An organizational analysis of an adolescent substance abuse treatment program: a case study.

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AN ORGANIZATIONAL ANALYSIS OF
AN ADOLESCENT SUBSTANCE ABUSE TREATMENT PROGRAM:
A CASE STUDY

A Dissertation Presented
By
RAYMOND L. HILTON

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

September 1981

Department of Education
AN ORGANIZATIONAL ANALYSIS OF
AN ADOLESCENT SUBSTANCE ABUSE TREATMENT PROGRAM:
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DEDICATION

I would like to dedicate the results of this effort to loving memories of my late mother and father, Isabel and O'Donnell Hilton. Their support, counsel and moral guidance have given me the zeal to achieve my life goals.
ACKNOWLEDGEMENTS

The completion of this investigation effort has involved a number of supportive persons including my doctoral committee, the Substance Abuse Treatment Unit, many friends and relatives.

The successful completion of this dissertation is largely due to the extraordinary patience, guidance and inspiring support of my advisor and dissertation chairman, Dr. Byrd Jones. Dr. Atron Gentry was always ready to offer encouragement and provide constructive feedback during the process. My respect and appreciation are given to Professor Castellano Turner, who has been an outstanding model as an effective professional. Potential pitfalls in the data analysis were avoided thanks to the counsel and reassurance by Dr. Gene Orro.

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A very special word of appreciation goes to my family, without whose support and encouragement this project would have been unthinkable. My loving family includes my wife Judith, son Chris, daughters Elizabeth, Vanessa and Ramona.
The difficulties of completing my graduate requirements were significantly eased by my sisters and brothers. Supportive words were always offered by many other friends and relatives. My own efforts were no greater than the sacrifices my family and friends endured to make possible the completion of this our mutual reward.
ABSTRACT

AN ORGANIZATIONAL ANALYSIS OF AN ADOLESCENT SUBSTANCE ABUSE TREATMENT PROGRAM: A CASE STUDY

September 1981

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Directed by: Professor Byrd Jones

This study deals with the growth and development of two organizations, each of which is part of a larger facility designed as a response to drug abuse. These treatment programs for drug abusers are pure examples of the current search for more humane organizations as alternatives to the present bureaucratic system.

The evolution of the delivery of services to clients will be examined by describing the development of agency/client relationships. By observing the natural history of these interactions, an attempt will be made to determine the parts played by the varying characteristics of clients and their behaviors in shaping organizational structure and processes. Only after the dynamics of organizational change are comprehended will an evaluation be possible for the practical question of what lies beyond bureaucracy in the human services.
This is a descriptive and exploratory study of organizational development in two informal, anti-bureaucratic drug abuse treatment programs. Major findings show that client inputs play an integral part in accounting for the development of each agency, but organizational change is also a result of the actions and responses of the staff and the clients.

The empirical results of the study are descriptive, but four different analytical mechanisms are offered, which appear to integrate client interests and organizational goals. These mechanisms, discussed in terms of the descriptive findings, appear relevant at different times during agency development and emerge from the conditions and consequences of client/staff interactions. The achievement of mutually acceptable organizational forms appears to result from exchange and accommodation mechanisms. The evolution of these mechanisms derives in part from the extent to which the agency recognizes and includes client inputs.

This research offers a framework for the exploration of client influences on agency policy. Any effort to identify or understand organizational development must take into account the implications of client characteristics and behavior. An awareness of the nature of client participation is vital to understanding the ways in which current structures function and the kinds of new service structures which will evolve.
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MILESTONES

1. July 1968 - Drug Dependence Unit had its origin in an 8 year grant awarded by NIMH - Director R. Stander.
2. September 1968 - The Outpatient Clinic began operations.
3. September 1969 - The Outpatient Clinic was reorganized and became Veritas House.
5. September 1971 - The Youth Services Division was founded and incorporated Veritas House and Alpha House under one overall director - Director R. Rapkin, M.D.
6. April 1973 - A downward shift in age of population being served from a median age of approximately 20 to a median age of 17.5 to 18.5.
7. August 1973 - Educational-Vocational Institute began providing services.
8. January 1975 - Center of Progressive Education (COPE) was founded and began providing educational services at Youth Services Division. Director N. French, R.N., M.S.
CHAPTER I
INTRODUCTION

Introduction to the Problem

Almost all known cultures have used psychoactive drugs to facilitate social intercourse, to alter consciousness, to heal. Our society's expanded chemical manipulations simply represent a larger technical capacity, more wealth, leisure, and greater individual choice; conversely, a significant reduction has occurred in constraining social settings, peer and family standards, and personal behavioral prescriptions. These conditions assure considerable variety in the drug behavior and associated outcomes of about 45 million Americans between the ages of 10 and 21, the population of specific interest in this paper. Because the present is also a time of rapid change, being young is difficult. School failure, children's suicide, accidents, venereal disease, running away, and delinquency have continued to increase in frequency (MacLeod, 1976).

Just as with these phenomena, youthful drug use may be understood to have stress as well as opportunity as part of its causation. Some of that drug use will be problematic; most will at the very least be significant in some manner to the youngster. Families and communities will be attentive to those excerpts from youthful drug conduct which are visible, unconventional, symbolically threatening, or which
do in fact prove to be an acute hazard, to impede normal development, or to forecast a declining career. Since there is a direct relationship between the risk of these disturbing features, their outcomes and the degree to which drug use (not integrated into approved familial and culture settings as at the family dining table or in the doctor's office) is unsupervised, there understandably is public concern with the extent of repetitive use.

Drug use surveys provide data on the actual extent of use among the youth population. The most recent comprehensive national survey, sponsored by the National Institute on Drug Abuse (NIDA) (Abelson et al., 1977), shows that among youth between the ages of 12 to 17, over 28 percent have tried marijuana, 9 percent have used inhalants (sniffing glue, gasoline, and the like), and 5 percent have taken heroin. Among medically available substances used without medical advice, other opiates (cough syrups or pain killers) have been used by 6 percent, 5 percent have used stimulants, 4 percent have used tranquilizers, and sedatives have been used by 3 percent. (The comparable figure for alcohol is 53 percent and tobacco 47 percent.)

Drug misuse, abuse and addiction are problems to the individual, family and society at large. Alcohol, when abused, is the most dangerous of all the drugs in use, second to none including heroin. It is our most pressing and serious drug abuse problem, dwarfing all others. There is no escaping the fact that we are a nation of drug users. The
majority of research findings presently available give evidence that the drug abuse problem will continue in its severity. Drug use is not a moral issue and should not be responded to as such. It should be addressed not emotionally but rather in a pragmatic and rational manner.

Statement of the Problem

Methods of intervention. Drug abuse is a complex syndrome that cannot be adequately managed by medication and psychiatric intervention. It is a behavioral response to a set of frustrations that are intertwined with lifestyle and self-concept and involves complex attempts to lessen pain and modify an inhospitable reality.

Facing a reality of unmet needs and blocked aspirations, certain individuals learn to "adjust" and accordingly modify their expectations. For others, "adjustment" is not possible. These latter individuals often adopt response patterns that are dissonant with normative behavior expectations. Consequently, these behaviors are sometimes labeled sociopathic or psychopathic.

These response patterns take at least two distinct forms: outer-directed aggression, and inner-directed aggression. Outer-directed aggressive behavior is characterized by striking out at the source of frustration, and may therefore be viewed as a more or less adaptive response (Caplan, 1970). Inner-directed aggression is characterized both by a striking out at oneself and by passivity. It is
thus associated with a wide range of maladaptive behavior that is part of a matrix of responses which are destructive of human potential: abusive use of drugs, suicide, victim-precipitated homicide, mental illness, etc. (Linton, 1956).

Though sociopathic and psychopathic labels are often pinned on the former response pattern (outer-aggressive behavior), it is normally the latter with which human service workers are called upon to be involved. Unfortunately, this work often centers around "adjustment" and psychopathology without giving adequate attention to the environmental factors that precipitate and/or sustain the difficulties, according to Thomas and Sillen (1972), Comer (1972). As Etzioni (1964) has noted, the tendency is for persons not to get "better".

It is unclear upon whom or upon what in our society the responsibility for drug abuse lies. On the one hand, it is argued that the sick individual has failed to adjust to existing institutions. On the other hand, it is also argued that maladaptive institutions fail to accommodate the individual. In all cases it is the individual -- the drug abuser -- rather than the institution who suffers. This suffering is then projected back upon society via the behavior in which the individual engages. Innocent individuals are robbed and mugged, businesses and homes are vandalized and neighborhoods deteriorate. The dynamics of drug addiction are not, however, the issue to which this paper is addressed; of particular concern here is adolescent
drug treatment.

Today there is a wide variety of approaches to the treatment of youthful drug abusers. These include: multimodality programs; drug-free therapeutic communities (TC); psychoanalytically oriented individual, group and family therapy; naloxone-aided therapeutic communities; and programs dealing primarily with the underlying social issues of drug abuse, among others.

The evolution of so many approaches is evidence that we have not yet arrived at any one solution to the problem of youthful drug abuse. Moreover, one solution will probably never be reached, since drug abuse is a symptom with many causes and seen by many different types of individuals. It is with these facts in mind that the scope of this paper will be limited to the exploration of the therapeutic community model.

What is a therapeutic community? A haven, a residence, a collective parent, a rehabilitative process, an ideology --- a therapeutic community can be all of these things. The term is most often used, however, to mean a particular method for treating drug abusers, although many communities open their doors to any person who has a problem too great to handle alone.

The work within therapeutic communities usually centers around changing an individual's behavior, rendering that individual more productive and less destructive, both to the individual and to society. By their very nature, therapeutic
communities involve small groups of people interacting with each other and with staff members in a relatively closeknit residential setting.

Specific techniques vary from program to program, and range from actual group psychotherapy and strict hierarchical structures to free-wheeling group interaction and loose systems of rewards. Some programs supervise and discipline individual activity; others do not. Some programs exhibit a family-like cohesiveness; in others the residents seem bound only by their proximity. Some depend upon a dynamic and inspirational leader for guidance; other programs adhere to committee or group decisions, or well-worn procedures. Some programs are completely voluntary; some accept involuntary entrants and court referrals.

Most therapeutic community programs operate in relative isolation from the surrounding society -- and from other drug programs, including other therapeutic communities. Most are based upon the belief that an individual's past environment had a great if not determinative influence upon his or her particular behavioral problems. Therefore, the basic process of rehabilitation itself encourages isolation from a person's past associations and an affinity for a new environment -- the therapeutic community.

Although therapeutic communities have operated largely in isolation from one another, their roots can be said to be common ones. The first therapeutic community, as the term
is now used, was Synanon in California. The former residents of Synanon, whether ex-narcotic addicts or not, have spread across the country establishing their own programs, displaying their own variations of the group rehabilitative process. These branches of the parent tree form the basis of the "therapeutic community movement".

Collectively the therapeutic community movement has considerably influenced the ways in which this society views social conditioning, individual dysfunctioning, and narcotic addiction. However, the influence has been recognized to a greater extent by those outside the movement. Those within the movement have been more concerned with effecting the progress of their programs than with totaling their impact or with collecting the praise which may follow their efforts. Furthermore, isolated from each other and pursuing their own unique paths, therapeutic communities have often been unable to appreciate the accomplishments of other programs or to share their own successful methods.

Rationale and theoretical orientation of the study. It is with such a therapeutic community that this researcher has been associated for a period of nine years--from the conception of the initial idea to the functional delivery of services. Because of rapid growth and, on occasion, the quick death of such agencies, the overwhelming mandate and predisposition to action and sometimes evaluation are usually non-applicable and suffer from a large time delay. It
is hoped that this study has overcome these shortcomings by insight provided by the researcher's presence in the therapeutic community as participant observer (action) followed by a return to academic study (reflection).

**Historical Background of the Organization**

**Drug Dependence Unit.** The Youth Services Division is the component of the Drug Dependence Unit which addresses itself to adolescents. Before describing the Youth Services Division, it is important to give a history of the Drug Dependence Unit (DDU). The Drug Dependence Unit had its origin in July 1968, when an eight-year grant was awarded by the National Institute of Mental Health to establish one of the first community drug treatment programs. (See Figure 1.)

It had been envisioned from the beginning that the DDU should be a multi-modality program. While many community drug dependence treatment programs adopted the term "multi-modality", it has been our observation that few have developed the variety of programs and/or the consolidation of treatment techniques that have evolved in the New Haven area. Over the years the DDU has grown to be a highly diversified yet closely coordinated treatment program. This fact was recognized nationally in September 1975, when the American Psychiatric Association awarded the DDU its Gold Medal Award as a model community mental health program. (See Figure 2.)

The philosophy guiding program development within DDU was expanded in July 1975, when the Substance Abuse Treatment
Figure 1. Drug Dependence Unit 1970 Organizational Chart
Figure 2. Drug Dependence Unit 1974 Organizational Chart
Unit (SATU) was created. SATU consists of two separate treatment programs, one for alcohol abusers and one for drug abusers. While each program remains separate the clinical directors of the Drug Dependence Unit (DDU) and the Alcohol Treatment Unit (ATU) are both accountable to Herbert D. Kleber, M.D., the Director of the Substance Abuse Treatment Unit (SATU). (See Figure 3.)

Historically, when Dr. Kleber was director of the DDU, he established not only the objectives of treatment but also research activities in its area of drug dependence and a broadly based educational program for the community. Thus treatment, research, education and consultation each consistently received high priority. Each component of the DDU has been held accountable for being involved in all of these objectives. As the drug abuse population seeking treatment changed, so the DDU changed in an attempt to meet those needs. One of the long-range goals of the program has always been to attempt to determine which treatment modalities are best suited to which individuals.

Drug dependence has always been viewed as a problem not only of the individual but of society as well. The same is now true for alcohol abuse. Therefore, the DDU has always remained intimately involved with those institutions and groups in society which were perceived as being concerned with either producing or perpetuating the problem of drug dependence. In addition, the DDU has always attempted to stimulate others to improve or develop their activity in
Figure 3. Substance Abuse Treatment Unit Organizational Chart

H.I.P. = High Intervention Program
Meth. A = Methadone Maintenance A
Meth. B = Methadone Maintenance B
E.B.T.U. = Evaluation/Brief Treatment Unit
E.V.I. = Educational-Vocational Institute
COPE = Center of Progressive Education
the field of drug dependence. As part of a major university scientific complex, the DDU has worked with individuals and groups to encourage additional research into the problems of drug abuse.

Since the establishment of the program in 1968, the number of admissions per year has grown from 400 in 1968-69 to approximately 1200 in 1974-75. This is reflective of the reputation which the DDU has gained in the community as being a competent treatment program. While the median age of first admission was approximately 25.5 years at the outset of the program, by 1970 it was approximately 22 years.

One of the most striking changes in the population over time has been in the reported drug of abuse on admission. While several years ago 89 percent of the clients applying for treatment reported heroin as their major drug of abuse, less than one half of new admissions in 1975 reported opiates as the primary drug of abuse. No clear pattern in drug abuse emerged except the fact that barbiturates, amphetamines, LSD, and marijuana have all tended to increase. This increase is particularly dramatic in the adolescent population, which is also the population with a large number of persons having alcohol abuse as one of the presenting problems in this multiple drug abuse.

The DDU has always been an integral part of the Connecticut Mental Health Center (CMHC), which opened in 1966 as a joint endeavor between the Connecticut Department of Mental Health and Yale University Department of Psychiatry.
The Director of the CMHC is jointly responsible to the Connecticut Commissioner of Mental Health for the delivery of services and to the chairman of the Department of Psychiatry, Yale University School of Medicine, for teaching and research. Since the DDU is a component of the Mental Health Center, the director of the unit is responsible to the director of the Center and works through him in solving problems that relate to either of the two organizations.

The administrative structure of the DDU has changed progressively to reflect the growing complexity of the organization. While initially the organization could function with a leadership group composed of the director, associate director and administrator, it became clear as the unit grew that multiple associate directors were needed. Consequently a multiple associate directorship (MAD) was implemented in 1973. With this structure there are several associate directors, each of whom is directly responsible for some phase of the DDU activities. This group, affectionately called the MAD Committee, has met three times a month to help solve problems, discuss issues, and set policies that are program-wide. This group has consisted of the Director of SATU; an Associate Director for Administrative Affairs; Director of DDU; and the Administrator of Addiction-Prevention, Treatment Foundation, Inc.

In addition to the MAD Committee there exists a Coordinating Committee which meets once each month and provides advisory input to the more frequent meetings of the MAD
Committee. This committee includes component directors and other leadership personnel from each component. Each component director has always been expected to take charge of the running of his or her own program and to relate to the staff those policy decisions reached by him and his supervisor as well as the decisions of the MAD Committee.

At the present time the DDU includes five distinct treatment modalities ranging in intervention levels from semi-weekly outpatient groups to residential treatment. The primary outpatient modalities of treatment include the High Intervention Program (HIP) and Methadone Maintenance. Alpha House and Daytop are the two residential facilities and Veritas is a day-treatment facility. Alpha and Veritas are administratively linked and, with the educational facility called the Center of Progressive Education (COPE), form the Youth Services Division (YSD). In addition, the DDU encompasses a Research and Evaluation component and a community resource and referral agency.

Youth Services Division. The Youth Services Division has had an interesting evolutionary process; many changes have occurred since its inception in the fall of 1968. Each of these changes has reflected a clearer conceptualization of the complex problems involved in treating the adolescent population. Initially this component served as the intake division to all of the DDU components and also undertook to treat those individuals for whom Methadone Maintenance and
Daytop were inapplicable treatment modalities. The fact that it was both the intake division and a treatment modality reflects the DDU philosophy that treatment programs had to be constructed to fit the population applying for treatment. By 1968 it was clear that there was a growing number of adolescents and young adults, and that these persons needed a special peer group program.

This was indicated not only because their addiction histories were less extensive than the adult population but also because, as adolescents, they responded to the adult population in treatment more as adults than as fellow drug abusers. Initially this group was almost exclusively heroin abusers. However, as the years have passed YSD has found itself treating a larger and larger percentage of psychedelic, barbiturate, and amphetamine abusers. Screening eventually became a separate intake unit and the YSD began an evolution to its current organizational structure.

The treatment function of YSD began as individual and family therapy in the Outpatient Clinic (OPC). This approach to adolescents and young adults was relatively ineffective; the emphasis was therefore switched to "here and now" group therapy. Specialized groups were formed such as the "head groups" for psychedelic users, the adult abstinence groups for young adults who were heroin abusers, and the adolescent abstinence groups. This model continued to be the mainstay of YSD until September of 1969 when evaluation of the results again indicated that effectiveness was
It was clear that an outpatient model which left the client with a large amount of unstructured time was not a sufficient level of intervention for this age group. At that point two major changes were made: (1) The shift was made to a day basis in which patients were expected to be present from 9:00 a.m. to 5:00 p.m., five days per week; (2) A modification was made to begin to incorporate some of the ideas of ex-addict staffed therapeutic communities in the day treatment setting. This model proved to be considerably more effective: retention rates increased, staff morale was noticeably improved, and concrete behavioral and attitudinal changes on the part of the clients could be seen. This day program was named Veritas House and continues to be the day and outpatient section of YSD. Also, major modifications have now been made in the concept model which continues to serve as the foundation for treatment in both YSD programs (Veritas and Alpha).

In September 1971, an inpatient facility called Alpha House was opened. This was the result of the fundamental philosophy of the DDU that not all drug abusers are alike, that different treatment programs would suit different clients, and that a client might need different programs for different phases of his treatment. Our experience in the YSD with youthful drug abusers indicated an increasing need to place order and structure in the lives of those
Figure 4. Outpatient Clinic 1969 Staffing Pattern
individuals who came with considerable turmoil in their lives. We had found that some adolescents could not tolerate their chaotic home and street environments even while participating in the day program, largely because of the many provocative influences during the evening hours and on weekends when they were not involved in the treatment program. For those individuals, a need for geographical isolation from sources of drugs and unstable living arrangements within the community indicated the necessity for an inpatient therapeutic community. (See Figure 5.)

While the Daytop facility provided many of these supports, a clear need existed for short-term residential placement with higher visibility in the community. In addition, the population at Daytop consisted primarily of adults. Given the state of development of the adolescents and the peer nature of therapeutic community treatment, it was felt that a separate facility was needed for the adolescent population. It was also felt that the length of stay for adolescents should be shorter than the 18-24 months required for graduation from Daytop. Instead it was proposed that the length of stay at Alpha House be only 4-12 months.

In addition, we wished to build a therapeutic community which encouraged graduates to go back to school to be trained in conventional technologies as far as their abilities could take them. In order to provide them with maximum flexibility in job choice and life style, we felt that the emphasis
Figure 5. Youth Services Division 1971 Organizational Chart
on the trained ex-addict as a career goal found in many therapeutic communities was not suitable for most adolescents. In addition, the life maturational tasks of the adolescents indicated that further modification of the treatment techniques used at Daytop might be necessary. Thus, Alpha House was to be a short-term residential treatment center for adolescents using modified Daytop techniques with a special emphasis on education and community re-entry. Further, the linkage of Alpha House and Veritas under a single administrative structure was designed in order to facilitate movement of the client from inpatient to day to outpatient status as he progressed through treatment.

By the time Alpha House was opened the organization had also become aware of the existence of a significant number of clients in the adolescent population who manifested major psychiatric problems in addition to their problems with drug abuse. It was felt that this population was not being adequately treated either by traditional psychiatric facilities or by less traditional therapeutic communities. It was hoped to combine therapeutic community principles with more traditional psychiatric treatments in a blend that would be both acceptable and effective to the client. It should be noted that with continued experience in both components of the YSD, most of the adolescents who manifest symptoms of major psychopathology have these symptoms in addition to presenting evidence of severe character disorders. Thus, as experience was gained it was found that
if the psychopathology can be managed with psychotropic medication, there is a greater opportunity to treat the characterological problems which have led to similar behaviors as in the rest of the youthful drug abuser population.

During the period from 1970 to 1973 few changes were made in the treatment programs. However, beginning in 1973 the age of the population began to shift downward toward the younger adolescent. While initially there were seldom clients under the age of 17 and the median age was approximately 20, this situation changed to a median age of 17.5 to 18.5 with the increase of ages 14 and 16. This age shift has been primarily responsible for re-evaluation of the essential treatment services that are necessary within the clinical programs.

Two major changes occurred at the time of this re-evaluation. The first change was in program emphasis. Initially the YSD concentrated very heavily on vocational rehabilitation as the major re-entry focus. With the downward trend in the age of clients served, however, greater emphasis had to be placed on the educational program. Much more time each week had to be devoted to individual tutoring provided by school systems from which the clients came and in special classroom sessions conducted by the Educational-Vocational Institute (EVI) of the DDU. Thus, educational services now became a primary emphasis of the YSD.

Initially the educational program was called the Learning Center and was conceived as a separate component of
YSD. Now the educational programming within both Alpha and Veritas House is incorporated as a part of treatment even though it has continued to be provided by EVI. This view that educational services are such a critical part of the clinical program for adolescents led to including the director of EVI as a part of the policy group within YSD. This reflects the organization's view of the importance placed upon educational services as a part of, rather than separate from, the treatment process.

The primary purpose of the educational services within YSD has always been to provide a transitional learning experience which assists students in sorting out questions and goals relative to education. More specifically, the goals of the educational programs include preparation for high school equivalency tests, remedial and makeup study for those returning to high school, tutorial enrichment and learning workshops for those who wish to develop specific skills, and educational consultation for those who wish to go on to higher education programs. From the beginning the organization's belief has been that clients within the YSD need a learning experience which they can perceive as significant and different from academic experiences they have known before. For the vast majority of YSD clients, traditional schooling has been a singularly unpleasant experience. Clients need a good experience to counteract this before they can risk getting back into the highly structured system of most public schools.
This experience is generally provided through the educational component COPE, a private, state approved, special educational facility. The primary purpose of COPE is to serve as a stepping stone for Youth Services Division clients who wish to continue their education. It provides an individualized remedial learning experience which assists the student to sort out questions and goals relevant to their education.

The second major change resulting from the decrease in the age of the population was a re-evaluation of the need for family treatment as a part of the total clinical program. It became clear that rather than working with older adolescents and young adults who were in the process of personal emancipation, the organization was now dealing with a population who would remain within their family structures for a number of years following the completion of treatment. In addition to this factor, it had also become clear based upon organizational experience that the young client could not be treated successfully without family treatment.

While peer relationships for the adolescents are certainly a major influence on their behavior, the family has to be considered as having a central role in the creation of personality and behavior characteristics. The family is seen as the basic socializing unit and is therefore the place where social roles begin. Thus, if there is not an understanding of the adolescent substance abuser's role in the family system which helped to produce him as a deviant,
the "rehabilitated" client is likely to revert to the same problem behavior once he leaves the treatment facility and returns home to his previous role in the family environment. Our view then is not only that the treatment focus on the adolescent and his individual problem of substance abuse, but also that the treatment must focus upon and attempt to change the family system, with particular emphasis on the ways in which the family members relate to one another.

In the fall of 1975, the family therapy program again became an integral part of the treatment program at Veritas House. Family therapy was first instituted in the day treatment setting of YSD because it was evident that the continuation of family interaction during the evening and on weekends was seriously affecting the resident's ability to change much of his self-destructive behavior as it related both to his drug abuse and to attitudes toward responsibility. Multiple family groups consisting of five or six families were established with co-therapists, one being a staff member from the therapeutic community and the other being someone with primary expertise in family therapy. During the first six weeks of a client's admission to the program, family therapy groups are held once a week; after that point the family meetings are held every other week for the duration of the program.

It is clear that, for many families, this form of family therapy is not sufficient to intervene adequately in the level of family pathology which is present. In particular,
it was found that family members tend to be extremely dis-engaged from one another to the extent that no family member is willing to look at his responsibility in the behavior of others. It is frequently necessary to meet with individual families between multiple family group sessions, due to crises which occur and must be managed in order not to threaten the participation of the resident in the program. The need for being available for crisis intervention also appears partially to be the result of many of these families relating to one another only at times of crisis. The families have often not developed any means of supportive communication patterns for the interim between crises. It is now clear that many of the families need both individual family therapy as well as the multiple family groups, particularly during the initial stages of treatment.

