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ABSTRACT

This document is a collection of the second session of hearings on drug abuse in the schools, conducted for the House of Representatives' Select Committee on Crime. This particular part delves into the drug problem in San Francisco. Witnesses from this city whose statements were heard in the 1972 hearings include school teachers, former drug addicts, undercover police officers, district attorneys, school principals, and executive administrators of city school systems. Relevant data are included in tables and charts throughout the documents. The findings on the other cities involved in these hearings can be found in the ERIC collection. (SES)

DRUGS IN OUR SCHOOLS

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SELECT COMMITTEE ON CRIME

HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

SECOND SESSION

SAN FRANCISCO, CALIF.

SEPTEMBER 28-30, 1972; SAN FRANCISCO, CALIF.

Printed for the use of the Select Committee on Crime
(Created pursuant to H. Res. 115)

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DRUGS IN OUR SCHOOLS

THURSDAY, SEPTEMBER 28, 1972

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CRIME,
San Francisco, Calif.

The committee met, pursuant to notice, at 10 a.m., in the ceremonial courtroom, U.S. District Court, 450 Golden Gate Avenue, San Francisco, Calif. Hon. Claude Pepper (chairman) presiding.

Present: Representatives Pepper, Waldie, Murphy, and Winn.

Also present: Joseph A. Phillips, chief counsel; Michael W. Blommer, associate chief counsel; Chris Nolde, associate counsel; and Leroy Bedell, hearing officer.

Chairman PEPPER. The committee will come to order please.

It brings back pleasant memories to those of us on this committee who are here to be back in this very delightful courtroom where we were permitted to hold hearings before this committee in the fall of 1969. Those were very significant hearings because, among other things, they brought out the extent of the illicit traffic in amphetamines which was going on in the country and across the borders of the United States and Mexico.

Here in this room we had 13 large bins embracing 1,300,000 amphetamine pills which had been shipped by a drug firm from Chicago allegedly to a consignee in Tijuana, Mexico, to a specific address. It was discovered by Federal officials, with the cooperation of the staff of this committee, that these drugs were not shipped to a drughouse in Tijuana because that address wasn't a drug establishment at all but was the 11th hole of the Tijuana golf course. It was simply a fraudulent practice that had been carried on for several years by this drughouse, knowingly or unknowingly, which permitted people by some sort of wrongdoing to get the custody of all of these amphetamines and to put them back into the black market in the United States, where they sold for 25 cents a piece. That was one of the things that bothered this committee and had a terrible effect upon the policy of our country to reduce the amount of amphetamines that were produced and distributed in the Nation. And so, working with other committees of the Congress and with the executive branch of the Government, we have now been able to bring about a reduction in the number of amphetamines produced and distributed in this country by some 82 percent. We are still working to reduce the number further.

I just wanted to recall one of the meaningful aspects of our visit here in 1969.

We wish again to express our very great gratitude to the chief judge of the U.S. district court here for his kindness in allowing us to use

these very effective facilities and we are very grateful and we will extend personally our thanks to his Honor before we depart.

This morning this committee is initiating the fourth of a series of hearings that we have held dealing with the problem of drugs in the schools across the Nation. We started these hearing in New York City; thereafter we held hearings in Miami, my home city; then in Chicago; and now we are in this great city on the Pacific Coast. These hearings are concerned with drugs in our schools—a condition which has become so extensive and so pervasive that it has assumed the proportions of a national scandal. Our hearings are designed to determine the extent to which drugs are being bought, sold, and abused by children in our schools and to see what can be done to help the schools to meet this problem through the educational process and machinery of our school system.

More importantly, however, the committee will inquire into the abject failure of our governmental institutions—especially our schools—to aggressively attack the problems and control the increase in narcotics abuse by school age children. Some school systems have no policy or programs to combat drug abuse.

School authorities often suspend children when they determine they have a drug problem. The fact that no effort is made by such school systems to rehabilitate these children is disastrous. The student continues his or her drug addiction and rapidly becomes involved in a spiral of criminal activity.

Regrettably, the drug policy of most school boards seems to be one of turning away from the problem by refusing to acknowledge the extent to which it exists at the local school level. Sweeping this problem under the rug, as has been the case, is a tremendous disservice to our youth and our community.

As the President proclaimed last year, our Nation is presently involved in a national drug epidemic—a national emergency. The number of drug addicts has been steadily and alarmingly increasing—from 315,000 in 1969 to 556,000 in 1971. Most tragically, the overwhelming portion of that increase has been among our Nation's school-age youth.

Recently, a national commission found that 6 percent of our Nation's high school pupils had used heroin. That means that 1½ million of our schoolboys and schoolgirls are already gravely endangered by that deadly menace. Experimenting with heroin or any other hard drug can only lead to a life of crime, degradation, and death.

I am reminded that here in this ceremonial courtroom this committee in 1969 heard one of the most dramatic and tragic stories of all, when Mr. Art Linkletter sat here and told us for the first time in a publicized statement about the death of his beautiful 20-year-old daughter who took her life because she had begun to use drugs and she began to feel that she could not escape from the effect of it. She had stopped using this drug but her mind suffered the effects of taking the drugs and she thought she was facing a life of mental infirmity and, therefore, her life wasn't worth living under those circumstances.

The national drug epidemic has been especially devastating to our major cities and metropolitan areas. In New York we found that drug abuse and the crime integrally connected with it was corroding and destroying the very fabric of the school system. According to many

responsible officials the schools had become sanctuaries and havens for drug sales due to the laxity and ineffectiveness of the school officials. It is the same everywhere that we have been. We had an undercover police officer testify in Chicago that with money that was made available a student went to her own school and while she was under the general supervision and surveillance of this undercover police officer she bought $20 worth of heroin and in 1½ hours brought it back and put it into the hands of police authorities. Later on, in the course of the following day and a half, she bought four other dangerous types of drugs in her own school just to show how readily available it is.

It is the same way everywhere we have been, New York and Miami as well.

Drug abuse in New York City's schools is spreading most tragically like a raging and uncontrollable epidemic. The same situation prevails in Miami and Chicago.

Unless all of us, therefore, act immediately, the devastating results which occurred in New York and which we have learned about in other cities will be repeated everywhere in the country.

California's metropolitan areas have not been spared by this national epidemic. Unfortunately, as was pointed out last evening in an interview by a distinguished member of this committee from California, Congressman Jerome Waldie from whom you will hear later, California's high schools lead the Nation in drug abuse by a substantial margin. Drug abuse in California's school system with amphetamines, barbiturates, psychedelics, and cocaine, far exceeds the national average. In a representative school here, more than 30 percent of the students had used barbiturates or downers; more than 30 percent had used amphetamines; 21 percent had used LSD—acid; 23.4 percent had used other psychedelic drugs—mescaline, peyote, THC and PCP; 17.6 percent had used Methedrine—speed; 8 percent had used cocaine; 5 percent had used heroin; and 56 percent had used marihuana. The percentages for amphetamines, barbiturates, LSD, psychedelics, and Methedrine are 5 to 10 percentage points above the national average.

The students who take these drugs come from every major socioeconomic, religious, and ethnic group. In my city of Miami the 18-year-old son of the president of the largest financial institution of its kind in the South died from taking heroin. The drugs used by these students are most commonly bought and sold right on the school grounds. It is most disheartening to note that the drug pusher in our schools is not the usual criminal but is most often one of the school students.

In preparation for these hearings the committee's investigative staff has interviewed teachers, principals, students, police and court officials, health and medical authorities, and many others. On the basis of these preliminary evaluations, it can be concluded that drug abuse in San Francisco Bay area schools is extremely serious, widespread, and growing worse. One Government official has advised us that large amounts of any type of drugs are readily accessible in practically all high schools in this area.

When the incipient signs of drug abuse are ignored by school authorities and go untreated, many high school students accelerate their drug use, become truants, drop out of school, and ultimately become

drug addicts. We found that last year 12,000 students dropped out of the school system of Chicago, one of the best systems in the country.

In San Francisco it is estimated that there are already between 4,500 and 7,200 hard-core heroin addicts. These heroin addicts require between $40 and $250 a day in order to support their addiction. The heroin addict obtains the money to support his habit by stealing, by committing robberies and burglaries, and by selling drugs to others.

In addition, in San Francisco there are between 13,000 and 14,000 drug abusers who are "strung out" or in the advanced stages of habituation on amphetamines, barbiturates, and hallucinogenics. These figures do not include marihuana smokers or those beginning drug abusers who have only experimented with these drugs.

In Alameda County it is estimated that there are 10,000 heroin addicts, and comparable amounts of other addicts who are involved with barbiturates, amphetamines, and hallucinogenics. One Oakland official has advised us that drug abuse here is like an iceberg, that no matter how hard they look at it, only 10 percent is visible about the surface.

Tragically, more than 650 school-age children have died of drug overdoses in this State in the last 3 years. Over 450 have died in Dade County, my home county in Florida, in the last 5 years. In the last 3 years deaths from overdoses have doubled. All of these young lives could have been saved if we had discovered their drug problem and supplied them with adequate rehabilitation facilities. We cannot let this intolerable situation continue.

On the basis of the evidence produced at our hearings thus far, it appears that concerted and determined effort by the National, State, and local governments is desperately needed if this crisis is to be abated. The Federal Government must take an active and prominent role in the fight against drug abuse, especially at our schools. We cannot let these young children's lives turn to crime, degradation, and death. It is my hope that these hearings will be the first step in an effort which will result in the reclamation of these young drug users. We hope these hearings are the beginning of a national commitment to assure drug-free schools.

In the course of our hearings we will be taking testimony from leading authorities concerned with the problem of drug abuse. We will hear testimony from undercover police officers who purchased drugs in the schools. A cross section of the school system, including the superintendent, school administrators, principals, and classroom teachers, will be represented. We will also call a number of school-age youngsters who have been in the drug scene and can testify from first-hand experience about the crisis in our schools.

The Select Committee on Crime is here as the result of Congressman Jerome Waldie's resolution calling for this hearing. Mr. Waldie is the ranking member on the Democratic side of this committee and has, from the beginning, been one of the most influential and meaningful members of this committee. His timely resolution called this problem to the attention of the Congress and the Nation. Congressman Waldie called for this inquiry when he learned of the survey by Columbia University which showed extensive drug abuse in California schools. Other members of the committee who are attending these hearings are, on my right, beyond Mr. Waldie, Hon. Morgan Murphy of Illinois, of the Chicago area, who is an outstanding authority on world-

wide drug traffic. He has made a number of trips to Vietnam and Southeast Asia and to European countries and has joined with one of his colleagues in the preparation of reports that have been very influential in getting legislation and policies established by our Government which have had much to do with the efforts now being made to abate the importation of heroin into this country, and also in providing measures to deal with this problem in the Nation.

On my left is Hon. Larry Winn, a Republican member of our committee from the State of Kansas, who has been a very knowledgeable and very dedicated member of this committee. We are holding hearings later in the State of Kansas at his invitation.

On my far left you will find one of your own distinguished Representatives, the Honorable Don Edwards, who is chairman of Subcommittee No. 4 of the Judiciary Committee of the U.S. House of Representatives, which has been doing outstanding work in this whole field of drugs and drug traffic. We are very fortunate to be able to have Mr. Edwards honor us with his presence here and we are going to hear from him as we begin these hearings this morning.

On my right is the chief counsel of the committee, Mr. Joseph A. Phillips; and on my left, the second one on my left, is the associate chief counsel to the committee, Mr. Michael W. Blommer.

Down to the right is an associate counsel, Mr. Chris Nolde, of the committee.

Mr. Waldie, would you like to add anything further?

Mr. WALDIE. Nothing, Mr. Chairman.

Chairman PEPPER. Mr. Murphy?

Mr. MURPHY. Nothing, Mr. Chairman.

Chairman PEPPER. Mr. Winn?

Mr. WINN. No.

Chairman PEPPER. Mr. Edwards, we will be pleased to have you testify from here or from the witness table.

STATEMENT OF HON. DON EDWARDS, A U.S. REPRESENTATIVE FROM THE STATE OF CALIFORNIA

Chairman PEPPER. We are pleased to have you today here and we welcome any statement or comments that you care to make. We hope you can remain with us throughout the hearings. We would be pleased to have you.

Mr. EDWARDS. Mr. Chairman, I appreciate your hospitality very much and I join with my colleague, Mr. Waldie, in welcoming the other members and the staff to the Bay area for these very important hearings.

I am also a member on the Judiciary Committee with Mr. Waldie and can personally testify as to the work that he does in this area on that important committee also. My compliments go to Mr. Waldie and to you, Mr. Chairman, for being here today, tomorrow, and the next day on this vital subject.

As you mentioned, I am chairman of the Subcommittee No. 4 of the Judiciary which has jurisdiction over the Narcotic Addict Rehabilitation Act and much of the Federal criminal law, including the Federal program called LEAA, Law Enforcement Assistance Administration.

Our subcommittee was concerned, too, and has been for 2 years about

the heroin epidemic in the United States and we have held a series of hearings. Before that we asked the General Accounting Office to go into Chicago, New York, Washington, D.C., San Francisco, Alameda County, and Los Angeles County and give us a report on what the drug programs are, are they being effective and how is Federal and local money being spent. Later, Mr. Chairman, I would like to submit for the record these rather excellent but discouraging reports from the General Accounting Office.

What these reports show and what our hearings prove and what we must with dismay report is that the Federal Government is failing both to provide assistance to local governments in drug rehabilitation and treatment and, further, that the Federal Government is failing to develop model programs of its own.

The shocking truth is that we are losing the war against narcotics in this country and there is little hope for our success unless Congress can develop some truly effective programs and then produce whatever administration is in office into implementing these programs.

The Bureau of Narcotic and Dangerous Drugs estimates, as you accurately said, Mr. Chairman, that there are probably 560,000 heroin addicts in the United States, and I won't dwell on the absolutely ravaging effect an epidemic of this size and this proportion is having on our country in terms of crime alone. The results are devastating.

Our witnesses indicated at least 50 percent of the street crime in the United States today is caused by heroin addicts seeking money to support their habit.

The head of the drug treatment program in Alameda County testified in Washington before our subcommittee that in testing 123 burglars, they found 121 of the burglars were heroin addicts.

So we are faced with this enormous national epidemic of half a million addicts. What is the Federal Government to do.

Our hearings indicated that the Federal Government has responded in token fashion. Twenty-six thousand one hundred ninety-six of the estimated 560,000 addicts in the United States are enrolled in programs having a Federal connection. Twenty-six thousand out of 560,000.

The Federal Government has its own programs——

Chairman PEPPER. Would you repeat those figures, Mr. Edwards, to be sure we have them correct.

Mr. EDWARDS. Those shocking figures are, Mr. Chairman, out of the estimated 560,000 heroin addicts in the United States, only 26,196 are enrolled in local programs receiving Federal help. The Federal Government has its own rehabilitation and treatment programs, titles I and II of the Narcotic Addict Rehabilitation Act, and here again the results are so meager as to be outrageous.

The General Accounting Office figures on all of these programs show there are 257 in-patients and 1,430 out-patients. So despite the thousands upon thousands of Federal prisoners or addicts who are arrested for Federal crimes, a small handful of less than 2,000 patients are in Federal programs.

The General Accounting Office said that somewhere, and these figures are also very loose, between 4,500 and 7,200 addicts are in San Francisco; a minimum of 5,000 addicts, probably closer to 10,000, I believe, Mr. Waldie, are in Alameda County. Here again only a small percentage of them are in treatment. Many others want treatment; they are

on waiting lists because local governments don't have the funds for expansion of the existing treatment programs which are filled to capacity.

The same picture exists in Los Angeles with thousands of people on waiting lists, and the picture is the same in New York and Chicago and, Mr. Murphy, when we have the report on Chicago we are going to need your help.

I have been in communication with every Governor of every State and every Governor tells me the same thing: please help us; the problem is bigger than we are, we need help very badly from the Federal Government, that we are not getting. It is really imperative that the Federal Government start to make itself felt in this area. After all, every bit of heroin that comes in illicitly is smuggled in from elsewhere in the world. We don't have opium production in this country. And yet the new budget, Mr. Chairman, the 1973 administrative budget, provides no real evidence of realistic Federal commitments.

Mr. Nixon on June 1971, promised that there would be a massive new Federal effort and yet the 1973 budget provides $365 million for drug treatment and rehabilitation. That sounds like a lot of money but then you start to look at it. Of the $365 million proposed for the war on drugs, $230 million is budgeted for treatment of narcotic addicts. However, of the $230 million, $84 million goes to the military or to Veterans' Administration, so there is only $146 million left to distribute to State and local governments for help. And this is only $21 million more than the previous year.

Well, now, New York State alone provides quite a lot more money than that, $161 million. So the total Federal effort is $146 million while the State of New York provides $161 million.

Chairman PEPPER. Excuse me. I recall Governor Rockefeller telling us, I believe, the State of New York has already spent over $750 million of its own in this area.

Mr. EDWARDS. That is correct, Mr. Chairman; they have done everything they can. There is some criticism of many of the programs in the State of New York but the bare facts are that New York State is willing to put out that kind of money whereas the Federal Government is willing to put out less for all 50 States than what just one State is spending. I am sure that we all regret this lack of commitment by the administration.

I have my own bill that has been introduced, H.R. 15760, the Narcotics Rehabilitation Treatment Act of 1972. I am honored, Mr. Chairman, that you are also a cosponsor of this bill and I am sure we will have discussions about its provisions. It would for the first time provide a nationwide mechanism for Federal funding which we just don't have now. It is now very much of a hit or miss problem, it is sort of a narcotics treatment Marshall plan to help local communities through LEAA provide care to these thousands and thousands of addicts who want care, need care, but who can't get it.

We don't intend or don't hope to enact it in this Congress but Dr. Jerome H. Jaffe will testify again before my subcommittee next Thursday and we hope we can have strong bipartisan support for some legislation that will provide a nationwide plan for starting to get at this terrible American problem that we have.

Hearings like this, Mr. Chairman, Mr. Waldie, Mr. Murphy, and Mr. Winn, certainly are most useful. They are vital if the American

people are going to start to be concerned about it and instruct their legislators to do something about it.

I thank you again for your hospitality. I also thank you for allowing me to sit in with the distinguished members of the committee.

Chairman PEPPER. Well, Mr. Edwards, we are most grateful to you for coming because you have been doing splendid work, you and Mr. Waldie, in the Judiciary Committee as well as Mr. Waldie on this committee, and it is a challenging national problem as you have pointed out. You know this committee will support you and work with you in every way we possibly can and we are pleased to have the honor of having you here.

Mr. WALDIE. I am a member of the subcommittee Mr. Edwards chairs. This is the first time the Judiciary Committee has taken the interest in this problem that they should have years ago, and I thank the gentleman for this leadership.

Mr. EDWARDS. Thank you very much.

Chairman PEPPER. Mr. Murphy?

Mr. MURPHY. Thank you Mr. Chairman.

Congressman Waldie has alluded to your fine work, Congressman Edwards, and I agree with you.

We just concluded hearings in Chicago and being chairman of the subcommittee for the Judiciary Committee maybe you can give me some insight as to what is happening to the funds that we give under the LEAA program? It seems in Chicago funds aren't getting down to where they are needed because of bureaucratic costs and there doesn't seem to be a general program. Funds aren't getting to the schools, they are not getting to the law enforcement people. They absolutely had no programs in Chicago and I am wondering if it is our responsibility in the Congress to check to see where these funds go. What are your comments on this, what has been your experience in tracing these funds?

Mr. EDWARDS. Well, Mr. Murphy, the experience of our subcommittee has been that it is too much of a hit or miss proposition with very little rhyme or reason as to how the money is allocated. Practically all of the programs, of course, are looked upon as pilot programs which expire after 1 or 2 years. This is very upsetting to the local people to establish a program and then right out of the blue have to finance it fully locally when they really don't have the money. There is a considerable amount of LEAA money for treatment and rehabilitation of heroin addicts but it is allocated on a hopscotch method throughout the United States. I think it ought to be audited. I think we ought to have a much more reasonable national plan.

Mr. MURPHY. Thank you.

Chairman PEPPER. Mr. Winn?

Mr. WINN. Thank you, Mr. Chairman.

I agree with Mr. Edwards in many parts of his statement and I want to commend him for the work that he has done and for appearing before this committee.

I do want to clarify a part of the statement though and point out that although I agree we probably haven't spent as much money on the problem of drug abuse and allocated enough from the Federal Government, I would like to point out that under the present administration that we jumped almost 10 times what the previous budget was for the year 1970–71. Then shortly after that Dr. Jaffe was appointed Director of the Special Action Office for Drug Abuse Prevention. So I think that in all fairness we want to point out there have been some steps

taken by the administration and by the Congress to do a better job, but I would wholeheartedly agree we are not moving fast enough and we are going to have to allocate more money and move much faster.

Mr. EDWARDS. Thank you. Mr. Winn. My observations were not partisan. I think we all have to work together, whoever is in the White House, to require a larger national effort.

Mr. WINN. I think the gentleman made that clear in the earlier part of his statement. Thank you.

Chairman PEPPER. Thank you very much, Mr. Edwards, and we will be glad to have you sit with us as long as you can.

(Congressman Edwards' prepared statement and the reports referred to follow:)

PREPARED STATEMENT BY HON. DON EDWARDS, A U.S. REPRESENTATIVE FROM THE STATE OF CALIFORNIA

Mr. Chairman, I deeply appreciate the opportunity to particpate in these important hearings.

As you know, I am the Chairman of the House Judiciary Subcommittee with legislative jurisdiction over the treatment and rehabilitation of narcotics addicts. My Subcommittee has been conducting exhaustive investigations of the problem of narcotics treatment throughout the United States as a whole, as well as in various specific cities, including not only San Francisco and Alameda Counties, but also Los Angeles, Washington, New York and Chicago. It is with great dismay that I must state, Mr. Chairman, that all of these investigations have led me to the conclusion that our Federal Government is failing both to provide adequate assistance to State and local governments in combatting narcotics and to develop model Federal programs. The shocking truth is that we are continuing to lose the so-called "war against narcotics." We will continue to have little hope for success unless, as the outgrowth of hearings such as this and of those held by my Subcommittee, the Congress is successful in developing a truly effective national program, and prodding the Administration into implementing such a program fully.

Currently, the Bureau of Narcotics and Dangerous Drugs of the United States Department of Justice estimates that there are 560,000 heroin addicts in the United States. I need not dwell, Mr. Chairman, on the ravaging effects on our society of a heroin epidemic of that proportion. In terms of crime alone, the results are devastating.

In most cities, for example, almost 50 percent of all so-called street crimes are committed by addicts. There is evidence that burglaries in particular are attributable largely to addicts. In this regard, my Subcommittee recently received testimony from Mr. Richard A. Bailey, Coordinator of Alameda County's Comprehensive Drug Abuse Program, that an analysis of 123 arrests for burglary revealed the existence of heroin in 121 cases. Yet, as incalculable as are the effects of this addict-related crime, the effects on the addicts themselves and their families and friends and on the quality of life in all of our communities is even more devastating.

Faced with the enormity of a national epidemic comprised of more than a half million heroin addicts, our Federal Government has responded in what is scarcely more than a token fashion. The evidence accumulated by my Subcommittee indicates that only 26,196 of the estimated 560,000 addicts in the Nation are presently enrolled in community-based State and local programs which receive Federal support. As for the Federal Government's own program, which is embodied in Titles I and III of the Narcotic Addict Rehabilitation Act, the treatment efforts are so meager as to be outrageous. In this regard, the latest figures made available to us by the General Accounting Office indicate that in the Federal program only 527 patients are receiving inpatient treatment and 1,430 patients are being treated in aftercare facilities. In spite of the fact that every day literally thousands of heroin addicts are arrested by the Federal Government for Federal crimes, this small handful of less than 2,000 patients represents the entire Federal program.

My Subcommittee's investigations in San Francisco and Alameda Counties indicate that between 4,500 and 7,200 addicts reside in San Francisco and that a minmum of 5,000 addicts reside in Alameda County. Of these, only a very small percentage are in treatment. Others are on waiting lists seeking treatment which is simply not available because of lack of funds. The picture is the same in Los

Angeles and in all the other great urban areas. The number of addicts is enormous; the waiting lists are long; and not enough money is available to the local community to develop effective treatment programs. I have communicated personally with the Governor of every State regarding this problem and find that basically the same picture exists everywhere.

Although Federal funds are not in themselves a remedy for addiction, there can obviously be no effective treatment programs unless they are adequately funded. Under the circumstances, it is simply imperative for the Federal Government to muster every possible resource and provide maximum Federal assistance. Yet despite the enormous need for Federal assistance, the Nixon Adminstration's fiscal 1973 budget provides no evidence of the needed expanded Federal commitment to the treatment of narcotics addiction.

In June 1971, President Nixon promised a substantial new Federal effort, and the Administration's budget request for fiscal 1973 for drug abuse programs totals $365.2 million, a purported substantial increase over last year's budget. But when one examines this increase it is apparent that most of the existing funding is scheduled for programs designed to meet the military drug abuse problem. For example, of the $230.2 million budgeted for the treatment and rehabilitation of narcotics addicts, $84.2 million will be spent by the Department of Defense and the Veterans Administration, leaving but $146 million for the treatment and rehabilitation of civilian addicts. This $146 million represents only $21 million more than was allocated for non-military treatment programs in the budget for fiscal 1972 and falls far short of the amount allocated by New York State, which has budgeted $161.5 million for drug abuse treatment programs during its 1971–72 fiscal year.

Mr. Chairman, I believe all of us know what an enormous task we face in Our efforts to find a solution to the drug problem. Yet, I believe such a solution can be found, and that some of the work done by my legislative subcommittee, as well as by this Committee, will make a major contribution to such a solution. In this regard, I am pleased that my Subcommittee now has before it my bill, H.R. 15760, the "Narcotics Addict Treatment and Rehabilitation Act of 1972". It is gratifying to me, Mr. Pepper, that you have joined with me as a cosponsor of this legislation. I am also gratified to note that the bill has the strong support of my good friend, the Speaker of the California Assembly, Robert Moretti, who has advised me that enactment of this measure by the Congress will greatly assist bipartisan efforts in California to develop effective drug legislation.

My bill, H.R. 15760, creates, for the first time, a nationwide mechanism for the funding of State and local treatment programs by the Federal Government through the Law Enforcement Assistance Administration—a "narcotics treatment Marshall plan" to finance treatment programs in every community which needs them. $100 million in additional LEAA funding are authorized for the establishment of State drug treatment programs. In addition, the bill creates a special emergency fund of $100 million for those cities and counties where narcotics addiction has reached emergency proportions—the kind of massive Federal effort which has been in the past associated with natural disasters.

Because of the linkage between narcotics addiction and criminal activity, the bill also focuses upon the establishment of model procedures in Federal and State criminal justice systems to divert narcotics addicts into treatment.

At this point, Mr. Chairman, I would like to include for the record the following materials: A copy of H.R. 15760, as well as each of the companion bills, together with an explanation of them, and copies of the reports prepared by the General Accounting Office for my Subcommittee. I would also like to include a copy of the hearings held by my Subcommittee last year and to furnish for the record at a future date copies of the hearings which we are currently holding as soon as they become available. [The hearings referred to above are a matter of public record and were held by Subcommittee No. 4, Committee on the Judiciary, U.S. House of Representatives.]

Next Thursday in Washington my Subcommittee will continue hearings on this proposal and we will have as our witness, Dr. Jerome H. Jaffee, who is the Director of the White House Special Action Office for Drug Abuse Prevention. I that even though this is a very political year, we will be able to develop a strong develop a strong bipartisan commitment in the Congress to the enactment of this important legislation.

I believe, Mr. Chairman, that the hearings that you are now holding will serve further to demonstrate the need for this legislation, as well as for the development of other effective programs. Therefore, I am looking forward, in particular, to any suggestions that the witnesses before this Committee may have regarding specific proposals for legislative action by the United States Congress. In my capacity as a Subcommittee Chairman of the House Judiciary Committee, I will certainly give any such proposals thorough consideration.

(The following identical bills were introduced: H.R. 15760 by Mr. Edwards of California, June 29, 1972; H.R. 15840 by Mr. Rodino, June 30, 1972; H.R. 16218 by Mr. Edwards of California, for himself, Mr. Abourezk, Mrs. Abzug, Mr. Begich, Mr. Bell, Mr. Biaggi, Mr. Biester, Mr. Brademas, Mr. Brown of Michigan, Mrs. Chisholm, Mr. Conyers, Mr. Corman, Mr. Danielson, Mr. Dellums, Mr. Dow, Mr. Drinan, Mr. Eilberg, Mr. Fraser, Mr. Green of Pennsylvania, Mr. Halpern, Mr. Hechler of West Virginia, Mrs. Hicks of Massachusetts, Mr. Holifield, Mr. Horton, and Mr. Mikva, August 7, 1972; H.R. 16219 by Mr. Edwards of California, for himself, Mr. Mitchell, Mr. Pepper, Mr. Podell, Mr. Rangel, Mr. Rees, and Mr. Sarbanes, August 7, 1972. The text of these bills follows:)

92D CONGRESS
2D SESSION

H. R. 15760

IN THE HOUSE OF REPRESENTATIVES

JUNE 29, 1972

Mr. EDWARDS of California introduced the following bill; which was referred to the Committee on the Judiciary

A BILL

To amend title 18 of the United States Code to enable the Federal criminal justice system to deal more effectively with the problem of narcotic addiction, to amend the Omnibus Crime Control and Safe Streets Act of 1968 to enable the States and municipalities to deal more effectively with that problem, and for other related purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Narcotics Addict Treatment and Rehabilitation Act of 1972".

TITLE I—THE FEDERAL CRIMINAL JUSTICE SYSTEM AND NARCOTIC ADDICTS

SEC. 101. Chapter 314 of title 18 of the United States Code is amended to read as follows:

"Chapter 314—NARCOTIC ADDICTS

"§ 4251. Conditional release pending criminal proceedings

"Any court or person having the authority to release an individual under chapter 207 of this title (relating to release pending criminal proceedings) may, if consistent with the purposes of such release, require as a condition of the release of an individual under that chapter that such individual undergo examinations and treatment provided under section 4254 of this title and may refer any individual so released to the Secretary of Health, Education, and Welfare for such examinations and treatment.

"§ 4252. Contingent deferral of prosecution pending medical examination and treatment

"(a) Each officer of the United States charged with the responsibility of prosecuting offenders against the laws of the United States may, in the case of any eligible individual who is charged or about to be charged, upon indictment or information, or otherwise, with any offense which, in the judgment of such officer is sufficiently connected with such individual's narcotic addiction as to make it in the best interests

of such eligible individual and of society to defer the prosecution of that individual under this section, exercise discretion to defer the prosecution of such eligible individual with respect to such offense or offenses and refer that individual to the Secretary of Health, Education, and Welfare for examinations and treatment as provided under section 4254 of this title, if such individual will agree to undergo such examinations and treatment. In the case of an individual who is found to be an addict such officer may continue to defer such prosecution, if in the judgment of such officer such continuing deferral is in the best interest of such individual and of society, only so long as that individual cooperates with the treatment provided him under section 4254 of this title and makes satisfactory progress in such treatment or is rehabilitated. No prosecution shall be abated as a result of the provisions of this section, other than as would otherwise result from the application of any lawfully established period of limitation on the commencement of such prosecution.

"(b) For the purposes of this section, an 'eligible individual' is any person who is about to be charged with, or is charged with, any misdemeanor, or with any felony which does not involve the use or threat of force or violence against another person.

"§ 4253. Treatment and sentencing

"(a) Each officer of the United States, having the au-

thority to sentence offenders to the penalties prescribed by law for any offense or offenses against the United States, may, in the case of any such offender whom such officer believes may be an addict—

"(1) sentence such offender to such penalty, and require such examinations and treatment of such offender, either under section 4254 of this title or otherwise, as is consistent with that penalty, and is in the interest of both such offender and of society; or

"(2) suspend the sentence of such offender if such suspension is permitted by law, and if such officer considers such suspension in the interest of both the offender and of society, upon condition that and only so long as such offender undergoes such examinations and treatment as provided under section 4254 of this title, or otherwise, and only so long as such offender, if an addict, continues to make progress in such treatment or is rehabilitated, except that the period during which such condition shall be operative may in no case exceed the maximum period of imprisonment provided by law for the offense or offenses with respect to which such sentence is imposed.

"(b) Any presentencing report submitted to such officer shall include such information as is reasonably obtainable

to assist such officer in the determination of whether such offender should be sentenced under this section.

"(c) Each offender who is sentenced or receives a suspended sentence under this section and who is to receive examinations and treatment under section 4254 of this title shall be referred to the Secretary of Health, Education, and Welfare for such examinations and treatment.

"§ 4254. Referral for examinations and treatment

"The Secretary of Health, Education, and Welfare shall provide, either directly or by contract with any public or private entity or person he deems competent to the purpose, to each individual referred to him under the provisions of this chapter, such examinations and treatment, consistent with the provisions and purposes of this chapter, as are best suited to the timely discovery of whether such individual is an addict, and to the care of any such individual who is determined to be an addict.

"§ 4255. Rights of addicts to examination and treatment

"(a) Each addict held in custody of any person in order to await trial for any offense against the laws of the United States shall have the right to such examinations and treatment as are provided under section 4254 of this title.

"(b) Each addict who is in the custody of the Attorney General on account of such addict's conviction of any

offense against the United States shall have the right to such examinations and treatment under section 4254 of this title as are consistent with and appropriate to the duration of such custody and the penalty to which such addict has been sentenced for such offense.

"§ 4256. Examinations and treatment not convictions; use of information

"None of the examinations or treatment made or provided under this chapter shall be construed or deemed a criminal conviction for any purpose. None of the information derived from such examinations or treatment shall be used for any other purpose than for further proceedings, examinations, or treatment under this chapter. Such information shall not be used against the examined or treated individual in any criminal proceeding or investigation, except that the fact that such individual is an addict may be elicited on cross-examination as bearing on credibility.

"§ 4257. Definitions

"As used in this chapter:

"(1) The term 'addict' means any individual who habitually uses any narcotic drug as defined in section 102 (16) of the Controlled Substances Act so as to endanger the public morals, health, safety, or welfare, or who is or

has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(2) The term 'treatment' includes medical, educational, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by eliminating his dependence on addicting drugs, or by controlling his dependence and his susceptibility to addiction, and by increasing his ability to participate in normal and legal pursuits."

SEC. 102. (a) Chapter 175 of title 28 of the United States Code is repealed, and the table of chapters of part VI of such title is amended by striking out the item relating to such chapter.

(b) Titles III and IV of the Narcotic Addict Rehabilitation Act of 1966 are repealed.

(c) Section 341 (a) of the Public Health Service Act (42 U.S.C. 257 (a)) is amended by striking out "treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment or" and inserting in lieu thereof "and treatment of persons who are".

TITLE II—THE CRIMINAL JUSTICE SYSTEMS OF THE STATES AND MUNICIPALITIES AS THEY RELATE TO NARCOTIC ADDICTS

SEC. 201. The Omnibus Crime Control and Safe Streets Act of 1968 is amended by—

(1) redesignating parts F, G, H, and I of title I, as G, H, I, and J, respectively, and inserting immediately after part E the following new part:

"Part F.—EMERGENCY NARCOTIC ADDICTION PROGRAMS

"SEC. 471. It is the purpose of this part to provide direct emergency aid to any unit of general local government when the level of narcotic addict-related crime in the area under the jurisdiction of such unit reaches emergency proportions.

"SEC. 472. Whenever the Attorney General determines, upon application by a unit of general local government, that the rate of narcotic addict-related crime in the area under the jurisdiction of that unit of general local government reaches emergency proportions, such unit shall be eligible for assistance under this part during such period of time as the Attorney General determines the emergency is in effect, and such determination, along with an account of the reasons therefor, shall be transmitted by the Attorney General to the Congress.

"SEC. 473. (a) The Administration is authorized to make grants, on such terms and conditions as it deems necessary, including the requirement of periodic reports concerning the use of assistance given under this section, to any unit of general local government determined to be eligible under section 472 of this title in order to enable such unit to implement a plan, approved by the Administration, providing for a broad range of medically sound programs for the treatment of addicts, and having as its overall goal making treatment available to every addict in such unit.

"(b) Such programs and facilities shall be in addition to existing addict treatment programs and facilities, whether funded by Federal or non-Federal sources, and grants shall not be made unless the Administration is satisfied that the level of funding for such existing programs and facilities will not be decreased as a result of such grants, except as is consistent with the purposes of this part in order to eliminate outmoded or ineffective programs and facilities.

"(c) Each program or facility assisted under this part must establish adequate evaluation procedures utilizing the following criteria:

"(1) accessibility of the facility or program to addicts;

"(2) cost of creation and operation per addict treated;

"(3) frequency of arrests in connection with criminal offenses of addicts treated in such facility or program;

"(4) extent of continued illegal use of drugs by addicts treated in such facility or program;

"(5) extent to which addicts in treatment are able to participate in normal, noncriminal, community life;

"(6) extent and nature of profitable and satisfying employment of addicts during and after treatment;

"(7) extent to which addicts in need of treatment are retained in such facility or program; and

"(8) extent to which the treatment program is made an integral part of community life through the providing and coordination of community resources, services, and programs to reintegrate the addict into normal community life.

"(d) The President is authorized to make available to any unit of general local government which is eligible under section 472 of this title the full resources and facilities of the Federal Government for the purposes of assisting in the treatment and rehabilitation of addicts.

"SEC. 474. As used in this part and in section 303 of this title:

"(1) The term 'addict' means any individual who habitually uses any narcotic drug as defined in section 102(16)

of the Controlled Substances Act so as to endanger the public morals, health, safety, or welfare, or who is or has been so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction.

"(2) The term 'treatment' includes medical, educational, s[illegible]., psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services designed to protect the public and benefit the addict by eliminating his dependence on addicting drugs, or by controlling his dependence and his susceptibility to addiction, and by increasing his ability to participate in normal and legal pursuits.

"SEC. 475. There are authorized to be appropriated, in addition to any sums otherwise authorized to be appropriated for the purposes of this Act, $100,000,000 for the fiscal year ending June 30, 1973, and such sums thereafter as are necessary for the purposes of this part.";

(2) striking out "and" at the end of paragraph (11) of section 303;

(3) striking out the period at the end of paragraph (12) of such section and inserting in lieu thereof "; and";

(4) adding immediately after such paragraph (12), but before the final sentence of such section, the following new paragraph:

"(13) demonstrate (A) the existence, or satisfactory progress toward the establishment, in such State of a broad spectrum of effective facilities and programs for the treatment of addicts charged with crime and awaiting trial, addicts convicted of crime, and addicts who voluntarily seek treatment; and (B) that such facilities and programs have as their overall goal the easy availability of treatment to every addict in such State, and especially to those addicts who voluntarily seek such treatment, and that such facilities and programs have adequate evaluation procedures utilizing the criteria prescribed by section 473 (c) of this title."; and

(5) adding the following sentence at the conclusion of section 520: "There is also authorized, in addition to all other sums authorized to be appropriated for the purposes of this title, $100,000,000 for the fiscal year ending June 30, 1973, and such sums thereafter as may be necessary, for narcotic addict treatment and rehabilitation programs under part C."

[From the office of Congressman Don Edwards]

EDWARDS PROPOSES MASSIVE NEW FEDERAL NARCOTICS TREATMENT EFFORT—A "NARCOTICS TREATMENT MARSHALL PLAN" FOR STATES AND CITIES

Congressman Don Edwards (D-Calif.), chairman of the Judiciary Subcommittee with jurisdiction over narcotics treatment, today introduced a bill to provide a $200 million increase in the Federal funding of State and city narcotics treatment programs as well as for the creation of new Federal criminal procedures for addicts.

In a speech on the House floor, Edwards said, "the Judiciary Subcommittee, of which I am chairman, has held extensive hearings and, at my request, the General Accounting Office has made a comprehensive investigation of treatment programs in a number of cities. In addition, I have also communicated with all 50 State governors. The accumulated evidence is clear: less than 5% of the estimated 560,000 addicts in the Nation are now enrolled in federally-assisted treatment programs. The states and cities are being made to carry the enormous burden of narcotics treatment with little or no Federal help."

"My bill," Edwards explained, "creates, for the first time, a nationwide mechanism for the funding of State and local treatment programs by the Federal Government through the Law Enforcement Assistance Administration—a 'narcotics treatment Marshall plan' to finance treatment programs in every community which needs them. $100 million in additional LEAA funding are authorized for the establishment of State drug treatment programs. In adidtion, the bill creates a special emergency fund of $100 million for those cities where narcotics addiction has reached emergency proportions—the kind of massive Federal effort which has been in the past associated with natural disasters.

"Because of the linkage between narcotics addiction and criminal activity," Edwards stated, "the bill also focuses upon the establishment of model procedures in Federal and State criminal justice systems to divert narcotics addicts into treatment.

"My Subcommittee will schedule hearings on the bill immediately after the Democratic National Convention."

STATEMENT ON THE NARCOTICS ADDICT TREATMENT AND REHABILITATION ACT OF 1972 BY HON. DON EDWARDS, OF CALIFORNIA, IN THE HOUSE OF REPRESENTATIVES

Mr. Speaker, I am introducing today the Narcotics Addict Treatment and Rehabilitation Act of 1972.

The purpose of this bill is to amend title 18 of the United States Code to enable the Federal criminal justice system to deal more effectively with the problem of narcotics addiction, and to amend the Omnibus Crime Control and Safe Streets Act of 1968 to enable the states and municipalities to deal more effectively with that problem.

Because of the necessary linkage between narcotics addiction and criminal activity, drug addicts are often not identified as addicts until they are arrested and charged with a crime. It is, therefore, imperative that a means be developed to more effectively use the criminal justice system in the identification of addicts and their referral to treatment and rehabilitative services. The record is clear that punishment of convicted addicts through incarceration in correctional institutions merely leads to a return of the addict to addiction and crime upon release.

The Federal criminal justice system should be a model for the Nation in the establishment of procedures to divert narcotics addicts who commit crimes because of their addiction into treatment so that their rehabilitation from narcotics addiction and its related criminal activity may be accomplished.

The Narcotic Addict Rehabilitation Act of 1966 has been the addict diversion mechanism for the Federal criminal justice system. The Narcotic Addict Rehabilitation Act was, at the time of passage, a breakthrough in the law toward the treatment of narcotics addiction as a medical problem. In its statement of objectives to treat the addict for his addiction, rather than to punish him for the criminal offense charged, the Act broke significantly with attitudes of the past. The Narcotic Addict Rehabilitation Act created a system of civil commitment which provides compulsory institutionalized treatment for eligible addicts in lieu of prosecution or after conviction on the criminal charge.

The Narcotic Addict Rehabilitation Act of 1966 (NARA) was a response by the Congress to the "revolving door" process which had characterized the treatment of narcotics addicts at the Federal Public Health Service hospitals at Lexington, Kentucky and Ft. Worth, Texas. The experience of these hospitals in

not being able to hold addicts for sufficient lengths of time to effectuate a treatment program motivated the belief that there was need for use of the Government's coercive power to hold the addict in a treatment program long enough to allow him to derive the full benefit of the program.

The experience of the past five years with the Narcotic Addict Rehabilitation Act has shown that it has not fulfilled its promise. Because only those deemed "likely to be rehabilitated" have been selected as eligible for participation in the treatment afforded by the Act, many eligible addicts have been rejected for treatment. Because of the restrictive eligibility criteria in the Narcotic Addict Rehabilitation Act, the large majority of narcotics addicts sentenced to serve prison terms for Federal offenses have not been eligible for sentencing to treatment for their addiction. Only one or two percent of the addicts sentenced to Federal prisons since the passage of NARA have been sentenced under the provisions of the Act. The United States Attorneys, given responsibility by the Act to initiate the civil commitment proceedings, have rebelled against what they deem to be a "social work" function and have not used the Act to the extent anticipated.

Thus despite predictions during hearings on the Narcotic Addict Rehabilitation Act in 1966 that there would be an average of 900 commitments per year under the commitment in lieu of prosecution provisions of the Act alone, in the first three years of the program only 207 persons were examined for admission to treatment in lieu of prosecution and only 179 were accepted for treatment under the provisions of the Narcotic Addict Rehabilitation Act. It is, therefore, clear that the Narcotic Addict Rehabiliation Act does not serve its intended function as a procedure for diverting narcotics addicts into treatment in the Federal criminal justice system.

