American Handbook of Psychiatry

THE CONTROL OF EPIDEMIC DRUG ABUSE

Stanley F. Yolles

THE CONTROL OF EPIDEMIC DRUG ABUSE

Stanley F. Yolles

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

Table of Contents

THE CONTROL OF EPIDEMIC DRUG ABUSE

Organizing a National Program

Legislative Authorities

Drug Research

Prevention, Treatment, and Rehabilitation

Bibliography

THE CONTROL OF EPIDEMIC DRUG ABUSE

Organizing a National Program

Traditionally, in the United States social programs designed and operated to meet the health and welfare needs of the American people have developed through evolution rather than revolution. Typical of the national reluctance to change its laissez-faire attitudes is the fact that today, even though there is a growing acceptance of the need to establish a national health program to provide for the equitable delivery of health services throughout the population, the form and scope of such a program are matters of professional and political controversy.

In this frame of reference, therefore, it is understandable that the government and the people are experiencing extreme difficulty in evolving a national drug-abuse program. Drug abuse has been variously defined as a legal, moral, medical, health, or social problem. For many years, the federal government's effort to control the use of narcotics was predicated on the notion that the use of narcotics was a crime, per se, and that drug addicts should be punished as criminals. Whether from cause or effect, this federal attitude was reflected in public attitudes. The few professionals who advocated treatment rather than punishment were largely ignored.

As recently as 1966, federal concern over the abuse of illicit drugs

continued to be limited almost entirely to narcotic addiction. Treatment of addicts was provided for by the federal government in the barred, prison-like environment of the federal narcotic hospitals at Lexington, Kentucky, and Fort Worth, Texas. With very few exceptions, states and local communities limited their concern with narcotic addiction to the enforcement of punitive statutes. The inadequacy of token treatment programs brought pressures to bear through the national legislative process, and in 1966 the Narcotic Addict Rehabilitation Act was adopted by the Congress.

Under terms of this statute, the federal government accepted a mandate to provide community-based treatment and rehabilitation for those narcotic addicts who elected to accept civil commitment in lieu of standing trial for federal offenses, as well as volunteers for civil commitment. Thus, the federal government took its first significant step toward the establishment of a national program designed to provide treatment and rehabilitation, rather than punishment, for narcotic addicts. Under the administration of the National Institute of Mental Health (NIMH), the bars came down at Lexington and Fort Worth, treatment replaced custodial care, and addiction research centers were established. However, in 1966 public concern over dangerous drugs other than narcotics was still moderate, and the Narcotic Addict Rehabilitation Act made no provision for treatment of other drugs of abuse.

The Narcotic Addict Rehabilitation program, with federal funding

support, established community-based addiction treatment units through contracts with existing state and local agencies. In so doing, it paved the way for further developments throughout the comprehensive community mental health services program.

When the Community Mental Health Centers Act was adopted in 1963, no specific provisions were made for support of alcohol and narcotic addiction programs within the new community mental health centers. But, since such programs were not specifically excluded, a number of mental health centers organized treatment programs for alcoholics, while remaining ambivalent about narcotic addiction. Following the initiation of the Narcotic Addict Rehabilitation program, amendments to the Community Mental Health Centers Act were proposed, providing special incentives to initiate alcohol and narcotic programs. Numbers of congressmen and senators sponsored a variety of proposals for special alcoholism programs; but the sense of immediacy was lacking and for a variety of reasons, the programs were not funded. The NARA program continued its exploratory and deliberate expansion; proponents of amendments to the Community Mental Health Centers Act marshaled their forces in order to try again.

Then, in rapid succession, a chain of events occurred that affected the social and cultural life of the entire population: Lysergic acid (LSD) tripped out of the laboratory on to the campus; marijuana suddenly became a symbol

of youthful defiance and “everybody’s child” who smoked a “joint” became a criminal by definition under federal statutes; and then heroin jumped out of the ghetto and the gutter into the affluent suburbs and the armed forces. Public apathy changed to panic; the administration certainly began to doubt; and the great drug debate took center stage in the American consciousness.

In 1967 and 1968 various agencies within the federal government were moving on a collision course in their efforts to control drug abuse. The Department of Justice proposed legislation during 1969 providing for increased mandatory minimum penalties for everyone convicted of possession and/or use of illicit drugs. The proposed legislation would have forced the courts to deal with a youngster caught smoking his first marijuana cigarette in the same fashion as with a professional peddler of narcotics. Under federal law, marijuana was still legally classified as a narcotic, and in the proposed legislation, the scheduling of drugs in risk classifications attributed a higher risk to marijuana than to LSD, the amphetamines, and other chemical compounds classified as dangerous drugs. Proponents of these legislative proposals continued to believe that increased penalties for drug abusers would prevent drug abuse.