The family therapy program is now being extended to include the Alpha House population. While the staff of Alpha House has always been in contact with families, this contact has often centered around a crisis orientation and, as a result, families were more likely to become anxious and sabotage treatment in their anxiety. We have understood this to be the result of multiple factors. First, it is not uncommon that when the client is first admitted to the program, both he and his parents are extremely angry with one another. Initially, then, the admission serves to relieve tension and provide a "vacation" from one another.
However, guilt over the extrusion of the adolescent often overtakes the family and, simultaneously, the adolescent begins to fear that the family will "close ranks" and permanently exclude him. The pairing of these two phenomena may then result in both the parents and the adolescent deciding that they have made a mistake and that they should immediately try again to be together at home.

At a more covert level the need to have the adolescent return home may relate to the hypothesis that, for family stability, the interaction patterns must be maintained and that a necessary role in the family is that of the deviant adolescent. In particular, if having a deviant adolescent in the household has protected parents from marital discord, the removal of the adolescent could potentially cause the marital situation to become more evident. This situation might thus increase the likelihood that the parents would unconsciously sabotage the treatment in order again to be protected from coping with their own relationship. It is viewed that, with family therapy, there is a greater likelihood that these roles can be understood by all and approached in a concerted way so that the family will be less likely to undercut treatment.

Philosophy of the treatment programs at YSD. The basic treatment structure of both Alpha House and Veritas is highly stratified: upward movement is a reward for desired behavior and social sanctions agreed upon by the staff and
Peer groups are a means of controlling undesirable attitudes and behavior. The need for a highly structured environment for the substance-abusing adolescent is best understood by conceptualizing the treatment process as a three-step engagement in change on the part of the individual.

The first step is intervention in uncontrolled "acting out" behavior. Once this intervention has been accomplished, the second step is to engage the resident in a process of thinking through situations and making responsible decisions, taking into account both himself and others. Only after the accomplishment of these two steps can the person understand with any depth the relationship of feelings to particular ways of thinking and behaving.

These steps in the engagement of the adolescent in treatment are based on the hypothesis that young people who are involved in substance abuse have developed this involvement as a way of coping generally with very intense, denied feelings. The rigidity of this treatment structure has been softened considerably from the approach of the adult therapeutic communities and the individualization of rewards and punishments as well as individual attention in other ways has been further emphasized.

The family nature of the residential living environment continues to be stressed and constant confrontation about behavior with the other adolescents remains central. Often for the first time the adolescents are confronted with the need to recognize their behavior and the response of others
around them. Identification remains the key to the YSD structure: the person making decisions about the adolescent's life is a person with whom the adolescent can readily identify. Authority then cannot be seen as something dehumanized and easily dismissed; rather authority becomes a tangible, positive force in the adolescent's life. Eventually it is expected that the adolescent becomes the authority.

Organizationally Alpha and Veritas House continue to be divided into functions or departments. Each department takes the responsibility for the functioning of a specific aspect of the house. The resident may be assigned to any department. As a general rule, the resident will initially get the lowest job in the department which has the most menial tasks to perform. The resident may then work his way up. This stratified structure is creatively used to assist residents in facing difficult areas in a constructive manner. The functions of the departments are therefore not only a matter of maintaining the house but serve a positive therapeutic function with every resident as well. (See Figure 6.)

**Organizational Growth**

The essential link between sociological theory and the social problem of human service delivery lies in the question of how the goals of an organization and of its members are integrated during the course of development.
Figure 6. Youth Services Division 1979 Organizational Chart
A number of models have been proposed to describe this process, but they have been oriented primarily toward efficiency of organization. Their inadequacy is apparent when criteria other than efficiency are used to evaluate the success of an organization. Indeed, in the "real world" efficiency may actually be antithetical to the goals of delivering service to populations that manifest a disdain for efficiency as an end in itself.

In short, we are unable to grapple closely with critical areas of substantive and theoretical concern, even though at least two of the key questions of interest may be traced back to the concerns of Weber and other traditional sociological theorists: (1) what produces rigidity or disregard for clients in some organizations and not in others; and (2) what are the dynamics of formal organizations and how do they relate to the delivery of service to clients?

There are at least two reasons, theoretical and methodological, why sociology has stumbled onto these questions. Theoretically, the question of what comprises an "organization" has been solved primarily by definition. The bureaucratic model and questions which flow from it historically have been concerned with the internal features of organizations. Considerations of the impact of clients on organizational structure have largely been ignored, since clients usually do not appear on organizational charts. However, political conflict between organized clients and
service organizations necessitates broader, empirically based conceptions of organization (Lefton and Rosengren, 1966).

Methodologically, there have been few studies employing research strategies useful in examining organizational change. There has been a heavy reliance on survey methodology and few longitudinal studies of organization (Blau and Schoenherr, 1971). Where case study methods have been applied to single organizations, the findings are difficult to generalize.

Purpose of the study. The purpose of this study is to examine empirically the development of two service organizations which have been designed to serve the social needs of alienated, drug-using adolescents. The writer will concentrate primarily on the exploration and description of those processes that reconcile the relationship of client to organization. This will be accomplished by describing in what ways and to what extent varying client inputs shape both the responsiveness and the structure of the organization.

The ultimate purpose of this investigation is to improve organizational performance by providing to the organization enhanced self-understanding. This, in turn, would mean necessary change and goal clarification for that therapeutic community. In addition, the investigation will explicate how such agencies evolve and the ways in which they are shaped and influenced.
Postulates of the Study

This study is predicated upon four basic postulates. The first postulate is that external forces (social and environmental influences) are the greatest influencing factors upon human service organizations. These external forces are also a significant factor in the development of internal organization.

External influences. The supposition that external pressure by funding sources and surrounding organizations exercises the greatest influence on funded programs has long been recognized but not widely documented. Connery (1968) highlighted the political influence on programs and their ideologies in his writings about federally funded community-based mental health programs. A book by Etzioni (1961) covers briefly environmental influences on organization behavior. Comparative Studies in Administration includes a number of writings on organizations in several different cultural settings and the effect of a culture's ethos upon the organizations. Selznick (1953) documented through case studies the relationship between governmental agencies and the population which they were intended to serve. Of extreme importance is Selznick's writing on the subject of commitments enforced by the social and cultural environment.

Any attempt to intervene in history will, if it is to do more than comment upon events, find it necessary to conform to some general restraints imposed from without. The organizers of this attempt are committed to using forms of intervention
consistent with the ongoing social structure and cultural patterns. Those who ascend to power must face a host of received problems; shifts in public opinion will demand the reformulation of doctrine; the rise of competing organizations will have to be faced; and so on. The institutional context of organizational decision, when not taken into account, will result in unanticipated consequences. Thus intervention in a situation charged with conflict will mean that contending forces will weight the consequences of that intervention for their own battle lines. The intervening organization must therefore qualify decision in terms of an outside controversy into which it is drawn despite itself. More obviously, the existence of centers of power and interest in the social environment will set up resistances to, or accept and shape to some degree, the program of the organization. (Selznick, 1953)

This passage crystallizes the explanation of why external factors have the greatest influence on the direction which organizations will take; and in the case of governmental agencies that influence is paramount in deciding goals, philosophy, and program input and/or output.

There exists very little in the area of systematic theory about the way in which internal power structures react to outside influences. Thompson and McEwen (1958) in their study noted the importance that environment plays in these power adjustments. They hypothesize that one way of analyzing the degree of power exercised by outside influences is to identify the time of entry of these forces into the decision-making structure: the earlier the entry, the greater the power. Four models are established for entry: (1) competition, which is a condition of influence but not one in which formal entry occurs; (2) bargaining,
in which separation of power centers is retained; (3) co-optation, by which the informal sharing of powers occurs; and, (4) coalition. Selznick (1953) also talks about cooptation and defines it as "the process by which power, or the burdens of power, are shared." He then differentiates between informal and formal cooptation. Selznick's work is most beneficial in explaining the effects of external influences upon internal structure.

Of additional interest is the work done by Lawrence and Lorsch (1969) in the area of organization/environment interface. Their thesis is that the characteristics of an organizational unit must in some way match those of its segment of the environment if healthy transactional relations are to prevail. Along with the certainty-uncertainty continuum, the concepts of stability vs. change and organization-environment mismatch are developed. Both demonstrate the large effects of various external influences upon organizations and their internal structure.

Finally, Dickson (1968) discusses environmental influences in relation to the Federal Bureau of Narcotics. In this work it is argued that, similar to the earlier expansion of narcotics legislation, the Marijuana Tax Act was the result of a bureaucratic response to environmental pressure. The study states that the Narcotics Bureau, faced with a non-supportive environment and a decreasing budget which threatened its survival, generated a crusade against marijuana use which resulted in the passage of the act and the
alteration of a societal value.

Leadership and evolution. The second postulate of this study is that leadership is a prime factor in the evolution and development of organizations and in their resulting products or programs.

Essentially, leadership means power, and power over others enables a person to do things, to obtain things, to accomplish feats that, by oneself, are unattainable (Fiedler, 1971). This is one definition of leadership taken from one of the many studies available. Others (Etzioni, 1964; Hutchinson, 1967; Cartwright, 1965; Blanchard and Hersey, 1969) provide variations on the same theme -- that leadership is often regarded as the important modifier of organizational behavior (Pfiffner and Sherwood, 1969). In order to be effective, the leader of an organization, regardless of the type of leadership one employs -- scientific management (Taylor, 1911) or human relations (May, 1945; McGregor, 1967; Argyris, 1964) -- must in some way deal with the concepts of power, control, influence, motivation, direction, and authority. In discussing leadership within the context of this study, this document specifies the type of leadership employed, how the above concepts were actualized, and the effects on the development of the organization and implementation of the program.

Goals and their implementation. A third postulate of this study is that what actually occurs (reality) in implementa-
tion differs greatly from what organizations state they intend to accomplish (theory).

This postulate really addresses itself to the area of goals and goal measurement. Organizations which do not produce material outputs are extremely difficult to evaluate (Etzioni, 1964). Depending on the method of measurement, human service organizations generally rate fairly low on the scale of goal accomplishment. This is due both to the lack of agreement on the method of goal attainment and to the overwhelming size of the task. Organizations such as hospitals, schools, and social service agencies can never effectively cure everyone, teach all, or serve every individual need. Etzioni (1964) talks about the concepts of goal displacement, Selznick (1943) about goal succession multiplication, and Pfiffner and Sherwood (1969), expansion and multi-purpose goals. All of these phenomena play a role in the difference which occurs between organizational intentions and actual accomplishments.

Intra-organizational activities. The final postulate:
Intra-organizational activity plays a large role in the setting of intermediate goals, staff and functional relationships, organizational philosophy, and eventual products or programs.

All activity which goes on inside an organization -- organizational, intra-personal, and inter-personal -- can be considered intra-organizational by definition (Selznick,
This activity on the intra-personal level has a strong influence on the development of staff relationships both in the carrying out of the task and in the socialization process. In the day-to-day behavior of the group, activity also becomes centered around specific problems and approximate goals which have primarily internal relevance; these can be termed intermediate goals (Selznick, 1943). Selznick suggests further that through intra-organizational activity, the organization acquires a self, a distinctive identity which might be labeled "organization character."

The existence of organization character can be seen in the frequency of new organizations created to administer new programs; the chances of adjusting the character of old organizations to new requirements are remote indeed. The character of an organization develops through the same general processes as that of an individual.

The development of organization character might also be termed the development of "organizational philosophy." When such a philosophy is established (i.e., certain beliefs are verbalized by a majority of the group that relate to the task), it has a direct bearing on the outcome of the product or, in this case, the individual being treated.

**Significance of Study**

The significance of this study can be stated in terms of its potential use by similar organizations. It is
imperative in a time when social problem agencies are still rapidly expanding that research be undertaken which will provide such organizations with relevant data (both empirical and descriptive in nature) and analysis thereof, with the expectation that it will be of benefit for self-evaluation and continually improved functioning. Many social problem agencies are started and then quickly abandoned on the basis of the degree of apparent ineffectiveness, that being judged from various measures, however imperfect (Campbell, 1969). A demonstration of social research appropriate to these programs is needed.

Such social research should look at operations in context to see what, in fact, goes into the making of the final evaluation which, in turn, will determine the fate of such organizations. Just as programs can be political, so evaluations can be as well -- political in the sense that the evaluation of social-educational programs is subject in large part to individual interpretation and bias, and can easily be influenced by a number of sources. This is not the case in the evaluation of scientific programs where there is a large knowledge gap between program officials and consumers, and where the criteria for measurement are so exact that it leaves little room for any type of influence. The results of social-educational program evaluation carry with them so many behavioral and social implications relevant to everyone's life that this fact in itself becomes a variant which colors the quality of the investigation. The time
has come when evaluation must begin to allow room for discussion of intervening external variables, such as politics, in an attempt to understand more fully the results or products of social problem agencies.

Description of Chapters

Chapter I will focus on the history of the drug usage and its treatment in this country. A detailed study of the various modes will be presented with emphasis on the therapeutic community for adolescents in New Haven, Connecticut. The researcher shall attempt to reconstruct through historical analysis the goals, theory, philosophy, and original purpose of this project.

Chapter II will address some of the basic problems inherent in the diagnosis of an organization established to impact upon a social problem. The researcher will trace the development and organization of the project vis-a-vis the initial functional stages of client, staff and program development.

Chapter III will review the research methodology and procedures utilized in this investigation. This chapter will include a presentation of the research design, data collection, analysis, reliability, validity and the limitations of this study.

Chapter IV will present information which will document the critical interventions both internal (intra-organizational)
and external (social and environmental). This chapter will analyze the effects of these interventions upon the goals and functions of the organization.

Chapter V will contain a review of information contained in quarterly and annual reports presented to the funding sources. This chapter will include an evaluation and a documentation of performance with regard to meeting original goals and purposes of the project. Reasons will be presented for including education as a part of the total rehabilitation process. Suggestions will be offered for the development of an interdisciplinary approach to the treatment of adolescent substance abusers.

In conclusion, this chapter will offer reasons why the clients of treatment programs should be involved in the program's decision-making process, and why there exists a need for programs and communities to work together to afford the clients a better mode of treatment.
CHAPTER II
REVIEW OF THEORIES FOR ORGANIZATIONAL DIAGNOSIS

The purpose of this chapter is to present an overview of literature in the field of organizational diagnosis, a rapidly developing area in the field of behavioral science. Alderfer (1974) defines organizational diagnosis as:

... the process of publicly entering a human system, collecting valid data about human experiences with that system, and feeding that information back to the system to promote increased understanding of the system by its members.

Thus organizational diagnosis is analogous to the physical diagnosis that a physician formulates after examining a patient. The organizational diagnostician formulates an analysis of a client system.

In one way or another, we are forced to deal with complexities, with "wholes" or "systems", in all fields of knowledge. This implies a basic re-orientation in scientific thinking. (Ludwig von Bertalanffy, 1972)

Organizational Diagnosis

Organizational diagnosis often involves complex analytic procedures and requires extensive training in organizational behavior, data-collecting methods, and interpersonal and intergroup skills. However, some analytic techniques and models associated with organizational diagnosis can be mastered and used by interested individuals.
The following diagnostic method can be used to scrutinize the behavior and condition of an enterprise. Although this proposed method of organizational diagnosis represents a basic approach, it is a useful tool for understanding organizations.

Briefly, organizations are open systems that can be examined from various diagnostic domains. These domains are vantage points from which one can choose to reach an understanding of the reality of an organization and its present condition. For the purpose of this model, six diagnostic domains from which an organization can be scrutinized are listed below (Katz and Kahn, 1966):

1. History of the organization
2. Goals and tasks of the organization
3. Organizational structure
4. Boundary management
5. Organizational culture
6. Organizational processes

There are, in addition, vantage points from which an organization can be scrutinized (e.g., demography; how the organization generates, allocates, and utilizes its resources; effectiveness and efficiency of the enterprise). The six diagnostic domains above are, however, sufficient for successful completion of an organizational diagnosis.

**History of the organization.** Crises are linked to unresolved issues, or what might be called historical crises. In effect, each crisis is both an effect of the previous
phase and a cause for the next one. To predict future dilemmas, managers and consultants must be aware of the historical process of the enterprise, because understanding the processes is the first step in controlling them. The consultant must not only know how the organization is functioning and why, but also how the forces evolved and what historical forces continue to influence its activity (H. Levinson, 1973). The dynamics discussed here only begin to touch upon the manner in which historical forces influence the life and development of an enterprise. The answers to the questions of how organizations grow and the struggles and crises encountered in their development require further study and inquiry.

Goals and tasks of the organization. The way in which an organization defines, communicates and manifests its tasks and goals has a myriad of consequences for the work and life of the organization. By examining these areas, one can better understand the present condition and future survival of an organization. Organizations have multiple goals (the end toward which work is aimed) and tasks (activities carried out in service of goals), although each organization has a primary goal/task of survival. Definition of the tasks and goals is important because they provide the basis for decisions about the mode of work and the technology that will be employed and that affect the organization's export products. They also form the basis for the organization's
social structure and process. Selznick (1956) suggests that "an appropriately defined primary task offers stability and direction to an enterprise protecting it from adventurism or costly drifting."

In the human services field, the process of defining and the definitions determined for primary tasks and goals may generate conflicts, particularly if the definitions are developed and shared only among top management. The tasks and goals will be open and subject to distortion, fluctuation, and confusion from subordinates and the larger community. For example, if members of an institution are unclear about their mission and what is expected of them, a potentially chaotic and anxiety-provoking situation is created and task performance is impaired.

The ambiguity and lack of clarity regarding task definition has major consequences for the system by providing the opportunity for competing, incompatible goals and irrelevant task behavior to emerge. However, sometimes a group or its leadership may foster ambiguity and confusion regarding the primary task definition because there are external and internal definitions. This frequently occurs when the sociopolitical milieu in which the organization is embedded does not permit an organization to make its primary task overt and explicit, because to do so would endanger its existence and survival. For example, under the guise of social change and the amelioration of social pathology
(i.e., poverty, hunger and racism), a predominantly Black enterprise actually may be funded to control any upheaval in the community. The enterprise, however, views its primary tasks as promoting social change, Black assertiveness, and community control. If its true primary task was made explicit, it is quite likely that funding would cease.

Organizations and groups are engaged in many tasks other than the stated task (Bion, 1961). Miller and Rice (1967) suggest that an organization often creates an "as if" task (i.e., it behaves as though its tasks are other than those that are stated). For example, if there is a great deal of confusion and conflict in an organization, it could be said that the organization is acting "as if" its task is to fight internally rather than to do its assigned work. The organizational diagnostician must attempt to find out how the conflict and confusion serves the organization. Often in an organization, people create confusion and conflict in an unconscious attempt to avoid work or to defend against the anxiety related to performing their tasks (Menzies, 1961; Levinson and Newton, 1973). For example, in a drug prevention program, the tasks and goals are so broad and often unmeasurable that it may be psychologically more comfortable to maintain conflict than it is to struggle with the questions of program effectiveness, the organization's method of operations, etc.

Confusion, conflict and chaos also are often system
manifestations of an ill-defined or blurred task definition. If desired outcomes are unclear, tasks often are unclear. Therefore, the organizational diagnostician should determine if the goals of the organization and its subsystems are stated clearly. Task and goal definition is a crucial domain that warrants inquiry in order to assess the dynamics of an organization. How an organization defines its primary tasks and goals, and the mode in which these are communicated and manifested, provide essential criteria for the evaluation of organizational performance, effectiveness, and future potential.

Organizational structure. The organizational structure of an enterprise encompasses all arrangements (Singer et al., 1975) for managing and utilizing time, territory, technology, material, tasks, and both human and institutional resources. It sets the forms, patterns, and devices for integrating, organizing, and coordinating the organization's activities. In addition, structures also are developed to manage and utilize the "collective life forces" (i.e., social dynamics and processes that occur in organizations). Therefore, an understanding of an organization's structure is important to the organizational diagnosis process. In this model, organizational structures are conceptualized as a conglomeration of substructures interacting with and interconnected to each other. From this perspective organizational structure has a latent or covert, as well as a
manifest or overt substructure. Additionally, enterprises have substructures for time and task management, power, and friendship.

There are two basic and essential aspects of organizational structure on which other substructures are dependent: division of labor and division of authority (hierarchy). The division of labor defines the way in which the work and activities of the enterprise are organized, and also refers to the arrangement of the organization to accomplish its task. Because all enterprises are divided into subsystems, integration of various sectors is needed. In the process of dividing labor, organizational positions are created. According to Daniel Levinson (1959), a position is an element of organizational autonomy, a location in social space, a category of organizational membership. In an organizational structure, positions are more or less permanent; they are subject to change when organizational structure changes.

Another aspect of organizational structure are roles, which involve function, adaptation, and process (Levinson, 1959). Related to their positions, people perform certain roles within the organization. Role performance is the interaction of the individual and the social structure. It is important to emphasize the distinction between role and position; if one loses the idea of position and thinks only in terms of role or role performance one tends to overem-
phasize process, activity, and function, and to obscure the structural properties from which organization life emerges.

The division of authority provides the vehicle for managing, coordinating, and integrating the work of the various subsystems of the enterprise. The division of authority indicates the pattern of stratification within the enterprise and its subsystems. Within the organizational structure, authority is invested in the position and not in individuals. A position of responsibility to coordinate the work must hold the authority to accomplish it.

Every member of an organization has a formal position and role, and functions according to the division of labor and division of authority. However, because of the many aspects and components of organizational substructures (e.g., friendship, power, etc.), a member can be viewed as occupying a variety of positions and role functions in the various substructures in which he participates. Such a view accounts for the numerous relationships and phenomena that occur in organizational life (e.g., the informal cliques, the reference group, etc.). Menzies (1960) and Jacques (1955) suggest that organizational structures are developed in order to cope with the anxiety that is inherent in organizational life. This anxiety is related to existential fears of losing one's individuality and threats to one's sense of identity.
Katz and Kahn (1966) have identified five organizational subsystems:

1. Production subsystems are concerned with getting the work done;

2. Supportive subsystems procure the input, dispose of the output, and deal with institutional relations;

3. Maintenance structures (such as personnel administration) promote adequate role performance by tying people into their functional roles;

4. Adaptive subsystems facilitate the organization's responsiveness to the changing environment; and

5. Managerial subsystems direct, adjudicate, and control the various subsystems and activities of the organization.

This diagnostic domain views the structural characteristics of an organization from a multidimensional perspective. The life of an enterprise can be understood in light of its structural properties. Clearly, organizational structures are developed to manage the task as well as other dimensions of organizational life. It is the analysis of the structural characteristics by which the organization's life operates and emerges that gives insight into phenomena. Ill-defined, ambiguous structures can add to confusion and chaos. If an organization's structure is incongruent and non-supportive to its primary task, its survival and health are jeopardized. The issues of position, role functions, and their authority relationships are key ingredients determining the weakness or strength of the enterprise. [For
a detailed discussion on roles and position, see Cyert and MacCrimmon (1962) and Levinson (1959).]

**Boundary management.** This diagnostic domain explores the nature of organizational boundaries -- how they are defined, controlled, and managed. Organizational boundaries play an important function for the total health of a system by separating the inside from the outside and separating the organization from what is external to it (i.e., the environment), defining the various internal operations of the system, and serving a transactional function that allows exchange between the organization and its environment.

Open systems import energy or matter across boundaries, apply conversion processes to transform the material, and export the transformed material back across the boundaries. This import-conversion-export process could involve developing a new product, providing treatment services to human beings, or implementing drug abuse preventives. Typically, a prevention program imports clients, provides them with a variety of activities (group process skills, alternatives, self-help projects, etc.), and hopes to export a more aware, self-actualized, healthy individual.

**General boundary characteristics.** Organizational boundaries may be objective or subjective. Objective boundaries include: walls, doors, maps to mark spatial boundaries, clocks to indicate time boundaries, organizational charts to illustrate the boundary around a particular work unit,
and a list of an organization's clients and staff to describe human boundaries. Subjective boundaries refer to the human feelings that are often associated with concrete boundaries.

Boundaries in organizations are defined by the "4 T's:" time, territory, technology and task. In order for an organization to be effective, the boundaries between the 4 T's must be appropriate in relation to each other. If any one of the 4 T's are ill-defined, unknown, or not mutually supportive of each other, there is a loss of vitality in the system. If these elements are incongruent with each other, the life of the system is jeopardized. Obviously, how an organization manages its boundaries in terms of time, territory, technology, and task is crucial to its survival.

**Boundary permeability.** An organization's survival is contingent upon continuous I-C-E (import-conversion-export) interaction with its environment (see Figure 7). This interaction can be categorized in terms of the permeability of its organizational boundaries. The degree and type of permeability affect the organization's ability to adapt to its environment. A system with too porous a boundary (underbounded) is indistinguishable from its environment; on the other hand, a too rigid, non-porous boundary (overbounded) closes a system to its environment. Although these two boundary conditions represent opposite ends of the spectrum, there is a tendency for some systems in marked disequilibrium to vacillate between the two extremes. (See Figure 8 for an application of the I-C-E process to service programs.)
Figure 7. **Import - Conversion - Export** Processes

(Adapted from Karl Deutsch's Psycho-Cybernetic model for understanding with complex organizations.)
Figure 8. Organizational Resources and Activities

- Family Counseling
- Peer Counseling
- Counseling Activities
- Fundraising
- Retreat Workshops
- Student Council Alternatives
- Education Services
- Drug Education
- Rap Sessions
- Group Activities
- Client Activities
- Adult Groups
- Young People
- Community

Program Evaluation
- Research
- Public Relations

Support Staff:
- Administrators
- Clerical
- Maintenance

Drug Program Management
- Counselors
- Outreach Workers
- Community Organization
- Teachers
- Social Workers

Exports
- More self-aware, self-actualized people

Conversion

Program Activities
In Figure 9 Alderfer (1975) illustrates how organizations lose vitality by being either overbounded or underbounded.