The Narcotics Addict Treatment and Rehabilitation Act of 1972 replaces the cumbersome NARA referral process with the grant of ample authority to the prosecutor to exercise his discretion in determining at what stage in the criminal proceeding an accused addict will be referred for appropriate diagnosis and treatment. The prosecutor is given three alternatives in my bill:

1. In the case of an accused who is about to be charged with, or is charged with any misdemeanor, or with any felony which does not involve the use or threat of force or violence against another person, the prosecutor may defer the prosecution of such eligible person pending successful entry into and progress in an appropriate narcotics addiction treatment and rehabilitation program.

2. In the case of any individual charged with a Federal crime, the prosecutor may, subsequent to arraignment, support the requirement, as a condition of release pending criminal proceedings, the entry of the accused into a narcotics addiction treatment and rehabilitation program.

3. The prosecutor may proceed, in the cases of those individuals who, in his judgment, should not be afforded the opportunity for treatment with deferral of the determination of the charges pending against them. with the criminal proceedings. If the accused is found guilty, the bill empowers each judicial officer of the United States to require examination and treatment of the convicted offender to determine the fact of his addiction, and if such fact is found, to require the individual to enter into treatment and rehabilitation during the term of his sentence.

The Secretary of Health, Education, and Welfare has been given responsibility in my bill for the diagnosis of narcotics addiction, for conducting the appropriate examinations required for referral to treatment, and for providing appropriate treatment facilities. By giving this responsibility to the Secretary of Health, Education, and Welfare, it is my intention to place the examination and treatment of narcotics addiction in the hands of medical professionals and to relieve the prosecuting attorney of the responsibility of determining what is appropriate treatment for an accused addict.

The bill provides that each narcotics addict held in custody in order to await trial for any offense against the laws of the United States, or any addict held in custody because of such addict's conviction of any offense against the United States, shall have the right to examination and treatment of his narcotics addiction. The bill thus sets forth clearly the right of every narcotics addict who comes in contact with the Federal criminal justice system to receive from that system an appropriate opportunity for the treatment of his addiction. By establishing this right it is my hope that the Federal criminal justice system will begin to be an effective tool for providing treatment for narcotics addiction. At the same time, however, my bill provides adequate safeguards to prevent the accused narcotics addict from manipulating the system to escape punishment for his crime.

The accused narcotics addict is given the right to treatment of his addiction, but is given no other right that is not also due to other accused individuals in the Federal criminal justice system.

Despite its failure to develop an effective diversion system in the Federal criminal justice system, the Federal Government is, in general, far ahead of State and local governments in providing for the diversion into treatment of addicts accused of crime. The great majority of addicts are accused of violating State and local laws. Except in a very few jurisdictions, however, State and local prosecutors have no choice but to process accused narcotics addicts in the same manner as all other accused criminals. They do not have the alternative of providing opportunity for treatment and rehabilitation to accused addicts because there are no treatment and rehabilitation programs available to the criminal justice system of most State and local jurisdictions.

When the addict is convicted of a crime and sentenced, he must enter the correctional system of the State, but again at this point there is generally not available an opportunity for treatment of his addiction. Although good sense as well as good medical practice dictates that an institutionalized narcotics addict receive treatment for his addiction as a part of his correctional program, at the present time almost all addicts imprisoned in this country serve their sentences without receiving any treatment for their addiction. Most states, because of a combination of lack of funds and a lack of experience, exacerbated by the large and increasing number of narcotics addicts entering their correctional systems, are unable to offer even the most minimal treatment programs for narcotics addiction in their correctional institutions.

The Law Enforcement Assistance Administration, created by the Omnibus Crime Control and Safe Streets Act of 1968, should be more effectively used as a vehicle to provide State and local governments with assistance in the creation of programs and facilities for the treatment and rehabilitation of narcotics addicts accused of crimes. My proposed bill will provide states and localities with funding for narcotics treatment and rehabilitation programs to serve addicts who are led to seek treatment because of experience with the criminal justice system.

My bill is also aimed at channeling additional Federal resources into the treatment and rehabilitation of narcotics addicts. Less than 5 percent of the estimated 560,000 narcotics addicts in the Nation are presently enrolled in federally-supported treatment programs. We need to establish as a national priority a commitment to provide treatment and rehabilitation services to every narcotics addict. At the present time throughout the country there are waiting lists of addicts who want treatment, but who cannot enter treatment programs because there is no room for them. In all of the cities my Judiciary Subcommittee has examined, as soon as multi-modality treatment programs open their doors, addicts are lining up for treatment. The New York City Health Servcies Administration, for example, reports that despite a major effort to increase the availability of places in that City's treatment programs, the number of addicts coming forth desiring treatment is outpacing the provision of treatment facilities by fifty percent.

Given the nationwide existence of waiting lists of addicts desiring entry into voluntary treatment programs, there is need for the Federal Government to provide emergency funding for expansion of treatment facilities in those localities most impacted by large numbers of untreated narcotics addicts. My bill establishes within LEAA a special emergency fund to provide local governments with direct, emergency assistance in meeting their critical narcotics addiction related problems. It authorizes the appropriation of $100,000,000 for this fund to enable a massive Federal effort akin to that which is made in the aftermath of natural disasters.

Simultaneously with the creation of the Emergency Narcotics Addiction Programs Fund, the Narcotics Addict Treatment and Rehabilitation Act of 1972 creates a requirement that states which apply for funding from the Law Enforcement Assistance Administration include in their overall plans a comprehensive State plan for the treatment of narcotics addicts in the criminal justice system and for the establishment of voluntary narcotics treatment and rehabilitation programs. One hundred million dollars in additional LEAA funding is authorized for the funding of State narcotics treatment and rehabilitation programs.

In addition to providing for the establishment of State programs, the bill sets forth a number of evaluative criteria by which the performance of such programs is to be measured. These evaluative criteria are an attempt to establish, for the first time, measurable Federal standards for assessing the performance of nar-

cotics treatment and rehabilitation programs. The present lack of such standards is a primary cause of the failure of the Federal Government to demand accountability for the millions of dollars committed to narcotics addiction treatment and rehabilitation programs. The purpose of these evaluative criteria is to provide information for governmental decisionmakers, and for the general public, on whether the treatment programs we establish are meeting their intended objectives.

In my view, the Narcotics Addict Treatment and Rehabilitation Act of 1972, which enables Federal, State, and local governments to provide treatment and rehabilitation programs and facilities for all narcotics addicts who desire treatment, and which provides the criminal justice system with programs and facilities to enable the treatment of narcotics addicts, provides for a more effective use of Federal resources than the expansion of civil commitment programs under the Narcotic Addict Rehabilitation Act of 1966.

My experience in this area convinces me that there are no simple solutions to the problem of effective treatment and rehabilitation of narcotics addicts. A treatment modality which is successful with one addict can be utterly unsuccessful with another. Motivation plays an extremely important role in determining the likelihood of successful rehabilitation of the addict, and an addict may not be sufficiently motivated towards rehabilitation until he has experienced successive failures to achieve rehabilitation.

What is clear, however, is that there is a need for increased numbers of treatment programs offering increasing varieties of treatment modalities. We must adopt a national goal of providing treatment for every drug addicted person, tailored to his individual need, and we must commit the needed Federal resources to achieve this goal.

SUMMARY OF THE NARCOTICS ADDICT TREATMENT AND REHABILITATION ACT OF 1972, SPONSORED BY CONGRESSMAN DON EDWARDS (D-CALIF.)

A BILL To amend title 18 of the United States Code to enable the Federal criminal justice system to deal more effectively with the problem of narcotics addiction and to amend the Omnibus Crime Control and Safe Streets Act of 1968 to enable the States and municipalities to deal more effectively with that problem, and for other related purposes

TITLE I

THE FEDERAL CRIMINAL JUSTICE SYSTEM AND NARCOTICS ADDICTS

Chapter 314 of title 18 of the United States Code is amended to provide the following:

Section 4251—Conditional release pending criminal proceedings

Under present Federal bail procedures (chapter 27 of title 18 of the United States Code), treatment for narcotics addiction may be required as a condition of release pending criminal prosecution. Proposed Section 4251 provides specific authority for such treatment by the Secretary of the Department of Health, Education, and Welfare.

Section 4252—Contingent deferral of prosecution pending medical examination

Authorizes Federal prosecutors to defer the initiation of prosecution of any person who is about to be charged with, or is charged with, any misdemeanor, or with any felony which does not involve the use or threat of force or violence against another person, upon the determination that the offense committed is sufficiently connected with such individual's narcotic addiction as to make it in the best interests of the individual and of society to defer the prosecution of that individual. The prosecutor refers the individual to the Secretary of Health, Education, and Welfare for examination and treatment and can continue to defer the prosecution for so long as he determines the individual to be making progress in the treatment and rehabilitation of his addiction.

Section 4253—Treatment and sentencing

Authorizes each Federal judicial officer to sentence an individual for treatment and rehabilitation of narcotics addiction, or to suspend the sentence upon condition that the offender enter into treatment.

Requires inclusion in the pre-sentencing report of information necessary for the determination of sentence under this section.

The Secretary of Health, Education, and Welfare is given the responsibility to provide the necessary examination and treatment of addicts sentenced under this section.

Section 4254—Referral for examinations and treatment

Gives the Secretary of Health, Education, and Welfare the responsibility to provide, either directly or by contract with other agencies or persons, examinations and treatment designed to determine whether an individual is an addict and to treat addicts upon such determination.

Section 4255—Rights of addicts to examination and treatment

Provides each addict held in custody to await trial on any Federal offense, or in custody because of conviction of any Federal offense, with the right to examination and treatment related to his narcotics addiction.

Section 4256—Examination and treatment not conviction; use of information

Referral to examination or treatment is not to be construed as a criminal conviction. None of the information derived from the addict during examination or treatment is to be used against him in any criminal proceeding or investigation.

Section 4257—Definitions

The terms "addict" and "treatment" are defined. Both terms retain the definitions given in the present Narcotic Addict Rehabilitation Act.

TITLE II

THE CRIMINAL JUSTICE SYSTEMS OF THE STATE AND MUNICIPALITIES AS THEY RELATE TO NARCOTICS ADDICTS

The Omnibus Crime Control and Safe Streets Act of 1968 is amended by adding the following new part:

Part F—Emergency narcotic addiction programs

Authorizes the provision of special emergency funding for any unit of general local government when the Attorney General of the United States determines, upon application by the local government unit, that the rate of narcotic-related crime in the local jurisdiction has reached emergency proportions. When the Attorney General makes that judgment, such determination, and the reasons supporting it, are transmitted by the Attorney General to the Congress.

Upon the determination of an emergency narcotics crime-related condition, funds are provided for the establishment of a broad range of programs for the treatment of addicts with the goal of making treatment available for every addict in the affected jurisdiction. All programs established under the emergency funding must provide adequate evaluation procedures based on eight criteria. All new programs must be certified to be in addition to existing narcotics treatment programs in the local jurisdiction.

The President is authorized to make available the full resources of the Federal Government to assist the local jurisdiction in meeting its narcotics emergency.

One hundred million dollars are authorized for the fiscal year ending June 30, 1973 for emergency funding purposes.

Amendment of comprehensive requirements in State plans

A new Paragraph 13 is added to the 12 existing requirements for State plans submitted in support of Law Enforcement Assistance Administration funding. Paragraph 13 requires that each State, in order to qualify for LEAA funding, demonstrate the existence of a broad spectrum of effective facilities and programs for the treatment and rehabilitation of narcotics addicts in the State criminal justice system, and the availability and existence of voluntary treatment programs to every addict in the State who desires treatment.

One hundred million dollars are authorized for the fiscal year ending June 30, 1973 for the funding of State narcotics addict treatment and rehabilitation programs through the Law Enforcement Assistance Administration.

REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

Narcotic Addiction Treatment And Rehabilitation Programs In Washington, D. C. B-166217

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

APRIL 20, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-166217

Dear Mr. Chairman:

In accordance with your October 15, 1971, request, the General Accounting Office has obtained information on narcotic addiction treatment and rehabilitation programs in Washington, D.C. This is the first in a series of five reports to be issued pursuant to your request. Other reports will cover the cities of New York, N.Y.; Chicago, Illinois; and San Francisco and Los Angeles, California.

We have discussed the contents of this report with the Administrator of the District's Narcotics Treatment Administration and his staff. Their comments have been incorporated into the report.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Don Edwards
Chairman, Subcommittee No. 4
Committee on the Judiciary
House of Representatives

82-401 O - 72 - 3

Contents

ABBREVIATIONS

BDC	Blackman's Development Center
CATC	Community Addiction Treatment Center
DAMS	Drug Addiction Medical Service
GAO	General Accounting Office
NARC	Narcotic Addict Rehabilitation Corps
NTC-RTC	Neighborhood Treatment Center - Residential Treatment Center
NTA	Narcotics Treatment Administration
SENAB	Southeast Neighborhood Action Board

COMPTROLLER GENERAL'S
REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

NARCOTIC ADDICTION TREATMENT
AND REHABILITATION PROGRAMS
IN WASHINGTON, D.C. B-166217

D I G E S T

WHY THE REVIEW WAS MADE

This is the first of five reports requested by the Chairman of the Subcommittee on programs for treatment and rehabilitation of narcotic addicts. This report concerns programs in Washington, D.C. Other reports will cover programs in New York, N.Y.; Chicago, Illinois; and San Francisco and Los Angeles, California.

The General Accounting Office (GAO) was asked to obtain for each city data on

--the amount of money spent by governmental agencies on narcotic treatment and rehabilitation programs,

--numbers of addicts being treated under various types of treatment,

--goals of the programs,

--criteria to measure accomplishments of the programs, and

--efforts by sponsors to measure the effectiveness of programs.

GAO was not asked to evaluate program performance.

The Subcommittee is concerned that, in developing legislation for narcotic treatment and rehabilitation programs, adequate provision be made for assessment of the programs so that the Congress and the executive agencies will have a basis on which to take action to improve the programs.

FINDINGS AND CONCLUSIONS

The number of narcotic addicts in the District of Columbia has been estimated at 20,000. The number of narcotic addicts is difficult to determine for any area because there is no accepted definition of the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as an addict unless he is arrested or enrolls in a treatment program.

The Narcotics Treatment Administration (NTA) carries out most of the addiction treatment programs in the District of Columbia. The agency was organized in February 1970 as a part of the D.C. Government to lead and

coordinate a comprehensive community effort against the problem of heroin addiction. NTA provides services through 12 treatment centers it operates and through four centers operated by contracts with private organizations. Since February 1970, NTA has received Federal support totaling about $12.3 million. (See p. 15.)

NTA has set four primary goals in treating and rehabilitating addicts.

--Assist the addict in finding productive employment or job training.
--Stop illegal drug use.
--Eliminate criminal behavior.
--Keep the addict under treatment.

NTA has initiated several studies to determine how well its programs are achieving these goals. NTA periodically collects data on employment status, urinalyses, arrest records, and duration of treatment for each patient in the studies. This data is summarized and evaluated at 6-month intervals.

Results of the study after 18 months showed:

--For 450 adult patients, that 84 (19 percent) met all program treatment goals and that 124 additional patients (27 percent) had been in treatment for 18 months but had failed to meet one or more of the program goals. Employment posed the largest problem. (See p. 22.)

--For 150 youth patients, that two (1 percent) met all program treatment goals and that 18 additional youths (12 percent) remained in treatment but failed to meet one or more of the other program goals. (See p. 24.)

NTA research studies are discussed in detail on page 21.

NTA also has conducted studies of the results being achieved by its contractors. (See p. 26.)

NTA's data collection system is being expanded to include a number of new reports summarizing data for all patients at a treatment center and for all NTA patients. GAO believes that the data in these reports should provide a means for continually assessing program results.

To obtain additional information on the results of NTA's drug treatment programs, GAO analyzed reported information for selected groups of NTA patients. (See pp. 29 and 31.)

GAO visited all the treatment centers operated by NTA and its contractors to obtain information on problems and needs of the centers and ways to improve the drug treatment program. According to program administrators, counselors, and patients, NTA needs include:

--Additional and better trained staff members to provide more effective services to patients.

--Additional supportive services, such as job placement, training, and recreation, for patients.

--Better physical facilities. (See ch. 4.)

AGENCY COMMENTS

The Administrator of NTA told GAO that, during NTA's 1st year of operation, emphasis was placed on growth and that as many patients as possible were enrolled in treatment programs. During its 2d year, NTA's growth rate was lower and its efforts were concentrated on broadening services to its patients and restructuring many treatment centers.

In the 1st year most treatment centers offered all types of treatment. During the 2d year many centers began to specialize in one type of treatment--abstinence, methadone maintenance, or detoxification.

Currently, according to the Administrator, NTA is becoming increasingly concerned about the total human needs of each patient. NTA attempts to meet as many of the patient's needs as possible at the treatment centers. When NTA cannot provide services, it acts as a "broker" to arrange for services to be provided by other agencies. The Administrator has stated that NTA never should expect to meet all the needs of its patients because to do so would involve duplicating many social service functions provided by other governmental agencies.

Presently most of NTA's counselors are ex-addicts. The Administrator acknowledged that more and better trained counselors were needed. He advised GAO that ex-addict counselors usually were effective but indicated that many of them resisted training which would increase their effectiveness. He stated that NTA needed to work on this problem and to hire more professionals as counselors.

CHAPTER 1

INTRODUCTION

Our Nation today is faced with a serious narcotic addiction problem. The President, in his January 20, 1972, state of the Union message, remarked that:

> "A problem of modern life which is of deepest concern to most Americans--and of particular anguish to many--is that of drug abuse. For increasing dependence on drugs will surely sap our Nation's strength and destroy our Nation's character."

In a June 17, 1971, message to the Congress, the President described the nature of the drug problem, as follows:

> "Narcotic addiction is a major contributor to crime. The cost of supplying a narcotic habit can run from $30 a day to $100 a day. This is $210 to $700 a week, or $10,000 a year to over $36,000 a year. Untreated narcotic addicts do not ordinarily hold jobs. Instead, they often turn to shoplifting, mugging, burglary, armed robbery, and so on. They also support themselves by starting other people--young people--on drugs. The financial costs of addiction are more than $2 billion every year, but these costs can at least be measured. The human costs cannot. American society should not be required to bear either cost."

Throughout the Nation questions are being asked concerning the most effective way to deal with this problem. Standards setting forth the results expected from treatment and rehabilitation programs are vague, and frequently there are no standards. Results of various methods of treatment are debated by experts. Data on the number of addicts in the Nation is based on educated guesses, at best. Data on people in treatment throughout the country generally is lacking as is data on program costs and results achieved.

Because of the seriousness of the narcotic addiction problem and the need for information to arrive at rational decisions, the Chairman, Subcommittee No. 4 of the House Committee on the Judiciary, requested GAO to assist the Congress in obtaining information on the progress being made in the rehabilitation of narcotic addicts. The Subcommittee Chairman asked that GAO's review include programs receiving Federal, State, or local funds in five cities--Washington, New York, Chicago, Los Angeles, and San Francisco--and that individual reports be prepared for each.

GAO was asked to obtain for each city data on the amount of money being spent by Federal, State, and local agencies on narcotic rehabilitation programs and the extent of program assessment efforts being made by the funding agencies. GAO was not asked to evaluate program performance.

The Subcommittee is concerned that, in developing legislation related to the treatment and rehabilitation of narcotic addicts, adequate provision be made for program assessment efforts so that the Congress and the executive agencies will have a basis for taking action to improve the programs.

This report is concerned with treatment and rehabilitation programs for narcotic addicts in the District of Columbia funded by the D.C. Government; the Department of Health, Education, and Welfare; the Department of Justice; the Office of Economic Opportunity; and the Veterans Administration. Locations of treatment centers are shown on the map in appendix IV. Treatment agencies not receiving Government funds were not included in our review.

In February 1972 there were nearly 3,800 narcotic addicts receiving treatment in programs supported with Federal or D.C. funds. The amount of funds provided for these programs by the Federal or the D.C. Government was about $5.9 million for fiscal year 1971. About $4.7 million of these funds were available for programs administered by NTA.

According to NTA there were approximately 20,000 narcotic addicts in the District of Columbia as of

September 30, 1971. NTA officials admit, however, that they cannot attest to the reliability of the estimate because it is based, in part, on an estimating technique developed in New York City which may have no applicability or validity in the District, and, in part, on several other techniques which rely on a number of unproven assumptions and relationships.

The task of determining with any degree of reliability the number of narcotic addicts in the District, or in any other area, is made extremely difficult because there is no commonly accepted definition for the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as a narcotic addict unless he is arrested or enrolls in a treatment program. The methods used by NTA to estimate the number of narcotic addicts in the city and certain other indicators which provide some insight into the size of the District's addiction problem are discussed in appendix III.

An estimate of the annual cost of heroin addiction in the District is provided by a November 1970 report entitled "The Economics of Drug Addiction and Control in Washington, D.C.," prepared by the District's Department of Corrections through its Office of Planning and Research. The report estimated that the annual cost of heroin addiction in the District might exceed $200 million. This represents an estimated outlay of (1) $175 million for the illegal acquisition of heroin by addicts, (2) $8 million for police and court costs, (3) $9 million for jail and parole expenses, and (4) $13 million in earnings lost to those addicted to heroin.

The $175 million estimate was based on the assumption that there were 15,000 addicts in the District and that the cost of an average heroin habit in the District at that time was about $40 a day. The daily cost of an average heroin habit was based on information obtained by NTA from residents of the District's jail during a study conducted in August and September 1969.

The report states that addicts finance their habits through a combination of means which include (1) "pushing" or selling drugs, (2) prostitution, (3) obtaining funds from family or relatives, (4) working in legitimate, though

low-wage, occupations, especially in the early stages of addiction, and (5) burglary, larceny, and robbery.

The Department's report states that, to estimate the amount of property and money that heroin addicts must steal to support their habits, several assumptions must be made as to how addicts obtain heroin and as to the sources of funds available to heroin addicts. These assumptions, according to the report, are based on discussions with program officials and not on the empirical research which is essential for reaching valid conclusions.

It was assumed in the report that 20 percent of all heroin consumed by the addict population is obtained by pushing. The report points out that this does not mean that 20 percent of all addicts are pushers but that 20 percent of the heroin used by addicts is obtained for services rendered in the distribution system.

The report has assumed, concerning the funds required for heroin purchases, that:

1. 60 percent are obtained through burglary, robbery, and larceny.

2. 15 percent are obtained through legitimate sources.

3. 15 percent are obtained through prostitution.

4. 10 percent are obtained through other illegal activity, such as forgery, auto theft, and confidence games.

It was assumed also that, of the amount gained by theft, 20 percent would be stolen money and 80 percent would be stolen property that could be converted to money for approximately one third of the property's value.

On the basis of these assumptions, the November 1970 report showed that, to obtain the $175 million needed annually by 15,000 addicts to support their habits, the addicts would steal cash and property valued at $273 million and would obtain $22 million through other illegal activities, such as forgery, auto theft, and confidence games; $33 million through legal activity; and $33 million through prostitution.

CHAPTER 2

NARCOTICS TREATMENT ADMINISTRATION

NTA was established within the Department of Human Resources, District of Columbia, in February 1970 to lead and coordinate a comprehensive community effort to cope with the problem of heroin addiction in the District. The Administrator of NTA informed us that, during NTA's 1st year of operation, primary emphasis was placed on enrolling as many patients as possible and that a variety of treatment modalities was offered at all treatment centers. During NTA's 2d year of operation, the rate at which new patients were added slowed down and NTA began to expand its services from a medically oriented mode of operation to a more comprehensive approach designed to meet patients' total needs (i.e., treatment, education and job placement, etc.). As part of this broadening process, NTA adopted the concept of specialized centers which offered one primary modality of treatment.

NTA's stated objectives are to provide comprehensive and effective treatment for all addicts in the District, to carry out research to increase the understanding of heroin addiction, and to advance a major educational and preventive program aimed at reducing the recruitment of new heroin addicts. Our review considered only the treatment programs of NTA, not its research and education programs.

As requested by the Chairman of the Subcommittee, we obtained the following information on NTA's treatment and rehabilitation programs.

--Program goals.
--Treatment modalities.
--Patients in treatment and services available.
--Source of funding.
--Treatment cost of various modalities.
--Criteria used to select patients for treatment.
--Program assessment efforts.
--Program results.

PROGRAM GOALS

NTA has four primary goals for all patients.

--Productive and self-fulfilling social functioning in a job or training program.

--Cessation of illegal drug use.

--Elimination of criminal activity.

--Retention in treatment.

TREATMENT MODALITIES

NTA operates 12 treatment centers throughout the city, including inpatient and outpatient centers and a surveillance unit for persons who must demonstrate that they can remain drug free as a condition of their probation or parole. In addition, NTA has contracts with community-based private agencies to provide services for heroin addicts at four other centers. Two of the 16 centers provide both inpatient and outpatient services, two provide only inpatient services, and the other 12 are outpatient centers. Most of the centers offer one predominant modality of treatment in keeping with NTA's present operating concept of specialized clinics.

NTA's program design makes extensive use of methadone treatment. Methadone is an addictive synthetic narcotic which shares many pharmacologic properties with morphine, heroin, and other opiate drugs. Methadone, when used to treat chronic heroin addiction, has several unique properties. A single dose, taken orally, suppresses withdrawal symptoms in a heroin-dependent person for 24 to 36 hours. If given in large enough doses, it also blocks the euphoric effects of heroin. Additionally, methadone-addicted persons, unlike heroin addicts, do not continually need increasingly larger quantities to prevent withdrawal effects, once their daily doses are in the range of 40 to 80 milligrams of methadone a day.

General categories of treatment, as defined by NTA, are:

--Abstinence--for patients attempting a drug-free life but needing the support of counseling and urine monitoring.

--Methadone detoxification--for patients desiring to withdraw from physical addiction with minimal discomfort. Decreasing dosages of methadone are given on an inpatient or outpatient basis. Methadone detoxification periods are scheduled to range from 2 weeks to 6 months but may be extended beyond 6 months, depending on patient needs.

--Methadone maintenance--for eligible candidates usually at least 18 years old with a minimal 2-year history of heroin addiction who voluntarily consent to treatment. Daily stabilization doses of methadone which satisfy the craving for heroin and block its effects are given over a prolonged period of time.

--Methadone hold--for immediate treatment, with methadone, of walk-in patients prior to determination within no more than 2 weeks of the most appropriate treatment regimen after complete examination, diagnosis, and consultation.

--Urine surveillance--for patients referred for drug use evaluation or needing to demonstrate that they can remain drug free for a specified period of time, i.e., awaiting court action or validation of a motor vehicle license.

NTA's methadone maintenance clinics are designated as induction or stabilization clinics. There is only one induction clinic. This clinic serves new methadone maintenance patients who require from 4 to 6 weeks to become stabilized on blocking doses of methadone. The induction clinic operates 7 days a week because new patients must take their methadone at the clinic and do not have take-home privileges. Once stabilized, the patient is transferred to a stabilization clinic where there is less contact with the clinic and the patient is allowed weekend take-home privileges for methadone. Stabilization clinics operate on a 5-day week. As treatment progresses and the patient becomes more advanced in the program, secures a steady job, uses no illegal drugs, and generally fits into society as a functional citizen, he may take home as much as a 3-day supply of methadone.

PATIENTS IN TREATMENT AND SERVICES AVAILABLE

Any resident of the District of Columbia who is found to be a narcotic addict is admitted by NTA for treatment. In addition, we were advised by NTA that there is no waiting list for treatment. Briefly during the spring and summer of 1970, intake proceedings had to be stopped because facilities were full. As soon as this situation was remedied, people were again admitted to treatment on a first-come-first-served basis.

Within the first 2 years of its operation, the number of patients enrolled in NTA treatment programs grew considerably. In February 1970 NTA had 153 patients in treatment. The following table shows the treatment modality for all 3,506 reportable patients at NTA or contractor centers as of February 4, 1972.

NTA and Contractor Patient Count
As of February 4, 1972

	Type	Total patients	Modality: Abstinence	Maintenance	Detoxification	Hold
NTA centers						
Community Addiction Treatment Center	Outpatient	417	12	403	2	-
Criminal Justice Surveillance Unit	"	214	211	-	-	3
Drug Addiction Medical Service Clinic	"	542	0	509	32	2
Drug Addiction Medical Service--inpatient	Inpatient	58	29	16	11	2
Emerge House	"	27	18	3	6	-
Detoxification-Abstinence Clinic	Outpatient	319	28	3	287	1
Far East Addiction Treatment Service	"	356	16	270	80	-
G Street Clinic	"	298	-	295	3	-
Model Cities Addiction Treatment Program	"	345	-	342	3	-
Narcotic Addict Rehabilitation Corps	Inpatient and outpatient	70	58	11	-	1
Narcotic Addict Rehabilitation Corps Clinic	Outpatient	246	2	243	1	-
Youth Center	"	251	33	55	155	8
Total		3,163	416	2,150	580	17
Contractor centers:						
Neighborhood Treatment Center	Outpatient	99	86	1	12	-
Southeast Neighborhood Action Board--adult	"	134	4	105	16	9
Southeast Neighborhood Action Board--youth	"	31	31	-	-	-
Bonabond Step-one	Inpatient and outpatient	79	79	-	-	-
Total		343	200	106	28	9
Total NTA and contractor centers		3,506	616	2,256	608	26
Percentage of total patients in treatment		100%	18%	65%	16%	1%

Services available at centers differ, depending on such factors as staffing, patient case load, physical limitations of the facility, and the needs of the patients.

All centers offer individual counseling and utilize urine testing to determine illegal drug use. Observed urine specimens are usually taken two times a week.

Most centers also offer some supportive services such as job placement, education and training assistance, health services, housing assistance, financial aid, and assistance in obtaining furniture and clothing. The extent to which such services are provided depends on the availability of staff. We noted that some centers have individual staff members who specialize in job placement or education and training, but most often all of these functions must be performed by the counseling staff in addition to their regular duties. In addition, centers are required to perform an outreach function to seek out patients who have dropped out of the program and to persuade them to return to treatment. The extent to which the outreach function is performed depends on staff availability.

Services available at each of the NTA and contractor centers are more fully discussed in appendix II.

SOURCE OF FUNDING

Since its organization in February 1970, NTA has received the following financial support.

	Total	Fiscal year 1970	1971	1972
District of Columbia appropriation:				
Directly to NTA	$ 4,914,200	$354,000	$2,690,200	$1,870,000
Indirectly through the Department of Corrections	1,386,500	240,400	417,300	728,800
Total appropriated	$ 6,300,700	$594,400	$3,107,500	$2,598,800
Federal grants:				
Office of Economic Opportunity	678,300			
Department of Housing and Urban Development	215,200			
National Institute of Mental Health	923,800			
Law Enforcement Assistance Administration	4,217,300			
Total grants	6,034,000			
Grand total	12,334,700			

TREATMENT COST OF VARIOUS MODALITIES

We were unable to obtain actual per patient cost data for the various treatment modalities because NTA does not accumulate costs on a treatment-center basis. We asked NTA officials to provide us with estimated per patient costs for the various methods of treatment. Since many of the treatment centers operated by NTA offer a combination of treatment methods and services, it was necessary for NTA to develop models for typical treatment centers. NTA chose to develop models for a methadone maintenance center, a detoxification-abstinence center, and a halfway house.

The methadone maintenance and detoxification-abstinence models provided for average staffing patterns, average salary and benefit payments, and estimates of such other operating expenses as travel, equipment, rent, supplies, methadone, and urinalysis. The models also considered the estimated cost of administrative overhead for Department of Human Resources personnel.

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The model for the halfway house consisted of a typical operating budget for the residential center at 456 C Street, Northwest, which is a halfway house for patients referred by the criminal justice system. Estimates were included in the budget for NTA centralized treatment support and for Department of Human Resources overhead.

NTA estimated average annual per patient costs, as follows:

Treatment method	Total	Annual per patient costs			
		Direct	Treatment support	NTA administrative direction	Dept. of Human Resources overhead
Outpatient methadone maintenance	$1,001	$ 655	$150	$110	$ 86
Outpatient detoxification-abstinence	2,032	1,308	300	220	208
Residential Halfway house	6,225	4,096	938	688	503

It should be noted that the operating costs of the halfway house may be higher than the operating costs of halfway houses in other programs around the country because the patients being treated in the NTA model are parolees from criminal institutions over whom NTA has been assigned custody. More staff is required to maintain custody over these people than is required at halfway houses where patients are admitted voluntarily and are free to leave at any time.

The Administrator of NTA suggested that it would be meaningful to compare the cost of treating addicts with the cost to society of not treating them. As indicated on page 8, the Department of Corrections estimated that annually 15,000 addicts steal cash and property valued at $273 million and obtain another $22 million through such other illegal activities as forgery, auto thefts, and confidence games. This amounts to an approximate $20,000 annual loss to society caused by each addict's criminal activities.

A comparison of the estimated loss to the cost of treating an addict, assuming that the cost estimates are valid and the addict's criminal activities are reduced during treatment, would suggest that the cost of treatment is well worthwhile. We cannot endorse such a conclusion, however,

because we did not verify the validity of the estimated cost of treatment or the estimated cost to society from untreated heroin addiction and because we did not obtain complete information on the extent of addicts' criminal activities before and after entry into treatment.

CRITERIA USED TO SELECT PATIENTS FOR TREATMENT

Any resident of the District of Columbia is eligible for treatment by NTA. All applicants for treatment by NTA, whether voluntary or court-recommended, are examined and processed at one central intake facility. Basically, this central facility consists of a medical section and a counseling-intake section. The facility's operations are funded through a grant from the Law Enforcement Assistance Administration of the Department of Justice.

The medical section is responsible for performing a physical examination, which includes blood studies, urinalysis, X-rays, and electrocardiograms, and for obtaining a medical history of each applicant.

The counseling-intake section, in addition to confirming an applicant's age, identification, and referral source, is responsible for counseling and assisting each applicant. Counselors ensure that each person becomes familiar with the program and understands the services available from NTA, including the role of methadone in the control of drug abuse.

Each new applicant is extensively interviewed by a counselor who obtains and records information on employment, educational, military, criminal, and social histories. An extensive drug-abuse history, including a medical opinion as to the extent of drug abuse, is also completed for each applicant. A decision as to the appropriate treatment modality is made jointly by the counselor and the patient. Physicians are available for consultation in this process. After the treatment modality is agreed on (methadone maintenance, methadone detoxification, or abstinence), the patient is sent to the appropriate NTA treatment center. A summarization of important social and medical needs of the patient is sent to the treatment center by the intake unit.

At the treatment center the patient is assigned a permanent counselor and the specific treatment needs, including the dosage level of methadone for the patient, are determined. The treatment recommendations made by the intake unit do not have to be followed if center personnel have reason to believe that they are not appropriate.

PROGRAM ASSESSMENT EFFORTS

In its 2 years of operation, NTA's program assessment efforts have consisted primarily of follow-up studies for selected patients in four of its treatment programs and at four contractor treatment centers. Data on retention in treatment, arrests, employment, and illegal drug use for the patients is collected and compared with NTA's four primary goals of treatment.

Data utilized to measure the progress of NTA programs is obtained primarily from four different sources--the central intake unit, the individual treatment centers, the urine-testing laboratories, and the Department of Corrections. Much of this data is entered into a centralized computer file system which allows the preparation of reports concerning the effectiveness of treatment methods. At the time of our review, a number of new reports were being prepared which should provide NTA officials with a means for continually assessing the effectiveness of their programs. The NTA data collection systems and the reports being generated by the system are discussed in chapter 3.

In May 1970, 3 months after NTA began operations, its Bureau of Research initiated a study aimed at providing information to enable it to evaluate the results of its treatment programs on 600 randomly selected patients. The patients selected were from the Community Addiction Treatment Center (CATC), the Drug Addiction Medical Service (DAMS) outpatient clinic, the Narcotic Addiction Rehabilitation Corps (NARC) residential halfway house, and the Youth Center--the only centers operated by NTA at that time. For each program 150 patients were selected from those people on the program rolls in May 1970. According to NTA, a total of 1,060 heroin addicts were in treatment on May 15, 1970.

Since May 1970, NTA has been collecting data for the 450 adult patients and 150 youths, by which to measure such factors as retention in treatment, the number of times each patient has been arrested, the extent to which the patients are employed or in a training program, and the extent to which each patient is continuing to engage in illegal drug use. Statistical summaries of program results for this study group have been prepared by NTA at 6 month intervals--

the latest being November 15, 1971. Also, a more comprehensive analysis was prepared to show data for patients as of May 15, 1971--1 year after initiation of the study.

In addition, a new study was initiated in January 1971 of 379 patients at the same four centers. The objectives of this study are to measure the same factors discussed above. We were also advised that NTA's Bureau of Research was making a comparative study of the effects of treatment on patients who entered NTA treatment programs voluntarily as opposed to those who entered via the criminal justice system. NTA estimates that this study will be completed around April 1972. In addition, NTA has collected data on the results being achieved by four of its contractors.

PROGRAM RESULTS

Program results as shown by NTA's assessment efforts are discussed below. Patients in youth programs were primarily in methadone detoxification treatment while those in the adult programs were primarily methadone maintenance patients. NTA stated that its youth programs differ significantly from its adult programs and that the two should be considered separately.

We have not drawn any conclusions from the information summarized below because NTA has not established standards as to what constitutes acceptable program results. We did not verify the results reported by NTA.

Results achieved by NTA adult programs

As of May 15, 1971, 12 months after the start of the study, NTA found that, of the 450 patients:

--232 (52 percent) were still in NTA treatment programs;

--104 (23 percent) were arrested sometime during the 1-year period;

--109 (24 percent) of the original group were employed or in training, either full- or part-time;

--160 of the 232 patients who remained in treatment had their urinalysis results studied during the 12th month of the study: 72 (45 percent) tested positive for illegal drug use during the month--five (3 percent) tested positive every time and 67 (42 percent) tested positive some of the time--and 88 (55 percent) tested negative every time.

A summary analysis of the 12-month study showed that, overall, 105 (24 percent) of the 450 adult patients were retained in treatment for 1 year and met all program goals. An additional 127 (28 percent) were retained 1 year but did not meet one or more of the program goals.

NTA found that those patients who had elected to be placed on methadone maintenance were more likely to remain in treatment and satisfy all program goals than were those in detoxification or abstinence programs. Moreover, NTA stated that those patients on high doses of methadone (60 milligrams or more) were more likely to remain in treatment than patients on low-dose methadone.

As of November 15, 1971, 18 months after the start of the study, NTA found that, of the 450 adult patients:

--208 (46 percent) were still in NTA treatment programs;

--126 (28 percent) had been arrested sometime during the 18-month follow-up period;

--76 (17 percent) of the original group were still in treatment and were employed or in a training program;

--109 of the 208 patients who remained in treatment had their urinalysis results studied during the period October 24 to November 21, 1971: 34 (31 percent) tested positive for illegal drug use during the 1-month period--seven (6 percent) tested positive every time and 27 (25 percent) tested positive some of the time--and 75 (69 percent) tested negative every time.

NTA's summarization of the results of the 18-month study showed that 84 (19 percent) of the 450 adult patients studied met NTA's program goals of (1) retention in treatment, (2) employment or training, (3) arrest free, and (4) cessation of illegal drug use, either completely or on a regular basis. An additional 124 adult patients (27 percent) had been retained in treatment for 18 months but had not satisfied one or more of the other NTA program goals.

According to NTA, employment posed the largest problem in the rehabilitation process. Of the 450 patients, 137 (30 percent) were retained in treatment, were arrest free, and were not using illegal drugs, except on a sporadic basis, but were not employed at the time the study was made. The summarization noted also that, after 18 months, it was

likely that at least some of the dropouts represented patients who had completed treatment and were living productive lives in the community.

A graph illustrating the results of the first research study for each of the adult and youth programs after 18 months is shown on page 27.

With respect to NTA's second research study involving 272 adult patients in the same three treatment programs discussed above, its Bureau of Research found after the first 6 months that, of the 272 patients:

--131 (48 percent) were still in NTA treatment programs;

--36 (14 percent) had been arrested sometime during the 6-month follow-up period;

--49 (18 percent) of the original group were still in treatment and were employed or in a training program;

--112 of the 131 patients who remained in treatment had their urinalysis results studied during the last 4 weeks of the 6-month period: 71 (64 percent) tested positive for illegal drug use during the 4-week period--13 (12 percent) tested positive every time and 58 (52 percent) tested positive some of the time--and 41 (36 percent) tested negative every time.

Results achieved by NTA youth programs

As of May 15, 1971, 12 months after the start of the study of the youth programs, i.e., those for patients under 20, NTA found that, of the 150 youths:

--24 (16 percent) were still in NTA treatment programs;

--81 (54 percent) were arrested sometime during the 12-month period;

--13 (9 percent) were still in a treatment program and were employed or in a training or educational program;

--23 of the 24 youths who remained in treatment had their urinalysis results studied during the period April 11 to May 8, 1971: six (26 percent) tested positive for illegal drug use during the 1-month period--one youth (4 percent) tested positive every time and five (22 percent) tested positive some of the time--and 17 (74 percent) tested negative every time.

As of November 15, 1971, 18 months after the start of the study, NTA found that, of the 150 youths:

--27 (18[1] percent) had remained in NTA treatment programs;

--92 (61 percent) were arrested at sometime during the 18-month period;

--11 (7 percent) were still in a treatment program and were employed or in a training program;

--21 of the 27 youths who remained in treatment had their urinalysis results studied during the period October 24 to November 21, 1971: 11 (53 percent) tested positive for illegal drug use during the 1-month period--six youths (29 percent) tested positive every time and five youths (24 percent) tested positive some of the time--and 10 (47 percent) tested negative every time.

The Bureau of Research reported that, after 18 months, only two (1 percent) of the 150 youths included in the study group had remained in treatment for 18 months, were employed, were arrest-free, and were either not using any illegal drugs at all or were not using illegal drugs on a regular basis. An additional 18 youths (12 percent) remained in treatment but failed to satisfy one or more of the other program goals.

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[1]The percentage of patients retained after 18 months is higher than the percentage retained after 12 months because it includes three patients who dropped from the treatment program and subsequently returned.

A comparison of the results of the first youth program study with the first adult program study is shown by the graphs on page 27.

With respect to NTA's second research study involving 107 patients in treatment in the youth program, its Bureau of Research found after the first six months of treatment that, of the 107 youths:

--45 (42 percent) were still in NTA treatment programs;

--27 (25 percent) had been arrested sometime during the 6-month follow-up period;

--19 (18 percent) of the original group were still in treatment and were employed or in a training program;

--35 of the 45 patients who remained in treatment had their urinalysis results studied during the last 4 weeks of the 6-month period: 21 (60 percent) tested positive for illegal drug use during the 4-week period--two (6 percent) tested positive every time and 19 (54 percent) tested positive some of the time--and 14 (40 percent) tested negative every time.

Results achieved by NTA contractors

To evaluate the effectiveness of its contract programs, NTA made a study of 302 addicts being served by four contractors. The number of patients selected for the study entered treatment programs at the following facilities during the period September 15, 1970, through January 14, 1971.

Southeast Neighborhood Action Board (SENAB)	88
Bonabond, Step-one	81
Blackman's Development Center (BDC) (note a)	81
Neighborhood Treatment Center (NTC) and Residential Treatment Center (RTC) (note b)	52
Total	302

[a]At the time of our review, BDC was no longer an NTA contractor.

[b]Both NTC and RTC are located in the same building. Although RTC has never been an NTA contractor, it was included in the study because of its proximity to NTC.