Some members of Congress, however, took another course. They requested information from the NIMH and the Food and Drug Administration on progress of research on LSD, marijuana, and other dangerous drugs and

heard testimony on research needs as well as on means to support public information and education programs in drug abuse.

In 1968, the scope of research, either funded by the NIMH or utilizing LSD from NIMH supplies, covered a wide range of activity from surveys and epidemiological studies through basic biochemical and experimental psychopharmacological research. The NIMH during fiscal 1968 was supporting fifty-eight studies, at a cost of $3.4 million for research in the area of LSD and other hallucinogenic agents, including studies designed to measure the extent and trends of LSD and other hallucinogenic use. A number of studies produced findings that suggested that LSD can cause severe psychotic reactions and may cause chromosomal damage. When this information was disseminated among young people, use of LSD began to decline, indicating that factual information concerning risk of adverse effects had some effect on the rate at which a specific drug was abused. As a result, Congress appropriated funds with which the NIMH initiated the first drug information program using the mass media; other funds were provided the NIMH and the Office of Education for pilot programs designed to educate schoolteachers about drugs, so that they, in turn, could present the available facts about drug abuse to their students. The White House collaborated in this program by establishing a drug-abuse education program focus, through which television and radio executives, the clergy, and others were provided with drug-abuse information at a series of White House meetings. During

subsequent months, research findings on the risks of abuse of amphetamines and other dangerous drugs provided additional data on the effects of these drugs. Even though abuse of the drugs continues, there is evidence that drug abusers accept the validity of current research findings. Methamphetamine is a case in point. Throughout the drug culture, the knowledge that "Speed kills" has been demonstrated, and the rate of its use has declined.

The situation surrounding the use of cannabis, however, is more complex. When the hippies, the flower children, and the college students overwhelmed the traditional American society, marijuana use became a symbol of dissent throughout the "square," or traditional, adult population. The controversy over marijuana, therefore, was in actuality only one part of a much larger and deeper phenomenon, variously called "alienation of the young," the "generation gap," or "the flight from reality."

While, in actuality, parents and their children were in conflict over the rejection of an entire life style, what they talked about was marijuana, and most of the arguments were based on myth and fable rather than fact. At the time when marijuana became the catalyst for controversy within the entire phenomenon of drug abuse, information about cannabis was in short supply.

As early as 1964, the NIMH was supporting research to effect a synthesis of the tetrahydrocannabinols, since the only source of the natural

plant came from confiscated supplies of varying potency, and efforts to extract tetrahydrocannabinol were inefficient. Early efforts were unsuccessful, but during 1966, Raphael Mechoulam in Israel synthesized tetrahydrocannabinol; during 1967 Petrzilka published a method for synthesizing it; and during 1968 the NIMH contracted for the production of research quantities of both delta-8 and delta-9 tetrahydrocannabinol for distribution to the research community.

By the time research into the effects of the drug itself began to be effective, however, the entire marijuana question had gotten out of hand, and any relationship between argument and rational thought was coincidental. Eventually, faced with legislation that would continue to equate drug-abuse control with law enforcement under the system of criminal justice, the medical and scientific communities began to add their testimony before Congress to that of law enforcement officials.

Legislative Authorities

The immediate result as far as legislation was concerned was the 1970 adoption of the Comprehensive Drug Abuse Prevention and Control Act. Mandatory minimum penalties were abolished; marijuana was taken out of the classification as a narcotic; provisions for parole for first offenders were provided; and the Secretary of the U.S. Department of Health, Education, and

Welfare was given the authority to establish the comparative risk of each drug included in the schedule of dangerous substances, on which penalties under the law are based.

Of major significance in the adoption of this statute is the fact that the federal government accepted the notion that a federal responsibility exists in the establishment of a program of treatment, rehabilitation, and prevention of narcotic and drug abuse as a national policy. The statute authorized support of a more comprehensive treatment program; grants for development of materials and curricula dealing with drug education; training of professionals in treatment methods, rehabilitation programs and health education; and a special project grants program for detoxification and other special services. Given adequate funding, this statute, with other existing authorities, makes it possible for the federal government to assume the leadership in developing a comprehensive national program.