Alderfer also lists eight dimensions by which overbounded and underbounded organizations differ: authority, role definition, communication, human energy, affect, economic condition, and time span of concern.

**Authority.** Both organizational systems show problems with authority. In overbounded organizations, authority is well defined and often very rigid. It is typically authoritarian, status oriented and controlling, and is centralized in several key positions. In underbounded organizations the authority and accountability structure are unclear. Sometimes it appears as though several individuals and groups hold responsibility for the same thing. Authority relations are tentative and rapidly change.

**Role definition.** In overbounded systems roles are defined too specifically, reducing the opportunity for normal growth and development. Individuals are not encouraged to develop their talents and skills, and there is very little sharing across jobs. In underbounded systems, people are uncertain about their roles and tend to act in response to crisis situations. People are uncertain about the priorities and the limits of their work.
Figure 9. Graph of Organization Boundaries (Alderfer, 1975)
Communication. Members of overbounded systems have comparatively few problems meeting face-to-face, but the way they communicate is often a problem: they tend to distort and withhold information from each other. In underbounded systems, people typically do not discuss common problems because diffuse authority relations and role definitions tend to keep people apart.

Human energy. Overbounded systems typically have problems releasing their energy to the environment. Members of overbounded systems may find themselves blocked by system boundaries that have become barriers. Underbounded systems have problems harnessing energy to do work. It is difficult to organize the staff; they are often pulled in different directions by conflicting pressures.

Affect. In overbounded systems, members tend to act in ways that are experienced as egoistic and ethnocentric; members are inclined to attribute positive qualities to themselves and negative qualities to others. Emotional feelings are supposed to be sublimated. Emotional expression in underbounded systems is less constrained and of a different quality. Members tend to have more negative (anxious and hostile) feelings about themselves and tend to appear to be less egoistic and ethnocentric.
Economic condition. Overbounded organizations are typically wealthier than underbounded systems. Underbounded organizations typically have fewer funds and exist with greater uncertainty about sources of income.

Time span of concern. Underbounded organizations continuously deal with survival issues, and live with a crisis-oriented mentality. Overbounded systems have problems in responding to changes in the environment. As time passes, overbounded systems become less able to recognize and respond to problems that confront them.

It is essential that the organizational diagnostician explore the degree of permeability of an organization's boundaries. Clearly, boundedness of an organization can explain a great deal about an organization's vitality and how its management functions.

Boundary control. Miller and Rice (1967) suggest that management of an organization requires four types of boundary control:

1. Regulation of the task system (i.e., control of enterprise as a whole, its import-conversion-export processes, and its various support systems).
2. Regulation of emotional boundaries between groups of people (e.g., between cliques or informal groups and their assigned work task groups).
3. Regulation of the organizational boundaries with the environment.
4. Regulation of the boundaries between task, emotional, and organizational boundaries.

Is the management of the organization controlling all of these boundaries? Is the boundary between the organization and environment adequately monitored? Is the executive director securing enough funds and resources for the enterprise to survive? Are the import-conversion-export process activities connected and well coordinated? These types of questions must be addressed by the organizational diagnostician when attempting to understand the condition and future of an organization.

Organizational culture. This diagnostic domain explores the cultural properties of a social system. The culture of an organization plays a vital role in organizational behavior and is a potential source of strength as well as a potential source of stress in organizations.

Culture includes the traditions, values and philosophies of the enterprise. The organizational ideology and ethos are aspects of the culture. Symbols, slogans, customs, taboos, and prohibitions represent cultural properties of the organization. Another major dimension of culture is the organization's mythology which is expressed and enacted through the folklore and organizational images expressed by the individuals. Do they view the organization as an extended family led by a benevolent father or a strong, nourishing mother? Is it experienced as a profitmaking
machine without concern for the individual, or is it a noble enterprise devoted and dedicated to the well-being of its employees and clients?

The culture dynamics of a system are based on distinctive group identities and behavior patterns (including languages and dialects, aesthetic styles, bodies of folklore, religious beliefs and practices, political allegiances, family structure, food and clothing preferences, and other contrasts) derived from specific national or regional origins and unique personal histories. On the other hand, the organizational ethos (i.e., its character, symbols, values and norms) are formed by the founders and by the organization’s history. The cultures of individuals and the ethos of an organization interact in various ways: they may range from being totally fused to being so divergent that the contradictions are unresolvable.

Cultural dynamics produce energy for the enterprise to harness and use. If the enterprise membership is diverse and heterogenous in race, sex, socioeconomic, age, etc., it can benefit from the differences, experiences, and understandings of its members. This can be a creative source for expanding the organization, thereby increasing its problem-solving and decision-making capacities.

In contrast, energy produced by cultural dynamics could be acted out in interpersonal and intergroup tensions, producing a source of stress within the organization. Intergroup
conflict often has its origins in cultural properties and dynamics and should be diagnosed as such. Frequently it is misperceived as hierarchical or lateral structure conflicts.

Organizational mythology is a major cultural property of an enterprise, symbolizing historical and current events in the life of an organization. For example, a discussion between employees might include recalling the time when Joe wore shorts to work and was fired the same day.

Physical character of an office can provide some information about the cultural properties of an enterprise. For example, the color and texture of a room creates images that can elicit warm or cold responses and can make a person feel comfortable and secure, or uncomfortable and ill at ease. Another crucial feature of decor that provides information about the culture is the number of nurturing objects displayed (including coffee, soda, or juice dispensaries; pictures of nature; an abundance of sunshine; a member or staff lounge; the existence of outside affairs -- bowling, softball teams, annual company dinners; and the kind of health plans or lack of them). Often the union takes on these roles of the caring about the individual.

Newton and Levinson (1973) suggest that culture and organizational structure tend to be relatively congruent. However, in a dynamic changing system, the fit will not be perfect because over time, changes in one are likely to produce changes in the other. When culture and goals are
not congruent, this often becomes a source of tension. When culture and goals are congruent, this can facilitate goal accomplishment.

Organizational processes. Organizational structures, as described earlier, are the framework and foundation of the enterprise. Organizational processes are the actual activities and functions of the system.

Within this domain, organizational processes can be examined according to five dimensions (Katz and Kahn, 1966):

1. the intrapersonal dimension
2. the interpersonal dimension
3. the group-level dimension
4. the intergroup-level dimension
5. the inter-system dimension

Each refers to levels of behavioral processes that are conceptually different from, but related and interconnected to, each other.

Intrapersonal dimension. The intrapersonal dimension of an enterprise refers to the individual's inner life and management of anxiety and impulse. The focus is on character traits, unconscious motives, mode of ego defense, ego ideals and life goals. Emphasis in this domain is given to the various elements that attempt to explain individual behavior. Behavioral or psycho-dynamic approaches are useful in understanding the intrapersonal dimension of organizational processes.

By exploring the intrapersonal dimension, one can discover
whether there is a fit between the organization and the inner structural requirements of the individual. Does the manner in which the organization operates gratify the desires or provide fulfillment of the value systems of its employees? Often the intrapersonal characteristics of the members are in conflict with system goals and values, and stress is created. Often the system changes or the member adapts or is driven out of the organization.

An analysis of the intrapersonal dimension allows assessment of each member's interpersonal style and competence. It gives important information about the individual's potential for assuming various roles on behalf of the system. For example, what are the intrapersonal characteristics that express themselves as dependent behavior?

Interpersonal dimension. The interpersonal dimension of an enterprise refers to the interactions between members. The focus is on relationships between and among individuals and emphasis is given to communication patterns, information flow, the interpersonal climate and the feedback properties of an organization; management/subordinate interpersonal relations and/or examination of how management makes sanctions, gives directions, etc.

Research on interpersonal role behavior provides insight about the effectiveness and the cohesion of the enterprise. Typically, the interpersonal dimension is divided into two categories: process and content. The process
level focuses on the emotional aspects of the enterprise and the content level refers to task-relevant behavior.

Various role functions are performed by members to maintain a balance in the content-process categories. Maintenance functions in the interpersonal dimension refer to group building roles (e.g., encouraging and being friendly, gate-keeping, coordinating, and pointing out deviation from norms or tasks). Task functions involve members seeking and giving information and opinions. The individual-centered function is when the member interferes with the progress of the organization by arguing, resisting beyond reason, digressing, getting off the subject, leading the discussion in a personally oriented way, or attempting to call attention to oneself by boasting, loud and excessive talk or unusual behavior, etc.

The interpersonal dimension usually sets the tone and the climate of the intragroup tension and dynamics and is closely related to the intrapersonal characteristics of an individual.

Theoretical constructs, such as those developed by individuals associated with the National Training Laboratory, provide a framework for examining the interpersonal dimensions of the organizational process. Principles of cyclical communication, conflict resolution, and third party peace-making (Walton, 1969) are helpful in comprehending member-to-member relationships.

Team building and developing trust are approaches that
focus primarily on the interpersonal aspect of organizational processes. The use of human relations or "T" groups is the major tool employed in interpersonal training. Human relation techniques and exercises have been effective in altering the interpersonal characteristics of an enterprise.

Group-level dimension. The group level of organizational processes refers to the behavior of the group as a social system, and the individual's relation to that system (Bion, 1959). This perspective is best exemplified by the Tavistock tradition of group relations (Rice, 1965, 1963; Klein and Astrachan, 1971; Rioch, 1970). The primary focus is on the group and individual behavior is conceptualized as a function of the group's collective sense. One assumes that when individuals act, they act not on their own behalf, but on behalf of the group they represent. This implies recognition of a group mentality -- a collective entity with a mind of its own. In this context, individual behavior is not just a function of an individual's idiosyncrasies but a synthesis and interaction with the collective force.

Employing this perspective, one can understand organizational processes that are not accounted for by an intra- or interpersonal level analysis. Acting-out behavior of an individual in a group (e.g., a class clown) is expressing not only one's feelings about the teacher or the class, but also the covert feeling of the classroom collectively. Other classroom members live out and express their feelings vis-
a-vis the individual. This view is confirmed when this individual is pushed out of or leaves the system. Another class clown will emerge if the teacher cannot manage or harness these processes. The force of the collective group distributes, differentiates, and locates emotions in various individuals, who in turn manifest them on behalf of the group. These dynamics exist within each individual at best on a covert or an unconscious level.

Group-level analysis lends itself to an understanding of sibling rivalries and group fantasies surrounding the authority. Leadership dynamics also are expressed at the group level. Indeed, the exploration of group level phenomena is crucial for understanding organizational processes.

**Intergroup level dimension.** The intergroup level of organizational processes refers in part to relationships among various groups or subgroups. The intergroup dimension focuses on the various group memberships of individuals and their behavior toward the out-group. Intergroup processes develop from the hierarchical structure, from the subordinate/manager relationship, the union-management intergroup, work-flow intergroups, and those based on race or ethnic membership or age or sex.

The total organization can be viewed as a conglomeration of intergroups interacting with each other. Analysis of intergroup phenomena provides information about competition -- the degree of cooperation and conflict that exists
among the various sectors in the enterprise. An examination of intergroup processes gives information on how each subsystem functions in the system.

**Intersystem dimension.** The intersystem dimension of organizational processes refers to the dynamics that exist between the enterprise and its environment. The focus is on the quality of the relationships that an organization has with other organizations and the community at large. Interorganizational conflicts, competition, and cooperation are revealed when examined from an intersystem perspective. Also, internal change within an enterprise can be a direct result of intersystem events.

Because behavior is multidimensional, organizational processes can be examined and understood by use of any or all of these dimensions, and the order in which the dimensions were discussed does not reflect their value in relation to each other or to organizational processes.

Organizational processes characteristically include rhythms of work (i.e., the dynamics that interfere with or facilitate the work of an enterprise in accomplishing its mission). Organizational process, the dynamic connecting forces of enterprise, provides the cement or the dynamite of the organization. An in-depth inquiry of organizational process reveals how the enterprise is holding together or splitting apart.

Each of the six diagnostic domains are internally
complex. Alone each can reveal important aspects of an organization, and when combined, they provide a relatively comprehensive approach to organizational diagnosis. They do not, however, represent all the vantage points from which an enterprise can be analyzed.

**Exchange Theory**

When an analysis is made of a young human services delivery organization, one must give due consideration to the need for that organization to develop a regular supply of clients. This need may determine entirely the outcome of client-organization interaction. With the physical limits of resources and available technologies, the organization might be expected to seek foremost the satisfaction of its clients. This is plausibly the "normal" first stage in an organizational career path. Organizational process in this period would be characterized by a wide scope of adjustment movements vis-a-vis the client, e.g., rescheduling of hours, increase in staff, or application of particular technologies. In this exchange client interests and organizational goals have a reciprocal importance. Subjectively, each is important to the other in a specific period of time.

Organizational exchange theory provides a basis for understanding established organizational relations. Our main concern, however, is with the way in which such relations
originally emerge (Boguslaw, 1965). The exchange framework has been far less frequently used to study change empirically, although a number of connections have been suggested. Greenley and Kirk (1974) point out that the basis of exchange may sometimes be involuntary, suggesting dissatisfaction as the root of organizational imbalance. Marcus and House (1973) similarly argue that a shift from an expressive to an instrumental basis of exchange might stimulate organizational re-formulation. In either case, even if exchange is unstable, it does not necessarily follow that the succeeding patterns of exchange will be only variants of the initial system. In fact, they may be quite different but still not revolutionary.

**Socialization Theory**

We might conceive of a second developmental stage following the dissolution of the original exchange system, when the antecedent of structure of process is located in either the clientele (environmental) or the internal organizational structure or both. Organizations may learn to act on, or react to, a fluid environmental setting. For example, as agencies react to clients or to a clientele, the manifest desires and expectations of individual clients may become less pertinent to explanations of organizational conditions or of client satisfaction. In short, agencies may fabricate a history of relations with clients for purposes of understanding their dilemmas. Reassured by these rationalizations
and ideologies, the agencies may often act with increasing firmness on clients in attempts to socialize or constrain people to fit a clearly delineated client role. Stanton (1970) suggests this pattern of relationships in her analysis of the influence of staff actions both on clients and on the parent citizens board in a mental health association. However, experienced individual clients or an organized clientele may come in contact with young organizations, with the consequence that the agency is socialized to their perspectives. Tripi (1974), for example, demonstrates that experienced clients can effectively control encounters with welfare officials. Tom Wolfe's "mau-mauuing the flak catcher" (1970) is a perfect example of only one of many possible strategies. On balance, there are at least two directions in which socialization may proceed: agency socialization of the client and client socialization of the agency.

Control or Accommodation

Socialization clearly may be as equally unstable as the earlier pattern of exchange, either because clients feel alienated because there are scarce alternative choices or because an outraged bureaucracy reacts. This suggests a third, and arbitrarily final, stage for the analysis, in which organizational structure might be unrelated to the characteristics of clients. However, selected features of
the supporting clientele may still shape agency processes because of disease-specific lines of encounter (Lefton and Rosengren, 1969). The social psychological characteristics of staff and clients could become less relevant to explanations of the situation in the agency than the availability of key resources.

It seems plausible to suggest that the more routinized the interaction patterns become between clients and organization, the more impervious these patterns are to change. (Since Walter Bagehot (1971), at least, sociologists have noted the inertia of social customs.) Regardless of their personal differences, for example, even the most sensitive practitioners may begin to see types of cases rather than people (patients, students, or clients). The interactional capacities of members may thus become limited, and the organization subsequently may become less dynamic. Basically, the service organization gains mastery over its critical environmental variable, the client. The outcome of the clients' interactions with the organization can then be controlled by the organization (e.g., by codified rules, precedents, or the structuring of interactions).

This discussion has suggested four major processes of integrating client interests with organizational structure: exchange, client socialization, agency socialization, and control. If these are considered in a developmental sequence, a fifth process -- accommodation -- becomes apparent.
Accommodation, as distinct from control, denotes a reciprocity of contribution or sacrifice which is similar to exchange, except that a longer, more involved changing relationship is indicated. The two outcomes, control or accommodation, also appear to derive from different organizational careers. This discussion would also be framed in terms of social power. A situation in which clients retain power while the organization exhibits accommodation (or the openness of the organization to client-initiated or client-conditioned changes) would be more descriptive of organization/client relationships than control. Yet this power need not be exercised or even recognized by participants, even though it plays an important role in shaping agency development.

In this argument, the social age of the organization has been related to its structure. Our discussion is primarily devoted to explaining the development of certain organizational characteristics, such as the agency's responsiveness to clients. We might anticipate that clients prefer accommodation to control, although this is entirely a matter of perspective. It would be premature to judge which historical path is ultimately the most effective in treating specific problems.

The relationship between organization and client environment is a function of time and the contingencies of action encountered along the various career paths. The
method suggests that the development of bureaucracy in anti-formal organizations, oligarchy in democratic settings, or informality in structured groups may be all viewed as part of a more general developmental process. Change may be influenced by organizational members, by incipient members, and by fortuitous encounter with persons, groups, and events external to the organization. All of these, however, are interpreted or, according to W. I. Thomas (1976), "defined" by the organization's perception of its "environment."

The nature of changes resulting from the interaction of the organization with this environment is structured by the organization's previous development and its current definition of the situation.

The career of an organization in its client environment has significance beyond accounting for the internal structure of a particular organization. As the organization acts on its environment, the fabric of society at large is changed. The forms of action that an organization may take toward its environment are an interactive consequence of its developing internal structure. Relationships with clients and other organizations should be reflected in the developing internal structure.

This discussion of the internal state of an organization is in many ways a fairly gross characterization of the organization, essentially describing an ideal type. No organization includes only staff-client exchange rela-
tionships. While many more permutations are possible, the five types included are sufficient here, since our purpose is to anticipate and direct field observation. In any case, these relationships are framed in social time; they are contingent and not imperative processes. The exploratory use of the career perspective only suggests plausible forms of change which may emerge. In short, it offers a starting point for describing events in the field, for guiding the participant observer through the confusion of organizational life, while aiding in the generation of inferences about the dynamics of the formal structures encountered.

**Summary**

The focus of this study is the evolution of client/staff (organization) interaction patterns in order to identify the contributions which client characteristics and behaviors make in the determination of organizational structure. Examination of the face-to-face interaction between staff and clients over periods of organizational development may help to untangle and specify the role of internal and external influences on organizational structure. It is suggested that the examination of these boundary-spanning behaviors will facilitate our understanding of how clients and organizations achieve (or fail to achieve) an integrated, mutually acceptable organizational structure. The significance of this issue lies in its relationship to the larger social
issue of whether people can devise new forms of social organization which can serve their needs.
CHAPTER III
RESEARCH METHODOLOGY AND PROCEDURES

This chapter presents the research methods and procedures that were used in the study. Throughout the analysis the writer has attempted to draw on the works of numerous authors. Some of these writings were used on personal observations, others provided theoretical insight, and some utilized empirical investigations. Perhaps the most striking common factor was their approaches to the acquisition of knowledge. It should be pointed out that most of these authors were influenced by the social sciences and a rational set of rules for how one comes to "know" something.

The major purpose of this chapter is to acquaint the reader with some general statements about the philosophy of science and the scientific method, and the way in which this philosophy affected the development of the methodology and procedures utilized in this paper. In viewing the philosophy of science, one finds a general theme being presented. The rational approach of scientific analysis, although certainly the most frequently used in the area of organizational behavior, is not the only way to acquire knowledge. We shall, however, attempt to point out both the strong and weak points of using the participant observer technique.

As noted by B. Jones (1980), techniques like participant observation are not new to the field of organizations,
for "qualitative" techniques have been traditionally applied to the case study of individual organizations. Since this study is concerned with the development of one component of a larger entity, it seems appropriate to discuss the question of whether the project is truly an "organization" in the usual sense of the word. Particularly in the early stages of the research, if the agency is quite small, the added usage of the participant observer technique raises the question of whether the study was more an autobiography than a social biography. There is no definite answer to this question, although to some extent it can be anticipated in analysis.

Early in the study, however, primary attention was directed toward establishing relations with former employees of the project and former clients. This activity provided a starting point for data collection efforts.

An important question is raised here: at what point do recurrent actions of individuals become relevant to the study of a particular organization? What, in fact, are the limits of an organization? As will be suggested later, the responsibility of the agency for the behavior of its clients and staff became a very controversial community issue.

Definition of an Organization

It has been indicated that non-empirical definitions of an organization present serious obstacles to the study of agency growth. How will this problem be confronted? What
operating assumptions must be made when focusing on organizational development?

Usually, resource limitations force researchers to define arbitrarily the limits to their field of study, thus producing at least de facto definitions of organizational boundaries. In the approach used in this study, two criteria taken from early field work were judged as minimal in justifying treatment of this small agency as an organization: recurrent patterns of events with supporting roles and norms were observed which clearly identified that the organization was operating as a unique social unit. In a definitional sense, the first observation implies that relative stability and differentiation are important features of organizations. The second element involves the legitimization of the organization and is essentially a phenomenological issue. Since the purpose here is not to develop a rigorous typology to distinguish organizations, it is sufficient to separate organizations from less developed forms. Agreement on the nature of the starting point, however, is important for the study of growth processes that proceed from that point.

Neither feature of this definition specifies a reason or purpose for the existence of an organization. In most cases, the roles, norms, and values (ideology) supporting organizational interaction patterns probably underlie some abstract purpose which forms the basis of legitimization by the community and participants. However, others have argued
that this is not a necessary condition. In fact, there may be little consensus on what an organization is accomplishing, and even less on its aspirations of accomplishment. If one focuses on the formal character of an organization, the most valid source of information concerning organizational goals would probably be some category of personnel (e.g., top management) (Price, 1971). This type of information, however, may not agree with the characterizations made by lower level participants or by society in general. Although top level staff usually control developmental resources and, consequently, agency direction, organizational problems typically arise at times when intended outcomes fail to occur. If organization goals could be defined simply as the objectives which major decision makers actually pursue, then data would be needed only on the intentions and activities of those leaders. However, such a model of organizational growth would tend to ignore the potential direct impact of clients on organizational development.

Instead, goals were identified in the center under study according to three dimensions: client, staff, and organizational careers. The motivations, intentions, and actions of individuals are examined within those three contexts. The sources of data are participant observations, informal open-ended interviews, and official documents where appropriate. In effect, the study will examine the separate ideologies which arise from the norms and values held in each of the three contexts. An evaluation will be made of
their relative contributions to organizational ideology. The way in which organizational ideology changes or does not change as different structures emerge becomes an important concern.

In the subsequent analysis, the reports of the participant observer were developed as descriptive narratives of the agency's development. The observer did not look at relationships among specific members but rather at the overall pattern of development of the project. Variables examined in the analysis were organized in terms of these perspectives generated by the career model. These variables can be classified as characteristics of clients, staff, or of the agency.

Individuals who were categorized as clients were examined in terms of three types of characteristics: (1) primary characteristics, which are those reasons (such as problems or illness) that lead to contact with the agency, e.g., type of drug use, medical problem or family difficulty; (2) related characteristics -- attributes such as age, ethnicity, or sex, which may directly affect the handling of primary characteristics; and (3) extraneous or cultural norms, which affect the capacity of the clients to utilize the services (Lefton, 1970).

Pertinent staff characteristics included not only personal attributes as discussed, but also the more important characteristics of behavior and attitude toward clients and consequent style of work.
Design of the Study

Description of procedures. The data for this study were drawn from a larger comprehensive evaluation of three treatment programs. Only data relevant to the YSD program were considered for inclusion in this study. The other two facilities, a methadone maintenance clinic and a facility using a narcotic antagonist, were both designed to deal with different aspects of the substance abuse problem compared to the limited aim of the adolescent treatment program.

In the past century advances in evaluation have been made in the area of the behavioral sciences. These advances have occurred not only in the increase of tools available for the quantification of data, but also in the recognition of the many diverse methodologies needed to begin to understand why individuals and organizations behave, function, or operate as they do. The procedure employed here is a relatively new method to approach institutional evaluation. This method could be best explained by the term "participant observation" (Goffman, 1961; Becker, 1958); in this case, however, I, the observer, did not enter the agency with the expressed purpose of evaluation. It was only after working in the formulation and implementation of the organization that I decided upon an evaluation based on several factors: (1) historical analysis of the 1970-1979 period; (2) my observations and personal notes; (3) data gathered during the 1970-1979 operational years; and (4) an analysis of
the critical internal and external interventions. The final outcome could best be termed a "case study" (Clark, 1961), for while making some generalizations, the research is concentrated in depth upon one organization -- Youth Services Division.

The selection of this particular design was made for several reasons. First, in the evaluation of "broad-aim" social programs, experimental design creates technical and administrative problems so severe as to make the evaluation of questionable value (Weiss and Rein, 1970). The experimental model has been criticized by Stufflebeam (1968), Suchman (1968), and Schulberg and Baker (1968) as being intrinsically unsuitable for the evaluation of broad-aim social programs. A more historically oriented and qualitative evaluation has greater value (Weiss and Rein, 1970).

Secondly, the case study approach will enable analysis of several different aspects of the organization incorporating various research designs, and this analysis will allow a clearer picture of the total organization, showing the interrelation of all segments. In addition, the organization has been presented with the most applicable type of research for self-understanding and possible change. Finally, this method is the style with which I am most comfortable and competent.

I must include a note of caution in relation to the type of research which will be undertaken. This is the kind
of study which probes rather deeply into organizational and human behavior. In the process a veritable hornet's nest of interests and involvements will be raised and more questions will probably be asked than answered. Because of my prior position with the organization and my access to certain information, situations, people and experiences, there is no possibility that another researcher could validate my findings. There have been enough studies in the social sciences prior to this time to verify that error and bias are integral parts of all evaluations. This type of study may certainly be more open to those possibilities. In an attempt to limit (not eliminate) the extent of errors and bias, I will check my findings whenever possible with other members of the organization.