Some of the findings disclosed by this study are illustrated graphically on page 28. In summary, the study showed that, after 6 months

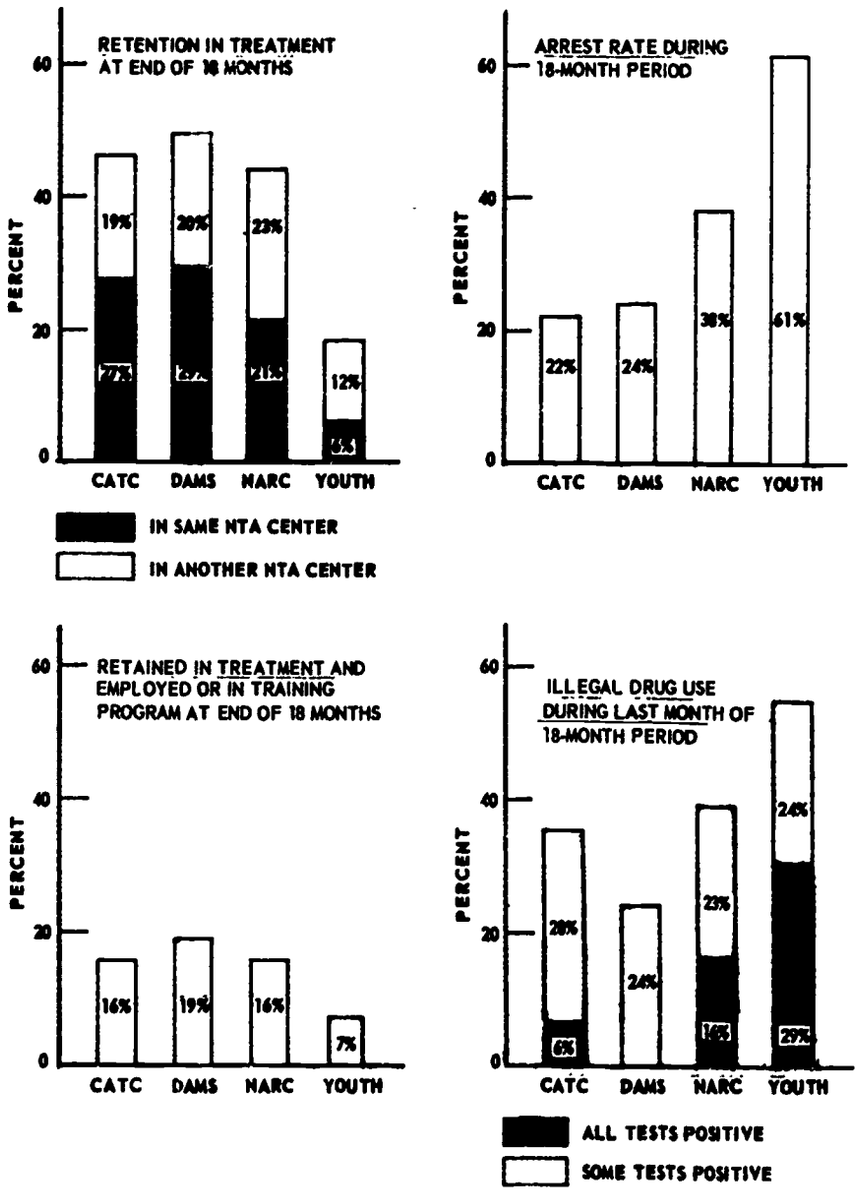
--each of the four contractors had 52 percent or less of the original group still in treatment;

--23 percent, or less, of each of the original groups were employed or in training programs, on either a full- or part-time basis;

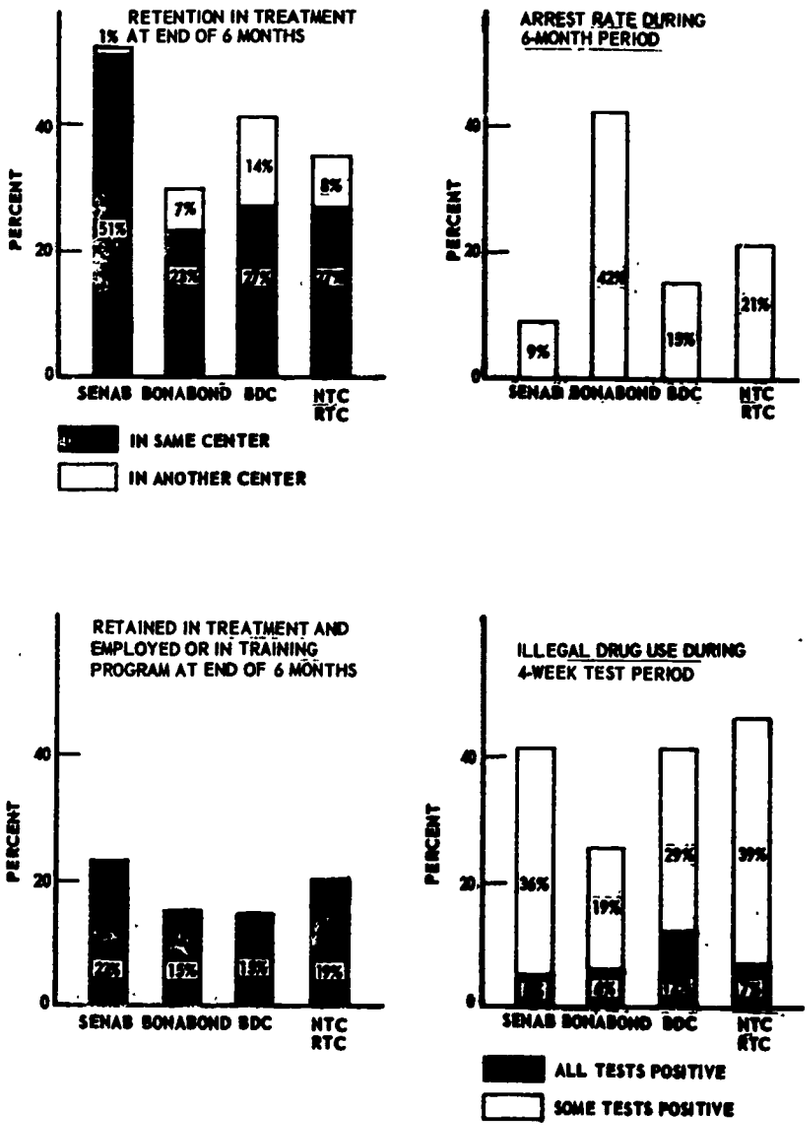
--for each of the four contractors, 9 to 42 percent of the original group had been arrested during the 6-month period; and

--for each of the four contractors, 25 to 46 percent of those tested during a 4-week period showed some indication of illegal drug use.

SUMMARY OF 18 - MONTH FOLLOW - UP STUDY OF NTA PATIENTS



SUMMARY OF 6 - MONTH FOLLOW - UP STUDY OF CONTRACTOR PATIENTS



CHAPTER 3

ADDITIONAL INFORMATION ON NTA PROGRAM RESULTS AND NTA DATA COLLECTION SYSTEM

To obtain additional information on the results of NTA's drug treatment programs, we analyzed reported information for selected groups of patients at two NTA treatment centers--the Youth Center and the Community Addiction Treatment Center. In addition, we considered the adequacy of NTA's data collection system to provide information for program assessment purposes.

PROGRAM RESULTS AT THE YOUTH CENTER

To obtain an indication of program retention rates and illegal drug use, we selected for study a group consisting of the entire case load of patients--293 youths--receiving treatment at the Youth Center as of April 11, 1971. At that time about 63 percent of the youths were methadone detoxification patients.

The month of April was selected because this was the first month that urinalysis data was available on the patient monthly record printouts from the NTA central computer file system. For the period April through November 1971, we examined the monthly printouts to determine the number of the 293 patients who dropped out of NTA treatment programs and the number who used illegal drugs while in treatment, as shown by urinalyses. We did not analyze data for new patients entering treatment after April 11, 1971.

Our analysis showed that, during the 8-month period, 169 patients, or 55 percent of the test group, dropped out of NTA treatment programs. Our analysis showed also that a relatively consistent percentage of patients continued to show signs of illegal drug use each month, as illustrated by the schedule on page 30.

Month	Test group patients remaining in program	Patients using illegal drugs once		Patients using illegal drugs twice		Patients using illegal drugs three or more times	
		Number	Percent	Number	Percent	Number	Percent
April	278	79	28	22	8	59	21
May	203	44	22	23	11	37	18
June	186	45	24	28	15	39	21
July	158	35	22	17	11	20	13
August	149	35	24	12	8	25	17
September	145	46	32	17	12	25	17
October	129	32	25	12	9	21	17
November	124	24	19	9	7	13	11
Average percent of illegal drug use			25		10		17

We found that patients frequently would be "dirty" (use illegal drugs) one month and be "clean" (not use illegal drugs) the next month. What this appears to show is that a large percentage of the youths continuing in treatment at the Youth Center are continuing to use illegal drugs on an intermittent basis. This can best be illustrated by the following tabulation of individual case records.

1971	Patient 1		Patient 2		Patient 3		Patient 4		Patient 5	
	Dirty tests	Total tests	Dirty tests	Total tests	Dirty tests	Total tests	Dirty tests	Total tests	Dirty tests	Total tests
April	2	10	2	11	4	4	8	8	-	6
May	-	15	1	7	3	13	5	10	-	5
June	1	12	-	6	1	11	6	6	1	8
July	-	9	-	-	-	9	3	9	-	9
Aug.	3	12	1	1	-	1	3	7	1	12
Sept.	-	11	1	1	-	-	7	10	-	11
Oct.	1	9	3	8	5	8	1	6	-	9
Nov.	-	10	-	4	-	10	3	8	-	11

As can be seen by the above tabulation, some patients would go several months without having dirty urine tests and then would produce dirty urine tests during the next several months. In other cases there was evidence of continued illegal drug use each month by the patients, either part of or all the time. In still other cases the rate of illegal drug use was very nominal.

PROGRAM RESULTS AT THE
COMMUNITY ADDICTION TREATMENT CENTER

As of April 11, 1971, there were 558 male and female patients receiving treatment at the Community Addiction Treatment Center. Most of the patients were adults receiving methadone maintenance treatment. Our analysis of reported information showed that, as of mid-February 1972, 274, or 49 percent, of these 558 patients had dropped out of NTA treatment programs.

We also analyzed the results of the urine tests for the period April 1971 to February 1972. Our analysis showed that an average 21 percent of the patients tested each month were positive for illegal drug use once during each month, an average 11 percent were positive for illegal drug use twice during each month, and an average 17 percent were positive for illegal drug use three or more times during each month. The results of this analysis are comparable to the results of the analysis at the Youth Center. (See p. 30.)

To get an indication of whether the patients in treatment were being arrested, we also searched records at the District jail for the period April 1971 to February 1972. These records showed the names of all males arrested and detained at the jail. These records did not show the names of males arrested but released on bond after a hearing or the names of women arrested. Consequently our findings, as discussed below, probably understate the actual arrest rate.

We found that 43, or 10 percent, of the 417 male patients registered at the Community Addiction Treatment Center on April 11, 1971, were arrested and detained at the District jail sometime during the 10-month period. Of these 43 patients, 29 were arrested once, 12 were arrested twice, and two were arrested three or more times. The most common charges for those arrested were possession of narcotics, larceny, and robbery. During the month of their arrests, 26 of the 43 patients were active in the program.

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We have not drawn any conclusions from the results of the work performed at the Youth Center and at the Community Addiction Treatment Center, because, as stated on page 21, NTA has not established standards as to what constitutes acceptable program results.

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NTA DATA COLLECTION SYSTEM

As stated previously much of the data required to enable program officials to make assessments of program effectiveness is gathered from four different sources--the central intake unit, the individual treatment centers, the urine-testing laboratories, and the District of Columbia Department of Corrections. At the central intake unit, a complete medical and drug history is obtained from each patient, along with his criminal history. The treatment centers generate data on the number of contacts with each patient; number of urine specimens taken; category of treatment that the patient is in; number of counseling sessions in which the patient participates; employment status of the patient; and the number of milligrams of methadone, if applicable, that the patient is given each day. The urine specimens are analyzed at two contract laboratories for the presence of narcotics, and the results are reported to NTA.

At the time of our review, much of the data generated was being entered into a computerized central file system at NTA's Bureau of Computer Systems. Some of the reports being produced by this system prior to the start of our review were:

--Biweekly urine report--An alphabetical listing of all patients by treatment center showing the test results of each urinalysis.

--Master patient register--An alphabetical listing, produced weekly, of all registered patients. The report includes for each patient such information as the date the patient entered into treatment, the date of last contact with the patient, the treatment center to which the patient is assigned, and the treatment modality in which the patient is registered.

--Methadone and counseling report--An alphabetical listing, by treatment center, showing the days each patient received counseling and methadone and the quantity of methadone the patient was given.

--Patient monthly record--A report listing the treatment activity of every patient, including methadone

given, counseling received, the results of urinalyses, and employment status.

We noted that a number of new reports initiated after December 1971 contained summary data for all patients at a center and for all NTA patients. Some of these reports were:

--Methadone inventory report--A monthly report, by treatment center, showing the total quantity of methadone dispensed each day and the number of patients receiving methadone.

--Weekly inactive report--An alphabetical listing, by center, of the patients who became inactive (no contact with the program for 14 days) in the 1-week period preceding the report. This report allows centers to initiate outreach work promptly.

--Weekly report on patient population (in three parts)--This report shows and summarizes by centers and all NTA patients (1) new admissions by race, sex, age, and referral source, (2) reason for patients' dropping out, if known, (3) dropout analysis, including patients' referral source, time in treatment, last methadone dosage, counseling received during last 2 weeks, percentage of illegal drug use in last 2 weeks, duration of illegal drug use, age, modality, sex, race, and employment status.

--Patient profile report--Summarizes, by center and for all NTA patients, the age, employment or education status, marital status, duration of addiction, percentage of dirty urine tests in last 2 weeks, number of times admitted to program, and schooling completed.

--Urine and counseling summary--A monthly report by center showing how many patients gave urine specimens, the total number of specimens taken, how many patients received counseling, and the total number of counseling sessions. Data is summarized by centers and for all NTA patients.

--Dropout analysis report--Provides summary information on patients who dropped out of the program. Includes information on age, sex, race, employment status, marital status, education, length of addiction, number of times admitted to treatment, time in treatment, and last dosage of methadone for all dropouts.

At the time of our review, no reports were being produced that showed arrest data. To date arrest data has been obtained by NTA only for those patients included in studies made by the Bureau of Research. This data was obtained by manually searching District jail arrest files and records of the juvenile court. NTA officials informed us that they would be able to obtain magnetic tape records of arrests from the Police Department, which should increase their ability to determine whether any NTA patients had been arrested.

We believe that the information included in the reports currently being produced should provide a means for continually assessing program results.

CHAPTER 4

PROBLEMS AT TREATMENT CENTERS IN THE DISTRICT OF COLUMBIA

As part of our review, we visited all the treatment centers of NTA and its contractors to obtain information on problems being encountered, operational needs of the centers, and ways in which the drug treatment process could be improved. At most centers we spoke with the administrator or his assistant and sometimes with some of the counselors and patients. The most frequent responses from these persons follow.

--Additional and better trained staff members are needed to provide more effective services to patients.

--Additional supportive services, such as job placement, training, and recreation, are needed for patients.

--Better physical facilities are needed for patients.

STAFF AND STAFF TRAINING

Most of the treatment center administrators and their staff members informed us that one of their greatest needs was for additional and better trained staff members. For example, several treatment center administrators stated that one of the greatest needs of their counselors was training in basic writing and communication skills. Others told us that they needed more staff members in order to better serve patients' needs.

The administrator of one treatment center, where the patient-to-counselor ratio was 94 to 1 at the time of our visit, stated that he needed additional staff members and that he felt that more professional employees were needed to provide supportive services. At another center the administrator expressed the opinion that an effective patient-to-counselor ratio was about 25 to 1 as opposed to the 56 to 1 ratio that existed at his center at the time of our visit. This administrator stated also that professional staff

members were needed to handle supportive services and that an outreach team could be used to contact patients who had dropped out of the program to encourage them to return.

The administrator of another center advised us that he presently had enough staff members but indicated that a high turnover of staff members, as a result of employees' being transferred to better jobs at other NTA facilities, had caused his center to be less effective than it could have been.

At another center the administrator told us that most counselors never had held jobs or never had been given any responsibilities prior to coming with NTA. The administrator said that, although these counselors performed well in most cases, he felt that they were hampered in carrying out their duties because of a lack of training and experience.

SUPPORTIVE SERVICES

Detoxification or stabilization of an addict usually is only the beginning of the treatment process for narcotic addiction. Experts have stated that detoxification (the process of eliminating an addict's physical addiction to heroin) usually can be accomplished in a relatively short period (up to 2 weeks) in an inpatient or outpatient surrounding. Stabilization of an addict on methadone to a point where the methadone eliminates the craving for heroin and blocks the euphoric effects of heroin usually can be accomplished in a few weeks.

After a heroin addict is detoxified or stabilized on methadone, the treatment process does not, and should not, end. According to experts in the field of narcotic addiction and many of the administrators of NTA's treatment centers, many addicts are in need of more education, job training, and psychological assistance. Many require job-placement assistance.

NTA has recognized the need for such supportive services, and many of its treatment centers have attempted to provide these services. As indicated in the preceeding section of this chapter, however, many of NTA's treatment centers are in need of additional counselors, particularly

counselors having the training and skills necessary to provide supportive services.

One administrator of an NTA treatment center informed us that there was a need for such additional supportive services as job training and placement, particularly in fields where job opportunities existed. Another treatment center administrator stated that his center's greatest need was for job opportunities for patients. According to this administrator job opportunities for ex-addicts are particularly difficult to develop.

The administrator of one center told us that the main problem at his center was boredom on the part of patients, due to a lack of organized activities. At the Youth Center, which serves only persons under 21 years of age, we observed that, outside of an outdoor basketball hoop on a post in the parking lot, there was little recreation equipment. The administrator advised us that he hoped to obtain some recreation equipment in the near future. He also told us that there was an even more pressing need for jobs and job training for the youths at the center.

PHYSICAL FACILITIES

For the most part the treatment centers we visited in the District of Columbia were located in buildings ranging from old residences, usually in need of repair, to converted warehouses. At a number of centers, the condition or size limitations of the physical facilities appeared to hamper operations. For example, individual counseling had to be done in large open rooms with several counselors and patients sharing the rooms. In other cases the facility was in such bad physical condition that it could not possibly add to the desire of a patient to stay in the program.

We met with the Administrator, NTA, to discuss our observations at the treatment centers. At this meeting the Administrator explained that, during NTA's 1st year of operation, emphasis was placed on growth and that as many patients as possible were enrolled in treatment programs. NTA's 2d year of operation, according to its Administrator, involved a lower growth rate than the 1st year but its efforts were concentrated on broadening supportive services

for its patients and restructuring many treatment centers to offer specialized treatment, such as methadone maintenance or detoxification. In NTA's 1st year, most centers offered all modalities of treatment.

Currently, according to the Administrator, NTA is becoming increasingly concerned about the total human needs of each patient. NTA attempts to meet as many of the patient's needs as possible at the individual treatment centers and to act as a "broker" to arrange for services to be provided by other agencies when NTA itself cannot provide them. The Administrator has stated that NTA never should expect to meet all the needs of its patients because to do so would involve duplicating many social service functions--job training and placement and education--provided by other governmental agencies. The Administrator has stated also that NTA therefore has to find some middle ground in this area in which to operate.

The Administrator acknowledged that the need for additional and better trained counselors was a problem. Most of NTA's counselors are ex-addicts. He advised us that ex-addict counselors usually functioned quite well but indicated that many of them resisted training which would make them more effective. He indicated that NTA needed to work on this problem and to hire more professionals as counselors.

CHAPTER 5

INFORMATION ON OTHER TREATMENT PROGRAMS

RECEIVING GOVERNMENT FUNDS

In addition to NTA programs, there are four other programs in the District of Columbia that are supported by Federal or District of Columbia funds. The location of the centers operated as part of these programs are shown on the map which is included as appendix IV. The table below shows the number and treatment status of patients as of February 1972.

Program	Type	Total patients	Patients by modality: Abatinence	Maintenance	Detoxification
Saint Elizabeths Hospital--Last Renaissance	Inpatient	26	26	-	-
Veterans Administration Hospital	Inpatient and outpatient	117	-	102	15
Narcotic Addict Rehabilitation Act--aftercare	Outpatient	84	71	13	-
D.C. Department of Corrections work release program--Residential Treatment Center	Inpatient	24	19	3	2
Total		251	116	118	17

SAINT ELIZABETHS HOSPITAL--LAST RENAISSANCE

This therapeutic community, modeled after Synanon in California and Phoenix House in New York, has been operating since July 1970 and is located in Holly House at Saint Elizabeths Hospital. Last Renaissance is funded as part of the hospital's operation by the National Institute of Mental Health. Since the opening of the program, about 200 applicants have been accepted. About half of the patients drop out of the program within the first 3 months. At the time of our review, there had been 12 patients who had met all the program's goals before leaving Last Renaissance.

Patients are limited to residents of the Southeast area of the District. Admission to the program is through an interview process which attempts to determine whether

the applicant has a genuine desire to rid himself of the use of drugs. Before admission to the house, all patients must be detoxified with methadone at the hospital or without drugs at Last Renaissance.

The goals of the program are to free persons from drug use and to give them a new value system and improved life style. Upon entry to the drug-free program, patients are not permitted contact with anyone outside the Last Renaissance community for at least 6 weeks. This is done to orient them to the life style of the community and to help them stay with the program.

Patients live in the community voluntarily and may leave at any time. Treatment consists of (1) group sessions held once a week, (2) encounter groups held three times a week, and (3) individual counseling on request. As a patient progresses within the program, he enters the reentry phase which consists of getting a job so that he can be ready to reenter society as a productive citizen when he leaves the program. Both the individual and the staff share in the decision of when the patient is ready to leave the program. This decision is based largely on the patient's progress in the program and his motives for leaving. The success of the program is measured by the return of the patients to the community as productive citizens.

Because Last Renaissance is funded as part of Saint Elizabeths Hospital, there is no cost directly attributable to the program other than the hospitalwide per diem rate of $41.09. On the basis of an average population of 30, the program would cost approximately $450,000 annually, or about $15,000 a year for each patient.

VETERANS ADMINISTRATION HOSPITAL

Methadone detoxification, methadone maintenance, and abstinence treatment are available to inpatients and outpatients at the Washington, D.C., Veterans Administration Hospital. Admission to the treatment program is available to any eligible veteran. Patients may be referred by other agencies or may simply walk in. The goal of the program, which has been operating for about 1 year, is to help each patient obtain a meaningful life style, which includes

(1) relief from physical pain, (2) a feeling of "belonging" by involvement in the program, and (3) self-esteem resulting from his ability to find employment and to manage his own affairs outside the program.

After a patient is admitted to the program, a physician and the patient determine the most suitable method of treatment. Mental attitude and vocational abilities are ascertained to establish specific therapy and treatment needs. Treatment consists of group therapy, urine surveillance, and individual counseling. Family therapy to assist in the rehabilitation of the patient is also available. Supportive services offered by the drug treatment unit are being expanded.

Program assessment consists of consideration of (1) the retention rate, (2) patient participation in the program, (3) interrelation between staff and patients, and (4) staff satisfaction with individual patient's progress in the program. This assessment does not involve a formal procedure but does involve personal contact of the program director, staff, and patients.

The program director told us that there were no overall statistics available on persons dropping out of or completing the program. We were advised by the Veterans Administration that a data collection system was initiated in January 1972. Statistics compiled showed that in January 1972 seven inpatients had completed treatment, 29 inpatients had transferred to the outpatient program, three outpatients had transferred to the inpatient program, and 81 outpatients had dropped out of the program without completing treatment.

On the basis of per diem rates for the drug program at the hospital, the annual cost would be about $16,300 for an inpatient and about $1,370 for an outpatient. With an average annual count of 20 inpatients and 100 outpatients, the total annual cost would be about $463,000. The treatment unit has a staff of about 35 and is planned for a total patient load of 200.

NARCOTIC ADDICT REHABILITATION ACT

The Narcotic Addict Rehabilitation Act, passed in 1966 (28 U.S.C. 2901), provides for:

--Pretrial civil commitment for treatment, in lieu of prosecution, of addicts charged with certain Federal crimes (title I).

--Sentencing to commitment for treatment of addicts convicted of certain Federal crimes (title II).

--Civil commitment for treatment of addicts not charged with criminal offenses (title III).

Titles I and III of the act are administered by the National Institute of Mental Health. Inpatient treatment is given at either the Lexington, Kentucky, clinical research center or at a contractor facility. This phase of treatment occurs after it has been determined that an addict is suitable for treatment. Following the inpatient phase of treatment, the patient receives aftercare from a community organization under contract with the National Institute of Mental Health.

Title II is administered by the Bureau of Prisons, Department of Justice. Inpatient care is provided at a Federal correctional institution. Upon the patient's release from the institution, aftercare is provided in the community by an organization under contract with the Bureau of Prisons.

We were informed that under all three titles there were 84 patients undergoing aftercare as of February 7, 1972. The Bureau of Rehabilitation of the National Capital Area is the present aftercare contractor for both the National Institute of Mental Health and the Bureau of Prisons.

Aftercare consists of (1) individual therapy, (2) group therapy, (3) urine surveillance, (4) training, (5) job placement, (6) assistance--money, clothing, housing--as needed, (7) family counseling, and (8) medical aid. Those aftercare patients on methadone maintenance receive their medication at one of the NTA clinics. Although aftercare generally is rendered on an outpatient basis, such

treatment, if the counselor believes that a patient would benefit from a short stay in a residential treatment setting, can be provided in one of the residential facilities that the Bureau of Rehabilitation operates.

Assessment efforts are directed toward the individual rather than toward the program as a whole. Factors considered include (1) urinalysis results, (2) employment, (3) patient's attitude, (4) change in life style, and (5) family relationship.

The Bureau of Rehabilitation started furnishing aftercare for the title II program in August 1969 and for the title I and III programs in September 1969. The following table summarizes available data on program results through February 7, 1972.

	Titles I and III	Title II
Total number of patients	80[a]	87
Patients active in program	36	48
Patients successfully completing program	6	(b)
Patients discharged as failures	25	-
Patients recommitted to Clinical Research Center	3[c]	-
Patients violating provisions of the act and returned to institution	-	39
Patients to be recommitted but still on the streets (note d)	8	-
Patients transferred to another aftercare agency	2	-

[a]Includes patients transferred to the Bureau of Rehabilitation when it became the aftercare contractor.

[b]This is a 3-year program, and there have been no completions since the Bureau of Rehabilitation became the aftercare contractor.

[c]As of February 7 1972, only three recommitments were at the Clinical Research Center. Twenty others had been recommitted but were back in aftercare, or had successfully completed the program, or had been discharged from the program.

[d]Patients whose performance was unsatisfactory and who were recommended for recommitment to the Clinical Research Center.

Contract cost data follows.

	Fiscal year 1971 actual	Fiscal year 1972
National Institute of Mental Health contract	$82,725	Not to exceed $191,245
Bureau of Prisons contract	71,300	Not to exceed $155,225.76

The Bureau of Prisons contract provides for a monthly cost for each patient of about $100. The National Institute of Mental Health contract is a cost-reimbursement contract with the cost for each patient being determined by actual services received.

D.C. DEPARTMENT OF CORRECTIONS
WORK RELEASE PROGRAM--
RESIDENTIAL TREATMENT CENTER

The District of Columbia Department of Corrections operates a work release program which permits a person convicted of certain offenses to be released to work at his employment or to seek employment when such a privilege is deemed justifiable by the judge of the sentencing court. The privilege may be granted at the time sentence is imposed or later. It may be revoked at any time, either by the Department of Corrections or by the court.

The Department of Corrections has 13 halfway houses functioning in this program. Only two, however, are used for the treatment of narcotics addicts. One--the Narcotic Addict Rehabilitation Corps--is operated by NTA. The other--the Residential Treatment Center--is contractor operated.

The Residential Treatment Center is operated by the Bureau of Rehabilitation of the National Capital Area. A staff of approximately 11 provides services to an average population of 24 males. Patients are required to attend individual counseling services twice a week, to participate in group therapy sessions at least four times a week, and to give observed urine specimens three times a week. The center also offers family therapy, vocational assistance, job placement, and short-term financial assistance.

Evaluation of the program's success is centered primarily around measures of the patients' performance, which include (1) relation with therapists, (2) results of urinalyses, and (3) a comparison with patients at other halfway houses in the city. There were no overall statistics available on program performance. The program director did state that he believed that about 70 percent of the p .ents released from the program were doing well.

The contract with the Department of Corrections provides for payment of $18.35 for a patient-day. On the basis of an average 24 patients, the cost would amount to $160,746 annually, or about $6,700 a patient.

APPENDIX I

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
WASHINGTON, D.C. 20515

October 15, 1971

Honorable Elmer B. Staats
Comptroller General of the United States
Washington, D. C. 20548

Dear Mr. Staats:

To assist the Subcommittee in its continuing consideration of legislation concerned with the treatment and rehabilitation of narcotic addicts, we would appreciate having the General Accounting Office make a review and provide a report on program assessment efforts made by Federal, State, and local agencies involved in narcotic rehabilitation activities. The Subcommittee's concern is that in developing legislation for treatment and rehabilitation, adequate program assessments are made to provide a basis for the Congress and the executive agencies to take action to improve the rehabilitation programs.

For an appropriate mix (Federal, State, and local) of programs, your review should provide information on the treatment modality, program goals, and established controls and techniques for measuring program accomplishments. The Subcommittee also desires information on program costs including, if possible, information on amounts spent on program assessment efforts. The information gathered should be supplemented by your comments on any identified weaknesses relating to the efforts of program sponsors to evaluate program effectiveness. We would appreciate your suggestions as to actions needed to improve such efforts.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report would be most helpful if it could be available to the Subcommittee by June 1972.

Sincerely,

Don Edwards

Don Edwards
Chairman
Subcommittee No. 4

APPENDIX II

NARCOTICS TREATMENT ADMINISTRATION

TREATMENT CENTERS

COMMUNITY ADDICTION TREATMENT CENTER

The Community Addiction Treatment Center is a methadone maintenance stabilization clinic with a staff of about 22. Counseling and supportive services are designed to meet the needs of three primary groups of addicts: addicts who continue to use illegal drugs; addicts who have an alcohol problem; and addicts with behavioral problems. In addition to individual counseling, group therapy sessions are held to meet the needs of each group.

CRIMINAL JUSTICE SURVEILLANCE UNIT

This facility has a staff of 23 and provides counseling and urine surveillance for individuals who must demonstrate the ability to remain abstinent as a condition of parole, probation, or presentence investigation. Surveillance is also provided for those who must remain drug free to obtain or regain their driver's licenses.

DRUG ADDICTION MEDICAL SERVICE--CLINIC

This methadone maintenance stabilization clinic operates with a staff of about 21 who place emphasis on intensive counseling with the objective of improving the patients' life style. Capacity is planned for 500, and patients are being transferred to other NTA facilities to reach this level. Group encounter sessions are a part of the intensive counseling.

DRUG ADDICTION MEDICAL SERVICE--INPATIENT UNITS

This facility has an inpatient capacity of 70 consisting of two 35-bed units. One unit is used for methadone detoxification purposes. The other is a residential rehabilitation unit offering methadone maintenance and abstinence services.

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APPENDIX II

EMERGE HOUSE

Emerge House is one of two NTA facilities serving the youth. Patients living voluntarily in the house may be enrolled in an abstinence or methadone detoxification program. Methadone is not dispensed at the house but is obtained at another NTA facility. Group and individual therapy along with the requirement that all residents work or attend school are intended to help the patient attain the goal of changing his life style. The program does not isolate the participants from the community but rather tries to help them adjust to the community and become part of it.

DETOXIFICATION-ABSTINENCE CLINIC

The emphasis in this clinic is toward assisting patients to become completely free of all drug use including methadone. Patients entering this clinic are those that are considered to have the desire and motivation to free themselves entirely from the use of drugs.

Detoxification schedules setting forth the duration of the detoxification period are worked out between the patients and the medical staff. Methadone is given during this period in decreasing amounts. The schedules vary depending on the patients' physical conditions, tolerance levels, and mental attitudes, but usually the periods are no longer than 3 months. Patients who are unable to complete the detoxification period may elect to transfer to another facility and another program such as methadone maintenance. The most important aspect of this program is considered to be counseling through which a change in life style is attempted.

FAR EAST ADDICTION TREATMENT SERVICE

The Far East Addiction Treatment Service is an exception to the specialized facility concept. This treatment center provides the full range of treatment modalities to both inpatients as well as outpatients for a specific service area in the Northeast section of the city. At the time of our fieldwork, a building was being renovated for use as an inpatient facility planned for a capacity of 48. Abstinence, methadone detoxification, and methadone maintenance services will all be available to residents of the center.

APPENDIX II

Outpatient services are also provided. All patients make at least four contacts with the program each week. Methadone maintenance patients meet with their counselors five times a week. Of particular interest is that the outpatient program has an outreach function which attempts to contact all persons who drop out of the program.

G STREET CLINIC

This is a methadone maintenance stabilization clinic with a staff of about 20. The overall objective of this treatment center is to help a patient fit back into society by making him more responsible to himself. Extensive counseling is continued even after patients have demonstrated the ability to remain free from illegal drug use. If a patient misses 2 consecutive days, the clinic staff has an outreach team which attempts to locate him and persuade him to return to treatment. The clinic is designed to eventually serve a patient population of 500.

MODEL CITIES ADDICTION TREATMENT PROGRAM

This is NTA's only methadone maintenance induction clinic. The facility operates with a staff of about 23 to serve new methadone maintenance patients referred from central intake. Treatment consists of intensive counseling while a patient is brought to a stabilization level of methadone dosage. Outreach is a part of this program, and an attempt is made to contact all patients who miss 3 consecutive days of treatment. A medical doctor is a full-time member of the staff and is available to meet health needs of the new patients.

Patients are usually transferred to an NTA methadone maintenance stabilization clinic in 4 to 6 weeks. The time of transfer is based on urinalysis results, employment status, and the opinion of the patient's counselor.

NARCOTIC ADDICT REHABILITATION CORPS

This halfway house, with a capacity of about 65 and a staff of about 20, treats male referrals from the criminal justice system on an inpatient basis. The center is operated by NTA as a part of the District of Columbia work release

program. About 95 percent of the patients come directly from penal institutions and the remaining 5 percent come from parole supervision or other halfway houses. All patients are required to remain in the program and all are within 6 months to a year of their release date from the criminal justice system. The program's goal is to prepare a man for his return to society.

Each resident of the house is assigned to a treatment family consisting of several other patients and two counselors. Also a treatment board at the house consists of the total staff and a representative from each treatment family. This board meets twice a week to discuss special patient problems and to administer privileges or punishment.

Patients are required to obtain employment outside the house and are required to make their whereabouts known at all times.

NARCOTIC ADDICT REHABILITATION CORPS--CLINIC

This center is a methadone maintenance stabilization clinic located in the basement of the Narcotic Addict Rehabilitation Corps halfway house. Counseling and urine surveillance are required of all patients. Voluntary group counseling sessions are also held. Job counseling and referral for training and education are available. Training, education, involvement in the program, and employment are considered to be important indications of progress. The center is staffed by about 16 people and has the capacity to serve around 350 patients.

YOUTH CENTER

This center is another exception to NTA's concept of specialization in that it operates to serve all treatment needs of young addicts under 21 years of age. The center has a staff of about 15 and a capacity to serve about 300. Group and individual counseling, urine surveillance, an outreach program for dropouts and limited recreation activities make up the program. Completion of a renovation program at the center should make more space and facilities

available at the house. Notwithstanding the goals of detoxification and eventual abstinence, the importance of education, training, and employment is recognized as essential to making the patient a part of society.

NEIGHBORHOOD TREATMENT CENTER

This center is operated by the Bureau of Rehabilitation of the National Capital Area[1] under contract with NTA. The primary modalities of treatment at this outpatient center are detoxification and abstinence. No methadone is dispensed on the premises. Patients in a methadone detoxification program obtain their medication at the Drug Addiction Medical Services clinic.

The staff of about 11 provides individual counseling, urine surveillance, and group therapy sessions. Job placement, training, assistance, and referrals for welfare and education are among the supportive services offered. Family-oriented cultural and recreational programs, as well as drug prevention and education activities, are part of the program. A Citizens Advisory Committee made up of local merchants, residents, and organizations makes this program a part of the community.

SOUTHEAST NEIGHBORHOOD ACTION BOARD--ADULT PROGRAM

This predominantly methadone maintenance program is funded through a contract with NTA and operated by the Southeast Neighborhood Action Board. Services offered by the staff of twelve are generally limited, because of the number of patients, to urine surveillance and counseling. Because of a high patient case load, individual counseling is done on an as-needed basis as determined by a patient's progress and performance.

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[1]The Bureau of Rehabilitation of the National Capital Area is a private nonprofit community service agency which also operates a work release halfway house for narcotic offenders under contract with the D.C. Department of Corrections and also provides aftercare services for Narcotic Addict Rehabilitation Act patients. (See ch. 5.)

Although there was only a 15- to 20-patient waiting list at the time of our visit, we were told that about 650 patients had been in the program at one time or another but had dropped out. Program officials plan to start outreach work and expand to a larger facility with more staff if an extension of the NTA contract can be negotiated.

SOUTHEAST NEIGHBORHOOD ACTION BOARD--YOUTH PROGRAM

This youth program is operated by Southeast Neighborhood Action Board under contract to NTA. The project had just gotten under way at the time of our review. Eventually, the project is expected to serve 60 inpatients at a therapeutic halfway house and 240 outpatients from the juvenile population of the Anacostia area of Washington.

BONABOND STEP-ONE

This drug-free residential facility is operated by Bonabond, Inc., a community service organization under contract with NTA. The program started as a halfway house with several sources of patient referral. Currently all patients are court referrals of young male addicts between arrest and trial. Men come for at least 90 days and take part in a drug-free program of therapy and counseling which places emphasis on the psychological aspects of addiction. The goal of the program is to help a young man direct his thinking against drugs and to adapt to society. The program includes urine surveillance, group encounters, a social studies course, and tutoring.

APPENDIX III

INDICATORS OF THE SIZE OF THE DISTRICT'S ADDICTION PROBLEM

The task of determining with any degree of reliability the number of narcotic addicts in the District of Columbia or in any other area is made extremely difficult because there is no commonly accepted definition for the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as a narcotic addict unless he is arrested or enrolls in a treatment program. The methods used by NTA to estimate the number of narcotic addicts in the city and certain other indicators which provide some insight into the size of the District's addiction problem are discussed below.

ESTIMATES OF NUMBER OF NARCOTIC ADDICTS

One estimate of the number of narcotic addicts in the District of Columbia was based on an estimating technique developed by the Deputy Chief Medical Examiner for New York City.

The Deputy Examiner for New York City reported that in 1968 about 1,000 narcotic-related deaths had occurred in New York City. At that time, the city had approximately 50,000 names on its narcotic register. The register is used to compile data on numbers of addicts from a variety of sources such as treatment agencies and law enforcement agencies.

The Deputy Examiner also found that about one half of those addicts who died from narcotic-related causes were listed on the city's narcotic register. Relating these two known factors, the Deputy Examiner concluded that one out of every 100 people on the register died of narcotic-related causes in 1968. This factor multiplied by the number of known narcotic-related deaths produced a result of 100,000, which was assumed to be the approximate total number of narcotic addicts in the city. The Deputy Examiner informed us that the 100,000 estimate seemed to be in line with other estimates of narcotic addicts for the city.

APPENDIX III

The Deputy Examiner informed us that, although about half of the 1,000 narcotic-related deaths were directly attributable to an overdose of heroin, he did not draw any relationship between the number who died as a result of a heroin overdose and the number that was on the city's narcotic register.

To estimate the number of narcotic addicts in the District, NTA used the technique developed in New York City but assumed that there was a direct relationship between the number of narcotic overdose deaths and the total narcotic addict population (an assumption which NTA believes can be corroborated). Since about half of the narcotic-related deaths in New York City were caused by overdoses of heroin, NTA assumed that an estimate of the total number of narcotic addicts not in treatment in the District of Columbia could be made by simply multiplying the number of narcotic overdose deaths by 200.

To determine the number of narcotic overdose deaths in the District of Columbia, unexplained deaths in fiscal year 1971 were surveyed by the District of Columbia Coroner's Office for the possibility of narcotic overdose. This survey attributed 75 deaths to narcotic overdose. NTA then multiplied this number by 200 and added the result to 2,700, which was the average number of addicts in treatment with NTA during fiscal year 1971, to produce an estimate of 17,700 narcotic addicts in the District.

Another estimating technique used by NTA assumes that the number of addicts who volunteer for treatment but drop out can be used to estimate the total number of addicts in the District of Columbia not currently receiving treatment. For example, for the period September 27 through October 13, 1971, NTA found that, of a total of 186 patients who volunteered for treatment, 43, or about 23 percent had been previously registered with NTA but had dropped out of treatment. This percentage was divided into the total number of addicts who had registered for treatment with NTA but subsequently dropped out--3,679--to arrive at an estimate of the total number of addicts not currently receiving treatment--15,900. An estimate of about 20,000 addicts for the District was made by adding the 15,900 to the number of addicts receiving treatment.

APPENDIX III

This method of computing the District of Columbia narcotic addict population was considered to have some merit after NTA found that a comparable 23 percent of all narcotic addicts appearing before the Superior Court in September 1971 had registered at some time with NTA but had dropped out of treatment.

Still another estimating technique used by NTA attempted to draw a relationship between the number of narcotic addicts known to NTA and those known to the Bureau of Narcotics and Dangerous Drugs. In May 1971, NTA found that about one fourth of the 1,225 addicts known to the Bureau were also known to NTA. At this time there were about 5,000 addicts known to NTA. Assuming that addicts were not being counted twice, NTA simply multiplied four times the number of addicts known to it to produce another estimate of about 20,000 addicts in the District of Columbia.

As previously stated, the validity of the estimated number of narcotic addicts for the District can be questioned because, as admitted by NTA officials, the estimating techniques rely on a number of unproven assumptions and relationships.

NARCOTIC ARRESTS REPORTED BY METROPOLITAN POLICE DEPARTMENT

The following information, provided by the Narcotic Branch of the Morals Division of the District's Metropolitan Police Department, shows the number of persons arrested and charges placed for violations of laws regulating the illicit traffic and use of narcotics and dangerous drugs during calendar year 1971.

	Persons arrested	Additional charges	Total charges
Harrison Narcotic Act (sale)	96	4	100
Harrison Narcotic Act (possession)	558	51	609
Marihuana Tax Act (sale)	15	-	15
Marihuana Tax Act (possession)	4	7	11
Controlled Substance Act (sale)	318	-	318
Controlled Substance Act (possession)	600	121	721
Uniform Narcotic Act (heroin)	770	146	916
Uniform Narcotic Act (marihuana)	595	66	661
Drug Abuse Control Act	33	20	53
Dangerous Drug Act	217	192	409
Possession of implements of crime	700	835	1,535
Present in illegal estsblishment	108	223	331
Uttering forged narcotic prescription	15	-	15
Maintaining common nuisance	-	81	81
Total	4,029	1,746	5,775

The total changes placed exceed the number of persons arrested because more than one change may have been placed against an individual at the time of arrest. These figures do not reflect indictments by the grand jury. According to the Narcotic Branch, figures for grand jury indictments could increase the totals in felony cases by as much as 10 percent.

NUMBER OF ADDICTS APPEARING BEFORE DISTRICT OF COLUMBIA SUPERIOR COURT

In early 1970 the Chief Judge of the Superior Court started a urine testing program to determine whether the following persons were narcotic addicts: (1) arrested persons, (2) persons undergoing presentence investigation, and (3) persons on probation. A staff of paraprofessional counselors was assigned to the central cellblock in the court to interview all persons, other than those arrested for petty offenses, to come before the court.

The procedure followed was to observe, interview, and make a recommendation to the arraigning judge, through the D.C. Bail Agency, on whether a person should be tested for narcotic use. On the basis of this recommendation and on the basis of any representations made by the prosecution or defense counsel, a determination was made in open court, at the time bail was set, whether urine testing should be required as a condition of release. During 1971 about half of the 1,500 persons brought before the court were recommended for urine testing and about half of those tested showed positive results for the use of heroin.

NARCOTIC OFFENDERS AT THE DISTRICT JAIL

To obtain an indication as to use of heroin in the District, NTA made a study during August and September 1969 of 225 men admitted to the District's jail. Interviews were held with the prisoners and urine specimens were collected from 129. This study showed that 45 percent of the 225 offenders were addicted to heroin. The report on this study also stated that the sample was representative of the jail population and concluded that 45 percent of persons admitted to the jail could be described as addicted to heroin. No projection of the total number of addicts was made.