Illustrative of the trend that brought about the passage of the Drug Abuse Prevention and Control Act was the adoption, earlier during 1970, of the Community Mental Health Centers Act amendments, which had been under consideration for months. The 1970 amendments reflected a new awareness within the Administration of the need to develop special programs for dealing with the problems of alcoholism and drug abuse and that federal support should be provided as an integral part of the network of community

mental health services.

Testifying before Congress, Administration spokesmen said,

> Preventive and curative services for drug abusers and for alcoholics must be a part of a comprehensive mental health system and should not lead to separate facilities and services. The mental health centers model is an ideal one in which to integrate facilities for services for alcoholism and drug abuse.
>
> For a number of reasons, services for alcoholics and narcotic addicts at the community level will require very special efforts and incentives. Therefore, preferential matching of funds and a longer period of Federal support are necessary.

The 1970 amendments signaled a renewed interest within the Administration in the community mental health services program and a realization that the 452 community mental health centers already receiving federal support could and should provide drug-abuse programs in areas where the need was greatest. The statute therefore provided for preferential support in poverty areas.

The President's budget for fiscal year 1972 had originally included $105 million for support of the mental health centers program. However, most of the money was committed to the funding of grants already made. Additionally, therefore, the Congress approved a $67 million supplementary request for treatment of narcotic and drug abuses and a $7 million supplemental for the alcoholism program. All this related to widened

government perceptions of the potential role of the community mental health center in meeting social problems underlying the manifest illness or disturbance of an individual, which certainly is inclusive of the causes of narcotic addiction and drug abuse.

Meanwhile, under the Narcotic Addict Rehabilitation program, by fiscal year 1971, the federal government had funded a total of twenty-three narcotic addict community treatment units in twenty-one cities. Furthermore, in addition to support of continuing and new staffing grants, this program in fiscal year 1971 was projecting further support through contracts; funds for special projects; program evaluation; and initiation and development grants providing seed money for local programs.

The estimates of federal funds for drug abuse programs by category, shown in Table 40-1, are indicative of the shift in emphasis from law enforcement to treatment, rehabilitation, education, training and research. These estimates include funding in the federal agencies involved in drug abuse with the exception of the Department of Defense. In essence, events in the calendar years 1968 through 1970 had brought about increased federal support in all facets of the narcotic addiction program and had established the foundation for support of a comprehensive program to cope with the problem of abuse of other dangerous drugs as well.

Table 40-1. Federal Funds for Drug-Abuse Programs: Estimated Budget Obligations

CATEGORY	1969a	1970a	1971a
Law enforcement	$22.3bb	$ 39.3b	$ 48.7b
Treatment and rehabilitation	$28.5	$ 38.5	$ 73.5
Education and training	$ 2.0	$ 10.0	$ 10.6
Research and other support	$15.1	$ 17.3	$ 21.9
Total	$67.9	$105.1	$154.7

a Fiscal years.

b Millions of dollars.

Throughout 1971, as federal agencies sought to reach agreement on the means to administer a comprehensive national drug-abuse program, the evident increase in the use of heroin among the population within the continental United States was compounded by the spread of heroin use among the armed forces throughout Southeast Asia.

Estimates of narcotic addiction in the United States are reported annually by the Bureau of Narcotics and Dangerous Drugs. Estimates of the size of the actual addict population in the United States can be approached by comparing these figures with those from the New York City Health Department's addiction register, as well as through extrapolations of the number of heroin-related deaths in New York. These data indicated that in

1969 there were approximately 104,000 heroin addicts in New York City alone. Thus, the number of addicts throughout the United States may have been as high as 250,000.

In the spring of 1971, a poll purported to show a 16.15 percent drug-use rate among servicemen in Vietnam; and by mid-1971, evidence of heroin addiction among servicemen returning from Vietnam brought about Presidential action.

On June 17, the President of the United States, in a special message to Congress, termed the drug problem "a national emergency." By executive order, President Nixon assigned central and overriding authority for federal efforts in solving the narcotic and drug-abuse problem to the White House; created the Special Action Office for Drug Abuse Prevention to direct and coordinate all federal programs relating to drug abuse; submitted legislation to establish the office; and increased his fiscal year 1972 budget request by asking Congress for a government-wide total of $371 million for drug-abuse programs, including the further testing of anti-addiction compounds.