Procedures. The collection of data will be accomplished by reviewing original documents (grant and contract); relevant statistics compiled in the data-keeping system, informal interviews, and conversations with members of the organization; and personal observation, participation, and recollection. The analysis of this data will be made by the researcher's selection and amalgamation.

Discussion of the Research Design

The purpose of the design of this evaluative study is to examine the changes that occurred at the treatment center by looking at the program as an organization. The major
focus of this study is upon the historical development and staff relations within the program.

Two basic sources of data were used which generally correspond with these foci. These sources were existing records and interviews with clients and staff members and the recollections of the participant observer.

The research was limited at times by problems of access. Much of the client-staff interaction occurred in situations where formal interviews were inappropriate. Furthermore, program directors were opposed to seeking out clients for interviews outside of the organizational context. This, in effect, forced increased reliance on less formal methods of data collection, such as participant observation. Data collected on clients and staff would therefore be less systematic than expected. To some extent, this was offset by increasing the length of time the observer covered. Initially, the role of the observer was one of passive observation.

Collection and Treatment of the Data

Participant observation is probably one of the most controversial and difficult methods of data collection in social science research. Probably nowhere else do issues regarding the scientist's objectivity, accuracy, and value neutrality take on more significance. These issues are not insurmountable, however, and it appears that the method
employed is especially attractive for the study of a deviant population (McCall and Simmons, 1969; Bruyn, 1966; Becker, 1970; and Filstead, 1970). Further, it was the only method which could be employed because of restrictions in the research setting. Beyond the capacity of this method for monitoring ongoing organizational development, it also has the potential to offer subjective understanding of the processes involved. It was the most intensive aspect of fieldwork employed in this study.

For the purpose of this paper, the Schwartz' definition of participant observation seems appropriate:

The observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed and by participating with them in their natural setting, he gathers data. (Schwartz and Schwartz, 1955)

The meaning and significance of the events to the participant become clear as he enters the subjects' world. The observer maintained a journal, had access to the original proposal, annual reports, and regular contact with organizational personnel. These encounters were treated as data collection situations for the purposes of analysis.

Reliability of the Source of Material

The general data on substance abuse treatment in this country was derived from reading in publications indicated and the author's personal experience working in the field. A more complete study would have required direct contact
with the information service of the National Institute of Drug Abuse (NIDA), National Institute of Alcoholism and Alcohol Abuse (NIAAA), Federal Narcotics Bureau and a multitude of other governmental agencies, in order to gain access to first-hand work on modern data.

Validity of the Method

The participant observer method used is valid, and in this case is based on the dialectic attitude of research where reality is considered as a constantly developing source of information. When reality is confronted in this way, it continually presents antitheses to the assumptions with which one began. If one can accept and look for this constant "back and forth", while maintaining a healthy approach to the problem, then new data can develop around the core of material already found. But when this dialectic method is interrupted or aborted, the dynamic confrontation with reality is frozen and rendered static. If the process of criticism is stopped too early, then one becomes the prisoner of what one has found. The work of synthesis becomes incomplete, biased because it lacks the next half-step of development.

Limitations of the Study

A number of specific methodological limitations to this research have become apparent during the investigation. Explicit recognition of these limitations is especially neces-
sary when these data are utilized so that the reader can fully evaluate the quality. The remainder of this chapter will underline several of these limitations.

An initial problem confronted when using participant observation was related to size of the organization studied. In the early stages of the research the agency was occasionally functioning with as few as three or four staff members present at times when they were observed, due in part to the shift-covering factor. This again raises the question of whether the observer was the "organization" on those occasions. As indicated, role passivity was impossible in such situations.

Perhaps a more important limitation was the designation of this investigation as an evaluation study. In the early stages of the study other agency staff members tended to cast the observer in the role of "professional expert". Fear of the consequences of evaluation and the potential implications of organizational failure certainly contributed to this tendency. Only constant denial of this role by the observer eventually alleviated this condition. As Wax (1971) has illustrated, the consequences of an investigator's failure to maintain adequate contact with the research setting during the period of data collection can be devastating. This problem was avoided almost entirely in this research, and there is evidence to suggest that there was adequate compensation for practical problems of data collection.
In reporting my observations in subsequent chapters, I will employ essentially a client-centered model (Rosengren and Lefton, 1969; Hillenbrand, 1970). Within this context, organizations will be viewed historically. This way of integrating material is a variant of the two currently dominant approaches in organizational studies (Etzioni, 1964). The first method involves analysis of the success of an organization with respect to its goals. The second is a systems view which identifies the structures and ongoing processes of an organization. The success model fails to identify particular needs because the goals of a young organization are not always clearly formulated. The systems model is also flawed in that it is essentially historical, and may fail to deal with the fact that processes are not always the same through time. More to the point, the small organizations under study may not yet have become "organizations" in the sense that their character is currently being shaped by all of those individuals involved in it, while fully developed agencies are more independent of the characteristics of individual participants.

In a practical sense, efficiency, cost effectiveness, and the general systems orientation are cornerstones of today's managerial response to social problems. Yet these terms seductively hide the factor of ambitions, passions, and misinformation that help to shape all organizations. Critics of sociology frequently suggest that social theory ignores one or more critical dimensions of human reality,
e.g., the problem of personality conflict in organizational development (Argyris, 1973). Yet it remains difficult for theorists to organize comprehensively the reality of a personality into a theoretical or methodological guide that connects other key dimensions.

An alternative to these approaches is the career orientation, particularly suited for this study because it makes possible the analysis of essentially unstable, rapidly developing organizations. The sociological concept of career usually concerns the historical path of an individual through an institution or organization; however, the concept has also been applied to the path an organization itself may follow through an interorganizational field (Rosengren, 1970). For the present, it is plausible to entertain the notion that organizations pass through discernible stages in their history, much like people. Katz and Kahn (1966), for example, note three distinct stages in the life cycle of an organization: Stage 1 - the entity may not be an organization if consistent role behavior and coordination are missing; Stage 2 - both an authority structure and an informal counterstructure may develop; Stage 3 - these structures are elaborated. It should be possible to identify the social forces in the organization's career which cause these changes. These forces should include staff characteristics, both attitudinal and behavioral, the nature of the organization as an entity and its interaction with
larger organizations in the external environment, and finally, the clients themselves, who may be central to understanding the particular course of an organization's career.

In the agencies under study, careers of clients in the organization and their component therapy groups are the entry points leading to understanding the total operation of the programs, including not only manifest goals, policies, and activities, but also the latent, unanticipated consequences of the organization's actions (Merton, 1968). The career approach calls for three separate social biographies: that of the organization as an entity and of the staff and clients who compose it. The data in this study are presented under these general headings in the form of narrative descriptions of agency development.

The most important idea is that there is a reciprocal influence relationship between organization and client. Clients represent only one potential dimension of an organizational environment. While any institution must seek some equilibrium with the environment in which it "lives," there are a number of different aspects of environment: social, technological, economic, organizational, or political. Each of these contains elements of differing importance. The prime factor here is centered on the clientele to the extent that it forms the "service environment" of an organization. The people who are served and the amelioration of their problems provide the criteria for
judging effectiveness and possess the greatest potential for changing and shaping an organization's structure in its early stages.

Summary

Empirically, the study remains at the descriptive level; hence, findings can be viewed as plausible. Concepts offered such as the organizational career are used procedurally to assist in the presentation of materials. The agency selected is clearly a special case: it is young and small, dealing with a select population, and it possesses an unusual client-centered ideology.

However, limitations such as these are very defensible, because of the paucity of theoretical and empirical work in the area and the absence of comparative longitudinal studies of change in any type of organization. Discussion of the methods of this study and the research process has highlighted the practical problems of a qualitative evaluation of change in the formal organization under observation. However, the research design was the only means allowed by constraints imposed by the setting. It is, moreover, one of the few means available to gain subjective understanding of the events which constitute the organization career to be presented.
CHAPTER IV
ANALYSIS OF THE ORGANIZATION

The Substance Abuse Treatment Unit is considered a prototype multi-modality treatment facility. Formed as a spin-off from a large, established, community mental health center, it has enjoyed a continuous, productive history and professional, trained leadership. Critical events in the organization's history and inputs of client demands, staff concerns, and community pressures have played a dynamic role in the structuring of the facility, and in the areas of staff training, attitudes, and objectives.

Description of Findings

Within SATU the Youth Services Division, an outgrowth of a community mental health center, began as a small project which initially grappled with issues of deep personal concern to its members. The format was to be open, nonbureaucratic, and accepting of adolescent ideas. This pattern was disrupted by increasing attendance and a greater variety of client interests. Social and recreational concern de-emphasized the role of intimate discussion and produced a divergence of client and staff views regarding the program's future. The professional and nonprofessional staff had conflicting ideas on the meaning of drugs and the appropriate organizational response to increasing client deviance,
including boisterousness and use of soft drugs such as pills (e.g., amphetamines) and marijuana. Varying staff measures to control behavior through explicitly instituted rules and formalization were attempted, although counter to the open format, but they had only partial and temporary success.

A general goal of providing group and individual counseling for the problem of drug use was not achieved, apparently because the young people who attended had different concerns. They had a wide variety of worries, ranging from family problems to sexual behavior, and wanted to have an opportunity to deal with these as well as to have a social gathering place. The organization came to recognize the importance of these client interests and attempted to incorporate them in the program where feasible. Veritas House continued as a program for counseling, recreational, and educational activities and was able to maintain a precarious balance between openness and some measure of control when the study was terminated.

Although Alpha House was modeled after the neighboring program of Daytop, there were some marked differences. The most significant of these involved support from a wide array of community leaders on the board of directors and the utilization of a largely all-professional staff. Alpha's director hoped to avoid patterns of client deviance prevalent at that time in Veritas House. Formal and informal groups were developed to address topics salient to youth,
including drugs. However, there emerged the same pattern of client deviance and recreational and social interests that existed at Veritas House. This was at first attributed to the rising attendance and consequently higher client/staff ratio, but increases in the number of professional staff failed to provide a remedy.

Both before and after changes in staff size, attempts were made to reduce unstructured activity by the addition of formal rules, scheduled groups, and individualized counseling set up with an appointment system. Ambivalent perceptions of the organization by clients and staff persisted as the staff attempted to help youth with problems. Clients did not generally appear concerned with drugs as an issue, but some evidenced troubles in family and peer relations. Often these clients did seek out staff for assistance, but many simply appeared to want a place to "hang out". Much staff time was spent controlling the behavior of the latter group, which threatened staff accomplishment with the troubled clients. At the end of the study, the program continued to provide both of these services. This result was quite different, both in style and content, from the original intent of the program.

**Intake Procedures**

All candidates for admission to the project must be initially interviewed at the project site. At this interview
the social, education, drug, alcohol, and family history of the client is discussed and a recommendation to treatment is made by the intake counselor. The intake counselor makes an appointment for the client to meet with the staff of the project. If after the interview it is determined the client is eligible for treatment at the project, he is admitted to the program. If the person is not eligible for treatment the staff refers the person back to the intake counselor for another recommendation to an appropriate treatment agency.

If at any time in a client's treatment stay at the project it is felt that another setting would be more appropriate, contact is made with other facilities and the client may be transferred to another program. If a client needs psychiatric testing done in a hospital setting, the project staff are responsible for maintaining close contact with the client at the hospital until the client is referred back to the project.

Once the person has become engaged in treatment he will be able to have the level of intervention increased or decreased based on clinical indicators. That is, if someone is admitted to the outpatient program but continues serious abuse even with treatment, then transfer to day or inpatient status would be negotiated. On the other hand, if after a period of time in either the inpatient or day program there is clear indication that the person can continue treatment at the outpatient level, he will then be transferred into
this section of the program.

Following entry into the program each client within the first week will have an extended evaluation on those parameters begun at intake (previously described). In addition, family evaluation will be begun within the first week and the person placed in family therapy by the end of the second week. Families will have both individual and multiple family therapy involvement.

The primary content of the treatment plan will consist of a number of both short-term and long-term goals which the client will actively develop and then pursue under guidance from the primary counselor. The treatment plans are intended not only to focus on outcomes in achieving specified goals but also on the process by which these goals are reached. Treatment plans for clients are also evaluated at a weekly staff meeting, which includes the primary counselor, program supervisor, and other vital staff members whose input into the treatment process is relevant to the clients' needs. The treatment being applied to meet these objectives is collectively discussed. Progress notes regarding the client are reviewed and updated on a weekly basis with direct clinical supervision at scheduled monthly intervals. All objectives being developed by the primary counselor and client are reviewed weekly.

Clients who are not likely to be referred to other types of services are those who demonstrate behavior which cannot
be handled adequately on an outpatient basis. Those clients could be referred to the inpatient facility where close monitoring of their behavior could be performed. This type of referral would be made collaboratively by project director, project psychologist, program supervisor, and primary counselor. Other types of referrals would be for vocational/higher educational purposes. Youth Services Division has a long standing and excellent working relationship with Connecticut Division of Vocational Rehabilitation (DVR); this agency provides vocational assessment whereupon acceptance of client absorbs cost of any aforementioned training. Referrals of this type are handled by the program's vocational rehabilitation specialist.

For a number of years, Youth Services Division has maintained a high level of community consciousness. It is the current intent of the program to continue active involvement in the community by presenting informative, educative speaking engagements to various organizational bodies with particular emphasis on substance abuse in school, families in crisis, and problems in peer relationships.

**Family Counseling**

Family therapy is viewed as a prime factor of the program. The involvement of parents in the treatment of their child is seriously encouraged. The initial phase of family involvement usually begins prior to formal admissions within Youth Services Division. This service is provided as an
evaluation of the present and historical family situation as noted in the admissions procedure. Free placement evaluations consist of at least two sessions with the clients and the parents. Siblings and others significant to the family situation may also be involved in these interviews. Individualized family therapy begins for each family within the first two weeks of admissions to the program. This therapy counseling begins on a weekly basis throughout the treatment.

The program does not rely solely on one single method of family treatment but develops a family treatment plan based on the needs of that particular family. This may include sessions with individual parents, a joint session with both parents, or in the case of divorce, parent with step-parent. There are also less formal ways in which parents and other family members participate in program functions. Open houses are held twice a month by the program clients, and all family members are invited to attend. These open house meetings allow parents to meet other parents as well as to meet the senior and line staff members. This serves as a way for families to become familiar with the program concepts, policies and procedures. Refreshments are prepared and served by the clients during the course.

During the course of the school year, several open houses are also held by the Center of Progressive Education (COPE) staff. This allows parents to meet with teachers
and to discuss their child's educational process. There are various support groups for family members, e.g., single parents or mothers' groups, re-entry parents' groups, new parents' groups, etc. Parents are encouraged to get involved with the program activities and special projects, such as sports or other recreational opportunities. Family members are also invited to participate in seminars with the total program population.

Through past experience we have discovered that some families may need to be broken down into separate components for closer examination and to meet certain specific needs. After a period of time the family is united to form a workable unit. The methods of counseling used are family, multi-family, individual, couples, adolescent group, and adult group therapy.

Family therapy proposes to integrate the entire family into the treatment of the substance abuser. The importance of family therapy in treatment of the substance abuser is emphasized, and the program strongly encourages each member to participate.

A family is more than the sum of its parts and each family possesses a character of its own. It has been suggested that a family possesses a character of its own: a "body", "mind", and "spirit". Speaking in these terms the family can be viewed as a living organism, which can be healthy and functional or ill and dysfunctional. Cultural
background influences the family life style, the hierarchical structure, and the decision making processes.

Another major determinant of family function is the degree of psychological stability of its members. Many times the member of the family who is abusing a substance or the one in treatment is not the member of the family most ill but only the one who feels the pain. Many times this is a form of self-medication or a cry for help because of other problems in the family. As seen in reverse, the family member who is acting out may be the main problem but affects other members to the point of causing a crisis situation. In either case it is imperative to treat the entire family in order to reveal the existing dynamics and to provide services as necessary.

Multi-family therapy involves several families in treatment joined together in a group setting. The concept of multiple family therapy was originally established to increase the family's understanding of the client.

In many ways this group resembles a neighborhood and tends to demonstrate the various ways these individual families relate to other families in their respective communities and to society in general. Although the size of the group is large, intense feelings are frequently expressed. New families in the community are able to get much needed support from those who have been in treatment for some time. The new family is encouraged and relieved to find out that
others have similar problems and are being helped.

Another important aspect of multi-family therapy is that it provides a setting in which the parent of one family can understand the feelings of an adolescent of another family because he is not as emotionally tied to someone outside the family. This is also true of the adolescent. He or she may be able to hear what the parent of another is saying because the emotions are less intense in that relationship. In other words, this provides an objective observer outside the family to give support and insight into the situation.

Individual therapy is designed to: (1) develop a meaningful relationship between client and therapist; (2) to help client become more aware of internal conflict, express feelings surrounding the conflict, and establish resolution; (3) to help client shift focus of control from one which is primarily external to predominantly internal control.

Couples therapy is therapy conducted only with husband and wife of a family unit. Primary focus is on interaction between the two concerning topics within the marriage to enhance communication.

Adolescent group therapy is a structured group setting which utilizes peer interaction for conformation, support, and expression of feelings. The peer group influences the adolescent more profoundly than does the adult and this treatment method has been found effective partially for this
reason. Adolescents relate to each other in a way that is unique to their age group. Through this way of relating they feel less isolated and begin to identify with each other. In any group a natural leader evolves. This person usually has more ego strength and possesses certain skills that the peers may not have. The others can then model certain behaviors that have been proven by peers to be effective. Through these processes the adolescent becomes less defensive and more receptive to change and psychological growth.

Adult group therapy forms a small community environment in which members can share common interests and explore problem areas. Expression of feelings is encouraged as well as feedback to facilitate growth and self-awareness. Confrontation and support are two methods used to generate a feeling-oriented level of communication by group leaders and clients.

In order to treat the substance abuser more effectively and reduce the number of families in conflict, it is felt that all of these methods of treatment are necessary -- especially family therapy.

**Educational Programming**

Another important part of the Youth Services Division is the attempt to counter the strong anti-education feelings which many of our clients have developed. Throughout their
school years these youngsters have been exposed to repeated failure both academically and socially and have closed their minds to school. This frustration has been shown by their acting out in the classroom, truancy, and dropping out. All YSD clients regardless of their previous school status are required to attend the Center of Progressive Education, the YSD educational facility which is located within close proximity of the project.

Clients are in school for a minimum of five hours a day, five days a week. School is staffed by experienced, certified and well-trained teachers who evaluate the clients' current academic strengths and weaknesses and prescribe an individualized educational program which progresses at the student's own pace, thereby assuring that he or she will finally achieve a rewarding educational experience.

The client works individually or in small groups under the direct guidance of the teacher. The school is equipped with the latest in multi-modality teaching approaches and emphasizes the audio-visual materials, bringing light into the classroom. The school library with its collection of fiction, non-fiction, reference sources, and magazines is a gathering place for many of the clients during the school hours and at other times as well. A number of the clients are academically gifted. Such clients, if interested, can take advanced courses or work on their own independent studies. The school also offers courses to help the adoles-
cent prepare for the High School Equivalency Test as well as the Scholastic Aptitude Test for those wishing to go to college. If both the client and the school determine it to be appropriate as part of their aftercare process, a placement can be made back in the client's local school system with the client spending the day in the school and returning to the program in the afternoon for counseling and other clinical matters.

The Center of Progressive Education is a state-approved special educational facility providing the clients with services in strict compliance with Public Law 94-142. Upon the successful attainment of the intended short and long term goals established by the client and counselor, an evaluation process commences regarding the client. This detailed evaluation includes the client as the participant. Initial short and long range goals are reviewed and progress in attaining them is discussed. The client or the staff may change or add goals as time and treatment progresses and new areas are highlighted or uncovered. When a client is presented for evaluation, his or her primary counselor serves in an advocacy role for the individual. The evaluation team consists of the project director, the educational administrator from the school, the program supervisor and the program psychologist. The evaluation process includes a staff discussion and review, an interview with the client, and finally a wrap-up discussion by the staff. At the end of
the evaluation, both the staff and the client are expected
to have more clarity on the progress of the treatment and
the next areas of focus for the subsequent time period.
This evaluation takes place at the end of each phase of
the treatment program with the final stage moving into
graduation and finally discharge from the treatment program.

Staff

While all staff members at the program shared a gener-
alized, negative attitude toward substance abuse, vaguely
defined recruitment patterns appear to have created a
variation in orientation toward possible solutions. Pro-
fessionals recruited largely from adolescent psychiatric
institutions favored a therapeutic role with the project
using extensive one-to-one counseling sessions. Their
attitudes toward drugs were basically negative in nature.
In their personal lives alcohol seemed to be the commonly
preferred drug, and there was little, if any, orientation
to the clients' view of drug use. Professional objectivity
and role separations were the model orientations.

All staff seemed to agree that the program was not
solely a drug rehabilitation facility. Some drugs were
viewed as symptomatic of pervasive underlying pathology.
As a symptom, drugs received attention and were salient
elements of problem identification for both staff and cli-
ents. For the staff, the issue of drugs added an aura of
glamor to staff participation in the project by introducing a life-or-death element to the clients' perceived needs. As one former director described one client, "... he was on some black beauties and he wrapped his car around a pole -- he could be dead today, you know? Not from the beauties, but because of what he was doing when he was on them. And of course, if this keeps up they could kill him too."

For other staff, client involvement in drugs was less a symptom of pathology than one among a range of possible adolescent problems of adjustment. The ambiguity of dealing with drugs as a core problem and as a developmental stage introduced some tension within the organization. But drugs acted as a boundary maintaining mechanism in that they dramatized involvement and provided a common enemy for orientation in the face of divided staff perception of the clients' real underlying needs (Young, 1970).

The staff had a very high commitment to the projects. In any system individual interests may become attached to the organization through a rational belief, a personal orientation, or moral commitment. The open, interpersonal approach of the projects tended to draw chiefly on the personal dimension. While this is not in itself dysfunctional for the organization, it does conflict with professional modes of impersonal behavior, and the resultant disparity in staff styles possibly limited the organization
in reaching its goals.

The question of how to reach the clients once they did establish relationships with the program was a most difficult one for the staff. The professional social workers were accustomed to working in the structured setting of a welfare agency where role expectations, norms, and values regarding both client and staff behavior are well defined. In this sense bureaucracy, with its rational procedures, facilitated their "downtown work" and allowed for orderly and efficient activities. In the program, however, problems were not clearly defined and because of goal ambiguity the relationship of staff to client was not clear. Except where there were formal groups, many staff found it difficult even to approach individual clients. Many professional staff seemed unsure of exactly how they were expected to relate to the youth.

A related issue was the role of the worker vis-a-vis destructive behavior in the program. Professional workers tended to avoid any form of police action, probably because it interfered with the therapeutic relationship. The workers who did enforce the rules against dope and weapons, often physically, were the younger, peer-oriented counselors. These counselors, however, were criticized by some professional staff as "comic book freaks" because of the time they spent reading and just "hanging out with the kids" in the program.
At a staff meeting designed as a "getting it together" session, many of the staff were caught up in personal problems of their own. One was preoccupied with what his girlfriend was doing, and another graded papers throughout the meeting. Still another mentioned that this was his second job (and this was so for most of the people) and "when I come here I'm really tired, so that I might tend to go through the motions. I might tend to just do my job and get it over with."

While it was agreed that all staff members should fulfill their responsibilities to the program, the main complaint that surfaced was that relations among staff members were too impersonal. "We're not at ease with each other as people and we tend to avoid each other." This interpersonal insecurity among staff, in general, seemed to reflect the mentioned differences in attitudes toward therapy. One counselor stated, "When I got the job I expected it to be very exciting, and I wanted to learn a lot from the other staff because I expected them all to be innovative, and I guess kind of far out, and you're not." Another staffer replied, "You don't seem to be learning from your experiences that you should be doing, rather than trying to pick up on what other people are learning from theirs."

The non-professional staff was also concerned with the problem of treatment. While drug problems provided meaning and purpose for the professionals who were less familiar with
them, the drug wise, non-professional counselors could not get excited simply because the clients were users. For example, one commented that the main problem that he saw was that the clients did not care, that they did not come in with serious problems -- problems that the staff could have helped with. They tended to "take their own problems and solve them, and then come to the program and tell how they had been handled."

As a result of these developments, subsequent staff meetings contained more pointed critiques of therapeutic methods and of individual staff members and their orientations. In a sense the staff was wrestling with the problem of actual goals. The general problem was rooted in different staff job orientations which rested on individual conceptions of the program's objectives and caused selective enforcement of rules by program personnel. Consistency in counselor activities toward clients was hindered.

Inconsistency was further accentuated by a lack of systematic internal accounts of staff/client relations. Staff meetings were ostensibly designed to inform staff members of individual staff/client associations. But since no formal records were kept on each case, relations with all but the most deviant clients tended to be ahistorical. Workers sometimes kept brief notes, and accounts of numbers of clients were collected. Communication regarding client problems tended to flow upward toward the direction; staff
consultations were infrequent and, when they did occur, did not appear to cross the basic staff divisions of professional/non-professional.

To summarize, differential recruitment produced a staff with various professional training or non-training and thus different therapy orientations, some interpersonal distrust, a lack of shared goals and idiosyncratic procedures for the handling of clients, all of which contributed to staff dissension. In one sense, staff meetings provided a latent substitute for the bureaucratic rules and regulations in welfare agencies by serving as an arena within which to work out conflicts over appropriate behavior at the program. The basic problems of effective roles and technology were not expressly identified and have been clouded by the continuing sense of organizational newness and the importance of interpersonal rather than structural issues within the organization.

Implications of these conclusions for the clients and their problems can clearly be traced in reviewing careers in the organization of clients both collectively in the encounter group and individually.

The Clients

The clients at the programs are difficult to describe. However, the initial group of clients might appear in retrospect to have belonged to a special set which was fundamentally
different from later clients in several respects. Primarily this group was interested in discussing problems of personal concern and wished to do so, and events in the organization's career precluded participation of later clients on a similar basis.