APPENDIX III

BUREAU OF NARCOTICS AND DANGEROUS DRUGS LIST OF KNOWN ADDICTS AND ESTIMATE OF TOTAL ADDICTS

Another indicator of the size of the addiction problem in the District is the number of addicts reported by the Bureau of Narcotics and Dangerous Drugs of the Department of Justice. The Bureau has reported the following numbers of known addicts for the District.

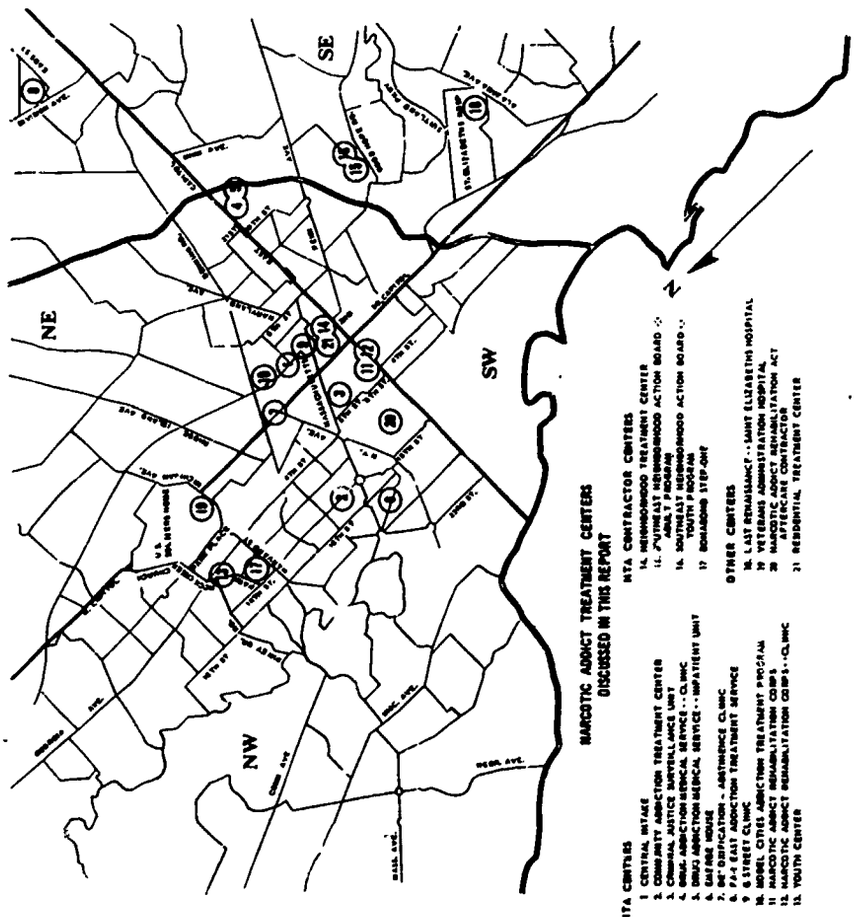
1966	1,164
1967	1,106
1968	1,162
1969	1,636
1970	1,743
1971	2,524

The Bureau estimated the total number of addicts in the District as of December 31, 1971, at 14,634.

To determine the number of persons using narcotics, the Bureau asks local enforcement agencies to furnish information on the arrested person when there are clear indications that the person is addicted to the use of narcotic drugs. The reporting process is strictly voluntary and agencies use their own judgment as to whom they should report as an addict. Because of these two factors, there is reason to believe that the total number of addicts reported to and by the Bureau is understated. For example, only 27 percent of the people identified as narcotic addicts by NTA's study of residents at the District jail had been reported to the Bureau.

A further reporting problem is that, although the Bureau accepts information from all sources, health and social agencies apparently are reluctant to provide names to the Bureau either because the confidentiality of the doctor-patient relationship may be violated or because they fear that the names may be used for law enforcement purposes.

APPENDIX IV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NARCOTIC ADDICT TREATMENT CENTERS
DISCUSSED IN THIS REPORT
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1 CENTRAL INTAKE
2 COMMUNITY ADDICTION TREATMENT CENTER
3 CRIMINAL JUSTICE SURVEILLANCE UNIT
4 DRUG ADDICTION MEDICAL SERVICES - CLINIC
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8 P24 EAST ADDICTION TREATMENT SERVICE
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10 MODEL CITIES ADDICTION TREATMENT PROGRAM
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21 RESIDENTIAL TREATMENT CENTER

REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

Narcotic Addiction Treatment And Rehabilitation Programs In The County Of Los Angeles

B-166217

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 21, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-166217

Dear Mr. Chairman:

In accordance with your October 15, 1971, request, the General Accounting Office has obtained information on narcotic addiction treatment and rehabilitation programs in the county of Los Angeles, California. This is the second in a series of five reports. Other reports will cover New York, N.Y., Chicago, Ill., and San Francisco, Calif. We have previously sent you our report on Washington, D.C.

We have discussed the contents of this report with program officials of the various agencies involved, and their comments were considered in preparing this report.

We plan to make no further distribution of this report unless copies are specifically requested and then only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Don Edwards
Chairman, Subcommittee No. 4
Committee on the Judiciary
House of Representatives

Contents

ABBREVIATIONS

GAO	General Accounting Office
NARA	Narcotic Addict Rehabilitation Act
OEO	Office of Economic Opportunity
UCLA	University of California at Los Angeles
VA	Veterans Administration

COMPTROLLER GENERAL'S
REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

NARCOTIC ADDICTION TREATMENT
AND REHABILITATION PROGRAMS
IN THE COUNTY OF LOS ANGELES
B-166217

D I G E S T

WHY THE REVIEW WAS MADE

This is the second of five reports requested by the Chairman of the Subcommittee on programs for treatment and rehabilitation of narcotic addicts in Chicago, Ill., New York, N.Y., Los Angeles and San Francisco, Calif., and Washington, D.C.

This report is on programs in the Los Angeles County area. The General Accounting Office (GAO) previously reported on programs in Washington.

In developing legislation relating to treatment and rehabilitation of narcotic addicts, the Subcommittee is concerned that adequate provision be made for assessing program performance so that the Congress and Federal agencies will have a basis for improving present treatment and rehabilitation efforts.

GAO was asked to determine, for each of the five cities, the

--amount of money being spent by governmental agencies on narcotic treatment and rehabilitation programs,

--goals of the different programs,

--methods of treatment,

--number of patients in treatment,

--services available,

--cost of various treatment methods,

--criteria used to select patients,

--extent of efforts to assess program performance, and

--information gained from this feedback.

No attempt is made in this report to assess the performance or achievements of the various Los Angeles programs, beyond presenting the information requested by the Chairman.

There is no single agency, department, or organization in Los Angeles County designated to coordinate and evaluate the efforts of the 100 or more organizations offering some type of service to drug abusers. No attempt has been made

to evaluate the overall effectiveness of these programs. As indicated, programs are financed and sponsored by Federal, State, and local government agencies and private groups. The total funds spent by these agencies or groups have not been compiled. GAO estimated that at least $18 million of public funds was being spent annually on major narcotic treatment and rehabilitation programs in the county. (See p. 11.)

GAO's review in the Los Angeles area included programs selected from the county because prime responsibility for providing drug rehabilitation services rests with the county instead of the city.

FINDINGS AND CONCLUSIONS

A reliable estimate of the number of narcotic addicts in Los Angeles County was not available. Estimates ranged from 15,000 to over 60,000.

Estimating the number of narcotic addicts with any degree of reliability is complicated by the absence of an acceptable definition for the term "narcotic addict" and by the absence of a complete and reliable reporting system. (See p. 10.)

State and county officials, program administrators, and addicts informed GAO of the following operational needs of drug rehabilitation and treatment programs in Los Angeles County.

--Improved coordination and planning.
--Increased effort to both define and evaluate program effectiveness.
--More and better trained staff members.
--More supportive services, particularly job placement, for patients.
--More and better facilities.
--Greater capability to treat more addicts.

Each of the programs is summarized in the following table.

Tear Sheet

Name of program	Date program started	Treatment method	Number of patients
Metropolitan State Hospital (See p. 14.)	November 1970	Inpatient --Detoxification (8 days--5 days using methadone, 3 days using nonnarcotic medication) --Short-term or intermediate phase (21 days' abstinence) --Long-term or family phase (6 to 12 months' abstinence)	Through December 31, 1971 --2,957 admitted for detoxification, --1,078 admitted to intermediate phase, --183 to family phase. During 1971 the average numbers of patients in the detoxification and intermediate phases were 35 and 30, respectively. As of December 31, 1971, 99 patients were in the family phase
Los Angeles County Health Department Drug Abuse Program (See p. 17.)	March 1970	Outpatient. --Detoxification (10 days using nonnarcotic medication) --Methadone maintenance	Through December 31, 1971: --6,097 came to clinics for detoxification or other services. --486 were admitted for methadone maintenance --About 2,300 were on waiting list for maintenance As of December 31, 1971: --462 of the 486 addicts admitted for methadone maintenance were still in the program
California Civil Addict Program (See p. 25.)	1961	Inpatient (abstinence) Outpatient (abstinence and methadone maintenance)	Through December 31, 1971, 16,713 addicts had been committed for treatment. As of December 31, 1971, 1,731 inpatients and 6,883 outpatients were still in the program
Narcotic Addict Rehabilitation Program at Federal Correctional Institution, Terminal Island (See p. 34.)	August 1968	Inpatient (abstinence) Outpatient (abstinence)	August 1968 through December 1971: --245 admitted as inpatients --129 admitted to outpatient phase in Los Angeles County As of December 31, 1971: --91 inpatients --86 outpatients
Suicide Prevention Center--Methadone Withdrawal Program (See p. 41.)	March 1970	Outpatient methadone withdrawal, with the goal of eliminating use of both narcotics and methadone	Through March 1972, 60 participants As of March 1972, 29 in treatment

Program costs	Program evaluation criteria	Pertinent program results
July to December 1971, $760,668	No criteria had been established to measure program performance	11 people graduated from family phase. All 11 were believed to be drug free. Ten were employed in drug rehabilitation programs.
March 1970 through December 31, 1971, $1,058,773	Effectiveness of methadone maintenance can be evaluated in employment, drug use, and criminal activity	Program's report for calendar year 1971 showed that 58 percent of the 462 methadone maintenance patients were employed at the end of the year; 81 arrests of patients from November 1970 through December 1971. For 34 of 37 patients who had been in the methadone maintenance program for an average period of about 14 months, 362 urine specimens tested positive for illicit drug use and 116 specimens from 35 of the patients tested positive for narcotics use.
For fiscal year 1971, about $10.7 million	Completion of 2 consecutive years as an outpatient without use of illicit drugs.	8,063 had been in treatment long enough to have satisfied program criteria for successful discharge -only 1,603 (2 percent) had been discharged as successful.
During fiscal year 1971, inpatient program cost was $141,000, exclusive of housing, feeding, and guarding inmates	Number of patients not returned to prison.	Of 129 released as outpatients from August 1968 to December 1971- --22 returned to prison --1 was being sought for parole violation.
Estimated at $60,000 per year	Number of patients who stop using both narcotics and methadone	Of 31 who left the program: --19 successfully withdrew from methadone --5 were dropped for violation of program rules --6 transferred to other programs --1 quit Of participants at March 31, 1972: --27 were arrested prior to entering program, none since joining --14 tested positive for illicit drug use after joining --19 were employed, 5 were students

Tear Sheet

Name of program	Date program started	Treatment methods	Number of patients
Veterans Administration's Drug Dependency Program-Brentwood Hospital (See p. 44.)	October 1971	Inpatient detoxification (6 or 7 days using methadone followed by 2 or 3 weeks in hospital to receive additional assistance in overcoming the mental craving for narcotics) Outpatient: --Detoxification (6 or 7 da s using methadone) --Methadone maintenance	Through March 1972 --435 inpatients --406 outpatients As of March 31, 1972 --9 inpatients --272 outpatients
House of Uhuru (See p 50.)	February 1970	Inpatient detoxification using methadone Outpatient: --Detoxification using medication other than methadone --Rehabilitation including individual and family counseling and group therapy sessions	Through December 1971 the program served about 1,600 drug addicts. About 900 were served during 1971. 502 patients were participating in the program to some extent as of December 1971.
Narcotic Prevention Project (See p. 54.)	July 1967	Outpatient rehabilitation, including counseling and assistance in obtaining acceptable living pattern. Outpatient detoxification by referral	During 1971, 3,349 were referred for detoxification As of December 1971, 350 active patients
Comprehensive Program of Community Drug Abuse Treatment and Research (See p. 57)	July 1971	Inpatient: --Methadone detoxification --Methadone maintenance half-way houses --Drug-free therapeutic community Outpatient methadone maintenance	As of January 1972, 128 in treatment
Synanon Foundation, Inc. (See p. 61.)	1958 In Santa Monica	Inpatient (abstinence)	At March 1972, 775 people residing in the Santa Monica facility and about 1,700 in all of Synanon's facilities.

Program costs	Program evaluation criteria	Pertinent program results
Fiscal year 1971 budget for direct costs was $271,411	No formal criteria established to measure program performance.	Study of 176 methadone maintenance patients showed that 66 (37 percent) were employed. Of an estimated 1,600 urine specimens tested for all patients over a 2-month period 302 (19 percent) were positive for illicit drug use.
Calendar year 1971 expenditures were about $229,000	No formal criteria established to measure program performance	From February 1970 through December 1971, 983 of 1,490 detoxification attempts were successful; 110 successfully completed rehabilitation phase.
July 1967 through December 1971, $1,703,520	Reduction in illicit drug use and keeping addicts out of jail	None reported
Fiscal year 1972 funding amounted to $394,000	None	Preliminary report issued on program in March 1972, but contained no conclusions on program effectiveness
Total expenses for all Synanon facilities were reported to be about $2.3 million in 1971	Synanon believes it is successful if it can create an atmosphere in which the participant can develop to his fullest potential	None reported

Tear Sheet

CHAPTER 1

INTRODUCTION

Our Nation today is faced with a serious narcotic addiction problem. The President, in his January 20, 1971, state of the Union message, remarked that:

> "A problem of modern life which is of deepest concern to most Americans--and of particular anguish to many--is that of drug abuse. For increasing dependence on drugs will surely sap our Nation's strength and destroy our Nation's character."

Throughout the Nation the question is being asked as to what is the most effective way to deal with this problem. Criteria setting forth the results expected from treatment and rehabilitation programs are vague and frequently are lacking. Results of varying methods of treatment are debated by experts. Information on numbers of addicts in the Nation is based on educated guesses, at best. Data on people in treatment throughout the country is generally lacking, as is information on program costs and results achieved.

Because of the seriousness of this problem and the need for information to arrive at rational decisions, the Chairman, Subcommittee No. 4, House Committee on the Judiciary, requested the General Accounting Office (GAO) to assist the Congress in obtaining information on the progress being made in the rehabilitation of narcotic addicts. The Chairman asked that GAO's review include programs receiving Federal, State, or local funds in five cities--Washington, D.C., New York, N.Y., Chicago, Ill., and Los Angeles and San Francisco, Calif.--and that individual reports be prepared for each city. A report entitled "Narcotic Addiction Treatment and Rehabilitation Programs in Washington, D.C." (B-166217), was issued to the Chairman on April 20, 1972.

The Subcommittee is concerned that, in developing legislation related to the treatment and rehabilitation of narcotic addicts, adequate provision be made for program assessment so that the Congress and the executive agencies will have a basis for improving the programs.

This report covers treatment and rehabilitation programs in the county of Los Angeles. Our review encompassed selected treatment programs located throughout the county because prime responsibility for providing drug rehabilitation services rests with the county instead of the city.

EXTENT OF NARCOTIC PROBLEM

The exact extent of the county's narcotic[1] addiction problem is not known. Estimates as to the number of narcotic addicts in the county range from 15,000 to over 60,000. County officials informed us that the reliability of any estimate of the number of addicts is questionable because there is no reliable or complete reporting system for compiling such statistics and because there is no commonly accepted definition for the term "narcotic addict." The Los Angeles County Sheriff's Department advised us that, due to the insufficiency of data, it was not able to estimate the number of narcotic addicts in the county or the annual monetary loss resulting from crimes committed by narcotic addicts.

Notwithstanding the lack of reliable estimates on the number of addicts, several indicators point up the seriousness of the county's problem. In fiscal year 1971 there were 483 deaths attributable to accidental drug overdoses, of which 229 involved the use of narcotics. Drug arrests in the county during this period totaled 61,935; 7,361 of these involved narcotic-related charges. Also, more than 3,900 addicts from Los Angeles County are in the State's Civil Addict Program.

TREATMENT AND REHABILITATION PROGRAMS AND RELATED COSTS

There is no single agency, department, or organization in Los Angeles County designated to coordinate and evaluate the efforts of the hundred or more organizations offering some type of service to drug abusers in the county. Programs are financed and sponsored by a variety of agencies,

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[1]Throughout this report the term "narcotic" refers to drugs which are derived from opium, such as heroin, morphine, and codeine.

including Federal, State, and local government organizations and private groups. The total amount spent by these agencies on narcotic treatment and rehabilitation programs had not been compiled by the county at the time of our review.

Our estimate of the amount of public funds currently being spent annually on major programs in the county--identified through discussions with knowledgeable officials--is presented in the following table. The information shown in the table is not all inclusive, but it does provide an indication of the magnitude of treatment programs.

Type of agency or group operating the program	Estimated costs			
	Federal	State	Local	Total
	000 omitted			
Federal	$1,114	$ -	$ -	$ 1,114
State	690	5,115	-	5,805
Local government (cities and county)	764	2,715	5,672	9,151
Community organizations	2,336	-	89	2,425
Total	$4,904	$7,830	$5,761	$18,495

To furnish the information requested by the Chairman of the Subcommittee on--program goals, treatment modalities and their costs, patients in treatment and services available, source of funding, criteria used to select patients for treatment, extent of program assessment efforts, and results of assessment efforts--we visited the following types of treatment and rehabilitation programs:

--County-operated programs.

--State of California's Civil Addict Program.

--A narcotic addict rehabilitation program operated by the Bureau of Prisons, Department of Justice.

--Privately funded programs.

--A drug dependency program operated by the Veterans Administration.

--A community program funded by the Office of Economic Opportunity.

--A community-operated program jointly funded by the National Institute of Mental Health; Department of Health, Education, and Welfare; and the Department of Housing and Urban Development.

--A program sponsored by the University of California at Los Angeles, jointly funded by the University and the Law Enforcement Assistance Administration, Department of Justice.

We reviewed selected programs of the types identified above to acquire an overview of the programs operating in the county. These involved several different types of treatment modalities and financing sources. Information gathered on these programs is presented in subsequent chapters of this report. Needs of treatment and rehabilitation programs in Los Angeles--as described by various officials and addicts--are discussed in chapter 11.

CHAPTER 2

COUNTY OF LOS ANGELES NARCOTIC PROGRAM

The county of Los Angeles has been concerned with the drug abuse problem for many years. In 1963 the Los Angeles County Board of Supervisors established a Narcotics and Dangerous Drugs Commission for the purpose of recommending new drug programs and legislation. The commission was successful in effecting several changes in State law. The commission was also instrumental in the formation of an interdepartmental committee to coordinate proposals for drug programs submitted by county departments. In September 1970 the California State Legislature enacted legislation requiring counties with populations of over 40,000 to formulate comprehensive drug abuse control plans. In response to this requirement, Los Angeles County developed a plan called "Outline for Development of the Los Angeles County Drug Abuse Plan 1970-71."

Essentially, the county's goals were to

--treat drug abusers' physical and mental health needs,
--convert individuals to productive members of society,
--reduce the actual rate of drug use, and
--reduce drug-related criminal activity.

The principal agencies of the county providing treatment and rehabilitation services to narcotic addicts are the Department of Hospitals, the Department of Probation, the Department of Mental Health, and the Department of Health. The services range from emergency treatment for overdoses to methadone maintenance treatment and are delivered on both an inpatient and an outpatient basis, as shown in the following table.

Department	Services	Addicts served annually	Annual funding			
			Total	Federal	State	Local
			000 omitted			
Hospitals		11,200	$4,643			$4,643
County/University of Southern California Medical Center	Emergency treatment for drug overdose					
Harbor General	do.					
Martin Luther King, Jr.	do.					
Rancho Los Amigos	70 beds set aside for drug treatment and rehabilitation. Psychological counseling and occupational and physical therapy.					
John Wesley	38-bed ward set aside for treatment of hepatitis. About 60 percent of hepatitis cases are drug related.					
Olive View[a]	Psychiatric treatment on an emergency basis, drug therapy (not methadone), and individual and group counseling.					
Probation	Parole supervision and individual counseling (specially trained probation officers with smaller caseloads are used for addicts).	600	049		649	
Mental Health		3,800[b]	1,249[c]		1,124	125
Camarillo State Hospital	Detoxification, group encounter sessions, and therapeutic community					
Metropolitan State Hospital	do.					
Outpatient Clinics	Patients with mental disorders are provided psychiatric and related services. Some of the patients have problems with drugs.					
Health	Detoxification on an outpatient basis and methadone maintenance.	4,100	1,059	85	----	974
		19,700	$7,600	$85	$1,723	$5,742

[a] Olive View had a 25-bed drug abuse inpatient service which was destroyed during the February 1971 earthquake. Services are being provided by the medical service clinic.

[b] Services are provided to residents of Los Angeles, Orange, Santa Clara, and Ventura Counties.

[c] Funding covers only a 6-month period.

Detailed information on treatment and rehabilitation programs administered by the Metropolitan State Hospital and the county Health Department follows.

METROPOLITAN STATE HOSPITAL

Metropolitan is a State-operated hospital for mental patients and has an inpatient program aimed specifically at narcotic addicts. The program is jointly funded by the State and by Los Angeles and Orange Counties.

Treatment modalities

The treatment modalities of this program are referred to as the detoxification, the intermediate, and the family phases. The detoxification phase is an 8-day inpatient program--5 days of withdrawal from narcotics through the use of methadone and 3 days of nonnarcotic medication. This phase is conducted in one of the four hospital wards used for the drug program. The ward has a 52-bed capacity.

The intermediate phase, which is housed in a ward with a 40-bed capacity, is a 21-day inpatient program designed to provide direct therapeutic treatment. All patients in this phase must first go through the detoxification phase. During the intermediate phase, participants are informed of the family phase and other drug programs available to them.

The family phase is housed in two wards of the hospital having a total capacity of about 140. This phase is long-term (6 to 12 months) residential treatment and provides for encounters and confrontations among patients in discussion groups to enable them to identify and learn to cope with their problems. All patients who enter the family phase must first complete the detoxification and intermediate phases.

The program staff, totaling 48, included six social service aides who were ex-addicts who had completed the family phase.

Selection criteria and number served

Any person may enter the detoxification phase if he is a resident of Los Angeles or Orange Counties and has a desire to break or reduce his drug habit. An addict must be referred to the hospital by either the Orange County Community Clinic, a county-operated health services facility which also provides treatment for narcotic addicts, or the Los Angeles Narcotics Prevention Project. (See p. 54.) These agencies screen and maintain the waiting list for the detoxification phase. As of January 1972 Orange County had 30 addicts and Los Angeles County had 133 addicts on the waiting list. Metropolitan can accept about 50 addicts each week for detoxification.

Metropolitan began accepting narcotic addicts in its program in November 1970. From November 1970 through December 31, 1971, 2,957 addicts were admitted to the detoxification phase--2,071 from Los Angeles County and 886 from Orange County. During this period 1,078 persons entered the intermediate phase and 183 entered the family phase. As of December 31, 1971, the population of the family phase was 99. Of those who entered the family phase, 73 had dropped out prior to completion and their whereabouts were not known. According to program officials the average populations of the

detoxification and intermediate phases during 1971 were 35 and 30, respectively.

We were informed by the program director that 11 persons had graduated from the family phase of the program and that all 11 were believed to be drug free. Ten of these persons were working in drug rehabilitation programs in January 1972.

Program cost

The State computes the average daily cost per patient in its hospitals and charges the counties on the basis of the average per diem rate for each patient the respective counties have in the hospital. The counties pay 10 percent; the State absorbs 90 percent. As of January 1, 1972, the per diem rate computed by the State was $22.50 for the Metropolitan State Hospital. Information was not available on the cost of the program from inception in November 1970 through June 1971 or the cost by treatment phase. We were able to obtain certain cost information for the period July 1 through December 31, 1971. The costs for this 6-month period were $509,981 for Los Angeles County and $250,687 for Orange County.

Assessment efforts

Two reviews of the Metropolitan State Hospital program have been made, one by the California State Department of Mental Hygiene and one by the Los Angeles County Mental Health Department. These reviews were directed toward gathering information on program activities, and no attempts to evaluate program performance were made. Program officials stated that criteria or goals had not been established for measuring program performance and therefore no assessment of the effectiveness of the program was made.

LOS ANGELES COUNTY HEALTH DEPARTMENT
DRUG ABUSE PROGRAM

The Los Angeles County Health Department operates a multimodality outpatient program for drug abusers, participation in which is voluntary. Program services are offered at eight outpatient clinics located throughout the county. Six of the clinics are located in established health centers where other health services are provided, and two clinics are used exclusively for drug abuse treatment. The program is financed with county funds, with the exception of one clinic which is Federally funded by the Department of Housing and Urban Development under the Model Cities Program.

The Los Angeles County Health Department has not established criteria sufficient for measuring the performance of its programs nor devised an adequate system for gathering information on participants' activities while they are in the program or after they leave the program.

Treatment modalities

The program provides for detoxification, methadone maintenance, and supportive services, such as individual and group counseling and employment assistance. The detoxification component became operational in March 1970, and methadone maintenance began in November 1970, with supportive services being provided by each component. The following table shows the services provided by each clinic and the dates when services were begun.

Clinic	Detoxification service started	Methadone maintenance service started
West Hollywood	Mar. 1970	Nov. 1970[a]
Southeast	Mar. 1970	Nov. 1970[a]
Northeast	June 1970	Nov. 1970
Florence/Firestone	Nov. 1970	-
Venice	Feb. 1971	Sept. 1971
Imperial Heights	-	Feb. 1971
Pacoima	Mar. 1971	-
El Monte	Mar. 1971	-

[a]Service discontinued in January 1971.

Detoxification

Detoxification is a 10-day outpatient process, during which time the addict receives nonnarcotic medication prescribed by the clinic doctor. Individual and group counseling and employment assistance are also available, but participation usually is not required. Most of the addicts seeking detoxification assistance do not complete the full 10-day program.

There are no eligibility criteria for detoxification services and patients are not tested for illicit drug use[1] during the 10-day period. A program official estimated that 90 percent of those seeking detoxification are heroin addicts. The remaining 10 percent are seeking help for other types of drug abuse. There is no waiting list for detoxification and the clinics serve all who apply.

Methadone maintenance

Methadone maintenance treatment is an attempt to block an addict's desire for heroin through daily doses of methadone. No concerted effort is made to withdraw maintenance patients from methadone. To qualify for methadone maintenance an addict must

--be at least 18 years of age,

--have a history of chronic dependence on narcotics for at least 2 years,

--have narcotic use as his primary drug dependency,

--be free of major physical or mental illnesses which would preclude the use of methadone, and

--have a confirmed history of two or more prior treatment failures.

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[1]As used in this report, illicit drug use means the unauthorized use of amphetamines, barbiturates, and narcotics.

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Eligibility is determined during a 2-week intake process at the Imperial Heights clinic. A physical examination is given to determine whether the applicant has any serious illnesses; court records are searched to determine the period of addiction; urine tests are given to determine whether narcotics are the primary drugs being used; and the applicant's age and prior treatment failures are verified.

If an applicant is eligible, he begins receiving methadone on an outpatient basis at a daily dosage level prescribed by the clinic doctor, usually about 40 milligrams. The dosage is taken orally under the supervision of a nurse. The dosage level is gradually increased by the doctor and can reach a maximum of 160 milligrams per day. However, most patients are maintained on about 100 milligrams per day.

Supportive services, such as individual and group counseling and employment assistance, are available, but their use is not mandatory. Illicit drug use is determined by tests of urine specimens which are taken at least once a week. The patients are not told when specimens will be taken, and the results of the tests are recorded.

The capacity of the Los Angeles County Health Department's methadone maintenance program is 550, as established by the California State Research Advisory Panel which was created by State law in 1968 to approve drug research programs, including all programs which dispense methadone.

Staffing at the health department's clinics varies between six and 12 employees and includes doctors, public health nurses, investigators, social workers, community workers, and health educators.

At the three clinics offering methadone maintenance and detoxification services, the same staff members may work with participants in both programs.

Number served

The county had not compiled statistics on the number of persons who came to the clinics seeking detoxification or the number of persons who had actually completed the

detoxification program. In the absence of such information, we developed the following statistics showing the number of persons who came to the clinics for detoxification or other services.

Clinic	Fiscal year 1970	Fiscal year 1971	July 1 to Dec. 31, 1971	Total
West Hollywood	394	809	153	1,356
Northeast	12	1,361	312	1,685
Southeast	739	855	103	1,697
Florence/Firestone	-	132	24	156
Venice	-	266	242	508
Pacoima	-	286	125	411
El Monte	-	114	170	284
Total	1,145	3,823	1,129	6,097

From November 1970 through December 1971, 3,368 persons applied for methadone maintenance treatment; 1,070 applications were processed and 2,298 individuals were on a waiting list. Of the 1,070, 486 were admitted to the program, and the remaining 584 either were ineligible, had left voluntarily during intake, had not reported for intake, or were incarcerated at the time they were scheduled for intake. Those in the last category will be placed at the top of the waiting list when they are released from jail.

As of December 31, 1971, 462 of the 486 addicts accepted for methadone maintenance were still in the program.

Of the 24 terminations, four were for illicit drug use, six were for poor attendance, two were incarcerated, three died, two contracted serious illnesses, and seven left voluntarily. Although there are no firm criteria for terminating a patient from the program, the patient's total experience in the program, including social life, employment status, and incidence of crime, is considered when possible termination becomes an issue.

Expenditures

Program records of the county health department do not distinguish between the amounts expended for detoxification and the amounts expended for methadone maintenance treatment.

Expenditures made from March 1970, the date of program inception, through December 1971 were as follows:

Period	County funds	Federal funds	Total
March 1970 to June 1970	$157,621	$ -	$ 157,621
July 1970 to June 1971	417,017	51,880	468,897
July 1971 to December 1971	399,437	32,818	432,255
Total	$974,075	$84,698	$1,058,773

The program's annual report for calendar year 1971 stated that a good estimate of expenditures made for each first-year methadone maintenance patient would be from $1,900 to $2,100--$900 for the intake function and $1,000 to $1,200 for treatment services.

Assessment efforts by program officials

Criteria have not been established for measuring the effectiveness of the detoxification process. Statistics are not compiled on the number of patients who apply for or complete the process, and records are not maintained to determine whether former patients remain "clean"; i.e., use no illicit drugs after leaving the program. Little followup on patients is performed due to a lack of staff.

According to program officials, the effectiveness of methadone maintenance can be evaluated by the level of employment, the extent of illicit drug use, and the level of criminal activity of the participants. Standards for assessing an acceptable level of drug use, criminal activity, or unemployment have not been developed.

The program's annual report for calendar year 1971 showed that 58 percent of the 462 patients were employed as of December 31, 1971. However, this information was obtained

from the participants and was not verified by the clinic staff.

The report also indicated that there had been 81 arrests of participants from November 1970 through December 31, 1971. Program officials informed us, however, that there had been additional arrests which were (1) not reported by the patient to the clinic staff, (2) not reported by the clinic staff to program headquarters, or (3) not recorded because the arrest occurred before July 1, 1971, the date the staff began recording the arrests. The number of arrests per participant was not indicated.

During a 2-month test period, 41 of 416 patients, or about 10 percent, had at least one positive urine specimen indicating the use of narcotics. The report did not indicate the number of patients who had more than one positive urine test during the 2-month period or the length of time the patients had been under treatment.

GAO analysis of program performance

We developed information on the criminal activity, illicit drug use, and employment history for 57 patients who began receiving methadone under the county health department program on or before March 1, 1971, and were still in the program on March 1, 1972. The average time in the program for the 57 patients was 14 months. We used existing program records to determine employment and illicit drug use and records from the California State Department of Justice to determine the incidence of arrests. An official in this Department estimated that the names of about 95 percent of the people arrested in California appear on the Department of Justice records and that most out-of-State arrests of California residents would also be listed.

We obtained information on the number of arrests for 56[1] patients during a 3-year period prior to enrollment in the county health department's methadone maintenance program and the number of arrests after beginning the program, and we computed annual averages for both periods. The yearly

[1]Arrest data was available for 56 of the 57 patients.

average arrest rate declined from 1.3 arrests per patient prior to entry into treatment to 0.7 per patient after entry into treatment as shown below:

	Patients arrested		Arrests	
	Number	Percentage	Number	Yearly average
Prior	52	93	214	1.3 per patient
After	24	43	42	.7 per patient

For the 56 patients the arrest rate

--for 34 (61 percent) decreased after the patients began the program,

--for 16 (28 percent) increased after they began the program (however, eight of the 16 had only one arrest after beginning the program), and

--for six (11 percent) did not change (four had not been arrested during either period).

The number of arrests per patient after beginning the program ranged from none to six and the most common charges were burglary, theft, possession and/or sale of narcotics, and violations of the vehicle code.

Analysis of information reported for 56 of the 57 patients still in the program as of March 1, 1972 (records were not available for 1 patient), showed that the 56 patients had submitted 3,123 urine specimens from the time they began the program through February 1972, and averaged 56 specimens per patient. Of the 3,123 specimens, 362, or about 12 percent, tested positive for illicit drug use. Of the 362, 116 (32 percent) tested positive for narcotic use. An analysis of the tests follows:

All Illicit Drug Use (note a)

Range of positive tests per patient	Total number of positive tests	Number of patients
None	-	2
1 to 5	95	30
6 to 10	123	17
11 to 15	53	4
16 to 20	-	-
Over 20	91	3
	362	56

Narcotic Use Only

Range of positive tests per patient	Total number of positive tests	Number of patients
None	-	21
1 to 5	71	32
6 to 10	9	1
11 to 15	14	1
16 to 20	-	-
Over 20	22	1
	116	56

[a]Urine specimens are analyzed to detect the presence of amphetamines, barbiturates, and narcotics.

There was no discernible pattern to the patients' drug use. Some appeared to experiment with drugs during the first month or so, while others used drugs more frequently after having been in the program for several months.

Information provided by 56 patients but not verified by the clinic staff showed that, when they began the program, 26 were unemployed; as of March 1972, 37 were employed, 16 were unemployed, and the remaining 3, although unemployed, were either students or housewives.

CHAPTER 3

CALIFORNIA STATE CIVIL ADDICT PROGRAM

The California State Civil Addict Program was established by legislation passed in 1961. The intent of the legislation was to provide a means of treating certain persons addicted to, or near addiction to, narcotics.

The program provides for two phases of treatment--inpatient and outpatient. An addict is confined at the California Rehabilitation Center, which has two facilities, for inpatient treatment. Outpatient treatment is provided under the supervision of the Parole and Community Services Division of the California State Department of Corrections.

INPATIENT TREATMENT

Inpatient treatment for male narcotic addicts is provided by a detention, treatment, and rehabilitation facility operated by the State Department of Corrections at Corona, Calif., a community about 50 miles southeast of the city of Los Angeles. According to the superintendent of the center, the Corona facility has a capacity for about 2,000 patients. Inpatient treatment for female narcotic addicts is provided in a separate facility on the grounds of Patten State Hospital. This facility located near San Bernardino, Calif., a city about 60 miles east of Los Angeles, can accommodate about 400 patients.

Eligibility criteria for commitment

Following are the criteria for commitment for treatment:

--The individual must be over age 18.

--The case history of the individual must show that he has a primary problem of addiction to narcotics or is in imminent danger of becoming addicted to narcotics as opposed to his having a criminal or delinquent pattern of behavior of which narcotic addiction is only a part.

--The person can be controlled, treated, and managed in a minimum-security, open-dormitory type of facility.

--Any trafficking in narcotics, marijuana, or dangerous drugs has been of a relatively minor extent and only to provide for the addict's need for narcotics.

All commitments of addicts or persons near addiction are made through court action, which may result from any one of the following:

--Voluntary commitment.

--Petition by district attorney for involuntary commitment of an individual not charged with a crime.

--Conviction of a misdemeanor.

--Conviction of a felony.

Patients in the program at December 31, 1971, had been committed, as follows:

	Percentage of inpatient population	Maximum years of commitment (note a)
Voluntary	4	2-1/2
Nonvoluntary but not charged with a crime	14	7
Nonvoluntary and convicted of a misdemeanor	12	7
Nonvoluntary and convicted of a felony	70	7
	100	

[a]As of December 1971 the average stay as an inpatient was 8 months.

Treatment modalities

The therapeutic community is the primary treatment modality at the center. This treatment is delivered through a group arrangement. A typical group is made up of about 60 patients and is served directly by four center employees--a correctional counselor and three correctional officers. The group is called a community and attempts to identify the basic causes of patients' addiction problems through intensive encounter sessions. The treatment includes: assigned work to establish a set work routine for patients who may never have had such a routine; vocational rehabilitation to assist patients in obtaining employment when they are released from the center; and basic education for patients in need of additional academic training. Individual counseling and psychiatric therapy are also available to patients in need of such services.

The center has a staff of 528 employees, including both professionals and paraprofessionals. Many of the staff members are college trained and have experience in dealing with social and behavioral problems. In addition, the program employs five ex-addicts to assist the professional staff.

OUTPATIENT PROGRAM

A patient is paroled from the center for outpatient services by the Narcotic Addict Evaluation Authority, established by legislation as the parole board for the Civil Addict Program. The authority consists of four members who are appointed by the Governor of the State. According to its chairman, the authority is responsible for reviewing civil addict cases referred to it by the center's superintendent, the Parole and Community Services Division of the State Department of Corrections, or county superior courts. These case reviews are made to determine whether

--a patient at the center has recovered from addiction to such an extent that release to outpatient status is warranted,

--an individual in outpatient status should be returned to the center as a result of some violation of the conditions of outpatient status, or

--certain addicts should be given the opportunity to participate in the outpatient phase without first spending some time at the center.

The outpatient treatment continues to assist the patient in making an attitude change regarding his drug abuse problem. At the same time the outpatient program has parole responsibility which includes monitoring for illicit drug use through urinalysis and sufficiently controlling other activities of the patient to protect the interests of society.

The outpatient program is organized into six geographical regions throughout California. Region V has responsibility for most of Los Angeles County.

Treatment modalities

According to the Region V Administrator, the treatment received by patients is not segregated into distinct treatment modalities. The basic treatment provided a patient is through his relationship with a parole agent. Besides being responsible for monitoring and controlling a patient's activities, a parole agent performs the following functions:

--Teaches the addict social skills in interpersonal relationships with family, friends, employers, police, and others.

--Directs group counseling sessions.

--Provides individual counseling.

--Refers patients to other agencies.

--Encourages the addict to upgrade his academic and/or vocational skills.

--Encourages the addict to upgrade his standard of living through employment and recreation.

--Provides the addict with assistance in crisis situations.

--Enforces agency policies openly and fairly.

--Teaches conformance to parole expectations through rewards and sanctions to shape acceptable behavior.

--Illustrates the benefits of appropriate social behavior.

Region V also makes available to a limited number of patients two halfway houses, a methadone maintenance program, and a special program called the Direct Community Release Project which is federally funded by the Office of Economic Opportunity (OEO).

Halfway houses

Region V has two halfway houses, Parkway Center for men, and Vinewood Center for women. These halfway houses serve as temporary residences for patients who, at the time of their release from inpatient treatment, have no place to live. The staffs at the halfway houses provide individual and group counseling and job referral services, with major emphasis on helping the patient find employment.

Parkway Center, a former motel with a capacity of 57, served an average residency of 42 patients during fiscal year 1971. Vinewood Center, a former hotel with a capacity of 26, served an average residency of 21 patients during fiscal year 1971.

Methadone maintenance

The California Department of Correction's Methadone Maintenance Program was initiated in Los Angeles County in April 1971. The authorized capacity of the program is 200; however, the capacity may be increased to 220 to provide for special cases. To be eligible for admission, which is voluntary, an individual must: (1) be under the Department of Correction's field supervision in the Los Angeles area; (2) be at least 21 years old; (3) have at least a 5-year narcotic use history; and (4) have experienced a minimum of one prior treatment failure. Since program inception, 495 applications for treatment have been received. As of February 1, 1972, the status of the applicants was as follows:

212 were active in the program,
35 had been dropped from the program,
73 had been rejected, and
175 were on the waiting list.

495 Total

As of February 1972, 172 patients had been on methadone for at least 90 days and the quantities of methadone needed had been stabilized. According to a report by the California Department of Corrections, results of regular urine testing for illicit drug use from the beginning of the program in April 1971 to February 1972 for the 172 patients were, as follows:

	Patients	
	Number	Percentage
No further narcotic or other illicit drug use	57	33
Two or less instances of illicit drug use	31	19
More than two instances of illicit drug use; otherwise positive adjustments made	65	37
Used illicit drugs on a fairly regular basis	19	11
	172	100

Approximately 62 percent of the 172 patients were unemployed at the time of admission into the program. At February 1972, 78 percent of the patients were employed or enrolled in vocational or academic training programs.

Direct Community Release Project

The Direct Community Release Project is an OEO-funded experimental program to determine the feasibility of bypassing inpatient treatment and releasing addicts directly to the outpatient treatment program. The project provides for short-term, intensive evaluation and treatment, including a medical examination, testing of individuals' vocational aptitudes, and counseling. These services are

provided by a psychiatric hospital on a contractual basis. After completion of the short-term program which normally lasts about 3 or 4 weeks, the patient is transferred to the regular outpatient program which includes supervision by a parole agent, counseling, and urine testing.

As of January 1972, 50 addicts had participated in the Direct Community Release Project. Of the 50, 16 were in the short-term inpatient phase, 15 had completed the short-term inpatient phase and had transferred to outpatient status, and the remaining 19--14 males and five females--had returned to an inpatient facility for treatment--15 because of failure to comply with program rules and four because of unsuitability for the direct release program. Of the 15 patients who had been referred to outpatient status, 13 were still active participants and two had left the program without authorization and warrants had been issued for their arrests.

NUMBER SERVED BY THE CIVIL ADDICT PROGRAM

The total number of people served by the California State Civil Addict Program from its inception in 1961 through December 31, 1971, was 16,713

As of December 31, 1971, there were 1,731 in the inpatient phase of the program, about one-third from Los Angeles County, and there were 6,883 in the outpatient phase, 3,326 from Los Angeles County.

PROGRAM COST

The total cost of the program from its inception through June 30, 1971, was $68,797,779, of which $56,885,644 was for inpatient treatment and $11,912,135 for outpatient treatment. The costs for fiscal yea. 1971 were, as follows:

	Total	Inpatient		Outpatient
		Men	Women	
Average daily population	6,796	1,788	284	4,724
Average cost per year per patient		$ 3,828	$ 5,433	$ 485
Total cost	$10,680,453	$6,844,782	$1,542,955	$2,292,716

Amounts budgeted for fiscal year 1972 were $9,481,398 for the inpatient phase, about $4,648 per patient, and $3,346,467 for the outpatient phase, about $592 per patient.

ASSESSMENT EFFORTS

Criteria for measuring program effectiveness

One criterion established for measuring the effectiveness of the program was the number of patients remaining drug free for 2 consecutive years while on active outpatient status. Remaining drug free for 2 years is also the criterion for successful discharge from the California State Civil Addict Program. Another criterion used to measure program effectiveness is the patient's active participation in the outpatient phase after release from inpatient treatment. The rehabilitation center's superintendent stated that, in

addition to the above-stated criteria, another factor to consider in evaluating the effectiveness of the program is the service it provides to society by supervising and controlling the activities and behavior of addicts, most of whom are convicted felons.

