohol abuse could not be avoided.

Alcohol is by far the most serious drug problem facing the Commonwealth in terms of potential harm to the individual, incidence of use in the general and school-age population, and social costs. During 1974-75, approximately \$2 million was available to the Department of Health's Bureau of Alcohol Studies and Rehabilitation for the purpose of planning, designing, and administering its own alcohol programs. These costs do not include costs incurred by MHMR, the Department of Corrections, and local treatment programs. For example RUBICON, a Richmond based drug treatment program, recently received a \$1.2 million, three-year grant to operate an alcohol program.

For several years, the General Assembly has indicated increasing concern about the need to address the State's alcohol and drug abuse problems in a coordinated and more efficient manner. On the one hand, a VALC Committee was directed by Senate Joint Resolution No. 58 of 1974 to study the feasibility of combining all drug and alcohol abuse programs in one State agency. In contrast, Senate Bill 337 passed by the 1975 General Assembly, but vetoed by the Governor, proposed the establishment of a Division on Alcohol Problems within the Department of Health, and local programs for alcoholism treatment and rehabilitation.

Although JLARC has not reviewed the outcomes associated with alcohol treatment, careful attention has been given to efficient and effective means of organizing the State's response to both drug and alcohol problems.

Historical Development of Alcohol Problems

Virginia has a long history of involvement in alcohol programs, beginning in 1948 when the General Assembly created the Bureau of Alcohol Studies and Rehabilitation (BASR) in the Department of Health. Until 1972, the department's commitment to treatment of alcoholism remained relatively stable with 11 community alcoholism clinics organized at the local level and administered by the department, and an in-patient facility at the Medical College of Virginia. In FY 1970-71, BASR had a budget of \$896,000 entirely supported by State funds.

The Governor in 1972 designated the Department of Health, BASR, as the single state agency for alcohol as prescribed under the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. The bureau is, therefore, responsible for planning, developing, and implementing a statewide community based alcoholism plan. Formula grant funds are available from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) for planning, implementing, operating, coordinating, and evaluating projects concerned with alcohol abuse and alcoholism. Since 1970, federal involvement in the State's alcohol program has increased and during 1975-76, NIAAA's share of the single state agency's budget will be slightly over \$1 million. The addition of federal funds enabled BASR to expand the number of local alcoholism clinics in the State from 11 to 15, as well as increase its staff.

Functional Program Organization (Alcohol and Drugs Contrasted)

The core of the alcohol program consists of 15 Divisions of Alcoholism Services (DAS) organized as part of a local health department, primarily in urbanized areas. Each division has a coordinator responsible to the local health director on all areas related to coordinating alcohol activities with other local health services. In regard to the administration and implementation of the State Alcoholism Plan, however, the coordinators are responsible to the director of BASR.

Advisory bodies assisting BASR in its planning and implementation activities are: (1) Alcoholism Advisory Council, (2) Interdepartmental Coordinating Committee, and (3) Health Director's Advisory Council. As reflected in the membership of the Interdepartmental Coordinating Committee, many of the agencies involved in alcohol programs also participate in drug abuse programs. Unlike DDAC, however, BASR is responsible for both planning and implementing (administration and funding of treatment programs). Program priorities and recommendations included in the State Plan for Alcoholism, therefore, have a much better chance of being implemented. The director, although responsible to the Deputy State Health Commissioner, has considerable influence over statewide alcoholism planning and management, DAS program expansion, budgets, training, and personnel. Also, BASR operates within a major State agency, the

Department of Health, which can be called upon to provide technical and program support when needed. The Department has qualified professionals experienced in areas of medical-social problems as well as alcohol treatment and rehabilitation services.

DDAC, although required by federal statute to operate under a similar single agency concept as BASR, must share its policy-making and decision-making responsibilities with VDAAC, comprised of the same agencies DDAC must attempt to coordinate. The council can overrule the recommendations and decisions of the director of DDAC. The conflicting roles of VDAAC and DDAC in planning and implementing authority has diluted the effectiveness of the State's drug effort.

Planning

Of prime importance to each agency is the preparation of a statewide plan, establishing goals, objectives, priorities, and needs. A JLARC review of the drug abuse and alcohol plans revealed that while the alcohol plan was more specific and program oriented, primarily concerned with the needs of the 15 DAS's and BASR, it is not comprehensive and excludes such resources as law enforcement and education which are outside the Department of Health.

In contrast, the 1975 drug abuse plan, while vague and lacking direction, is comprehensive. Where DDAC depends on planning inputs from regional drug abuse council staffs, BASR relies on the coordinators of the 15 DAS's for information. Although it approved the 1974 alcohol plan, NIAAA did express concern about the lack of local involvement in planning and priority setting.

A management information system for monitoring and evaluating State and local drug abuse programs is being established by DDAC. The Department of Health and BASR have also developed a similar but independent system for alcohol programs.

Grant Review for Alcohol Programs

Similar to the drug grant review process, BASR reviews and comments on State and local applications for financial assistance. The bureau processed 19 grant applications in 1974. Where VOAAC has delegated its review authority to the Grant Review Committee, assisted by the DOAC staff, the bureau does not depend on a committee of external client agencies and citizens. Representatives of the Department of Health, primarily staff of BASR, conduct the review.

Two interagency agreements exist between BASR and other State agencies for coordinating grant reviews: (1) DJCP and BASR jointly review alcohol grants for LEAA funds; and (2) VDAAC and BASR review and comment on grant applications for federal funds for combined drug abuse and alcohol demonstration projects.

The bureau has had several disagreements with NIAAA for not responding to its comments on local alcohol grant applications. In fact, the bureau

feels that federal agencies often approve funds for a local alcohol program before receiving the grant review comments and recommendations of the single state agency. DDAC has had similar problems with federal agencies disbursing drug abuse funds to local programs but its voice is considerably weakened.

BASR evaluates alcohol grants and DDAC evaluates drug abuse grants. Recently, however, there has been a growing tendency for local programs to become involved in both alcohol and drug treatment, creating problems of grant review coordination and evaluation at the State level. Two such programs are the Rubicon Black Alcohol grant (an extension of Rubicon's drug activities in alcoholism) and the Harrisonburg Clinic (an alcohol treatment program formerly funded by MHMR with drug funds). Such developments indicate a need for closer integration of the two responsible agencies.

Service Delivery

Another major difference between BASR and DDAC is the degree of involvement in providing service to clients. DDAC is not involved in the direct operation of local treatment programs, as is BASR. Confusion exists between alcohol and drug abuse treatment programs which are purely oriented toward one substance and those programs that handle mixed addictions. Neither the State drug nor alcohol plan addresses this question. In May, 1974, a NIAAA review of the Virginia State Plan formula grant application stated that "Indications of coordination of alcohol and drug services are absent particularly in the case of poly-drug abusers... The alcohol abuse area of methadone maintenance needs to be examined."

CREATING A COMBINED AGENCY

Based on JLARC's analysis of the existing organizations for state-wide alcohol and drug abuse planning and coordination, there appear to be several key factors that should be considered regarding the establishment of a single alcohol and drug abuse coordinating agency.

- Unless an umbrella agency is delegated the authority to implement its plans there will, exclusive of direct provision of client services, continue to be little control over resource allocation.
- Consolidation of alcohol planning and coordination activities under the present drug abuse organization, with all its inter-program conflicts, would probably result in an overall reduction of alcohol program efficiency and effectiveness.
- Because the 15 DASs conform to planning district boundaries, regional drug abuse councils could assist in the preparation of the State Alcohol Plan. This would alleviate the burden of the DAS coordinators who are now responsible for gathering areawide alcohol statistics.
- The activities which seem to offer the greatest opportunity for efficiency through consolidation of drug and alcohol planning

and control functions are treatment of poly-drug abusers, development and implementation of management information systems, and development of a single state plan.

- Combining the two single state agencies would serve to place the State's drug and alcohol abuse programs in proper perspective by providing central direction, focus, and a more effective State voice in dealing with the corresponding federal agencies.

JLARC's evaluation of the State's drug abuse program clearly establishes the urgent need for an improved drug abuse control organization. Lack of a single agency with clearly established responsibilities and commensurate authority has been responsible for many of the program's shortcomings.

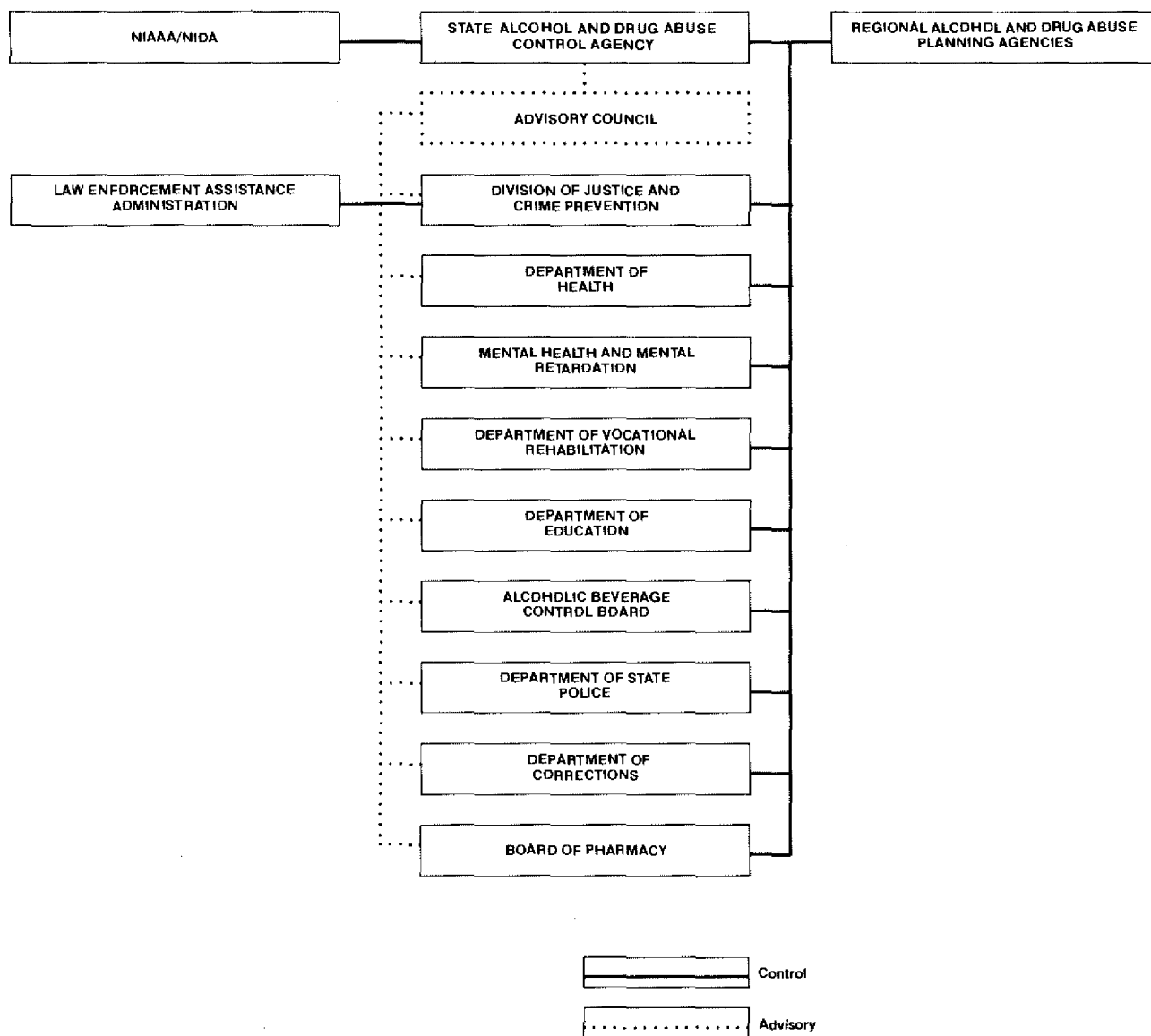
The pressing need to provide a carefully coordinated State response to all drug problems, including alcohol, created by the abuse of both legal and illegal drugs calls for combining the State's drug and alcohol control programs. JLARC strongly recommends that consideration be given to the establishment of a single state agency responsible for the planning, coordination, and control of all State alcohol and drug programs. Figure 22 provides a graphic illustration of one proposed form of organization. Under this concept, the functions and resources of the Virginia Drug Abuse Advisory Council, and the Division of Drug Abuse Control and the planning and control functions of the Bureau of Alcohol Studies and Rehabilitation should be combined within a new agency for alcohol and drug abuse control. Furthermore, VDAAC and the Alcoholism Advisory Council should be reorganized to serve as an advisory body to the new agency. Such an arrangement would provide for a more efficient and effective response to the Commonwealth's drug problems and needs. The powers and duties of the new agency should include:

- The development of a comprehensive State Plan, establishing policies, priorities, and procedures for developing coordinated alcohol and drug abuse control programs;
- Review and comment on all applications for all State or federal funds or services to be used in alcohol or drug abuse control programs;
- The development of a comprehensive management information system for investigating the extent of alcohol and drug abuse, surveying alcohol and drug facilities and programs, and assessing all factors contributing to alcohol and drug abuse; and
- Review and comment on agency drug and alcohol abuse control budgets, and final approval authority over all drug and alcohol control expenditures.

The umbrella agency should have a director responsible to the Governor, and no State funds for alcohol or drug abuse control should be expended without the prior approval of the new agency. It should also have an advisory council consisting of the representatives of the operating agencies for alcohol and drug abuse control, with citizen participation. The duties of the council should be restricted to advise the State's agency for alcohol and drug

Figure 22

PROPOSED REORGANIZATION OF ALCOHOL AND DRUG PROGRAMS



Source: JLARC, July, 1975

abuse. While agency and citizen input into the planning process must be maximized, there must be a single state agency with the responsibility, and the authority, to insure the effective management of public resources.

CONCLUSION

A key issue now facing the State is the decreasing commitment of the federal government to fund drug abuse control efforts. Federal funding is now provided through NIDA and DJCP, while the State and local governments continue to provide both direct and indirect support. The level of federal funding, however, will be reduced over the next several years, and the sliding scale policies of NIDA and DDAC coupled with DJCP's cost assumption policy will leave the Commonwealth with a burden of several million dollars to maintain drug programs at their current level of funding. JLARC recommends that DJCP be required to make a full accounting of the implications of their cost assumption policy for drugs as well as for all other categories of grant activities.

State efforts to deal with the drug abuse problem have lacked overall coordination and direction. As a result, no definition of the problem has been developed, and priorities have not been established among competing agency interests. The Comprehensive Plan published by VDAAC reflects this critical weakness. JLARC recommends that existing agencies involved in the planning, coordination, and control of alcohol and drug abuse programs be replaced by an independent umbrella agency responsible for both alcohol and drugs. Furthermore, specific weaknesses in the planning process, as well as technical and administrative difficulties in developing the STRAP management information system, must be addressed. These changes are necessary to insure an effective State response to drug abuse and provide for accountability of public expenditures.

END NOTES

1. Task Force on Narcotics and Drug Abuse, The President's Commission on Law Enforcement and Administration of Justice, *Task Force Report: Narcotics and Drug Enforcement* (Washington, DC: U.S. Government Printing Office, 1967).
2. *Ibid.* pp. 1-20.
3. The National Commission on Marijuana and Drug Abuse, *Marijuana: A Signal of Misunderstanding* (Washington, DC: U.S. Government Printing Office, 1972), and *Drug Use in America: Problems in Perspective* (Washington, DC: Government Printing Office, 1973).
4. Commission on Marijuana and Drug Abuse, *Marijuana ...*, p. 495.
5. *Ibid.* p. 496.
6. *Drug Abuse Education Act of 1970, PL 91-527.*
7. Commission on Marijuana and Drug Abuse, *Marijuana ...*, p. 496.
8. *Ibid.* p. 281.
9. Sybil Cline, *Governmental Response to Drugs: Fiscal and Organizational* (Washington, DC: Drug Abuse Council, Inc., 1974), p. 25.
10. *Ibid.* pp. 11-15.
11. Edward M. Brecher and the Editors of Consumer Reports, *Licit and Illicit Drugs* (Boston: Little, Brown and Company, 1972), pp. 491-496.
12. Bureau of Alcohol Studies and Rehabilitation, Virginia State Department of Health, *Comprehensive Community Alcoholism Plan* (Richmond, 1974), p. 2.
13. This conclusion is in part based upon a comparison of the results of Virginia's drug abuse survey with those of 12 other states. Because of the small frequencies associated with the use of some drugs such as heroin, however, caution must be exercised when using the survey data to project an estimated number of drug users as discussed in Chapter VIII. Used in conjunction with other sources of information, however, the survey provides one of the few available tools for measuring the scope of drug use.
14. It is important to note that Figure 5 does not suggest that all students who reported habitual use of marijuana also reported "a Serious Problem". Rather, a significantly higher proportion of respondents who reported this level of marijuana use also described the problem in this way. Thus, the shaded cells in the matrix do not imply unanimity, but a tendency for student opinion (as to the seriousness of the problem) to vary according to type of drug and frequency of use.
15. Commission on Marijuana and Drug Abuse, *Drug Use in America ...*, pp. 162-163.
16. Brecher, pp. 261-262.
17. Edward M. Brecher and the Editors of Consumer Reports, "Marijuana: The Health Question," *Consumer Reports*, March, 1975, pp. 143-149.

18. Illinois Economic and Fiscal Commission, *Drug Abuse Program: An Evaluation* (Springfield, Ill., 1975), p. 91.
19. Byron G. Fiman, Lucia Maxwell, and Victor H. Cohn, "An Evaluation of a Teacher Training Program in Drug Education: Results and Implications," *Journal of Drug Education*, IV (Spring, 1974).
20. Department of Counselor Education, School of Education, University of Virginia, *Guidance and Counseling in Virginia* (Charlottesville: University of Virginia, 1975).
21. Commission on Marijuana and Drug Abuse, *Drug Use in America...*, p. 351.
22. Dr. Louise G. Richards, "Evaluation in Drug Education: Methods and Results," *Resource Book for Drug Abuse Education* (Rockville, Maryland: National Clearinghouse for Drug Abuse Information).
23. John D. Swisher, Et al., "Drug Education; Pushing or Preventing?" *Peabody Journal of Education*, (October, 1971).
24. Rosalie M. Berberian and W. Douglas Thompson, "The Relationship Between Drug Education and Changes in Drug Use," Paper presented to the North American Congress on Alcohol and Drug Problems, San Francisco, December, 1974.
25. Telephone interview with Rosalie M. Berberian, Director, Center for Survey Research, Yale University, April, 1975.
26. North Carolina Department of Public Instruction, *Life Skills for Health: Focus on Mental Health* (Raleigh, 1974).
27. Richard Carney, "An Evaluation of the Effects of a Values Oriented Drug Abuse Education Program," March, 1971, in Richards, *Evaluation of Drug Education...*
28. John D. Swisher, *An Evaluation of Keystone Central School Districts' Drug Education Program* (University Park, Pa.: The Pennsylvania State University).
29. Eugene P. Visco, JoAnne F. Fenotti, "SPARK Program Analysis," Final Report for NIDA, September, 1974.
30. Unpublished materials provided by Don Samuels, Coordinator, Substance Education Program, Dade County Public Schools (Miami, Florida, February, 1975).
31. Bureau of Research Services, College of Education, VPISU. "Analysis of 1972-73 Drug Knowledge and Attitude Tests: Responses and Total Scores."
32. Thomas P. Muncy, Jr., Drug Education Consultant to the Waynesboro-East Augusta Mental Health Association, "Report of the School Organization on Developing Attitudes," 1972, and Donald B. Curtis, "Report of Waynesboro-East Augusta Student Attitude Survey," April, 1972.
33. Kathy Hintz, Drug Education Coordinator, Alexandria City Schools, "Evaluation of Pilot Course in Drug Education for Student Resource Persons and the SEE Program," June, 1974.

34. Virginia Commission on Narcotic and Drug Laws, *Report of the Commission on Narcotic and Drug Laws* (Richmond, 1972), p. 2.
35. *Ibid.* P. 4.
36. Two possible reasons for this percentage being lower than the 1973 and 1974 marijuana arrest rates presented in Chapter IV are: (1) juvenile arrests and dispositions were not included as part of the CCRE analysis (among juveniles, marijuana arrests comprise a high percentage of all drug arrest); and (2) hashish and marijuana cases are combined in Table 35.
37. Richard A. McGee "A New Look at Sentencing," *Federal Probation*, June, 1974, p. 6.
38. Virginia Commission on Narcotic and Drug Laws, P. 5.
39. Under optimum conditions the Federal Judicial Center's *Guide to Community Relations of United States Probation Offices* estimates that it costs \$400 a year to supervise a probationer. JLARC used \$200 as a conservative cost estimate for supporting probationers in Virginia.
40. Virginia, Department of Welfare and Institutions, *Report of the Department of Welfare and Institutions* (Richmond, Va., 1973), p. 6.
41. Virginia Probation and Parole Board, Bureau of Special Services, "Drug Team Component", 1973. p. 7.
42. Strategy Council on Drug Abuse, *Federal Strategy for Drug Abuse and Traffic Prevention* (Washington, DC: U.S. Government Printing Office), p. 23.

APPENDICES

	<i>Page</i>
<i>Appendix for Chapter I</i>	<i>A - 1</i>
<i>Appendix for Chapter II</i>	<i>A - 3</i>
<i>Appendix for Chapter III</i>	<i>A - 8</i>
<i>Appendix for Chapter IV</i>	<i>A - 27</i>
<i>Appendix for Chapter V</i>	<i>A - 44</i>
<i>Appendix for Chapter VI</i>	<i>A - 50</i>
<i>Appendix for Chapter VII</i>	<i>A - 52</i>
<i>Appendix VIII</i>	
<i>Agency Responses</i>	<i>A - 67</i>
<i>JLARC Comments</i>	<i>A - 109</i>

APPENDIX I

Table I-1

ESTIMATED FUNDS AVAILABLE FOR DRUG ABUSE PROGRAMS 1974-75

DJCP/LEAA	\$ 1,427,778
DDAC (General Funds)	206,320
NIDA (409 and 410 Funds)	4,380,000
Health	375,500
MHMR	550,000
State Police	1,023,355
ABC ^a	239,200
Pharmacy	239,020
Consolidated Labs	541,796
Local Law Enforcement ^b	4,821,500
Probation and Parole	224,130
Courts ^c	NA
Corrections ^d	339,706
Education ^e	59,752
Vocational Rehabilitation	<u>450,000</u>
Total	\$14,878,957

^aEstimated by taking 27% of total enforcement funds; 27% of arrests during 1973-74 were for drug law violations.

^bProjected by multiplying the estimated 11,260 local drug arrests by the average cost per State Police arrest (\$428.20).

^cJLARC estimates that approximately 18,000 adult and juvenile drug cases were brought before the courts of record and courts not of record in 1974. JLARC did not estimate the cost of processing these cases because of inadequate data.

^dCosts are for the period July, 1974 - September, 1975, and do not include the correctional training program.

^eDoes not include teacher costs of local school divisions incurred in providing drug education.

Source: Compiled by JLARC.

Table 1-2

ESTIMATED FUNDS AVAILABLE FOR
DRUG ABUSE PROGRAMS
1970-75

DDAC (General Funds)	\$ 295,955
DJCP	6,237,778
NIDA	6,929,000
Health	1,001,000
MHMR	1,150,000
State Police	3,891,220
ABC ^a	570,817
Pharmacy	651,215
Consolidated Labs	1,445,995
Local Law Enforcement ^b	13,753,100
Probation and Parole	370,246
Courts ^c	NA
Corrections	473,039
Education ^d	187,452
Vocational Rehabilitation	<u>667,177</u>
Total	\$37,623,994

^aEstimated by taking 27% of total enforcement funds; 27% of arrests during 1973-74 were for drug law violations.

^bProjected by multiplying the estimated 11,260 local drug arrests by the average cost per State Police arrest. (\$428.20)

^cJLARC estimates that approximately 18,000 adult and juvenile cases were brought before the courts of record and courts not of record in 1974. JLARC did not estimate the cost of processing these cases because of inadequate data.

^dDoes not include teacher costs of local school divisions incurred in providing drug education.

Source: Compiled by JLARC.

Table II-1

DRUG INCIDENCE AND CHARACTERISTICS OF DRUG USERS

	Total Users	Regular or Heavy Users	Non-Medical Users	Sex		Age			Race	
				Male	Female	Under 21	21- 35	Over 35	White	Non-White
Liquor	956,700	148,500	956,700	NA	NA	NA	NA	NA	NA	NA
Beer and Wine	1,480,100	269,600	1,480,100	NA	NA	NA	NA	NA	NA	NA
Sleeping Pills	65,000	10,100	18,000	32%	68%	8%	20%	72%	12%	92%
Barbiturates	79,400	21,600	17,300	21%	79%	17%	24%	59%	91%	9%
Glue	3,600	1,400	3,600	67%	33%	77%	23%	--	67%	33%
Tranquilizers	155,200	57,700	33,200	13%	87%	13%	25%	63%	84%	16%
Cocaine	10,800	1,400	10,800	88%	12%	43%	57%	--	100%	--
Methamphetamines	28,900	11,500	28,900	60%	40%	42%	58%	--	100%	--
Amphetamines	21,700	4,300	13,000	29%	71%	28%	64%	8%	93%	7%
Codeine-Darvon	93,900	27,400	17,300	21%	79%	11%	50%	39%	86%	14%
Heroin-Opiates	3,600	2,900	3,600	56%	44%	25%	56%	19%	81%	19%
LSD	21,700	1,400	21,700	47%	53%	43%	57%	--	100%	--
Marijuana	187,700	72,100	187,700	59%	41%	42%	58%	--	91%	9%

A-3

Source: Virginia Division of Drug Abuse Control, *Virginia Statewide Drug Abuse Survey, Summary Report*, (Richmond, 1974).

Terms & Symptoms of Drug Abuse

This chart indicates the most common symptoms of drug abuse. Therefore, all of the signs are not always evident, nor are they the only ones that may occur. Any drug's reaction will usually depend on the person, his mood, his environment, the dosage of the drug and how the drug interacts with other drugs the person has taken or contaminants within the drug.