The first group of clients which formed the core clientele were visibly disenchanted with society. The foremost problem area discussed was that of parental relations, at least in part because the parents were the source of societal coercion. Evidence of serious pathology was lacking among these upper-middle-class youth. However, when discussing deviance or drug use, they invariably portrayed their usage in escapist terms. In a discussion with a staff member a client related that when he was younger, he and his friends used to go out and get drunk; "that was our escape from reality . . . whereas now, people are turning to drugs."

In later sessions, clients revealed an increasing difficulty in accepting this view, and this was especially the case among newer members in the groups. "What's wrong with using drugs?" would be a typical question. Clients would be urged to find "a more positive way" and reminded that sooner or later "they would have to face up to the problem". However, the personal illustration and the confrontation did not line up. These young people were aware that while research on the effects of drugs such as marijuana or LSD was controversial, medically and psychologically alcohol is unquestionably one of the most dangerous drugs.
Many program clients engaged in the "client game" by making responses in terms consistent with staff expectations. However, from a treatment perspective, it may not have mattered whether or not the client told the truth or the staff perceived the actual problem. The encounter itself increased the chances that the person would find help.

The staff many times would interpret one client's troubles in psychological terms, believing the client was a defensive person who used sexual overtures and drugs to protect himself. When he complained that he was bored with the program, the staff concluded this was another manifestation of his lack of ego strength.

When clients discussed drugs outside of the counseling groups, most of them indicated that they used drugs mainly out of curiosity. As one youth put it: "You know how you get curious about it and you know people who had taken it or had heard about it." Another added, "People try anything. On the weekend, everybody would say, what are we going to do; there's nothing to do. Let's get stoned." Very few of the clients seemed to believe their reasons for using a drug involved some life problem or that the drugs themselves were problems.

It is difficult to ascertain whether these youths faced anything more serious than the typical adolescent confusions attendant to the maturation process. Since the staff was in search of deeper problems, they tended to direct the self-
discovery process toward areas that appeared significant to them from a professional social work perspective. Thus most discussion revolved around family problems. Drug use, sexual behavior, truancy, and shoplifting were defined as family related, because clients did not agree with paternal restrictions and definitions of appropriate behavior. Family difficulties served as a vehicle for entry to a much wider area of concern.

Recruitment patterns of new clients reinforced a recreational orientation. Initially participants told their friends about the programs and then brought those friends as the programs' reputation spread laterally through the higher age groups. The younger siblings of many of the original clients became interested in the programs because their brothers or sisters had been in the programs. When they too began attending, they informed their friends and a new age cohort was thus formed. Soon the organizations mirrored the complexity and range of concerns and behavior patterns in the original target population.

Clients' interests thus exerted pressure to mold the programs to a suitable shape, while the staff in its fashion also pressed to control organizational behavior. In one program there was a conscious effort to shape the organization, whereas in the other program the effect was unplanned. Indeed the young people's purely recreational interests were not granted legitimacy by staff in the context of Alpha's objectives but were attributed to lack of maturity and failure
to recognize the significance of "meaningful" as opposed to trivial issues.

**Leadership**

In all organizations there is a great deal of interchange that takes place on both the staff-on-staff and staff-on-leader level. This intraorganizational activity plays a large role in determining what the final program (product) is, or what occurs in the staff/participant interchange. In YSD, activity occurring within the agency revolved around leadership, staff behavior patterns, and sources of conflict.

Essentially, leadership means power over other people, and power over others enables a person to do things, to get things, to accomplish things which by oneself were unattainable (Fielder, 1971). By understanding the leadership of an organization one can better comprehend the why's and how's of staff and product. It is much like looking at a cell for the first time in a microscope -- one's attention is focused at first on the cell as a whole and its large distinct movements. The longer one looks, the more things seem to appear and one's attention begins to focus on the center or the controlling part of the cell, the nucleus. If he watches the nucleus carefully, he begins to get an idea of how and possibly later why those large distinct movements take place. The nucleus of YSD during the nine-year observational period has changed four times, the
directorship of Alpha House has changed four times, and the directorship of Veritas House four times. By understanding the leader, his philosophy, and his leadership style (personality), one should be able to understand YSD, an organization in transition.

The one factor common in all of these individuals in leadership was the philosophy about drug abuse: it could be summarized by saying that it was looked upon in terms of social and institutional pathology and the cure was the restructuring of society's vital institutions through social change. In this paper social change is conceptualized as being metamorphosized rather than predetermined change, that is, change brought about as the logical consequences of the collective action of individuals. This is an evolutionary model of social change which holds that it is virtually impossible to change the direction of history (flow of social change), but it is possible for small groups of people to greatly accelerate change in opposition to an unsympathetic or passive majority -- as evidenced by the civil rights movement, and anti-war movements of the 1950's, '60's, and '70's. In discussions with each of the past directors a common theme emerged that one could influence enough individuals both within and outside of positions of authority collectively to cause a catalytic effect on the social change continuum.

Earlier in the definition of leadership, the word
"power" was utilized. It is important to note that the extent and type of power employed by the directors was a factor in their leadership styles. Power as used here means "the ability to secure the dominance of one's values or goals," as opposed to authority, or "the right to command" (Pfiffner and Sherwood, 1960). Previous leadership styles in YSD could be generally categorized as something similar to social workers. When each arrived they were viewed as individuals who could get things going, and might be able somehow to make a better world. Their power, therefore, was based on identification (referent power) which, compared to the other four areas of reward, coercion, legitimacy, and expertise, was the strongest and broadest type of power. Initially this identification had to do with a number of factors, the most important of which was perhaps the "feeling of oneness" in the area of social goals and values. These so-called "honeymoon" periods were usually of short duration before the realities of budget cuts struck. Each left for greener pastures and more success in other fields of endeavors.

Conflict

There was a disparity between the staff and the leader often regarding the reason for the organization's existence. The staff believed that the way to approach drug abuse and treatment was by facilitating social change. The staff
believed in a model which was more revolutionary than evolutionary in nature. The staff wanted YSD to commit major portions of its program, money and man-power in this direction. More emphasis was desired in the area of street work, community organization, and action programs. With this approach less time and effort would have to be devoted to the treatment program. The leaders and senior staff members (leadership) agreed with the social change approach, but preferred an evolutionary model for it. Leadership contended that YSD existed because of the funding for the treatment slots and, although ancillary activities such as street work could take place, the main business had to be addressed. Otherwise there would be no program at all. Although the staff recognized the practicalities of this concept, they did not acknowledge them internally, and this became a major area of conflict—conflict on principles. For many of the staff members it was interpreted continually as a betrayal and backing down by the leaders on the original goals of the project.

**External Factors**

It is a known fact that in order to survive organizations must carry on transactions with their environment (Lawrence and Lorsch, 1969). Organizations seldom are truly closed systems. Most depend on some form of contract with the outside for their support and survival. It follows that the
social and environmental factors or external influences which are greatest are those on which the agency depends for most of its support -- financial or ideological. The way in which agencies carry on transactions with these external influences is most crucial when examining the final outcomes.

At YSD the external influences can be divided into three areas: (1) those which have direct influence, such as money or power in determining what gets done; (2) sources which have an indirect influence, such as input into philosophy or drug treatment or abuse; and (3) areas of influence which are circuitous, in that they add to the climate of the environment in which the agency exists. (See Figure 10.)

Data on environmental relations of the organization are sketchy and largely secondhand.

External influence. The greatest source of external influence on YSD was the large funding agency. Without its support YSD could not have operated or existed in the form that it did. The controls and boundaries which the large funding agency established were in evidence from the initial point of preparing the grant proposal. A document had to be submitted that met the expectations of some mysterious review board in order for them to provide funds for operation. Along with funding went stipulations on how the money could be spent or in what categories we could allocate funds.
Figure 10. External Influences upon Youth Services Division
In return for the funding, we would have to deliver a certain product (37 clients) for a certain period of time (per month) under certain conditions.

The influences of the large funding agency on YSD constituted the greatest source of external pressure. This is probably the case, however, with all government funded projects, and is an area of growing concern for numerous universities who continue to become more and more dependent on grants as a major source of support. Although the influence was large, it could have been even greater were it not for the time of funding. At the time the original grant proposal was submitted, no other similar projects were being funded, and drug abuse treatment was a priority -- virgin territory, a new frontier. Even though the proposal had to be written in a style that would be attractive to the large funding agency they had no previous experience as a basis for comparison.

Roundabout influence. Throughout the early period of organizational development the staffs were very concerned about parental views of the programs. Some mothers and fathers complained that the programs were just places where "kids went to complain about their parents". Some parents of Veritas' clients also protested that their children were out late on school nights and that a number of clients used the program as an excuse to get out of the house and then did not actually go there. Attempts at making rules reflected
not only a therapeutic concern and the obvious need for limits but also an awareness of the consequences of negative labeling of the organization by parents.

**Indirect influence.** In terms of broad community relations, the programs played an important role in a number of drug education programs through speaking engagements and community meetings. However, the immediate community was a particular problem because "they don't want a bunch of junkies around." These conflicts in the immediate neighborhood have been difficult to manage since client behavior around as well as within the programs had been uncontrollable on occasion.

The same relationship describes the program's accommodation with the police. On a police community level there appeared to be acceptance of the basic function that the programs sought to provide. On an operational level, however, police patrols reportedly harassed clients near the programs, increased surveillance around it, and instituted an informant system which was especially damaging to client relations with the programs. Reportedly, when a youth was apprehended on a drug charge, he was promised immunity if he informed on two of his acquaintances who were also using drugs. This created an atmosphere of distrust and paranoia among both drug-using and non-using clients, and made open communication more difficult.
Summary

In this chapter we have observed a particular pattern of organizational developments. A small group of clients and staff met regularly to discuss a set of accepted problems and personal concerns. Increasing rates of attendance by new clients created a wider area of clientele concerns, many of them being purely recreational and inconsistent with the program's therapeutic goals. Staff control was undercut and incidents of deviant behavior increased. Consequently, a need was shown for more rules, scheduled discussions, and other measures, and thus the formality of the program tended to increase. Basic issues of appropriate behavior in the program became the main focus of client/staff conflict.

At the end of the observational period, however, the outcome of this situation was still indeterminate. The staff did not consider that it had obtained desired goals and the clients tended to find the program dull and boring in terms of their casual, recreational interests. However, different organizational strategies, staff composition, and less environmental pressure all tend to support the tentative conclusion that client behaviors and expectations played an integral role in determining the developmental path of the organization.
CHAPTER V
SUMMARY AND CONCLUSIONS

The objective of this study has been to describe and explore the development of mechanisms or processes which help to explain the relationship between clients and emerging organizational structures. It was expected that examination of interaction between clients and staff might illuminate the role of clients and other influences on organizational structure. Although no formal hypotheses were offered, a number of expectations were derived from an initial consideration of client interests and organizational goals. These will be reconsidered in light of the findings. Finally, the wider implications of the study will be reviewed in the context of questions which emerge from the data.

Data for this study were derived from open-ended interviews with former clients, past and present staff members, and from over two thousand pages of typewritten notes of the observer in the agencies for a nine-year period. Participant observation refers to a process in which the observer's presence in a social setting is maintained for the purpose of the study. Moreover, actual participation in daily organizational activities promised to enhance understanding of direct as well as subtle client influences.

The assumption was that qualitative methods of data collection
would provide a feasible means of monitoring agency development. Participant observation was the most intensive aspect of fieldwork utilized in the study.

Veritas House was both a day and evening program depending heavily on walk-ins for clients. While Alpha House tended to reach out and actively seek new clients, Veritas' pattern was relatively passive. In terms of organizational development, this passivity tended to increase client impact on the agency's structure and functioning because the youth themselves largely determined what was acceptable behavior at the program. Client deviance was a more significant problem in this program and remained so throughout the duration of the observational period. In addition, early in its history the staff included adult and adolescent professionals and non-professionals. Drug use was sometimes reinforced and supported by the younger elements of the staff. Since many staff and clients thus shared the same views, little need for behavioral change was recognized.

Client interests in program operations gradually increased and several former clients volunteered to become staff members. They brought pressure for "services" consistent with client interests, which were largely social and recreational involving considerable soft drug use. These particular staff members' interests emerged despite opposition from the other leaders of the organization. In short, an increase in client behavior problems at the program, coupled with a decline in members, meant that the
organization's survival was threatened as long as the agency continued to function without staff initiative.

Client Behavior and Organizational Consequences

One of the most critical problems faced by organizations which seek to change human behavior is that of attracting and motivating clients (Katz and Kahn, 1966; Lefton, 1970). They are not usually considered part of the organization's business. Clients are, however, also members since their often voluntary presence in the program is necessary for organized action. This bifurcation of the client role as member and non-member presents systematic problems to the development of service organizations, because it may limit administrative autonomy. This situation was especially apparent in the agency studied.

When faced with the problem of organizational control emanating from diverse and inconsistent client interests, these programs essentially "purchased" client participation. Attempts were made to mirror adolescent concerns through an open format and acceptance of recreational social activities. Because the clients were left alone to enjoy themselves rather than being "hassled", prodded, or "social-worked", the counseling and treatment activities sometimes suffered. At Veritas, surrender to client interests produced a reversal of the organization's original purpose of counseling drug abusers; instead, it enhanced drug use and threatened the community's acceptance of the program. At Alpha House,
this same openness and acceptance of clients was tempered with staff assertiveness. However, the active staff role departed from the desired non-directing organizational style, which produced conflicts with clients and threatened youth acceptance of the program.

It appears, then, that client characteristics and behaviors were salient in explaining the "bureaucratic" development at Alpha House. On the other hand, the program had to be highly responsive to the needs of the youth as perceived by them; e.g., Alpha was forced to allow for recreational activities as well as to provide therapy groups. Nevertheless, the staff had to react in ways that were not attractive to the clients if they were to prevent collapse of the program and prevent negative sanctions from the community environment. Veritas House did not make this response, partially because clients virtually took over the staff; consequently, the program's evening section was not preserved and literally was non-existent for a period of time.

Eventually, Veritas moved to incorporate client interests by increasing "sensitivity" sessions and other counseling modalities, such as individual conferences, but responded to behavioral problems by increasing rules and other formal procedures. Alpha faced the same problem in a different manner, in part by recognizing the legitimacy of client activity in the program and in part because youthful staff crackdowns on the more bizarre antics of the
clients were acceptable to some clients. Many young people found comfort in some rules. Thus, it can be concluded that a combination of client variety and clientele size influenced these programs to move from a more open format to a structure with some bureaucratic elements.

Finally, staff characteristics and response to client activities were critical influences on the agency's development. In the absence of explicit agreement on objectives, programs with the broadest range of staff backgrounds initially appeared to have suffered more internal conflict. At Veritas, youth and adult staff members were constantly at odds over a range of drug-related issues, and the split was nearly impossible to manage. At Alpha, the process of staff development was similarly problematic due to workers' varied backgrounds; however, near the end of the observational period this organization was finally able to reach an acceptable modus vivendi. As staff members became more experienced, they became increasingly aware of the positive contributions made by both professional and non-professional staff. Eventually, this awareness helped to produce a more unified staff. When internal conflicts then began to abate, client/staff communication was facilitated by the wide range of competency among counselors.

The initial similarity of goals and procedures of these organizations and their consequent development is intriguing. Given the impact of client characteristics and behavior upon
this development, the question arises as to the conditions under which client input and organization response can resolve themselves in mutually satisfying outcomes for the organization.

**A Postulate Revisited: Client Interests and Organization Goals**

In the first chapter, a set of expectations relating to client/agency interaction during organizational development was offered. Specifically, the problem of client influence on organization development was centered in the relationship between client interests and organization goals. A simple paradigm involving permutations of initial and emergent interests and goals produced five major types of integration mechanisms: exchange, client socialization of the agency, agency socialization of the client, control, and accommodation processes. It was suggested further than these processes or mechanisms can be arranged and considered as career developments that can be plausibly anticipated.

**Evidence of exchange processes.** The central feature of exchange conditions resides in the interaction between agency and client; both need and seek each other. A good example of this type of relationship is independent, professional, service-for-fee counseling. The length of the relationship between a client and the agency is perhaps unimportant as long as the equity of investment for each side is maintained.
Exchange has frequently been postulated as a model for general interorganizational and environmental relations and has been broadened here to include client/staff interactions. This is an extremely useful concept of organizational behavior which facilitates planning and development. While the model appears to be heuristic, it is not exactly clear from several aspects: (1) how exchange relations are managed by those concerned with clients under changing conditions; (2) whether or not the occurrence of exchange denotes shared or disparate interpretations of the social interaction; and (3) whether these exchange relations are unstable and, if so, why.

Exchange clearly characterizes the initial interaction patterns between staff and client in each of the two programs. At Alpha, community and professional interest in a program for drug abusers was complemented by clientele interests in maintaining encounter groups for discussion of issues of personal concern. Discussions specific to drug use were central to the definitions of organizational purpose for each side. At Veritas, small groups of sympathetic staff members discussed drug issues with clients who recognized their immediate need for some kind of assistance. However, drug issues were of sole importance to only a few of the clients. Instead, the youth discussed a wide variety of adolescent problems.

Adolescent adjustment problems thus provided the content of interaction. The delivery style was intended to be
informal and open, and to show concern for the client as an individual rather than a cipher. For the staff in each program the conditions were easily obtained, insofar as the clients initially shared the therapeutic perspective on discussions; i.e., the point of discussions was to alleviate or change "problems". However, new clients were introduced into each program, thus widening the type of problems with which the organization would have to be concerned.

At Alpha, there occurred higher client attendance. This growth resulted from formal publicity and the high repute of the programs among their clients. Consequently, primary client characteristics (as defined earlier) began to change (e.g., the reasons clients came to the organizational settings broadened to include a wider range of issues which were not all amenable to solution in these types of organizations).

Some clients were emotionally disturbed and thus presented special control problems to the agency; they could not be trusted to maintain self-control without assistance. More importantly, the client perspective on adolescent problems began to depart sharply from the accepted staff view of these problems. Sexual problems, for example, which were initially framed in terms of client questions such as "should I remain a virgin?", were broadened by clients to include "horniness" and discussion of the problematics involved in finding a sexual partner. The basic areas of content did not appear to change; sex-related problems and family concerns
remained salient. But client perspectives on these problems were expressed in a more open fashion. This also strengthened client perception of a lack of drug problems. Thus, initial staff acceptance of the client did more than enhance client attendance. It also encouraged discussions and behaviors that were, by staff definitions, frivolous or otherwise not meaningful or appropriate.

These staff definitions in turn threatened the second goal related to delivery style. From an agency perspective, further passive organizational response to these new client concerns would only support future irrelevant client behavior. This was especially important because new client elements were constantly being introduced, and the possibility existed that the deviant trends might become institutionalized, thereby threatening agency existence.

Within this context, then, client secondary characteristics had changed: younger, less mature clients, evidencing need for adult behavioral supervision, began to attend the agencies. This necessitated in each of the programs a reconsideration of the passive organizational style. The decision to change the agency's response style in turn affected extraneous client characteristics. Newer clients were seen by the agencies as being unable to utilize an open response style. However, as the adaptations were then instituted, older clients became less able to utilize the service because the "hassles" involved in a more structured service were antagonistic to their feelings and perceived needs.
At the point where client interests and staff/agency goals diverged, the exchange period can be considered to have terminated. This was especially evident at Alpha House. At Veritas House, this situation also occurred early in the organization's career, but it was masked to some extent by the replacement of staff members by former clients. A process of competition for control and persuasion between youth and staff then began in each of the programs. Given the existence of the same initial exchange conditions in these programs, it is interesting to note the similarities and differences in agency development. Although the pattern at Veritas was unique, the same forces were at work (but handled differently) at Alpha. The growth in these two agencies seemed parallel in the initial stages of expansion, although different means of organizing client/staff interactions finally led to different structural outcomes.

Evidence of socialization: agency on client. The two programs studied responded to problems of divergent client interests and problematic behavior; one was successful. Alpha House moved actively to reduce undesired client behavior. Persuasive appeals were initially employed at this program. To a lesser extent, Veritas' adult staff also attempted to move in this direction. Aberrant clients were reminded and appealed to by peers sympathetic to the organizations' changing of their structural arrangements. At Alpha, staff continued to perceive a need to channel client
activities in order to permit therapeutic outcomes. The brevity of client/staff contact and the absence of formal relations to structure these encounters did not allow adequate opportunity to change client attitude or behavior.

This agency then proceeded to move away from its informal structure. Staff attempted to create a longitudinal relationship with clients by structuring contacts with youths. Organizational decisions and actions which did not directly confront clients were initiated; e.g., case notes on each client were kept and staff meetings for discussion of client problems were initiated after each night's activities. New and more active positions toward the client were considered; e.g., rules, appointments, group schedules, and so on were instituted. These attempts reflected the problems that the agencies faced in socializing the participants into acceptable client roles within the context of the original open-agency format. There existed a basic dilemma for the programs: the informal style was threatened by the rules and the existence of the programs was threatened by client deviance.

Further departures from the initial agency models appeared to signal a new, more resolute series of socialization attempts. However, as its attempts to socialize the client failed, the organization was gradually pushed toward more structured approaches which ultimately led to use of control mechanisms. Before examining this pattern, we must consider
the simultaneous attempts by clients to socialize the agencies or staff.

Evidence of socialization: client on staff. Socialization is undoubtedly a reciprocal process. It is evident in these data, however, that under certain conditions one side or another may be dominant. These outcomes to socialization attempts might be anticipated, assuming that both parties recognize their interest in modifying positions held by the other party. First, the agency might succeed in changing the client, but this did not occur in any of the centers examined. Second, the agency and the client might "draw", in which case there may be little overall change in positions or interests, or both sides might change substantially. In any case, both of these conditions could presumably lay the basis for subsequent accommodation mechanisms. Third, the client might succeed in socializing the agency.

At Veritas, clients did effectively socialize the staff (agency). Client impact on the definition of relevant behavior in the organization was evident. Their ability to shape or veto program policy was repeatedly demonstrated, and the process whereby clients became part of the staff finally produced an agency of clients. In effect, this was cooptation in reverse. This was due partly to the existence of a sizeable clique of clients in the program from its inception. This group remained loosely organized as members moved up to staff level positions and, in the process, formed a recognized
but unofficial second system.

At Alpha, the potential for client control never materialized although it seemed for a period that the organization could combat this possibility only by dissolution. In many respects the staff responded to client needs by the area of contact between client and agency through inclusion of recreational interests, by moving to counseling with families (seen by the youths to be the core of the problems), and by attempting to establish continuity of relations between school and youth.

Evidence for accommodation and control mechanisms. The two final stages considered in this paper are those most relevant to the question of alternatives to alienating bureaucratic forms. What characteristics produce accommodation between organization and client, on the one hand, or coercive control of participants, on the other; and what does accommodation look like?

Examples of both processes are provided by the data. At Veritas House, accommodations between clientele and agency clearly took form in the organization's decision to recognize the legitimacy of certain client interests. The purposes of client/staff interactions were redefined in the minds of the staff, and the image of the ideal client was then redesigned. Client participation in planning program activities was increased. At the same time, the staff took account of its interests by moving to formalize various aspects of the
original format, thus maintaining agency responsibility for activities through the elaboration of rules, procedures of exclusion, and the use of broadened staff response, such as individual counseling. In effect, these developments formed a new and satisfying basis of exchange in client/organization interaction.

Alpha House, choosing to ignore client interests because of their implicit threat to therapeutic intentions of the staff, instituted more formal control procedures. The program also moved to decrease its dependence on recalcitrant clients by attempting to recruit more pliant, agreeable clients. Furthermore, interaction and feedback were sought mainly from the clients who shared the organization's definition of appropriate program behavior. Despite the organization's increased ability to choose its members, it could not attract the desired type of client. This seems to be evidence that ultimately the subjectively perceived needs of the wider youth culture may play a decisive role in this agency's development.

For Veritas House, the data did not allow consideration of developmental outcomes. Staff turnover with client replacement and subsequent staff conflict immobilized the organization so that it could not even sustain a training regimen. Basic maintenance of the program was threatened, and it was doubtful that the organization could long survive in this condition, given the hostility of outside agencies.
In summary, it appears that the two programs had slightly different developmental outcomes, even though they shared the same initial objectives. Although the data were incomplete for Veritas, this program was the most open with respect to client autonomy but the least able to establish operating goals which satisfied its supporting agency and other community elements. Alpha had problems with client behavior similar to those of Veritas, but responded to them in a more active manner by attempting to formalize (and thereby routinize) client activity. When these attempts interfered with the official goals and with individual staff orientations, a compromise was struck among client interests, staff and organizational goals, and the realities of the situation.

Exchange, then, emerges as the most pervasive mechanism of integration. It may be the most collectively satisfying condition for all participants. Yet the content of exchange appears to be the subject of constant interactional definition and redefinition. When the initial basis of exchange in these programs was first disturbed, staff and clients each attempted to formulate a new exchange equilibrium. It is clear that pressure for advantage arises in both parties. Ultimately, however, clients may suffer from a paucity of organizational alternatives.

Client dissatisfaction with control conditions is a critical feature of the current unpopularity of bureaucracies.
This dissatisfaction is not necessarily a function of objective conditions. In many instances, a client will gladly suffer long waiting lines, triplicate forms, and weak treatment as long as the ultimate outcome is advantageous and pain is alleviated. The terms of the exchange and their subjective interpretation outweigh the negative aspects of real situations. Unfortunately, it would seem that the reverse could also be true.

It is also clear that the terms of the exchange need not be manifest or consensually defined by both sides of the trade. Satisfying interaction can still occur, although this may contribute to further strain in exchange relations. At Veritas House, for example, large numbers of clients continued to use the program as a place to have fun, buy drugs, or find sexual happiness. In many of these cases, staff members were unaware of these orientations, even that drug dealing regularly took place at the program, because they actively sought interaction with clients who were there for "serious business." However, when both clients and staff made such side adaptations as those which occurred in Veritas, the consequences reverted to the parent organization.