Program results

Information prepared by the center's research division showed that, of the 16,713 addicts committed to the program from inception to December 31, 1971, 8,063 had been in the program long enough to have satisfied program criteria for successful discharge--completion of 2 consecutive years without use of illicit drugs while in an outpatient status. However, only 1,603 had been discharged after satisfying this criteria--a success rate of about 20 percent.

To measure the length of time patients were remaining in active outpatient status, the research division reviewed the status of patients released to the outpatient phase during calendar year 1969. The research division found that 36 percent of the men and 43 percent of the women were still in active outpatient status 1 year after their release from inpatient treatment.

Information on program results has been developed through two systems--a population accounting system and an outpatient followup system. The population system locates and follows inpatients through the various activities at the center. The followup system provides information concerning outpatient activities. The followup system is being replaced by a system called the roster system field data collection. In this system, parole agents will periodically complete an informational data form on each person under their supervision. The form will contain such information as a patient's employment status, illicit drug use, and arrests. This information will be compiled into a written report which will be distrubuted throughout the Department of Corrections on a quarterly basis. The division is also developing a system for obtaining information on patients released from the program.

We believe that these new systems, when implemented, will provide data which will be useful to program managers for measuring program results.

CHAPTER 4

REHABILITATION PROGRAM AT FEDERAL CORRECTIONAL INSTITUTION, TERMINAL ISLAND

Terminal Island is one of five Federal correctional institutions with rehabilitation centers providing services to narcotic addicts convicted of violating certain Federal laws and committed for treatment under the authority of title II of the Narcotic Addict Rehabilitation Act of 1966 (28 U.S.C. 2901). Title II provides for inpatient treatment for institutionalized addicts and aftercare services for addicts paroled from the institution. A court may place an offender in the custody of the Attorney General for an examination to determine whether he is an addict and whether he is likely to be rehabilitated through treatment.

When a person is referred to Terminal Island for examination, he is evaluated to determine whether he should be admitted for treatment. To be eligible for treatment, a person must be a narcotic addict; must be likely to be rehabilitated; and must not have

--been convicted of a crime of violence;

--been convicted of a felony on two or more occasions;

--been convicted of unlawfully importing or selling, or conspiring to import or sell, a narcotic drug;[1]

--a prior charge of a felony pending against him;

--been previously committed on three or more occasions under title I of the Narcotic Addict Rehabilitation Act (title I authorizes the pretrial civil commitment

[1]A person convicted for these offenses may take advantage of the provisions of title II if the courts determine that the sale or importation was for the primary purpose of enabling him to obtain a narcotic drug which he required for his personal use because of his addiction to such drug.

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for treatment, in lieu of prosecution, of addicts charged with certain Federal crimes).

Offenders must receive a minimum of 6 months treatment at the institution before being released to aftercare.

INPATIENT TREATMENT

The Terminal Island institution began inpatient treatment for male and female addicts in August 1968. Essentially, three treatment approaches have been used. The first approach was the so-called traditional approach which included individual and group counseling. As part of this approach, some addicts also received "linker training," a 16-week program in which addicts were trained to provide a link between staff and program participants.

In May 1971 this approach was altered to include a more aggressive type of therapy. The second approach dropped group counseling and added group encounter sessions and a therapeutic community.[1]

In December 1971, aspects of the first two approaches were combined into a third approach, resulting in the following treatment modalities.

--Individual and small group counseling and specialized psychiatric treatment.

--Linker training.

--Therapeutic community.

The institution staff includes a director, a correctional treatment specialist, and six counselors. Eight consultants assist in providing psychiatric treatment, linker training, encounter sessions, and staff training.

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[1]This therapeutic community involves self-help treatment provided by participants living together in one dormitory and conducting their own group encounter sessions.

Number of patients

At December 31, 1971, 91 inmates (76 male and 15 female) were receiving inpatient treatment at Terminal Island. In addition, 21 inmates were being evaluated to determine whether they should be admitted to the program.

Only a small number of inmates--23 at the time of our visit--were members of the therapeutic community. Members of the community live together in one dormitory and are involved fulltime in the drug rehabilitation program. Other inmates are assigned to regular institution work activities when not involved in treatment sessions.

Through December 1971 the following number of inmates had been considered for the inpatient phase of the program.

Evaluation	Number considered
Ineligible or not accepted:	
Determined not to be addicts	63
Found not likely to be rehabilitated	49
Had criminal charges pending against them	9
Had committed more than two felonies or crimes of violence	15
Eligible but not accepted. Recommendation made to court that they be referred to a community-based program for treatment.	32
	168
Admitted:	
After evaluation	245
Readmitted without evaluation or transferred from another prison without evaluation	77
Total	322

Program expenditures

About $408,000 was spent for the inpatient program from August 1968 through November 1971. During fiscal year 1971 about $141,000 was spent on treatment, an average of

$2.70 per day per participating inmate. These amounts did not include the cost to house, feed, and guard the participants which amounted to about $9 per day. Thus the daily cost for each participant was about $11.70.

Program assessment efforts

Officials stated that persons remaining active in, or completing, the aftercare phase are considered successes. The Terminal Island inpatient unit, however, does not receive periodic reports indicating how persons released to aftercare are doing. Program officials said that they usually learned of successes and failures from releasees or from people living in their communities

AFTERCARE TREATMENT

The Bureau of Prisons Research Division recently completed a study of the aftercare performance of releasees from the five Federal institutions having rehabilitation centers. A Bureau of Prisons official told us that copies of the study were distributed to these five institutions, and program officials were briefed on the results of the study. The results for Terminal Island as of September 30, 1971, were, as follows:

Inpatient phase		Aftercare			
Released	Number released to aftercare	Active	Successfully completed program	Violators (note a)	Deceased or deported
8-68 to 3-69	9	–	–	9	–
4-69 to 9-69	15	8	–	6	1
10-69 to 3-70	30	16	–	12	2
4-70 to 9-70	43	36	–	5	2
10-70 to 3-71	49	44	1	4	–
4-71 to 9-71	29	27	1	1	–
Total	175	131	2	37	5

[a]Returned to prison or arrest warrants issued.

Program officials informed us that discussions with releasees and parole officers indicated that many of the active participants in aftercare had returned to illicit drug use but had escaped detection.

Patients in aftercare

Aftercare services in Los Angeles County are provided by either the Suicide Prevention Center, a private social service agency under contract with the Bureau of Prisons, or the Probation Office of the U.S. District Court.

From August 1968 through December 1971, the Probation Office had treated 94 releasees. Of these, 57 were still in treatment on December 31, 1971; 16 had transferred to aftercare programs in other States; and 21 had returned to prison.

Of the 35 releasees treated by the center from March through December 1971, 29 were still receiving treatment, three transferred to other aftercare programs, one had returned to prison, one had died, and one had violated parole and a warrant had been issued for his arrest.

Cost of aftercare

The following table summarizes the expenditures for the program:

Period	Suicide Prevention Center	Probation office	Total
8-68 to 6-69	$ -	$ 1,726	$ 1,726
7-69 to 6-70	-	19,608	19,608
7-70 to 6-71	10,073	31,095	41,168
7-71 to 12-71	20,549	18,207	38,756
Total	$30,622	$70,636[a]	$101,258

[a]Includes $36,928 for research.

We estimated the monthly cost per participant at the center to be $189 from July 1 through December 31, 1971.

Expenditures of the Probation Office do not include the salaries of the parole officers and certain administrative and clerical support. If these costs were included, the monthly cost for the Probation Office participants would be comparable to the monthly cost of treatment at the center.

Program assessment efforts

Upon release from an institution, the releasee is placed on parole for the duration of his sentence. He may be released from the aftercare program for good behavior prior to the expiration of his sentence; however, he still remains on parole.

Parole officers monitor the releasee's performance by reviewing the results of urine tests and preparing monthly progress reports which may include information on social activities and employment.

According to a program official, there are three instances in which the Federal Board of Parole will be requested to revoke parole: (1) the releasee has two consecutive positive urinalyses, accompanied by a deteriorating social life, (2) the releasee is convicted of a felony or serious misdemeanor, or (3) the releasee fails to report for parole supervision.

The effectiveness of the aftercare program is measured by the percentage of releasees who do not return to prison. There is no formal system for reporting to the Bureau of Prisons, but the Bureau's regional coordinator monitors the program's effectiveness by reviewing the parole progress reports prepared by the releasees' parole officers and the results of the urine tests.

The results of a special study of the aftercare programs by the Bureau of Prisons Research Division were presented on page 38. Also, the Probation Office contracted with the University of Southern California to evaluate the program. The University studied activities of 52 persons released to the Probation Office's aftercare program prior to July 1, 1971. The report on this study indicated an overall success rate; 83 percent of the releasees (43 of 52) were not recommitted to prison. For those in aftercare less than 1 year, the rate was 94 percent (31 of 33), and for those in aftercare more than one year, the success rate was 63 percent (12 of 19).

The report qualified these findings in several respects; i.e., the releasees had not been in aftercare very long and the sample size was too small. Also, the report noted that the results of urine tests were not too reliable, and some leniency was allowed in the use of drugs. The report also listed some program deficiencies, including minimal employment assistance and "the conflicting role of a therapist-authority figure" (parole officer).

CHAPTER 5

SUICIDE PREVENTION CENTER'S METHADONE WITHDRAWAL PROGRAM

In addition to serving as an aftercare agency for the Bureau of Prisons, the Suicide Prevention Center operates a methadone withdrawal program, initiated in March 1970. The objective of this program is to withdraw the patient from both narcotics and methadone.

To be eligible for this program, an applicant must (1) have at least a 2-year history of drug addiction, (2) have unsuccessfully attempted withdrawal from narcotics on two occasions, (3) be at least 18 years of age, (4) be currently using narcotics, and (5) exhibit a willingness to change his life-style and stop using narcotics.

An applicant's eligibility is determined through an intake interview and a urine test to ascertain whether the applicant is using narcotics. The director of the program stated that it was important to screen out those addicts who did not have a genuine desire to withdraw from both narcotics and methadone, because they would be better served by a methadone maintenance program.

After an applicant is accepted, he is given methadone twice a day during the first week to stabilize his behavior. Thereafter, most participants receive methadone daily under the supervision of a nurse. Some participants who have demonstrated acceptable behavior and for whom transportation to the clinic is a problem may receive up to a 3-day, take-home supply of methadone.

The maximum daily dose of methadone given to a patient is 80 milligrams.[1] Patients begin withdrawal from narcotics at low methadone-dosage levels which are gradually increased

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[1] Maximum dosage permitted by the State Research Advisory Panel is 160 milligrams. However, an individual program may establish a lower maximum.

to about 60 milligrams, where the patient is stabilized. After stabilization, the dosage level is gradually decreased until the patient withdraws and becomes drug free. The length of time a patient may receive methadone is indefinite and varies among patients.

Various supportive services are also offered, including group therapy sessions, individual psychiatric treatment, physical examinations, home economics classes, and employment assistance. Participants are encouraged to continue receiving these services for 1 to 2 years after withdrawing from methadone.

The only full-time staff member is the director, who has a master's degree in social work. Part-time staff includes psychiatrists, nurses, a doctor, several paraprofessionals, and ex-addicts.

PATIENTS IN TREATMENT

Since its inception in March 1970, 60 persons (20 females and 40 males) have participated in the program and 29 were still active at March 1, 1972. The median age was 26 years. The reasons 31 persons left the program were (1) 19 successfully withdrew from methadone, including five who transferred to another rehabilitation program, (2) five were dropped from the program for violation of program rules, (3) six transferred to other programs prior to withdrawal from methadone, and (4) one quit.

PROGRAM EXPENDITURE

Actual expenditures for the program were not available, but the director estimated the annual cost to be $60,000. About one-third of the cost is borne by program participants who pay from $3 to $250 per month for treatment, depending upon their ability. Other funds are obtained from private contributions. According to the director, the annual cost per participant is about $2,000.

PROGRAM ASSESSMENT EFFORTS

The effectiveness of the program is measured by the number of persons able to stop using both methadone and

narcotics. Participants who exhibit social movement, such as improved family life, employment, and fewer arrests, but are unable to withdraw from methadone are not regarded as successes. Those who withdraw from methadone and leave the program usually contact the Suicide Prevention Center staff three or four times a year to inform them of their progress.

We asked the director to contact the 31 persons, who had left the program, to determine their status. He advised us that (1) 12 were not using illicit drugs, (2) six were using illicit drugs, (3) five were participating in a methadone maintenance program, (4) three were incarcerated, (5) one was hospitalized with cancer, (6) one was deceased, (7) one was participating in a drug-free rehabilitation program, and (8) two could not be located

At our request, the director also compiled data on the arrest history, drug use, and employment status of the 29 active participants. They had been in the program from 1 to 21 months, and averaged 6 months. Prior to joining the program, 27 of the 29 participants had been arrested at least once, and averaged three arrests. None of the participants had been arrested after joining.

Review of the urine test results indicated that 14 participants, at March 31, 1972, had had 27 positive urine tests after joining the program, ranging from one to three per participant. Program participants submit an average of three urine specimens every 2 weeks.

Review of employment status revealed that 19 were employed (16 after joining the program); five were students (three employed part time); and five were unemployed.

CHAPTER 6

VETERANS ADMINISTRATION'S DRUG DEPENDENCY PROGRAM AT BRENTWOOD HOSPITAL

The Veterans Administration (VA) operates two narcotic treatment programs in Los Angeles County, one at the Brentwood Hospital and one at the Sepulveda Hospital. We obtained information on the treatment program at Brentwood.

The program at Brentwood, which is about 20 miles west of downtown Los Angeles, began operation in October 1971 to rehabilitate veterans who were addicts and to return them to the community. To accomplish this goal a multitreatment modality program is offered on both inpatient and outpatient bases. Services include medical treatment, detoxification, counseling, methadone maintenance, and social and recreational activities. Participation in the program is open to eligible veterans addicted to narcotics.

Program officials stated that criteria had not been established to measure program effectiveness, nor had a formal reporting system been implemented to collect data which could be used to measure results.

TREATMENT MODALITIES

The Brentwood program involves three phases: intake, inpatient, and outpatient.

Intake

In this phase a prospective patient is interviewed and evaluated by two counselors to determine his eligibility and whether he is properly motivated for participation in the program.

Patients accepted in the program are given physical examinations and psychological evaluations. Those patients with acute medical needs, as determined by the physician, are sent to the medical ward for special treatment. Drug addicts without acute medical needs are sent to the drug

abuse treatment ward, where determinations are made to treat them on either an inpatient or an outpatient basis.

Inpatient detoxification

Inpatient detoxification consists of eliminating the physical need and mental craving for narcotics. Eliminating the physical need for narcotics takes about 6 or 7 days with the assistance of methadone.

After a patient has been physically detoxified, he remains in the hospital for an additional 2 or 3 weeks to receive assistance in overcoming the mental craving for narcotics. During this period, efforts are made to solve legal, family, and employment problems and to find residences for the patients.

Other services available to the inpatients include individual and group counseling, job counseling, and social and recreational activities.

Three urine specimens are collected each week, one of which is randomly selected and analyzed for narcotics or other drugs.

Outpatient detoxification

Some veterans seeking detoxification assistance are immediately placed in outpatient status because their needs are not sufficiently acute to require inpatient status or because all 20 beds in the inpatient ward are occupied.

Physical detoxification takes 6 or 7 days, during which the individual receives medication (usually methadone) twice a day. Individual, group, and family counseling, in addition to group therapy, are available on a voluntary basis. Generally the patients do not participate in these activities on a regular basis. Instead they come to the detoxification ward when faced with a crisis situation, such as legal, family, or employment problems. The outpatient ward is open about 14 hours a day.

Methadone maintenance

The staff attempts to place the long-term, hard-core addicts into an outpatient methadone maintenance program. A prospective methadone patient must have a

--documented history of physiological dependence on narcotics,

--confirmed history of one or more prior treatment failures, and

--current physiological dependence on narcotics.

Patients are carefully screened to insure that methadone maintenance is absolutely necessary.

When accepted, both inpatients and outpatients are physically detoxified before beginning methadone maintenance. Patients are required to come to the hospital each day to receive their methadone, which is taken in the presence of a staff member. Other services available to the methadone maintenance patients are generally the same as those provided to detoxification patients. A patient is required to provide three urine specimens each week, one of which is randomly selected and analyzed for narcotic or other drug use.

The staff for both inpatient and outpatient care consisted of 19 full-time employees at February 1972. The staff included two physicians, one psychologist, four registered nurses, four counselors, nursing assistants, and administrative personnel.

The counselors are ex-addicts who have worked in other treatment programs. The two physicians have extensive experience in drug treatment.

PATIENTS IN TREATMENT

Inpatient

From program inception in October 1971 through March 31, 1972, 435 veterans were treated on an inpatient basis. As of March 31,

101 had completed the detoxification phase and had been discharged,

223 had been transferred to outpatient status,

57 had left voluntarily prior to completion,

45 had left for other reasons, such as expulsion or transfer to other programs, etc., and

9 were still being treated.

435

Outpatient

From October 1971 through March 31, 1972, 406 patients received outpatient care. Of these 223 had transferred from inpatient care and 183 were placed in outpatient status immediately after admission. As of March 31, 1972,

86 had completed the program and were no longer active,

17 had been returned to inpatient status,

29 had left voluntarily prior to completion,

1 had transferred to another VA hospital,

1 had dropped out of the program,

272 were still active

406

The 272 active patients included 144 who were in the methadone maintenance program.

EXPENDITURES

For fiscal year 1972 the drug program was allocated $271,411 to cover direct salary, supplies and services, and equipment costs. General hospital costs allocable to the drug program were paid from the hospital's general funds.

PROGRAM ASSESSMENT EFFORTS

Criteria have not been established to measure program effectiveness, nor has a formal reporting system to monitor program results been implemented. The officials stated that the reasons for the lack of evaluation were insufficient funds, inadequate staffing, and the newness of the program. The officials plan to establish criteria for measuring effectiveness which will include such factors as arrest and employment data and progress in social relationships.

Although formal assessments of program effectiveness have not been made, program officials have gathered data providing some indication of program results.

A survey of 116 methadone maintenance patients conducted on March 3, 1972, revealed that 66 were employed and 50 were unemployed. This information was reported by the patients but was not verified by the staff.

The results of the urine tests also give some indication of program results. Program officials estimate that from December 15, 1971, through February 18, 1972, 1,600 urine specimens were analyzed. Our analysis of records of these tests showed that 302, or 19 percent, were positive for illicit drug use. The results of the urine tests were not compiled by program component, so we could not determine the extent of illicit drug use among methadone maintenance patients and detoxification patients.

PROGRAM PLANS

Program officials informed us that the drug program was disorganized in its initial months because there was not

enough personnel to handle the large influx of patients. Program officials recognize that they cannot provide directly all the services necessary to treat an addict. They plan to develop close, working relationships with several community-based treatment programs whereby VA would pay for treatment. Officials also hope to establish a residential halfway house at the Brentwood Hospital.

CHAPTER 7

HOUSE OF UHURU

The House of Uhuru Drug Program is a component of the South Central Los Angeles Multi-Purpose Health Service Center. The center, a project funded by the Office of Economic Opportunity (OEO), has been in operation since October 1967, and began operating a drug program in February 1970. Services to drug addicts are generally provided on an outpatient basis and consist of physical examinations, detoxification, individual and group counseling, and referral to jobs or to other community resources. Criteria for measuring program effectiveness have not been established nor has a system for developing data on program results.

TREATMENT MODALITIES

The program, available to all addicts seeking help, consists of four basic phases--entry, treatment, rehabilitation, and followup and aftercare.

Phase I (entry) generally lasts about 1 week, during which the patient provides personal background information and is given a physical examination. Also, program personnel attempt to help patients who are facing crises involving legal, family, or employment matters.

In phase II (treatment), patients are detoxified either in a hospital or as outpatients. Initially all patients were detoxified as outpatients; however, since April 1970 a nearby hospital (Harbor General) has been providing, on an as-available basis, up to 10 beds for detoxification purposes. Addicts were then given a choice of receiving detoxification as outpatients or as inpatients. Patients detoxified as outpatients receive medications, other than methadone, to ease withdrawal symptoms. Methadone is used for detoxification in the hospital to ease narcotic withdrawal symptoms. Because of the limited number of available beds, a waiting list and priorities for inpatient detoxification were established by program officials. First priority was assigned to barbiturate addicts, second priority to narcotic addicts with severe medical problems, and third priority to narcotic addicts without severe medical conditions. At

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January 13, 1972, 31 addicts were on the waiting list for inpatient detoxification.

In phase III (rehabilitation), services provided to patients include individual and family counseling, group therapy sessions, and referral to other available community resources. Also certain recreational activities are provided. Because the House of Uhuru's program is on a voluntary basis, patients are not required to attend program activities except that, in detoxification, outpatients are required to attend group therapy sessions during their first 6 weeks to receive medication.

According to program officials, phase IV, followup and aftercare, is the weakest part of the program. Insufficient personnel was cited by officials as the reason for limited followup and aftercare. Program staff includes a director, an assistant director, a community relations counselor, an employment counselor, an environmental health specialist, 15 counselors, and clerical personnel. Most of the staff are high school graduates with some college training. Many of the counselors are ex-addicts. In addition to the program staff, a vocational counselor and the professional staff of the Health Center, which includes physicians, registered nurses, and social workers specializing in psychiatry, provide services to patients.

PATIENTS IN TREATMENT

From its inception in February 1970, through December 31, 1971, the program served about 1,600 drug addicts, about 900 during calendar year 1971. According to a program official, heroin was the predominant drug used by program participants and a high percentage of participants were referred to the program by probation and parole departments. At December 31, 1971, 502 addicts were participating in the program to some extent.

PROGRAM EXPENDITURES

Program expenditures from inception through December 31, 1971, totaled about $397,000, about $229,000 for calendar year 1971. OEO has approved a budget of $533,658 for the

program's 1972 operation. Some services, such as detoxification at Harbor General Hospital, are obtained without cost to the program.

Cost per participant or cost by modality of treatment cannot be computed becaused costs are not allocated among the various program phases.

PROGRAM ASSESSMENT EFFORTS

Formal criteria for measuring program effectiveness have not been established, nor has a formal system for developing data on program results been established. Participants who come into the program with a drug problem and leave drug free are considered successes. A detection system, such as urinalysis, has not been established or used in the program to determine whether participants are drug free.

OEO requires a quarterly report showing, among other data: (1) participants entering the program during the quarter, (2) outreach activities, and (3) consultant services. Information, such as status of active participants, number of participants successfully completing the program, and recidivism rates, is not included in the report.

From the quarterly reports we attempted to compile statistics which would provide some insight into the results of the program, but inconsistencies among the various quarterly reports prevented us from doing so. At our request program officials reviewed individual case files and compiled the following information for the period February 1970 through December 31, 1971.

Category	Number of participants
Detoxification attempts	1,490
Participants not needing detoxification entering rehabilitation program	86
Total	1,576
Number sucessfully completing detoxification	983
Unsuccessful detoxification attempts	507
Total	1,490
Number successfully completing phase III (drug free)	110
Number still active or semiactive	502
Number not currently participating in program	409
Total	1,021

Program officials indicated that they were aware of the need for better data concerning program results. They are currently planning to develop a data system which will provide such information.

OEO made at least two reviews of the Health Center, which included looking into the drug program. OEO reports on these reviews contained, basically, descriptions of how the drug program operates, and did not mention the results of the program.

CHAPTER 8

NARCOTICS PREVENTION PROJECT

The Narcotics Prevention Project is located in the predominantly Mexican-American community of East Los Angeles. It was formed in July 1967 as a delegate agency to the Economic and Youth Opportunities Agency of Greater Los Angeles, the local community action agency sponsored by OEO. Federal funds for the project are currently being provided by the Departments of Housing and Urban Development; Health, Education, and Welfare; and Labor.

The project's basic program consists of a specialized service, called crisis intervention, which essentially consists of helping narcotic addicts meet or resolve problems, instead of returning to narcotics as a solution. The two primary goals of the project are to (1) assist drug addicts in their efforts to attain socially acceptable and self-rewarding community living patterns and (2) develop methods and procedures for using such services as employment and welfare assistance which are available through existing social services agencies. Criteria or methods to measure the extent to which these goals are being met have not been established.

TREATMENT MODALITIES

Crisis intervention emphasizes frequent contact between program staff and the addict, individual counseling, and a series of aggressive community-oriented activities designed to call upon any and all assistance that local social service agencies and programs can provide. Services provided include job counseling and referral, family counseling, detoxification, legal assistance, referral for financial assistance, temporary residential facilities, and drug abuse information. Addicts seeking detoxification must wait 2 to 3 weeks for treatment because of the large demand on available detoxification facilities. Detoxification services are provided by Metropolitan State Hospital at no cost and by Rosemead Lodge, a private hospital, on a contractual basis.

PATIENTS IN TREATMENT AND SERVICES PROVIDED

At December 31, 1971, the project had a caseload of about 1,460 addicts, including about 350 who were actively participating in the program and 1,110 who were active to some extent.

The following table gives some indication of the amount of service provided during calendar year 1971 and from program inception in July 1967.

	Calendar year 1971	From inception through 1971
Number of participants referred for detoxification	3,349	5,448
Number of family and job counseling sessions	1,091	3,153
Number of other services provided (such as job referral)	320	2,821

SOURCE OF FUNDING

At December 1971 the project had obtained operating funds from four Federal sources, as shown below.

Source of funds	Amount	Period	Expenditures from July 1967 through Dec. 31, 1971
Office of Economic Opportunity	$ (a)	-	$1,398,722
Department of Housing and Urban Development	407,900	5- 1-71 to 4-30-72	93,714
Department of Health, Education, and Welfare:			
National Institute of	126,168	6-21-71 to 5-31-72	22,440
Mental Health	519,127	10- 1-71 to 9-30-72	176,040
Department of Labor	129,081	12- 1-71 to 10-31-72	52,604
Total	$1,182,276		$1,703,520

[a]As of Oct. 1, 1971, the project no longer received OEO funds.

Because of the variety of services provided to participants, it was not possible to compute the cost of services by treatment modality.

EFFECTIVENESS OF PROGRAM

The executive director of the project views the drug problem in two ways; the problem the addict has with himself and the problem the addict has with society. Officials believe that imprisonment as a solution is ineffective for these problems. Therefore, the project concentrates its efforts on keeping the addict out of jail and functioning satisfactorily in the community. They consider anything that reduces the use of drugs or keeps the addict out of jail a success; however, a method has not been established to measure the extent to which these goals are being met.

CHAPTER 9

COMPREHENSIVE PROGRAM OF COMMUNITY DRUG ABUSE TREATMENT AND RESEARCH

The University of California at Los Angeles (UCLA) began a comprehensive multimodality narcotic addict treatment and rehabilitation program in July 1971. The program is funded jointly by the Federal Government and UCLA.

The goals of the program are to provide treatment to selected narcotic addicts on a voluntary basis and to observe their activities in the various treatment modalities with a view toward developing a model for use in future narcotic treatment programs.

The program has five different components providing treatment and rehabilitation services to narcotic addicts. Included as part of the comprehensive program is a research project under which data on participants' behavior under various conditions is collected and evaluated. Two of the components, inpatient detoxification and methadone maintenance, are operated by UCLA on campus. The other three, a halfway house for methadone maintenance patients, a drug free therapeutic community, and a referral and counseling service, are operated by community organizations in the Venice section of Los Angeles, about 10 miles from the campus.

A preliminary report on the program was issued in March 1972. Included in the report prepared by UCLA were detailed descriptions of the operations of each component and information on program participants. The report, however, did not contain any conclusion as to the effectiveness of the program.

A brief description of the program modalities and their major objectives and goals follows.

TREATMENT MODALITIES

Detoxification

Four beds are set aside in UCLA's hospital for the detoxification of narcotic addicts. The patient receives treatment for about 14 days. During the first 7 days, methadone is administered to withdraw the patient from the use of narcotics. Dosage is decreased at a rate that allows the patient to be narcotic free by the seventh day. The next seven days of treatment permit the patient to stabilize physiologically and to use various hospital rehabilitative services, such as counseling, individual and group therapy, vocational guidance, and recreational activities.

Because of the few beds available for detoxification, only applicants considered to have a good chance of overcoming their narcotic habits are accepted. To help in assessing motivation, applicants are required to attend several group and individual counseling sessions before being placed on the detoxification waiting list.

Mathadone maintenance

The primary objectives of methadone maintenance are to (1) help addicts eliminate illegal drug-seeking behavior, (2) develop constructive life-style behavior free of illicit drug use, and (3) observe acceptable behavioral patterns while receiving metnadone. This program component can handle 16 to 21 addicts. To be eligible, an applicant must

--be 21 to 45 years of age.
--have been a heavy heroin user for more than 2 years.
--have had several unsuccessful treatment attempts.
--not be a psychotic.
--not have a history of drug abuse other than heroin.

Two psychiatrists and two nurses assist in this treatment on a part-time basis.

Prevention Referral and Counseling

Prevention Referral and Counseling, a community operated organization, provides the intake and followup services for

UCLA's detoxification program. Services include emergency referral and care to drug addicts in crisis situations, preventive education on drug abuse, and supportive counseling. The four permanent staff members of the organization are former drug addicts.

Methadone halfway house

This modality is also a community-based organization. It functions as a residential facility for persons on methadone maintenance who need additional support in their adjustment to a new life-style. The house provides a temporary residence for approximately 90 days, a program of therapy and counseling, and ancillary services, such as employment counseling and referrals to other programs. The house is run by a director and the residents.

Tuum Est

Tuum Est opened in September 1970 as a full-time, drug-free therapeutic community devoted to the rehabilitation of drug addicts. The therapy consists of group encounter sessions and daily discussion seminars.

The operations of Tuum Est are carried out by the residents under the supervision of a director and an assistant, both of whom are ex-addicts.

NUMBER SERVED

The number of people served by each modality is shown in the following table:

Program	Active participants at January 1972	Number served July 1971 to January 1972	Waiting list at January 1972
Detoxification	4	60	12
Methadone maintenance	18	18	-
Prevention Referral and Counseling	52	90	-
Methadone halfway house	14	14	-
Tuum Est	40	58	60
	128	240[a]	72

[a]Some were counted more than once because they received services from more than one program.

FUNDING LEVEL OF PROGRAM

The program is funded jointly by the Federal Government and UCLA. The Federal share is $393,979 and UCLA contributes $258,491, most of which is by in-kind contributions. The Federal funds were made available for fiscal year 1972 through a grant provided to the State by the Department of Justice Law Enforcement Assistance Administration.

The grant budget for fiscal year 1972 was broken down as follows:

Program modality	Budget
UCLA's treatment program	$179,974
Program analysis and development (UCLA)	46,869
Methadone halfway house	47,040
Tuum Est	62,637
Prevention Referral and Counseling	57,459
	$393,979

CHAPTER 10

SYNANON FOUNDATION, INC.

Synanon is a private tax-exempt foundation established in 1958 in Santa Monica, Calif., to help alcoholics. Since then, additional facilities have been opened outside of Los Angeles County. The emphasis now is on helping narcotic users and addicts.

The Santa Monica facility is about 20 miles from downtown Los Angeles and provides a self-contained environment for the participants, including living quarters, dining facilities, medical and dental service, recreational facilities, staff offices, library, meeting rooms, and schools for children. Synanon also has three apartment complexes to house participants.

Persons living at Synanon may be classified as either "life-stylers" or residents. The life-stylers, who make up about 10 to 15 percent of the population, are persons who live at Synanon but work in the community. They must pay for room and board. Residents live and work at Synanon or its enterprises, and receive a nominal allowance ranging from $7 to $50 a month. In many cases both the residents and life-stylers have their families with them.

Synanon officials stated that firm criteria for determining who can be a resident have not been established. Very few persons are denied admission. The decision on whether to accept an applicant is made by a staff member after a discussion with the applicant. Synanon does not attempt to verify, by means of urine tests, arrest records, medical history, or other means, whether an applicant is a narcotic addict. Synanon officials told us that most of the residents had been addicted to narcotic or other illicit drugs.

TREATMENT MODALITY

At Synanon the life-style is considered to be the treatment. Synanon attempts to create a drug-free environment in which a person can develop to his fullest potential. According to Synanon officials, it is not a drug rehabilitation

program per se; rather, it is a social movement. In part, the Synanon philosophy states:

> "No one can force a person towards permanent and creative learning. He will learn only if he wills to. Any other type of learning is temporary and inconsistent with the self and will disappear as soon as the threat is removed. Learning is possible in an environment that provides information, the setting, materials, resources, and by his being there."

Synanon views narcotic addiction as a character disorder which must be corrected by reeducating the addict to a different life-style. The key therapeutic activity is the "Game," which usually involves 12 to 15 people and affords the addict an opportunity to express himself and to examine his behavior. An addict who exhibits anti-Synanon-accepted behavior is verbally attacked by the other game players so that he may understand his improper behavior and correct it. Peer pressure thus plays an important role in changing the addict's life-style. Many other activities are also offered, including vocational training, seminars, discussions, lectures, and movies. These activities occur with varying frequency throughout the week.

Once admitted, addicts are detoxified cold turkey (without medication). This usually takes 1 or 2 weeks. During this period the addict is also oriented to the Synanon life-style. In his first year at Synanon, the addict's life-style is more structured than the life-style of those who have lived there longer. An addict works fewer hours during the first year but must attend more seminars and meetings and participate in the game at least seven times a week.

PATIENTS IN TREATMENT

Statistics on the number of residents at the Santa Monica facility were not available prior to fiscal year 1964 (Sept. 1, 1963 to Aug. 31, 1964). The average number of residents from September 1, 1964, by fiscal year, follow.

Fiscal year	Average number	Number at end of year
1965	159	143
1966	149	154
1967	254	355
1968	463	571
1969	633	694
1970	623	551
1971	511	472

In the past the Santa Monica facility has not had a waiting list. However, in the fall of 1971, Synanon started a recruiting campaign which resulted in 300 persons' being admitted as residents. This large influx placed a heavy burden on the staff, and, as a result, no one was admitted from January through April 1972.

PROGRAM EXPENDITURES

The fiscal year 1971 financial statement for Synanon listed the following four sources of revenue.

	1971	1970
Synanon Industries	$ 907,000	$ 655,000
Contributions	1,927,000	2,558,000
Contributions of land and building	1,361,000	-
Other	148,000	214,000
Total	$4,343,000	$3,427,000

The contributions include payments by the life-stylers for room and board and contributions from private citizens. The contribution of land and building represented a donation of property to the San Francisco, Calif., facility.

Synanon expenses at all facilities in 1970 and 1971 totaled $2,452,000 and $2,538,000, respectively. Records showing expenses for individual facilities are not maintained. At March 1972, the Santa Monica facility had 775 (42 percent) of the 1,700 persons living in Synanon facilities. A program official informed us that Synanon's annual cost to support a participant was $1,790, exclusive of donated goods and services.

ASSESSMENT EFFORTS

Synanon believes it is successful if it can create an atmosphere in which the participant can develop to his fullest potential. Thus Synanon's objective is to foster personal growth, a goal which cannot be statistically measured.

Synanon makes no concerted effort to return residents to the outside community, but residents may, and do, leave voluntarily. Records showing the number who have left are not maintained, and Synanon does not have records showing a person's status after he leaves.

CHAPTER 11

NEEDS OF DRUG REHABILITATION AND TREATMENT PROGRAMS IN LOS ANGELES COUNTY

We were informed by State and county officials, program administrators, and addicts of the following operational needs of drug rehabilitation and treatment programs in Los Angeles County.

--Improved coordination and planning.

--Increased effort to both define and evaluate program effectiveness.

--More and better trained staff members.

--More supportive services, particularly job placement for patients.

--More and better facilities.

--Greater capability to treat more addicts.

IMPROVED COORDINATION AND PLANNING

Of paramount concern to several officials was the need for improved coordination of the many and varied types of treatment and rehabilitation efforts and planning for future drug programs, both public and private. These needs are especially acute in Los Angeles County because of the large number of health districts and government jurisdictions and the large number of treatment programs in the private sector.

In 1969 the Los Angeles County grand jury noted that:

"In Los Angeles County there is no comprehensive plan for drug abuse education, information or treatment. All County health agencies and volunteer community programs must be coordinated and properly funded ***."

In its 1971 report, the grand jury stated that:

"*** this committee must conclude that the situation, as far as a comprehensive and coordinated drug-abuse plan, remains unchanged. In spite of dedicated efforts by many individuals and groups, plus large expenditures of time and money, it is tragic that Los Angeles County drug abuse programs remain fragmented, uncoordinated, inadequate, and lost in a maze of bureaucracy and interdepartmental maneuvering."

At least three groups, the county's Narcotics and Dangerous Drugs Commission, the Los Angeles Community Liaison Association, and the Interagency Committee on Drug Abuse were individually working on ways to improve the coordination and planning of drug programs at December 1971.

EVALUATION OF PROGRAM EFFECTIVENESS

Program officials acknowledged that program effectiveness criteria generally were not well defined and program effectiveness could not be measured objectively. In general, information systems had not been developed to gather evaluative data regarding an individual's progress during and after treatment. For example, the effectiveness criteria for one program were the decrease in arrests and in illicit drug use and improved employment capability. However, the program has not defined what constitutes an acceptable level of arrests, illicit drug use, or unemployment.

NEED FOR MORE AND BETTER TRAINED STAFF

Several program officials informed us that program effectiveness was hampered by inadequate staffing, usually as a result of insufficient funding and that program effectiveness could be improved by better trained staff. For example, personnel at two programs indicated that the staff needed training in the habits, action, and vocabulary of addicts. The importance of this type of training was underscored when several addicts informed us that effective counseling could not be provided by persons not knowledgeable about drug users and their environment.

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MO E SERVICES

Many addicts indicated to us that employment is almost a prerequisite to successful rehabilitation. Without employment the addict must find alternative ways to spend his free time, and this often means returning to the street to renew relationships within the drug abusers' environment.

Program officials recognize the importance of assisting the addict in finding gainful employment and have attempted to provide such a service. However, many programs do not have professionally trained employment counselors who can devote their full attention to helping addicts find jobs.

EXTENDING SERVICES
TO MORE ADDICTS

Drug treatment and rehabilitation services are not available to all who need and desire such services. This fact is most graphically illustrated by the existence of waiting lists at several programs. For instance, the county's methadone maintenance program has about 2,300 persons waiting to join. (See p. 20 .) A program official said that it would take about 3 years to serve these persons unless supplementary funding is obtained.

Another example of unmet need was evident at Terminal Island. (See p. 34 .) Eligibility criteria for the Narcotic Addict Rehibitation Act (NARA) program preclude certain addicts from participating because they (1) are not likely to be rehabilitated, (2) have been convicted of two or more prior felonies, or (3) have been convicted of a crime of violence. Officials at Terminal Island informed us that a significant number of inmates could benefit from the program but did not satisfy the eligibility criteria. The ineligible inmates may receive some group counseling but do not receive any other specialized treatment directed at their drug abuse problem.

On May 10, 1972, a Bureau of Prisons' headquarters official told us that, after the provisions of Senate bill 2713 became law (the legislation, Public Law 92-293, was signed by the President on May 11, 1972) Terminal Island would, depending on available capacity, provide narcotic treatment and rehabiliation services to inmates ineligible for the NARA program. The purpose of the legislation is to insure that treatment will be available to addicts who do not qualify for treatment under NARA, and the Attorney General is given authority to care for narcotic addicts placed on probation, released on parole, or mandatorily released. Inpatient care for such persons is currently being provided by the Bureau of Prisons at seven Federal correctional institutions under the authority of section 4001 of title 18, United States Code, which provides for the treatment, care, rehabilitation, and reformation of Federal offenders.

Another example of unmet needs involves the VA program at Brentwood Hospital. VA regulations prohibit the program from treating the spouses of veterans. Officials view this

as unfortunate because, in many cases, the wife of a patient is also an addict and in need of treatment and rehabilitation services. Thus, any positive effects of the VA program may be diminished because the patient may live in an environment where drugs are being used.

BETTER FACILITIES

Staff members at several programs complained that limited and inferior facilities were not conducive to effective treatment and rehabilitation. For instance, one program conducted its treatment activities at centers where other health services were also provided. The centers are usually very busy and very noisy, making it difficult for the staff to conduct counseling sessions. Also, urine specimens at these centers must be collected in public restrooms, which is embarrassing to the patients as well as to the staff who must observe the giving of the specimens.

APPENDIX I

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
WASHINGTON, D.C. 20515

October 15, 1971

Honorable Elmer B. Staats
Comptroller General of the United States
Washington, D. C. 20548

Dear Mr. Staats:

To assist the Subcommittee in its continuing consideration of legislation concerned with the treatment and rehabilitation of narcotic addicts, we would appreciate having the General Accounting Office make a review and provide a report on program assessment efforts made by Federal, State, and local agencies involved in narcotic rehabilitation activities. The Subcommittee's concern is that in developing legislation for treatment and rehabilitation, adequate program assessments are made to provide a basis for the Congress and the executive agencies to take action to improve the rehabilitation programs.

For an appropriate mix (Federal, State, and local) of programs, your review should provide information on the treatment modality, program goals, and established controls and techniques for measuring program accomplishments. The Subcommittee also desires information on program costs including, if possible, information on amounts spent on program assessment efforts. The information gathered should be supplemented by your comments on any identified weaknesses relating to the efforts of program sponsors to evaluate program effectiveness. We would appreciate your suggestions as to actions needed to improve such efforts.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report would be most helpful if it could be available to the Subcommittee by June 1972.

Sincerely,

Don Edwards

Don Edwards
Chairman
Subcommittee No. 4

U.S. GAO, Wash., D.C.

REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

Narcotic Addiction Treatment And Rehabilitation Programs In San Francisco And Alameda Counties, California

B-166217

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

JULY 24, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-166217

Dear Mr. Chairman:

In accordance with your October 15, 1971, request, the General Accounting Office has obtained information on narcotic addiction and treatment in San Francisco and Alameda Counties, Calif., and at the Veterans Administration Hospital at Palo Alto, Calif. This is the third in a series of five reports to be issued pursuant to this request. Other reports issued or to be issued cover Washington, D.C.; New York City; Chicago, Ill.; and Los Angeles, Calif.

We discussed this report with the appropriate Federal, State, county, and city officials, but we did not obtain their formal written comments. Oral comments received have been considered in preparing this report.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Don Edwards
Chairman, Subcommittee No. 4
Committee on the Judiciary
House of Representatives

Contents

ABBREVIATIONS

BCMP	Berkeley Community Methadone Program
GAO	General Accounting Office
GROUP	Growth Reorientation Opportunities Unlimited Project
LEAA	Law Enforcement Assistance Administration, Department of Justice
OEO	Office of Economic Opportunity
VA	Veterans Administration
VAHPA	Veterans Administration Hospital at Palo Alto, Calif.

COMPTROLLER GENERAL'S
REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

NARCOTIC ADDICTION TREATMENT AND REHABILITATION PROGRAMS IN SAN FRANCISCO AND ALAMEDA COUNTIES, CALIFORNIA B-166217

D I G E S T

WHY THE REVIEW WAS MADE

This is the third of five reports requested by the Chairman of the Subcommittee on programs for treating and rehabilitating narcotic addicts in Chicago, Ill.; Los Angeles and San Francisco, Calif.; New York City; and Washington, D.C.

This report is on programs in San Francisco and Alameda Counties and the Veterans Administration Hospital in Palo Alto, Calif. The General Accounting Office (GAO) previously reported on programs in Washington and Los Angeles.

In developing legislation relating to treating and rehabilitating narcotic addicts, the Subcommittee is concerned that adequate provision be made for assessing program performance so that the Congress and executive agencies will have a basis for improving treatment and rehabilitation.

GAO was asked to determine for each of the five cities:

--The amount of money being spent by governmental agencies on narcotic treatment and rehabilitation.

--Goals of the different programs.

--Methods of treatment.

--Number of patients in treatment.

--Services available.

--Cost of the different treatment methods.

--Criteria used to select patients.

--Extent of efforts to assess program performance.

--What was learned from this feedback.

JULY 24, 1972

FINDINGS AND CONCLUSIONS

Size of narcotic addiction problem

San Francisco officials estimated that the number of heroin addicts in San Francisco County ranged from 4,500 to 7,200, and Alameda County officials estimated that a minimum of 5,000 heroin addicts resided in the county. (See p. 8.)