		DROWSINESS	EXCITATION & HYPERACTIVITY	IRRITABILITY & RESTLESSNESS	BELLIGERENCE	ANXIETY	EUPHORIA	DEPRESSION	HALLUCINATIONS	PANIC	IRRATIONAL BEHAVIOR	CONFUSION	TALKATIVENESS	RAMBLING SPEECH	SLURRED SPEECH	LAUGHTER	TREMOR
MORPHINE	M, deamer, white stuff, hard stuff, morpho, nokur, Mist Emma, monkey, rubo, tauri, tab, tmsel, hucus, morphiu, nishie	●	■		■	●	■	●	■		■			●		■	
HEROIN	Snow, stuff, U, junk, big Harry, raballo, Quater, buy, horse, white stuff, Harry, hairy, my powder, salt, dipe, Duiger, hard stuff, schmeek, shit, skag, ibing.	●	■		■	●	■	●	■		■			●		■	
CODEINE	Schnitztoy	●	■		■	●	■	●	■		■			●		■	
HYDROMORPHONE	Dilaudid, birds	●	■		■	●	■	●	■		■			●		■	
MEPERIDINE	Demipol, Isomacaine, Dilantol, Pethidine	●	■		■	●	■	●	■		■			●		■	
METHADONE	Dolophine, Dolties, doltis, amidone	●	■		■	●	■	●	■		■			●		■	
EXEMPT PREPARATIONS	P.C., H.O., blue velvet (Paregic with antihistamine), red water, bitter, licorice	●	■		■	●	■	●	■		■			●		■	
COCAINE	The leaf, snow, C, Cecil, coke, dynamite, flake, speedball (when mixed with Heroin), gel, happy dust, joy powder, white girl, girl dust, Corrine, Berries, Birse, gut, Bernice, Star dust, Carrie, Chilly, heaven dust, naralise		●	●		●	●	●			●					●	
MARIHUANA	Smoke, straw, Texas tea, ive, pod, muth, sohi, Acapulco Gold, Bharg, him, hush, butter flower, Gania, weed, grass, nut, muggles, tea, hat, hemp, griffin, Indian hay, loco weed, hay, herb, L, ou, giggler-smoke, live weed, Mary Warner, Mohasky, Mary Jane, mini sticks, nishie, saliva, mach,	●	●	●		●	●	●	●		●				●		
AMPHETAMINES	Pep pills, bennies, wake-ups, syn-poppers, lid poppers, co-pilot, trunk driers, peaches, riot, hearts, car-whips, whites, coat to coast, LA turnabouts, browns, Innoballs, greenies, dumbbells, oranges, dixies, jolly-bean, A's, jolly babies, sweets, bean, uppers		●	●		●	●	●	●		●					●	
METHAMPHETAMINE	Speed, meth, splash, crystal, bombua, Methedone, Dne		●	●		●	●	●	●		●					●	
OTHER STIMULANTS	Pep pills, uppers		●	●		●	●	●	●		●					●	
BARBITURATES	Yellow, yellow jackets, nimble, nimble, red, pink, red birds, red devils, seggy, secco, pink ladies, blues, blue birds, blue devil, blue heaven, red & blues, double trouble, troups, Christmas trees, rheonies, harts	●	■	●	■	●	■	●	■		●	●		●	●	■	
OTHER DEPRESSANTS	Candy, goofballs, sleeping pills, narcotics	●	■	●	■	●	■	●	■		●	●		●		■	
LYSERGIC ACID DIETHYLAMIDE (LSD)	Acid, rubes, nearly gates, heavenly blue, rural blue, wedding belt, sugar, big D, Blue Acid, the Chant, the Hawk, instant Zen, Z5, Zen, sugar lump		●			●	●	●	●	●			●			●	
STP	Serenity, tranquility, mistic, DOM, syndicate and					●	●	●		●			●			●	
PHENCYCLIDINE (PCP)	PCP, peace pill, synthetic marijuana	●				●			●	●					●		
PEYOTE	Mescal button, mescal beans, hikori, hikori, buatori, soni, yinkovi, ractus, the button, tops, a moun, half moon, U, the half seed, Big Chief, Mesc.		●	●		●		●					●				
PSILOCYBIN	Sacred mushrooms, mushrooms		●	●		●	●	●	●		●		●				
DIETHYLTRYPTAMINE (DMT)	DMT, 45-minute psychosis, business-man's special		●			●	●	●	●		●		●				

SLANG TERMS

● SYMPTOMS OF ABUSE

■ SYMPTOMS OF WITHDRAWAL

Source: Drug Enforcement Administration, Drugs of Abuse.

STAGGERING	IMPAIRMENT OF COORDINATION	DIZZINESS	HYPERACTIVE REFLEXES	DEPRESSED REFLEXES	INCREASED SWEATING	DILATED PUPILS	UNUSUALLY BRIGHT SHINY EYES	INFLAMED EYES	RUNNY EYES AND NOSE	LOSS OF APPETITE	INCREASED APPETITE	INSOMNIA	DISTORTION OF SPACE OR TIME	NAUSEA AND VOMITING	ABDOMINAL CRAMPS	CONSTIPATION	PHYSICAL DEPENDENCE	PSYCHOLOGICAL DEPENDENCE	TOLERANCE	CONVULSIONS	UNCONSCIOUSNESS	HEPATITIS	PSYCHOSIS	DEATH FROM WITHDRAWAL	DEATH FROM OVERDOSE	POSSIBLE CHROMOSOME DAMAGE	ORALLY	INJECTION	SMOKED
●			●	■	●	■		■	●	■		■	■	■	●	○	○	○	○	○	○		○			○		○	
●			●	■	●	■		■	●	■		■	■	■	●	○	○	○	○	○	○		○			○		○	○
●			●	■	●	■		■	●	■		■	■	■	●	○	○	○			○		○			○	○	○	
●			●	■	●	■		■	●	■		■	■	■	●	○	○	○			○	○		○			○	○	
●			●	■	●	■		■	●	■		■	■	■	●	○	○	○			○	○		○			○	○	
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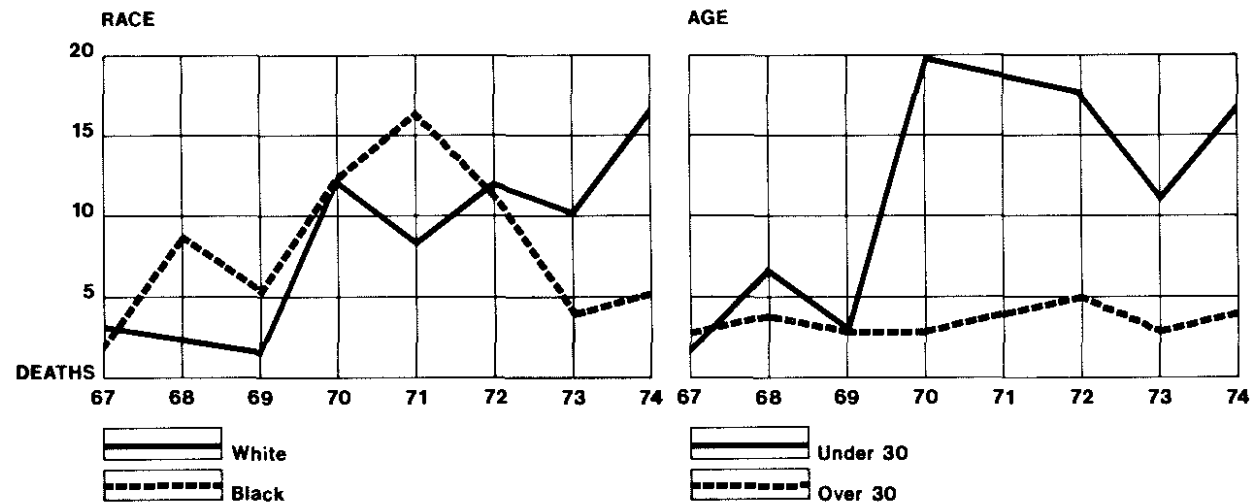
○ DANGERS OF ABUSE

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○ DANGERS OF ABUSE

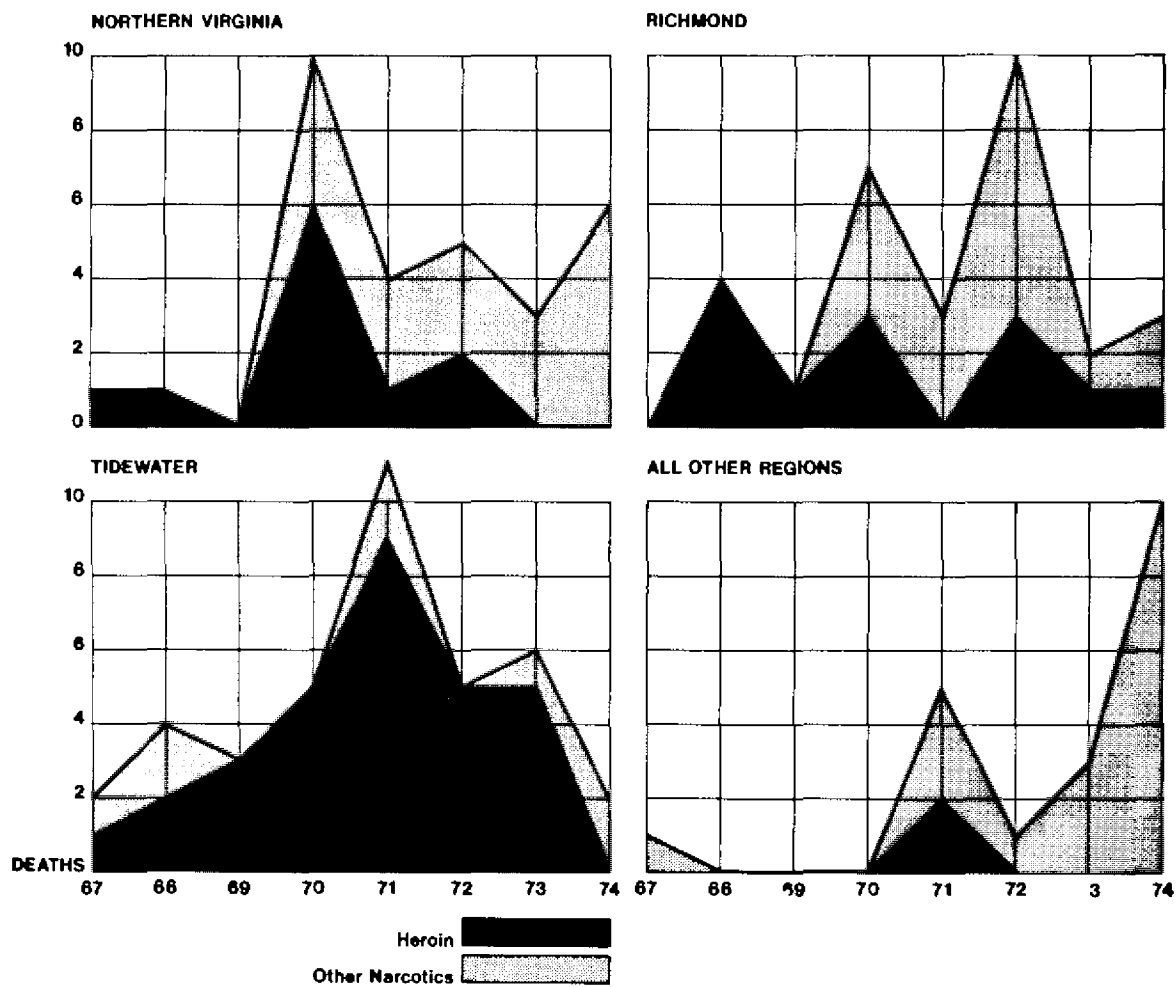
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Figure II-1
RACE AND AGE TRENDS IN NARCOTIC DEATHS
 1967 - 1974



Source: Bureau of Health, Bureau of Vital Records and Health Statistics

Figure 11-2
NARCOTIC DEATHS BY REGION
1967-1974



Source: State Department of Health, Bureau of Vital Records and Health Statistics.

APPENDIX III

SURVEY METHODOLOGY

In order to assess student and faculty opinion of drug education and training, JLARC conducted three sample surveys of senior high school students, health and physical education teachers, and guidance counselors. Each of the three questionnaires was field tested in Richmond and Henrico County Public Schools during November, 1974, in order to refine the survey instrument.

Urban, Suburban, and Rural Classification

In this report, a 1970 U. S. Census definition is used to distinguish urban, suburban, and rural jurisdictions. Urban is defined as 90-100% urbanized, suburban is 30-80% urbanized, while rural is 0-29% urbanized. Using this criterion, each of the State's cities is classified as urban, as well as Arlington and Fairfax Counties. The following counties are classified as suburban: Amherst, Campbell, Chesterfield, Culpeper, Dinwiddie, Henrico, King William, Loudoun, Montgomery, Prince Edward, Prince George, Prince William, Pulaski, Roanoke, Smythe, Tazewell, and Warren. Each of the remaining counties is classified as rural. While such a classification scheme is not perfect, it does provide a general framework for comparing urban, suburban, and rural jurisdiction.

Student Survey

JLARC used a cluster sampling approach in its student survey, and on December 2, 1974, 50 secondary English teachers were selected at random from a master list of teachers maintained by the Department of Education (SDE). With the cooperation of SDE and the local school divisions, each teacher in the sample received a package containing 35 questionnaires and instructions for administration of the survey to randomly selected 10th, 11th, or 12th grade English classes. Almost all secondary students in Virginia are required to take an English course each year, so this procedure gives each student an equal chance of being selected. As there is no master list of students, JLARC believed this to be an acceptable means of drawing a random sample.

Each of the 50 English teachers returned the package of questionnaires, although the number returned from each class varied. A total of 1,227 usable questionnaires were received, broken down as follows:

		<u>Sample %</u>	<u>Actual (%)</u>
<u>Sex</u>	Male	49.8	50.8 ^a
	Female	50.2	49.2
<u>Race</u>	Black	17.4	18.6 ^b
	White	78.7	80.9
	Other	2.9	.5
	No response	1.0	---

<u>Grade in School</u>	Ninth	1.6	---
	Tenth	34.0	37.4
	Eleventh	31.1	32.6
	Twelfth	33.3	30.0
<u>Type of Community</u>	Urban	52.1	51.4 ^c
	Suburban	23.4	18.4
	Rural	24.5	30.2

^aFrom 1970 Census, 15-17 year olds.

^bFrom 1970 Census, racial distribution in general population.

^cFrom SDE 1973-1974 *Annual Report*, for all secondary students.

With a 100% return rate by English teachers, the survey provides an accurate cross-section of student opinion. It should be noted, however, that there was a 5% over-representation of suburban students, corresponding to a 5.8% under-representation of rural students. As this could introduce a sample bias in survey results, JLARC recomputed the proportion of students who reported that several or most of their friends use drugs, based on an ideal sample distribution of urban, suburban, and rural students.

A	<u>Sample Distribution</u>		<u>Proportion reporting that several or most of their friends use drugs</u>	<u>Projected number of students reporting that ...</u>
Urban	642	X	(.484)	311
Suburban	287		(.409)	117
Rural	198		(.268)	80
Total	1,227			508

$$\frac{508}{1,227} = 41.4\%$$

B	<u>Ideal Distribution</u>		<u>Proportion</u>	<u>Projected Number</u>
Urban	630	X	(.484)	305
Suburban	226		(.409)	92
Rural	371		(.268)	99
Total	1,227			496

$$\frac{496}{1,227} = 40.4\%$$

Correcting for the under-representation of rural students, the proportion of students reporting peer group drug use dropped by only one percent, from 41.4% to 40.4%. Therefore, JLARC does not believe that its survey findings are significantly affected.

Health and Physical Education Teacher's Survey

A random sample of 391 health and physical education teachers was obtained from the master list maintained by SDE. Packages of questionnaires were distributed to local school divisions, along with the student survey, with instructions that each teacher selected was to receive a questionnaire and return envelope. A total of 227 questionnaires (58.1%) were returned. The distribution of the teacher population, the original sample as mailed, and the final sample as returned to JLARC are as follows:

DISTRIBUTION OF HEALTH AND PHYSICAL EDUCATION TEACHERS

	<u>Urban</u>	<u>Suburban</u>	<u>Rural</u>	<u>Total</u>
Actual distribution of H&PE teachers in Virginia:	34.3%	16.5%	49.2%	100%
Original sample distribution as mailed:	45.5	13.8	40.7	100
Final sample as returned to JLARC:	40.1	13.6	46.3	100
Return rate	51.1	57.4	66.0	58.1

The return rate for health teachers was not as high as expected. However, a sample of 227 teachers, from a population of 3,200 is sufficient, within a 95% confidence interval, to draw conclusions within a 6.3% standard error.

The original sample over-represented urban health teachers, yet the final sample as returned was closer to the actual distribution. In order to determine whether this remaining discrepancy might have caused a sample bias, JLARC did a Chi Square test on the urban, suburban, and rural return rates.

<u>Questionnaires</u>	<u>Urban</u>	<u>Suburban</u>	<u>Rural</u>	<u>Total</u>
Returned	91	31	105	227
<u>Not Returned</u>	<u>87</u>	<u>23</u>	<u>54</u>	<u>164</u>
Sent Out	178	54	159	391

The Chi Square was found to be $\chi^2 = 7.68$ with 2 degrees of freedom, which is significant at the .05 level. For this reason, care should be taken in drawing comparisons between urban, suburban, and rural health teachers.

Nevertheless, the final sample was closer than the original sample to the actual distribution, and a t-test was conducted on the

largest discrepancy, between the proportion of urban teachers in the actual population (34.3%), and the urban proportion in the final sample (40.0%). The following formula was used:

$$SD_p = \frac{p_1 q_1}{N_1} + \frac{p_2 q_2}{N_2}$$

Where SD_p = Standard deviation of the proportion
 p_1 = actual proportion of urban teachers (34.3%)
 p_2 = sample proportion (40.0%)
 $q_1 = 1 - p_1$
 $q_2 = 1 - p_2$
 N_1 = total number of teachers (3,030)
 N_2 = sample size (391)

The t-test was performed by the following equation:

$$t = \frac{p_1 - p_2}{SD_p}$$

$t = .02617$

Because this is not a significant variation in the total sample, JLARC believes that its survey of health and physical education teachers represents a valid indicator of statewide trends.

Guidance Counselors

Along with the previous two surveys, JLARC distributed questionnaires to a sample of 397 guidance counselors, also selected at random from the SDE master list. A total of 295 questionnaires (74.3%) were returned. The distribution of urban, suburban, and rural returns were as follows:

DISTRIBUTION OF GUIDANCE COUNSELORS

	<u>Urban</u>	<u>Suburban</u>	<u>Rural</u>	<u>Total</u>
Actual distribution of counselors in Virginia	55.8%	16.8%	27.4%	100%
Original sample distribution as mailed	55.4	15.9	28.7	100
Final sample as returned to JLARC	54.6	12.9	32.5	100
Return Rate	73.2	60.3	84.2	74.3

As the rate of return was sufficiently high, JLARC believes the counselors survey provides an accurate reflection of statewide

trends and opinions. The largest discrepancy between actual and sample distribution was for rural counselors: While only 27.4% of all counselors were from rural divisions, 32.5% of the final sample was rural. However, a t-test showed that this was not a significant difference ($t = .58$), and so the survey also provides a good indication of urban, suburban and rural differences.



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November 26, 1974

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HERBERT H. BATEMAN
Senator

ROBERT S. BURRUSS, JR.
Senator

VINCENT F. CALLAHAN, JR.
Delegate

ARTHUR R. GIESEN, JR.
Delegate

EDWARD E. LANE
Delegate

L. CLEAVES MANNING
Delegate

THEODORE V. MORRISON, JR.
Delegate

LACEY E. PUTNEY
Delegate

FORD C. QUILLEN
Delegate

EDWARD E. WILLEY
Senator

JOSEPH S. JAMES
Auditor of Public Accounts
Ex Officio

RAY D. PETHTEL
Director

Dear Student:

The Joint Legislative Audit and Review Commission is preparing a report on drug abuse control programs in Virginia. One part of this study is a review of drug education in the public schools.

Student opinions regarding drug education, as well as student assessment of "the drug problem," are important to know.

You are one of a small number of students selected to receive a questionnaire; it is important that you answer each question completely. Your response will be treated in strict CONFIDENCE. Our concern is with overall student opinion, and not with that of any one student.

Please take just a few minutes to complete this questionnaire, then return it to your teacher. Your assistance is greatly appreciated.

Sincerely,

Ray D. Pethtel
Director

RDP:kjb

Enclosure

Office
Use
Only

- 7 1. Grade in school: _____ 2. Male _____ Female _____
9
10 3. Do you consider yourself: Black _____ White _____ Other _____
11 4. In what city or county do you live?

City _____ County _____
- 14 5. How would you describe the level of drug use (not including alcohol) in your
15 school? (You may check more than one)
16
1. _____ None or very little.
2. _____ Limited number of experimental users.
3. _____ Widespread experimental use.
4. _____ Limited number of occasional users.
5. _____ Widespread occasional use.
6. _____ Limited number of habitual users.
7. _____ Widespread habitual use.
- 17 6. Based on your estimate of drug usage, how would you describe the drug
problem in your school?
1. _____ No problem.
2. _____ A problem, but not serious.
3. _____ A serious problem.
7. What are the most frequently used drugs in your school? For each drug,
write 1, 2, 3, or 4 in the space provided, according to whether you believe
the drug is not used, or is used experimentally, occasionally, or
habitually:
- | | |
|----------------------|--------------------|
| 1 - not used | 3 - occasional use |
| 2 - experimental use | 4 - habitual use |
- 18 _____ Marijuana, hashish.
19 _____ LSD, mescaline, hallucinogens.
20 _____ Cocaine.
21 _____ Heroin.
22 _____ Methadrine, methamphetamine ("speed").
23 _____ Amphetamines ("uppers, pep pills, bennies, dexies").
24 _____ Barbiturates ("downers, barbs, blues, reds").
25 _____ Methaqualone ("sopors, Vitamin Q").
26 _____ Tranquilizers (Darvon, Librium, Valium).
27 _____ Alcohol.
28 _____ Cough syrup, codeine.
29 _____ Glue, inhalants.
30 _____ Poly-drug use (more than one drug at one time).
- 31 8. How many of your friends turn on with drugs?
1. _____ None.
2. _____ Very few.
3. _____ Several.
4. _____ Most.

32 9. Circle the grades in which you received drug education in Virginia public
 34 schools:
 36
 38 1 2 3 4 5 6 7 8 9 10 11 12

40 If you have not had drug education in Virginia, check here: _____

10. Do you agree or disagree with the following statements about your most recent drug education class in Virginia? Circle the number which indicates your response on the scale below.

		Disagree Strongly				Agree Strongly
41	The teacher seemed to really care whether or not the students used drugs:	1	2	3	4	5
42	The teacher seemed to know a lot about drugs:	1	2	3	4	5
43	The teacher was really good at getting us to talk about the reasons why people use drugs:	1	2	3	4	5
44	The textbooks seemed to be relevant to the drug problems of today:	1	2	3	4	5
45	The films we saw seemed to be relevant to the drug problems of today:	1	2	3	4	5
46	The teacher talked about both legal and illegal drugs:	1	2	3	4	5
47	The teacher believed that students should make their own decisions about whether or not to use drugs:	1	2	3	4	5
48	Drug education has made me more aware of different kinds of drugs and their effects:	1	2	3	4	5
49	The teacher listened to us as much as we listened to the teacher:	1	2	3	4	5
50	I think drug education is a good thing for all students to have:	1	2	3	4	5

11. Do you agree or disagree with the following statements about drug abuse?

		Disagree Strongly				Agree Strongly
51	Drug abuse means using any drug for non-medical purposes:	1	2	3	4	5
52	Alcoholism is a much more serious problem today than abuse of any other drug:	1	2	3	4	5
53	Laws against marijuana should be made more severe:	1	2	3	4	5
54	Alternatives, such as treatment programs, should be provided for arrested drug users:	1	2	3	4	5
55	Police should concentrate on arresting people who sell drugs rather than on those who use them:	1	2	3	4	5
56	Most people try drugs because their friends use them:	1	2	3	4	5
57	If I had a serious drug problem, there is someone in my school other than a student to whom I would turn for help:	1	2	3	4	5
58	12. Do you think that drug education has helped to reduce the level of drug abuse in your school?					

Yes _____ No _____

Briefly explain why or why not:

If you have any further comments about drug education, or about the drug problem, in general, please feel free to enclose another sheet. Thank you for your cooperation!

DRUG TRAINING AND EDUCATION SURVEY

Office use
Only

1,7
8
9

1. How would you describe the level of drug use (not including alcohol) in your school? (You may check more than one)

1. _____ None or very little.
2. _____ Limited number of experimental users.
3. _____ Widespread experimental use.
4. _____ Limited number of occasional users.
5. _____ Widespread occasional use.
6. _____ Limited number of habitual users.
7. _____ Widespread habitual use.

10

2. Based on your estimate of drug usage, how would you describe the drug problem in your school?

1. _____ No problem.
2. _____ A problem, but not serious.
3. _____ A serious problem.

3. What are the most frequently used drugs in your school? For each drug, write 1, 2, 3, or 4 in the space provided, according to whether you believe the drug is not used, or is used experimentally, occasionally, or habitually:

1 - not used	3 - occasional use
2 - experimental use	4 - habitual use

- 11 _____ Marijuana, hashish.
- 12 _____ LSD, mescaline, hallucinogens.
- 13 _____ Cocaine.
- 14 _____ Heroin.
- 15 _____ Methadrine, methamphetamine ("speed").
- 16 _____ Amphetamines ("uppers, pep pills, bennies, dexies").
- 17 _____ Barbiturates ("downers, barbs, blues, reds").
- 18 _____ Methaqualone ("sopors, Vitamin Q").
- 19 _____ Tranquilizers (Darvon, Librium, Valium).
- 20 _____ Alcohol.
- 21 _____ Cough syrup, codeine.
- 22 _____ Glue, inhalants.
- 23 _____ Poly-drug use (more than one drug at one time).

- 24 4. Do you believe that the drug problem in your school is more or less serious than it was three years ago?

1. _____ More serious.
2. _____ Less serious.
3. _____ About the same.
4. _____ It's still not a problem.

- 25 5. If you believe that the drug problem is more serious, is this because alcohol abuse is more of a problem today?

Yes _____ No _____

- 1, 26 6. What is your age? _____
- 28 7. How many years of experience do you have in teaching? _____
- 30 8. How long have you been in your present position? _____
- 32 9. What is the highest level of education which you have attained?
1. _____ Bachelor's 3. _____ Master's
2. _____ Bachelor's plus 4. _____ Master's plus
5. _____ Doctorate
- 33 10. Are you: Male _____ Female _____
- 34 11. Do you consider yourself: Black _____ White _____ Other _____
- 35 12. How many hours of in-service drug training have you received since 1970?
- _____
13. How many of these training hours were provided by the following:
- State Department of Education
- 36 Intensive workshops _____ hours
- 38 Regional meetings _____ hours
- 40 Other: _____ hours
- 42 Your local school division: _____ hours
- 44 College or University: _____ credit hours
- Please list:
- _____
- _____
- 46 Other: _____
- 48 14. Circle the grade levels in which you are teaching drug education classes this year:
- 1 2 3 4 5 6 7 8 9 10 11 12
- 52 15. In what type of area do most of the students in your school live?
1. _____ Large city 16. In which city or county do you teach?
2. _____ Small city
3. _____ Suburban county _____ 53
4. _____ Rural county
5. _____ Small town
- 56 17. Does your school have a policy for dealing with students who have a drug problem?
1. _____ Yes
2. _____ No
3. _____ Don't know

18. We would like you to evaluate the one drug training program which you considered to be most beneficial in helping you to perform as a health teacher. How effective was this program in the following respects:

		<u>Not at all</u>				<u>Extremely</u>
		<u>Helpful</u>				<u>Helpful</u>
1, 57	Recognizing the basic classifications of drugs and the symptoms of their abuse:	1	2	3	4	5
58	Understanding the reasons for drug use among students:	1	2	3	4	5
59	Increasing your ability to communicate openly and honestly with students:	1	2	3	4	5
60	Learning to distinguish between drug experimentation, use, and abuse:	1	2	3	4	5
61	Learning more about local treatment programs and other community resources:	1	2	3	4	5
62	Learning to help students to better understand themselves, so that they can make their own decisions regarding the use of drugs:	1	2	3	4	5
63	Learning to help individual students who may have problems:	1	2	3	4	5
64	Learning how to involve students in the educational process:	1	2	3	4	5
65	19. Who sponsored the program you considered to be most beneficial?					