The fact that the Congress had not acted on the President's request when it adjourned for Christmas 1971 is a measure of the political complexities inherent in establishing a national drug-abuse program. The Congress, for example, has the prerogative to review programs administered

by agencies within the executive branch of the government. It also has the responsibility to hold these agencies accountable for the manner in which funds are used. The President's request to establish a central office for drug-abuse programs within the executive office of the President affects congressional prerogatives, because the proposal requests permission to transfer funds from one agency to another at the discretion of the White House.

Although concern over the spread of heroin use in the armed forces undoubtedly triggered the President's request to the Congress for centralized authority within his executive office, other data indicated that the drug scene at home was also undergoing significant change. It is difficult to secure information on the patterns of use of illicit drugs, because of the possibility of criminal action; it is also difficult to secure information about the careers of drug users and the factors influencing their drug use and other behavior. However, as interest in drug research increases and additional funds become available, it has been possible to analyze trends in drug abuse, estimate the extent of abuse, and project possible avenues for the development of a program of prevention, treatment, and rehabilitation.

For 1969, the number of users, categorized by the drug used, has been estimated as follows: heroin, 250,000; LSD, 1 million; amphetamines, taken orally, 4 million; marijuana, anywhere from 10 to 20 million; barbiturates, 2

million. The number of persons who inject amphetamines, mix barbiturates with other drugs, or use inhalants cannot be estimated, except to assume from available evidence that their numbers are small in comparison with the above estimates.

The extent of use is only one measure of the problem; but increasing use is an indicator of other factors in the quality of American life which must be considered to be drug related. During 1971, for example, using any of the measures available, drug use and abuse continued to increase within an ever-widening age group. The "recreational" use of marijuana is currently so widespread that it is no longer considered to be a symbol of dissent and rebellion by young people.

Drug Research

Recent trends in narcotic addiction, outside the armed forces, indicate that typical patterns include increasing experimentation with heroin among middle-class suburban youth; intravenous use of methamphetamine as an adjunct to heroin; and more frequent overdoses. Addiction still tends, however, to be concentrated in the ghettos of large cities, where 80 percent of the addicts are male and about half the arrested addicts are in the twenty-one to thirty age group.

Preliminary results of an NIMH study of high school and junior high

school students during 1971 indicated that present concern over heroin must not blot out other drug-abuse problems. One county that has had relatively high rates of drug use among its high school population has now conducted the same type of student survey for four consecutive years. Results for the 1970-1971 school year now show a marked increase in the use of all drugs with the exception of tobacco. Alcohol use, which some have suggested might be replaced by marijuana use, showed the largest apparent increase over 1970 in this group of junior high and high school students.

During 1971, the NIMH was supporting some sixty-six projects in marijuana research at a total cost of nearly $3 million a year, a little more than three years since it mounted an intensive research program in this field. This federal program has achieved several major objectives:

1. It has made cannabis research respectable, so that highly competent researchers are entering the field without fear of adverse publicity, professional disapproval, or disapproval of law enforcement officials.

2. It has made available, in standard dosage forms of known potency, a wide variety of natural and synthetic materials basic to continued research.

3. Investigations have shown that delta-9-tetrahydrocannabinol not only is broken down in the body, but that some metabolites can be found up to six to eight days after a single

administration. This suggests a long duration of action and possible interference with other drugs.

4. Toxicity studies performed during the past year have clearly shown a large safety index between the behaviorally active and the toxic doses.

5. Subjective and objective effects of single dose, acute administration of cannabis and its active components have been greatly elucidated.

6. Present overseas studies of chronic effects of cannabis will be expanded, as will studies of the complex motivations of users, in an effort to determine the implications of cannabis use as they relate to human conditions that may trigger its abuse.

7. Research on other psychoactive drugs has also been accelerated. Current findings relating to the effects of amphetamines, for example, indicate that these drugs have potential for serious dependency, addiction, and even death. The emergence over the past year or so of the youthful polydrug user heightens the need for additional research on the interrelationship of the effects of all drugs.

Within this new drug research climate, it will be possible within a very few years to make a determination of the comprehensive effects of these drugs, if funds and other resources are assembled to mount a research program actually responsive to the need for it. This objective must be

considered to be a vital component of any effective national drug-abuse program.