Treatment programs and objectives

Narcotic addicts in San Francisco were assisted by treatment and rehabilitation programs operated directly by, or under contract with, the San Francisco County Department of Public Health and by private programs. The department was preparing a coordinated drug abuse program with the assistance of the San Francisco Coordinating Council on Drug Abuse. The program will, in part, set forth the roles of the public and private sectors in the diagnosis, treatment, rehabilitation, education, and prevention of drug abuse and addiction. (See p. 12.)

In Alameda County narcotic addicts were treated under city and county operated and contracted programs and by private programs. The major purpose of the county's comprehensive drug abuse program was to reduce the number of drug abusers. (See p. 13.)

Assessment efforts

Neither San Francisco County nor Alameda County evaluated its drug abuse programs, but both intend to and are working toward collecting data for this purpose. (See p. 18.) Evaluations of individual treatment and rehabilitation programs by program personnel generally were informal or were in the planning stage.

Problems and needs of treatment programs

GAO discussed with State and local government officials problems being encountered, operational needs of the programs, and ways in which the programs could be improved. GAO was informed that:

- --Narcotic treatment programs needed to be registered and licensed to insure quality of treatment. (See p. 57.)
- --Standards as to the type of data that should be gathered needed to be developed to use in measuring program results and to enable comparisons of different types of programs. (See p. 58.)
- --The lack of facilities in the San Francisco-Oakland area was hampering the effectiveness of the State's program for the civil commitment of narcotic addicts. (See p. 59.)

In addition, GAO noted that the San Francisco Methadone Research Program was experiencing difficulty in obtaining arrest records for program applicants

from a State agency. The agency believed that furnishing arrest information to the program was not authorized by the State penal code. (See p. 59.)

Analyses of major narcotic addict treatment programs

To provide an overview of programs operating in San Francisco and Alameda Counties, GAO obtained information on several programs funded by Federal, State, and local government agencies and private sources. Information on the programs, discussed in detail in the report, is summarized in tabular form below. Other programs are discussed in less detail in appendixes II and III.

Program	Date started	Treatment method	Number of patients
Center for Specisl Problems (See p. 20.)	7/69	Outpatient: Methadone maintenance Detoxification	352 methadone maintenance patients as of 12/71. About 15 to 20 detoxification patients per month.
Walden House (See p. 29.)	8/69	Inpatient therapeutic community	150 served from 8/69-12/71
Haight-Ashbury Medicsl Clinic (See p. 32.)	6/67	Outpatient detoxification	250 outpatients as of 5/72
The Center for Solving Special Socisl and Health Problems--Fort Halp (See p. 35.)	12/70	Outpatient methadone maintenance	100 on the everage
West Oakland Health Center Methadone Maintenance Reseerch Program (See p. 38 .)	8/71	Outpatient methadone maintenance	120 as of 5/72
G.R.O.U.P. Community Services (See p. 42 .)	Summer 1970	Inpatient therapeutic community	82 as of 2/72
Eden Drug Abuse Clinic (See p. 46 .)	7/71	Outpatient methadone maintenance	93 as of 2/72
Veterans Administration Hospital at Palo Alto (See p. 50.)	8/70	Inpatient: Rehabilitation Detoxification Abstinence Outpatient: Methadone maintenance Detoxification	301 treated by all phases of the program from 1-11/71

Program costs	Program evaluation criteria	Pertinent program results
Fiscal year 1972 budget: --$685,500 methadone maintenance --$17,000 detoxification	Eliminate illicit drug use Stop criminal activity Help patients find employment Improve family relationships	In 4/71, 16 percent of 371 urine tests showed illicit drug use. From 1-6/71, 11 of 215 patients were arrested; 10 of 352 were arrested between 7/1-12/31/71. 65 percent of 217 were employed, were in school or training, or were homemakers at 6/71.
Fiscal year 1972 budget--$142,000	Develop greater personal strength and self-confidence	Staff estimated that about 25 percent of persons served had made meaningful life changes in work and school.
Annual budget--about $305,000	No stringent criteria established.	Program officials estimate that a minimum 50 percent of those detoxified will need to be detoxified again.
Monthly budget, including services for other than addicts--about $10,000	Decrease drug dependency Increase social and vocational functioning Eventual withdrawal from methadone	No followup done because 6 months was the longest time any patient had been out of program.
Budget for 4/72-3/73--$120,000	Reduce addiction and crime rate in Model Cities area Reduce drug use by school children	From 8-12/71, 14 percent of 2,059 urine specimens from patients showed illicit drug use.
$70,000 annually	Enable individuals to become productive and responsible and to develop the confidence to make decisions and stand behind them	Since the summer of 1970 --5 persons have completed the program and --25 of those who left before completing the program were believed to be drug free.
$115,850 available for 1972	Stop heroin use Develop more productive life-style Stabilize emotional life and increase self-esteem Eventually withdraw from methadone	During a 1-week period in the latter part of 1971, 24 percent of urine specimens tested showed illicit drug use.
$554,000 for 1971	Help patient learn to live without drugs or function satisfactorily on methadone	The staff is not sufficient to perform complete evaluations. A pilot study of 34 former patients showed: --77 percent had not used narcotics since leaving. --81 percent had not been arrested. --52 percent were employed. --23 percent had been or were in training.

Tear Sheet

CHAPTER 1

INTRODUCTION

Our Nation today is faced with a serious narcotic[1] addiction problem. The President, in his January 20, 1972, state of the Union message, remarked that:

> "A problem of modern life which is of deepest concern to most Americans--and of particular anguish to many--is that of drug abuse. For increasing dependence on drugs will surely sap our Nation's strength and destroy our Nation's character."

Throughout the Nation questions are being asked as to what is the most effective way to deal with this problem. Criteria setting forth the results expected from treatment and rehabilitation programs are vague or frequently lacking. Results of varying methods of treatment are debated by experts. Information on numbers of addicts in the Nation is based on educated guesses at best. Data on people in treatment throughout the country are generally lacking as is information on program costs and results achieved.

Because of the seriousness of this problem and the need for information to arrive at rational decisions, the Chairman, Subcommittee No. 4, House Committee on the Judiciary, requested us to assist the Congress in obtaining information on the progress being made in rehabilitating narcotic addicts by various modalities of treatment. The Chairman asked that our review include narcotic addiction treatment and rehabilitation programs receiving Federal, State, or local funds in five cities--Washington, D.C.; New York City; Chicago, Ill.; and Los Angeles and San Francisco, Calif.--and that separate reports be prepared for each. This report concerns programs in San Francisco and Alameda Counties, Calif., and at the Veterans Administration Hospital in Palo Alto, Calif. (VAHPA).

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[1] Throughout this report the term "narcotic" refers to drugs which are derived from opium, such as heroin, morphine, and codeine.

For each city, we were asked to obtain information on the amount of money being spent by governmental agencies on narcotic addict treatment and rehabilitation programs, numbers of addicts being treated by each modality, program goals and criteria used to measure program accomplishments, and efforts being made by program sponsors to measure the effectiveness of their programs. The Subcommittee's interest was that, in developing legislation concerned with programs for treating and rehabilitating narcotic addicts, adequate provision be made for program assessment efforts so that the Congress and executive agencies would have a basis for improving the programs.

Estimates of the number of addicts in San Francisco[1] ranged from 4,500 to 7,200, and Alameda County estimates indicated that a minimum of 5,000 narcotic addicts resided in the county. The number of persons arrested in San Francisco for all categories of drug violations, including sale, possession, and use of all dangerous drugs and marihuana, were 6,408 in 1970 and 7,147 in 1971. In Oakland, Alameda County's largest city, arrests for narcotic law violations totaled 3,583 in 1970 and 2,063 in 1971.

A study based on interviews with 1,700 narcotic addicts at San Francisco's Haight-Ashbury Medical Clinic during 1970 by the clinic's epidemiologist showed that the addicts had obtained during 1 year $29 million to acquire heroin. The $29 million was obtained in the following ways:

Source	Amount (millions)
Thievery and burglary (~~$21~~ million in goods sold at one-third value)	$ 7
Cash robbery	-
Prostitution and pimping	4
Welfare	2
Jobs	7
Selling drugs	5
Other	1
	$29

[1] As used in this report, San Francisco refers to both the city and the county, which are coterminous.

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The study indicated that the overall cost of heroin addiction in the San Francisco Bay Area would be about 10 times this amount, or approximately $290 million.

Alameda County estimated that (1) the direct costs of arrests, confinement, probation, hospitalization, and other expenses as a result of drug use exceeded $5 million in 1971 and (2) $100 million had been spent each year to purchase heroin.

CHAPTER 2

TREATMENT AND REHABILITATION PROGRAMS IN SAN FRANCISCO AND ALAMEDA COUNTIES

Narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties were funded by the local governments (city and county), by State and Federal agencies, and by private sources. The budgeted fiscal year 1972 financial support from Federal, State, and local governments for drug treatment and rehabilitation programs[1] in these counties was as follows:

		Amount	
San Francisco			
City and county		$93,[illegible]	
State		$6[illegible],857	
Federal			
National Institute of Mental Health, Department of Health, Education, and Welfare		[illegible],073	
Law Enforcement Assistance Administration LEAA, Department of Justice		[illegible]61,255	
Total			[illegible],748,690
Alameda County			
Local			
County	$ 25,749		
City of Berkeley	62,500	88,249	
State		517,377	
Federal			
Office of Economic Opportunity (OEO)	274,783		
Model Cities Program, Department of Housing and Urban Development	126,049		
National Institute of Mental Health	18,000		
LEAA	146,123		
		564,955	
Total			1,170,981
Total San Francisco and Alameda Counties			$3,919,181

FEDERAL PROGRAMS

As shown in the above table, the Federal Government provided funds for treating and rehabilitating narcotic addicts in San Francisco and Alameda Counties through the National

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[1] We were unable to identify narcotic rehabilitation and treatment program costs since most programs offer services to abusers of all drugs.

Institute of Mental Health, OEO, the Model Cities Program, and LEAA.

In Alameda County the OEO-funded program was not fully operational as of March 1972, and the program, which received Model Cities funds, had been in operation approximately 6 months as of that time.

In addition, VAHPA provided narcotic treatment and rehabilitation for veterans in the San Francisco Bay area. (See p. 50.) This program maintains a satellite methadone maintenance center in San Francisco to dispense methadone and provide supportive services.

STATE PROGRAMS

California provided funds for narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties through the Department of Mental Hygiene, the California Council on Criminal Justice, and the California Department of Corrections.

Department of Mental Hygiene

The department operated State hospitals for the mentally ill and provided funding for mental health services under the Short-Doyle Act. The Lanterman-Petris-Short Act, which amended the Short-Doyle Act, established a 90-percent-State and a 10-percent-county financing formula for mental health services rendered to patients treated in State hospitals or community programs.

Each county with a population of over 100,000 was required to have a plan for mental health which established priorities of services. The county plans were forwarded to the State Department of Mental Hygiene for approval. Drug abuse programs were included as one of the authorized mental health services, but the amount of money spent on any service was left to the county's discretion.

California Council on Criminal Justice

The council, a 29-member board chaired by the attorney general of the State of California, administers LEAA grants

for California and determines which programs will be granted LEAA funds. Membership on the council was established on a regional basis. There were 23 regions, each with one to four participating counties. Of the LEAA funds the council receives, 75 percent must go to local units of government, such as city councils or county boards of supervisors.

California Department of Corrections
civil addict program

This program provides institutional and outpatient care to narcotic addicts committed for treatment and rehabilitation by the courts. Inpatient treatment and rehabilitation is provided at the California Rehabilitation Center facilities in Corona and at Patten Hospital near San Bernardino. Region II of the Parole and Community Services Division of the Department of Corrections administers the outpatient program in San Francisco and Alameda Counties. Our report on narcotic treatment and rehabilitation programs in Los Angeles included additional information on this program. However, problems which may be unique to the San Francisco and Alameda outpatient treatment programs are discussed later in this report. (See p. 59.)

LOCAL GOVERNMENT PROGRAMS

Drug abuse treatment and rehabilitation in San Francisco was primarily the responsibility of the county's Department of Public Health. The department either operated facilities which provided narcotic addiction treatment and rehabilitation or contracted with private local programs to provide such services to community residents.

A comprehensive community drug abuse program for San Francisco was being developed by the department. The San Francisco Coordinating Council on Drug Abuse, which comprised more than 70 public and private entities, was assisting with the development of this program. When completed it will set forth the roles of the private and public sectors in the diagnosis, treatment, rehabilitation, education, and prevention of drug abuse and addiction in San Francisco.

The program will provide for an epidemiological approach to drug abuse--that is, it will utilize techniques

similar to those used for the control and elimination of an epidemic disease. The techniques are to (1) identify, diagnose, and treat cases, (2) find sources, (3) identify modes of transmission, (4) define suspects, (5) break the cycle of transmission, (6) provide educational programs, and (7) emphasize prevention programs.

The services to be provided by the drug abuse program include (1) information and referral, (2) treatment and emergency services, (3) education and prevention, (4) rehabilitative and support services, and (5) research and evaluation.

In Alameda County addicts were treated under city and county operated and contracted programs and by private programs. The need for a comprehensive program for drug abusers, including education, prevention, treatment, and rehabilit.ion, became a pricrity in the fall of 1969. As a result, a county program, called the Alameda County Comprehensive Drug Abuse Program, was developed, which had a major purpose of reducing the number of drug abusers in the county.

The policymaking board for the program consisted of the Director of the County Health Care Services Agency, the Chief Probation Officer, the District Attorney, the Sheriff, the County Superintendent of Schools, judges from the municipal and superior courts, and the Chairman of the Alameda County Drug Abuse Coalition. The Drug Abuse Coalition is an organization composed of representatives from 21 drug abuse programs and interested agencies in the county.

TREATMENT MODALITIES

We identified four basic treatment and rehabilitation approaches which the various narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties were using. The four approaches, or modalities, were:

1. Outpatient methadone maintenance.

2. Inpatient methadone detoxification.

3. Residential therapeutic communities.

4. Drug abstinent detoxification, both inpatient and outpatient.

The above modalities normally include support services, such as psychological assistance, education and job-placement assistance, and referral for additional treatment or social services, in addition to the prescribed treatment.

Methadone maintenance

The outpatient methadone maintenance approach utilized a daily oral dose of methadone, normally 80 to 120 milligrams, to block the need for narcotics.

In the programs we visited in San Francisco and Alameda Counties, the length of time a patient was to remain on methadone varied. Voluntary withdrawal from methadone, with staff approval, usually did not occur until a patient had been in the program at least 6 months and had not used illicit drugs during the 6-month period.

In both counties to be eligible for admission to a methadone maintenance program, a person generally

--must have been a narcotic addict (daily user) for a minimum of 2 years,

--must have been over 18 years of age,

--must have had a history of failure of other legitimate treatment attempts, and

--must have been deemed acceptable by the program staff.

The California Research Advisory Panel, which had the authority to establish criteria and approve and evaluate methadone maintenance programs in California, placed the following requirements on methadone maintenance programs.

--No patient was to be admitted to a methadone maintenance program without a documented history of at least 2 years of narcotic addiction.

--Methadone was not to be administered except in a suitable volume of solution.

--Each take-home dose was to be labeled and was to show the name and location of the methadone treatment center, the nature of the drug, the name of the patient, the date, and an appropriate warning.

--Take-home doses were to be secured in locked containers, and take-home dosage bottles were to be returned and checked in to the program.

Methadone detoxification

Short-term inpatient detoxification from narcotic addiction using methadone is usually a 1-week program providing for decreasing daily dosages of methadone. The daily dosages are scheduled so as to ease the withdrawal from narcotics.

Therapeutic communities

Therapeutic communities are residential treatment facilities ususally offering a drug abstinent life-style which concentrates on instilling a new and positive meaning to the addict's life. Length of voluntary program participation varies from 6 months to the remainder of an addict's life. Most therapeutic communities use group confrontation or attack therapy patterned after an early therapeutic residential treatment approach for alcoholics and drug abusers developed by Synanon Foundation, along with other encounter and counseling techniques.

Nonmethadone detoxification programs

These programs provide short-term (1- to 2-week period) detoxification from narcotics by using medications, such as sedatives and tranquilizers, to assist the addict in the detoxification process. Detoxification is accomplished on either an inpatient or an outpatient basis.

METHOD OF ENTRY TO TREATMENT

In San Francisco and Alameda Counties, persons entered narcotic addiction treatment programs through the following processes:

--Voluntary submission.

--Commitment by Federal or State courts.

--Referral by local police or judicial or parole agencies.

Individual narcotic treatment and rehabilitation programs set forth various entrance requirements, such as minimum age, residence, or addiction history. The criteria for the programs that we gathered information on are discussed in chapter 3 for San Francisco and in chapter 4 for Alameda County.

PATIENTS IN TREATMENT AND SERVICES AVAILABLE

The Director of the San Francisco Department of Public Health stated that information on the total number of persons in treatment for narcotic addiction in San Francisco was not available. He stated that funds were not available, to cover the cost of gathering this type of information and that this had been listed as a priority need in the county's plan for treating drug abusers.

The Drug Abuse Coordinator, and the Director of the Health Care Services of Alameda County stated that the total number of persons being treated for narcotic addiction in Alameda County was not presently available. According to the Drug Abuse Coordinator, the county needed this information and it was hoped that in 6 months to 1 year this information would be gathered.

We contacted the major narcotic treatment and rehabilitation programs to determine the approximate number of addicts in treatment in May 1972. The following table summarizes estimates program officials made.

Estimated Number of Addicts in Treatment
in San Francisco and Alameda Counties
as of May 1972

Program		Total patients	Modality			
			Methadone maintenance	Methadone detoxification	Nonmethadone detoxification and outpatient rehabilitation	Therapeutic community
San Francisco:						
	County	747	400	6	341	-
	State	286	-	-	286	-
	Federal	89	89	-	-	-
	Private	735	170	-	442	123
	Total	1,857	659	6	1,069	123
Alameda:						
	County	117	102	15	-	-
	State	274	-	-	274	-
	Private	722	270	-	44	408
	Total	1,113	372	15	318	408
	Total	2,970	1,031	21	1,387	531

PROGRAM ASSESSMENT EFFORTS

The Director of Public Health, who is also the coordinator of the San Francisco comprehensive drug abuse plan, stated that county-funded programs had not been evaluated. The comprehensive drug abuse plan provided that (1) when the program was fully operational, research and evaluation would be performed and (2) a research team would collect and assemble data, develop measurements, and provide information regarding drug abuse to those interested. Some of the factors to be evaluated by the team included:

1. The effects of short-term detoxification programs.
2. Followup of patients successfully detoxified.
3. Success of multimodality program in reaching the community.
4. Pre-drug-abuse education.
5. Referral efforts and feasibility of referral.
6. Cost per patient served.

In Alameda County a uniform data collection system was designed for neighborhood counseling centers, hospital detoxification, general emergency services, medical wards, and county-operated outpatient drug abuse clinics. The evaluation plan provided for by the system called for reviewing treatment modalities and their successfulness, or cure rates, at 3-month intervals once the system was instituted. Alameda County officials stated, however, that they had not evaluated or analyzed county operated or funded drug abuse programs as of December 1971.

In our opinion, the planned evaluation components of the San Francisco and Alameda drug abuse programs, once fully operational, should provide drug treatment officials with valuable information which can be used in assessing the effectiveness of the counties' efforts in treating drug addicts. We believe that Federal, State, and local authorities should give priority to implementing these planned evaluation programs.

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As requested by the Chairman of the Subcommittee, we obtained information on the following aspects of selected programs in San Francisco and Alameda Counties which were being financed with State, Federal, and local government funds:

--Program goals.

--Treatment modalities.

--Number of patients being treated and services available.

--Source of funding.

--Criteria used by programs to select patients for treatment.

--Program assessment efforts.

--Results of assessment efforts.

We also visited some programs financed with private funds and VAHPA and its satellite methadone maintenance center in San Francisco.

The information gathered on these programs is discussed in chapters 3, 4, and 5 and in appendixes II and III. Comments by program officials are discussed in chapter 6.

CHAPTER 3

INFORMATION ON SELECTED PROGRAMS IN SAN FRANCISCO

We visited eight drug rehabilitation and treatment programs in San Francisco and gathered information on them through discussions with State and San Francisco program officials, from program literature, and by observation. Information on treatment philosophies and program results was obtained from program literature or records and through interviews with program officials and staff.

Following is a list of the programs visited.

1. Center for Special Problems
2. Walden House
3. Haight-Ashbury Medical Clinic
4. The Center for Solving Special and Health Problems
5. Northeast Community Mental Health Center
6. Teen Challenge
7. Langley Porter Neuropsychiatric Institute--Youth Drug Unit
8. San Francisco Drug Treatment Program

Information gathered on the first four programs follows. Information on the other four programs is included in appendix II.

CENTER FOR SPECIAL PROBLEMS

The Center for Special Problems, operated by the San Francisco Health Department, dealt with problems related to alcohol dependency and abuse, narcotic and other drug dependency and abuse, sex, crime, delinquency, and suicide.

The treatment approach included psychotherapy, medication, social services, occupational therapy, and counseling.

The center's narcotic program was composed of an outpatient detoxification program, which did not use methadone, and an outpatient methadone maintenance program.

The administrative functions and nonmethadone detoxification services were performed at the center's main office near downtown San Francisco. The methadone maintenance program utilized an induction center in San Francisco's northeast community mental health district. Three satellite clinics for methadone dispensing were located in the northeast, westside, and mission community mental health districts.

The staffing of the center's methadone maintenance program on December 31, 1971, included eight doctors--four full-time and four part-time--22 nurses, 19 rehabilitation workers, five counselors, nine clerical workers, and five community workers. The center's outpatient detoxification service was operating in January 1972 with one medical doctor on a half-time basis.

Treatment modalities

Methadone maintenance

To qualify for treatment in the center's methadone maintenance program, which began in July 1969, the applicant must (1) have at least a 2-year documented narcotic addiction history, (2) show no evidence of being addicted to drugs other than narcotics, (3) be over 18 years of age, (4) have a history of failure at other legitimate treatment attempts, (5) be a resident of San Francisco, and (6) be accepted by the program staff. Each applicant must also go through a final screening evaluation conducted by counselors, a psychiatrist, and a nurse. In this evaluation the applicant's addiction history--including his use of drugs and alcohol, motivation, psychological stability, and employment potential and the likelihood that he could be helped by other treatment approaches--is considered.

Upon acceptance the applicant is given a physical examination. The results of two of three urine tests, taken

prior to the administration of methadone, must be positive for narcotics to confirm the applicant's addiction. The addict is required to pay a $50 advance fee for the first 5 weeks of the program before admission. He is charged a $10 fee for each week thereafter.

After acceptance into the methadone maintenance program, the patient begins a 6-week trial period during which his daily dosage of methadone is increased until a stabilized dosage is reached. He attends weekly counseling sessions with a nurse or counselor during this period.

During the first 3 months following successful completion of the trial period, a patient makes daily visits to a clinic to receive his methadone and to give urine specimens. The giving of urine specimens is observed by the center's staff to eliminate the possibility of falsified or substituted samples. Three of these specimens are tested for illegal drug use each week. Vocational guidance, psychotherapy, and referral for other services are available if considered necessary by the center staff during this period. If a patient remains clean (i.e. uses no illicit drug) for 3 months, his visits to a clinic are reduced to three a week. Daily doses of methadone can then be taken home but must be safeguarded in a locked box. If a patient remains clean for 3 additional months, his visits to a clinic may be reduced to two a week.

In January 1972, 43 percent of the active patients were visiting a clinic 5 days a week, 27 percent were visiting 3 days a week, and 30 percent were visiting twice weekly. No patient was visiting a clinic less than twice weekly.

The center's methadone maintenance program offered the following four methadone withdrawal plans for persons leaving the program.

1. If agreed on by the patient and the program staff, a patients may elect a gradual voluntary withdrawal from methadone, usually over a 1-year period, after at least 1 successful year in the maintenance program. If the patient encounters difficulty with drug abstinence after the withdrawal period, he may be immediately reinstated in the maintenance program.

The center follows up on those patients completing the withdrawal period to determine how successful they are in remaining drug free.

2. Patients requesting withdrawal against medical advice are advised to follow a 1-year withdrawal schedule; however, the schedule may be completed in less time if the patient prefers. Patients are eligible to reapply for the maintenance program if they revert to illegal drug use.

3. Patients who go to prison may be assisted in withdrawing from methadone by decreasing their methadone dosage by 10 milligrams a day over a minimum of 5 days. The methadone is taken to the jail by a nurse or physician, and the drug must be properly accounted for by them.

4. Patients may be involuntarily released from the program for illicit drug use, severe disruptive behavior, or being $50 or more in arrears and having made no suitable arrangements for payment. Involuntary removal from the program is usually preceded by a warning period and a probation period, each lasting 15 days. Warning and probation periods are supplemented by appropriate counseling or other services. If the objectionable behavior continues, the patient will be withdrawn from methadone by reducing the dosage by 10 milligrams every 10 days until a 40-milligram dosage is reached; thereafter, dosage will be reduced 5 milligrams a week.

Outpatient detoxification

The outpatient detoxification program of the center is a 5-day program for short-term narcotic users. Under this program sedatives and tranquilizers are used for detoxification purposes.

Psychiatric and other counseling services of the center are available to the patients after detoxification, but use of these services is voluntary. Psychotherapy is not offered during detoxification because the director believes that the patients would not be receptive to this therapy while experiencing withdrawal symptoms.

Funding

The fiscal year 1972 budget for the center's methadone maintenance program was $685,499 and for the outpatient narcotic detoxification program was about $16,900. Funds were provided from local tax revenues (city and county) and by the State of California under the Short-Doyle Act.

The director of the center provided us with an estimated budget for the center's methadone maintenance program which showed that the center could provide the first year of treatment for 100 addicts at an estimated cost of $180,750. According to the director, operating costs for the second year of treatment would be lower than those of the first year because of less frequent psychotherapy, fewer urine tests, and reduced equipment costs. The director of the center estimated that the average cost for the first and second year of methadone maintenance would be about $23 a week per person, or approximately $1,200 a year.

Program participants

Methadone maintenance

The center's methadone maintenance program accepted 429 persons (including only those who received at least one dose of methadone) for treatment from July 1, 1969, to December 31, 1971. The median age of the participants was 32.8 years, and the average length of narcotic use was about 14 years. Admissions to the center's methadone maintenance program from July 1, 1969, to December 31, 1971, can be accounted for as follows:

Admissions	Readmissions	Discharges	Active patients
429	12	89	352

The program expanded from 20 active patients in December 1969 to 352 in December 1971, as shown by the following schedule:

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Active patients

December 1969	20
June 1970	40
December 1970	88
June 1971	217
December 1971	352

The director of the center informed us that, as of November 1971, about 400 persons were on the waiting list for the methadone maintenance program. He added, however, that this was not a true representation of the number of addicts waiting for treatment because, when addicts learned that the program was not accepting patients, they did not apply.

As of January 1972, two methadone maintenance patients had completed withdrawal from methadone with staff approval. One had been discharged for 5 months and was still returning to the clinic to give urine specimens and discuss his progress. Information was not available on the other patient. Seven patients had voluntarily withdrawn from methadone without staff approval. One of these patients had been released from the program for 24 months and was still refraining from illicit drug use. The center had no information on the status of the other six patients.

Outpatient detoxification

We were told that the number of patients in the outpatient detoxification program averaged about 15 to 20 a month. The number of patients in the program varies, depending on the availability of medical doctors to operate it. At the time of our visit, the program was being operated by a medical doctor on a part-time basis. In the past, up to three physicians have been involved in the operation of the program and the number of patients served has been up to 15 a week.

Program evaluation and effectiveness

Methadone maintenance

The goal of the center's methadone maintenance program is the rehabilitation of narcotic addicts to a more acceptable style of living. To reach this goal patients are expected to:

--Give up the use of narcotics and the abuse of other drugs.

--Cease criminal activity.

--Realize their potentials as human beings by working productively, caring for themselves and their families, developing satisfactory interpersonal relationships, coping with the problems of daily living, and improving life-styles.

To measure the program's effectiveness, the following types of data are collected for patients:

--Drug use as determined through urinalyses.

--Criminal activity while on maintenance.

--Social productivity as determined by jobs and educational activities.

Background data on the patient's age, sex, race, education, length of narcotic addiction, and arrest history are also retained for comparative purposes.

Urine tests are used to determine the incidence of illicit drug use. Urine samples are collected during each visit, but not all samples are tested. During the period before the patient's methadone dosage is stabilized, the patient's urine is tested three times a week. After stabilization, the urine testing schedule will be determined by the center staff on the basis of the patient's drug use record, the staff's judgment, and random sampling. All methadone maintenance patients have their urine tested at least once a week.

Results of urine tests for 1 week during April 1971 indicated that 16 percent of the specimens tested were positive for illicit drug use. Of 371 urine specimens tested, 55 showed evidence of narcotic use (nonmethadone), three showed evidence of amphetamine use, and one indicated the presence of barbiturates. Program officials stated that the 16-percent rate was rather high and probably reflected the substantial proportion of new patients who were in the patient population during that week.

A July 1971 semiannual report on the center's methadone maintenance program included the results of a study of illicit drug use by patients who had been on methadone maintenance for varying periods of time. The study showed the number of patients using illicit drugs one or more times during their 9th, 45th, and 90th week of treatment. The results were as follows:

Number of weeks in treatment when tested for illicit drug use	9	45	90
Number of patients	164	65	26
Percentage of patients using illicit drugs	27	5	-

The criminal activity of methadone maintenance patients was also monitored by the center. If a patient did not come to a clinic to receive his methadone, the center staff tried to determine the reasons for his absence through discussions with others in the program or with the patient upon his return. To insure confidentiality this procedure was used in lieu of direct police contact. Information regarding the patient's past arrest history was obtained through interview when he applied to the program. The center felt that this information was relatively reliable.

During the period January 1 to June 30, 1971, 11 patients were arrested for offenses allegedly committed while they were in the program. These arrests resulted in one conviction and prison sentence for possession of narcotics and one fine for being drunk and disorderly. Charges against five of the other individuals who had been arrested were dismissed, cases were still pending for three, and the

disposition of the charge was not known in one case. As of June 1971, 217 patients were in the program. We were told that, from July 1 to December 31, 1971, 10 patients were arrested and three convictions resulted. The number of patients in the program as of December 1971 was 352.

The development of socially acceptable behavior, as indicated by the patient's employment and education record is considered by the center staff as an indicator of program effectiveness. As of June 30, 1971, according to a San Francisco Department of Mental Health report on the center's program, 65 percent of the active patients were working, were enrolled in school or training programs, or were full-time homemakers; 20 percent were unemployed but were considered to be living socially acceptable lives; while the remaining 15 percent were considered to be pursuing lifestyles unacceptable to society.

Outpatient detoxification

The center's nonmethadone outpatient detoxification program, according to the director, has a dropout rate of 75 percent by the 4th day of the 5-day program. About 25 percent of the patients complete the 5-day program. The director estimated that perhaps 8 to 10 percent of the detoxification program's graduates remain free from illegal drug use. The director advised us, however, that verification of this estimate was virtually impossible because most addicts were never heard from after they left the program. The director stated that the detoxification program's success rate was not too impressive, but he believed it was about all that could be expected from any detoxification program.

WALDEN HOUSE

Walden House is a voluntary, residential, therapeutic community which has been in operation in San Francisco since August 1969. It is a private nonprofit corporation with a program for treating persons with a variety of emotional and social problems, particularly those associated with drug abuse. Some of the persons in treatment were referred by correctional agencies.

The Walden House staff includes the clinical director, three administrative employees, four clinical employees, and three staff trainees who are Walden House graduates. None of the staff has professional medical training, but voluntary medical services from doctors not otherwise connected with Walden House are available to residents as the need arises.

Treatment modality

The Walden House residential treatment program lasts 6 to 8 months. The program uses a variety of treatment techniques to enable a resident to uncover and resolve emotional problems and fears and to develop greater personal strength and self-confidence. A prospective resident must attend a prescreening interview, during which personal data and information on the program are exchanged. The applicant is asked to take several days to contemplate the decision and commitment he is going to make and then to return for an intake interview. The intake interview, conducted by four residents and one staff member, deals extensively with the applicant's motivation, commitment, and honesty.

After the intake interview, persons accepted will be assisted in becoming settled in the program by a fellow resident called a "big brother" or "big sister." Those not accepted, because they are not appropriate for the program, are referred to an agency that more closely meets their needs.

The initial phase of the program lasts approximately 2 weeks during which new residents are restricted to Walden House. During this period, a new resident is assigned to a work crew, such as the kitchen or maintenance crew, and usually has minimal responsibility.

When he has completed the initial phase, a new resident is formally accepted into the program's family structure through a ritual involving another interview and sensitivity exercises aimed at reinforcing the individual's acceptance in the family and destroying any feeling of isolation he might have. After acceptance, the resident is given a position of more responsibility and restrictions are relaxed. He is allowed to have visitors and to leave the house with a responsible resident. After several months restrictions are eliminated; the resident is allowed to leave the house unaccompanied and to develop his social life. He may also be given a supervisory position within the house.

The treatment processes used by the program to teach and facilitate interpersonal growth include many types of therapeutic groups, seminars, oral reprimands, learning experiences, house meetings, and speaking opportunities. Residents participate as both listeners and lecturers during the seminars and therapy sessions, speaking or lecturing on any topic they desire. The goal is to gradually uncover and resolve emotional problems and fears so that the resident will develop greater personal strength and self-confidence. Education is provided through a combination of seminars, tutoring, outside education resources, and various vocational training programs.

We were told by a program official that as of March 1972 a few residents of Walden House were also in methadone maintenance programs in San Francisco on an outpatient basis.

Funding

The Walden House budget for fiscal year 1972 was $142,000. Walden House estimated that about $50,000 would be obtained from private sources, $62,000 from the California Council on Criminal Justice, and $30,000 from the San Francisco Juvenile Probation Department.

Expenditures from November 19, 1969, to August 31, 1971, were about $154,000. We were told that the average cost per day was $19 for a resident at Walden House.

Program participants

Walden House had a capacity to serve 22 residents and served 150 persons from the date of inception to December 1971. We were informed that in May 1972 there were 11 people in the house whose problems were related to narcotic addiction. Over half of the residents have been between the ages of 15 and 21, with the age range being 15 to 40. Over 40 percent of the residents have come to Walden House while on probation and 21 percent have been parolees.

Since program inception, about 90 percent of the residents have been drug abusers. Of these, about 50 percent had used heroin, and the other 50 percent had used amphetamines, alcohol, psychedelic drugs, and barbiturates. Sixty-five percent of the heroin users had used the drug for 2 years or less. At the time of our review, Walden House did not have a waiting list although they have had one in the past.

Program effectiveness and evaluation

The Walden House staff believes that 25 percent of the persons who have entered the program have made meaningful changes in the areas of work and school as a result of the program. According to the program director, a review by the staff of program data for the past 2 years showed that the program had had good results with young people. The program staff checked on the status of former participants through personal contacts on the street and through ex-residents who visited the house. We were informed that liaison was also maintained with the probation department.

At the time of our review, the Walden House staff was in the process of evaluating the program's effectiveness. We were told that initial results of the evaluation indicated that residents were showing encouraging progress after 3 months at Walden House, and as a result the program was working to shorten the overall length of the residents' stay and to extend supportive services to help residents find jobs and obtain additional education. The evaluation was not complete at the time of our review.

HAIGHT-ASHBURY MEDICAL CLINIC

The Haight-Ashbury Medical Clinic was opened in June 1967 as a volunteer-staffed crisis center. The clinic provided services for all persons seeking help through three treatment centers: (1) medical and dental, (2) psychiatric, and (3) drug detoxification, rehabilitation, and aftercare. Services were provided in three converted houses in the Haight-Ashbury district in western San Francisco.

Treatment modalities

The Haight-Ashbury drug program offered narcotic addicts outpatient and inpatient detoxification and rehabilitation services. The outpatient detoxification service involved short-term withdrawal from narcotic addiction without the use of methadone. Medications such as mild sedatives and tranquilizers were used to ease the effects of narcotic withdrawal. The program was designed to accomplish withdrawal over a maximum period of 16 days. Psychiatric counseling was available to the patient after detoxification.

An inpatient narcotic detoxification program which had the capacity to serve six patients was started on November 1, 1971. The maximum period for inpatient detoxification was 2 weeks. The program used the same medications used for outpatient detoxification. As of December 1971, 12 patients had been treated. Clinic officials told us that short-term inpatient detoxification treatment was discontinued in April 1972.

The rehabilitative services consisted of psychiatric therapy--both individual and group--and vocational counseling. These services were made available to detoxification patients, at their option, and to nonnarcotic users who sought help at the clinic. A clinic vocational counselor told us that vocational services emphasized craft skills, community services, and trades acceptable to the youths being served.

Funding

Until August 1971, the drug program operated on private funds from various sources. According to the clinic's

epidemiologist, the annual budget was about $305,000. We were told by the director of the clinic that detailed expenditure data were not available for periods prior to August 1971. On that date the program received a drug abuse service project grant from the National Institute of Mental Health. The funds awarded for the first year of the grant amounted to $296,087.

From August 1 through November 20, 1971, the drug program had charged operating expenses of $61,862 against the grant. Clinic officials estimated that the average cost per patient-day of the outpatient detoxification program was $16.70. Cost figures were not available for the inpatient detoxification program.

Program participants

Drug program patients were from various areas of San Francisco and from outside the city. The only criteria for admission were that the addicts must need help and must be at least 18 years old. Between November 1969 and November 1971, the outpatient clinic treated 1,800 narcotic addicts and developed the following statistics from interviews with these addicts.

Average age	26.5 years
" " at first narcotic use	20.7 "
" cost of narcotic habit	$48 per day
Sex	73 percent male
Race:	
White	72 "
Black	21 "
Mexican-American	6 "
Oriental and others	1 "

During the last 6 months of calendar year 1971, according to a program staff official, there were about 4,100 patient visits for outpatient detoxification services. As of March 1972 the outpatient clinic was handling about 60 visits a day. There was no waiting list for outpatient services. At May 1972 the program was treating 250 outpatients.

Program evaluation and effectiveness

Data concerning a patient's age, sex, race, birthplace, employment, drug use history, and criminal history were gathered by the clinic. The patient's addiction to drugs was verified by urine testing at the time of admission. Thereafter, urine tests were performed on every fifth patient visiting the clinic each day. In addition, more frequent tests were performed on specific patients if requested by the counselor or patient. Periodic tests of the clinic's laboratory performance were made by submitting urine samples from staff members or by having test results sent to other laboratories for verification. As of May 1972, according to program officials, laboratory results were not being summarized.

The drug program had not established stringent criteria for measuring success because clinic officials considered that there were many levels of success to be reached by an addict. For example, clinic officials advised us that, if a patient was self-sufficient and not totally drug dependent, although not entirely drug free, he would be considered successful. According to a program official, no formal patient followup was carried out. We were told by the clinic's epidemiologist that at least 50 percent of the persons detoxified returned to the clinic or went to another facility to again detoxify.

THE CENTER FOR SOLVING SPECIAL SOCIAL AND HEALTH PROBLEMS--FORT HELP

The Center for Solving Special Social and Health Problems, more commonly known as Fort Help, is a private nonprofit program designed to aid people with any type of social problem, such as drugs, sex, crime, and overweight. Fort Help started treating patients in December 1970. Its treatment techniques include psychotherapy, encounter groups, and vocational counseling. We were told that a "living room" environment was created with the intention of divorcing the program from the clinical white-coat atmosphere found in some other programs. In line with this philosophy, all patients are referred to as "guests."

The staff of Fort Help's drug program included three medical doctors, two psychologists, four nurses, and five ex-addict counselors. The program director was called the "leader."

Treatment modality

Outpatient treatment is provided for drug abusers and includes such activities as individual and group counseling, vocational counseling, recreational outings, and a methadone maintenance program. Detoxification services are available to methadone maintenance patients who wish to withdraw from methadone.

Methadone maintenance patients are encouraged to eventually withdraw from methadone. The leader of the program indicated that an attempt to withdraw from methadone should be made after about 6 months of maintenance. In an attempt to discourage persons from becoming life-long methadone maintenance patients, methadone mixed with water was given to the patients. This was in contrast to most other programs which used orange juice or a sweetened mixer. Water is used to allow the bitterness of methadone to be tasted, which supposedly reminds the patients that they are using a drug and are therefore drug dependent.

All methadone maintenance patients receive individual counseling at least once a week from a doctor, nurse, or former addict.

Funding

Fort Help receives funds from three sources--contributions, a grant from a private foundation, and fees. The fees are paid by patients in the methadone maintenance program. Each patient is required to pay $20 a week, with the exception of married couples, who pay $30 a week.

The monthly budget for the overall operation of Fort Help was about $10,000. The leader told us that more detailed cost data, such as by service and treatment modality, were not available.

According to the leader, Fort Help has not accepted any governmental funding (Federal, State, or local) in the past, nor is it likely that such funds will be sought in the future. The leader believes grant regulations hinder creativity and require bureaucratic administrative structures which adversely affect staff and patients.

Program participants

At any given time Fort Help has about 500 guests receiving treatment for various social problems. We were advised by the program leader that in May 1972 Fort Help was serving about 150 narcotic addicts and that 100 were methadone maintenance patients.

From inception of the methadone maintenance program in March 1971 to the end of December 1971, approximately 200 persons participated in the program. As of January 1972, about 600 persons were on the waiting list for methadone mainte nce. Some of those on the waiting list were receiving counseling while waiting to get into the program. The leader of Fort Help believes that there is considerable duplication between the names on Fort Help's waiting list and the names on the waiting list of another program in the area.

Program evaluation and effectiveness

The leader of the Fort Help program considers the program successful if the use of, or dependency on, drugs is decreased and if social or vocational functioning is

increased. In his opinion, a person who abstains from the use of drugs for just a few months should be considered a partial success.

To verify that an individual is not abusing drugs while on methadone, all patients were subject to urinalysis once a week. A list is posted daily of those required to provide urine specimens and the patients do not know what day their names will be on the list. Specimens are to be provided under the observation of a staff member, who signs a slip stating that he has observed the specimen being provided. The patient gives the signed slip to a nurse and receives the methadone. If a patient does not have the signed slip from a staff member and his name is on the list of those required to give a urine specimen that day, he cannot receive his methadone.

Reports that could be useful in evaluating the program had not been prepared at the time of our review.

There had been no followup on the patients leaving the methadone maintenance program because the longest period any individual had been off methadone was 6 months. The leader believes that any followup at this point would result in artificially high results because an ex-addict may not go back to drugs immediately. However, followup is planned for patients once they have been off methadone for 1 year or more. To maintain contact, all patients are required to sign a consent form prior to entering the methadone program. This form is worded, in part, as follows:

> "I also understand that following termination of my treatment in the research project, I will be expected to cooperate by remaining in contact with the program for the purpose of providing follow-up information at specified intervals, in order to permit evaluation of the results of the program."

CHAPTER 4

INFORMATION ON SELECTED PROGRAMS IN ALAMEDA COUNTY

We visited six drug rehabilitation and treatment programs in Alameda County. Information on these programs was gathered mainly from discussions with cognizant program, State, and county officials; from program literature; and from our observations. Information on treatment philosophies and on the results of the programs was obtained from program literature or records and from interviews with program officials and staffs.

The following programs were visited:

1. West Oakland Health Center Methadone Maintenance Research Program.
2. G.R.O.U.P. Community Services.
3. Eden Drug Abuse Clinic.
4. Berkeley Community Methadone Program.
5. Soul Site.
6. Fairmont Methadone Detoxification Program.

Information on the first three programs follows; information on the other three programs is included in appendix III.

WEST OAKLAND HEALTH CENTER METHADONE MAINTENANCE RESEARCH PROGRAM

The West Oakland Health Center is a comprehensive health-care center operated by the West Oakland Health Council, Inc., a nonprofit community organization. A Methadone Maintenance Research Program and an Outreach Center are operated by the mental health component of the West Oakland Health Center. The Methadone Maintenance Research Program started operating in August 1971 under contract with the Oakland Model Cities Agency.

The Outreach Center, also known as "Trouble House," opened in October 1971 and provides crisis intervention, referral services, "rap" sessions, job counseling, and individual and group therapy for drug abusers. We did not gather information on the operations of the Outreach Center.