1. _____ State Department of Education
2. _____ Your local school division
3. _____ College or University
4. _____ Other: _____

20. How important do you believe the following objectives should be in your school's efforts for dealing with drug abuse?

		Not at all Important			Extremely Important		
1,66	Warning students about the dangers of drug abuse:	1	2	3	4	5	
67	Providing factual information about drugs:	1	2	3	4	5	
68	Exploring the reasons why people use both legal and illegal drugs:	1	2	3	4	5	
69	Distinguishing between drug experimentation, use, and abuse:	1	2	3	4	5	
70	Developing interpersonal and group communication skills:	1	2	3	4	5	
71	Helping students to learn more about themselves, so that they can make their own decisions regarding the use of drugs:	1	2	3	4	5	
72	Providing counseling services for individual students with problems:	1	2	3	4	5	
73	Working directly with parents to help alleviate family problems:	1	2	3	4	5	
74	Referring students with problems to local community services:	1	2	3	4	5	
75	Involving students in drug abuse curriculum development and evaluation:	1	2	3	4	5	
76	Helping students to explore positive alternatives to drug use:	1	2	3	4	5	
77	21. Approximately how many hours per class would you estimate that you actually spend teaching drug education in each school year? _____						
79	22. Approximately how many students are enrolled in your typical drug education class this year? _____						

23. Do you disagree or agree with the following statements about the effectiveness of drug education programs:

		Disagree <u>Strongly</u>			Agree <u>Strongly</u>		
2, 7	Providing factual information about the harmful effects of drug abuse will prevent students from using drugs:	1	2	3	4	5	
8	Drug education has helped to make students more aware of the facts about drugs:	1	2	3	4	5	
9	Drug education has helped to reduce the level of drug <u>experimentation</u> in my school:	1	2	3	4	5	
10	Drug education has helped to reduce the level of <u>serious drug problems</u> among students in my school:	1	2	3	4	5	
11	In order to be more effective in the future, drug education should concentrate on helping students to understand themselves, their emotions, and their own motivations for using drugs:	1	2	3	4	5	
12	Group discussions are generally more effective than lectures:	1	2	3	4	5	
13	My main goal as a teacher is to provide information to the students:	1	2	3	4	5	
14	The main goal of drug education is to reduce the incidence of drug <u>use</u> :	1	2	3	4	5	
15	We should concentrate more on the positive aspects of health and mental health:	1	2	3	4	5	

24. Do you agree or disagree with the following statements about drug abuse:

		Disagree Strongly				Agree Strongly
2,16	Drug abuse means using any drug for non-medical purposes:	1	2	3	4	5
17	Alcoholism is a much more serious problem today than abuse of any other drug:	1	2	3	4	5
18	Laws against marijuana should be made more severe:	1	2	3	4	5
19	Alternatives, such as treatment programs, should be provided for arrested drug users:	1	2	3	4	5
20	Police should concentrate on arresting people who sell drugs rather than on those who use them:	1	2	3	4	5
21	Most people try drugs because their friends use them:	1	2	3	4	5
22	25. Do you think that that drug education has helped to reduce the level of drug abuse in your school?					

Yes _____ No _____

Briefly explain why or why not:

26. How would you like to see in-service training programs for health and/or drug education improved in the future?

Thank you for your cooperation!

DRUG TRAINING AND EDUCATION SURVEY

(Counselors)

Office Use
Only

- 5 1. How would you describe the level of drug use (not including alcohol) in your
6 school? (You may check more than one)
7
1. _____ None or very little.
2. _____ Limited number of experimental users.
3. _____ Widespread experimental use.
4. _____ Limited number of occasional users.
5. _____ Widespread occasional use.
6. _____ Limited number of habitual users.
7. _____ Widespread habitual use.
- 8 2. Based on your estimate of drug usage, how would you describe the drug
problem in your school?
1. _____ No problem.
2. _____ A problem, but not serious.
3. _____ A serious problem.
3. What are the most frequently used drugs in your school? For each drug,
write 1, 2, 3, or 4 in the space provided, according to whether you
believe the drug is not used, or is used experimentally, occasionally,
or habitually.
- | | |
|----------------------|--------------------|
| 1 - <u>not</u> used | 3 - occasional use |
| 2 - experimental use | 4 - habitual use |
- 9 _____ Marijuana, hashish.
10 _____ LSD, mescaline, hallucinogens.
11 _____ Cocaine.
12 _____ Heroin.
13 _____ Methadrine, methamphetamine ("speed").
14 _____ Amphetamines ("uppers, pep pills, bennies, dexise").
15 _____ Barbiturates ("downers, barbs, blues, reds").
16 _____ Methaqualone ("sopors, Vitamin Q").
17 _____ Tranquilizers (Darvon, Librium, Valium).
18 _____ Alcohol.
19 _____ Cough syrup, codeine.
20 _____ Glue, inhalants.
21 _____ Poly-drug use (more than one drug at one time).
- 22 4. Do you believe that the drug problem in your school is more or less serious
than it was three years ago?
1. _____ More serious.
2. _____ Less serious.
3. _____ About the same.
4. _____ It's still not a problem.
- 23 5. If you believe that the drug problem is more serious, is this because
alcohol abuse is more of a problem today?

Yes _____ No _____

- 24 6. What is the counselor's caseload in your school?
- One counselor for every _____ students.
- 27 7. How much of your time would you estimate that you spend counseling students who have personal problems, as opposed to academic advising?
1. _____ None
2. _____ 0-10%
3. _____ 11-25%
4. _____ 26-50%
5. _____ More than 50%
- 28 8. Of those students whom you do counsel for personal problems, how many would you estimate have problems associated with drugs?
1. _____ None
2. _____ 0-10%
3. _____ 11-25%
4. _____ 26-50%
5. _____ More than 50%
- 29 9. How many students did you counsel for problems associated with drugs during the last school year? _____
- 31 10. How many of these had a serious drug problem? _____
- 33 11. How many of those with a serious drug problem did you refer to some other person or agency? _____
- 35 Parents. _____
- 37 Personal or family physician. _____
- 39 Community social agency. _____
- 41 Treatment program. _____
- 43 School psychologist. _____
- 45 Other: _____
- 47 12. Do you consider the social service resources in your community adequate to meet the existing drug problems that you face in the schools?
- Yes _____ No _____
- 48 13. Approximately how many hours of in-service training have you received since 1970 in the field of drug abuse? _____
14. How many of those training hours were provided by:
- 50 State Department of Education: _____ hours
- 52 Your local school division: _____ hours
- 54 College or university course: _____ credit hours
- 56 Other: _____ hours
- 58 15. What is the highest level of education which you have attained?
1. _____ Bachelor's 3. _____ Master's
2. _____ Bachelor's plus 4. _____ Master's plus
5. _____ Doctorate

59

16. In what type of area do most of the students in your school live?

1. _____ Large city

2. _____ Small city

3. _____ Suburban county

4. _____ Rural county

5. _____ Small town

17. In what city or county is your school located?

60

63

18. Is your school a:

1 _____ Senior high school

2 _____ Middle or Junior high school

3 _____ Combined school

19. We would like you to evaluate the one drug training program you considered to be most beneficial in helping you to perform as a counselor. How effective was this program in the following respects:

	Not at all				Extremely
	Helpful				Helpful
64 Recognizing the basic classifications of drugs and the symptoms of their abuse:	1	2	3	4	5
65 Understanding the reasons for drug use among youth:	1	2	3	4	5
66 Increasing your ability to communicate openly and honestly with students:	1	2	3	4	5
67 Learning to distinguish among drug experimentation, use, and abuse:	1	2	3	4	5
68 Learning more about treatment programs and other community resources:	1	2	3	4	5
69 Learning to help students better understand themselves, so that they are capable of making their own decisions:	1	2	3	4	5
70 Learning new counseling techniques to help individual students who may have problems:	1	2	3	4	5
71 Who sponsored the program you considered to be most beneficial?					
	<p>1. _____ State Department of Education</p> <p>2. _____ Your local school division</p> <p>3. _____ College or University</p> <p>4. _____ Other: _____</p>				

20. Do you agree or disagree with the following statements about drug abuse:

		Disagree <u>Strongly</u>				Agree <u>Strongly</u>
72	Drug abuse means using any drug for non-medical purposes:	1	2	3	4	5
73	Alcoholism is a much more serious problem today than abuse of any other drug:	1	2	3	4	5
74	Laws against marijuana should be made more severe:	1	2	3	4	5
75	Alternatives, such as treatment programs, should be provided for arrested drug users:	1	2	3	4	5
76	Police should concentrate on arresting people who sell drugs rather than on those who use them:	1	2	3	4	5
77	Most people try drugs because their friends use them:	1	2	3	4	5
78	Counselors should be employed in elementary schools to provide early intervention for potential drug abusers:	1	2	3	4	5
79	Counselors in my school spend too much time doing clerical work, and not enough time counseling students:	1	2	3	4	5
80	Drug education has helped to reduce the level of drug abuse in my school:	1	2	3	4	5

21. How would you like to see training programs for counselors improved in the future?

Thank you for your cooperation!

APPENDIX IV

SENATE JOINT RESOLUTION NO. 60

1

2 *Directing the Department of State Police and all other law-enforcement*
3 *agencies in the Commonwealth to expend their major efforts in the*
4 *investigation of individuals who are engaged in the trafficking of the*
5 *drugs which present the most harm and danger to both the user and*
6 *society as a whole.*

7

8

Offered February 21, 1972

9

10

Patrons—Messrs. Walker and Aldhizer

11

12

Referred to the Committee on Rules

13

14 Whereas, the safety of the citizens of Virginia is of the utmost con-
15 cern to the General Assembly of Virginia; and

16 Whereas, the law enforcement agencies in the Commonwealth have
17 the responsibility for enforcing all laws relating to the trafficking and
18 abuse in all illegal drugs; and

19 Whereas, these agencies lack sufficient resources of manpower and
20 money to eliminate trafficking and abuse in all instances of illegal drugs;
21 and

22 Whereas, the recent report of the Organized Crime Detection Task
23 Force of the Virginia State Crime Commission attributes a portion of the
24 reason for the low level of, and lack of success in, drug law enforcement to
25 the lack of the establishment of any priorities toward the investigation of
26 the traffickers in the drugs which are more harmful to the users and to
27 society; and

28 Whereas, that same report states that the majority of the arrests for
29 drug violations in the Commonwealth during the first eight months of nine-
30 teen hundred seventy-one were for marihuana violations; and

31 Whereas, that same report states that in the same period of time, the
32 total drug arrests, with few exceptions, were at the user level which did
33 not involve or even affect the major traffickers; and

34 Whereas, the recent report of the Virginia State Crime Commission
35 states that the drug problem will not be significantly attacked until it is
36 possible to break up distribution at the major sources in the Commonwealth;
37 and

Senate Joint Resolution No. 60 2

1 Whereas, the recent report of the Commission on Narcotic and Drug
2 Laws ascribes to the trend toward more leniency toward drug users and
3 harsh punishments for distributors for profit; and

4 Whereas, on January twenty-eight, nineteen hundred seventy-one,
5 the President of the United States established the office of Drug Abuse Law
6 Enforcement which will draw on the United States Departments of Justice
7 and Treasury to assist State and local agencies in detecting, arresting and
8 prosecuting heroin traffickers; and

9 Whereas, the individuals involved in the distribution of heroin are
10 members of the hard-core, highly-organized criminal groups with direct
11 connections to the organized crime "families"; and

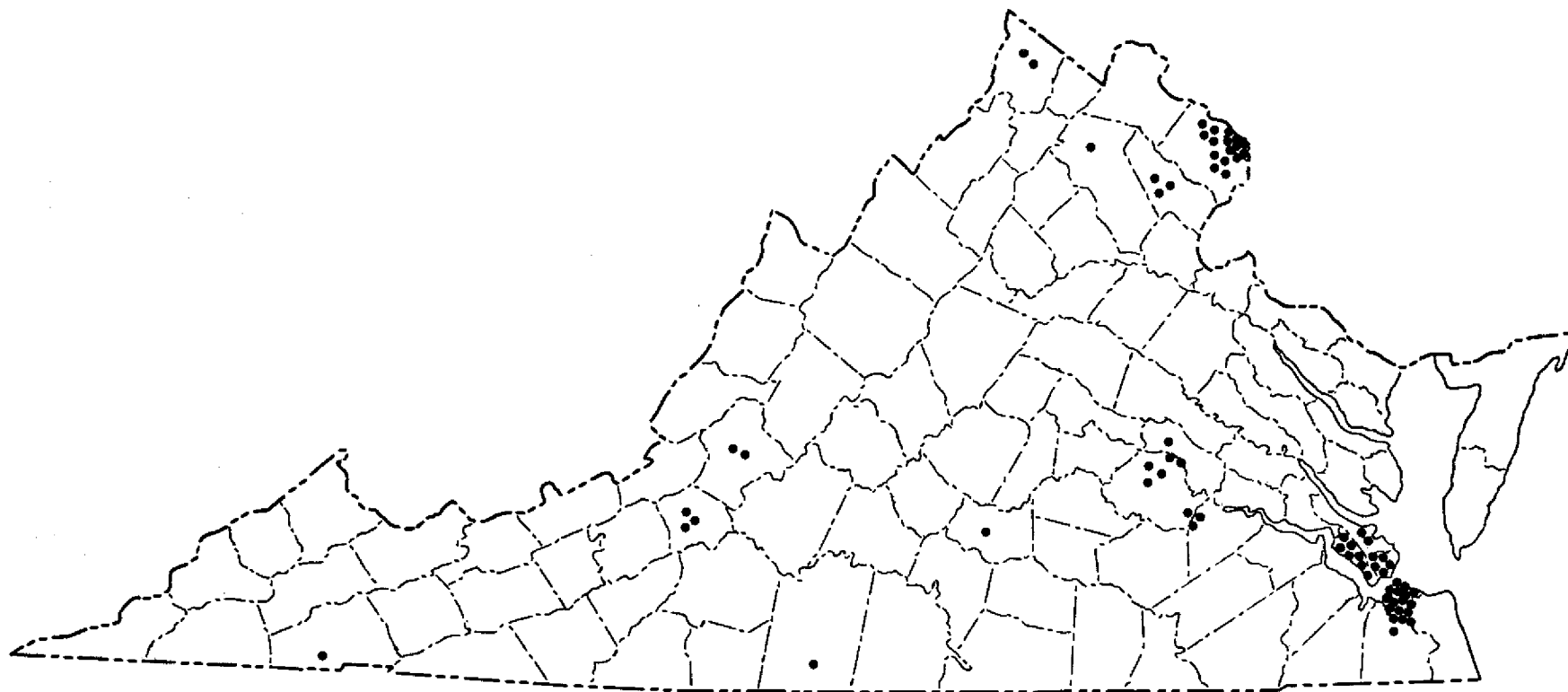
12 Whereas, heroin addicts require large daily sums of money to support
13 their habit for which monies they must resort to many of the crimes which
14 have frightened our population and paralyzed our cities; now, therefore,
15 be it

16 Resolved by the Senate of Virginia, the House of Delegates concur-
17 ring, That the Department of State Police and all other law-enforcement
18 agencies in the Commonwealth of Virginia are hereby directed to expend
19 their major efforts in the investigation of individuals who are engaged in
20 the trafficking and the abuse of the drugs which present the most danger
21 and harm to both the user and society as a whole.

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STATE POLICE HEROIN ARRESTS
1974

A-29



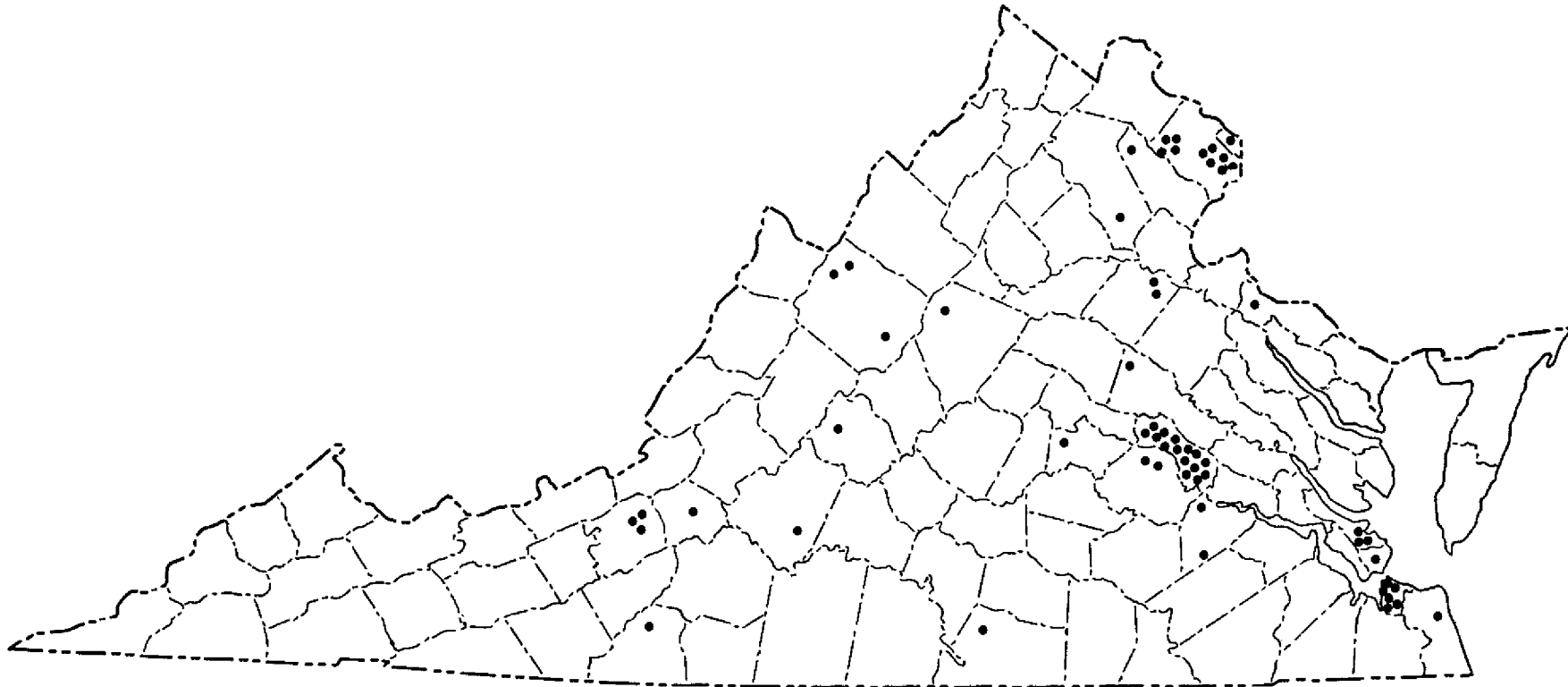
1 dot = 1 arrest
Total = 70 arrests

Note: Total arrests may include cases in which more than one drug was seized.

Source: Prepared by JLARC from data supplied by Department of State Police.

STATE POLICE COCAINE ARRESTS
1974

A-30



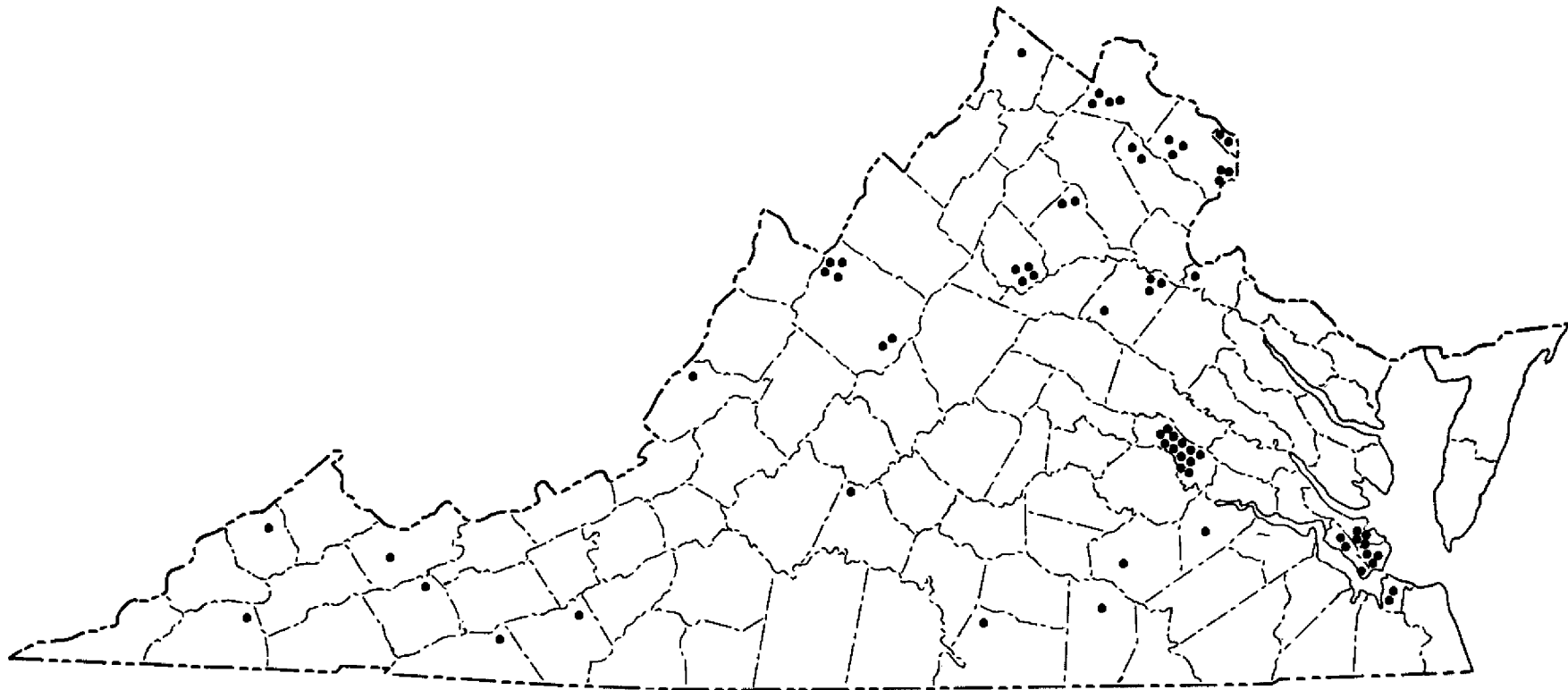
1 dot = 1 arrest
Total = 60 arrests

Note: Total arrests may include cases in which more than
one drug was seized.

Source: Prepared by JLARC from data supplied by Department
of State Police.

STATE POLICE BARBITURATES ARRESTS
1974

A-31

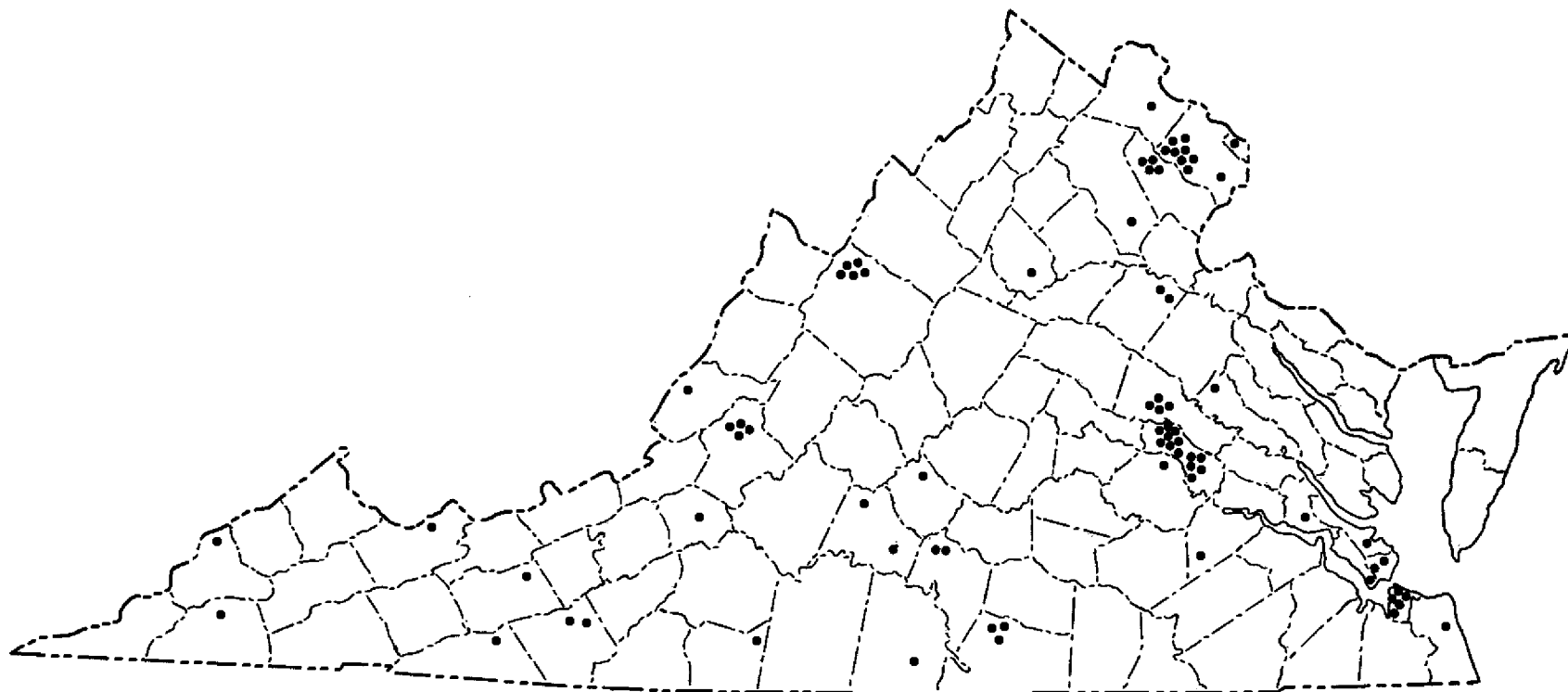


1 dot = 1 arrest
Total = 68 arrests

Note: Total arrests may include cases in which more than
one drug was seized.

Source: Prepared by JLARC from data supplied by Department
of State Police.