Consideration of types of client/organization interaction has underlined the contingent and developmental role of exchange, socialization, control, and accommodation mechanisms in the integration (or lack of it) of client interests and organizational goals. It appears that increased client
numbers and variety ultimately contributed to readjustment of the initial exchange equilibrium in both of the programs. One organization was better able to adapt to these changes, partly as a consequence of its recognition of legitimate change in clientele concerns. Theoretical and empirical attention to client participation as members of an organization may offer the most feasible starting point for designing organizational styles which can be satisfying to all participants.

Implications

To this point the problem has been cast largely in terms of the consequences of client/organization relationships. However, the results also bear upon issues of general importance to theorists concerned with other than client-serving organizations. To the extent permitted by this data, some of these issues will be raised and addressed.

Relationship between organization goals and consequent agency development. The role which goals play in organizational development is frequently questioned (Gross, 1969). The issue is very often engaged by consideration of two types of goals, official and operative (Perrow, 1961). Official goals are those potentially fictitious accounts produced by an agency to explain or rationalize actions to particular audiences (Warriner, 1965). Operative goals refer to the aims which participants pursue in terms of actual policies and
procedures. This distinction often helps to eliminate some of the confusion generated by the discrepancy between what organizations publicize and what they actually do. Yet the question remains whether official or operative goals or both are antecedents or consequences of organizational forms.

In the two programs studied, official goals regarding treatment of drug abusers in an informal, anti-bureaucratic style were made legitimate by initial community support and by acceptance of these premises by the early participants. However, the implementation of these goals generated different interpretations of purpose among client and staff of the programs. Newer clients did not generally consider drugs to be a problem. This divergence of opinion contributed to staff conflict and/or client behavior problems at the programs.

The staff in each of the programs developed different operative goals. These goals allowed them to maintain contact with at least some of the types of clients and problems designated by the official goals while de-emphasizing drug-related issues. These developing goals departed from official goals to a varying degree in each of the programs. For example, at Veritas House maintaining contact with clients who used drugs subordinated the objective of ending drug abuse. At Alpha House consideration of client interests led to accommodations in which both official and operative goals were tempered by consideration of some of the clientele's interests.
All of these factors seem to indicate that while there may be no fixed relationship between official and operative goals, the extent of discrepancy between the two and the strain generated by this have important consequences for ensuing organizational behavior. These results may in turn reshape even the official goals. In short, the official goals may be more amenable to adjustment, given the realities of client characteristics and remote, intangible, or inappropriate formal goals. Interaction with clients may be the most important constraint these organizations face.

All organization goals must be examined within a frame of reference which thoroughly considers the dynamics of client/agency interaction. The data seem to indicate that in these agencies goals may be a secondary feature of organizational development. Indeed, viewing organizational change from a position in which goals shape action may reify organizational structure at the expense of the fluid reality of agency development.

The relationship between individual client concerns and the service organizations. This relationship issue has been of fundamental concern to theorists throughout the history of the social sciences, especially to those persons concerned with organizations (Barnard, 1938; Argyris, 1964; Barrett, 1970; and Bennis, 1965). It culminates in the current popular search for alternatives to bureaucratic service.
This study has illustrated four distinct mechanisms which appear to integrate individual and organizational concerns: exchange, socialization, control, and accommodation. Exchange mechanisms based upon rational assessment of needs appear to be the most satisfying basis for client/staff interaction. However, exchange appears to be an unstable condition in the face of the complexity of increasing client numbers and diversity and/or client or staff turnover. Socialization of the client or of the staff (agency) or both was also unstable. The dissimilarity of intentions, which are manifest in the attempts of one group to change another, generated strain and dissatisfaction among clients and staff. Attempts to resolve differences through socialization point to basic competition or antagonism between agency and client, as well as a near balance of power.

Harmony is therefore not a necessary condition, nor does it necessarily result from socialization situations. Control of client activity in these programs emerged as a viable strategy for organizations to pursue if their power were enhanced by few alternatives for the gratification of needs as defined by clients. It was clearly not a satisfactory status for many clients. Client control of the agency was visible in one case, but this also led to increased conflict and finally threatened the existence of the program.

Accommodation mechanisms took into account both agency and client interests and appeared as an outcome of unsatis-
factory socializing mechanisms. Both control and accommodation may result from the inadequacy of socialization attempts. It should be added, however, that the extent to which one or both parties may covertly continue attempting to socialize the other party cannot be determined here. In any event, the new accommodations were less satisfying than the original basis of exchange to those early participants who remained with the organization. However, the compromises themselves generated a new basis of exchange which was acceptable to newer clients and staff. Satisfaction of individual needs may have been maximized under the original exchange conditions; however, as the situation became attached to the agencies, both aggregate clientele and staff needs seem to have been maximized through the accommodation. These were generally satisfying rather than optimal conditions for the individuals concerned.

Client-centered model: understanding organizational development. Within the limits of these data, general features of organizational development were clearly traceable to the behavior and characteristics of involved clients. In one agency changes in organizational structure and delivery style, such as increased formality, rules, or appointment schedules, resulted from changing features of the general clientele. The absence of changes in the second agency was accounted for by client dominance of the program.

This organizational development, however, was not an
entirely planned process. In fact, the nature of exchange and the contingent negotiation of exchanges may preclude this. If, in this study, the writer could have focused his research strategy on the behavior of organizational leaders, these findings would not have been duplicated. Regardless of the relationship between problem and method, attention to manifest characteristics of organizational functioning, such as leadership, is a traditional concern (Chandler, 1962).

In the agencies under review, decision making might appear retrospectively to have been well structured, despite the fact that rationality was relatively reduced by uniformed staff appraisal of client problems and the volatile role of clients in agency development. These organizational changes were not simply matters of agency or client response to fixed conditions but were the result of an interaction process. In addition, the findings at Veritas, where clients replaced staff, point to the deficiency of theoretical approaches which use strict definitions of organizational personnel.

Client input was of differential importance in accounts of change in various periods of organizational development. For example, at Alpha House one problematic client behavior stimulated a more active staff response, and client actions played a decreasing role in staff decision making. The staff found a self-satisfying style which still left them with
clients with whom to work (i.e., those few who agreed they had a problem). They began to decrease progressively the consideration of general clientele desires as they moved from a period of socializing to one of control regulation. There are, of course, other conditions (e.g., high client need) where agency autonomy vis-à-vis the client is enhanced for economic or other reasons.

Finally, the problem of informal versus formal behavior is recast in terms of a more inclusive model. Typically, only one authority system embodied in the organizational chart is considered legitimate (Maiolo, 1970). This is a well-defined feature of the sociological model of bureaucracy (Coch and French, 1958; Roethlisberger and Dickinson, 1964). Examination of interaction patterns, however, illustrated that several authority systems were possible in these programs. The existence of an "official" organization authority system did not preclude the legitimacy of other systems of staff or client authority. In fact, under some conditions, where the vacuum caused by an unusually high turnover rate of staff was filled by enthusiastic clients (e.g., Veritas House) the ostensibly informal became the form. Or, as occurred in the other program, competing and even antagonistic authority systems possessed elements of legitimacy recognized by each other.

This also raises the question of client membership in an organization. It is apparent in these data that the role
of the client may change during organizational development. It may be confusing at times even to distinguish between clients and staff, as was exhibited in Veritas House. The level of client influence on policy, however, need not often be as manifest as it was in these young and rapidly changing agencies. The results here do suggest that client impact on an organization may be directly related to the level of client (or clientele) "organization". Whether this simply means the social cohesiveness of a high school clique or the formality of a well-oiled consumer union, the power of the individual client to influence outcome is increased. Administrators may then be forced to look at overall clientele characteristics and desires as they affect planning of service delivery.

This does not, in effect, reduce the issue of client impact to a simple question of relative power. The relationship between client cohesiveness and impact on policy is dictated by the relationships between organization and client (Lefton and Rosengren, 1966). With long-term relationships present in inducting organizations, even latent client characteristics can mold the organizations. In total institutions, such as a prison, links between prison and prisoner are much stronger than links between clients and less formal agencies. Yet despite the almost total physical control over prisoners, there is no indication that the agency has had increased success in rehabilitation. Certainly
organizational systems can initially define the type of client served. Furthermore, in the course of agency development, certain types of clients may be included or excluded. But future interaction between organization and client may play a part in shaping agency structure and outcome of treatment.

Conclusion

This has been a descriptive and exploratory study of organizational development in two informal, anti-bureaucratic drug abuse treatment programs. Major findings show that client inputs played an integral part in accounting for the development of each agency, but organizational change was also a result of the actions and responses of the staff and the clients.

The empirical results of the study are descriptive, but four different analytical mechanisms were offered, which appeared to integrate client interests and organizational goals. These mechanisms, discussed in terms of the descriptive findings, appeared relevant at different times during agency development and emerged from the conditions and consequences of client/staff interactions. The achievement of mutually acceptable organizational forms appears to result from exchange and accommodation mechanisms. The evolution of these mechanisms derives in part from the extent to which the agency recognizes and includes client inputs.
This research offers a framework for the exploration of client influences on agency policy. Any effort to identify or understand organizational development must take into account the implications of client characteristics and behavior. An awareness of the nature of client participation is vital to understanding the ways in which current structures function and the kinds of new service structures which will evolve.
BIBLIOGRAPHY


Bagehot, W. Physics and politics; or, Thoughts on the Application of the principles of 'Natural Selection' and 'Inheritance' to Political Society. Farnborough, England: Gregg International, 1971.


Bennis, W. "Beyond Bureaucracy." Trans-Action 2, (July-August 1965), 31-35.


———. "Two Approaches to Organizational Analysis: A Critique and Suggestion." Administrative Science Quarterly 5 (September, 1960), 257-278.


APPENDIX
DESCRIPTION OF APPLICANT AGENCY - DUR

Background

The Drug Dependence Unit of the Connecticut Mental Health Center officially began in July 1958 when it was the recipient of a five-year grant from the National Institute of Mental Health. The grant involves a commitment on the part of the State to matching funds with the State portion rising to 50% at the end of five years.

During the first year of its operation, the goals of the Unit were to establish the various treatment, education, and evaluation components, recruit appropriate staff and find real estate in which to operate. Despite marked difficulties in these latter two aspects, the Unit was able at the end of the year to have all of its components open successfully and managed to see over 400 patients over its first 11 months. The Unit sees individuals from 14 on up who have difficulties with narcotics, amphetamines, psychedelics or barbiturates.

The description below sums up the operations of the Unit during the past year and its current status.

Administrative Structure of the Drug Dependence Unit

The Director of the Drug Dependence Unit, Herbert D. Kleber, M.D., is administratively responsible to the Director of the Connecticut Mental Health Center, who in turn is jointly responsible to the Chairman of the Department of Psychiatry, Yale University School of Medicine, and the Commissioner of Mental Health for the State of Connecticut.

There are six major components to the Drug Dependence Unit, each with its own head. These components are: Daytop, Inc., Methadone Maintenance Unit, Out-patient Clinic, NARCO, Inc., Epidemiology and Evaluation, and Education. The letter is headed by the Assistant Director for the total program. NARCO and Daytop are related to the Drug Dependence Unit on a contractual basis.

Daytop, Inc.

Daytop is a residential treatment community, staffed entirely by ex-addicts who are Daytop graduates. During the past year the main problem surrounding Daytop was in finding a facility adequate for their needs.

Daytop staff arrived in New Haven on August 8, 1968, and until November 25, 1968, were housed in a building too small to permit admission of new patients. Individuals who were recruited in that time for Daytop were sent to the Daytop facilities in New York state. In November a temporary facility was found which would house 25 patients, and this was their basis of operation until June 1969 when a new facility was located. In November 1968, in addition to the move to the new facility, a complete
break was made with the New York Daytop because of internal crises that had befallen that program. When the break was made a local Board of Directors was formed of New Haven citizens, and Daytop was incorporated as a Connecticut non-profit corporation.

In June 1969, Daytop moved to a building in Seymour, Connecticut, which is approximately 25 minutes from the Connecticut Mental Health Center. This facility can house over 50 patients and has provided finally a place for Daytop to carry on its therapeutic work. Although the program has budgeted for 50 patients, we are currently able to have only 35 at Daytop due to Zoning Board restrictions. These restrictions are in the process of negotiation. Daytop accepts patients from 10 on up who are drug dependent. It is not limited just to narcotics.

**Methadone Maintenance Program**

Initially this program began with patients being hospitalized on an inpatient unit for periods of between four and eight weeks. In the Fall of 1968, it was felt that this was not working due to the small number of people that could be seen on this basis and various problems with the psychiatric unit in which the program operated. At that time, the program began seeing patients on a completely outpatient basis without any initial inpatient stay. This too was felt to pose major problems. Finally, a day hospital program was evolved which has become the mainstay of the program to date.

Patients come in Monday through Friday from 8:30 a.m. to 4:00 p.m., and during this time receive their Methadone and are involved in a variety of therapeutic and rehabilitative measures. This stay lasts approximately three to six weeks, and patients are then seen on an outpatient basis. Urines are checked twice a week for narcotics, quinine, amphetamines and cocaine. The great majority of the patients are either in school, in training programs, or steadily employed. In addition to receiving Methadone, patients continue to remain in group therapy for at least six months after being discharged from the day hospital program. The Methadone Maintenance Program has as its minimum age 21 years and a minimum of two years of narcotics addiction.

**Outpatient Clinic**

After wrestling with severe problems of both staff and space, the Outpatient Clinic was finally able to recruit sufficient staff and move into partial occupancy of a building in April 1969. Full occupancy of the building could not occur until November 1969 because of difficulties with the State Fire Marshall and then delays in renovation.
The primary therapeutic modalities during the first year were group therapy, family therapy, and individual therapy, and a major thrust into the community through consultation and a variety of special outreach projects. Because of difficulties with relapses especially among adolescents drug users, the Outpatient Clinic has been formulating new programs to cope with these problems. In November 1969, a Day Status Program was initiated with an anticipated stay of three to six weeks and then graduation to outpatient status. During this time the adolescent is involved in a variety of vocational, educational and recreational programs simultaneously with more formal therapeutic endeavors. A Naloxone Maintenance program was initiated in February and should prove an additional help with adolescent narcotic users. The Outpatient Clinic sees individuals from age 14 up.

**NARCO, Inc.**

NARCO, a grass roots organization founded by ex-addicts from New Haven in 1966, was active during the past year in visiting addicts in hospitals and prisons, arranging for treatment and screening patients for referral to Daytop and the Connecticut Mental Health Center and especially in conducting many speaking engagements aimed at community education. In addition, they began an education program on drug dependency in the New Haven school system.

**Epidemiology and Evaluation**

This Unit has defined and set in operation data gathering and record keeping systems. A long range epidemiological study and the techniques for overall program evaluation have recently been set in motion.

**Education and Prevention**

Representatives of Daytop, the Methadone Maintenance program, NARCO, and the Outpatient Clinic have conducted hundreds of speaking engagements, panels, workshops, and meetings with agencies in an all-out desire to educate the community in the facts about drug abuse. Education and training programs have been conducted with many teachers, community leaders, students, youth workers, mental health professionals, and inner-city youth not in school.

**Other Connecticut Health Center Units**

All Connecticut Mental Health Center units have been involved with our program to some degree, especially the Emergency Treatment Service (ETS) and the Hill-West Haven Division.

**Admission to the Program**
There are currently two portals of entry to the program - The Screening Group held at the Outpatient Clinic at 104-106 Park Street and NARCO. From this first portal patients are evaluated and then referred to the treatment component most appropriate for their needs. Patients that come directly to NARCO are either admitted from there to Daytop or referred to the Screening Group for possible inclusion in the other treatment modalities. The Screening Group is held every Wednesday at 2:00 p.m., and no appointments is necessary. NARCO is open five days a week from 9:00 a.m. to 5:00 p.m., and individuals may go in there any time within those hours.

NEED FOR RESIDENTIAL FACILITY

Our experience with youthful addicts (please refer to the Outpatient Clinic Report, Appendix A) indicates an increasing need to place order and structure into the lives of individuals who come to us with considerable turmoil. The growth of our treatment program represents a process of adding more and more components which serve to mitigate against premature relapse to narcotics by isolating the addict from the source of his drugs at least during a major period of his week; to establish routes into education and employment following preparatory experiences in our Day Program; and insuring that enough time elapses, free of drugs, to enable the young addict to test out his capacity to make it in the straight world with the support the program provides. Thus, we have moved from once weekly Outpatient groups to a Day Program involving five days a week, 8 hours a day for an initial period of between 9-15 weeks. Nonetheless, the cumulative effect of drug abuse in terms of relationship with family, physical health, self-esteem, and stable living arrangements do not get resolved without considerable investment of time and energy over a significant period of time. We have found that despite our efforts along these lines, there are those who cannot sit still long enough, because of those provocative influences in their lives - not the least of which is the amount of drugs available to them from the time they leave the clinic building till they reach their homes - for the program to "work". For these individuals geographical isolation from the source of drugs and a stable living arrangement, with a community of peers in a therapeutic environment, is the only chance of abstinence from drugs.

Further, while our Daytop facility provides many of these supports, a need exists for a shorter term residential placement, with a higher visibility in the community, and an expectation of graduation from the facility within a period of six months (as against the two year average stay at Daytop). Our plan involves the establishment of a series of residential facilities, this proposal being the first, which will move from greater to lesser structure. Upon graduation from the halfway house, a member will move into a group apartment shared with other graduates until he
can establish complete independence. This initial residence is designed for teenagers and young adults whose neighborhoods and connections are too supportive of his habit, whose home situation is untenable, and those released from jail or hospital with no home to return to.

While several facilities exist in the catchment area for adolescents and young adults, none of these facilities to date have been willing to absorb individuals with a drug history for fear of contaminating their populations, and our efforts to open some of these doors to our program members have been unsuccessful. Also it is doubtful that these other facilities are able to deal effectively with members of the addict sub-culture.

DESCRIPTION OF FACILITY

A) Criteria For Admission

The halfway house would serve as a resource for the Outpatient Clinic and individuals assigned there through screening and evaluation procedures already established by the Drug Dependence Unit and for those program members already in treatment who require residential placement. Other specific criteria include:

1) Addicts between the ages of 14-21 with at least a three month history of drug abuse.

2) Those who do not present gross personality and physical disorders.

3) Those whose life styles and value systems do not require a more thorough re-organization and who have potential within a six month period of stabilizing their lives in terms of employment, education and more independent living arrangements.

B) Detoxification

Up to the present, detoxification of addicts when a necessary first step into one of our treatment programs has been effected at one of the medical facilities available to our program principally, C.V.H. in Middletown. It is anticipated that the proposed Narco Detoxification Center will more than accommodate the prior detoxification needs of admission to the Halfway House.

C) Naloxone

At the discretion of the screening committee or the residential
staff, or if volunteered by the resident, the narcotics blockading drug, Naloxone would be initiated ten days following detoxification. In some instances dispensing of Naloxone may be initiated at the Detoxification Center, under medical supervision; prior to admission to the House in order to effect a drug free transition between the two facilities. We have been using this drug along with our Day Program for the past four months and have found it useful as a blockading agent with minimal side effects.

D) Physical Plant

The house will be ideally located some distance from the major high risk neighborhoods but a reasonable distance from the Outpatient Clinic. The building will provide sleeping quarters for 220 residents and 9 residential staff. The general facility will also include 3 bathrooms, a community kitchen, living room and study and recreational area both inside and outside. A conference room or general meeting room, workshop, arts and crafts area and office space will also be included. If a large enough facility were obtainable, it is planned that part of the facility would be used as a community center for program members who are not in residence. Renovation, repair and maintenance, housekeeping and cooking would be the responsibilities of the residents.

E) Staff

Staffing needs include a Resident Director and an Assistant Director, a program coordinator, 2 counselors, a half-time administrator and a full-time secretary. In addition, we will have a volunteer medical staff and a volunteer bookkeeper. It will important to maintain liaison between the clinic and the residence for continued training of the residential staff as well as provision for continuity of the contact with members both prior to admission and after graduation.

It is anticipated that staff positions from Coordinator to Director will be filled, if not immediately, then eventually by graduates of the Drug Dependence Unit treatment programs. A pool of such talent, developed over the two year period of the program's existence, currently can fulfill most of the staffing needs of the facility, thus giving tangible evidence to newer program members of the program's rehabilitation aims while presenting acceptable role models with both savvy and skill.

F) Treatment Program - The facility will represent a microcosm of the outside world with a variety of roles, tasks and relationships to master. The content of treatment deals with the problem of mastery and the fulfillment of new responsi-
abilities. Confrontation occurs as much in the therapy sessions as at the breakfast table or carpentry crew. Participation in the development of limits and the regulation of behavior places responsibility on the community of members for the outcome of their efforts. Activity of the residential group is not confined to the residence, rather the approach developed by the Outpatient Clinic and its goals of affecting community institutions and agencies will necessitate drawing upon residents as participants in the clinic's consultative efforts.

Education will be both formal and informal. Preparation for graduation begins with admission. High school equivalency and return to formal education at the high school and college level will be worked through. Learning skills are sharpened and curiosity focused beginning where the resident is at, beginning with his specific interest and generalized outwards. The services of the clinic's educational specialist will be drawn upon both in planning discharge as well as structured opportunities for learning within the residence. Liaison and cooperative efforts with New Careers, DVR and the area's community colleges will be expanded. Major stress in the area of vocational work will be placed on the training of residents to fill positions in the varied youth-serving agencies with which clinic staff and members have had consultative relationships. (See Appendix A, Page 13) Resources available to us from the Yale community for educational endeavors will be exploited while residents will have responsibility for the "hustling" of additional supplies, equipment and human resources it requires for its program.

Following graduation and actualization of educational or vocational planning, the member moves into an apartment facility with two or more members who have graduated before him. At this time he is also coming twice weekly to evening programs at the Outpatient Clinic. The final step is establishment of a home residence, independent functioning and possible entry into a training position at the Drug Dependence Unit, leading to employment within the program or in similar facilities elsewhere.
VI. Narrative

A. Description of the Community to be Served

1. Geographical Boundaries

The service area of the proposed Residential Center for Youthful Addicts consists of the City of New Haven and 12 smaller cities and towns immediately adjacent to it. (See attached map A) The area coincides with the primary service area of the Drug Dependence Unit of the Connecticut Mental Health Center. It extends from Milford on the West to Madison on the East and also coincides with the South Central Connecticut Mental Health Planning Region. Twelve of the 13 communities comprise a Standard Metropolitan Area of the U.S. Census Bureau. Population figures that appear on the map are based on results of the 1970 Census. The total population of the area is approximately 404,297.

2. Access to Residential Center and Affiliated Organization

Map B shows the location of the Drug Dependence Unit (DDU) of the Connecticut Mental Health Center and the site for the proposed Residential Center in New Haven. Its location is such as to make it readily accessible both by automobile over major transportation arteries and by public transportation. Two local bus lines have stops a block from the facilities and suburban buses stop within four blocks. The facilities are within easy walking distance for many prospective patients of the program.

3. Location of Residential Center Site in relation to main addict areas.

There are two areas in the inner city of New Haven where there are major clusters of addicts. These are located in the Legion Avenue neighborhood (Census Tract 8) which is immediately adjacent to the Connecticut Mental Health Center and the proposed facility and in the Dixwell Avenue region (Census Tract 16 on Map C). There are growing clusters of abuse throughout the catchment area.

4. Location of Related Treatment Facilities

Three of the clinical components of the DDU are located within two blocks of the proposed site (Screening and Evaluation, Outpatient Clinic, Methadone Maintenance Program). Of particular relevance is the accessibility of the Outpatient Clinic, since it will provide some suppor-
tive services (see description of Service Program).

The Connecticut Mental Health Center is located within the complex known as the Yale-New Haven Medical Center. Yale-New Haven Hospital is a 766-bed general hospital that provides a full range of medical and surgical inpatient services. About 100,000 visits per year are made to its outpatient clinics and approximately 50,000 additional visits to its emergency service. The Connecticut Mental Health Center obtains many services from the hospital through a contractual arrangement.

Detoxification facilities are located at the Hill/West Haven Division of the CMHC with which the DDU has close working relationship.

Connecticut Valley Hospital where the majority of area addicts still go for withdrawal is 28 miles away in Middletown, Connecticut.

A proposed detoxification center administered by Narcotics Addiction Research and Community Opportunities, Inc. (NARCO), for which partial funding has already been approved, is located on Howard Avenue, five blocks from the proposed residence. NARCO has a storefront center on Congress Avenue, within four blocks of the Connecticut Mental Health Center, and in a ghetto area.

5. Description of the Applicant Organization and Affiliated Agencies

a. Addiction-Prevention, Treatment Foundation, Inc. (APT)

In the early part of 1970, it became clear to the senior staff of the Drug Dependence Unit that the problem of addiction in the New Haven area was continuing to increase and was far out stripping the resources available to the Drug Dependence Unit. It also seemed clear that considering the state of both the Federal and State economics that in the future it might be possible to fund an extremely important endeavor such as a halfway house for adolescents through one or the other sources and then find that matching funds were not available from the other sources. It, therefore, appeared imperative that attempts be made to find new sources of additional funding.

Accordingly, in the Spring of 1970, we had an attorney draw up plans for a private foundation to be
called APT: Addiction-Prevention and Treatment. In December, 1970, the I.R.S. approved the legal status of APT as a tax exempt, non-profit foundation.