Treatment modalities

The objectives of the outpatient methadone maintenance program were to (1) reduce the high rate of narcotic addiction within the Oakland Model Cities target area, (2) combat the use of drugs by schoolchildren, and (3) reduce the crime rate within the target area.

The West Oakland methadone maintenance program has the following admission requirements for patients. They (1) must reside in the West Oakland Model Cities target area, (2) must participate voluntarily, and (3) must have had one documented episode of withdrawal.

The medical director of the methadone maintenance program told us that the program's treatment philosophy was the "modified lifetime theory." Under this theory an individual must be on methadone maintenance for at least 6 months and must not abuse drugs during this period before the program staff will approve his withdrawal from methadone and his release from the program. In addition, the participant must demonstrate a positive life-style, through participation in educational activities or employment. At the time of our review, the program staff had not approved placement of any patients in a withdrawal program.

Prior to admission an applicant for the methadone maintenance program must (1) take an intelligence and personality test, (2) take a test to diagnose organic brain damage and significant mental illness, (3) have an interview with program officials (a screening panel), (4) have a medical examination, and (5) provide a complete social and medical history. In addition, three urine samples are tested in the week following the patient's interview with program officials. All three tests must show heroin use before the applicant can be accepted. Exceptions to this requirement are made only for participants who come directly from penal institutions.

After completing the screening process, each patient is assigned to a team comprised of a nurse, a social worker or rehabilitation counselor, and a case aide. The team is responsible for the patient's total program involvement and assists the patient in his efforts to disengage from the drug culture and to move into a more productive and satisfying life-style.

Patients are given an initial daily dosage of 30 milligrams of methadone which is increased by 10 milligrams a day until a maximum dosage of 90 milligrams is reached. As of December 31, 1971, it had been necessary to deviate from this pattern 11 times because at the maximum dosage these patients experienced prolonged side effects.

The methadone maintenance program's support services include group therapy, individual counseling, vocational and educational guidance, referrals for employment, and some medical and dental services.

Funding

The West Oakland Health Center methadone maintenance program is funded by the Oakland Model Cities program of the Department of Housing and Urban Development. The Oakland Model Cities budget for the methadone maintenance program was about $120,000 for the period November 1, 1970, to March 31, 1972. The approved budget amount for the period April 1972 through March 1973 was $120,000. The budget for the methadone maintenance program was supplemented by patient fees--a $16 initial fee and $10 a week thereafter.

Program officials estimated that the cost per patient for the first year of treatment would be about $1,000 to $1,500. However, they questioned the accuracy of this estimate because the program had been operating less than a year. Program officials believed that the cost per patient could be reduced by about 50 percent for a second-year methadone maintenance patient.

Program participants

As of May 1972 the West Oakland Health Center methadone maintenance program had about 120 active patients. There

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were 74 patients in the methadone maintenance program at December 31, 1971. Their median age was 35; 72 percent were black; 14 percent were white; and 14 percent had Spanish surnames. Also, 71 percent were male and 29 percent were female.

Program evaluation and effectiveness

To determine whether a patient was abusing drugs, a urine specimen was taken each time a patient visited the clinic for his methadone. For the first 2 weeks of participation in the program, the patient's urine was tested daily. Thereafter, although the specimens were still collected daily, only two per week were tested for each patient. The giving of the specimen must be observed by a program staff member.

From August 16, 1971, the date methadone dispensing began at the center, to December 31, 1971, program reports show that 2,059 urine specimens were collected for testing, an average of 32 tests per patients. Of these, 279, or about 14 percent showed illicit drug use, as follows: 169 showed heroin use, 83 showed barbiturate use, and 27 showed amphetamine use.

G.R.O.U.P. COMMUNITY SERVICES

G.R.O.U.P. Community Services (an acronym for Growth Reorientation Opportunities Unlimited Project), which began operating in the summer of 1970, is a private program for drug addicts, alcoholics, and persons with character disorders.

GROUP has three facilities--a storefront and residence quarters in a commercial area of East Oakland for the initial phase of the program, a long-term residence house (Family House) in the West Oakland Model Cities target area and a farm near Marysville, California, that, when renovated, will be used as a long-term residence facility.

GROUP's staff was comprised of ex-addict graduates of the program and residents. The East Oakland facility was staffed by a house manager and five trainees; Family House had a house manager and nine trainees; and the farm had a house manager and one trainee. Trainees are ex-addicts who are being trained for positions with GROUP.

In addition to this resident staff, the two Oakland facilities received the volunteer services of a medical doctor once a week and of a psychiatrist when needed.

Treatment modality

The treatment modality of the GROUP program is the drug-free therapeutic community concept which has three separate treatment phases and which lasts from 7 to 12 months.

A candidate enters the first phase, which lasts from 30 to 90 days, at the phase-in center in East Oakland. The first phase was generally referred to as a "tearing down" period during which an individual was exposed to his "hang-ups," bad habits, and attitudes. An addict was admitted to this phase if he demonstrated to the satisfaction of the house manager a willingness to stop abusing drugs. If admitted, the candidate spent the first 14 to 30 days "quarantined" from anyone outside the program and his only contacts were fellow candidates and the program staff.

The remainder of the time in the candidate phase was spent in developing certain qualities, such as good work habits and a sense of responsibility. The daily routine included housekeeping duties, "rap" (group discussion) sessions, critiques on the candidate's progress, seminars on such subjects as concepts of truth and honesty and fund-raising projects.

When a candidate had demonstrated to the satisfaction of the house manager and his staff a desire for total rehabilitation, he was sent to the Family House in West Oakland for phase two. An addict resides at this facility from 3 to 6 months and engages more intensely in such activities as group therapy and confrontation games. The purpose of this phase, in contrast with the "tearing down" phase, is to "build up" a person by helping him develop goals and rechannel his energies toward a positive life-style. The farm, in addition to the Family House, will eventually be used for phase two for those who wish to experience rural life.

The third phase is referred to as the "phase-out" period, during which an individual is a member of the staff at the East Oakland residence, Family House, the farm, or at a program in Berkeley called Soul Site. (See p. 67.) This phase lasts for about 3 months.

Future plans provide for an additional treatment period during which an individual would live in a GROUP residence for the first 2 or 3 months after the final phase and work or go to school. No restrictions would be placed on a resident; he would stay until he was both mentally and financially ready to settle in a place of his own.

GROUP does not detoxify anyone at the candidate center in East Oakland. Anyone who needs this service is referred to Soul Site in Berkeley (see p. 67) or to the Fairmont Methadone Detoxification Center in San Leandro, California. (See p. 68.)

Funding

GROUP receives no funds from governmental sources. Public funds have not been sought because the board of directors believes numerous conditions or restrictions on the program's

operation would be "attached" to the money. The directors want the freedom to continue to develop the type of treatment they feel is best.

GROUP's funding support comes from a variety of sources including disability payments received by some of the residents, cash and in-kind donations, and proceeds resulting from presentations before various community and civic organizations. The annual budget for the program is about $70,000.

Program participants

GROUP's staff estimated that about 50 percent of the participants in the program were narcotic abusers. At the end of February 1972, 82 patients were active in the program. The following tables show the caseload at each of the three facilities and the ethnic backgrounds of the patients.

Location	Number	Ethnic background	Number
East Oakland	27	White	53
Family House	45	Black	23
Marysville Farm	10	Mexican-American	5
		Oriental	1
Total	82		82

About 60 percent of the patients were male, and the ages of the patients ranged from 15 to 51 years. Data on the number of persons who entered GROUP since program inception were not available. The program has no waiting list.

Program evaluation and effectiveness

The primary goal or success criterion of the program was for a person to become a productive and responsible individual with the confidence to make decisions and stand behind them. The GROUP staff believes that, to instill attitudes, such as trust, honesty, and responsibility, the staff must demonstrate these concepts by trusting the patients. For example, urine samples have not been collected or tested for illicit drug use.

In the 18 months GROUP has been operating, there have been five graduates, all of whom started the program and are now the board of directors of GROUP. GROUP staff members had received information through telephone conversations with former patients and through the "grapevine" that about 25 persons who had left the program before completing the treatment phases had refrained from illicit drug use. GROUP does not compile statistics on program performance.

EDEN DRUG ABUSE CLINIC

The Eden Drug Abuse Clinic is operated by Alameda County and is located in the Alameda County Public Health Department outpatient clinic in the city of San Leandro.

The Eden clinic offers outpatient methadone maintenance, therapy and counseling for heroin addicts, and therapy and counseling for adolescents who abuse drugs other than narcotics. The services for adolescents comprise only a small part of the clinic's operations and are provided by one of the clinic's social workers.

The methadone maintenance program was started in July 1971 and is authorized to serve 110 patients.

Treatment modality

The Eden clinic is primarily a methadone maintenance outpatient clinic for heroin addicts. A prospective patient is screened by a counselor who determines whether he meets the following requirements. Patients must (1) be 21 years or older, (2) have a minimum 2-year history of addiction, (3) be a resident of Alameda County, and (4) be a voluntary patient. In addition, current addiction to heroin must be verified. After being admitted to the program, each patient is given a complete physical examination and is started on methadone. The initial daily dosage is 20 milligrams which is increased over a 2-week period to an 80-milligram maintenance level. As of December 31, 1971, most patients were receiving between 60 and 80 milligrams of methadone.

Support services offered include individual counseling and therapy, group therapy, vocational counseling, and medical followup and treatment.

Funding

The Eden clinic calendar year 1972 budget request for California Council on Criminal Justice funds was approximately $145,000, as follows:

Personnel services	$ 99,150
Travel	2,100
Consultant services	1,500
Supplies and operating expenses	39,700
Equipment	2,892
Total	$145,342

A county official told us that the final budget approved by the California Council on Criminal Justice was $80,350 and that Alameda County planned to provide an additional $35,500 which would make $115,850 available to Eden clinic during 1972. Cost allocations as listed above were not available for the revised budget.

At the time of our review, Eden clinic did not charge the patients for services. However, the clinic plans to initiate in the near future a sliding-scale fee schedule based on the patient's ability to pay.

Program participants

Approximately 300 heroin addicts have been interviewed at the clinic from program inception (July 1971) through February 24, 1972, as shown below:

	Number of patients
In program	93
On waiting list	148
Detoxified and released at patient's request	3
Detoxified and released by staff for disciplinary reasons	7
Did not meet requirements, went to other programs, never returned after reaching top of waiting list, or other reasons	50
Total	301

According to clinic officials, of the 93 patients in the program, about 15 were allowed to take their methadone dosages home. Two patients were allowed to take home enough methadone for 3 days; the remaining 13 patients were allowed to take home enough methadone for 1 or 2 days.

Program evaluation and effectiveness

The goals of the methadone maintenance program were, as follows:

--Stop heroin use.

--Develop more productive life-style (job or educational activity).

--Stabilize emotional life.

--Increase self-esteem.

--Eventually withdraw from methadone maintenance.

Eden clinic checks on heroin use by testing urine specimens from one of every five patients visiting the program daily and tests each patient at least once a week. The specimens were tested for opiates, amphetamines, barbiturates, quinine, and methadone. No tests were made for alcohol. All urine specimens were obtained under the observation of program staff. During a 1-week period in the latter part of 1971, results of urinalyses were:

Results of tests	Number of samples	Percent
Methadone only	47	76
Methadone and heroin	12	19
Methadone and amphetamines	2	3
Methadone, codeine, and heroin	1	2
Total	62	100

Patient withdrawal from methadone maintenance was the ultimate goal of the program. As of February 24, 1972, two persons were being wi awn from methadone with staff approval; one was an ov ent and one was in the hospital as a result of an automob c accident.

CHAPTER 5

VETERANS ADMINISTRATION HOSPITAL AT PALO ALTO

VAHPA, a general medical and surgical hospital, since August 1970 has offered a drug abuse rehabilitation program to veterans through the hospital's psychiatric service. The VAHPA drug program had (1) three inpatient rehabilitation wards offering a wide variety of therapeutic services, (2) an outpatient methadone maintenance program, (3) a short-term inpatient detoxification program utilizing methadone and/or other appropriate drugs, and (4) an outpatient methadone maintenance satellite clinic. These services were provided at the Menlo Park, California, and Palo Alto branches of VAHPA and at a satellite methadone maintenance clinic in San Francisco.

TREATMENT MODALITIES

The VAHPA drug program treatment approach focuses on the biological, social, and psychological factors which initiated and perpetuated the patient's addiction. VAHPA provided its drug rehabilitative services through the following treatment facilities.

Inpatient facilities

--A short-term, 15-bed detoxification ward at Menlo Park which uses methadone and other drugs for withdrawal from heroin, barbiturates, and other addictive drugs.

--A 20-bed inpatient eclectic rehabilitation ward with a wide variety of therapeutic services including methadone maintenance for heroin addicts.

--A 20-bed inpatient rehabilitation ward which uses a drug abstinence approach.

--A 15-bed inpatient rehabilitation ward similar to the above drug abstinence approach, with the exception that the patient population is a mix of drug abusers, alcoholics, sexual deviants, and other antisocial personality disorders.

Outpatient facilities

--An outpatient methadone maintenance service located at the 15-bed inpatient, short-term detoxification ward at Menlo Park.

--A satellite outpatient methadone maintenance clinic offering the same services as the facility above but for patients residing in San Francisco and other areas.

The above facilities are described in detail below.

Short-term inpatient detoxification ward and outpatient methadone maintenance program

VAHPA's short-term, inpatient detoxification ward and the outpatient methadone maintenance program at Menlo Park offered the following services: (1) inpatient detoxification from narcotics using methadone during a 5-day withdrawal period, (2) inpatient detoxification from barbiturate dependence using phenobarital over a 1- to 2- week gradual withdrawal period, and (3) outpatient methadone maintenance.

The inpatient detoxification ward followed a 3- to 4-day detoxification program for heroin withdrawal using methadone. Methadone maintenance was also started in this ward. When a stabilization level (50 to 60 miligrams) was reached, the patient was released to the outpatient methadone maintenance program or to the inpatient maintenance ward.

The outpatient methadone maintenance program was separated into four phases.

Phase I--Daily patient visits for methadone for at least 13 weeks.

Phase II--Patients visit the clinic Monday through Friday with a weekend supply of methadone to be taken home.

Phase III--Patients visit the clinic Monday through Thursday for a 2- to 3-month period with a 3-day supply of methadone to be taken home.

Phase IV--Patients visit the clinic on Monday, Wednesday, and Thursday and take home methadone for the other 4 days.

The director of this program stated that urine samples from each patient were tested at least once a week for illicit drug use. Should illicit drug use be detected, a patient in phases II through IV would be moved back to a lower phase.

Eclectic inpatient ward

This ward had about one-third of its patients on methadone maintenance and provided a wide variety of rehabilitative treatment services, such as group and individual psychotherapy, family group sessions, and vocational and educational counseling.

Inpatient abstinence ward

The inpatient abstinence ward operated as a therapeutic community and employed such treatment techniques as: (1) small group meetings, (2) community group meetings, (3) encounter groups, (4) one-to-one counseling, (5) sports and recreational activities, (6) community drug education and prevention talks, and (7) vocational and educational counseling.

Multidisorder inpatient ward

The multidisorder ward treated persons with varied emotional disorders in a therapeutic residential treatment setting. The primary treatment modality is confrontation or attack therapy.

Satellite outpatient methadone maintenance program

The satellite methadone maintenance outpatient clinic in San Francisco started operating on November 1, 1971, as an extension of VAHPA's outpatient methadone maintenance program located in Menlo Park.

The satellite clinic was open 6 days a week for methadone dispensing. Initially, patients visited the clinic

every day except Sunday to receive their doses of methadone. A take-home dose for Sunday was given on Saturday. After a minimum of 13 weeks, the patient may be given two doses to take home for the weekend. Urine testing was used to determine whether the patient was using illicit drugs while on methadone. The clinic collects patient urine specimens three times per week without advance notice. At least one sample per patient was tested each week by VAHPA to determine whether the patients were using illicit drugs while on methadone.

FUNDING

Total drug program costs for calendar year 1971 were allocated for us by VAHPA accounting department as shown below:

Program	Personal services	All other costs	Total program cost
All inpatient care	$450,632	$38,490	$489,122
Methadone maintenance (Menlo Park)	42,607	8,623	51,230
Satellite methadone maintenance (San Francisco)	7,543	5,744	13,287
Total for 1971	$500,782	$52,857	$553,639

The total program cost incurred for all inpatient care from July 1, 1970, through December 31, 1971, was $591,772. Since the methadone maintenance programs were both begun during 1971, amounts shown above represent total program costs from inception of the methadone maintenance programs.

PROGRAM PARTICIPANTS

VAHPA limited its drug rehabilitation services to veterans who had better than dishonorable discharges and who did not have pending criminal charges. Of the patients in the drug rehabilitation programs, approximately two-thirds were Vietnam veterans and one-third were World War II and Korean War veterans.

As of December 1971 VAHPA did not have a waiting list for any of its drug rehabilitation services. On January 14, 1972, as a result of closing certain buildings at the Veterans Administration (VA) hospitals in Livermore and Los Angeles, which was part of a plan to structurally upgrade VA facilities, a ceiling or quota was placed on the number of patients allowed in each ward at VAHPA, including the drug treatment wards. This action did not result in creating waiting lists at that time.

The following table shows, by treatment program, the number of patients treated since inception.

Program	Date of inception	Number of patients treated: Since inception	Number of patients treated: Jan. through Nov. 1971
Detoxification ward	9-1-71	158	158
Multidisorder ward (data on drug patients only)	8-1-70[a]	40	29
Abstinent ward	8-1-70	121	104
Eclectic ward	8-1-70	188	128
Outpatient methadone maintenance	9-1-71	62	62
Satellite methadone maintenance (San Francisco)	11-1-71	70	70

[a]Data available from this date on drug-dependent persons; this is not the date of program inception.

A VA official advised us that the above figures included patients treated by more than one program and that

eliminating the overlap resulted in a net figure of 381 separate patients treated from January through November 1971.

PROGRAM EVALUATION AND EFFECTIVENESS

The goal of VAHPA's drug program is to help the patient learn to live without drugs or to function satisfactorily on methadone maintenance. Each treatment component sets forth slightly different criteria for evaluation based on different goals as indicated below.

--The eclectic ward set forth as criteria for evaluation: (1) abstinence from drugs, (2) occupational rehabilitation, (3) stable living situation, and (4) better relationships with the family.

--As measurements of program effectiveness the drug abstinence ward looked for: (1) drug abstinence, (2) lack of problems with police, (3) a stable living arrangement, and (4) a goal-directed activity such as school, work, or training.

--The detoxification ward inpatient program measured its effectiveness by the number of patients involved in a rehabilitation program.

--The outpatient methadone maintenance program set the criteria of effectiveness as the number of patients still in the program.

The director of the drug program stated that VAHPA did not have the staff that would be required to perform evaluations on program results. However, in December 1971 a pilot followup study of the first 40 patients admitted to the eclectic ward was made. The patients were residents of the ward between August 1, 1970, and January 1, 1971. Thirty-five of the 40 patients were narcotic addicts, and the remaining five abused other drugs. Thirty-one of the 35 patients who were admitted as narcotic addicts were interviewed by a drug counselor who was a former patient of the eclectic ward. Contact was made entirely by phone, although some information was verified by checking with public agencies and families of the patients. Percentage responses to the six questions asked follow:

	Percent Yes	No
1. Have you used any narcotics since you left the program?	23	77
2. Have you been arrested since you left the program?	19	81
(a) Have you been convicted since you left the program	6	94
3. Have you been employed since you left the program	68	32
(a) Are you now employed?	52	48
4. Have you had education (enrolled in an institution) since you left the program?	23	77
5. Have you been in another treatment program since you left the ward?	19	81
6. Did you serve in Vietnam?	55	45

The pilot study was being used by a VA psychologist in an attempt to secure funds from the VA for a research project to evaluate the relative effectiveness of the drug programs at VAHPA.

The proposed research project would utilize background information on the patient's drug use, employment, education, arrest and convictions, and interpersonal relations collected during treatment and through mailed questionnaires at regular intervals for 4 years after the date of admission. These data would be supplemented by records and information from public agencies and by surprise visits with the patient after hospital discharge. Statistical analyses would be employed to determine which treatment modality was most effective.

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CHAPTER 6

COMMENTS BY PROGRAM OFFICIALS ON NARCOTIC TREATMENT AND REHABILITATION PROGRAMS

We discussed the treatment and rehabilitation programs in San Francisco and Alameda Counties with representatives of State and local governments and county drug abuse coordinating groups to obtain information of problems being encountered, operational needs of the programs, and ways in which the narcotic treatment programs could be improved. We were informed that (1) narcotic treatment programs needed to be registered and licensed, (2) standards as to the type of data that should be gathered for use in measuring program results needed to be developed, and (3) State-operated facilities in the San Francisco-Oakland area were lacking which was hampering the effectiveness of the State's program for the civil commitment of narcotic addicts.

We noted that San Francisco officials were experiencing difficulty in obtaining patient arrest information from the State because State officials believed that furnishing arrest information to the San Francisco Methadone Research Program violated the State penal code.

REGISTERING AND LICENSING OF NARCOTIC TREATMENT PROGRAMS

County officials in both San Francisco and Alameda Counties advised us that registering or licensing narcotic treatment programs would be beneficial.

The director of the San Francisco Department of Public Health, who was also the coordinator for San Francisco's Drug Abuse Control Plan, advised us that registering or licensing would permit the licensing agencies to exercise control over the quality of care given to addicts. Also, the director stated that licensing could result in more stable treatment and rehabilitation programs which would avoid interruptions in treatment caused by curtailment or discontinuance of services. The director stated that in a number of instances programs had been curtailed or discontinued because funds could not be obtained or for other reasons.

A third advantage of licensing or registering mentioned by the director was the establishment of a standard means for evaluating the results of a program or treatment modality. The use of a standardized evaluation system approved by the licensing agency could be made a condition of licensing or registering.

The director, Alameda County Health Care Services, told us that licensing would provide the county with the means for obtaining data on the number and types of drug abuse programs in operation. In addition, it would enable the county to know more about the programs in the area, such as the number of persons in treatment and the type of modality being used. He stated that, although a program evaluation methodology should be made a condition of licensing, the methodology should be general in nature and should not result in burdensome reporting and evaluation requirements which would interfere with the treatment.

An official in the State's Office of Narcotics and Drug Abuse Coordination informed us that State legislation requiring licensing by the State of certain drug abuse treatment programs is anticipated. However, he stated that there would probably be many exclusions, such as Federal, State, or county programs; programs affiliated with churches; and facilities such as hospitals and clinics which have other licensing requirements. He also said that, while the State would license certain programs, the contemplated legislation would require virtually all drug programs to register with the county.

STANDARDS FOR EVALUATION

The Director of Public Health for San Francisco stated that assessment and comparison of the variety of treatment approaches was not possible because uniform program data were lacking. He suggested that a committee of experts on different treatment modalities from various places throughout the country should be asked to arrive at a standardized evaluation program for all treatment approaches.

The director stated also that the data-gathering requirements should be similar for all programs and should provide information, such as the number of persons entering

treatment, the dropout rate, length of participation, extent of continued drug abuse and criminal activity, social productivity or employment, and patient activities and status after program completion. He stated further that the requirements for data gathering, followup, and public disclosure would have to apply to all programs--public or private--to add credence to the plan. The director advised us that the patient's confidentiality should be maintained at all times.

PROBLEMS OF THE STATE CIVIL ADDICT PROGRAM

Officials of the State Region II Parole and Community Services Division, which covers San Francisco and Alameda Counties, told us that there were not enough local methadone maintenance and detoxification programs to effectively treat outpatients of the State's civil addict program. We were told that if an outpatient returned to drug use and services either did not exist or were not available locally, the patient must be returned to the California Rehabilitation Center. (See p. 12.) This move not only disrupts the outpatient's family, homelife, and overall rehabilitation, but is costly.

The officials stated that they had attempted at various times to develop or to assist with the development of community-based facilities, but without success primarily because of funding restrictions. In addition, these officials stated that more former addicts should be hired to work with the outpatients from the center.

PATIENT ARREST INFORMATION

In a March 7, 1972, letter to the Chief of the State's Bureau of Identification, the director of the San Francisco methadone maintenance program explained that, for the past few months, the program had been obtaining arrest records of program participants from State parole officers but that recently the parole officers had stopped supplying these records on the basis that they were not authorized to do this.

The director explained in his letter that arrest information on applicants would assist the program in determining whether the applicant had a history of at least 2 years of narcotic addiction--a requirement for admittance to a methadone maintenance program (see p. 15)--and would be useful for program evaluation purposes. The director also explained that the program always obtained written consent from the patient to obtain arrest information and consequently felt that this practice was not a violation of the patient's confidence in any way.

The bureau's reply dated March 13, 1972, stated that it could not furnish arrest information to the program because such action was not permitted by section 11105 of the State penal code. This section of the code specifies those persons, organizations, and institutions to which the attorney general is authorized to furnish data about persons for which there is a record in the State's attorney general's office.

The bureau's reply indicated that the written consent obtained from the patient would have no bearing on the release of the information since it would not relieve the bureau of obligations imposed by statute. The bureau concluded that specific legislation authorizing the release of the information to the program would be necessary.

This matter had not been resolved as of June 1972.

APPENDIX I

October 15, 1971

Honorable Elmer B. Staats
Comptroller General of the United States
Washington, D. C. 20548

Dear Mr. Staats:

To assist the Subcommittee in its continuing consideration of legislation concerned with the treatment and rehabilitation of narcotic addicts, we would appreciate having the General Accounting Office make a review and provide a report on program assessment efforts made by Federal, State, and local agencies involved in narcotic rehabilitation activities. The Subcommittee's concern is that in developing legislation for treatment and rehabilitation, adequate program assessments are made to provide a basis for the Congress and the executive agencies to take action to improve the rehabilitation programs.

For an appropriate mix (Federal, State, and local) of programs, your review should provide information on the treatment modality, program goals, and established controls and techniques for measuring program accomplishments. The Subcommittee also desires information on program costs including, if possible, information on amounts spent on program assessment efforts. The information gathered should be supplemented by your comments on any identified weaknesses relating to the efforts of program sponsors to evaluate program effectiveness. We would appreciate your suggestions as to actions needed to improve such efforts.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report would be most helpful if it could be available to the Subcommittee by June 1972.

Sincerely,

Don Edwards

Don Edwards
Chairman
Subcommittee No. 4

APPENDIX II

INFORMATION ON OTHER PROGRAMS IN SAN FRANCISCO

In addition to the narcotic treatment programs in San Francisco discussed in chapter 3, we gathered information on the following programs.

NORTHEAST COMMUNITY MENTAL HEALTH CENTER

The San Francisco Northeast Community Mental Health Center provides comprehensive mental health services for alcoholics, the mentally disturbed, geriatric cases, and drug abusers. The staff consisted of about 125 members, of whom about 20 were directly involved in the drug abuse treatment services.

The outpatient program provided methadone maintenance to patients who were enrolled in a program operated by the Center for Special Problems. (See p. 20.) Counseling and referrals were provided to outpatient drug abusers as part of the overall Center program. In addition, the outpatient services included visits to the city jails by a psychiatrist who, as one of his responsibilities, assisted in the withdrawal treatment of addicts with or without the use of nonnarcotic medication.

The amount budgeted for drug abuse treatment, excluding the methadone maintenance program for fiscal year 1972, was $266,374. This consisted of $147,756 of Federal funds from the National Institute of Mental Health, $106,756 from the State (Short-Doyle Act), and $11,862 from San Francisco.

A residential drug detoxification program with a capacity of 12 persons started in January 1971 but closed down in November 1971. During the 10-month period about 250 persons, primarily heroin addicts, were treated by the program. This program was terminated because staff evaluations showed that the treatment methods employed were not very successful. Coordination with other programs was minimal. A new residential program was started in February 1972 and was designed to serve about 12 persons who could be amphetamine, barbiturate, or heroin users.

APPENDIX II

TEEN CHALLENGE

Teen Challenge, a private, nonprofit program under the sponsorship of a religious organization--Assemblies of God Church--is a therapeutic community designed to provide inpatient treatment to an addict for about 9 to 12 months. Heroin addicts, who comprise 60 to 70 percent of the participants in Teen Challenge, must withdraw from their addiction without medication. In May 1972 there were 25 residents at the therapeutic community we visited. The staff consisted of a director, two vocational counselors, three supervisors, and five resident trainees who were ex-addict graduates of the program.

Emphasis is placed on rehabilitation and prevention of drug abuse through religious activities, counseling, vocational guidance, and other activities. Each resident is helped to develop qualities such as self-discipline, Christian character, and a sense of responsibility.

Expenditures were $76,000 for calendar year 1971 and $211,000 for the 3-year period 1969 through 1971. All funding was from the church and from private donations. During the 3-year period, 439 persons entered the program. Program officials estimated that about 59 of these were not abusing drugs.

The program had no accurate information on program completions and results because a means for complete patient followup did not exist.

LANGELY PORTER NEUROPSYCHIATRIC INSTITUTE--YOUTH DRUG UNIT

This program provides for (1) psychiatric research into drug culture and drug history, (2) the residential treatment of drug abusers, and (3) staff training in the Langley Porter Neuropsychiatric Institute of the University of California Medical Center. Inpatient treatment consisted of group and individual therapy using techniques of counseling and "rap" or discussion sessions. According to program officials, optimum benefit from the program is derived if a patient remains in treatment for 3 to 6 months.

APPENDIX II

The institute's drug unit has a capacity to treat 14 persons, most of whom were referrals from law enforcement agencies and probation departments. The residents must be adolescents or young adults with a drug problem. About 25 percent of the patients treated are opiate users. The drug ward is staffed by a psychoanalyst, a psychiatrist, a clinical psychologist, an occupational therapist, and ward nurses.

Funding has been provided exclusively by the California Department of Mental Hygiene. We were told by the institute's Assistant Director that data on expenditures were not available but that the estimated patient cost had been about $100 a day. Since inception of the program, about 5 years ago, about 300 persons have been treated by the drug unit.

There had been no followup and evaluation of treatment results until about June 1971. For a 1-year period from that date, information was obtained on 11 heroin addicts who had been in the program. Five of the 11 had dropped out of treatment, three had returned to the use of drugs after completing the program, and three had not used drugs for at least 6 months. These results were considered to be good by the institute's Assistant Director--the psychiatrist in the program--because, in his opinion, it would be unusual for addicts who leave or complete a drug program to not continue the use of some drugs.

SAN FRANCISCO DRUG TREATMENT PROGRAM

This clinic offers an outpatient counseling program for drug abusers, about 90 percent of whom are heroin addicts. Therapy and counseling are used in attempts to alter the individual's behavior pattern in the use of drugs. Usually an addict makes between five and 10 visits to the clinic to complete the counseling treatment. There is a detoxification program utilizing nonnarcotic medications to reduce physical discomfort during the withdrawal period. The staff consisted of 11 persons (full and part time).

The budget for fiscal year 1972 provided for the receipt of funds from the National Institute of Mental Health, from the State (Short-Doyle Act), and from San Francisco.

APPENDIX II

The staff estimated that, of the 609 patients served during the period January 1, 1971, to November 17, 1971, about 62 percent continued to use drugs while in the program and about 38 percent may have been clean (i.e., no illegal drug use) upon leaving treatment. We were told that regular patient followup, as an integral part of the program, was initiated in early 1972.

APPENDIX III

INFORMATION ON OTHER PROGRAMS IN ALAMEDA COUNTY

In addition to the narcotic treatment programs in Alameda County discussed in chapter 4, we gathered information on the following programs.

BERKELEY COMMUNITY METHADONE PROGRAM

The Berkeley Community Methadone Program (BCMP), which started in May 1971, was one of 13 organizations in a consortium of drug addiction treatment agencies in Berkeley. BCMP also coordinated its program with the methadone maintenance programs in Oakland and San Leandro through monthly staff meetings in which common ideas and problems were shared. These meetings were also used to verify that patients were not enrolled in more than one local methadone maintenance program.

BCMP is an outpatient methadone maintenance program; its long-range goal is the detoxification of patients. It provides such ancillary services as group therapy, individual counseling, legal counseling, other group activities, and vocational rehabilitation through the California State Department of Vocational Rehabilitation.

The BCMP staff consisted of (1) a principal investigator--a medical doctor who was professionally and administratively responsible for the program, (2) a director, who was a medical doctor and who performed psychiatric evaluations of all patients, (3) an ex-addict, who was the program supervisor, (4) a registered nurse, who dispensed methadone and kept records, (5) a part-time registered nurse, who dispensed medication on weekends, (6) a part-time secretary, and (7) two ex-addict aides whose duties included collecting urine specimens and supervising discussion groups.

BCMP received funds from weekly patient fees and from the city of Berkeley. Although a weekly fee of $15 to $19 per patient was charged, no one had been refused admittance or had been discharged because of his inability to pay. To be eligible, an individual must meet the following criteria: (1) be over 21 years old, (2) have 2 or more years of documented addiction, (3) reside in Berkeley or Albany for at least 6 months (except for transfers from other methadone

maintenance programs), (4) have failed in previous efforts to detoxify, (5) show evidence of current use of opiates as confirmed by three consecutive positive urinalyses, except that this criterion may be waived for persons coming from penal institutions, and (6) be motivated to give up drugs.

The program had a capacity of 165 patients. As of January 13, 1972, 101 patients were in the program. About 40 percent of these persons were employed--the remaining 60 percent were unemployed.

Urine tests determined whether patients were remaining drug free. Random-sampling methods were used to determine which specimens would be tested. Also, specimens were given under the observation of a member of the program staff. We were told that there were plans to evaluate the program annually. The criteria established to measure patient progress were the extent to which patients (1) remained in the program, (2) remained drug free, (3) avoided arrest, and (4) were employed. The effectiveness of the program will be evaluated on the basis of the percentage of patients who successfully withdraw from methadone and do not return to drug use. Those who finally withdraw from methadone will be asked to periodically review their activities with program staff and to periodically have their urine tested for at least 2 years.

SOUL SITE

Soul Site, located in the city of Berkeley, is primarily a neighborhood counseling and drop-in information center. Soul Site's primary function is to refer drug abusers and addicts to various drug treatment programs. Soul Site also makes medical, educational, and employment referrals for nondrug users. An inpatient detoxification facility was opened in December 1971 primarily for heroin users. This facility had a capacity to treat 25 patients.

The detoxification program is scheduled to last 7 to 14 days. Such medications as tranquilizers are used for detoxification purposes. Soul Site's detoxification program had treated 120 patients from its inception to February 17, 1972. The Director stated that a study of the first 27 patients indicated that 13 discontinued treatment before

completing detoxification and that 14 completed the program. Of those completing the program, 10 went on to residential treatment programs and four returned to heroin use.

The staff of Soul Site consisted of a director and his assistant, both of whom worked part time, and volunteers from the community. The detoxification unit had a paid staff of three full-time counselors and one part-time counselor.

Soul Site had received $15,000 from the California Council on Criminal Justice through the county of Alameda. In addition, $15,000 for the detoxification program was provided by the city of Berkeley for the initial period (6 months) of operation. We were told that expenditure data were not available.

Soul Site's Director believes that persons in treatment can be considered successes if they stop using narcotics and other dangerous drugs, are productive in employment and education, and establish meaningful family relationships. The staff was developing a followup technique to determine whether the program was helping drug abusers. As of February 1972 the staff estimated that, of those clients contacted by phone, about 17 percent had refrained from heroin use and about 15 percent had used heroin occasionally. The remainder were back on drugs, were in jail, or could not be located.

FAIRMONT METHADONE
DETOXIFICATION PROGRAM

The Fairmont Detoxification Program is operated by Alameda County under the direction of a medical doctor who is also in charge of the Eden Drug Abuse Clinic. (See p. 46.) This short-term inpatient methadone detoxification project, located in Fairmont Hospital at San Leandro, began operations on January 31, 1972.

The program staff consisted of about 20 medical doctors, nurses, ex-addict counselors, and social workers on a full- or part-time basis. The budget for fiscal year 1972 was about $154,000, of which $139,000 was from the State (Short-Doyle Act) and $15,000 was from the county.

The program had a capacity of 23 patients; the average daily patient census was 15. Detoxification from heroin was completed in 4 to 7 days depending or extent of the patient's habit. Methadone was adminis vice daily in decreasing amounts. At the time of our w, after 24 days of operation, about 70 addicts had treated and 23 patients had completed the program.

In addition to short-term detoxific n, the program staff attempted to place detoxified add an aftercare program. We were told that this phase of program had not been very successful because only three patients had been placed in aftercare programs. As part of a followup program, it was planned to have former patients return periodically for visits and to have the staff contact programs to which detoxified patients had been referred to see how they were doing.

Chairman PEPPER. Mr. Phillips, will you call the next witness, please.

Mr. PHILLIPS. The next group of witnesses is a panel of undercover police officers who work here in the San Francisco and Oakland areas. Officer Thomas Griffin, Officer Joseph Kirley, Officer Bobby Shuemake, and Officer John Henson.

Will you gentlemen please come forward and have a seat.

In addition, Sgt. Charles Heonisch is here, head of the youth division of San Francisco. Sergeant Heonisch, would you come up and sit with these gentlemen. We would be happy to have you.

Officer Griffin, could you tell us how long you have been a police officer?

STATEMENTS BY PANEL OF UNDERCOVER POLICE OFFICERS: THOMAS T. GRIFFIN, CHARLES HEONISCH, AND JOSEPH KIRLEY, POLICE DEPARTMENT, SAN FRANCISCO, CALIF.; AND BOBBY SHUEMAKE AND JOHN M. HENSON, POLICE DEPARTMENT, OAKLAND, CALIF.

Mr. GRIFFIN. Yes, sir; I have been a police officer for approximately 2 years now.

Mr. PHILLIPS. And did there come a time when you were assigned to do uncover work in relations to narcotics?

Mr. GRIFFIN. Yes sir. When I first went to the police department I was assigned to the narcotics bureau.

Mr. PHILLIPS. How old were you then?

Mr. GRIFFIN. Twenty-one.

Mr. PHILIPS. You were assigned to do work in the schools.

Mr. GRIFFIN. Yes, sir; I was.

Mr. PHILLIPS. And particularly in what schools did you work?

Mr. GRIFFIN. I went to Mission High School. I was a student at Gallileo High School. I hung around Lowell High School and Washington High School in the city.

Mr. PHILLIPS. Could you tell us what the condition was in relations to drug use in Mission High School?

Mr. GRIFFIN. In Mission High School the first couple of days I was introduced to a certain number of people and after that I was able to buy a number of drugs from individuals at certain corners at the high school and inside the high school itself.

Mr. PHILLIPS. Could you tell us how extensive you observed children using drugs when you were there?

Mr. GRIFFIN. Well, my opinion was that I could buy drugs at any given time in the high school. I would just have to walk up to somebody, mention I wanted either a "red" or a "lid" of marihuana or some "bennies" and if he couldn't get it, I could get it from somebody else.

Mr. PHILLIPS. Drugs were readily accessible in that particular school.

Mr. GRIFFIN. Yes, they were.

Mr. PHILLIPS. Where in the schools could you buy these drugs; where were these transactions taking place?

Mr. GRIFFIN. You could buy it anywhere: In the lavatories, outside in the coffee shops, anywhere any of the kids were hanging out. All

you had to do was first know the kids and you could pick one particular individual and he would then say, "OK, John Doe is selling today, he is selling reds," or "Jim Harrington is going to sell some marihuana," anything you wanted to get.

Mr. PHILLIPS. Were both boys and girls selling these drugs?

Mr. GRIFFIN. Yes, sir; it was boys and girls.

Mr. PHILLIPS. Approximately, if you know, how many sellers were at Mission High School?

Mr. GRIFFIN. I had approximately 10 buys, 10 individuals that I bought off of during a 2-month investigation there. There were others that I could identify, but we were not able to effect an arrest on these individuals. I would assume there were other individuals selling but I was never able to get in contact with them.

Mr. PHILLIPS. You only came in contact with a small portion of the school population; is that correct?

Mr. GRIFFIN. Yes, sir.

Mr. PHILLIPS. In that population you had between 10 and 15 sellers?

Mr. GRIFFIN. Ten and 13; yes, sir.

Mr. PHILLIPS. Could you tell us what type of drugs they were selling?

Mr. GRIFFIN. Mainly it would be reds, secobarbital, and the way they would sell it would be in a four capsule package in a foil and you would pay $1 for it and the individual that was selling it would probably have, approximately, 100 reds on him at the time, so he would have 25 foils on him and you just walk up to him and ask him for some reds and he would say how many packages do you want, two, three?

Mr. PHILLIPS. Tell us about the bennies.

Mr. GRIFFIN. Well, at Mission High School I never encountered many people selling bennies. At other high schools, yes; but at Mission it would probably be reds and marihuana that was mainly in use there.

Mr. PHILLIPS. Did you purchase acid there?

Mr. GRIFFIN. If I had anything at all, it would probably be one or two occasions I bought acid at Mission and I doubt that, and at another school I bought a larger quantity of acid.

Mr. PHILLIPS. Did you have an opinion after being there for a while about what percentage of kids were into drugs?

Mr. GRIFFIN. Well, the people that I was involved with were actually the sellers, and like I stated before, that was only a small percentage that I could actually get into. It would really be difficult to say how many people used drugs there, but the people I hung around with, I would say that everybody had tried marihuana, at least marihuana, and I can't really state how many people of the whole population of the school used drugs.

Mr. PHILLIPS. What is your best estimate of how many were into things other than marihuana? Was it very difficult in the brief time you were there?

Mr. GRIFFIN. It is difficult, but I think I made approximately 10 buys of reds from different individuals, or you could state that each one of these individuals is selling at least four to five times a day, the different individuals. There you have 40 people during the day. So I would say 40, 50 people that I knew in population. So if there are other sellers you could say that you know that they do use reds. It is

really difficult to say how many people are trying because I never became involved with the rest of those.

Mr. PHILLIPS. Could you describe some of the sellers for us, what ages they were and what type?

Mr. GRIFFIN. High school in San Francisco starts at the sophomore year so that would probably be 14 or 15 years old. It goes up to 17 or 18. I bought from people 18 and I bought from people 14 years old. I bought from males and I bought from females.

Mr. PHILLIPS. Would you say that there are some cases where girls 14 years old were selling?

Mr. GRIFFIN. I think the youngest one as a girl I had was 15. At some point you will have a guy actually have girls sell for him so he doesn't have to get involved, and a girl can sell it to you and take a hike and that is about it.

Mr. PHILLIPS. Tell about the reaction of teachers.

Mr. GRIFFIN. In this high school I had a favorable reaction toward me. A few of the teachers knew I was a policeman. I asked their help in identifying them and even the principal and vice principal wanted to find out what the drug problem was, they wanted to do something. They were involved and they wanted to make sure their school had—they knew they had a drug problem and they wanted to find out how they could best solve it and the teachers knew they had drug problems and I tried to counsel some of the teachers at Mission how to talk to these kids and try to get them off drugs and I talked with a few of the teachers and I just had favorable reaction from all of them.

Mr. PHILLIPS. Was that true of all of the schools?

Mr. GRIFFIN. Well, not all of the schools, let's put it that way.

Mr. PHILLIPS. In some schools you got very little or no cooperation?

Mr. GRIFFIN. Yes, sir; to some extent.

Mr. PHILLIPS. Could you tell us what the teachers had to say about drug use when they observed it?

Mr. GRIFFIN. Some of the newer teachers didn't even know what was going on. They would see kids passing foils back and forth and they didn't know what it was. The older teachers knew what it was, but like any school there are problems that the teacher can't come up and grab a kid and take it away from him and they just knew it was going on but there is hardly anything they could do. At Mission there was two individuals that walked the campuses and these men actually did a great job. They took on kids and asked them who they were, if they belonged to the school, and if not they wanted them out of the school and didn't want them anywhere near the area. Both of these individuals had black belts in karate and none of the kids gave them back any lip. They did a very fine job of keeping down the drug problem.

Mr. PHILLIPS. And others ignored it?

Mr. GRIFFIN. Not that they ignored it, they knew it was there but they couldn't do anything about it. They told the principal about it and that is how we became involved. The principal called us and asked us if we could conduct and investigate and see if we could do something about it and that way they were involved.