A-32

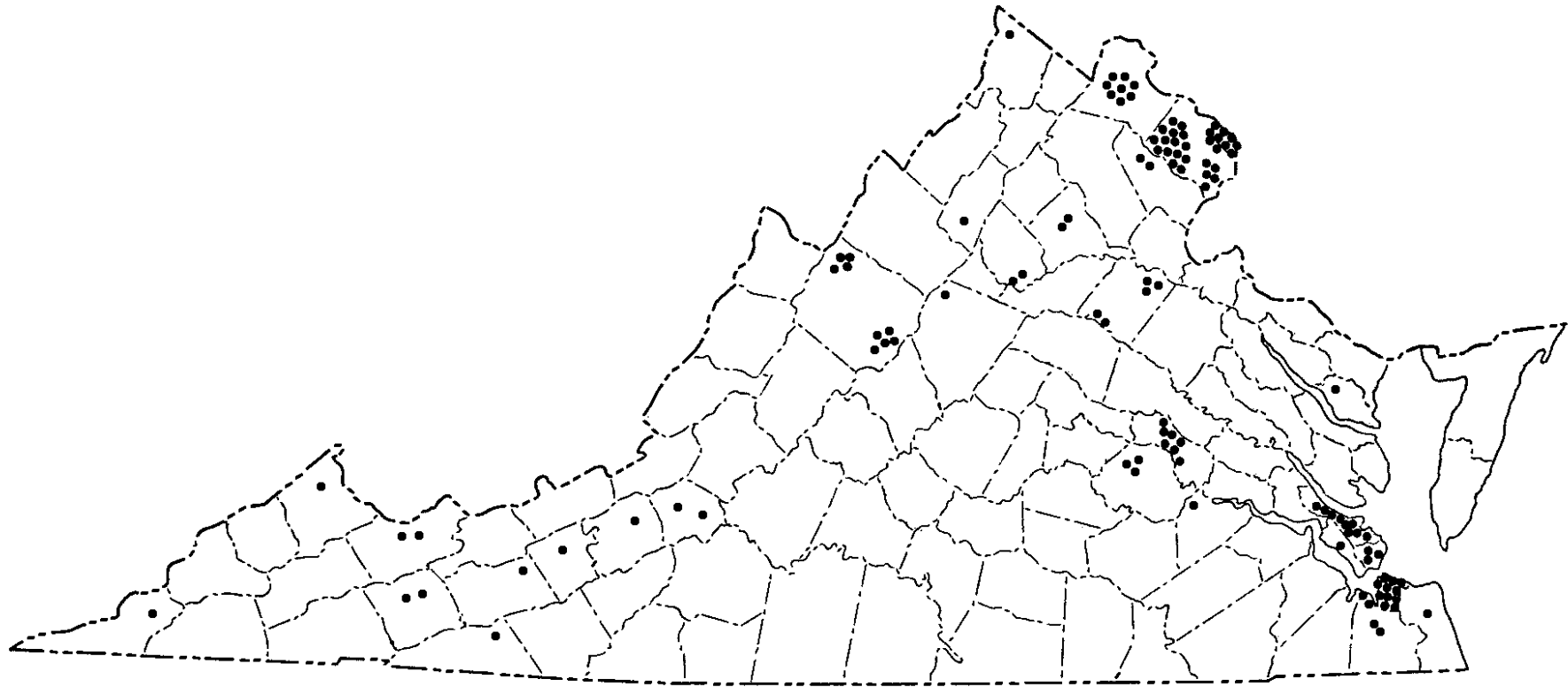


Note: Total arrests may include cases in which more than one drug was seized.

Source: Prepared by JLARC from data supplied by Department of State Police.

STATE POLICE LSD ARRESTS
1974

A-33



1 dot = 1 arrest
Total = 114 arrests

Note: Total arrests may include cases in which more than
one drug was seized.

Source: Prepared by JLARC from data supplied by Department
of State Police.

STATE POLICE MARIJUANA ARRESTS 1974

Alexandria	20
Arlington	11
City of Fairfax	4
Fairfax Co.	38
Loudoun Co.	37
Prince William Co.	31

Augusta Co.
Waynesboro

35
36

Fredericksburg 29

Henrico Co. 59
Richmond 125
Chesterfield Co. 28

Chesapeake	29
Hampton	46
Newport News	55
Norfolk	103
Portsmouth	14
Virginia Beach	22
York Co.	12

1 dot = 1 arrest
Total = 1,312 arrests

Note: Total arrests may include cases in which more than one drug was seized.

Source: Prepared by JLARC from data supplied by Department of State Police.

Table IV-1

Requests Solely from Police and
 Sheriffs' Departments for Drug Investigation Assistance
 July 1 - December 31, 1974

<u>Office</u>	<u>Requesting Agency</u>	<u>No. of Requests</u>
Richmond	PD Richmond	29
	PD Henrico	14
	PD Fairfax County	4
	SO Hanover	1
Culpeper	PD Alexandria	4
	PD Arlington	4
	SO Madison County	4
	SO Orange County	3
	SO Stafford County	1
Appomattox	PD Chase City	1
	PD Staunton	1
	SO Augusta County	1
	SO Campbell County	2
	SO Cumberland County	1
	SO Rockingham County	11
Wytheville	SO Scott County	1
Chesapeake	PD Chesapeake	2
	PD Hampton	19
	PD Hopewell	3
	PD Newport News	6
	PD Norfolk	9
	PD Portsmouth	2
	PD Suffolk	4
	PD Virginia Beach	2
	SO Northampton County	1
	SO Prince George County	3
	SO Southampton County	1
	SO Surry County	3
Salem	PD Danville	1
	SO Roanoke County	3
	SO Alleghany County	1

Table IV-2

NUMBER OF PERSONS ARRESTED AND
NUMBER OF DRUG CHARGES BY DIVISION

July through December 1974

	Division I Charges	Division II Charges	Division III Charges	Division IV Charges	Division V Charges	Division VI Charges	Total
Possession	295	49	64	30	239	24	701
Distribution	104	146	92	53	281	61	737
Manufacture	4	8	2	4	10	2	30
TOTAL	403	203	158	87	530	87	1,468 *
No. Persons Arrested	270	152	81	83	422	74	1,082

*On August 28, 1975, JLARC was provided with the following statistics. These did not include cases which had been microfilmed.

TOTAL

Possession	637
Distribution	699
Manufacture	29
	<u>1,365</u>

Possession	701	47.8%
Distribution	737	50.2%
Manufacture	30	2.0%
	<u>1,468</u>	<u>100.0%</u>

POLICE TRAINING SURVEY

1. How many officers do you currently have on your force? _____
2. Do you have a separate drug or vice investigative unit which handles all drug investigations?

☐ Yes

☐ No

If yes, how many officers are currently assigned, either full or part-time, to drug investigations? _____

3. How many officers have received special training in drug enforcement?

4. How many of these are members of a special drug or vice investigative unit?

5. Where did they receive their training (please list all sources)?

- ☐ Your own police training school
☐ Another local jurisdiction's police training school
☐ Community College
☐ Other College or University
☐ A regional police training academy
☐ State Police
☐ Drug Enforcement Administration
☐ Other (please list)
- _____
- _____

6. How many hours of basic training are required of your recruits? _____
7. If basic training is required, how many hours of drug enforcement training are included? _____
8. Where do your officers receive their basic training?

- ☐ Your own police training school
☐ Another local jurisdiction's police training school
☐ Community College
☐ Other College or University
☐ A regional police training academy
☐ State Police
☐ Other (please list)
- _____
- _____

9. Would you favor a regional police training facility in your area which would handle all basic and specialized police training?

☐ Yes
☐ No

10. Do you believe that the basic training now available for your recruits is sufficient to meet your needs for the immediate future?

☐ Yes
☐ No

If no, what should be given great emphasis:

11. Would you favor the creation of a state-wide police training academy, which would handle all basic and specialized police training?

☐ Yes
☐ No

If yes, who should operate such a facility?

- ☐ A College or University
☐ Jointly by all local participating police agencies
☐ State Police
☐ Department of Education
☐ Criminal Justice Officers Training and Standards Commission
☐ Other (please list)

12. How could the Criminal Justice Officers Training and Standards Commission better serve your needs at the local level?

13. How closely do you cooperate with the following agencies in drug investigations (please circle your answer)?

	A Lot				Very Little
a. The ABC Board	1	2	3	4	5
b. The State Police	1	2	3	4	5
c. The Drug Enforcement Administration	1	2	3	4	5
d. Other Local Police Departments	1	2	3	4	5

Table IV-3

LOCAL DRUG ARRESTS IN VIRGINIA

	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>
Reporting Agencies	4,245	5,677	7,942	9,383
Other Local Agencies ^a	<u>1,061</u>	<u>1,419</u>	<u>1,985</u>	<u>2,346</u>
Total	5,306	7,096	9,927	11,729

^aDrug arrests by reporting agencies were estimated to be 80% of all local drug arrests. Therefore, an additional 20% was added to determine total local arrests.

Source: JLARC Survey of local enforcement agencies.

Table IV-4

ADULT AND JUVENILE
DRUG ARRESTS

	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>
<u>Counties</u>				
Arlington	398	381	444	343
Fairfax	906	808	667 ^a	763 ^a
Chesterfield	56	138	140	337
Henrico	46*	105*	232*	201*
Loudoun	22	28	21	98
<u>Cities</u>				
Alexandria	197	315	225	362
Chesapeake	109	261	559	511
Danville	12	23	81	63
Fairfax	75	39	73	122
Falls Church	32	17	35	79
Hampton	206	460	544	912
Hopewell	34*	13*	53*	43*
Lynchburg	39	43	89	118
Newport News	165*	595*	830*	574*
Norfolk	514 ^b	707	786	1,264
Petersburg	82	96	190	186
Portsmouth	140	206	296	283
Richmond	592*	752*	1,796*	1,786*
Roanoke	103*	176*	277	270
Staunton	16	28	20	30
Virginia Beach	398	476	572	977
Waynesboro	<u>6</u>	<u>10</u>	<u>12</u>	<u>61</u>
Total	4,245 ^c	5,677	7,942	9,383

^aArrests made by Intelligence Division only.^bExcludes 97 juvenile arrests.^cIncludes 97 juvenile arrests.

*This figure was determined by dividing drug charges submitted by local enforcement agencies by a factor of 1.26 in order to obtain the number of persons actually arrested for drug violations.

Source: JLARC Survey of local law enforcement agencies,
November, 1974.

Table IV-5

MARIJUANA AND HASHISH
ARRESTS

	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>
<u>Counties</u>				
Arlington	254*	262*	292*	241
Fairfax	331	305	440 ^a	489 ^a
Chesterfield	NA	NA	NA	269
Henrico	23*	68*	147*	109*
Loudoun	16	26	16	85
<u>Cities</u>				
Alexandria	106	205	199	233
Chesapeake	20	157	456	435
Danville	4	12	48	52
Fairfax	48	28	57	87
Falls Church	11	11	18	30
Hampton	140	299	504	821
Hopewell	28*	8*	41*	25*
Lynchburg	18	28	74	89
Newport News	84*	345*	486*	491
Norfolk	227	416	592	961
Petersburg	28	39	96	134
Portsmouth	15	94	192	197
Richmond	194*	357*	1,154*	1,222*
Roanoke	36*	69*	214	225
Staunton	9	16	14	30
Virginia Beach	217	346	451	906
Waynesboro	<u>6</u>	<u>6</u>	<u>12</u>	<u>57</u>
Total	1,815	3,097	5,503	7,188

^aArrests made by Intelligence Division only.

*Charges were divided by 1.26 to obtain persons arrested.

Source: JLARC Survey of local law enforcement agencies,
November, 1974.

Table IV-6

OPIUM, COCAINE OR THEIR
DERIVATIVES ARRESTS

	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>
<u>Counties</u>				
Arlington	49*	37*	29*	42*
Fairfax	51	42	24 ^a	43 ^a
Chesterfield	NA	NA	NA	NA
Henrico	2*	7*	11*	12*
Loudoun	3	1	3	10
<u>Cities</u>				
Alexandria	77	74	16	75
Chesapeake	3	23	34	7
Danville	3	3	2	2
Fairfax	7	1	1	4
Falls Church	4	4	3	-
Hampton	17	41	20	60
Hopewell	2*	2*	2*	9*
Lynchburg	4	4	10	18
Newport News	49*	146*	172*	53
Norfolk	230	194	115	154
Petersburg	5	25	40	22
Portsmouth	105	90	72	62
Richmond	182*	187*	164*	94*
Roanoke	6*	15*	13	5
Staunton	-	2	-	-
Virginia Beach	40	22	13	28
Waynesboro	-	-	-	-
Total	839	920	744	700

^aArrests made by Intelligence Division only.

*Charges were divided by 1.26 to obtain persons arrested.

Source: JLARC Survey of local law enforcement agencies,
November, 1974.

Table IV-7
SYNTHETIC DRUG ARRESTS

	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>
<u>Counties</u>				
Arlington	76*	64*	52*	31
Fairfax	71	57	NA	NA
Chesterfield	NA	NA	NA	NA
Henrico	16*	21*	60*	20*
Loudoun	3	1	2	3
<u>Cities</u>				
Alexandria	1	11	9	13
Chesapeake	1	1	-	1
Danville	3	-	21	4
Fairfax	9	1	5	24
Falls Church	10	1	4	47
Hampton	49	120	20	15
Hopewell	3*	-	10*	6*
Lynchburg	8	5	13	3
Newport News	32*	103*	172*	13
Norfolk	18	25	29	75
Portsmouth	8	17	31	20
Richmond	15*	17*	59*	40*
Roanoke	2*	6*	11	4
Staunton	3	4	2	-
Virginia Beach	49	42	42	20
Waynesboro	-	4	-	4
Total	377	500	542	343

*Charges were divided by 1.26 to obtain persons arrested.

Source: JLARC Survey of local law enforcement agencies,
November, 1974.

APPENDIX V

Table V-1
VIRGINIA DRUG LAWS

(Effective October 1, 1975)

Prohibited Acts and Penalties

DRUG	POSSESSION	Manufacture, sell, give, distribute or possess with intent to manufacture, sell, give or distribute	Distribution by persons at least 18 years of age to persons under 18 and at least 3 years their junior
Schedule I (§54-524.84:4) Narcotics such as heroin Hallucinogens such as marijuana, PCP, LSD, THC, mescaline, peyote, etc.	Not less than 1 year nor more than 10 years or, in the discretion of the court or the jury, up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-250(a)) Marijuana exception - up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-250(b))	5 to 40 years imprisonment and up to \$25,000 fine (§18.2-248(a))* Accommodation exception - not less than 1 year, nor more than 10 years or, in the discretion of the court or the jury, up to 12 months confinement and up to \$1,000 fine, either or both. If a person gives, distributes, or possesses with intent to give or distribute marijuana only as an accommodation, then up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(n))	10 to 50 years and up to \$50,000 fine (§18.2-255)
Schedule II (§54-524.84:6) The amphetamines, opium and prescription narcotics such as methadone, morphine and codeine	Not less than 1 year nor more than 10 years or in the discretion of the court or the jury, up to 12 months confinement, and up to \$1,000 fine, either or both. (§18.2-250(a))	5 to 40 years imprisonment and up to \$25,000 fine (§18.2-248(a))* Accommodation exception - not less than 1 year nor more than 10 years or, in the discretion of the court or the jury, up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(n))	10 to 50 years and up to \$50,000 fine (§18.2-255)
Schedule III (§54-524.84:8) Certain barbiturates	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-250(b))	5 to 40 years imprisonment and up to \$25,000 fine (§18.2-248(a)) Accommodation exception - Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(n))	10 to 50 years and up to \$50,000 fine (§18.2-255)
Schedule IV (§54-524.84:10) Barbital, mephobarbital, phenobarbital, etc.	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-260)	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(b))	No special penalties
Schedule V (§54-524.84:12) Substances containing limited quantities of certain narcotics combined with medicinal ingredients.	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-260)	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(b))	No special penalties
Schedule VI (§54-524.84:13) Prescription drugs not included in above schedules.	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-260)	Up to 12 months confinement and up to \$1,000 fine, either or both. (§18.2-248(b))	No special penalties

* Second or subsequent conviction involving opiate or synthetic opiate drug: in the discretion of the court or jury imposing the sentence - 5 years to life

DEFERRED JUDGMENT
QUESTIONNAIRE - PROBATION AND PAROLE
(July 1, 1973 to Present)

PLEASE ANSWER THE FOLLOWING QUESTIONS CONCERNING THE USE OF THE DEFERRED JUDGMENT STATUTE AND ITS EFFECTS ON THE PROBATION AND PAROLE SYSTEM.

1. My probation and parole district serves a predominately:
Rural area _____.
Suburban area _____.
Urban area _____.
2. What is your district's total probation and parole caseload? _____
3. How many officers do you now have? _____
4. Since July 1973, how many deferred judgment, probation cases has your office carried? _____.

How many deferred judgment, probation cases are you now carrying? _____

Are most of these cases for possession of marijuana? Yes _____. No _____.
5. Since July 1973, has the number of deferred judgment, probation cases been increasing relative to your office's total caseload? Yes _____. No _____.
6. Are the courts granting more deferred judgments now than six months ago? Yes _____. No _____.

Do you expect the courts to make greater use of this statute in the future? Yes _____. No _____.
7. If your caseload has increased because of deferred judgment cases, have you requested or received in the past twelve months, (or will you request in the next twelve months), additional probation and parole officers?
Yes _____. No _____.

If yes, how many? Received _____. Requested _____. To be requested _____.
8. Does your office have a probation and parole officer assigned specifically to deferred judgment cases? Yes _____. No _____.

If yes, what is the officer's caseload? _____.
9. Since July 1973, how many persons granted a deferred judgment have violated the terms and conditions of their probation? _____.
10. Are you experiencing any problems with transferring active deferred judgment cases to other probation and parole districts, or states? Yes _____. No _____.

If yes, please explain: _____

11. In your opinion, should all persons granted deferred judgment be placed on supervised probation? Yes _____. No _____.

If no, explain alternative: _____

12. Compared to other active probation and parole cases, my officers devote
less ☐
equal ☐
more ☐ supervisory time to deferred judgment cases.

If less, explain: _____

13. Do many persons granted a deferred judgment receive any type of treatment for drug abuse? Yes ☐. No ☐.

If yes, what percent would you estimate?

0 to 5% <input type="checkbox"/>	11 to 20% <input type="checkbox"/>	31 to 40% <input type="checkbox"/>
6 to 10% <input type="checkbox"/>	21 to 30% <input type="checkbox"/>	41 to 50% <input type="checkbox"/>

14. In your probation and parole district, do all judges (includes only those hearing drug cases) equally apply the deferred judgment statute to possession cases involving first-time marijuana offenders? Yes ☐. No ☐.

ADDITIONAL COMMENTS:

Address: _____

THANK YOU FOR YOUR COOPERATION.

Table V-2

SUSPENDED SENTENCES BY LENGTH OF SENTENCE OF DRUG OFFENSE
N = 437

Length of Sentence	Offense					
	Possession	Possession With Intent	Distribution	Accommodation	Manufacture	Unknown
1 to 30 Days	93 (60.0%)	5 (41.7%)	3 (42.9%)	---	1 (100.0%)	5 (62.5%)
31 to 60 Days	23 (65.7%)	1 (50.0%)	---	---	---	---
61 to 90 Days	99 (74.4%)	8 (100.0%)	1 (50.0%)	---	1 (100.0%)	1 (100.0%)
6 Months	36 (66.3%)	10 (90.9%)	2 (28.6%)	---	1 (100.0%)	2 (66.6%)
1 Year	36 (56.3%)	22 (73.3%)	21 (56.8%)	13 (81.3%)	1 (100.0%)	2 (40.0%)
2 to 4 Years	3 (27.3%)	5 (45.5%)	4 (57.1%)	---	---	---
More than 4 Years	3 (30.0%)	2 (18.2%)	16 (51.6%)	2 (28.6%)	---	1 (33.3%)
Unknown	5 (55.6%)	---	5 (100.0%)	---	---	4 (100.0%)
Total	298 (63.3%)	53 (62.4%)	52 (53.1%)	15 (46.8%)	4 (100.0%)	15 (71.4%)

Table V-3

AMOUNT OF FINE BY TYPE OF DRUG OFFENSE
N = 613

Amount of Fine	Offense						Total
	Possession	Possession With Intent	Distribution	Accommodation	Manufacture	Unknown	
\$1 to \$100	189 (41.8%)	16 (28.1%)	19 (42.2%)	9 (75.0%)	1 (25.0%)	23 (53.5%)	257 (41.9%)
\$101 to \$200	64 (14.2%)	6 (10.5%)	4 (8.9%)	2 (16.7%)	1 (25.0%)	4 (9.3%)	81 (13.2%)
\$201 to \$300	183 (40.5%)	18 (1.6%)	9 (20.0%)	---	2 (50.0%)	2 (50.0%)	214 (34.9%)
\$301 to \$999	12 (2.6%)	13 (22.8%)	8 (17.8%)	---	---	3 (7.0%)	36 (5.9%)
\$1000 +	1 (.2%)	4 (7.0%)	3 (6.7%)	1 (8.3%)	---	---	9 (1.5%)
Unknown	3 (.7%)	---	2 (4.4%)	---	---	11 (25.6%)	16 (2.6%)
Total	452 (100.0%)	57 (100.0%)	45 (100.0%)	12 (100.0%)	4 (100.0%)	43 (100.0%)	613 (100.0%)

Source: Department of State Police, CCRE Case Disposition.

THE FOLLOWING QUESTIONS APPLY ONLY TO GENERAL DISTRICT COURTS.

1. At the general district court level, do judges have a problem obtaining sufficient background information on persons eligible for a deferred judgment? Yes ☐ No ☐

If yes, has this resulted in some persons being granted a deferred judgment even though there was a prior conviction record? Yes ☐ No ☐

2. Should probation and parole officers prepare a record check on persons before a judge grants a deferred judgment? Yes ☐ No ☐

If yes, should probation and parole officers be specifically assigned to district court judges to perform this function? Yes ☐ No ☐

ADDITIONAL COMMENTS:

Address: _____

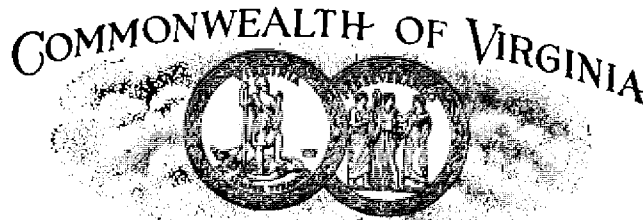
THANK YOU FOR YOUR COOPERATION.

APPENDIX VI

WALLACE B. THACKER
PRESIDENT
LYNCHBURG

LINWOOD S. LEAVITT
VICE-PRESIDENT
VIRGINIA BEACH

WILLIAM R. MATNARD, JR.
RICHMOND



THOMAS W. RORER, JR.
WAYNESBORO

THOMAS F. MARSHALL, JR.
URBANNA

J. E. CARSON
804/770-2031

JUL 14 1975

STATE BOARD OF PHARMACY

SUITE 206 INSURANCE BUILDING
10 SOUTH TENTH STREET
RICHMOND, VA. 23219

July 8, 1975

Mr. Philip A. Leone
Senior Legislative Analyst
Joint Legislative Audit and Review Committee
1823 East Main Street
Richmond, Virginia 23223

Dear Mr. Leone:

Since approximately November 1974, at your request, the following state Correctional Units were inspected with respect to their drug handling procedures:

1. Pocahontas Correctional Unit, #3
Chesterfield, Va.
2. State Industrial Farm for Women
Goochland, Va.
3. Botetourt Correctional Unit, Camp 25
Troutville, Va.
4. Wise Correctional Unit 18
Coeburn, Va.
5. Adult Correctional Enterprises, Unit #22
Chesapeake, Va.
6. Haynesville Correctional Unit
Haynesville, Va.
7. Caroline Correctional Unit, #2
Hanover, Va.
8. New Kent Correctional Unit, #16
Barhamsville, Va.
9. Department of Corrections
Pre-release Activities Center
Chesterfield, Va.
10. Virginia State Penitentiary
Penitentiary Hospital
Richmond, Va.
11. St. Brides
Chesapeake, Va.

Mr. Philip A. Leone


- 2 -

July 8, 1975

The following deficiencies were found to be a general rule at these units.

1. Most of the units maintained a bulk stock of Schedule VI drugs.
2. There was lack of proper security in that unlicensed personnel had access to all schedules of drugs.
3. Unlicensed personnel were administering and dispensing drugs.
4. There was a lack of proper record keeping of Schedule II-V controlled drugs administered and dispensed.
5. Drugs which had been relabeled were improperly labeled and therefore were misbranded.
6. Drugs were being dispensed in paper envelopes and therefore in a manner contrary to all official standards for the dispensing of drugs.

Sincerely yours,


J. B. Carson
Secretary

JBC/r1

APPENDIX VII

CLIENT FOLLOW-UP STUDY METHODOLOGY

JLARC conducted its assessment of drug treatment programs in Spring, 1975. In conducting the study, a random sample of roughly 100 clients was drawn from each of four programs studied. To select the clients JLARC sampled every second, third, or fourth name (whichever was appropriate to reach 100) from a master intake list maintained by each program. Anyone seen by a program since it first opened, through June 30, 1974, was included. A client seen after that date was considered likely to either still be in treatment or to be out for too short a time to be fairly evaluated. A client who first came to a program prior to June 30, 1974, and who was still in the program was, however, included. The table below shows the period of time covered by each program, the number of clients seen, and the size of the final sample.

<u>Program</u>	<u>Period Covered by Sample</u>	<u>Total Clients Seen Thru 6/30/74</u>	<u>Total Clients Sampled</u>
Program A	4/2/73-6/30/74	207	99
Program B	10/7/71-6/39/74	328	107
Program C	11/1/70-6/30/74	834	96
Program D	3/21/73-6/30/74	368	89

Program A and B were both strictly methadone and hence only one master list had to be used. Program C, however, had both a therapeutic community (TC) and an out-patient component. JLARC studied only the TC in this program and used a separate intake log that was available for just this component. Program D also had both a therapeutic community and an out-patient component. JLARC studied both components, however, only one master intake list was available.

Once a name was selected, JLARC pulled the client's file and copied all relevant information on a separate record sheet.^a (For copy of record sheet used, see end of this Appendix.) In the event a client had come to the program more than once, JLARC randomly picked one of the admissions listed and copied as much information pertaining to that admission as was available. Dates of all other admissions were also noted, including the length of time stayed and reason for leaving, but other supplemental information was not. The one admission picked formed the basis for the analysis of client turnover shown in Figure 20. As explained in Chapter VII, taking other admissions into consideration did not alter the results (see Figure VII-1 in this Appendix).

To find out how well clients were being rehabilitated, JLARC matched client data with employment data from the Virginia Employment Commission (VEC) and arrest data from the Central Criminal Records Exchange. Employment information was obtained from a wage-record file maintained by the VEC on everyone in the State that pays Unemployment Compensation Insurance. The file contains basic

^aFederal law 92-255 expressly provides for the use of client records in conducting "management or financial audits and program evaluations" as long as client confidentiality can be maintained. One of several key steps taken by JLARC to insure the confidentiality of these data was to record all key items which would identify a particular client separately on a tear-off sheet attached to the front of the form. Later, during the processing of the data, this sheet was separated from the form and kept elsewhere under lock and key.