From the time that APT was legally incorporated until early 1971, the governing body was made up of a Board of Directors composed of various staff members of the Drug Dependence Unit. Once the legal status was clarified, these members resigned from the Board and were replaced by various prominent New Haven area citizens. These new Directors are persons who are concerned about the alarming rise in adolescent drug use and who are willing to devote some time and attention to doing something concrete about the problem. These new members and their outside titles, given for the sake of identification, are as follows:

Lester H. Aaronson, Esq., Judge, Probate Court
Richard Belford, Esq., Attorney in private practice
former Director of the City Commission on Equal Opportunities.
Robert Brubaker, M.D., Medical Director, Winchester Division, Glin Corporation
John Cox, President, Orange National Bank
Michael Pezza, M.D., Physician in private practice
Edward Fortes, Assistant Director, New Haven Foundation
Louis J. Kaplan, Assistant to the Dean, Yale University School of Medicine
David Konowitz, Esq., Attorney with Sachs and Sachs
Ernest L. Osborne, Director, Recruiting and Special Programs, Yale University

Although APT has not as yet engaged in any general fund raising activities, it has already been the recipient of some funds from individuals and groups who had learned about its formation and wished to help it along. It has also been the technical instrument for the evaluation of the Addiction Research Treatment Corporation Methadone Maintenance Program in New York, and receives funds from that Corporation for this purpose.

In keeping with its aim of increasing services to adolescents, it has also recently rented a storefront whereby the Drug Dependence Unit would be able to increase its screening activities and provide new outpatient programs for adolescents.
At a recent APT Board Meeting, the Board voted approval of the submission of a grant for a halfway house and pledged to raise the necessary funds for match. They have already started negotiations to purchase a building suitable for the halfway house which will by itself make up a substantial portion of the match. The prominence of the various Board members, their well established ties to key elements of the New Haven community, plus the sense of urgency felt by the community around the need for additional programs for drug-using adolescents, make it virtually certain that the match to the Federal funds for this grant would be easily made available.

b. Drug Dependence Unit (DDU) and its components

The Drug Dependence Unit of the Connecticut Mental Health Center officially began in July 1968 when it was the recipient of a five year grant from the National Institute of Mental Health. The grant involves a commitment on the part of the State to matching funds with the State portion rising to 50% at the end of five years.

Now at the end of its third program year, the DDU has accomplished the establishment and stabilization of three treatment components and the growth of its education and training unit into a regional training institute.

The Director of the Drug Dependence Unit, Herbert D. Kleber, M.D., is administratively responsible to the Director of the Connecticut Mental Health Center, who in turn is jointly responsible to the Chairman of the Department of Psychiatry, Yale University School of Medicine, and the Connecticut of Mental Health for the State of Connecticut.

There are six major components to the Drug Dependence Unit, each with its own head. These components are: Daytop, Inc., Methadone Maintenance Unit, Outpatient Clinic, NARCO, Inc., Epidemiology and Evaluation, and Drug Dependence Institute. The latter is headed by the Assistant Director for the total program. NARCO and Daytop are related to the Drug Dependence Unit on a contractual basis.

(1) Daytop, Inc.

Daytop is a residential treatment community, staffed entirely by ex-addicts who are Daytop
Daytop staff arrived in New Haven on August 8, 1968 and until November 25, 1968, were housed in a building too small to permit admission of new patients. Individuals who were recruited in that time for Daytop were sent to the Daytop facilities in New York state. In November a temporary facility was found which would house 25 patients, and this was their basis of operation until June 1969 when a new facility was located. In November 1968, in addition to the move to the new facility, a complete break was made with the New York Daytop because of internal crises that had befallen that program. When the break was made a local Board of Directors was formed of New Haven citizens, and Daytop was incorporated as a Connecticut non-profit corporation.

In June 1969, Daytop moved to a building in Seymour, Connecticut, which is approximately 25 minutes from the Connecticut Mental Health Center. This facility can house over 50 patients and has provided, finally, a place for Daytop to carry on its therapeutic work.

(2) Methadone Maintenance Program

The Methadone Maintenance Program is designed to serve heroin addicts, over 21, with: (1) a history of significant previous effort to stay clean; and (2) a history of two years continuous addiction to heroin.

Since the program began in the fall of 1968 several different induction procedures have been tried. Currently new members start the Program in Day Evaluation. Here they are required to come in seven days a week for medication, five days a week for hour-long Day Evaluation group meetings, during which there takes place orientation to the program. We also collect urine specimens approximately twice weekly in accordance with a statistically randomized system of collections. It is during this phase of the Program that major logistical issues are handled i.e., getting on Welfare if necessary, finding a place to live, fulfilling the requirements of proper medical care. Thus at the completion of
Day Evaluation members should be ready to devote themselves full time to the issues unique to the Day Hospital Phase.

The Day Hospital Program meets five days a week from 8:30 - 4:00 and with rare exceptions members stay on this program for six weeks. The effort here may be roughly divided into two parts. One is an effort at "getting your head together" and here emphasis is on self awareness and particularly black self awareness with an accompanying special interest in black history of addiction in black communities. The second part of the Day Hospital Program consists of orientation toward job/training/education/career/new forms of recreational and/or cultural pursuits. Members are expected to leave the Day Hospital phase of the Program with a constructive vocational role firmly in hand. This requirement stays in effect throughout the Program membership.

The proposition of membership as opposed to patienthood entails restricting 'therapy' to exceptional circumstances, and therapeutic contracts are designed as temporary affairs dealing with temporary malfunctions. The great body of work in the Program, then, is carried on in Smart teams, each of which has specific assignments in managing specific areas of the Program. For example, Smart I--Standards and Guidelines for the Program, Smart II--Developing recreational facilities, Smart III--maintaining adequate working relationships with community agencies of health and social service, Smart IV--establishing projects in handicrafts and the arts, Smart V--maintaining working relationships with agencies of Corrections, Smart VI--property maintenance and construction.

The program also provides encouragement for those interested in gradual withdrawal from Methadone. We now have 18 people functioning in our "Detox Groups" which are designed to offer psychological supports to those undertaking this new, and hence anxiety-provoking step. Several members of the group have actually attained zero dosage and continue to participate as they are expected to do in their weekly group meetings for a period of six months following the attain-
ment of zero dosage. Our position on Detox is that our Program must be able to accommodate those who wish to function without methadone, those who feel they must continue with methadone, and those who wish to try to do without methadone and then find that they need it after all.

(3) Outpatient Clinic

The Outpatient Clinic has recently increased both its structure and the demands made on its treatment population. Most of our energy is invested in the Day Program which is designed to offer creative structure on a day to day basis to drug addicts between the ages of 14 and 26 years, who demonstrate a commitment to change themselves, the patterns of their lives, and eventually the social structures and institutions around them. Those eligible have used drugs at least 6 months, but have potential of stabilizing their life styles within a reasonable period of time.

As a self-help abstinence program, we rely mainly on group pressure and support as methods of changing the new member's life style. The non-addictive blocking drug Naloxone is used as an aid, supporting the member's decision to abstain from narcotics. Recognizing that to compete successfully with the pleasures of the drug world, we must offer real and continuous gratification, risk taking and mastery, our program has taken on a strong training emphasis. The program member rises in a continuous hierarchy culminating in his position as a highly visible staff member/field worker who is expected to gain some academic credentials as part of his training.

The major problem in the day program has been holding members in the initial stages; it is hoped that an initial residential stay will help solve this.

Outpatient Clinic staff also run two once weekly "head groups" primarily for young soft drug users who have enough outside supports to profit from minimal involvement here. The head groups do successfully demand of their members a
high degree of abstinence and productivity.*

(4) Narcotics Addiction Research and Community Opportunities, Inc., (NARCO)

NARCO, a grass roots organization founded by ex-addicts from New Haven in 1966 is active in visiting addicts in hospitals and prisons, arranging for treatment and screening patients for referral to DDU treatment facilities. NARCO staff conducts many speaking engagements aimed at community education. in addition, they began an education program on drug dependency in the New Haven school system.

(5) Epidemiology and Evaluation

This Unit has defined and set in operation data gathering and record keeping systems. A long range epidemiology study and the techniques for overall program evaluation have recently been set in motion.

(6) Drug Dependence Institute

The Drug Dependence Institute is a component of Yale University Department of Psychiatry and is integrally related to the Connecticut Mental Health Center, Drug Dependence Unit, and the Addiction-Prevention, Treatment Foundation. Supported by grants and contracts from the National Institute of Mental Health, the Institute was established to offer training in the prevention of drug abuse and to advance knowledge and understanding of drug dependence.

Major emphasis has been given to a two-week full-time Internship Program. Interns spend two weeks in New Haven studying and working with addicts and adolescents in a demanding, intensive program. Trainees are exposed to the pertinent literature in the field, to ex-addicts

*Since the Outpatient Clinic is the component with which the proposed facility will have its principle tie-in, a more complete description of this unit will be found in the Appendix.
and addicts in treatment, and to many of the leading theoreticians and practitioners in the field of drug dependence.

3. Incidence of Drug Abuse:

The problems of accurately assessing the epidemiology of addiction for any area are well known. The usual indices, e.g., number of arrests, may reflect the dimension of community attention as much as it might indicate a rise or fall in incidence of abuse. With this in mind we present the following data: The number of arrests for possession of heroin in New Haven for July - December 1970 was almost double for that period in 1969 and nearly ten times the number of arrests for a seven month period (January-August) in 1967. (See table 1)

The figures on all drug arrests for the two comparable periods show a rise in 1970 of over 100%. Although the relationship between the number of narcotic arrests and the actual number of addicts is not known, estimates are that arrests account for only about one third of the number of addicted individuals. This would place the estimated number of addicted in the New Haven area at about 1,600, or twice the estimate in 1968. Although we realize that New Haven police may be more active than police in larger cities it is nonetheless the case that per capita arrests on drug charges in New Haven are greater than those in New York City.

A comparable increase in the number of individuals applying to the Drug Dependence Unit of the Connecticut Mental Health Center affords an additional verification of the apparent rise in incidence. As seen in Table 2 there was a 67% increase in individuals on the rolls of the DDU from 1969 to 1970.

A total of 634 applications for treatment at the DDU were made during 1970 (See Table 3). Of these, 61% did not find their way into treatment following evaluation. While attrition can be accounted for on the basis of a variety of factors, the experience of the Screening and Evaluation staff continually pointed to the limitation of options open to them in deciding on treatment of choice. This was particularly true in the case of individuals for whom residential placement was indicated or would have been more acceptable to the court as an alternative to incarceration, but for
whom the thought of an extended 24 month stay, as in our Daytop facility, was thought of as excessive or unnecessary.

Age was a major factor in the actual entrance of the applicant to a treatment program. While the average age of applicants to DDU in 1970 was 23.1, the age of those who entered treatment averaged 26.7. This is seen as significant in this grant application for a residential facility aimed at the younger addict.

B. Description of Service Program

1. The need for a short-term residential facility

Our experience with youthful addicts (See Appendix) indicates an increasing need to place order and structure into the lives of individuals who come to us with considerable turmoil. The growth of our treatment program represents a process of adding more and more components which serve to mitigate against premature relapse to narcotics by isolating the addict from the source of his drugs, establishing routes into education and employment following preparatory experiences in our Day Program, and insuring that enough time elapses, free of drugs, to enable the young addict to test out his capacity to make it in the "straight" world with the support the program provides. Thus, we have moved from once weekly Outpatient groups to the Day Program involving five days a week, 8 hours a day for a period of between 4 to 6 months. Nonetheless, substantial deterioration in relationships with family, physical health, self-esteem, and stable living arrangements are not resolved without considerable investment of time and energy over a significant period of time. We have found that despite our efforts along these lines, there are those who cannot sit still long enough, because of those provocative influences in their lives—not the least of which is the amount of drugs available to them from the time they leave the clinic building till they reach their homes—for the program to "work." For these individuals geographical isolation from the source of drugs and a stable living arrangement, with a community of peers in a therapeutic environment, is required.

Further, while our Daytop facility provides many of these supports, a need exist for a shorter term residential placement, with a higher visibility in the community, and an expectation of graduation from the facility within a period six months (as against the two year average stay at
Daytop). Our plan involves the establishment of a series of residential facilities, this proposal being the first, which will move from greater to lesser structure. Upon graduation from the halfway house, a member will move into a group apartment shared with other graduates until he can establish complete independence. This initial residence is designed for teenagers and young adults whose neighborhoods and connections are too supportive of his habit, whose home situation is untenable, and those released from jail or hospital with no home to return to.

While several facilities exist in the catchment area for adolescents and young adults, none of these facilities to date have been willing to absorb individuals with a drug history for fear of contaminating their populations, and our efforts to pen some of these doors to our program members have been met by only token response. Also, it is doubtful that these other facilities are able to deal effectively with members of the addict sub-culture.

We would wish to make it clear that by proposing this residence we are in no way abandoning the concept of "out-patient" treatment for youthful drug abusers. On the contrary, we feel we have amply demonstrated the viability of such a model. Rather, we see the residence as extending the range, in a sense, of an outpatient regime. By providing the opportunity to some individuals, as we will describe, to begin a treatment experience with maximum external support; to rely for others upon a 24 hour "base" to return to in time of "shakiness" or crisis; and finally to provide a natural setting for a wide range of social, educational and therapeutic activities for an expanding community of young ex-addicts.

The problem encountered by the young "ex-addict" in the area of "fitting in" to a social matrix which is both comfortable and safe from the standpoint of re-addiction is formidable. "Living in" a therapeutic community beyond "graduation" may be costly and unrealistic and "re-entry" of the treated ex-addict to the community has been a major problem. This proposal is an attempt to design and implement new models in the treatment and rehabilitation of the adolescent and young adult addict.

2. The Proposed Community Residential Center in the Context of Other Services.

The residence is seen as but one component in a comprehensive rehabilitation system designed to meet the needs of youthful addicts. (See table 4) The functional rela-
tionships of other established components to the proposed facility are as follows:

(a) The Screening and Evaluation Unit

This unit, which serves as the port of entry to the DDU is located at 136 Park Street, one-half block from the Outpatient Clinic. It is staffed by representatives of each of the DDU treatment modalities who feedback data to their components on the current and changing profile of the demand for services. In like manner the capacity of each of the treatment modalities to absorb new members is fed weekly to the Screening Unit. Referrals to the proposed facility will be made via the Outpatient Clinic following detoxification at a choice of facilities if this is necessary.

(b) Detoxification Facilities

Currently there are two major detoxification resources open to the DDU. The major facility, which has served the catchment area since the program was first established is a State Hospital, Connecticut Valley Hospital (CVH), located in Middletown, Connecticut, 23 miles from New Haven. Problems of distance, communication and periodic policy changes have limited this facility. DDU has developed a relationship with the Hill/West Haven Division of the Connecticut Mental Health Center whereby four beds are set aside in this facility, located two blocks from the Outpatient Clinic, for detoxification of young addicts screened by the Screening and Evaluation Unit and who are scheduled for referral to the Outpatient Clinic's Day Program, or to Daytop following the 28 day inpatient stay. A staff trainee (program member) of the Outpatient Clinic does his field work at this Unit as co-therapist in an addict group.

As seen in Table 4 another detoxification resource is to be opened soon. This is a 20 bed detoxification center to be operated by NARCO, Inc. The facility will be located on Howard Avenue, about five blocks from the DDU, and plans to accommodate most of the detoxification needs of the area. A number of additional beds will probably be made available by Yale New Haven Hospital in connection with efforts to locate all of the detoxification facilities within realistic access to the areas of highest incidence. It should be noted, however, that our priority has been on planning
for rehabilitation steps taken following detoxification.

(c) Day Program

The Day Program of the Outpatient Clinic, described earlier and in more detail in the Appendix, will continue as a parallel program to the proposed residence. It is designed primarily for individuals whose extra-program life does not tend to undo gains made in the program. The emphasis of this program, expressed in terms of ultimate "pay-off" has taken the shape of field work and training following or simultaneous with steps at "getting one-self together." This field work locates the young ex-addict, under considerable supervision, in a variety of settings -- clinical, educational, community -- which serve high risk youngsters. We are currently planning with a local four year college, a grant which will establish a New Careers program involving twelve of our program graduates yearly. The program will lead to an Associates Degree in Science and will allow transfer of the student to other educational/vocational tracks on completion of the program. While the major thrust of the New Careers program will enter the local school systems it is conceived that the proposed community residential center will also serve as a training site.

When the resident of the proposed facility is considered ready to take up residence in the community he may also be eligible to enter this New Careers program and continue in contact with Outpatient Clinic through the Day Program.

(d) Outpatient program members who reach "Step 7" status

These members are promoted from the daily "9 to 5" phase of the program, either to begin outside employment, resume schooling or remain with the Outpatient Clinic as Staff Trainees supported in part by DVR stipends. In any event, these members form a separate and growing group who meet at the clinic building several nights a week to discuss issues having to do with program management, personal problems and the use of leisure time. We shall discuss at great length the role of the proposed facility in the area of providing the resources for continuing education and leisure time activities for this population of active
program members. It should be noted here that the enormous task of establishing a program "culture," necessary to the efficient running of a facility as complex as a 24 hour residence for young drug addicts has already been accomplished in our Day Program. With the help of senior program members in training the residence can begin to function as a responsible "self-help" community from its inception.

3. Physical Plant and Location of the Community Residential Center

We have stressed in our work the need for program and program member visibility in the community to both challenge the "once a junkie..." mythology and to obviate the problem of "re-entry" of the treated ex-addict, which characterize many residential communities. The site chosen for the residence therefore, is within the city, between the two major narcotic "copping" areas. A 17 room, three-story brick building in excellent condition, and currently leased to members of the Yale community who will suffer no hardship when their lease is not renewed, will be available for lease or purchase by the end of June 1971. This building will adequately house 15 to 20 residents and staff with multi-purpose rooms available for educational and leisure time activities. Zoning ordinances are favorable and variances for the specific use have precedence in the neighborhood. Plans have been made to meet with the Neighborhood Corporation under the Community Action Program in order to discuss the planned use of the building and we have every anticipation of cooperation from this group. A floor plan detailing sleeping arrangements, living, kitchen and dining areas, staff quarters, workshop, library and multi-purpose rooms is enclosed. Renovation, repair and maintenance of the building, bookkeeping and cooking will be responsibilities of the residents.

4. Admission criteria

Admission to the residential component of the facility will be from Screening and Evaluation through the Outpatient Clinic and will stress the following criteria:

a. Previously detoxified heroin addicts and other drug abusers, male and female between the ages of 14 and 21 with at least six months history of drug abuse who do not present gross personality and physical disorders.*

*With no aspersions intended this included pregnancy.
Who also;

b. demonstrate a commitment to giving up drugs and who show potential within a six month period of stabilizing their lives in terms of employment, education and more independent living arrangements.

and;

c. members of the Outpatient program whose lives have become temporarily chaotic due to family or other crisis and who may need the support of a 24 hour stable "family" for a brief period.

In the latter case (c) we have in mind no more than a two to three week stay during which time the acute situation is resolved and "shakiness" overcome enabling the member to either return to his home or establish a new one. We would anticipate no more than 2 or 3 beds in the facility available for this kind of crisis intervention for a population of 50 - 75 active members.

Admission, or participation in the community, education and recreation component of the center will be restricted to members of the Outpatient program in good standing (e.g. members of the Day Program in Step V and above). We cannot spell this out too much in advance since our experience with program development tends to favor evolving practices over pre-judgements.

5. The Community Residential Center Program

a. Capacity and Organizational Structure

The proposed facility is conceived as a therapeutic self-help community staffed by individuals who are program members experienced in this kind of program management. The facility will be under the overall supervision of the Director of the Outpatient Clinic and integrated with the organizational structure of the Outpatient Clinic as seen in Table 4.

As described earlier, we are planning for a capacity of 15-20 residents at one time with an estimated turnover of between 30 and 60 residents yearly.

The social and recreational aspect of the program will serve a separate and additional population of between 40 and 60 Outpatient Clinic program members in good standing during the first year. The internal
organization of the facility will stress clearly assigned roles, opportunity for mastery of increasing responsibility and mobility through a series of graded steps, not unlike those of our Day Program. (See Table 5)

b. Staffing

The facility will have the immediate advantage of not having to begin "cold" since it will be staffed in large part by young adult program members now on a staff training level, who have already established close working relationships with one another and have demonstrated a commitment to the goals of the program. They will fill the 3 coordinator (Rehab Counselor) positions. The position of Senior Coordinator, Assistant Director and Resident Director will be filled by ex-addicts with more extensive experience in the drug rehabilitation field.

We wish to stress here that the approach we have developed towards young ex-addict staff is to discourage their remaining indefinitely in drug treatment work and to take responsibility for their acquiring academic credentials and training applicable to other areas in the helping professions. We see these positions therefore, as mainly training ones in a step towards this goal.

The Resident Director needs to be a person of extraordinary talent who can relate to both the resident population, affiliated agencies, and the various sectors of the community with equal skill, credibility and effectiveness. He must have good organizational ability, mature clinical judgement and wisdom about life. These would be regarded as more relevant than academic credentials per se. The Resident Director would be directly responsible to the Director of the Outpatient Clinic. We are fortunate in that we have several individuals in mind who are ex-addicts with extensive experience and demonstrated competence. The Learning Counselor is the only full-time staff member with "professional" background or training. The choice of Learning Counselor as job title is an effort to avoid some of the negative connotation of "school" and "education" as they are seen by young people. He would have a B.A. Degree preferably from a liberal arts college and a minimum of two years teaching experience in at least two subject areas. The Learning Counselor is a full-time resident of the
House, participating in day to day routines. However, his special province of responsibility is to respond to a wide variety of learning needs expressed by the residents. The rationale behind this position is to provide for the effective upgrading of academic skills in a setting which is conducive to the development of a positive attitude toward learning on the part of the residents.

A secretary will also be on staff, but not necessarily a resident. Her responsibility will be to handle the Center's correspondence, do the bookkeeping, oversee the purchasing and train assistants from the resident population. Her close contact with residents makes her as much a part of the clinical/teaching staff as others and her personal qualifications should meet the same specification.

Theoretically, and hopefully in practice all positions in the facility will be accessible by the resident population as they grow in the system and move on to advanced training.

c. Daily schedule

In order to give some idea of a sample daily schedule we include the following with the understanding that there are few precedents for the proposed facility and that routines develop and are not pre-packaged, that a facility evolves a style on the basis of many factors which we have not discussed here, and that above all we would want to insure a certain flexibility in the planning of the facility after the staff is collected and begins to tackle the job of setting the program in motion.

From 7:00 a.m. to 8:45 the house gets up and begins its day with washing up and eating breakfast. The Night Coordinator's last duty is to supervise this time slot. The morning meal is attended by all program members and at least one coordinator. This meal is served in one sitting. From 8:45 to 9:00, after the morning meal, the program has its first meeting of the day which consists of breaking up into small groups of work crews and planning out work for the day. Work crews will be supervised by Day Coordinators and Supervisors. From 9:00 to 12:00 work crews will perform their duties; coordinators will have meetings where all program members will be discussed and jobs will be changed, policies will be
will be made and general business will be taken care of. From 12:00 to 1:00 the program has lunch. From 1:00 to 1:15, after lunch, the work crews meet again and go over how the crews functioned that morning and how to improve. From 1:15 to 4:00 program work crews meet again and go back to work. From 5:00 to 6:00 the program sits down and has dinner. From 6:00 to 8:00 on Sundays, Wednesdays and Fridays the program splits up into small groups made up of graduates of the first stage of the halfway house and members of the halfway house. From 6:00 to 8:00 on Mondays, Tuesdays and Thursdays members will be involved in preparation for high school equivalency and other educational goals. Evenings from 8:00 to 10:00 will be taken up with homework assignments for classwork, with reading, crafts or other interests that are available in the house. At this time, people will also be able to relax, listen to records and interact with other program members.

2. Outpatient Clinic

"Nihil simul inventum est et perfectum"
(Nothing is invented and perfected at the same time)

I. Introduction

The Outpatient Clinic has taken shape over this past year since its Director has reduced the amount of time invested in the Methadone Program and two full-time and one half-time staff members were added. We have arrived at a more thorough understanding of the population we serve and a conceptualization of the needs and problems they present. We have experimented with a variety of intervention systems, programmatic features and special projects and have at this point a much better feel of what does and does not work.

In addition to the task of developing a viable clinical program, the Outpatient Clinic staff was engaged during the program year in other major activities, such as screening and evaluation, consultation and education and several outreach projects which will be discussed later on in this report. Consequently, the Outpatient Clinic and its staff has extended itself far beyond the resources allocated to it and will require additional staff and monies in the coming year in order to fulfill the commitments it has already begun. The more successful is OPC in engaging and holding youngsters in
the program, the higher the application rate seems to become and the more exacting the burdens on staff, space and time. The current staff consists of a full-time Director of OPC, a Coordinator of Group Work Services, one full-time Rehabilitation Counselor and one half-time Rehabilitation Counselor. It was not until September, 1969 when our quarters at 106 Park Street were fully renovated and we occupied the four offices in which we presently conduct our work. About 45 patients are in active treatment, 12 of whom are on day status. In addition, there are approximately 75 individuals in evaluation. Space has been a major problem, especially for our Day Program where 12 adolescents and young adults are confined to two rooms, one of which, a workshop. The proximity of our Day Program to the location of screening and evaluation groups and the problems encountered will be discussed in the section on Screening and Evaluation. Within these limitations, however, there has been considerable growth in OPC, but like all growing things, there needs to be accommodation to increased size, scope and interest.

II. Philosophy of OPC, Aims and Goals

The OPC mission involves construction of a system of engagement of young drug abusers in the service of having impact on drug abuse in their own neighborhoods. We recognize that we will see only a small portion of the adolescent and young adult user population and that each individual involved with us must on one level or another become an agent of change in his community. The community includes both peer group and institutions and agencies, especially the public school, which affect the lives of young people. Our interest here is not necessarily "treatment" in the traditional sense, nor drug education as it is usually practiced. Rather we are prepared, on the one hand to increase the life skills of program members, and on the other to advance opportunities within the community for young people to experience gratification without drugs. Our program addresses itself to the fundamental needs which characterize the population we serve:

(1) Opportunities for prompt and continuous gratification. Our experience with youthful addicts is typified by the individual of more than adequate but unrecognized talents, whose entusiasms are turned off early in his school career and who seeks immediate gratification of instinctual urges and of such ego promptings as need
for power, prestige, status, etc. This individual is apt to reside in a household lacking in controls in which frustrations and failure constitute unmanageable burdens. In our thinking about rehabilitation, therefore, it has been necessary to consider programs that offer not only immediate gratification but also genuine opportunity for continued satisfaction, growth and mastery.