The situation surrounding the use of methadone to control heroin addiction illustrates the current, fragmented, under-researched procedures now in vogue in adapting research findings to treatment. As a chemical blocking agent, methadone supposedly blocks the euphoric effects of heroin, but is itself an addicting drug. It is a short-acting drug; the drug substitutes one addiction for another, and as methadone becomes more readily available, it too has entered the illicit market. Because of the proliferation of small methadone programs, regulations to control its use were evolved in 1971 within the federal government. However, the subject is still highly controversial, and, while experts in the field agree that the search for better ways to block the effects of heroin must have the highest priority, methadone maintenance continues to expand as a hoped-for easy way out in treating heroin addicts. At best, methadone treatment can only be termed experimental, for the long-term effects of widespread usage of an addicting drug to block another addiction have yet to be experienced.

More work needs to be done not only in research on methadone but on other blocking agents, such as cyclazocine and naloxone, which are now in use. Research is already under way in developing longer acting cyclazocine and naloxone. L-alpha acetylmethadol, a longer acting derivative of

methadone, which is currently effective up to seventy-two hours, is still in experimental use.

Obviously, research on the drugs themselves is not sufficient. Studies of the heroin user are being conducted simultaneously with treatment of the known addict. But psychosocial studies of heroin users who have escaped detection by law enforcement officers and the courts are limited to clandestine surveys within the heroin culture. Not until the user is assured of anonymity can this research provide anything approaching definitive data.

Prevention, Treatment, and Rehabilitation

Given the current research climate and the increased knowledge provided through research findings, coupled with the new statutory authorities through which the federal government, states, and local communities can establish treatment and rehabilitation programs, physicians and other health professionals no longer have valid excuses to minimize medical and scientific interest and participation in the drug-abuse field.

The medical profession's role in narcotic and drug abuse has never been a completely pretty one, even though there have been periodic attempts to reform. The profession's responsibility has been intimately linked with addiction and drug abuse for many years, and not solely through treatment. The inexpert prescription of narcotics before, during, and after World War I is

a matter of general knowledge.

More recently, medicine would find it difficult to defend prescription practices that provide patients with an almost unlimited supply of pain killers, barbiturates, amphetamines, and other drugs whose properties are now known to be addictive in certain dosages under certain conditions. In general, the medical profession as a whole has rejected its responsibility in the problem of drug-abuse control, as well as in accepting drug addicts as patients.

The profession has known for a long time that the drug habit is a way of life that takes the user out of real life and occupies all his time and thought. Some free themselves; others do not. Therefore, addicts for the most part need sustained help over a long period of time, and the post-addict needs definite support in the community.

For the user of "soft drugs" as well as for the narcotic addict, there are broader considerations which go beyond the acute effects of the use of any drugs of abuse. These considerations are of special relevance to psychiatrists. Among the subtle changes observed in chronic marijuana users, for example, are decreased drive, apathy, distractibility, poor judgment, introversion, depersonalization, diminished capacity to carry out complex plans or prepare realistically for the future, a peculiar fragmentation of thought, magical

thinking, and progressive loss of insight.

Psychiatry needs also to be particularly concerned about the potential effect of any reality-distorting agent on the future psychological development of the adolescent user. Since adolescence is a time of great psychological turmoil, patterns of coping with reality developed during this period are most significant in determining adult behavior. Persistent use of an agent that serves to ward off reality during this critical period is likely to compromise seriously the future ability of the individual to make an adequate adjustment to a complex and demanding society. To date, awareness of these conditions has not been equated, to any significant extent, with the profession's acceptance of responsibility in the treatment of drug abuse.

A possible reason for disenchantment on the part of the entire medical profession with treatment in this field may be that physicians, like most other citizens, have tended to look at drug abuse as a single, homogeneous phenomenon and have been slow to realize that a national treatment program, assuming the current public acceptance of the need for it, can be effective if operated in a realistic climate of expectations and results.

Drug abuse ranges from minor experimentation up to and through serious involvement, dependency and death. Therefore differentiation should be made among at least four groups of drug abusers: (1) the uninitiated and

the abstainers; (2) the experimenters; (3) the moderate users; and (4) those for whom drugs have assumed a central role in life.

Simultaneously, in categorizing drug users, it is also necessary to arrive at a working definition of drug abuse, on which to base development of a drug program. Such a definition would be use of a drug or other substance with central nervous system activity in excessive amounts, or in a manner to produce any of the following: marked physical or psychological dependency; psychosis or serious personality disturbances; serious impairment of personal and social functioning, including significant behavioral toxicity; death or danger to life of the drug abuser or others; serious interference with personality and social development; biochemical, neurological, genetic, or other physical damage.