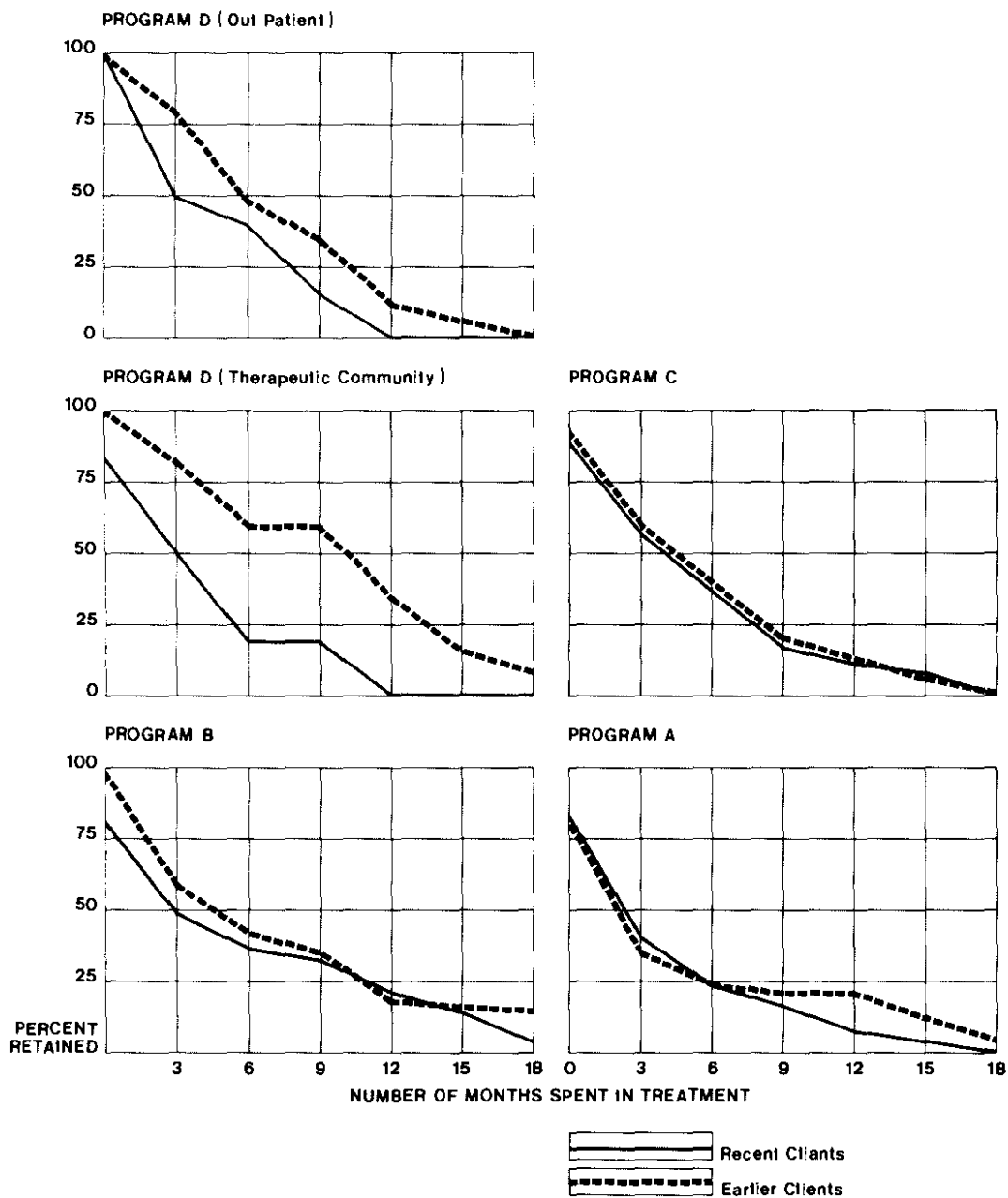
wage information on the latest five quarters and covers roughly 80% of all those employed in the State. For this study the period covered included the last quarter of 1973 through all of 1974.

In making the match, the VEC paired every client for which there was a social security number with the corresponding wage information. When a match was found an IBM card containing the desired information was punched and given to JLARC. JLARC then merged this information for each client sampled with the information already obtained from the client files. Always information was taken from the VEC wage-record file. Never was any information added to the VEC file. A member of JLARC's staff was present at all times during the process to insure that client confidentiality would be preserved.

Similar precautions were taken in obtaining the arrest data. A procedure was worked out between the Department of State Police and JLARC, and approved by the Attorney General whereby client information could be matched with CCRE arrest records. All arrests including date of arrest, type of charge and disposition were added to the employment data and background data that had already been collected for each client. Once arrest information was added the last step was to eliminate all references that could be used to trace any data back to a particular client. All such identifiers were deleted and a random number substituted. At the time of this publication any material which could be used to identify any specific client has been destroyed. As with the VEC file, the CCRE file was only used to add to JLARC's existing data. Never was any information taken from JLARC's data and added to the CCRE file. One of the members of JLARC's staff was present at all times to insure the confidentiality of the data would be respected.

The analysis of employment and arrest data focussed on all those who had actually received counseling and who were no longer in treatment. Excluded from this analysis were those who never received counseling (i.e. those never admitted or who only came once or twice and never returned), those admitted prior to June 30, 1974, but who were still in treatment, any that were now deceased, and in the case of the two methadone programs any who had only undergone detoxification (21 days or less) without receiving counseling. Also excluded from this analysis were all juveniles (anyone under 18). Juveniles represent a special group for which other indicators would be more appropriate (e.g. school attendance). Juveniles constituted only a small percentage of clients seen in all but one program, Program D. In Program D juveniles represented 39% of all clients seen. As a result, juveniles were not considered in any of the analyses for this program. See Table VII - 2 for the distribution of each sample in these different categories.

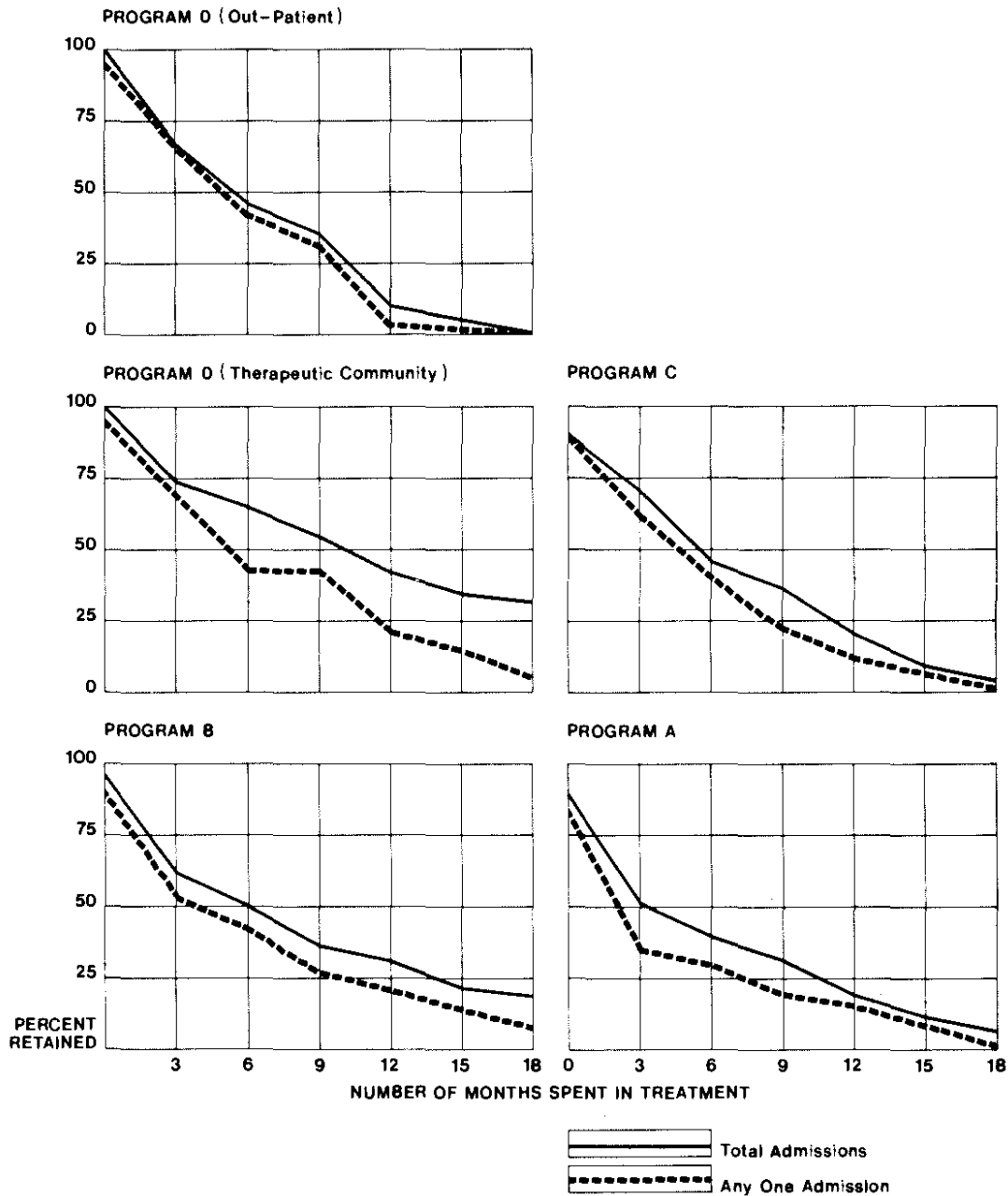
Figure VII-1
ATTRITION RATE CHANGES IN TREATMENT PROGRAMS
(Recent Clients vs. Earlier Clients*)



*Figures compare length of time clients spent in treatment during the first half of a program's existence to that spent in the second half.

Source: JLARC Client Follow-up Study

Figure VII-2
ATTRITION RATES FOR A SINGLE ADMISSION VERSUS
ALL POSSIBLE ADMISSIONS*



* Figures compare the length of time spent in treatment for any one admission versus all possible admissions clients might have had

Source: JLARC Client Follow-up Study.

Table VII - 1

ARREST HISTORY OF CLIENTS
STUDIED IN CLIENT FOLLOW-UP

<u>Status Prior To Treatment</u>	<u>Methadone</u>		<u>Therapeutic Community</u>		<u>Out-Patient</u>
	Program	Program	Program	Program	Program
	<u>A</u> <u>(58)</u>	<u>B</u> <u>(71)</u>	<u>C</u> <u>(65)</u>	<u>D</u> <u>(14)</u>	<u>D</u> <u>(25)</u>
No arrests	<u>10%</u>	<u>28%</u> ^a	<u>12%</u>	<u>14%</u>	<u>12%</u>
Arrests	<u>54%</u>	<u>34%</u>	<u>63%</u>	<u>50%</u>	<u>56%</u>
Avg. # of arrest per person	4.5	2.3	2.9	3.0	3.0
Avg # of charges per arrest	1.3	1.3	1.3	1.5	1.4
Percent of charges that are felonies	55%	59%	56%	56%	62%
Percent of charges by Type of Crime					
Violent	8%	10%	6%	13%	5%
Fund Raising	54%	42%	42%	34%	40%
Drug	22%	28%	30%	37%	38%
Miscellaneous	16%	20%	22%	16%	17%
Percent of charges resulting in convictions	48%	56%	56%	28%	59%
Percent (of total) who have spent time in jail on a conviction	28%	20%	29%	36%	32%
Data not available ^b	<u>36%</u>	<u>38%</u>	<u>25%</u>	<u>36%</u>	<u>32%</u>

^aThis program serves more women and may account for the higher arrest free figure.

^bThe majority of those for which there was no data indicated prior criminal records in their client files.

Table VII - 2

DISTRIBUTION OF CLIENTS SAMPLED
IN SELECTED CATEGORIES

	<u>Methadone</u>		<u>Therapeutic</u>	<u>Community</u>	<u>Out-Patient</u>
	<u>Program</u>	<u>Program</u>	<u>Program</u>	<u>Program</u>	<u>Program</u>
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>D</u>
<u>Total Sampled</u>	<u>99</u>	<u>107</u>	<u>96</u>	<u>25</u>	<u>49</u>
<u>Juveniles</u>	<u>2</u>	<u>--</u>	<u>12</u>	<u>3</u>	<u>17</u>
<u>Adults</u>	<u>97</u>	<u>107</u>	<u>84</u>	<u>22</u>	<u>32</u>
<u>Adults:</u>					
Never Counseled	15	16	10	4	3
Deceased	1	2	--	--	--
Detox Only, Not Counseled	1	5	NA	NA	NA
Still in Treatment	22	13	9	4	4
Out of Treatment	58	71	65	14	25

NA: Not Applicable.

Source: JLARC client follow-up study.

Table VII - 3

VIRGINIA'S 28 DRUG TREATMENT PROGRAMS
BY PLANNING DISTRICT

Name & Location Of Program	Number of Facilities			
	Total	Methadone	Therapeutic Community	Drug Free Out-Patient
<u>Northern Virginia</u>				
Alexandria	3	1		2
PRELUDE-Arlington	2		1	1
CROSSROADS-Fairfax	2		1	1
Second Genesis- Alexandria	3		1	2
<u>Richmond</u>				
Adolescent Clinic	2		1-P*	1
Rubicon	5		3	2
Jump Street	1	1		
MCV Polydrug	1		1-P*	
TASC	1	-- Not applicable --		
RADAPTS	1	-- Not applicable --		
Daily Planet	1			1
<u>Tidewater</u>				
CASP-Norfolk	2		1	1
Portsmouth Drug Free	1			1
Portsmouth Methadone	1	1		
Chesapeake Drug Program	1			1
Virginia Beach Comprehensive	1			1
<u>Peninsula</u>				
Hampton Roads Methadone Clinic	1	1		
ACSD-Hampton	1		1	
Alternatives-Newport News	1			1
Bacon St. - Williamsburg		-- Not applicable --		
<u>Roanoke</u>				
RADACC	2		1	1
<u>All Other</u>				
RAFT-Blacksburg	1			1
Harrisonburg Halfway House	1		1	
SON HOUSE-Culpeper	1			1
DASH-Lynchburg	1			1
Patrick Henry Drug Council-Martinsville	1			1
TREE HOUSE-Fredericks- burg	1			1
REAL HOUSE-Petersburg	1			1

*1-P; In-patient facility.

CLIENT RECORD SHEET

Name of Program _____

Date _____

Program Component _____

SECTION A

Name of Client _____
 Origin _____ City _____ State _____
 SS# _____

Demographic data at time of admission:

Date of Birth _____ Age _____
 Race ☐ W ☐ B ☐ P.R. ☐ Other ☐ Unknown
 Sex ☐ M ☐ F
 Marital Status
 ☐ Single ☐ Married
 ☐ Widowed ☐ Divorced ☐ Separated
 No. of Dependents _____

Highest Level of Education:

Less than 8th grade ☐
 9th - 12th ☐
 High school grad. ☐
 One year of college ☐
 2 - 3 years of college ☐
 College grad. ☐
 Post college ☐

Employment Status:

Unemployed ☐
 Student ☐
 Housewife ☐
 Employed ☐
 Full-time ☐
 Part-time ☐

Type of job _____

Average weekly salary _____

Military History:

Honorable discharge ☐ Dishonorable discharge ☐
 General discharge ☐ Check if client served in Vietnam ☐
 Bad Conduct ☐

SECTION B (This admission)

Date Screened _____

Date Admitted _____

If not admitted, explain: _____

Circumstances surrounding admission.

Voluntary () Why did client seek treatment at this time?

Involuntary ()

Court Referral ()

Nol Pross ()

Probation ()

Deferred sentencing ()

Parole ()

Suspended sentence ()

Tasc ()

Name of probation officer _____ District _____

Date Discharged _____

Length of time in treatment _____

Status at discharge:

Dropped against program advice (split) ()

Dropped with program advice ()

Completed treatment ()

Other ()

Explanation _____

Public assistance () _____

SECTION C (Client Progress)

Detox () Type of detox _____
 Length of time detoxing _____

Frequency of visiting program during treatment:

of times _____ 1st month _____ 3rd month _____ 6th month _____ 12th month

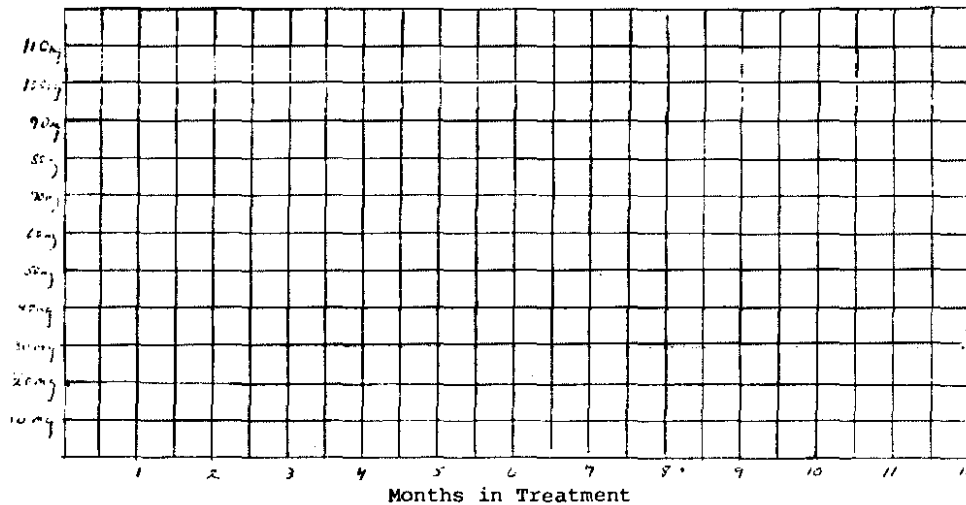
Drugs prescribed during treatment _____

Urinalysis:

<u>Date</u>	<u>Type of Drug Found</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Methadone

Dosage



Job training/Placement: _____

Education: _____

Incidents during treatment: _____

Progress as of discharge: _____

Comments: _____

Name of client's counselor _____

Check if paraprofessional ()

SECTION D

Readmission Data

Prior Admissions	1st	2nd	3rd
Date Admitted	_____	_____	_____
Date Discharged	_____	_____	_____
Length of time in treatment	_____	_____	_____
Length of time since this admission	_____	_____	_____
Circle if Voluntary or Involuntary	V I	V I	V I
Status at Discharge:			
Dropped <u>against</u> program advice	()	()	()
Dropped <u>with</u> program advice	()	()	()
Completed treatment	()	()	()
Other	()	()	()

Explanations _____

SECTION E

Readmission Data Continued

Subsequent Admissions	1st	2nd	3rd
Date Admitted	_____	_____	_____
Date Discharged	_____	_____	_____
Length of time in treatment	_____	_____	_____
Length of time since this discharge	_____	_____	_____
Circle if Voluntary or Involuntary	V I	V I	V I
Status at Discharge:			
Dropped <u>against</u> program advice	()	()	()
Dropped <u>with</u> program advice	()	()	()
Completed treatment	()	()	()
Other	()	()	()
Explanations _____			

SECTION F (Social History)

Drug Usage

<u>Type of Drug</u>	<u>Year/Age First Used</u>	<u>Year/Age First Regularly Used</u>	<u>Length of Time Regularly Using</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Circle which of the above drugs were being used at time of this admission.
Note which one is drug of primary abuse.

Frequency of drug use just prior to entering treatment:

Several times a day	()	Less than once a week, but more than once a month	()
Every day	()	Less than once a month	()
Several times a week	()	Not at all	()
Weekly (chipping)	()		

Check if client dealt in drugs ()

Type of drug(s) sold _____

Rate the extent of client's habit at time of admission.

7 6 5 4 3 2 1 0
Heavy No dependence No Drug Use
dependence evident Evident

Arrest Record

<u>Type of Arrest</u>	<u>Date</u>	<u>Result</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Criminal Activity _____

Employment History

	<u>Type of Job</u>	<u>Date</u>	<u>Average Weekly Salary</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Special skills (circle which, if any, of above jobs were in client's skill related area) _____

Socioeconomic status

Upper () Upper Middle () Middle () Lower Middle () Lower ()

Family background: _____

Health status: _____

Life style: _____

(Record Taker)

APPENDIX VIII

AGENCY RESPONSES

Department of Corrections

Division of Drug Abuse Control

Department of Education

Department of Health

Division of Justice and Crime Prevention

Board of Pharmacy

Department of State Police

Department of Vocational Rehabilitation

JLARC'S COMMENTS

JACK F. DAVIS
Director



COMMONWEALTH of VIRGINIA

DEPARTMENT OF CORRECTIONS
22 East Cary Street
Richmond, Virginia 23219

BUREAU OF PLANNING AND PROGRAM DEVELOPMENT

August 27, 1975

Mr. Ray D. Pethtel, Director
Joint Legislative Audit Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

In response to your letter of August 15, 1975, the Department has several areas of concern regarding the Preliminary Program Evaluation of Virginia's Drug Abuse Control Program. It is hoped that we will be able to meet in the near future to discuss these areas in depth.

Under the area of Education and Training (p. 123, paragraph 4) the report indicates that the Department has not met its training timeframe, there is no mention of these being departmentally imposed suspense dates. In addition, there is no mention of the 252 hours of training required of each correctional officer by the Law Enforcement Training Standards Commission.

In the area of research (page 129, paragraph 3) the report states that there is no evaluative research component within the Department of Corrections. Since the time that the report went into print the Department has received a discretionary grant from LEAA to create both evaluation and program development components. The program is scheduled to begin October 1, 1975 and will provide for three program evaluation specialists and two program development specialists. Although the program evaluators will be assigned to department programs, this will be inclusive of drug programs.

In regard to the section on drug control, you shall find enclosed the missions and functions of the Department's Central Pharmacy. It is anticipated that this pharmacy will be operational by December 1, 1975 and will meet the following requirements:

Mr. R. D. Pethtel
Page Two
August 27, 1975

- (1) Prescription drugs will be dispensed on an individual prescription basis.
- (2) Institutions and units will be keeping a smaller quantity of drugs on hand. There will be no "stock" bottles, thus making it more difficult for an unauthorized person to locate a drug.
- (3) Daily distribution method - easier to watch, check, and control drugs.
- (4) There will be less chance for errors, with no need to refer to charts and then select medication.
- (5) New procedures probably will result in each institution having a fresher supply of drugs since there will be less excess stock on hand than under the old method when individual units bought drugs separately and often in large quantities.
- (6) Because of bulk buying by the Department of Corrections, institutions will save on the purchase price of drugs in many instances.

In the area of Probation and Parole, it has been recommended that the following areas be addressed:

- (1) Cover sheet: Corrections, paragraph 2, last line:

I suggest be changed from "The Division of Probation and Parole Services and DVR should continue to work together as members of drug teams" to "The Division of Probation and Parole Services should be encouraged to continue and expand its teamwork approach into a comprehensive network of community and State human service delivery system resources, including DVR".

- (2) Page 132, subheading - Probation and Parole Drug Teams, first paragraph, line 4 should read:

"23 District Offices", not "21 . . ."

- (3) Page 133, first paragraph, add:

"The latest statistics as of March 1975 shows the number of these clients has increased to 6,000 cases, or approximately 60% of their total client caseload."

- (4) Page 133, last paragraph, beginning with line 3 should read:

"The budget does not reflect those district offices which have been encouraged to provide and maintain existing and additional drug officers and teams with existing resources: Arlington (5), Collinsville (1), Newport News (1 additional), Norfolk (2), Portsmouth (1 additional), Richmond (2 additional), and Suffolk (1) in response . . ."

Note: Check dollar figure statistics in Table 61.

- (5) Page 133, last paragraph, line 9-12:

I don't understand meaning - very ambiguous - what does "cost associated with drug officers not assigned to drug cases, . . ." mean? Could they refer to non-drug cases and Section 101.3 cases assigned to drug officers? I agree Table 61 doesn't present accurate picture of 24 "Drug Officers", plus those non-drug officers handling drug cases, including Section 101.3 cases.

- (6) Page 134, first paragraph, line 3-4 should read:

".... in nine Probation and Parole Districts (later expanded to thirteen)."

- (7) Page 134, 2nd paragraph, line 7-8 should read:

"committee is composed of a Probation and Parole Officer, DVR counselor, and community supportive resources including therapeutic community, outpatient drug treatment program, Methadone program, planning district commission, and other related agency representatives."

- (8) Page 134, paragraph 3, line 5 could read:

"..., (3) social competency/incompetency (vocational educational, social interactional, etc.) assessment"

- (9) Page 134, paragraph 4, line 4 should read:

"correct same . . . within the 13"

Mr. R. D. Pethtel
Page Four
August 27, 1975

- (10) Page 135, paragraph 5, line 8 add:

"longer exist as originally conceived, rather be expanded to include other community and State resource persons in an inter-agency collaborative approach they believe more comprehensive, pragmatic and meaningful in terms of desired results."

- (11) Page 135, comment on paragraph 6:

There has been no attempt, nor shall there be one, to exclude or "eliminate" DVR counselors as members of drug teams; rather just the opposite. We desire to go to an expanded "Team", including in appropriate districts to install multi-Probation and Parole officer, Drug/Alcohol Specialist teams in addition to the large inter-agency multi-disciplinary team approach.

- (12) Page 136, paragraph 4, line 1 should read:

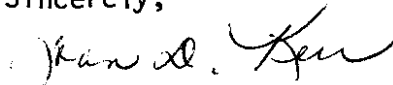
"The drug team programs of the Division of Probation and Parole Services have been ..."

- (13) Page 136, paragraph 7, comment:

I feel they should change this recommendation to be more global indicating Probation and Parole should continue to work closely with DVR under "a well-defined set of guidelines and responsibilities", but also be encouraged to expand its "team concept" to include the other agencies with related interests in their potentially mutually shared clients; and, if possible, recommend adequate funding for the assault on drugs/alcohol abuse the Department (including our Division) is mounting or needs to mount.

My colleagues and I are looking forward to the opportunity to discuss these points and others prior to the publication of your final draft.

Sincerely,



(Mrs.) Joan D. Kerr
Drug Coordinator

/dbw

cc: Herbert A. Parr
Lloyd T. Hall, Jr.
Wilhelm Haag
Randy Polisky
Robert Phelps

NOTE: Changes suggested by comments numbered 1,2,4,5,6,7,8,9,10, and 13 have been made in the final report.

MISSIONS AND FUNCTIONS
DEPARTMENT OF CORRECTIONS
CORRECTIONS PHARMACY

MISSION:

The mission of a central pharmacy, hereinafter named the "Corrections Pharmacy", is to supply all of our Centers, Field Units, Juvenile Units, and Jails with individual inmate prescriptions in compliance with Federal and State regulations. These prescriptions will be delivered to the Corrections Pharmacy by messenger or mail; they will be filled as expeditiously as possible and delivered to a guard or mailed to the address of the inmate, in care of a responsible person.

FUNCTIONS:

1. Receive, control and document all individual prescriptions submitted by the Department of Corrections institutions, field units, juvenile centers, and local jails.
2. Fill all prescriptions received within 24 hours from date of receipt.
3. Distribute filled prescriptions to designated Correctional personnel within the Department by mail or courier service.
4. Operate a central warehouse within the Department where all pharmaceutical drugs will be received, stored, and issued on an individual prescription basis.
5. Procure, through established state contracts to the maximum extent possible on a recurring basis, all pharmaceutical drugs for the Department.
6. Establish procedures for administering drugs on an individual basis for the Department and monitor its implementation on a recurring basis.
7. Establish procedures for storing drugs at the various sites throughout the Department and monitor its implementation on a recurring basis.
8. Provide technical advice and assistance to elements within the Department and local doctors as required.



COMMONWEALTH of VIRGINIA

Division of Drug Abuse Control

PATTY W. FOWLER
DIRECTOR

TELEPHONE 770-8517
SUITE 901
NINTH STREET OFFICE BUILDING
RICHMOND, VIRGINIA 23219

September 26, 1975

Mr. Ray D. Pethtel
Director
Joint Legislative Audit & Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

We appreciated the opportunity to informally respond to the draft report prepared for the Joint Legislative Audit and Review Commission. As you know, on August 29, we reviewed the draft in detail with Mr. Don Hardenbergh, Project Chairman, and members of the staff who conducted the study and wrote the draft. Our response, as requested, included our overall impression of the total document with cited examples, as well as specific inaccuracies which we were able to identify in the limited time from receipt of the draft on August 18.

Mr. Hardenbergh requested at that time that our oral remarks be confirmed in writing. Time constraints have prohibited us from going into such depth. Members of the staff did make notations of the errors we pointed out, and Mr. Hardenbergh has assured us in his letter of September 3, that these will be corrected prior to publication of the final report. We, therefore, have decided to confine our written response to the overall impressions and concerns which were expressed in the August meeting.