(2) Provision for alternate "highs". The drug high constitutes but one of a network of associated activities, (copping, hustling, eluding police) rich in experimentation, danger, excitement, extravagant rebelliousness, and mastery of complex skills. Thus, constructive and highly adaptive analogues to the drug experience exist in the straight world and must be utilized not only to provide the ego gratification of success but also to fulfill the need for excitement and adventure -- e.g. skiing, sailing, mountain climbing, etc. -- skills which involve mastery of a wide range of learning.

(3) Development of educational and vocational skills. Experience in the career field (Empey, Grant, Levin) suggests that entry into the world of employment is in itself insufficient to guarantee a constructive adjustment of time spanning consequence. Investment in a range of "trial" educational and vocational experiences in a structured setting needs to take place preparatory to, or in conjunction with, outside training or employment, especially where educational and work histories are marked by failure and frustration. Interdependence and mutual aid, responsibility, planfulness and achievement of short term, realizable goals are stressed along with development of marketable job skills. We will need further to consider arranging for specific steps up the career ladder and exploration of routes to academic and/or other, vocational credentials. In this connection we are negotiating with the New Careers for the establishment of formal training program for our program graduates in the field of group work, and have placed one of our program graduates with a local high school where he in turn trains other adolescents (see Operation Candle). The outpatient "style" and procedures takes into account the following approaches.

1. Reliance on development of group control and meaningful group expectation as against individual redemption (psychotherapy). Our groups assume major responsibility in the area of program development as well as disposition
addicts. The services of other DDU staff, not specifically allocated to Outpatient Clinic, have been called upon during the year, i.e. the Coordinator of Vocational Rehabilitation, Methadone nurses, psychiatric resident, but whose other commitments did not enable them to take any major ongoing responsibility.

By September, the building at 104-106 Park Street was fully renovated and OPC took over four offices, three on the second and one on the third floor of 106 Park Street. Two of these second floor offices house the Day Program; one becoming a Day Room where most of the day groups are held, and the other converted into a workshop. Funds were not available for renovation of the basement for this purpose and space for the Day Program has been inadequate and cramped. Screening and evaluation takes place in the OPC Director's office next to the workshop where upwards of 20 new applicants are seen each week, representing a major distraction and a security problem to the Clinic. Our two counselors do not have office space of their own and the demand on space for outpatient groups, families and individual work involves a constant game of musical rooms.

B. Structure of OPC - The following diagram indicates the route through which patients currently enter OPC and are involved in programs. Also the activities of OPC staff.

C. Screening and Evaluation - is a multi-functioned activity, whose responsibility till now has devolved almost entirely upon the Outpatient Clinic. Those in evaluation, with the exception of Methadone Evaluation, at any given time exceed the number of active patients in OPC, and, until recently, the numbers in the Methadone Program.

The fundamental work of screening and evaluation takes place at the Wednesday Screening Group (three hours), the Thursday Screening Committee Meeting (two hours) and the Friday Evaluation Group (three hours). OPC commits three staff members at these times, for both evaluation and research, unless some pressing issue or incident takes individual staff away for a period of time. The mob scene on both Wednesday and Friday seriously disrupts the clinic and its normal operations, especially the Day Program, bringing various security and other risks into
the clinic building on those days. Of those in evaluation - and the numbers have been averaging sixty - significant percentage need further individual assessment prior to disposition; the resolution of immediate crises such as the need for hospitalization, living quarters, etc., meetings with families; consultation with schools and hospitals, private physicians and other referral agencies. While other components participate in the two evaluation groups and the screening committee meetings, the additional work described has been performed exclusively by OPC staff. As the application rate has increased, the burden of this additional work has reached staggering proportions. Our policy of encouraging referral agencies to call prior to sending a person to screening, while not altogether successful, does amount to many calls a week on inquiries regarding patients and an exploration of their appropriateness for our service. In addition, we have been averaging about 10 walk-ins per week, some of whom present critical problems which need immediate attention and we do feel that crisis intervention of this sort should continue to be available. Individuals not known to us before who are freshly released from penitentiary or hospital are another group who may not be able to wait until the Wednesday Screening Group before spending even a few moments with one of our staff for some support until formal application can be made. One outcome of the proliferation of speaking engagements by our staff and growing public awareness of the drug problem is a mounting increase in our application rate. But there is a concomitant increase in the application rate of individuals who are not appropriate for our services. It was not been enough to return a 15 year old occasional pot smoker and school failure to his anxious parents with a message that he has knocked on the wrong door, but rather to state to those school people who haven't heard and reiterate to those who have, that there are resources within schools and other community institutions which can turn kids on to more successful functioning. It should also be noted that responsible management of cases of young people who are living at home and dependent upon their parents frequently calls for (much more frequently than we are able to accomplish) a meeting with the parents prior to a disposition with regard to treatment.
The collection of data for TCU, etc. has been the sole responsibility of screening staff with a more recent assist from the Research Department. Collection of this data has been problematic, inefficient and frequently improper, and at least five different systems have been tried in order to remedy the situation, including spending additional time during and after screening staff meetings to more properly fill out the log sheets.

It is clear then that a solution must be found in the very structure of our evaluation procedures, rather than in makeshift additions, deletions and reorganization which have characterized our previous approach to what has grown as a major DDU endeavor. The need is twofold: To free up the OPC staff so that its energies may be devoted more fully to the development of its program; secondly, that the work of evaluation and its associated activities may be performed with more efficiency.

D. Day Program - The Day Program in its present form is the culmination of prior efforts to place more structure into the lives of youthful addicts who apply to our program, provide opportunities for the resolution of initial reality problems and insure a serious beginning to abstinence from drugs through intensive group therapy, engaging programming and provision for immediate rewards and realistic long-term planning.

1. Eligibility -

   a. Addicts between the ages of 14-21 with a clear cut commitment to drugs demonstrated by at least 6 months of use.

   b. Those whose life styles and value systems do not require thorough reorganization and who have potential, within a reasonable period of time, of stabilizing their lives in terms of employment and living arrangements.

   c. Those ineligible for Methadone Maintenance or who do not wish to be maintained on a narcotic.

   d. Individuals who appear to have some commitment to change.
2. Detoxification -

A period of inpatient detoxification is required, if the patient is addicted, for no less than 10 days.* In the absence of local detox beds, we refer most of our applicants to CVII with whom we have a consultative relationship. Eligible patients enter the Day Program immediately upon discharge.

3. Structure of Day Program -

Space and staff considerations have limited the number of Day members to a maximum of 12. Members are expected to remain in Day Status 8 hours a day, 5 days a week from 5 to 15 weeks, depending upon their progress. Six steps mark the route to graduation beginning with Step 3 (Steps 1 and 2 are screening and detoxification) so that the member enters day status with money in the bank, as it were. Each step has specified tasks and responsibilities and members earn points for their successful fulfillment (e.g. daily responsibilities, resolution of court cases, knowledge of self and others, attitude, etc.). At the end of each week a test is given, the points tallied and if the proper number is earned, graduation to the next step is effected. Points are lost for lateness, dirty urines, etc. But the effort of both group and staff is towards aiding individual member's growth. If difficulties are encountered, the group is charged with responsibility for assisting a member's moving ahead. For example, when one member slipped (shot heroin) the group arranged for a buddy system so that this member could be clean long enough to begin Naloxone, which it also decided would be needed in order to further insure his abstinence.

Therapy groups meet each day for at least one 1 1/2 hour session with a closing session at the end of the day to evaluate the day's events, participation of members, staff, etc. On Monday, on all day marathon session is held to deal with the weekend's events. The Day Group has a strong core and a culture has finally been established so that major responsibility devolves upon

*The 10 day detoxification period is essential if the individual is to be maintained on Naloxone.
members. Member representatives attend all OPC staff meetings and the periodic all day planning and evaluation sessions. A residential experiment in January, in which the Day Group lived at a staff member's home for 10 days contributed enormously to the cohesion of the Day Program.

4. Activity Groups -

The activity groups serve a variety of functions in that they are designed to be appealing, provide opportunities for planfulness, mastery of new materials, undiscovered skills; enrich the individual's access to leisure time activities, provide a base for daily confrontations and produce a meaningful output for the program. Ideally, the activity groups offer opportunities to re-shape attitudes towards learning and open doors to more formal educational work. This is especially crucial insofar as most of our youngsters are school drop-outs who were either convinced by their academic experience that school was not for them or that learning constitutes a major submission to authority. Activity groups currently include carpentry (building of cabinets and furniture for Day Program use, Methadone Program, etc. and minor renovation and repair of building), arts and crafts (in a variety of media) sailing (re-building of a donated 20-foot sail boat and learning small boat handling, sailing, navigation), improvisational theatre group (with performances to a variety of audiences) and debate. We have experimented with yoga but found our group unready for so concentrated a discipline; and periodic trips to museums, etc. Delay in delivery of equipment has held up establishment of our TV Studio which plans to provide a series of educational tapes for schools.

5. Education and Vocational Placement -

In order to graduate from the Day Program, plans for job or continued education need to have been made. Built into each step are preparations coordinated by the DDU Vocational Rehabilitation Director. Both program members and staff regard this as the payoff of the Day
Program and its success hinges on the ability of the program to steer individuals towards meaningful employment and education. The liabilities in members' work history, prior skills and education, not to mention the individual's own despair at achievement, are formidable. Further, the job market and academic placements are limited currently and require a great deal of time to open the proper doors. What is needed in this area is additional personnel, namely an education/vocational specialist who will take charge of programming into OPC formal preparations for return to school, and develop routes into existing vocational training and educational institutions for program graduates.

6. Naloxone -

In January, with the cooperation of Endo Laboratories, we began use of Naloxone as a blocking agent for outpatient heroin addicts. Inclusion in the Naloxone study is voluntary and prior to establishing a more sophisticated research design, we felt we needed a body of experience, with no less than 20 patients. Because of the experimental nature of the drug, we included only patients who were members of the Day Program and only after this group had become stable.

Of the 11 patients who began the medication, the following chart indicates their current status:

<table>
<thead>
<tr>
<th>Status</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Use</td>
<td>5</td>
</tr>
<tr>
<td>Discontinued Use, but remained in program</td>
<td>1</td>
</tr>
<tr>
<td>Transferred to Methadone Maintenance</td>
<td>1</td>
</tr>
<tr>
<td>Terminated Program</td>
<td>4</td>
</tr>
</tbody>
</table>

Only five of the twelve current members of the Day Program are using the medication. With but one exception, those who began with the drug, and discontinued its use, have terminated the program, four in bad standing and one who was trans-
ferred to Methadone Maintenance*. While it is too early to report any definitive findings from so small a sample, our impressions are that Naxolone, as a program support, has considerable potential for those young addicts who are shaky and exposed to drugs on the street. Tentatively, we are thinking of terminating the drug with mutual agreement with individuals who have graduated the Day Program and have established some normalcy and other supports in their lives. Oddly enough, there have been fewer challenges to the blockade than we expected, partly because subsequent doses have brought on withdrawal symptoms. This "built-in" penalty for experimentation, while reducing its incidence also sets up some barriers to remaining in the Day Program should one slip. The Day Group has the option to require a member who did not originally choose to take the drug to begin its use if there is evidence of backsliding. Although, there were initial reports of uncomfortable side effects, including stomach upset, loss of appetite and sleeplessness, these have, by and large, abated along with medical attention. One member who uses Naloxone recently described its role in his life as a "friend in my pocket, a friend who I'm trying to learn to do without".

E. Outpatient Groups - Three outpatient groups meeting up to twice a week are currently in operation. Of the three, two are composed mainly of former psychedelic drug and "speed" users, one made up older ex-heroin addicts who rejected methadone maintenance.

1) Adult (heroin) Abstinence Group has had the largest turnover, although criteria for selection favors those who have the most supports in their lives, are working and, with a few exceptions are married. From this group, a number of transfers were made directly into the Methadone Program before major relapse to heroin took place. Among others, who became re-addicted, some have reapplied and have been admitted to methadone evaluation. The Adult Abstinence Group has never grown large enough to develop effective social supports. It is planned eventually to make Naloxone available to the older addict group who do not wish methadone, joined perhaps by those methadone members who will transfer
to this blockade as a transition to total abstinence and discharge from the DDU.

2) "Head" Groups have by far been the most stable of outpatient groups. Made up largely of white adolescents who are characterized by major interpersonal deficits and chronic family problems, the group has for some replaced former ties in the drug world and redirected energies into more acceptable activities. Weekend camping trips have served to cohere the group and families are frequently seen when crises arise or where planning towards independence becomes appropriate. There is evidence of markedly reduced psychedelic drug use and since in order to remain in the group, a full-time job or school attendance is necessary, an increase in productiveness, self esteem and competence.

A few group members have not been able to make it on outpatient status and have required more structure, either in the Day Program, or at Daytop. Referrals to Daytop have "stuck" with greater frequency, even without court pressure, where previous outpatient work had taken place.

F. Leadership Training - In line with our efforts to involve advanced OPC members as resource people to the community, a number of projects have been developed over the year:

1) The Other Theatre - In September OPC staff was asked to run a series of discussion groups for a local community center. A format was designed in which several active adolescent members of outpatient groups would lead the discussions. During preparation and training for this series, a number of role-playing incidents suggested the idea for an improvisational theatre group and soon a repertory of skits was developed. Frequent requests for speaking engagements by staff offered the opportunity to replace these rather static and often unproductive lecture/discussions with a more exciting and provocative presentation. The skits, drawn from the casts' own life experiences, dealt with the drug culture, adolescent-parent confrontations, the helping professions and their own experience of self-help. Discussion periods led by cast and outpatient staff were placed strategically among the skits and audiences invited to participate with the

*A 29 year old who had been addicted for 11 years and whose friends were on methadone maintenance.*
cast in role-playing different resolutions of episodes, especially those dealing with parent-child conflicts. The Other Theatre became quite popular and a total of 14 presentations were made to a variety of groups, including service organizations, PTA's, schools, professional associations, teen clubs, citizen groups and church organizations. A fee is charged (up to $150. per performance) and the earnings shared by the cast. Total earnings from October 1969 to April 1970 have been $1,205.00. Among the gains which the cast achieved during the year from its work, the staff has noted a deepening in understanding by our youngsters of the anguish and helplessness of parents confronted with their problems in dealing with their children, where they had previously experienced only the anger. T.O.T. has now become the "property" of the Day Program and its Director, an original member of the cast.

2) Operation Candle - "Candle" is an outgrowth of OPC consultation to a Branford High School teachers' group. Interested originally in "drugs" and eventually in ways in which high-risk students could be more successfully engaged in school, a program was developed in which 12 students would be selected and trained by an OPC program graduate only recently graduated from high school himself. The students would individually work with a selected number of elementary school students chosen for their need for additional help either for academic or interpersonal problems. The high school group, numbering 12, began meeting early in December and by the end of January, were working with their students twice weekly during school hours. They meet with their group leader, who is on the Branford Board of Education payroll, and who is supervised by the Outpatient Clinic Director. This group focuses mainly upon the tutor's problems with their young charges, and we have seen their growing insight generalizing to areas of their own academic and social functioning. The process of becoming re-identified by the school, from "problem kids" to "semi-staff", with the implied status and prestige has meant some shift in the high school student's attitude towards learning and authority. Regardless of any demonstrated gain in the spheres we had hoped would be effected by their experience, we are impressed by the degree to which the tutors (many of whom were described by the school as self absorbed and isolated) have taken seriously their responsi-
bility to their tutees:

"I was nervous when I first entered the school. How would Mark react? After all, I had been gone one week. Thankfully, there was no problem about that; he met me and told me he was glad to see me. I noticed that his speech is improving. Dave and Steve (another tutor and tutee) came over and since it was so nice out, we decided to play basketball, Mark and I against Steve and Ave. I notice that when we play Mark is snotty when he can't have his own way. He would grab the ball and run away with it. He did this several times until the van came to get us. I'm not sure how to handle this."

G. Individual and Family Therapy - While at any one time there are about 10 patients in individual or family therapy, our emphasis is upon fairly short term intervention and with a maximum of from six to ten sessions. In more benign cases, brief therapy has been sufficient. Some eventuate in referrals to other agencies while in other situations individual work is seen as preparation for entry into an outpatient group once resolution of immediate problems take place.

H. Consultation and Education - OPC staff has been involved in formal, on-going consultation relationships with institutions and agencies, and a variety of informative, one-shot presentations and speaking engagements. The preference is for establishment of more effective contacts of time-spanning consequence, especially where it may involve our program members as resource people. Further, our model of consultation, especially to youth-serving agencies, tends to emphasize the notion of young people as effective change agents and their assuming a greater role in the management of the institution. Although we are more frequently called upon specifically as "drug abuse experts", we attempt to address ourselves to the more fundamental questions of youth and the quality of their experiences. Finally, we are interested less in becoming indispensable professional resources to agencies than in supporting their wish to develop strategies of change with a hopeful outcome of reducing the number of referrals to OPC.
The following summarizes our work with community agencies during the past year:

1) Connecticut Valley Hospital: This agency, a large state psychiatric facility located 30 miles north of New Haven has served as our most important resource for detoxification. For many addicts, Connecticut Valley Hospital is the agency first involved with their efforts at rehabilitation and for others it is the agency we must utilize to effect detoxification procedures when, as a result of our screening activity, we feel detoxification is the appropriate next step. Thus, the fate of addicts at CVH is often a major determinant of the fate of rehabilitation efforts. If for example, the word in the street is that CVH treats addicts poorly or in a disinterested fashion and in this way exacerbates the suffering of addicts, it means that fewer addicts are going to take us seriously if we recommend a stay at CVH.

Accordingly, our first thrust into the community consisted of establishing liaison with the CVH staff and arriving at a common understanding about detoxification procedures. We then proceeded to establish a system of weekly visitation to CVH by which our ex-addict counselors would maintain contact with New Haven addicts in residence at that hospital. In addition, we have arranged to have bi-weekly professional staff contact alternatively at CVH and at DDU. These arrangements have made it possible for us to keep abreast of staff and programmatic changes at the State Hospital so that we might in turn be able to keep our patient groups in this way we have been able to take some of the mystery and hence some of the fear out of leaving town to "go to the Valley" for detoxification.

2) Correctional Agencies: We have established separate systems of monthly conferences with the local agencies of probation and parole and in these systems have worked out mechanisms of referral and follow-up so that maximum rehabilitation impact can be extracted from the implied coercion of correctional agency referrals. From the patient's point of view what this comes to mean is that it is in his interest to follow the Probation Officer's or (Parole Officer's) advice to become involved he can expect an increased measure of assistance from the correctional agent. Again the ultimate area of
impact becomes "the street" where information concerning the adequacy of confidentiality of clinical materials and meaningful cooperation amongst correctional and health and welfare agencies tends to generate increased appreciation of the reality of rehabilitation for addicts. Or, put differently, it tends to make inroads into the myth of "once a junkie, always a junkie".

3) Legal Assistance Association: The New Haven Legal Assistance Association is a relatively well endowed Legal Aid service with a distinctly above average interest in problems pertinent to the ghetto existence, poverty, deviance, and hence addiction. There have been major conferences with Legal Aid Association lawyers informing them of the details of Drug Dependence Unit's programs so that the lawyers may more effectively represent those in Court when that is pertinent and so that they can more effectively initiate referral of their clients. Members of our staff have also appeared in Court with LAA attorneys and with other lawyers representing program members -- and there have been a variety of informal, but very useful discussions with prosecutors and judge.

4) Police: At the time of drafting this report, we have just begun our systematic contacts with the Narcotics Squad of the New Haven Police Department and it is too early to ascertain what shape this consultative effort is likely to take. Our aim is to generate that order of regard for our work so that Police may be more tempted to make new referrals and less tempted to generate inappropriate pressure on the lives of program members.

5) Schools: We have been able to exploit initial requests by schools for assistance around drugs to establish substantial contacts representing a variety of styles and models of consultation. Two 10-session teacher groups have been led by OPC staff in Branford High School, the first of which culminated in plans for "Operation Candle" (described earlier) and the second, still in progress, which is discussing the setting up of teacher-student groups led by the participants.

In another high school (Wilbur Cross) an OPC staff member has been acting as co-leader with a teacher who was approached by a group of 15 youngsters, most of whom were heavily involved in drugs. After 10-
sessions, the teacher feels competent to continue on her own and the "natural" group taking up issues outside of themselves and preoccupation with chemical substances.

Staff has participated in a number of 1 to 3-day seminars for faculty of area schools, organized by DDU Education and Training Unit. These have included high schools in West Haven and North Haven and Lee, Hillhouse and Wilbur Cross High Schools in New Haven. Out of these contacts and those made by OPC staff in DDU Training Institute (OPC staff contribute on the average of 8 hours per week to the Institute) important liaison has been established with area schools and their guidance departments.

6) Other Agencies: Staff has collaborated with the professional staff and programs at the Connecticut Mental Health Center, principally its emergency treatment and Hill-West Haven Units, which have been available for detoxification of addicts. We are on call for the Emergency Room at Yale-New Haven Hospital on questions of management of acute cases and have met with their staff on a number of occasions to share our experiences. We have been particularly interested in making available to the medical institutions which have frequent contact with drug abusers in crisis the assistance of our ex-addict staff and program members who can help make these services more hospitable and coherent to recipients and bridge the distance to our own program. Agencies, such as child guidance clinics, could be more effective in sharing the burden of treatment of drug abusers. In this connection we have begun a bi-weekly series of meetings with supervisory staff of the Clifford Beers Child Guidance Clinic involving OPC staff and program members.

IV. Budget Requests 1970-1971

The statistics which accompany the DDU Grant reapplication show that the trend over the past year of applications to DDU has placed a burden on OPC disproportionate to its resources. If this trend continues, that is, of applicants below the age of 21, and the ability of OPC to absorb the load remains static, then we will not be able to fulfill our obligations to our catchment area. We are, therefore, requesting additional staff in order to continue our present program, accommodate more patients and increase the effectiveness of
our service. Along these lines we are also recommending the establishment of a separate Screening and Evaluation Unit for DDU. There will be no expansion of the services outlined in previous sections of this report.

In addition to current staff, OPC is requesting the following:

1) Administrative Assistant - To date OPC has shared with Education and Training the services of the Office Manager of the DDU administrative offices. This arrangement has been inadequate since the clerical and some administrative work of two programs fell to one person who had other supervisory duties. It has been especially problematic to the OPC Director whose major portion of time was devoted to clinical management. The enormous quantity of administrative details, scheduling of staff time, coordination of clinic routines, preparation of reports, handling of telephone inquiries, purchasing, etc. requires the energies of a full-time assistant.

2) Coordinator of Outreach Services (1) - As our efforts in the community have proliferated, in direct service to high risk groups ("Candle", Wilbur Cross), consultation to agency personnel (see Consultation and Evaluation) and special projects ("The Other Theatre"), the demands have grown in several ways: 1) supervision of trainees, 2) liaison with OPC, 3) establishment of additional placements among youth-serving agencies for program graduates. Current staff, especially the OPC Director has been attempting to manage these demands and the need is for a full-time person with group work skills and consultation and training experience who will work approximately half-time in the outreach sphere and half time in the clinical program, specifically in the Evening Program.

3) Ex-Addict Rehabilitation Counselors (4) - Our intention here is to draw from the ranks of current and future program members, young people of talent who are interested in careers in the human services. Several members who have graduated from our Day Program, and are now employed, are being considered for these positions. Their demonstrated leadership, responsibility, and appeal to our young members bring extremely important clinical strength to the program, while demonstrating the seriousness of our commitment to young helping youth. If we are to convince other agencies serving young people of the efficacy of this notion, then the hiring practice must begin here.

4) Public Health Nurse (1) - Our experience with our patient population has emphasized the need for thorough attention, not only to routine medical care but so long neglected condi-
tions. We have had high incidence of chronic hepatitis, gastro-intestinal involvements, and dental problems with some venereal disease and general ignorance in the area of health care. We have in the past been impressed with our work with public health nurses and feel their orientation towards patient care in all spheres is in consonance with our own. During the past five months we have had the services of a graduate student in Public Health Nursing from Yale whose assistance to us in these matters has been most useful. As our female patients grow in number, the specific needs, especially those engendered by out-of-wedlock pregnancy, make the addition of a public health nurse to our staff more vital. Further, the special responsibilities we have undertaken in connection with Naloxone, still in experimental stages of use, requires that we add personnel to our staff who can systematically collect, organize and report the data.

5) Pediatrician (1/2 time) - Although we anticipate that our public health nurse will be in the position to facilitate access to local medical institutions where her diagnostic assessment indicates that referrals be made, it would be useful to have a physician on the premises who would have administrative responsibility for the Naloxone experience, provide pre-Naloxone examination and subsequent periodic blood work. Further, he would be available in our treatment groups and in our consultation work. We have specifically in mind a physician with long experience and interest with adolescents, who has had additional experience in consultation to educational institutions.

6) Education Specialist (1) - We have already stated that a major thrust of OPC lies in the area of establishing routes to meaningful employment, career opportunities and education. For our population, this has proven to require a high degree of imagination and resourcefulness. It implies our readiness to program into our treatment regime, specific steps, trial work in educational experiences in order to advance our patients to the position where they are able to take the necessary risks with confidence and a chance of success. We are in deparate need for an individual who has the ability to organize this task and lead our members, by the hand as it were, to whatever individual tracks makes the most sense and to influence other agencies and institutions to join with us. We cannot stress with more urgency this requirement of a full-time staff person in this sphere. We have interviewed a number of candidates and have found one with the requisite experience, energy and flare with young people.
It might be noted in this connection, that all candidates for positions at OPC are interviewed by program members and that their reactions to prospective employees are taken most seriously by us.