A program based on such a characterization would bring about the development of treatment modalities appropriate to the presenting situation and related to the risk and severity of the consequences, both to the patient and to society.

In recent months, professionals already involved in the drug field have been discussing the objectives and goals of a national drug-abuse program. Of importance in achieving any success has been the tentative beginning of a search for methods by which organized, traditional medicine and the free

clinic movement can collaborate to minimize the adverse effects of drug abuse.

In 1971, approximately 150 free clinics existed throughout the United States, and in seeking help from them, drug abusers sense the safety of confidentiality and an empathetic concern for their problems. Without doubt, the element of trust between those who need help and those who seek to provide it is one of the necessary components of an effective service program.

A great deal of the polarization around drug abuse results from lack of communication. Schools, universities, neighborhoods, and community groups of all kinds have become involved in the effort to develop means of communication where drug abuse and other issues relevant to everyone who participates are included in the discussions.

Without doubt, the single most important part of a national drug-abuse program will be to establish veracity through educational programs aimed at substituting intelligent concern for panic and replacing propaganda with facts. As sensible education programs and community success in providing young people with interesting alternatives to drug highs begin to have an effect, it should be less difficult for the physician and other health professionals to become interested in and accepted by those in need of help.

Various types of motivational therapies are currently being used in the

treatment of drug abuse, but their acceptance to date has been minimal and is sought, for the most part, only when the experimental drug abuser has become further identified with some part of the drug culture and rejects his experience.

Programs aimed at the prevention of drug abuse will of necessity continue to be experimental. For those already involved in drug abuse two kinds of programs must be provided: emergency (first aid) services for acute crisis situations and continuing care to minimize the effects of dysfunctional behavior which accompanies chronic drug abuse. Within the customary medical care system, any properly trained emergency service can prevent death or disability. The free clinic system, however, provides public health services, such as contraception and suicide prevention, as well as crisis intervention for the acute drug episode itself and may include treatment of such related conditions as venereal disease.

Beyond the response to a crisis, continuing care is required in one way or another by all drug abusers during the period of time when the individual attempts to learn new patterns of living, separated from drug highs. Such programs now in existence are usually fragmented, but each of them has shown enough promise to warrant expansion and refinement. They include the therapeutic community, methadone maintenance, narcotic antagonists, civil commitment programs, psychiatric care, theologically and ideologically

based programs, and financial aid.

None of these alone, however, can be successful without the organization of long-term, easily accessible rehabilitation programs that are a part of continuing care and must be able to provide supportive aid in the community as a long-term service. Basically, all these program components imply a continuity of care for the drug abuser comparable to the continuity of care provided for emotionally disturbed individuals in comprehensive community mental health centers.

Community psychiatry has not, to any significant degree, made its skills and knowledge available to the drug abuser as yet; this is, no doubt, the immediate task to be confronted during the 1970s. Community psychiatry has already learned that many disturbed individuals can be maintained in the community if follow-up care is provided without time limitations. Pasamanick's follow-up study of acutely psychotic schizophrenics demonstrated that for a thirty-month period, more than three-quarters of the experimental group could be successfully maintained at home. Five years after termination of the demonstration, however, Pasamanick and his associates undertook a subsequent study of the same patients. They found that gradual erosion of the original significant differences occurred on the usual clinic and aftercare services, so that eventually no differences in social or psychological functioning could be found. "This indicates," Pasamanick

commented, “a need for the structuring of community mental health services on an intensive, aggressive basis, or we do nothing more than transfer custodial care to the community.” The analogy in establishing a national prevention, treatment and rehabilitation program for drug abuse is self-evident.

Bibliography

Assistant Secretary for Legislation, U.S. Department of Health, Education, and Welfare. Statement before the Subcommittee on Public Health and Welfare of the House Committee on Interstate and Foreign Commerce, U.S. House of Representatives, 1969.

Pasamanick, B., Davis, A. E., and Dinitz, S. “Five Years After an Experimental Demonstration: The Prevention of Hospitalization and Schizophrenia.” *American Journal of Orthopsychiatry,* April 1972.

San Mateo Dept. of Public Health and Welfare, Research and Statistics Section. *The Use of Alcoholic Beverages, Amphetamines, LSD, Marijuana, and Tobacco Reported by High School Students and Junior High School Students*. San Mateo, Cal., 94403, 1968-1969, and preliminary release of 1970-1971.