As you are aware, we were disappointed when we read the draft document. We had earnestly hoped and expected that the report would be written in a constructive manner, and that the various agencies would welcome it as an aid to increase their effectiveness.

Unfortunately, we feel the general tone of the initial draft is very negative, with semantics promoting a sense of sensationalism. What we feel to be major accomplishments, given the manpower and resources available, were in some instances made to appear as shortcomings.

Mr. Ray D. Pethtel
September 26, 1975
Page 2

We have a real concern that the manner in which the draft was written could damage the credibility of several agencies and types of programs. If a major purpose of the report is to help increase effectiveness of the programs and more efficient State services, this tone could result in unnecessarily creating an opposite effect. If credibility is destroyed, so also is the opportunity for progress.

In instances when the report criticizes an area for not being adequately addressed, it often implies that an agency is remiss for not addressing that issue sooner. We can find no indication that consideration was given to whether, in fact, that issue could or should have been addressed until this point in time -- given the historical perspective, the normal processes involved in program development and the manpower and resources available.

In order for agencies in the drug abuse control field to utilize findings in such a way as to contribute to improvement of the program, elucidation of a number of key comments would be helpful. This is particularly true in instances where criticism is leveled without specificity or documentation which would lead to correction of inadequacies.

We certainly give cognizance to many of the problems and areas needing attention which were cited in the draft; however, many other existing problems and critical issues were not addressed. A major issue, which received no comment, is that of the sub-state planning mechanism, which currently is required by Federal regulation and mandated by State law. Among other major concerns are the problems created by multiple funding sources.

While we can agree with many of the findings, we cannot always support the rationale stated for them. In some instances, we feel that explanations and documentation were insufficient, and at times even conflicting from one area of the report to another. As suggested during the oral discussion, we would hope for careful review and validation of rationale for recommendations and conclusions.

I sincerely believe members of the staff made every effort to be objective in their findings. This, however, is not apparent in reading the document. In fact, one issue gives us a definite impression that portions of the draft were written to support a preconceived conclusion. I am making specific reference to the suggestion that it may be necessary for the General Assembly to modify the existing laws regulating marijuana use. Based on information available to us, we certainly could not recommend that the General Assembly take such action at this time.

Mr. Ray D. Pethtel
September 26, 1975
Page 3

I hope these comments will be helpful in promoting a document which can provide a constructive evaluation. Such an evaluation would not only give recognition to the resources built since the State first began to address the problem of drug abuse control five years ago, but would deliver the desired message just as emphatically in a more positive and helpful manner. Certainly, reviews and evaluations are much needed and can assist the General Assembly, the Governor, and involved agencies in their efforts to increase the efficiency of State government and the effectiveness of the taxpayer's dollars.

Sincerely,

A handwritten signature in cursive script, reading "Patty W. Fowler".

(Mrs.) Patty W. Fowler

PWF/js



COMMONWEALTH of VIRGINIA

Division of Drug Abuse Control

PATTY W. FOWLER
DIRECTOR

October 10, 1975

TELEPHONE 770-8517
SUITE 901
NINTH STREET OFFICE BUILDING
RICHMOND, VIRGINIA 23219

Mr. Ray D. Pethtel
Director
Joint Legislative Audit & Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

As I indicated to you by telephone on Friday, October 3, it will not be possible for us to respond to the second draft of the evaluation of Virginia's drug abuse control programs by October 13.

We did read and respond to the initial draft and will be glad to make additional comments within our time constraints if you will send us documentation of the changes that were made.

I have read the summary in the second draft and was pleased to note that it was written in a more professional manner and that the tone was much more palatable than that of the initial draft. I hope these changes are reflected throughout the document, and that valid findings will be more readily recognized, accepted, and adequately implemented.

Sincerely,

A handwritten signature in cursive script that reads "Patty W. Fowler".

(Mrs.) Patty W. Fowler

PWF/js



COMMONWEALTH of VIRGINIA

STATE DEPARTMENT OF EDUCATION

RICHMOND, 23216

October 9, 1975

Mr. Don E. Hardenbergh
Senior Legislative Analyst
Joint Legislative Audit and
Review Commission
Suite 200, 823 E. Main Street
Richmond, Virginia 23219

Dear Mr. Hardenbergh:

After the review of the final draft of the JLARC evaluation, there still seems to be a number of items that were not amended and corrected after initial discussions. I am sure that you wish an accurate assessment of the Virginia drug abuse program. The following items are again noted for your information and to correct inaccurate information or misleading assumptions:

- (1) The section "Education's Response to Drug Abuse" states in the last paragraph that a survey of 400 health and physical education teachers and 400 guidance counselors was conducted. According to information on pages A5 and A7, only 227 health and physical education teachers and 295 guidance counselors responded. The 227 health and physical education teachers represent only .07 of the total health and physical education teachers in the State.
- (2) On page 37, "Teacher Preparation," it states that "a majority of both elementary and secondary teachers have not received drug awareness training, and correspondingly, health and physical education teachers appear to lack adequate training."

Records in the State Department of Education have been presented to show that all but 20 school divisions in the State conducted drug awareness programs in 1970-71. These 20 divisions represented only 3,483 teachers, or .07, refuting the statement found on page 40 that "only 21% of Virginia's classroom teachers had received drug awareness training as of 1973-74."

Mr. Don E. Hardenbergh

October 9, 1975

Page 2

On page 41 it is indicated that only "49% of all health and physical education teachers have either not received any training or appear to be inadequately trained." How can this be determined by a random sampling of .07 of the health and physical education teachers in the State? We feel that JLARC must be referring to its estimate that only 21% of the teachers were trained in 1973-74 as revealed by the survey. This section is not clear.

In addition to the training of 93% of teachers in 1970-71, the principals' surveys show the following:

In 1971-72 788, or 43%, of the schools conducted drug education programs for their teachers.

In 1972-73 489, or 29%, of the schools conducted drug education programs for their teachers.

In 1973-74 512, or 29%, of the schools conducted drug education programs for their teachers.

This certainly represents more than 21% of the teachers. It should be noted also that in 1973-74 1,300 schools reported that they had teachers who have had special training in drug education. In addition to the above, 525 schools reported having teachers and other personnel taking a drug education course during this school year. There needs to be a definition of adequate drug awareness training.

- (3) Reference is made on page 38 to the new endorsement requirements for health and physical education requiring only 9 semester hours in health education. In the preparation of health and physical education teachers, the courses in the "scientific background area" should be counted with those in the health education and safety area. This means that at least 18 hours are required.
- (4) On page 40 the following statement appears, "Department of Education officials believe that classroom teachers should have a full day of drug awareness training, however, JLARC staff believe this is inadequate for health and physical education teachers who are responsible for teaching drug education."

The statement is misleading in that the State Department of Education does not recommend this. Representatives of the Department discussed the types and lengths of training for three groups of teachers with the JLARC staff--the classroom teacher, the health and physical education teacher, and the guidance counselor. The State Department of Education does concur that one day of training would be inadequate for health and physical education teachers.

- (5) In reference to Table 13, page 43, what does the Neutral Column refer to? Factual information to a point is important and a health teacher needs to be familiar with the facts. If only 14% of the surveyed health and physical education teachers found "understanding the reasons for drug use among students" not helpful, then 86%, or the majority, must have found it helpful. This is true of all the training objectives.
- (6) A second reference is made on page 42 to 400 health and physical education teachers and 400 guidance counselors being surveyed, when in fact, it was only 227 and 295.
- (7) Also on page 42 the statement "another group of respondents believed there should be greater emphasis on counseling, etc." Who is this other group of respondents?
- (8) In the section "Evaluation of Drug Education" it should be pointed out that the group of students referred to are those students already in drug use, or having friends in drug use, and it should be recognized that these students are not going to be in agreement with the program. Two factors should be emphasized here.
 - a. The 10th, 11th, and 12th grade students surveyed by JLARC would not be recipients of the change in philosophy in drug education since the basic change came in 1972-73.
 - b. Only 1,227 10th, 11th, and 12th grade students were surveyed. This represented only .005 of the 10th, 11th, and 12th graders in the public schools in Virginia in 1974, which is a very small sample. It should be noted again that in Table 18, on page 56, the proportion of the students with negative responses was relatively small in comparison to positive

responses and the "neutral" group. The only item that almost 50% of the students disagreed with was the relevancy of the textbooks and this is completely understandable because of the content they would have been exposed to at the time they were involved in drug education.

- (9) The statement "on the other hand, mental health education is virtually untested" is made on page 51. However, on page 53 a reference is made to the favorable reactions to North Carolina's "Life Skills for Health: Focus on Mental Health." It should be noted that this is a 1974 publication. How has this been evaluated and what are the statistical data relative to its effectiveness?
- (10) Reference is made to the Dade County "PRIDE" program. JLARC should have mentioned in the report that 1.2 million dollars is put into this one program alone. The same is true of the "SPARK" program in New York. The State Department of Education staff is familiar with both programs.
- (11) The State Department of Education has not limited the scope of student involvement in drug education by defining SODA as the youth involvement program. It has been stated only that this is one form of youth involvement which has had positive results.

It is unfortunate that some feel a systematic evaluation of SODA programs needs to be developed. All SODA programs do their own evaluation at the local level and modify the programs to meet their own needs. How better could a program be evaluated when statistics show that of over 400 students having participated in one Virginia program, not one student has been arrested to date?

- (12) In the section "Conclusion" a statement again refers to "four-fifths of the classroom teachers who have not had special training in drug education as of 1973-74." Also, "of all health and physical education teachers, 31% reported no in-service training in drug abuse and 18% appear to be inadequately trained." Again, with only a .07 sampling of health and physical education teachers in Virginia, how can this conclusion be justified?

Mr. Don E. Hardenbergh
October 9, 1975
Page 5

A study of the guides, Health Education, Grades K-7, and Health Education, Grades 7-12, clearly shows a specific unit in mental health at every grade level for grades K-7, and a specific unit at both the 7th and 10th grade levels in the secondary guide. This again refutes the statement on page 65 that "although a brief unit on mental health is included in the State's curriculum, a more comprehensive mental health guide is needed to implement this approach."

- (13) Page 66 contained the statement, "The school's response to the drug crisis was, in many cases, to add a unit on drugs and drug abuse to the physical education program." In reality the unit on drugs and drug abuse was expanded and included as a part of a comprehensive health education program and not added to the physical education program.

In conclusion, a document that carries the significance of this fine study should be as accurate as possible, and it is hoped that these notations, after a second screening, can be corrected in order that this report will be meaningful to the legislature and to the general public.

I certainly appreciate the opportunity of being able to give you additional input before the final report is presented.

Sincerely yours,

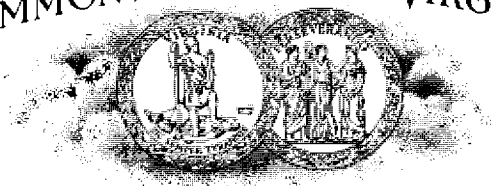


W. E. Campbell
Superintendent of Public Instruction

WEC:cp

COMMONWEALTH OF VIRGINIA

MACK I. SHANHOLTZ, M. D.
COMMISSIONER



DEPARTMENT OF HEALTH
RICHMOND, VA. 23219

September 4, 1975

Mr. Ray D. Pethtel
Director
Joint Legislative Audit and Review Commission
Suite 200, 823 E. Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

In reply to your letter of August 15, 1975, the following comments are submitted for review by the Commission. For simplicity, I have divided the comments into two sections, drug treatment and alcohol.

A. Drug Treatment

1. The implication on page 144, Chapter 10, Mental Health Services Board, is that because programs are funded through local health departments, there is a limitation on services, and if another funding conduit were utilized, this would not be true. Such is not the case, however. Each unit of local government has restrictions on the spending of its own monies. We have encountered the same problem with Chapter 10, planning districts, and local government in general. While it is true that a regional program is desirable, it is difficult to override local regulations on expenditures, particularly when surrounding localities select not to assist in providing match money.

2. A general disapproval of the record keeping system of all programs is made on page 150. The suggestion here is that all programs maintain the same level of inefficiency. In contrast, we have found when reviewing programs that record systems have been improving and that they do contain the legally required information. Since different programs maintain differing types of systems, it would be somewhat difficult for such an evaluation unit to correlate all programs within a short time frame. The decision was made, however, to allow the programs to use the record system most appropriate to their needs and structure.

3. The report states on page 152 that, "Except in the cases of methadone programs, which must comply with FDA regulations, none of the other State funding agencies have adopted such guidelines." In fact, there exist and have existed since 1973 official State rules and regulations regarding methadone programs. These regulations were written by the Health Department, reviewed in a public hearing, and are used as guidelines in funding and evaluating methadone programs.

4. Page 153 of the report states, "only DJCP conducts periodic assessments" of programs they fund. However, Virginia law requires that each methadone program be licensed. To provide such a license, the program is monitored and evaluated by the State Health Department at least once annually. This evaluation includes patient

Mr. Ray D. Pethtel
Page 2
September 4, 1975

records, compliance with State and federal laws, medical procedures, counseling efforts, and program administration.

5. In evaluating the effectiveness of programs, the Commission chose to use arrest records as a measure of success. By using this criteria rather than convictions, they are assuming guilt through their own subjective decision. Such clients, because of their history, are more frequently arrested than the average citizen and only by evaluating conviction rates can one determine criminal involvement.

6. The Commission likewise chose to use employment patterns as reflected by the V.E.C. computer record of unemployment insurance payments. These records, however, include only 80 percent of the positions in the state. Frequently, small business, self-employment, and municipal employment are not included in the computer record. To be accurate, the Commission should analyze the number of such positions held by program clients. It is likely that these positions would be filled by the former addict at a ratio greater than 20:80.

7. In evaluating methadone programs, the report commented that only 13 percent of patients in one program and 27 percent in another reached maintenance. They define maintenance as a constant dosage (\pm 20mg) for at least five months. They offer no basis though for such a definition of maintenance. No such definition exists in either federal or State guidelines. This choice appears to be an arbitrary standard. Unfortunately, methadone programs have been judged for years by arbitrary time standards picked by each new group of onlookers. The facts are: a) law requires detoxification or gradual decrease in dosage while in the program; b) most addicts push to attempt detoxification as rapidly as is feasible; c) some patients are admitted to treatment with the specific intent of detoxification. The concept of extended maintenance is valid. Those clients who remain in treatment longer at maintenance usually display greater success levels. It appears, however, that the report has subjectively determined a definition of maintenance, and has applied it without regard to concurrent variables.

8. The sloping of the report causes concern. While many of the conclusions drawn by the Commission and the problem areas focused upon by the report are accurate, the support work used in forming those opinions seems to be lacking. The report has highlighted most information from the negative with little concern for the newness of drug treatment, the effect of revolving federal regulations, or the environment in which treatment has evolved. The impact of the report is to negate what positive effort has been made and to suggest the possible removal of treatment. The long-term consequences of such a review should be more thoroughly weighed before being presented from such a perspective.

B. Alcohol

1. On page 9 of the report under the heading, "The Department of Health," the function of the Bureau of Alcohol Studies and Rehabilitation is described with considerable inaccuracy.

"A Bureau of Alcohol Studies and Rehabilitation reviews the problems involved in the prevention and treatment of alcoholism while the Medical College of Virginia operates clinical facilities for alcoholics."

Mr. Ray D. Pethtel
Page 3
September 4, 1975

There are actually two errors in the above quote. The first relative to the Bureau of Alcohol Studies and Rehabilitation; the second relative to the Medical College of Virginia.

The Bureau of Alcohol Studies and Rehabilitation is responsible to the Commissioner of Health for the planning, design and administration of the State's alcoholism program.

Among its responsibilities and functions are the following:

- a. It establishes and maintains 15 community-based alcoholism treatment centers established within local health departments and called Divisions of Alcoholism Services. Each provides medical diagnosis and treatment, group and individual counseling of alcoholics and family members, alcohol health education, orientation and referral to other helping resources, treatment transition management to alcoholics in crisis and in need of assistance. Each Division of Alcoholism Services is administered by a coordinator who is responsible to the external community and to all public and private agencies in the community to mobilize support and understanding of the problem of alcoholism.
- b. It administers an inpatient treatment facility consisting of 40 beds for inpatient care. The program provides 14 days of psycho-social and occupational rehabilitation. This is a State Health Department facility in the E. G. Williams Hospital of the Medical College of Virginia and functions independently of the Medical College of Virginia.
- c. It provides industry, State and local governments with occupational program consultation for the design and implementation of employee assistance programs. The Bureau of Alcohol Studies and Rehabilitation employs two occupational program consultants.
- d. In cooperation with the Virginia Commonwealth University Department of Rehabilitation Counseling, it administers an alcohol education center for the imparting and improvement of treatment and counseling skills for persons actively engaged in the service of alcoholic individuals and family members. The training also includes program administration and community organizational skill acquisition.
- e. It administers a grants-to-localities program for the establishment of quality intermediate care (halfway houses and residential treatment programs) facilities across the State.
- f. It provides leadership to the entire State through a State prevention coordinator who works with voluntary groups, community agencies and organizations, providing them direction toward developing alcohol education-prevention programs.
- g. It is responsible for the design and annual revision of the State Alcoholism Plan according to the requirements of the National Institute on Alcohol Abuse and Alcoholism.
- h. It provides critical grant review of all applications for funds submitted to Federal and State agencies for alcoholism services and programs. When

- i. appropriate it coordinates this grant review activity with other relevant agencies such as the Division of Drug Abuse Control, Division of Justice and Crime Prevention, and so forth.
- i. It is responsible for the design, implementation, and computerization of a data collecting, program evaluation and monitoring system for all alcoholism programs in the State.

2. On page 177 of the report, the statement is made, "Decisions can be made (by the Director of the BASR) without consulting the Advisory Council or Coordinating Council or Coordinating Committee....". This is not the actual practice. The Governor's Alcoholism Advisory Council is always consulted on program changes and innovations. Much of the business of each Advisory Council meeting deals with recommendations to change or improve the State Plan.

The Interagency Coordinating Committee (ICC) was set up as an independent decision of the BASR for the specific purpose of developing better communications and working relationships among State agencies having direct or indirect responsibility for alcohol-related problems. For example, whenever a better working relationship between the BASR and one or other of the participating agencies there is a maximum exchange of ideas and agreements are entered into. Such has already taken place between the BASR and the Division of Justice and Crime Prevention; between the BASR and the Highway Safety Division. In a word, both sides are amply consulted.

3. On page 178 a statement is made, "A management information system for monitoring and evaluating State and local drug abuse programs is being established by DDAC (Division of Drug Abuse Control)."

"If DDAC has not yet established its own management information system for monitoring and evaluating programs, what is the point of saying, 'To date the Department of Health and BASR have not developed a similar system for alcohol programs.'"

It is suggested that the JLARC interview the BASR's coordinator for program evaluation and research relative to its patient record and program evaluation monitoring system. The person to contact is Mr. Cecil Camlin, 770-3082.

Mr. Camlin is responsible for the design and computerization of the entire system and is working in cooperation with the 15 Divisions of Alcoholism Services and the Bureau of Data Processing of the Virginia Department of Health.

4. On pages 178-181 the JLARC recommends that alcoholism and drug abuse programs be combined under a Single State Agency reporting directly to the Governor.

How can the JLARC come to this conclusion after having conducted an indepth study of only the Virginia Drug Abuse Control program?

A major justification for combining alcoholism and drug abuse programs is the treatment of poly drug abusers. On page 176 the report states, "Alcohol is by far the most serious drug problem facing the Commonwealth." If this is true then it would seem to justify retaining a separate health delivery program aimed at the specific problem of alcoholism.

Mr. Ray D. Pethtel
Page 5
September 4, 1975

How is the merger of the two agencies supposed to overcome the duplication and fragmentation of services caused by the separate-ness of many other important health and social service agencies such as Mental Health, Welfare, Division of Justice and Crime Prevention, Highway Safety, Vocational Rehabilitation, Corrections and the Department of Education?

C. General Comments


Overall coordination should be developed; this could be accomplished without duplicating available resources.

In essence, there exist now three aspects of drug control--treatment, education, and law enforcement. Drug specific education has been shown to be ineffective, if not counterproductive. To establish an outside agency to supervise a function of the Department of Education only magnifies this problem. If this were logical, we should have an agency for juvenile delinquency, adolescent sexuality, personal hygiene, psycho-social behavior, etc. In fact, all of these, if the responsibility of the school system, must be coordinated into a meaningful program of life styles training and not dictated by splinter agencies from the outside.

Likewise, the priorities of Virginia law enforcement groups should be established by that agency and reviewed by the appropriate unit in the Governor's Office. If there is a question of the effectiveness of law enforcement or of their priorities, it should become an administrative matter to be handled by the State's executive body rather than an agency which has only a narrowed view of law enforcement and is hardly in a position to comprehensively evaluate that group's priorities, abilities, needs, or impact.

That leaves treatment. Perhaps here more than any other place the fractionating is most obvious. It would seem reasonable to collect the planning and coordinating activities of treatment and center them within one existing agency. This would seem more cost effective than duplicating existing resources and would provide for a more effective use and monitoring of treatment dollars.

Sincerely,


Mack I. Shanholtz, M.D.
State Health Commissioner

MIS/gl

cc: Mr. Otis L. Brown



COMMONWEALTH of VIRGINIA

MACK I. SHANHOLTZ, M.D.
COMMISSIONER

*Department of Health
Richmond, Va. 23219*

November 3, 1975

Mr. Ray D. Pethtel
Director
Joint Legislative Audit and Review
Commission
Suite 200, 823 E. Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

This is in reply to your letter of October 1, 1975 requesting comments on the final draft of the JLARC evaluation of Virginia's drug abuse program. This final draft does address the issues more accurately than the original and the committee is to be commended for the changes made. There remain, however, some issues which require clarification if the report is to objectively reflect the statewide drug and alcohol treatment effort.

A. Drug Treatment

1. Criticism is made of the inequitably large portion of funds given to Richmond programs. This is offered as evidence of poor state planning. The bulk of this funding, however, has been from the federal government. At present the National Institute of Drug Abuse funds three programs in Richmond. If the committee wishes to evaluate the State efforts in Richmond it should specify what amount of State dollars has been granted to this city. In fact, the proportion of State funds in Richmond is lower than would appear equitable at first glance. This has been the only available option to counter the concentration of federal dollars.

2. Comment is made on page 146 of the report that the distribution of types of treatment slots throughout the state is unbalanced. To demand the same proportion of treatment slots in each area, however, is counter to specific realities:

- a. The drug problem is not the same in all areas of the state.
- b. The localities developing treatment programs maintain the option of establishing the type of program which is most specifically suited to the needs, economics and structuring of that locality.
- c. Areas such as northern Virginia are influenced by the distribution of programs in surrounding districts. That area specifically has a decreased level of methadone slots; while Washington, D.C. maintained over twenty such programs within the area and were available to residents of northern Virginia. It would seem illogical to duplicate these services.

3. Comment is made that program management at the local level is more reflective of the directors' management capabilities than efficient State administration. This would appear logical and proper. Our efforts have been to increase local participation, and to encourage the merger of programs into local government. It would likewise seem a poor management construct to attempt to administer a variety of local programs from a Richmond office not legislated to be involved in direct service.

4. We would like the committee to quantify the extent of inadequate records. Four examples of record mistakes are listed in the report. Yet the committee reviewed records of four programs with a total of 620 treatment slots. It would be helpful if the report could give us measurable specifics of record insufficiencies rather than a generalized statement categorizing client files as a "wastebasket of information."

B. Alcohol Treatment

1. Page 178, paragraph 3, lines 5-8

"In contrast, Senate Bill 337, passed by the 1975 General Assembly, but vetoed by the Governor, proposed the establishment of an independent division on alcohol problems and local programs for alcoholism treatment and rehabilitation."

Comment: The above quotation is in considerable disagreement with the actual text of Senate Bill 337. Senate Bill 337 recommends the establishment of a division on alcoholism within the State Health Department and therefore not independent.

2. Page 178, paragraph 4

"Although the JLARC has not reviewed the outcomes associated with alcohol treatment, careful attention has been given to an efficient and effective means of organizing the State's response to both drug and alcohol problems."

Comment: How JLARC was able to arrive at an efficient and effective means of organizing the State's response to both drug and alcohol problems when it has failed to do an indepth study of the State's alcohol program. Data has in fact little or no bearing on this.

3. Page 179, paragraph 4, lines 2 and following

"A JLARC review of the Drug Abuse and Alcohol Plans revealed that while the Alcohol Plan was more specific and program oriented, primarily concerned with the needs of the fifteen DAS's and the BASR, it is not comprehensive and excludes resources outside the Department of Health."

Comment: The above statement is quite incorrect and clearly misrepresents the State's Alcoholism Plan. The fact that the Plan includes resources and actually funds programs outside the Department of Health can be demonstrated with the following information. There is currently an Alcohol Education Center established in the Virginia Commonwealth University on funds provided by a contract with the University and the State Health Department Bureau of Alcohol Studies and Rehabilitation. This Alcohol Education Center is currently providing training and education to professionals in the field of alcoholism prevention, treatment and rehabilitation.

Mr. Ray D. Pethtel
Page 3
November 3, 1975

The BASR has from the beginning actively funded non-Health Department organizations for the purposes of establishing alcoholism rehabilitation services in the forms of intermediate care. Some eleven new programs have been established by the BASR with its federal formula money.

Currently, the BASR has an intermediate care services payment program for persons unable to pay for such services. These payments are authorized through the various Divisions of Alcoholism Services at the local level.

It is a wonder that the JLARC has failed to note these facts which are clearly presented in the various revisions of the State Comprehensive Plan.

4 4. Page 179, paragraph 6

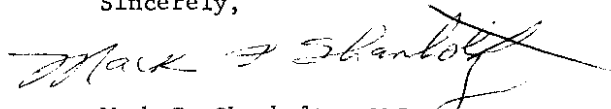
"A management information system for monitoring and evaluating State and local drug abuse programs is being established by DDAC. To date, the Department of Health and BASR have not developed a similar system for alcohol programs."

Comment: The same error was made in the first draft reviewed by the BASR.

The Bureau of Alcohol Studies and Rehabilitation has an evaluation and patient records system already in operation. It has been developed jointly with the staff of the fifteen Divisions of Alcoholism Services with the assistance of the Bureau of Data Processing of the Virginia Department of Health. If the JLARC wishes to review this patient records and evaluation system they should contact Mr. Cecil Camlin of the BASR. His number is 786-3082.

If you have any questions concerning my comments, please do not hesitate to call me.

Sincerely,



Mack I. Shanholtz, M.D.
State Health Commissioner

cc: Mr. Otis L. Brown



COMMONWEALTH of VIRGINIA

Division of Justice and Crime Prevention

RICHARD N. HARRIS
Director

8501 MAYLAND DRIVE
RICHMOND 23229
(804) 770-7421

COUNCIL ON CRIMINAL JUSTICE

September 29, 1975

Harold W. Burgess, Chairman
Richmond

Julian F. Hirst, Vice-Chairman
Chesterfield County

Gary L. Bengston
Danville

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Glade Springs

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Norfolk

Lawrence Douglas Wilder
Richmond

Woodrow W. Wilkerson
Richmond

Mr. Don E. Hardenbergh
Project Chairman
Joint Legislative Audit and Review Commission
Suite 200, 823 E. Main Street
Richmond, Virginia 23219

Dear Mr. Hardenbergh:

As per your request for written comments regarding the draft report on Virginia's Drug Abuse Control programs, please attach the following as DJCP's general comments. We respectfully reserve the right to submit a more detailed package pending final release of the report.

There are two aspects of the overall document which we feel are important. First, the draft, although very well written, and a most readable document, can easily be taken out of context by the casual reader. The theme generally presents a negative picture of what has been accomplished within Virginia in the past five years. The report seems more of a cross-sectional examination of the drug abuse field rather than a longitudinal one.

JLARC's lack of sensitivity and appreciation for Virginia's efforts over the above mentioned time period, and its lack of comparison to similar efforts nationally, is most upsetting and disturbing.

No one is quicker to admit the drug abuse system has problems than those of us involved in it, but we were looking toward this report for constructive criticism rather than a pointing finger.

Secondly, the document has a tendency to leave the reader with a feeling that a particular problem or situation illustrated in the report exists statewide rather than in isolated instances. The report also tends to make generalizations that are simply not true. Again, if read out of context, it can be very damaging and demoralizing.

Mr. Don E. Hardenbergh
September 29, 1975
Page 2

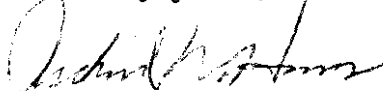
In regard to specific comments concerning this agency, I believe those errors will be corrected in the final draft as a result of our discussions with your staff. I will limit further comments to those areas we feel are of major concern.

1. Target Allocation: We question the relevance of this procedure to your report. If the subject is to be included in the final report, we feel the description of the reasoning behind the use of the Target Allocation approach should be more accurate than that reflected in the first draft.
2. Assumption of Costs: We feel there are errors in the description of the reasons and procedures regarding the adoption of the policy.
3. Financial Capabilities: We feel it is important to stress that we are meeting federal audit requirements for all our grants, including drug programs. We further feel that the report should mention our requirement that every grantee submit quarterly financial reports. This enables us to carefully supervise the financial aspect of all of our grants.

In meetings with members of your staff, we have dealt with specific issues and feel confident that these will be addressed in the final report. Therefore, this response is of a general nature, including only the major points we wish to raise. Again, I reserve the right for further comment pending my staff's review of the final report.

I look forward to seeing the final document.

Sincerely yours,



Richard N. Harris
Director

dbj

NOTE: Comments 1, 2 and 3 above were reviewed and appropriate clarification was made in final report.



LINWOOD S. LEAVITT
President
Virginia Beach

WILLIAM B. MAYNARD, JR.
Vice-President
Richmond

THOMAS W. RÖRRER, JR.
Waynesboro

COMMONWEALTH of VIRGINIA

State Board of Pharmacy

Suite 206 Insurance Building
10 South Tenth Street
Richmond, Va. 23219

August 28, 1975

THOMAS F. MARSHALL, JR.
Urbanna

WALLACE B. THACKER
Lynchburg

J.B. CARSON
Secretary-Treasurer
804/770-2031

Mr. Don E. Hardenbergh
Senior Legislative Analyst
Joint Legislative Audit and
Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Don:

Although I have not studied in detail all of the JLARC report on Virginia Drug Abuse Programs, the report is excellent and very objective with conclusions which are more than excellent.

We would suggest the following changes to the portions which apply to this Board:

Page 8 - first paragraph second line, change dealers in narcotics to dealers in abuse drugs or change to read to narcotics and other drugs subject to abuse; at the end of the first sentence, add and for registering a Controlled Substance Registration Certificate to all persons authorized to prescribe controlled substances or to use controlled substances in research or educational institutions; in the last sentence strike the word fine and insert Civil Monetary Penalty for violations of The Drug Control Act or Board Regulations.

Page 80 - we would suggest the following changes:

1. At the end of the first paragraph, insert number 4 , undercover shopping of pharmacies for unauthorized refilling of prescriptions and undercover shopping of medical practitioners for lack of good faith in prescribing drugs of abuse.
2. in the second paragraph, third line, omit the word registered.
3. in the third paragraph, at the end of the third sentence, insert the word medical; the last sentence should be stricken and in lieu thereof insert: violations obtained by inspection procedures or by undercover investigations are referred to the Board for appropriate action; violations by medical practitioners are referred to the appropriate licensing

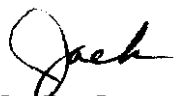
August 28, 1975

Board.

4. In the sixth paragraph, second line, between the words distributors, and insert the word prescriber; and in the listing add another category:
Controlled Substances Registration Certificate 8,700.
5. In the next paragraph, reflect the same change: in the second sentence, after the word distribution, insert the word prescribing.
6. We can furnish the number of break-ins for 1972-73 and all figures on 1973-74 and complete figures for 1974-75.

We look forward to discussion of the report with your staff.

Sincerely yours,



J. B. Carson
Secretary

JBC/r1

NOTE: All technical corrections have been made.

DEPARTMENT OF STATE POLICE COMMENTS PREPARED FOR
PRESENTATION TO THE JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OCTOBER 14, 1975
(Retyped for Publication)

Members of the Joint Legislative Audit & Review Commission:

We have carefully reviewed the second draft of the evaluation of Virginia's Drug Abuse Control Program. There are a number of items in the report on which we wish to comment.

First, we wish to point out several factual errors. These errors were previously pointed out to staff but have not been corrected.

Pages S-6 and 72

Charts on both pages give the source of the information as Central Criminal Records Exchange. These records come from the Department's Records and Statistics Division and not from the Central Criminal Records Exchange.

Pages 68 and 70

Tables 21 and 23 do not reflect correct money figures. See attached for correct figures. This correction will also change the figure in the paragraph preceding table 23 to \$2,064,855. These changes will necessitate changes in figures in tables 1-1 and 1-2.

Throughout the report staff is somewhat critical of the amount of enforcement effort directed toward marijuana. I should like to point out that on pages 18, 19, and 20, the report reflects that marijuana is rated the greatest problem in Virginia after alcohol. Also, a survey recently conducted by Quayle, Plessner & Company, Inc., for the Division of Justice and Crime Prevention, lists marijuana as one of the major concerns of Virginia's citizens. The Joint Legislative Audit and Review Commission's report lists "marijuana as the most widely used illegal drug". (page 32) Senate Joint Resolution 60, which has the effect of law, directed us to place emphasis on "traffickers and the abuse of drugs which present the most danger and harm to both the user and society as a whole". The Resolution did not direct that marijuana laws be ignored nor conclude that marijuana didn't present danger and harm to the user and society.

Much has been said about the fact that the Resolution did not intent us to direct any effort against the user. To the contrary, we feel it did when it refers to the word "abuser". On pages 13 and 14 staff defines drug abuse as a user of any illegal drug including marijuana.

The use, sale or possession of marijuana is still a violation of Virginia's laws; therefore, these laws cannot and must not be overlooked.

We concur that the use of hard drugs poses a threat to the citizens of this or any other state. Therefore, the most of our effort is directed toward that problem. Since we do not have national authority, such as the Federal Bureau of Investigation or the Drug Enforcement Administration, we must direct much of our effort from the bottom - or user - rather than the top - or the wholesaler - as hard drugs come into Virginia from out of the state or nation.

A program of this magnitude cannot be evaluated from statistics, for a six-month period, for several reasons.

1. Prior to this period of time (six months), the United States had entered into an international agreement with Turkey which resulted in a sizeable decline in the production of the poppy plant thereby reducing the availability and quality of heroin.
2. Undercover agents do not bring cases to a conclusion within a period of six months, and many times not within a year. When his cases are brought to a conclusion, he may not ever participate in arrests. This is necessary to protect his identity. Therefore, he may work as much as a year or 18 months without ever showing an arrest made.
3. When a police officer goes undercover, it may take six months or or longer to get himself established in the drug world.
4. In many cases, an officer will spend a long period of time on one case and then not be able to bring the case to a successful conclusion.

For instance in one case (not during the period of the study), our undercover agents, participating in a task force effort, spent 1,500 man hours on one shipment of marijuana (13 tons) which was destined to a port in Virginia. The state was set for the apprehension of the guilty parties in Virginia, when suddenly the boat turned north to another state. Close cooperation between our men and police officers of the other state brought about the arrest of the guilty parties and the seizure of the drug. We did not make the arrests or seizure, therefore, got no credit in Virginia for it.

A great deal of criticism has been directed toward us concerning the variations in arrests and costs per arrest and drug buys in our various field divisions. We explained this to the staff in great detail to no avail.

There is a great deal of difference in the enforcement of these laws in the cities and urban areas as compared to extremely rural areas.

First, an undercover agent is able to get about freely in cities without being identified, and in most cases is able to infiltrate the drug world, and still live and operate out of his home. This is not true in rural areas where it is necessary to provide him with living quarters other than his home. His equipment must be changed frequently, and he must commute long distances to carry out his duties.

It is absurd to attempt to arrive at an average cost per arrest over the entire state since no two cases can be handled alike. We cannot lessen our efforts in the rural areas since those citizens deserve the same protection as citizens in urban areas.

A suggestion has been made that we develop a small centralized investigative unit. We are unable to understand how this type unit can be effective since the area (State of Virginia) to be covered is so large and the problem so complex.

It has also been suggested that we develop a "prioritized" drug enforcement plan. We contend we have done this since more effort and man power is expended toward the drug problem than any other single problem in Virginia.

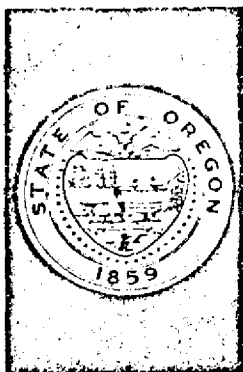
I wish to commend the Commission for making this study and bringing this very serious and difficult problem to the attention of the citizens of the Commonwealth. It is hoped that the public will be made aware of the fact that this matter is not lessening by any means, and it will take the combined efforts of all the citizens and the officials of the Criminal Justice System, as well as the Legislature, to bring the problem under control. No one official or organization can accomplish this alone.

In view of the fact that the latest survey, as previously mentioned, indicates the drug problem, especially marijuana, is one of the greatest concerns of our citizens, I cannot agree with staff that the penalty for the use of marijuana, or any drug, should be decreased in any way. To the contrary, we feel efforts toward the control should be strengthened with funds.

We are constantly evaluating all of our enforcement programs, and will welcome any suggestions, advice or constructive criticisms which the Commission has to offer.

Superintendent
Department of State Police

Enclosure



INFORMATION ATTACHMENT TO DEPARTMENT OF
STATE POLICE COMMENTS

DEPARTMENT OF
STATE POLICE

PUBLIC SERVICE BUILDING

• • SALEM, OREGON 97310

ROBERT W. STRAUB
GOVERNOR

September 29, 1975

Mrs. Pamela Meeks
Information Director
Division of Drug Abuse Control
Commonwealth of Virginia
Suite 901
Ninth Street Office Building
Richmond, Virginia 23219

Dear Mrs. Meeks:

Responding to your letter of September 24, correspondence between this department and Mr. Kenneth Fairly of the Mississippi Bureau of Narcotics was handled by Lieutenant Harold R. Berg, who tragically lost his life in May of this year in the Pacific Ocean.

In checking the lieutenant's files after his demise, we were unable to find any letter addressed to Mr. Fairly. We did, in fact, find a letter addressed to a Mr. Stuckey, an agent of the Mississippi Bureau of Narcotics, and this possibly could be the information contained within the Narcotics Control Digest of September, 1975.

Our law made simple possession or use of less than one ounce of marijuana a violation punishable by a maximum fine of \$100. This change did not affect cultivation, furnishing or transporting less than one ounce of marijuana as they still remain a felony in our state.

On the passage of the law in Oregon, we were unable to issue citations for possession of less than one ounce of marijuana during the first three months of 1974 due to an oversight on the part of the 1973 Legislature. Our law concerning the issuance of citation for criminal violations was restricted to those only in which an arrest could be made and, prior to March, 1974, an arrest could not be made for possession of less than one ounce of marijuana. A Special Session was called which corrected this oversight.

Mrs. Pamela Meeks
September 29, 1975
Page 2

Our arrest records from January 1 through June 30, 1974 versus a like period in 1975 show enforcement efforts by this department in possession of over one ounce of marijuana is minus 1.5 percent, while citations for those individuals possessing or using less than one ounce of marijuana reflect an increase of 36 percent. Perhaps a more realistic figure would be taking the period of April/June, 1974 versus a like period in 1975, which showed generally a decrease in arrests by this department in all areas of cannabis with the exception of possession of less than one ounce, which is up 21 percent. Copies of the statistics furnished other agencies are appended.

We are encountering problems concerning the operator of a motor vehicle who is under the influence of marijuana. Our courts and prosecutors have learned to depend on the breathalyzer as evidence in drunk driving cases. Based on the fact that there is no known standard for marijuana intoxication and no test to indicate when the defendant is under the influence of marijuana, our members find it difficult to arrest an individual for driving under the influence of narcotic drug when the drug used is marijuana. As a result of this, we many times find it necessary to lodge an individual on a charge of possession of less than one ounce or use of marijuana when the intoxicated individual is encountered on the highway operating a motor vehicle. Our records do reflect that January through August, 1973, we encountered 16 such individuals. During the same period in 1974, the figure increased to 23; the same period in 1975 resulted in 40 such arrests.

The figures we are supplying in the attachments are only those of our uniformed division of the Oregon State Police. These figures do not reflect the efforts of our specialized Narcotic Unit, which mainly infiltrates the larger dealers and suppliers in the State of Oregon, nor does it reflect any picture that might be encountered by one of our local police departments.

Our experience with the law in Oregon can best be summed up in two ways. It was the Legislature's intent that by decriminalizing possession of small amounts of marijuana the police officer would have more time to devote to enforcement of the drug laws in relation to stronger drugs; however, we have found this has not been so as we are now spending more time enforcing drug laws than we were prior to the liberalization law as borne out by the percentages of increase each year of those individuals possessing less than one ounce of marijuana.

Mrs. Pamela Meeks
September 29, 1975
Page 3

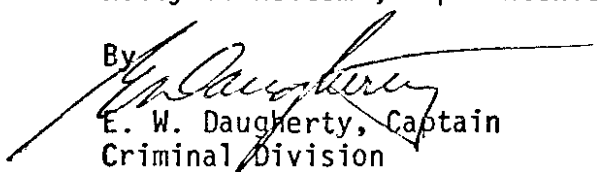
In defense of our law, we would like to say that by issuing only a citation for possession or use of minute quantities, it has made it less taxing on our police resources. The matter can be handled very expedately on the highway similar to the issuance of a traffic citation. Our records do reflect, however, that our members are seeing more marijuana and encountering more individuals using this toxic substance than in previous years. There is less antagonism between law enforcement officers and the individuals possessing marijuana since under Oregon law a person does not suffer any civil disability; i.e., have a police record, and the fine can be handled by mail rather than in person before the courts with a maximum of \$100 being levied.

We hope this information is of some value to you. If we can be of further assistance, please advise.

Sincerely,

Holly V. Holcomb, Superintendent

By



E. W. Daugherty, Captain
Criminal Division

ewd:mcb
attachments

OREGON STATE POLICE DRUG ARRESTS INVOLVING MARIJUANA
APRIL/DECEMBER, 1973, COMPARED TO APRIL/DECEMBER, 1974

The following figures were compiled in an effort to determine the effect new statutory provisions have had on the use, sale and possession of marijuana in Oregon. The period selected for a comparison, April through December of 1973 to a like period of 1974, was chosen instead of a full 12 months' period due to the fact that until the Special 1974 Legislative Session made corrections in the statute, the police had no authority to cite for possession of less than one ounce of marijuana. This oversight resulted in much confusion concerning what, if any, action could be taken on this charge. This confusion has mostly been overcome the past few months and it is felt that these statistics give a valid indication of marijuana usage trends.

A-100

	3-31-73/ 12-31-73	3-31-74/ 12-31-74	Percent Change
Cultivating	72	166	+130.6
Transporting	26	35	+ 34.6
Poss. over 1 oz.	705	254	*
Poss. less 1 oz.	103	910	*
Total Possession	808	1,164	+ 44.1
Furnishing	81	117	+ 44.4
Use	38	44	15.8
Promotion	60	244	+306.7
Total	1,085	1,770	+ 63.1

State Police Arrests Involving Other Drugs - Same Time Period

Other Drugs - Total 319 403 + 26.3

Total State Police Drug Arrests (Including marijuana) - Same Time Period

Total 1,404 2,173 + 54.7

*Not compatible.

OREGON STATE POLICE DRUG ARRESTS
INVOLVING MARIJUANA
JANUARY/JUNE, 1974, COMPARED TO JANUARY/JUNE, 1975

	January/June 1974	January/June 1975	Percent Change
Cultivating	74	49	-33.8
Transporting	22	7	-68.2
*Poss. over 1 oz.	134	132	- 1.5
*Poss. less 1 oz.	414	563	+36.0
Furnishing	59	34	-42.4
Use	21	6	-71.5
Promotion	147	64	-56.5
Total - Marijuana	871	855	- 1.9
Other drugs	308	288	- 6.5
Total - All drugs	1,179	1,143	- 3.1

*January through June figures for 1974 do not reflect an accurate picture with respect to possession of over or under one ounce of marijuana until the Special 1974 Legislative Session made corrections in the statute.

OREGON STATE POLICE DRUG ARRESTS
INVOLVING MARIJUANA
APRIL/JUNE, 1974, COMPARED TO APRIL/JUNE, 1975

	April/June 1974	April/June 1975	Percent Change
Cultivating	51	37	-27.5
Transporting	9	3	-66.7
*Poss. over 1 oz.	48	32	-33.4
*Poss. less 1 oz.	200	242	+21.0
Furnishing	15	2	-86.7
Use	9	1	-88.9
Promotion	65	21	-67.7
Total - Marijuana	397	338	-14.8

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COMMONWEALTH of VIRGINIA

DEPARTMENT OF VOCATIONAL REHABILITATION

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Telephone: (804) 770-2091

August 27, 1975

Mr. Don E. Hardenbergh
Project Chairman
Joint Legislative Audit and
Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

NOTE: Adapted for printing

Dear Mr. Hardenbergh:

Thank you for supplying a copy of the draft of Virginia's drug abuse control activities for review by this agency.

We have reviewed the draft, and particularly those sections that deal with the Department of Vocational Rehabilitation's involvement in drug abuse control.

We have found the draft to be essentially correct in the assessment of various DVR activities, and I do not believe it will be necessary to offer any corrections. However, because of new client eligibility criteria brought about by the Rehabilitation Act of 1973, we will be serving, in the future, a much smaller percentage of drug abusers than before. We are presently in the process of abolishing those specialty counselor positions dealing with drug abuse control and reassigning counselors with general caseloads to clients previously handled by special drug counselors.

Since this move will affect our ability to continue the "drug team" program, I believe it would be of advantage to your readers if a notation to that effect were inserted into the document prior to its publication.

I do wish to commend you on the thoroughness of your review and the general quality of the report.

If further information or comment is needed prior to final editing of the document, I shall be happy to oblige.

Sincerely,

Altamont Dickerson, Jr.

Altamont Dickerson, Jr.
Commissioner

ADJr:JLH:es



NOV 12 1975

COMMONWEALTH of VIRGINIA

Division of Drug Abuse Control

PATTY W. FOWLER
DIRECTOR

November 12, 1975

TELEPHONE 770-8517
SUITE 901
NINTH STREET OFFICE BUILDING
RICHMOND, VIRGINIA 23219

The Honorable Edward E. Lane
Chairman
Joint Legislative Audit and
Review Commission
1604 700 Building
Richmond, Virginia 23219

Dear Ed:

Pursuant to our telephone conversation of yesterday, we are enclosing sufficient copies of the Division's "Position Paper Concerning Laws Governing Possession of Marijuana" for members of the Joint Legislative Audit and Review Commission should you wish to make it available to them.

Although this formal position and the reasoning behind it was prompted by the recommendations of the JLARC staff and the ensuing public interest in the issue, it is of course an area given much consideration by this agency for an extended period of time.

We have concern that the dialogue in the report affords the reader insufficient evidence upon which to weigh the pros and cons of the impact were the recommendations to be implemented. We therefore hope that this white paper will be of assistance to members of the General Assembly as they gather information upon which to formulate their own determinations regarding this particular area of Virginia's criminal code.

As you suggested, we also will make copies of the paper available to the State Crime Commission.

Sincerely,

A handwritten signature in cursive script that reads "Patty".

(Mrs.) Patty W. Fowler

PWF/js

cc: The Honorable Otis L. Brown
The Honorable Edward E. Willey
The Honorable Stanley C. Walker

POSITION PAPER CONCERNING LAWS GOVERNING POSSESSION
OF MARIJUANA
VIRGINIA DIVISION OF DRUG ABUSE CONTROL

This paper constitutes a response to the findings and recommendations of JLARC staff concerning laws governing the possession of small amounts of marijuana. We do find ourselves in disagreement with the staff as to the desirability of lessening penalties in Virginia law for possession of small amounts of marijuana. Background and rationale are as follows:

JLARC staff have cited several studies to support findings: Consumers Union in Licit and Illicit Drugs, the 1972 report of the National Commission on Marijuana and Drug Abuse, a 1970 study of marijuana (ganja) use in Jamaica, and the October, 1974 survey by the Drug Abuse Council, Inc., on the impact of the new Oregon law concerning penalties for possession of one ounce or less of marijuana.

While citing these studies, others have been omitted, some of which are far more recent than the 1970 and 1972 studies. Indeed, in the reports cited, key elements which influence the validity of them are also missing. The Jamaican study's authors claim that seven communities were studied, and yet only one was reported upon. Why? Although the data on medical effects is detailed and specific, the sociological aspects of the study were presented on an infrequent and less than careful basis. The field worker aspect referred to by JLARC staff consisted of the observation of only four laborers who performed weeding and hoeing tasks, and as mentioned by JLARC staff, while motivation seemed to increase, quality decreased measurably. Although it is important to examine the marijuana smoking habits of different cultures, it is only correct to point out that the type (combined with tobacco) and manner in which Jamaicans smoke, coupled with tacit semi-acceptance by villagers and authorities alike may have significantly impacted on sociological aspects. We do not criticize the study per se, but would like to have seen more thorough documentation of findings and do not feel that Virginia can use this study as a basis for legislative changes.

The staff report stated that "a positive effect of the Oregon decriminalization was the increased priority given by police to crimes of violence and crimes against property. Furthermore, decriminalization removed approximately one-third of the total number of cases awaiting trial in local courts."

Notwithstanding the Drug Abuse Council, Inc., study of October, 1974, correspondence between the Oregon State Police and this office (September 29, 1975) indicates that the picture is not all that rosy. State Police records indicate that arrests involving marijuana increased 63.1% from April 1, 1974 through December 30, 1974, when compared with the same time period for 1973. They also show that for the same time period, arrests for possession of marijuana increased 44.1%. Arrests are continuing to increase as shown by Oregon's statistics for the period January 1, 1975 through June 30, 1975 as compared with a like period in 1974. These show that citations for those in possession or using less than one ounce increased 36 per cent.

Oregon is encountering other problems related to driving under the influence of marijuana. According to E. W. Daugherty, Captain, Criminal Division, "We are encountering problems concerning the operator of a motor vehicle who is under the influence of marijuana. Our courts and prosecutors have learned to

depend on the breathalyzer as evidence in drunk driving cases. Based on the fact that there is no known standard for marijuana intoxication and no test to indicate when the defendant is under the influence of marijuana, our members find it difficult to arrest an individual for driving under the influence of narcotic drug when the drug used is marijuana."

Also, addressing the issue of how well the new law is leaving the police free to pursue crimes of violence or crimes against property, Captain Daugherty stated that "it was the Legislature's intent that by decriminalizing possession of small amounts of marijuana the police officer would have more time to devote to enforcement of the drug laws in relation to stronger drugs; however, we have found this has not been so as we are now spending more time enforcing drug laws than we were prior to the liberalization law as borne out by the percentages of increase each year of those individuals possessing less than one ounce of marijuana." It would not appear that this intent has borne fruit.

We agree with the statement of JLARC staff that marijuana is not harmless. We do, however, question the definition of "moderate use", and suggest that the question of hazards to health have not yet been resolved.

Since 1971, the U. S. Department of Health, Education and Welfare has reported annually to the United States Senate on the results of research to determine the possible consequences of using marijuana, or to demonstrate its safety. During the first few years, research efforts were hampered by a plethora of barriers, legal, emotional and scientific. As recently as November, 1974, Dr. Robert DuPont, Director of the National Institute on Drug Abuse, HEW, reported to the Alcoholism and Narcotics Subcommittee, U. S. Senate, that the most recent report had been delayed in order to include new findings of great significance. He stated that the evidence indicated more than ever before that marijuana use may have serious health implications.

Although all evidence is still not in, and there are more unanswered than answered questions, the findings of the past year give rise to concern in several new areas including: effects on male sex hormone levels, interference with the body's immune response, effects on fundamental cell metabolism including DNA synthesis, and influences on driving performance while intoxicated.

The work of Dr. Julius Axelrod, Chief, section of pharmacology, Laboratory of Clinical Science, National Institute of Mental Health, gives cause for concern as to possible health effect on even the casual, occasional smoker. Dr. Axelrod and his associates reported to Subcommittee to Investigate the Administration of the Internal Security Act and Other Internal Security Laws in May, 1975. They reported findings that THC, like DDT, is highly soluble in fats and therefore tends to accumulate in fatty tissues of the body such as the brain and the reproductive system. These researchers were able to recover the metabolites of THC in the urine for more than a week after a single dose.

We do not say that we accept these findings as fact, or that we reject the studies cited by JLARC staff - merely that scientists and researchers cannot yet agree and we feel it is presumptuous, with such conflicting studies, for JLARC staff to assume marijuana use lacks serious health or social consequences.

We feel concern regarding any change in Virginia statutes which could lead to increased use of a drug about which so much is yet to be determined. We are reminded of the narrow margin by which the drug thalidomide almost became

a legal drug in the United States. It had been prescribed with no evident ill effects for numerous European women, including pregnant ones, and was on the verge of being approved for prescribed purposes in this country by the FDA. Had it not been for one doctor at FDA who held out through a determination that all research had not been satisfactorily completed, we might have many more deformed children in this country today.

We do not suggest that marijuana will lead to brain damage, deformed children, chromosome damage, or alterations in sex characteristics. We do suggest that Virginia would do well not to get on the bandwagon of six other states when all the facts are not yet in. Until very recent times, the research on marijuana has not been of a concentrated and valid type. Why press to change the laws when we do not know the answers to some of the questions posed above? We should take the time to find valid answers, thus providing the legislature with data sufficient to enable it to make responsible decisions. This would be a far better course than precipitous action to be sadly regretted in five, ten or twenty years.

We are concerned with recent indications that the average THC level in confiscated marijuana in the nation is of far greater potency than that of just two years ago and that there has been a steady progression of THC levels in marijuana since the mid 1960's. Roughly 18 months ago Jamaican and Columbian marijuana with a 3 - 4 per cent potency level began to enter the country. It has been pointed out in 1975 testimony before the U. S. Senate that we are nowhere near the end of potency escalation. With more careful harvesting, THC content of Mexican marijuana could be increased to 5 per cent or more. (The content of THC in the Jamaica study averaged just below 3 per cent.) Hashish oil (or liquid hash) is becoming more prevalent throughout the country, is easily made and varies in strength to as high as 90 per cent THC.

The staff report seems to imply that there are few social costs resulting from driving while under the influence of marijuana by showing high rates of convictions from driving under the influence of alcohol. This is misleading in that the report did not indicate that currently there is no feasible test to measure whether an individual is driving while intoxicated by marijuana. It is commonly accepted by even the most ardent proponents of marijuana law reform that its use interferes with driving performance.

Of equal concern in this regard are the synergistic effects of marijuana combined with alcohol. Frequently the smoking of marijuana is simultaneous with drinking alcoholic beverages, usually wine or beer. We should make clear that people who ingest marijuana do not necessarily content themselves with marijuana and stay away from alcohol or vice versa. There is evidence that amounts of marijuana or alcohol which are not themselves normally disabling, when combined in the same individual, can produce devastating effects in terms of driving ability.

JLARC staff have indicated their concern about the use of any mind-altering substance, including marijuana, on an experimental basis, and concern about the alarming proportions which this use has reached. We very much share that concern, and question how one would discourage use if the drug is "decriminalized."

We feel that lowering of penalties, interpreted by some as "decriminalization", no matter how well meant, in the belief that criminal records and

possible jail sentences are damaging to the individual, yet carries the connotation that the drug has been found less harmful than was formerly believed. One may argue that criminal sanctions do not deter the user, but this too is an area where conflicting research findings prevail. In any case, the control of a substance is, in and of itself, a statement that it does have potential for deleterious effects on the body and mind.

We do not feel that jail is therapeutic, and are dismayed at the thought of young people carrying a criminal arrest and conviction history. We do believe, however, that those who smoke marijuana are well aware that they are breaking the law when they possess even small amounts of marijuana, and that they should be responsible for the possible results of their decisions.

Virginia's laws as they now stand are not harsh ones. Simple possession is a misdemeanor, which under the law may be punishable upon conviction by up to \$1,000 fine and up to twelve months in jail. A majority of cases which are not prosecuted nor dealt with under the less stringent first offender statute (or similar means using probation with terms and conditions) receive a sentence of ninety days, suspended, and fine of \$100 to \$250. Under law enacted by the 1974 General Assembly of Virginia, with an emergency provision, persons charged with misdemeanor offenses no longer can be arrested under a warrant, but rather given a summons unless of danger to themselves or others, or determined within strict construction of the law to be unlikely to appear in court.

To say that penalties should be reduced because use is widespread is completely nonsensical. We feel certain that any heroin addict would also think it nice if penalties for possession of heroin were reduced to a fine status. The purpose of the control of substances is the protection of the individual and society. An intoxicated driver on the highway takes on the responsibility for persons other than himself, and for others than those in the automobile with him.

This agency will continue to support efforts to keep controlled substances from entering the Commonwealth illicitly, as well as those activities on the Federal level to block the importation of illicit substances, including marijuana, into the United States. We encourage efforts of the Bureau of Forensic Science in Virginia to carefully assess potency trends of marijuana available in Virginia.

In concert with JLARC staff, we will continue to discourage use, especially in young persons in the adolescent stage of life, and particularly will emphasize the hazard of driving under the influence of this mind-altering substance.

Today, the use of marijuana or tetrahydrocannabinol (THC) for therapeutic purposes, is being studied on an experimental and strictly controlled basis. We thoroughly support such research, and are hopeful that THC will be found beneficial in treating several types of illnesses.

We encourage the development of alternatives to fine and/or incarceration. Mandatory counseling sessions such as those available through the ASAP program for persons convicted of driving under the influence of alcohol are one possible alternative. We would like to see projects of this type explored on a pilot basis in the search to find what will deter repeated offenses and harm to the individual.

We do not feel that now is the time to change our laws.

We would like to have the opportunity to study the impact of other states' experiences following penalty structure changes, and to examine these over a long enough period of time to assure validity of removing the major portion of judicial discretion.

We do support uniform and equitable administration of the laws we now have.

* * * * *

10/14/75

JLARC COMMENTS ON AGENCY RESPONSES

JLARC policy provides that each agency involved in an evaluation be given an opportunity to comment on a preliminary draft. This process is one part of an extensive data validation process. Ten agencies were asked to comment on both the initial and revised preliminary draft of this report. These agencies were:

Department of Corrections
Division of Drug Abuse Control
Department of Education
Department of Health
Division of Justice and Crime Prevention
Department of Mental Health and Mental Retardation
Board of Pharmacy
Department of State Police
Virginia Drug Abuse Advisory Council
Department of Vocational Rehabilitation

While written responses were received from eight agencies, including initial responses from The Division of Drug Abuse Control, and are printed in the preceding pages, a position paper prepared by DDAC was not received until November 12, 1975, just as this report was being printed. To insure publication of that paper, as suggested by the division, it is included at the end of the agency responses. It should be noted that page references in the responses relate to the draft reports and do not necessarily correspond to the page numbers in the final report. In addition to the written replies, staff discussions were held with each agency. Appropriate corrections resulting from the meetings and written comments have been made in the final report. The JLARC staff has also prepared additional explanatory notes where necessary for clarification.

DEPARTMENT OF EDUCATION

The Department of Education's response raises several questions related to various survey sample sizes. The methodology used for each survey is contained in Appendix III. For students, the survey results are accurate within a maximum $\pm .03$ standard error with a 95% confidence level. For Health and Physical Education teachers and for counselors, the standard error is $\pm .06$ and $\pm .05$ respectively at a 95% confidence level.

Regarding teacher training, SDE has mixed data about school divisions with data about teachers. While many divisions conduct training programs, records submitted do not indicate the number of teachers trained in each division. Furthermore, normal teacher attrition suggests that any measure of the extent of training during 1970-71 should not be applied to 1975-76. The JLARC survey of currently employed health and physical education teachers revealed that half had not received in-service drug training or were inadequately trained. And, a majority of classroom teachers had not received in-service drug awareness training. JLARC concurs that "adequate drug awareness training" should be defined. This is a function of the State Department of Education.

SDE believes those students who report several or most of their friends use drugs (40% of students surveyed) will not favor drug education programs--expecting them to express negative opinions. JLARC found, quite to the contrary, that 69% of this target group (and 79% of all students) believed drug education was "a good thing for all students to have". For this reason, the responses of all students, including those whose friends already use drugs, are relevant. This group of students represent a target population with which the department has not successfully dealt.

Finally, while SDE's drug education philosophy may have changed in 1972-73, there is evidence to conclude this new philosophy has not been implemented across the State. Instead, available evidence indicates a factual rather than a mental health approach to drug education is the norm. SDE adopted the prevailing "factual information" philosophy in 1970 only to find that subsequent evaluations suggested it might be encouraging drug use. JLARC has concluded that careful evaluation of pilot programs is essential before adoption of another new "philosophy".

DEPARTMENT OF HEALTH

All factual corrections noted in the department's response have been included in the report, specifically as they regard the Bureau of Alcohol Studies and Rehabilitation. In reference to the bureau's comments, several general remarks are required.

First, the bureau states that JLARC approached the study with a preconceived conclusion to combine the State's drug and alcohol programs. This was not the case. JLARC had not originally intended to examine that issue but during the progress of the study, it became evident that alcohol (as an extensively abused drug) could not be ignored. It was not necessary, however, to conduct an evaluation of alcohol treatment outcomes to assess the State's overall organization for drug and alcohol problems.

Secondly, BASR takes issue with JLARC's statement that its alcohol plan is not comprehensive. This conclusion was reached after comparing the State's drug and alcohol plans. While the drug plan includes all State resources directed toward drug abuse control such as education, enforcement, treatment, and corrections, the alcohol plan addresses only those programs funded by the Department of Health and excludes such key resource elements as education and enforcement.

The department's final response to the distribution of drug treatment funds also requires additional comment. While it is true that much of the excess funds allocated to Richmond come from NIDA, this does not alter the fact that funding inequities exist. The State is helpless to control where NIDA allocates its funds. This is particularly alarming since NIDA should be working in close cooperation with the single state agency. In the past, this has not been the case although the situation appears to be improving. State dollars have also been inequitably distributed if DJCP funds are counted. DJCP dollars, though federal in origin, are under State control and all DJCP grants must pass through VDAAC's grant review committee. Unfortunately, the grant review process has not been effective.

The fact remains that treatment slots are distributed in a haphazard pattern across the State. Stronger controls need to be exerted at the State level to insure that inequities are kept to a minimum or exist only where there is good and sufficient justification.

DEPARTMENT OF STATE POLICE

The department states that the JLARC report reflects that marijuana is rated the greatest problem in Virginia after alcohol. The State Police also point to a survey recently conducted by Quayle Plessner & Company, Inc., listing marijuana as one of the major concerns of Virginia's citizens.

While JLARC reported that marijuana is the second most frequently used drug, the analysis of the drug problem also considered other factors such as the potential for individual harm and costs to society including associated crime, highway fatalities, and deaths. After consideration of all these factors, it was concluded that the abuse of alcohol, narcotics, and prescription drugs present a more serious problem than the occasional use of marijuana.

A review of the Quayle survey does indicate that 65% of the respondents said they are "very" or "somewhat concerned" about the "use of marijuana", and this concern was ranked sixth out of fourteen choices. However, the first and second concerns were the "use of heroin and hard drugs" (87%), and the "sale of heroin and hard drugs" (87%). Thus, Virginia citizens as reflected in the Quayle survey appear to be more concerned with the use and sale of heroin and other hard drugs than with marijuana use.

In regard to the State Police comments concerning SJR 60, JLARC believes a thorough reading clearly indicates an intent to establish drug law enforcement priorities, and that enforcement efforts against such drugs as heroin should be emphasized. While SJR 60 did not direct DSP to ignore any drug abuser, it did direct them to emphasize users of heroin and other hard drugs.

DSP contends they have developed a prioritized drug enforcement plan, because more effort and man power is expended on the drug problem than any other single problem in Virginia. By prioritized drug plan, the report is specifically referring to the need to establish priorities within the area of drug enforcement such as those directed by SJR 60.

JLARC examined the operations of the drug investigative unit for a period of six months. During this time there were cases under all stages of investigation and an examination of arrest statistics for all of 1974 indicates that the last six months were not unusual. Furthermore, JLARC examined all drug arrests made by DSP including those made by uniformed troopers so that arrests made as a result of an undercover operation but not by the officer himself have been accounted for.

DIVISION OF DRUG ABUSE CONTROL

The initial responses of the Division of Drug Abuse Control indicated that portions of the draft appear to have been written to support preconceived

conclusions, especially those parts pertaining to the regulation of marijuana use. It should be noted that on July 16, 1973, a committee of the Virginia Drug Abuse Advisory Council recommended "...that penalties for simple possession of marijuana remain a misdemeanor, but with fines up to \$100 levied only, and jail sentencing only after the third violation within a ten-year period. Possession of an amount of one ounce or less should be considered as a simple possession rather than possible possession with intent to distribute." Staff conclusions in this evaluation are not at all inconsistent with the earlier recommendation of the VDAAC committee.

In addition, the Division of Drug Abuse Control has prepared a position paper concerning laws governing possession of marijuana in response to the JLARC drug control evaluation. The following remarks have been prepared to comment on research questions raised by DDAC--not to respond to its position.

First, it is important to note that the JLARC staff considered marijuana as only one drug in the broader context of all drug abuse problems. Based on available evidence with respect to 1) incidence and intensity of use, 2) social consequences, and 3) potential harm to the individual, the staff concluded the most serious drugs of abuse in Virginia are: alcohol, narcotics, and legally prescribed drugs (including barbiturates and amphetamines). Marijuana, while not harmless, does not appear to be as significant a problem as these other drugs. Thus the report addresses the need to efficiently discourage marijuana use, while using the State's limited criminal justice resources to control those substances known to clearly present the greatest danger to both the user and society. This conclusion was based on previously established legislative intent statements regarding drug control.

In addition, several questions raised in the DDAC paper need to be answered or must be placed in proper context.

DDAC Comment: *JLARC staff, while citing several studies to support its findings, omitted others which are far more recent than 1970 or 1972.*

JLARC Response: The most recent study cited in the JLARC report was a March, 1975 review published in Consumer Reports, which summarized available research as of late 1974. The staff also reviewed the 1974 HEW Report to the U. S. Senate on Marijuana and Health; 1974 congressional testimony by officials of NIDA and NIMH; and the September, 1975 Task Force Report on Drug Abuse of the White House Domestic Council. None of these reports differ substantially from findings reported in the drug control evaluation.

DDAC Comment: *Key elements of the Jamaican study, which influence the validity of its findings, have been omitted...*

JLARC Response: The questions regarding the Jamaican study are those raised by Dr. Erich Goode, Professor of Sociology, State University of New York at Stony Brook in the July 4, 1975 issue of *Science* magazine.

Dr. Goode did raise methodological issues which he felt should be addressed in future research. However, he also concluded that the Jamaican study was an excellent report deserving widespread attention. He states: "Taken together, the five chapters on the acute and chronic effects of ganja (marijuana) are one of the most significant sets of findings on cannabis ever assembled."

DDAC Comment: *The Jamaican study's authors claim seven communities were studied, yet only one was reported upon. Why?*

JLARC Response: Dr. Lambros Comitas, Professor of Anthropology, Columbia University was co-author of the study. Dr. Comitas explained to JLARC staff that the findings reported in his book *Ganja in Jamaica* (1975) represent only a small portion of the research actually conducted and reported to NIMH in 1973. While the bulk of data collected has not yet been reported the remainder is currently being published in the form of doctoral dissertations. Dr. Comitas states there were no significant differences found in the other communities studied, and all of the general findings were confirmed.

DDAC Comment: *The field worker aspect consisted of the observation of only four workers...*

JLARC Response: Dr. Comitas also told JLARC that further studies of other types of workers were conducted, and that similar findings were obtained. Again, these findings were not included in the book, but are currently being prepared for publication. In addition, Dr. Comitas believes his findings have been confirmed by the recently released study of marijuana use completed by the U. S. Army.

DDAC Comment: *The Jamaican study should not be used as a basis for legislative changes...*

JLARC Response: The JLARC staff concurs. No single piece of research should be used as the basis for legislative change; however, cross-cultural comparisons of the effects of marijuana are valuable and necessary to determine the effects of the drug in different societies. As Dr. Goode concluded: "Only by examining the use of a drug in a wide range of settings and environments can we piece together anything like a well rounded picture of what it does to people."

The Jamaican study was not presented as the only basis for staff conclusions that the General Assembly should consider alternative penalties for simple possession. That conclusion was based upon a review of extensive research findings, discussions with numerous individuals and associations involved in the field of drug abuse, and the need to apply consistent and efficient sanctions. In addition, reduction of penalties for possession of small amounts of marijuana has been formally endorsed by many concerned organizations as reported in the JLARC study. The most recent listing includes:

American Bar Association
Consumers Union, publishers of *Consumer Reports*
National Conference of Commissioners on Uniform State Laws
American Public Health Association
National Advisory Commission on Criminal Justice Standards and Goals
National Council of Churches
The Governing Board of the American Medical Association
National Education Association
B'nai B'rith
Canadian Commission of Inquiry into the Non-Medical Use of Drugs
(LeDain Commission)
American Academy of Pediatrics

Illinois Bar Association
Minnesota Bar Association
Vermont Bar Association
New York Bar Association
Washington Bar Association
Massachusetts Bar Association

The September, 1975 report of the White House Domestic Council included the following statement regarding marijuana, which reflected the views of a majority of the Task Force members;

A great deal of controversy exists about marijuana policy. On the one hand, recent research indicates that marijuana is far from harmless, and that chronic use can produce adverse psychological and physiological effects. Therefore, its use should be strongly discouraged as a matter of national policy.

However, in light of the widespread recreational use--and the relatively low social cost associated with this type of use--the federal government has been de-emphasizing simple possession and use of marijuana in its law enforcement efforts for several years. For example, very few persons are arrested by federal agents for simple possession and use; those who are charged with this offense normally are also being charged with some other, more serious offense as well. However, vigorous law enforcement aimed at major traffickers has been and should continue to be undertaken at the federal level.

The task force endorses this moderate view and expects the lower priority that has been established for marijuana will also be reflected in our demand reduction efforts by the elimination of many non-compulsive marijuana users now in our treatment system.

While the Task Force believes marijuana is not harmless, there are relatively few social costs associated with its moderate use. The Task Force supports vigorous enforcement efforts aimed at major traffickers, in pursuit of a policy of discouraging marijuana use. JLARC staff conclusions are fully in keeping with this latest national report as is SJR 60.

DDAC Comment: *Notwithstanding the Drug Abuse Council survey of October, 1974, correspondence between the Oregon State Police and this office indicates that the picture is not all that rosy.*

JLARC Response: The October, 1974 survey found marijuana usage had not increased significantly since decriminalization was adopted in October, 1973. A follow-up survey in October, 1975 indicates the percentage of persons currently using marijuana has declined slightly. The experience of Oregon in marijuana legislation (October, 1973) is an important factor in any discussion of the marijuana issue. In its comments DDAC has not used information from the Oregon State Police accurately, nor has the division considered statewide effects. In a letter to DDAC (September 29, 1975) Captain E. W. Daugherty indicated the April/June, 1974 to April/June, 1975 statistical comparison represented the most realistic assessment of enforcement trends. These data

show total marijuana arrests declined by 14.8%, while citations for possession of less than one ounce increased 21%. As Captain Daugherty explained, the other statistics are not as valid because:

- no distinction has been made between arrests for more or less than one ounce prior to October, 1973; and
- due to a quirk in the law, police were not authorized to write citations for marijuana from January to March, 1974.

Moreover, the data provided referred only to Oregon's uniformed troopers, not to the specialized narcotics unit which focuses on major drug traffickers.

It is not surprising that uniformed State Police citations for possession of less than one ounce of marijuana have increased even though all other categories have decreased. A citation is easy to process and the penalty is less severe. Formerly, possession was a felony offense.

A full reading of the Oregon State Police letter suggests that a great deal of the legislative intent has been achieved in terms of preventing young people from receiving criminal records, improving the relations of the police officers in the field with citizens, and expeditious (efficient) handling of violations.

A similar conclusion was reached in a December, 1974 report by the Oregon Legislative Research Office. Decriminalization was reported to have been well received by local law enforcement agencies and the courts, although the level of marijuana use was not found to have changed appreciably. The report concluded decriminalization had accomplished its purpose of allowing law enforcement agencies to concentrate on other, more dangerous drugs.

In Portland, for example, the number of arrests for possession of marijuana declined from 797 in 1973 to 420 in 1974 (*Portland Oregonian*, January 3, 1975). In the Salem (Marion County) area, Lt. James Stovall of the Marion Inter-agency Narcotics Team (MINT) reported decriminalization has lessened local police involvement with marijuana, although through better police organization, there was an increase in all drug arrests. In Eugene (Lane County), District Attorney Pat Horton has testified (before the U. S. Senate Subcommittee on Alcoholism and Narcotics, November 20, 1974) that the acceptance of decriminalization has been overwhelmingly positive.

The impact on the criminal courts has been significant, for it has removed approximately one-third of the total number of cases awaiting trial from the docket, thus freeing valuable space in our courtrooms to adjudicate matters which have a serious concern to the community. By the same token, the jail population now is made up of serious felons rather than young people accused of possessing small amounts of marijuana who usually had no other criminal history...

Telephone interviews with Mr. Horton and other Oregon officials indicate this testimony is still an accurate assessment of Oregon's experience.

DDAC Comment: Dr. Robert DuPont, Director of NIDA reported to a 1974 Senate subcommittee that the evidence indicates, more than ever before, that marijuana may have serious health implications.

JLARC Response: Dr. DuPont appeared before the Senate Subcommittee on Alcoholism and Narcotics, November 19 and 20, 1974 to discuss both medical and legal aspects of marijuana use. His remarks provide an important source of expertise on the marijuana issue, but his statements need to be placed in context. Dr. DuPont expressed several concerns in regard to health hazards of marijuana, but cautioned that further research is required before these concerns can be accepted as fact:

Let me emphasize that I am not saying that cannabis has been proven to be more dangerous than we previously thought. Much of the research conducted to date is of a preliminary nature. A good deal of it has only been completed at the preclinical level--that is, testing in animals, not man. Some of the findings are frankly contradictory. But there is enough indication at this time of potentially serious health consequences from cannabis use for us to be concerned.

Dr. DuPont stated further research was required to determine the effect of marijuana on male sex hormone levels, immune response, and cell metabolism, as the implications of preliminary studies are speculative. At this point, Dr. DuPont would discourage the use of marijuana by pregnant women and adolescents, as well as the use of any drug while driving.

A final point made by Dr. DuPont was that in his view the mere existence of negative health consequences does not, in itself, justify the use of criminal sanctions. While he stated that available evidence supports a policy of discouraging the use of marijuana, he opposed the use of criminal penalties for possession of small amounts.

I suggest that there are two separate issues. One is the health consequences, and potential health consequences of smoking of marijuana. The other is how we can best handle marijuana in terms of the law. The mere existence of negative health consequences, of whatever severity, does not in itself, in my view, justify the use of criminal sanctions.

DDAC Comment: Testimony of Dr. Julius Axelrod, NIMH, before the Senate Subcommittee on Internal Security in May, 1975 gives cause for concern as to possible health effects on even the casual, occasional smoker.

JLARC Response: JLARC staff interviewed Dr. Axelrod regarding this comment. While reporting small amounts of THC have been traced in the human body after direct injection into the bloodstream, Dr. Axelrod noted the actual effect of THC on humans depends upon the dosage level. He further reported to JLARC that available scientific evidence indicates marijuana is not as harmful as alcohol or other drugs of abuse unless it is taken in enormously large doses.

Dr. Axelrod stated the Congressional Subcommittee report did not have a balanced viewpoint toward the marijuana issue, and his testimony was cut off before he could complete his remarks concerning the effect of different dosage levels. Finally, Dr. Axelrod presented his testimony in 1974, not in 1975 as cited.

DDAC Comment: *We are concerned with recent indications that the average THC level of confiscated marijuana in the nation is of far greater potency than that of just two years ago and that there has been a steady progression of THC levels in marijuana since the mid-1960's.*

JLARC Response: The Domestic Council Task Force Report on Drug Abuse expressed concern for the increasing availability of more potent derivations of the marijuana plant, including hashish and hash oil. We share this concern.

As to the potency of confiscated marijuana, however, we must question the division's data source. While referring to 1975 testimony before the U. S. Senate, the division cites no source for its statistics. Statements in the DDAC position paper are very similar to those in a letter from Mr. David Martin, Senior Analyst of the Senate Subcommittee on Internal Security. This letter refers to hearings held before the Eastland subcommittee in May and June, 1974, on the "Marijuana-Hashish Epidemic and Its Impact on United States Security".

Mr. Martin refers in his letter to Drs. Coy Waller and Carlton Turner of the University of Mississippi School of Pharmacy. Dr. Turner, Director of the Marijuana Project of the University of Mississippi has perfected a technique of determining THC levels of cannabis samples. The project cultivates marijuana for research studies and in addition will analyze samples of confiscated marijuana provided by DEA, the Customs Bureau, or other sources. In 1970, according to Dr. Turner, typical marijuana ranged in potency from 0.7 to 1.5% THC. Today, the typical range is 1.4 to 2.0%. The project's annual report for 1974 indicates the average THC level for all submissions was 1.51%. For January-June, 1975 average THC for all submissions was 1.77%.

Such statistics, however, are by no means a valid average for all marijuana products seized by drug enforcement officials. Dr. Turner points out that this figure only represents the average of the specific samples submitted to the project, without regard to amount confiscated. Potency levels can vary depending on several factors, including the age of the plant at harvesting and time of day when harvested. The standard herbal preparation can range in potency up to 4 or 5% THC. Hashish is usually 5 or 6% THC, and liquid hashish can range from 5 to 80% THC. Columbian, Jamaican, and Panamanian marijuana is generally harvested at a higher potency level than domestic or Mexican marijuana, yet Dr. Turner was not able to provide an average potency level for these sources. The most common foreign source today is Mexico, where harvested marijuana is approximately 1.4 to 1.5% THC.

It appears reasonable to conclude the average potency level of all cannabis samples submitted to the project did increase from about 1.1% THC in 1970 to 1.8% in 1975. While more careful harvesting certainly yields more potent marijuana, the average marijuana sample (tested by this project) does not appear to be of far greater potency than that of just two years ago as stated in the DDAC paper.

DDAC Comment: *The staff report seems to imply there are few social costs while driving under the influence of marijuana.*

JLARC Response: The JLARC report did not make any such implication. Operating a motor vehicle while under the influence of any drug including alcohol, amphetamines, or marijuana, or any combination of drugs is dangerous.

DDAC Comment: *The Division questions how one would discourage use if the drug is "decriminalized".*

JLARC Response: The staff report suggests one policy of discouraging marijuana use.

There is a need to impose penalties for the possession of marijuana in the Commonwealth in order to discourage its use. To achieve this objective at reasonable cost to taxpayers, however, consideration should be given to reducing the penalties for possession of less than one ounce of marijuana and substitution of a citation system with a fine.

Penalties for distribution and possession of more than one ounce of marijuana would not be affected by this change. This conclusion is similar to one made by a VDAAC subcommittee on July 16, 1973.

The JLARC staff reported that limited criminal justice resources should be directed towards those drugs posing the greatest danger to both user and society as mandated in SJR 60. Insofar as illicit drugs are concerned, heroin and other narcotics unquestionably pose a serious social and individual health problem. Marijuana use does not appear to deserve as high a priority as it has received, and the imposition of a standard fine would appear to be an appropriate sanction.

DDAC Comment: *We feel that lowering penalties, interpreted by some as "decriminalization", no matter how well meant, in the belief that criminal records and jail sentences are damaging to the individual, yet carries the connotation that the drug has been found less harmful than was formerly believed. One may argue that criminal sanctions do not deter the user, but this too is an area where conflicting research findings prevail...*

JLARC Response: An analysis of statewide drug arrests reveals a majority of marijuana offenses are committed by persons 18 to 25 years old with less than one ounce in their possession. During the period 1971 to 1974 there was a 296% increase in marijuana arrests at the local level, suggesting the State's marijuana laws have not effectively reduced usage.

DDAC Comments: *We do not feel that jail is therapeutic, and are dismayed at the thought of young people carrying a criminal arrest and conviction history. We do believe, however, that those who smoke marijuana are well aware that they are breaking the law when they possess even small amounts of marijuana, and that they should be responsible for the possible results of their decisions.*

Virginia's laws as they now stand are not harsh ones. Simple possession is a misdemeanor, which under the law may be punishable upon conviction by up to

\$1,000 fine and up to twelve months in jail. A majority of cases which are not nol prossed nor dealt with under the less stringent first offender statute (or similar means using probation with terms and conditions) receive a sentence of ninety days, suspended, and fine of \$100 to \$250... To say that penalties should be reduced because use is widespread is completely nonsensical.

JLARC Response: JLARC staff concurs the use of marijuana should be discouraged and since 1970, the General Assembly has enacted several revised laws regarding the drug abuser. However, the legislation is not applied consistently, as evidenced by staff review of case dispositions and detailed case study of application of the deferred judgment statute. Many courts have, in effect, already reduced the penalty for simple possession of marijuana by using the first offender statute or by not prosecuting offenders. Adoption of a standard sanction for simple possession of marijuana would relieve the courts, jails and the probation system of a sizable portion of their current caseload.

JLARC estimates that a citation system might remove as many as 7,200 cases from courts with a resulting savings for local jails because of decreased demand for detention facilities. Additionally, probation offices would be relieved of providing supervision for not only deferred judgment cases, but many other persons placed under supervision. Most important, however, is that such legislative action would provide uniform administration of justice.

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