Mr. PHILLIPS. You were telling us previously about reds being very popular. Could you tell us a little more about what reds are?

Mr. GRIFFIN. Reds are secobarbital, and the way it works on an individual taking it, it gets you drunk. If you take one you feel like you are drunk and if you take two you get worse, and actually it is a sleeping pill and these kids, I talked to a few of them, and they actually took these so they could go to class and not worry about what the teacher was saying. They wanted to go through the whole day without having to do anything and in that sense they could just forget about school entirely, and that is what actually a red does to you. There are a few kids that took reds and wine together but that would be at night. I never saw anybody taking reds and wine together during the day.

Mr. PHILLIPS. Do the kids who take a number of reds have any specific characteristics that are obvious?

Mr. GRIFFIN. If there is a kid here today, I couldn't say he was taking reds unless he is doing it every single day he might be so tired and doped up. I never ran into anybody that was taking it to such an extent they looked like that.

Mr. PHILLIPS. And you are talking about Mexican reds, M. & M. reds.

Mr. GRIFFIN. Let me tell you about the regular reds you buy in the foil. They are in a capsule and come four in a capsule, four in a pack. M. & M. reds actually sell for a lesser amount and it looks like an M. & M., a red M. & M. It is a lot more solid and you put it in your hand and you wet it, the coloring comes off and they try to disguise these reds because the Mexican's couldn't get it across the border in the other capsules so they put them in the M. & M. forms and they sold them to the kids. The kids didn't like them at Mission, they wanted the capsule forms.

Mr. PHILLIPS. Were some of the boys and girls who sell drugs doing it for money or just doing it for their own drugs?

Mr. GRIFFIN. I honestly figure that they were doing it for money. Like, to give an example, if you buy a jar, which is the largest you can buy from kids, there are a thousand in the jar, and you buy it between $100 when the economy is high and $120 when everybody is tight up for money. All right, what happens is if you can sell them two for a dollar, you can imagine the profit.

You bought it for a hundred and you have a thousand. You have to put two in a package to make five hundred. A kid could sell a thousand reds, if he is lucky, in a week or 2 weeks, so that is $400 profit you have. So there are a lot of them that make profit.

Mr. PHILLIPS. Did there come a time when you went to O'Connell?

Mr. GRIFFIN. Yes, sir.

Mr. PHILLIPS. Tell us what the situation was at O'Connell.

Mr. GRIFFIN. Well, at O'Connell again we had a principal and we had teachers that really wanted to help the kids out. The kids wouldn't let them so they asked us to come in. What I did was I became involved with this cafeteria across the street and met a bunch of guys over there. I had names, I thought, of the suspects who might be selling the drug and I started to meet these guys. What happened then, I said, "Listen man, I want to buy a few reds," and they would sell you reds. This is where bennies came in. I met a kid and his whole trip was bennies. He told me he took 10 to 15 bennies in 1 day. I never tried them but I imagine he wasn't doing much for the rest of that night. So what happened then I started buying reds, and let me state O'Con-

nell isn't the same as other schools, it is a technical school and the ages from 15 all the way up to your ages, gentlemen, but men weren't selling that were 50 or 60 years old. The people that I met, the oldest guy that sold to me was 25 years old. And this school here, the thing to do is to be tardy for school, not even go to class, go out and do anything you want.

I was enrolled in a history class and sheetmetal class and I met a lot of sellers in that class there. I bought drugs at this school. I tried to meet the suppliers of the drugs and at one time I did meet one individual.

Mr. PHILLIPS. Tell the committee what happened one morning in relation to the drugs in the metal shop.

Mr. GRIFFIN. I was telling a bunch of guys I wanted to make money, my parents had died and I needed about $200 or $300. So, all right, they said we can sell you a jar for $100 and you can make a pretty good profit. So I had arranged to buy either one or two jars of reds and I was taken by an individual to another location and another suspect came out. He brought me in his own car to another location. I was sitting there and two other guys came up. They said wait here, we will go get the stuff for you. I waited there and I noticed in the rearview mirror there was somebody coming up with a mask on. Before I could do anything the guy puts a gun to my head and pulled the trigger twice and his gun didn't go off which was lucky, so he then hit me with a blackjack, at which time I was reaching for my gun and I put my gun to his head and pulled my trigger and unfortunately my gun didn't go off. I had a faulty safety on my gun. By the time I got out of the car the suspect was running away with the gun in his hand. I yelled, "Police, stop," and he turned around to fire. I went to fire at him again but there were children all around the individual and I couldn't fire. The man started to run again. I chased him and we effected an arrest within 10 to 15 minutes, but this was all because of something to do with the school.

Mr. PHILLIPS. Let me ask you whether reds, marihuana, acid, or bennies were available at this particular school?

Mr. GRIFFIN. You said it right there. I bought every one of those. Just again reds were more available than anything else; but bennies, at one time we had one kid came out and there was 15 to 20 kids standing around just buying reds.

Mr. PHILLIPS. Can you tell us about the absentee situation in that school?

Mr. GRIFFIN. I never had any figures but at this school, I didn't want to go to school, I was tired from working the night before so, I usually was late or didn't go to certain classes. But just like any school, you have kids cutting and going out and smoking dope or going out and playing cards. So I can't put a figure on between one school at Mission or John O'Connell, what the figures are on absenteeism.

Mr. PHILLIPS. There is a tremendous amount of absenteeism.

Mr. GRIFFIN. In any school, right; and in John O'Connell you had the same thing.

Mr. PHILLIPS. By a tremendous amount, I mean there were 50 to 60 percent of the people missing from class?

Mr. GRIFFIN. I don't want to go that far. Some of these kids, it was a training school and this was actually going to be their job, their

technical job. At Mission you would have something else. You would have kids all the time cutting class. At John O'Connell you would have the same thing for history, or algebra, or something like that. If it came to their workshop they were there. But like any other school you are going to have people cutting.

Mr. PHILLIPS. Could you tell us briefly what your experience was at Lowell, which is one of the better high schools?

Mr. GRIFFIN. What happened at Lowell, we had the same effect. We had heard that individuals were selling drugs. We had supposedly their names. I went out there to make an investigation. The first day out there you can't come on too strong, you try to introduce yourself to certain people. But what happened was supposedly they had found out I was a policeman.

Mr. PHILLIPS. They immediately found out you were a policeman and you suspect the school authorities had something to do with that?

Mr. GRIFFIN. What I could suspect and what actually happened are two different things. What I think happened is somebody told somebody else.

Mr. PHILLIPS. The only people who knew you were there were school officials; is that correct?

Mr. GRIFFIN. As far as I know; yes, sir.

Mr. PHILLIPS. Tell us whether you saw any dealing in drugs going on at all.

Mr. GRIFFIN. In that school, yes; very much so.

Mr. PHILLIPS And that is probably the best school here in San Francisco.

Mr. GRIFFIN. Gradewise, yes. You have to have an A or B plus to get into that school.

Mr PHILLIPS. Sergeant, before we leave that school perhaps you could tell us about your efforts to start undercover operations in this school, and the discussions with the school authorities there.

Mr. HEONISCH. We had gotten reports from various sources, in fact we even had names of students that were supposedly involved in drug activities at Lowell High School. There was an area at the school called the "Pits," it is a wooded area between the school itself and the high school and the football field and athletic field. The students were supposed to congregate during school hours and partake in either marihuana smoking, or passing off barbiturates, and so forth.

One particular day we sent Officer Griffin out there to just observe and strike up conversations with the students, and Officer Griffin came back to us and reported he had observed what he thought were several drug transactions at this pit area. The next day, myself, along with Inspector Robert Gillen of our office, went out and talked to the dean of boys at Lowell High School. We also—I didn't know if that was the same day or a day after—we talked to the principal and told him we would like to put an undercover man in the area itself to see what we could find.

Officer Griffin went back the next day and I believe the next morning he was accepted by the students and partook in conversation. But, if I am not mistaken, by the next afternoon the students came to him and told him that they felt he was a narc. I don't know whether he was fingered by someone, but somehow the word filtered down to the students.

Mr. PHILLIPS. As a condition to that, were the school authorities unreceptive? You gave them certain information you had on people who were dealing in the school; is that correct?

Mr. HEONISCH. Yes, sir.

Mr. PHILLIPS. Can you tell us what they said about the young people you said were dealing in drugs?

Mr. HEONISCH. One particular person we talked to didn't think it could be possible. He knew the student personally and he felt that just couldn't happen.

Mr. PHILLIPS. He said he knew the students personally, that their parents were prominent people in the community, and, therefore, he could conclude they hadn't been involved in transactions with drugs; is that correct?

Mr. HEONISCH. With one particular student this is true; yes.

Mr. PHILLIPS. Officer Kirley, did you perform undercover work in the schools?

Mr. KIRLEY. Yes, sir; I did.

Mr. PHILLIPS. Could you tell us what school?

Mr. KIRLEY. I worked undercover in Lincoln High School in San Francisco.

Mr. PHILLIPS. Tell us what the drug situation was at Lincoln.

Mr. KIRLEY. Very free, easy to obtain, widely spread, widely used.

Mr. PHILLIPS. I think you told me that from your observation everybody was doing it?

Mr. KIRLEY. Everybody used marihuana or tried marihuana; yes, sir.

Mr. PHILLIPS. And other people tried other things?

Mr. KIRLEY. Yes, sir; quite a bit of other drugs were used out there.

Mr. PHILLIPS. Could you tell us what the other drugs were that were being used at Lincoln?

Mr. KIRLEY. Barbiturates, reds, and amphetamines, mini bennies, they called them; and LSD, mescaline, and hashish, which is another form of marihuana.

Mr. PHILLIPS. Were both boys and girls dealing in this?

Mr. KIRLEY. It was pretty well even. There was the same amount of girls selling as there were boys selling.

Mr. PHILLIPS. How old were these boys and girls that were selling?

Mr. KIRLEY. 15 to 18 years old.

Mr. PHILLIPS. Where did the transactions and deals take place?

Mr. KIRLEY. They took place, the ones I participated in and the ones I viewed, on the school grounds or in secluded areas in the school; hallways.

Mr. PHILLIPS. Hallways, cafeterias, classrooms?

Mr. KIRLEY. Yes, sir. I didn't see any deals going on in the classrooms, but in the hallways and in cafeterias and on the school grounds.

Mr. PHILLIPS. Did there come a time when you got involved in the purchase of a large amount of LSD?

Mr. KIRLEY. Yes, sir.

Mr. PHILLIPS. Tell the committee about that.

Mr. KIRLEY. I was introduced to a student at Lincoln High School by another student that I wanted to make a few dollars out there at the school and he told me he could give me a good deal on some LSD

and he had some that he wanted to unload and he could sell it to me for $45 for a hundred, as many hundreds as I wanted he could get me.

Mr. PHILLIPS. Did the kids ever tell you why they were taking drugs?

Mr. KIRLEY. I talked with a few girls out there and the girls used bennies, Benzedrine quite often out there, and they said that it would take their mind off of school. It was a pleasure to go to school if they took these drugs instead of a bore. They could make it through the day and enjoy school instead of being bored.

Mr. PHILLIPS. Could you tell us a little about the attitude of the teachers in relation to what they saw going on in front of them?

Mr. KIRLEY. Well, it was 50–50. There were some teachers that were interested in the problem. They didn't know I was a police officer, the dean and principal were the only ones that knew. Some teachers in the classrooms, if kids would come to the classroom under the influence, would either ignore it or not even know it, I don't know, where other teachers would call on them and tell them to go down to the dean's office. Some teachers were interested and others were not.

Mr. PHILLIPS. Could you tell us a little about the absenteeism that existed in the high school?

Mr. KIRLEY. The absentees were very high at that school. One time I was in a class enrollment of 32 and there were eight students present in the class and this was a civics class.

Mr. PHILLIPS. Eight out of 32 people were there?

Mr. KIRLEY. Yes, sir.

Mr. PHILLIPS. Did you observe any education program going on in the school about drugs?

Mr. KIRLEY. No, sir; I did not.

Mr. PHILLIPS. And did you observe gambling, or anything else going on?

Mr. KIRLEY. Yes, sir: there was. You could get a card game anywhere in the school. In the back they played cards, they played cards across the street in the park, and there was a stairway that led down to the tennis courts, you could play dice back there, and there was always a game going on.

Mr. PHILLIPS. Was there any security arrangement, any police officers in the school at all?

Mr. KIRLEY. Yes, sir.

Mr. PHILLIPS. Other than yourself?

Mr. KIRLEY. They had what they call patrol specialist. They were hall monitors. They were hired and they worked in the hallways. They would be responsible for clearing the halls during class time to make sure there was nobody in the hallways.

Mr. PHILLIPS. Do they do it?

Mr. KIRLEY. On occasions. They would have what they call sweeps where the dean would get these two hall monitors and they would make a hall sweep. It would last for about 10 or 15 minutes and the kids could see them coming and everybody would run and hide in the park, wait 15 or 20 minutes and then come back, and that would be it for the day.

Mr. PHILLIPS. Officer Shuemake, you also have done undercover work for the Oakland Police Department, but you don't go into the school; is that correct?

Mr. SHUEMAKE. Yes, sir.

Mr. PHILLIPS. And you have worked in a number of schools in Alemeda County; is that right?

Mr. SHUEMAKE. That is correct.

Mr. PHILLIPS. Can you tell us a little about what you found at Castlemont?

Mr. SHUEMAKE. Well, I discovered at Castlemont most of the dealers that were dealing around in the campus areas were nonstudents, the age averaged from 25 to 30.

Mr. PHILLIPS. They were the dealers?

Mr. SHUEMAKE. Yes, sir.

Mr. PHILLIPS. Did they have children in the school working for them?

Mr. SHUEMAKE. Yes, sir.

Mr. PHILLIPS. How many dealers would have how many kids working for them?

Mr. SHUEMAKE. Approximately four.

Mr. PHILLIPS. He would have four kids who actually went in the schools to sell drugs?

Mr. SHUEMAKE. Yes, sir.

Mr. PHILLIPS. Could you tell us what drugs were being sold in Castlemont?

Mr. SHUEMAKE. Marihuana, reds, and bennies, mostly.

Mr. PHILLIPS. Did you observe any cutting of classes in those schools?

Mr. SHUEMAKE. Yes, sir; I did.

Mr. PHILLIPS. Describe that for us.

Mr. SHUEMAKE. There was a parking lot adjacent to the school campus and from the time school started in the morning until school was out about 300 to 400 students would be in and out of the parking lot.

Mr. PHILLIPS. Not attending school classes?

Mr. SHUEMAKE. That is correct.

Mr. PHILLIPS. You have attended Oakland and you went to Oakland, Frick, and Freèmont. Could you tell us, were the conditions in those schools similar to the ones that you have just described?

Mr. SHUEMAKE. A little different.

Mr. PHILLIPS. How were they different?

Mr. SHUEMAKE. In the Freemont area there were dealers that were living in the area of the school, maybe across the street or around the corner, and students would leave campus and go there and make their buys.

Mr. PHILLIPS. Did you have any teacher cooperation or administration cooperation in your activities?

Mr. SHUEMAKE. The time I was working at the school I never approached or attempted to get any cooperation from the teachers there.

Mr. PHILLIPS. Well, I understand from other sources that the cooperation is nonexistent. Is that a fair description of it?

Mr. SHUEMAKE. Well, in my opinion it is. This is my opinion.

Mr. PHILLIPS. Did the teachers do anything about the drugs that they saw being transacted in the schools?

Mr. SHUEMAKE. Not that I know of.

Mr. PHILLIPS. Do you think that they are afraid, or what is your opinion about the teachers' lack of action?

Mr. SHUEMAKE. Well, in my opinion, I think they are afraid that the students might retaliate if they try to do anything.

Mr. PHILLIPS. Mr. Henson, you have also worked undercover for the police department in Oakland; is that correct?

Mr. HENSON. Yes, sir.

Mr. PHILLIPS. I think you have mostly worked the Skyline?

Mr. HENSON. Our activities in Oakland were not directed in the high schools themselves. Our organization was juvenile narcotics and we went out to hit the people that were pushing narcotics to juveniles, more specifically juveniles themselves. I never worked within a school. Around the street corners and across the street on occasions.

Mr. PHILLIPS. Can you tell us why San Francisco works in the schools and you do not?

Mr. HENSON. I have no idea. I would have a hard time passing myself off as a high school student. I think we were more concerned with the juveniles using narcotics and the narcotics falling into their hands rather than the juvenile pushing. This is only my opinion. This isn't the Oakland Police Department opinion, but my own.

Mr. PHILLIPS. Was there any prohibition about you going into the schools?

Mr. HENSON. Not that I know of.

Mr. PHILLIPS. You, on your own, decided not to go into schools?

Mr. HENSON. There was a problem, bigger problem on the streets outside of the schools than there was inside as far as I had knowledge of.

Mr. PHILLIPS. How did you know if you hadn't been in there?

Mr. HENSON. I started on the streets and I never could get in the schools, there was so much work on the street.

Mr. PHILLIPS. There was plenty of business outside?

Mr. HENSON. Yes, sir.

Mr. PHILLIPS. Can you tell us what you saw outside?

Mr. HENSON. Well, in cases that I have handled I have seen people pushing drugs from a 16-year-old kid that was pushing heroin to a 55-year-old man pushing grass. They have been both black and white and chicano, and I couldn't really put a racial tone to any amount of drug sales. Everybody seems to be dealing in it. Not specifically to their own races but to anybody that wanted drugs. I know a 40-year-old woman that deals Benzedrine to high school students, to her fellow workers and to anybody that wants to buy them.

Mr. PHILLIPS. And just one final question for you, Sergeant. You, as supervisor of the staff of people working juvenile narcotics, get reports from all over the city; is that right?

Mr. HOENISCH. Yes, sir.

Mr. PHILLIPS. Would you say the drug problem arrests and investigations you have conducted indicate a problem crossing all racial, ethnic, and sociological lines here in the area?

Mr. HEONISCH. Absolutely, in San Francisco.

Mr. PHILLIPS. And that would include Catholic schools, private schools, and public schools?

Mr. HOENISCH. Yes, sir.

Mr. PHILLIPS. I have no other questions.

Mr. WALDIE. Mr. Heonisch, I was curious as I listened to the testimony of your officers as to what efforts have been made to stop the

drugs getting to the student dealer. I presume that it has to come from the streets and I gather the emphasis of the police department is to attempt to attack it on the street. Your emphasis may also be in that direction in addition to the schools, but what can you tell the committee as to how the students who are dealing in the schools get their drugs; where do they get them?

Mr. HEONISCH. Somewhere along the line they purchase their drugs from the adults and what we try to do is in San Francisco we try to attack the drug problem on every level. When we are confronted with a high school student who has a drug involvement, particularly a drug sales involvement, we try to talk to him and try to find out where his sources are.

I think all officers involved in narcotics will agree that it does have to be attacked on every level and we just don't stop with the high schools. We try to find out their connections and if we are lucky enough to get their connections we try to go one step higher.

Mr. WALDIE. What successes have you had in getting information from the student dealers as to their sources of supply?

Mr. HEONISCH. Very limited success. High school students, juveniles, young adults, have a very, very strong sense of loyalty to their peers and also to their sources. It is very easy to turn a 25-year heroin addict, to have him turn his source; it is very, very difficult to turn a 17-year-old. We have gone into this problem time and time again. The loyalty is amazing among the young.

Mr. WALDIE. Am I correct in my assumption that the dealers in the school system are not addicts?

Mr. HEONISCH. Are you referring to heroin addicts?

Mr. WALDIE. Well, let me just say addict and then you can clarify what confusion that question might have in your mind.

Mr. HEONISCH. I would describe them more as users, users of barbiturates, users of amphetamines, users of marihuana.

Mr. WALDIE. I heard no officer mention the use of heroin in the schools. Is that because it is not present?

Mr. HEONISCH. I wouldn't be so naive as to say it isn't present. However, the three undercover officers that I had under my supervision found no evidence of heroin in the high schools.

In the last year I have had only one incident reported to me of a student found with heroin.

Mr. WALDIE. That is in the San Francisco schools?

Mr. HEONISCH. That is in San Francisco, yes.

Mr. WALDIE. May I ask Officer Shuemake and Officer Henson the same question related to the Alameda County schools, the Oakland school system.

No mention was made of heroin. Can we conclude that heroin is not a problem in these schools?

Mr. SHUEMAKE. In my opinion we haven't had too much success in making buys.

Mr. WALDIE. They haven't had success?

Mr. SHUEMAKE. No.

Mr. WALDIE. At least in your experience there has been no indication of heroin use in the schools that you can tell us about?

Mr. SHUEMAKE. That is correct.

Mr. WALDIE. I gather there was an illusion, and I think I understand that in total, that at least in Lowell, Officer Heonisch believed that there was a lack of cooperation on the part of those school authorities. Is that opinion based upon the fact that your cover as an undercover agent was broken and you suspect they may have done that?

Mr. HEONISCH. Well, sir, I don't know really what to suspect. Our reception out there wasn't the greatest that we ever had.

Mr. WALDIE. What I am trying to find out would be one of things the committee has been hearing, and that is there has been lack of cooperation of the school authorities. If there is indication would it be fair for you to tell us? I think it does not do the local authorities a service to suggest that that is the case without us being able to establish that is the case.

What I am really attempting to find out: Because Officer Griffin's cover was broken, is that the basis upon which you believe cooperation was not extended.

Mr. HEONISCH. No, sir; I got the feeling that when I went out to the school to talk to the dean of boys and the principal that they weren't really too happy with our presence. The other three schools we had an operation where we were given a great deal of cooperation by the administration.

Mr. WALDIE. In what way were you denied cooperation? What cooperation did you seek from the school authorities in the first instance. Could you answer that question?

Mr. HEONISCH. Well, the first thing we told them was we would like to put an undercover person in their schools for a certain amount of time and we then asked if we had their OK. Obviously, we just asked them to keep it to themselves and not to spread the word around, and then after several purchases were made we requested the school authorties to assist us in identification of students involved in the drug transactions.

Mr. WALDIE. And have you received that cooperation from all of the schools in San Francisco, with the exception of Lowell; is that what you are suggesting?

Mr. HEONISCH. No; I am not suggesting that at all. We received the cooperation of the school administrations in Lincoln, in Mission, and John O'Connell. We never got off the ground at Lowell.

Mr. WALDIE. Because of lack of cooperation or because Officer Griffin's cover was broken?

Mr. HEONISCH. The main reason was Officer Griffin's cover was broken.

Mr. WALDIE. I am trying to be as fair as I can in a congressional hearing and it is an easy tendency to make assumptions that aren't proven. The assumption that I gather was made, is that the unhappiness of Officer Griffin being identified by the students was the responsibility of the Lowell administration. I presume there is very little substance to that assumption.

Mr. HEONISCH. Well, this is correct. I am not accusing any administrator at Lowell.

Mr. WALDIE. Then it is fair to say that we have not really had a test other than the one as to how cooperative or uncooperative the Lowell authorities would be. Would it not be fair to say that?

Mr. HEONISCH. That is true.

Mr. WALDIE. You never had an undercover agent on the campus prior to Mr. Griffin.

Mr. HEONISCH. No, sir.

Mr. WALDIE. Have you had undercover agents on other campuses prior to Mr. Griffin?

Mr. HEONISCH. Yes, sir.

Mr. WALDIE. But the need for one at Lowell had not been determined to be necessary up to this time?

Mr. HEONISCH. No, sir.

Mr. WALDIE. Tell me one more thing. What happens to the student dealer when you make a purchase from him?

Mr. HEONISCH. Well, when we are ready to move into whatever school we are operating at we identify the dealers; we then arrest them. We have never arrested them in the schools. We normally set a date and what we do is usually early in the morning we will arrest them at home so as to not cause a commotion in the high schools. What happens then is they are taken to the youth guidance center and the authorities, the probation department, takes over.

Mr. WALDIE. What disposition is normally made then of the student?

Mr. HEONISCH. Well, I don't think that any student we have arrested for sales has gotten anything more severe than probation.

Mr. WALDIE. Have most of the arrests been because of marihuana or most of them because of reds.

Mr. HEONISCH. The arrests for sales I have broken down here. We are just talking about the two undercover officers in the three schools that we mentioned.

We made 14 purchases of reds or barbiturates; we made 18 purchases of marihuana; we made 12 purchases of amphetamines, bennies; we made eight LSD purchases; and we made four purchases of nothing, something that was purported to be drugs which in essence wasn't.

Mr. WALDIE. And that is in what period of time?

Mr. HEONISCH. This was in 1971.

Mr. WALDIE. Is the presence of an undercover agent on these high school campuses a rare thing? I gather from what you tell me it is.

Mr. HEONISCH. Absolutely.

Mr. WALDIE. Or fairly constant thing?

Mr. HEONISCH. It is a very rare thing for a number of reasons.

Mr. WALDIE. I have no further questions, Mr. Chairman.

Chairman PEPPER. Mr. Winn?

Mr. WINN. Thank you, Mr. Chairman.

I just would like to ask any of the members of the panel to answer a few questions that I might have and we may save some time.

I believe Officer Griffin said there were about as many girl sellers or females sellers as there were boys. Do you have any records on that?

Do you keep records as to whether they are boy or girl sellers?

Hr. HENSON. Yes, sir.

Mr. GRIFFIN. The records we have here at Lincoln High School, both buys of hash from boys, one buy of Benzedrine from a girl, one buy of marihuana was a boy, two from boys. We have nine boys with 15 buys and four girls with five buys. So there would be buys off the girls and in Mission High School it would be the same way. Actually it is—was the boys over the girls.

Mr. WINN. There are girls selling, too?

Mr. GRIFFIN. There are girls selling; yes.

Mr. WINN. One of the officers said that the girls might be representing boy pushers.

Mr. GRIFFIN. It was I who said that and at Mission High School there were two or three girls I knew who were actually selling for male counterparts. What took place was they would sell me a small quantity and I asked them if they could get a larger one and they stated they would have to talk to their man about it and they would come back to me.

Mr. WINN. Did any of you run into a situation wherein you felt that possibly a teacher was involved in the selling?

Mr. GRIFFIN. No.

Mr. WINN. Did you run into any? We have in other cities and that is why I brought this up. Did you run into any circumstances where you thought it possible teachers were users or did you have any knowledge of teachers being users?

Mr. GRIFFIN. I have no knowledge of it.

Mr. WINN. Any of the rest of you have?

Mr. SHUEMAKE. No.

Mr. WINN. Then I gather with the work that you gentlemen have done that you don't feel that, in fact, there might be some teachers that are users. That is really a problem in other area schools?

Mr. GRIFFIN. No, sir.

Mr. SHUEMAKE. I can't say. Like I said, we worked outside of the schools, adjacent.

Mr. WINN. You two worked outside of the schools mostly. But as I remember, Officer Henson was the only one who did mention heroin in his testimony?

Mr. HENSON. Yes, sir.

Mr. WINN. So you might not see heroin, any usage to speak of in the schools, but it is available right outside of the schools; is that what you are telling the committee?

Mr. HENSON. The whole thing with heroin is it is different than marihuana, not only being a narcotic. In the schools, there are undoubtedly heroin users.

Mr. WINN. Do you think there is a heavy use in the schools?

Mr. HENSON. In the city of Oakland I don't think we have a heavy problem of heroin users in our schools. The difference with the heroin users and marihuana users is an addict will sell heroin to support his habit. There aren't very many users in the schools so, therefore, he doesn't sell it in the school. The selling would be done on the street, as far as heroin, so it is hard to identify a heroin problem in the schools.

Mr. WINN. But some of these are students that you are talking about.

Mr. HENSON. They will be users but won't be pushers as will some of the users of the amphetamines and barbiturates or hallucinogenics.

Mr. WINN. You do think there are some users of heroin in the schools, but it is not a real problem?

Mr. HENSON. I do think anybody who uses heroin has a problem, but I don't think it is as widespread as Seconal.

Mr. WINN. I agree with you and I should have worded that differently. It is not as big a problem as we have run into in the East.

Mr. HENSON. I don't think it is as widespread in these schools as it is back in the East.

Mr. WINN. I believe you mentioned, Officer Shuemake, that you went to Castlemont. Is that the name of the school?

Mr. SHUEMAKE. Yes, sir.

Mr. WINN. I am not familiar with the area here. Is that black, white, black and white, or what?

Mr. SHUEMAKE. It is about 98 percent black.

Mr. WINN. The income level, would you call the students at that school low income, medium income, or what would they be?

Mr. SHUEMAKE. It is rather difficult to say but, for example, around Castlemont the dealers would sell mostly matchboxes, a marihuana package in a matchbox for $5.

Mr. WINN. You are talking about the type of sale?

Mr. SHUEMAKE. Yes, sir.

Mr. WINN. There are matchbox sales?

Mr. SHUEMAKE. Yes, sir. From that you can imagine the economical situation.

Mr. WINN. Would you explain? That is what I am trying to get you to do. Would you explain what you are talking about, a matchbox sale, and how much the matchbox would sell for?

Mr. SHUEMAKE. $5.

Mr. WINN. $5?

Mr. SHUMAKE. Yes, sir. In other areas I have discovered they deal mostly in lids, so I would gather that around Castlemont the economical situation is not as great and that they can't sell in large quantities.

Mr. WINN. So these students probably don't have as much money as students in some of the other schools?

Mr. SHUEMAKE. It is rather difficult to say.

Mr. WINN. But that is your opinion?

Mr. SHUEMAKE. Yes, sir.

Mr. WINN. One of you made a statement that teachers can't intercept sales even if they know or see what is going on. What is that based upon? I believe it was you, Officer Griffin. We were talking about sales going on and teachers in some of the schools did know it and could see it but they couldn't intercept it, they couldn't grab it. What is the reason for that; why can't they, if they know what is going on?

Mr. GRIFFIN. Figure it this way. You are 5 feet 8, 135 pounds, 140 pounds, and a kid you are going to take on is 6 feet 2, and 200 pounds.

Mr. WINN. You are talking about the teacher physically couldn't?

Mr. GRIFFIN. That is right.

Mr. WINN. You are not talking about any law or regulations?

Mr. GRIFFIN. No, sir.

Actually a teacher can do anything, if he sees anything going on in the classroom he can do anything.

Mr. WINN. That probably wouldn't start out to be a physical battle but it could end up that way, I am quite sure.

Mr. GRIFFIN. I think the possibility is greater than you can even think. You walk down a hall by yourself and you have got 100 kids coming at you during a break and if they want to get you they are

going to get you. I don't know of any instance this has happened, but all the kids that I knew of, you can actually see it going on, the kids selling, and a teacher one day saw a girl drop a box of pills and the teacher saw her pick up every one and didn't do anything. For one reason, she is not going to take the chance of taking the kid on.

Mr. WINN. Was this partially, as you say, because of the physical danger involved or partially because of the fact that some teachers in certain parts of the country and some teachers' unions have made it quite clear that teachers are not law enforcement officers and that is none of their business.

Mr. GRIFFIN. When I went to high school we had teachers if you had anything, these guys were either big or small, they went back there and they had the authority to take you by the neck and choke you to make sure you did the thing that was right, and actually we came. Nowadays teachers have no authority. If they touch a kid they are in hot water and if they try to do anything out of the ordinary the kid is going to go to the principal and they are going to have these groups come up and say the teacher is harassing them. And I am not a teacher. I used to be a janitor in the schools and I used to talk to the teachers and I know how some of these teachers feel. They are not going to take these kids on. Some teachers will do it just because they feel it is right, but the other ones are afraid of their jobs and are not going to do it.

Mr. WINN. You referred to the hall monitors. What types of guys are these? Are they teachers off duty or are they football coaches or men of any physical ability that could do this?

I don't quite understand what we mean by hall monitors.

Mr. GRIFFIN. Well, at Mission, John O'Connell, and Lincoln—Officer Kirley can tell you about this—at Mission and John O'Connell there were women there and all they did was tell you to get out of the hall and you tell them "Yes, sure," and keep walking on your way. At Mission we had two guys that were both Spanish, both black belts in karate, and they would actually walk up to these kids and they wouldn't take anything from these kids and they would walk up to them and if they were smoking dope they would take them and take their names or take them right to the principal and they would do justice to the kid. In John O'Connell the woman couldn't do it, but these two guys at Mission were not actually afraid of the kids. The kids were afraid of them and they always watched out for them. When I was there they would say watch out for the two guys and they are cops and narcs. I started laughing but they were working for the school department.

Mr. WINN. So in that case you had men with physical abilities and the students who were users respected them.

Mr. GRIFFIN. Right.

Mr. WINN. Or that talent.

Mr. GRIFFIN. There was actually a woman at Mission that would walk up and do the same thing and they were afraid of this woman because she wouldn't take anything from them.

Mr. WINN. Can any of you answer my last question about the assignment and authority of nurses, or do they have nurses in the schools here?

Mr. KIRLEY. There was a nurse at Lincoln High School.

Mr. WINN. What did she do? Some of these students must become ill during the day from using drugs. What authority did the nurse have

and can you relate their procedures as far as sending sick students home, or cal'ng doctors, or calling parents?

Mr. KIRLEY. No, sir; I never did get involved with that. I knew there was a nurse present on the campus.

Mr. GRIFFIN. When I was a janitor at Mission High School we would have kids come down from overdoses, or what they suspected to be overdoses. They would first take them to the nurse and the nurse would call the ambulance and they would send them to the general hospital and I imagine observe them for a day or whatever and then send them home.

Mr. WINN. Were the parents notified?

Mr. GRIFFIN. Yes, definitely they would have to be notified.

Mr. WINN. Thank you, Mr. Chairman.

Chairman PEPPER. Mr. Murphy?

Mr. MURPHY. Officer Henson, in your experience as an undercover agent and also your experience as a janitor in the school, how widespread would you say the use of barbiturates is in the area schools?

Mr. GRIFFIN. I will make a reference to this. What do you drink at home? Do you drink scotch or do you drink bourbon? Whatever you like. Some kids will want grass or marihuana and other kids want reds or bennies. So it is just whatever their preference is.

I think all four of us can state the some thing: You are not going to find one school all reds, or all LSD, or all anything else; you are going to find a variance between each kid, what he likes to do.

Mr. MURPHY. Are there many cases of overdoses in these schools?

Mr. GRIFFIN. I honestly don't have any records. The only thing I can state is before I noticed three times the ambulance had come alone at Mission High School within a year period that I know of and that was in the afternoon and they had to take a kid home and in that instance the kid had started a fight in class and they found out he was high.

Mr. MURPHY. In your opinion is there a program in the schools where a student, if he wishes to, can seek help for a drug problem, can go for counseling?

Mr. GRIFFIN. No, no, sir; that is the trouble. I honestly believe if they had somebody in there before, like having the hall monitors, enforcing the law and actually having somebody they could go to talk about their drug problem beside being outside in the community. What happens if they are inside the school, I think if they had programs like that something could be done about it. There is a combination of things that could be done, if at all possible, to stop the drug epidemic.

Mr. MURPHY. I would like to hear those recommendations.

Mr. GRIFFIN. One, like we do in San Francisco, find out who the supplier is, which is definitely very hard; two, have undercover officers inside the school constantly trying to find out who is selling the dope; three, have somebody, have some of the teachers making an effort to get to the kid and find out why they are taking the stuff and if they can help them; and, four, having somebody, a psychiatrist or anybody, inside of the school for these kids to be able to go up and talk to them and try to help these kids out before they have to go outside in the community, (1) not to have a job; or (2) either to commit crimes or just be a burden on the government.

Mr. MURPHY. Well, in other words, what you are telling me then is from your experience you haven't seen any concerted effort on the part of the school system to cope with this problem?

Mr. GRIFFIN. No, I am not saying that. I think the effort that they showed when we asked them for their help is an effort, but they can only go so far. Just because one school didn't help us, I am not saying that. We had four or five schools that actually wanted our help and actually gave us assistance and I think that is a great step forward.

Mr. MURPHY. But in any of these schools is there any counseling service for a youngster who has a problem with his parents or something bothering him at the school, or something in his life that is obviously making him turn to drugs for a solution? Is there any meaningful program there to help that youngster?

Mr. GRIFFIN. They have counselors who actually help them with their educational problems and who they can go down to talk to and say listen, I am having a problem with my girl friend or having a problem with work, and I imagine that there are some kids who go down and say listen, I am having a problem with drugs, can you help me, to a certain extent, but it is not large spread.

Mr. WINN. Would the gentleman yield on that?

Mr. MURPHY. Yes, sir.

Mr. WINN. In any of the schools did you see any literature which is available to students, parents, and through PTA groups?

Mr. GRIFFIN. I will tell you I saw one pamphlet, I think I saw several, but one pamphlet that I can remember. It had drug and it had the needle and it just gave some literature about it. I know it was in the school.

Mr. HENSON. I have seen some of the pamphlets. Most of them are outdated.

Mr. WINN. Most of them are outdated?

Mr. HENSON. Really archaic. If you are talking about a juvenile using narcotics today you wouldn't ask does he use marihuana, the terminology within the group is, joint, grass, weed, this type of thing. I think the biggest problem that we have in the schools today is not lack of the teachers turning their heads to the problem, it is the educational aspect. I think Benzedrine tablets, a mini-bennie can roll out of a student's pocket and most of your teachers couldn't identify it as Benzedrine. I think there is gross negligence on education of drugs. It's compounded with the teachers' problem of handling the students. There should be some organization, either local, State, or Federal that should provide a program for educating teachers to the aspect of, well, this is what a joint looks like and smells like, not this is cannabis, it grows like this. They have no idea what the drugs look like.

Mr. WINN. None of you saw any large organizations or table or display unit or bulletin board that said that this material was available?

Mr. HENSON. In Oakland they can come to the department and we can give demonstrations.

Mr. WINN. I am not criticizing that; I am talking about the school system. I am trying to figure out, and I think that is what Mr. Murphy is asking, what type of educational program do we have through the school system?

Mr. MURPHY. Right. It has been our experience in New York, Miami, and Chicago, that most of the school officials have admitted that teachers are not trained. The teachers don't know the difference between the drugs. This is not a problem of their generation, it is a

problem of this generation, and they are not adequately trained in their preparation to become a teacher, and they don't know where to turn for information. A lot of the films and a lot of the paraphernalia and literature is outdated. The kids are much smarter.

One of the things we have heard unanimously expressed by youngsters who are having a problem is they don't want someone coming in like a police officer or a Ph. D. or some doctor who is not of their peer level to instruct them on the pitfalls and the dangers of the use of drugs.

One of the things I think this committee will recommend—I know I will from my study of this and other investigations—is that the school system take into consideration in developing a program the use of Gateway Houses programs. I don't know what type of programs are in San Francisco, but the Seed in Miami, Fla., has youngsters who have used drugs and have experienced misery; girls are turning to prostitution and boys are committing armed robbery.

One individual in the Dade County schools in Miami committed over 400 burglaries in 4 years and was never caught; 400 unsolved crime statistics on the police record in Miami. The students would like to have somebody come in who has gone through this and explain it to them. I am wondering if there is such a program here in San Francisco?

Mr. HEONISCH. Could I answer that?

Mr. MURPHY. Yes.

Mr. HEONISCH. The San Francisco Unified School District has an office in the main board of education building and they do have a group headed by a Mr. Huber. I believe he is going to testify before this committee. And what they have done is they have set up a program within the schools and this program covers kindergarten through grade 12, through the senior year in high school. Every school, every public school in San Francisco, has a drug resource teacher. This drug resource teacher is responsible for the education, for the drug education, within his particular school.

Now. I can't really go into that because I am not familiar with it myself but I think once Mr. Huber gets here he could certainly answer your questions.

I feel, and we work quite closely with this office, it is the office of health education, and I feel they are making an honest effort in attempting to pass on——

Mr. MURPHY. Well, there is no question as to their honesty and intent. We are talking about effective results. As I say, the only effective programs I have seen so far are programs outside the school system. In some places the youngster is allowed to rap, using their terminology, with someone on their peer level who has had the bum experience using drugs and how it has affected their lives. This is what is meaningful to these youngsters. You can have an adult and someone with all the qualifications in the world come in and talk to high school students and they are going to turn them off. The students have told us that in talking to counselors face to face they have given answers that they know the counselor is looking for, and so they are really playing a game with them.

What I would like to know, from your undercover agents talking to the students, is if students have a place to go within the high school

system? Do the kids relate to you that they vould like to have somebody to talk to; that they can't talk at home because parents won't listen to them? Is there such a place in the school system for students to go?

Mr. KIRLEY. May I answer that?

Mr. Murphy, the kids that I have ran into in high school, they don't feel they have a problem. They feel that smoking marihuana and taking reds is the same thing as for us to go out and have a drink. They don't feel it is a problem in high schools. They feel that it is just something to put them in a good mood. They don't feel like they are users of anything bad. It is the same feeling as for us to go out and have a beer at lunch. That is the way they look at it, smoking marihuana or taking reds, they don't feel they have a problem.

Mr. MURPHY. Well, smoking marihuana and taking reds, but how about harder drugs? Unless you don't have a problem in San Francisco, and I am going to be amazed if you don't because you are unique then in the United States. Where do the kids get the money to buy these pills? Is this an affluent society out here in that they don't have to steal or rob, or go into their mother's purse or dad's wallet, or go into the department store and steal goods to pay for these things? Are they all walking around with $100 in their pocket for a jar of reds?

Mr. KIRLEY. Mostly the kids that I have ran into weren't dealers.

Mr. MURPHY. I am talking about purchases, officer. You purchase these pills with money, right?

Mr. KIRLEY. Yes, sir.

Mr. MURPHY. Where do they get the money?

Mr. KIRLEY. These kids have money nowadays, To take two reds is going to cost you 50 cents or a dollar. That is like 10 cents to us. When you were a kid that was like a nickel. To have $4 or $5 on you in school nowadays is nothing. Every kid in school has $4 or $5.

Mr. MURPHY. They have no problem with the purchase of lunch?

Mr. KIRLEY. No; it costs $1.25 a day in the school.

Mr. MURPHY. This is certainly different from the rest of the county. You are not really suffering that bad. Everything I have heard around the country is how these kids have resorted to crime to support their drug habit.

Mr. HENSON. If I can answer part of this. It seems to be correlated around the heroin problem.

Mr. MURPHY. Not only the heroin problem, I am talking about other drugs in schools.

Mr. HENSON. Your marihuana can cost $15 and last for 2 weeks if the kid only uses it himself. About $15 is probably the amount of the allowance of the child in high school.

Mr. MURPHY. In Chicago, we had an undercover agent go into a high school in a middle class neighborhood and in an hour and 15 minutes, as long as it takes some students to buy notebook paper and a pencil, he spent $100 and had with him every form of drug known to the drug culture—in an hour and 15 minutes. Can that happen in San Francisco?

Mr. HENSON. Yes; it can, and it can happen in Oakland.

Mr. MURPHY. Then who is buying it, if it isn't the student in high school?

Mr. HENSON. I know personally not only there are doctors that use, there are lawyers that use, and there are dentists that use. I have known cases of policemen that have used. You can't deal with it solely on a juvenile aspect although that is our biggest problem.

Mr. MURPHY. That is what this committee is dealing with at this time, officer. I am wondering where these youngsters get the money for this. One officer said they have it on them.

Mr. HENSON. From their parents. I had an allowance when I was in high school. I don't know if you did.

Mr. MURPHY. I didn't.

Mr. HENSON. Today an allowance is an everyday occurrence, $5 a week or $15, depending on the income of your family, that you are allowed to spend for lunches, clothes, and school books. The student no longer has to go and spend his money on a lunch when he can buy three amphetamine tablets and three Benzedrines and he doesn't eat all day and they spend their lunch money on drugs, and it is simple as that.

Mr. MURPHY. That is all the questions I have, Mr. Chairman.

Chairman PEPPER. Mr. Edwards.

Mr. EDWARDS. I have no questions.

Chairman PEPPER. Gentlemen, do you feel it would be beneficial if there were national legislation under which the Federal Government would give material funding assistance which would be available to the school authorities, at the local level, which would enable the school authorities to have an adequate number of drug counselors—call them whatever you like, people who help the students in dealing with a drug problem—who would be trained in respect to drug use to train the teachers so that they, too, would know the problem and would be able to deal with it; also to train the parents, because a lot of the parents don't know enough about the drugs, they wouldn't recognize some of these drugs if they were to see them. This would also provide permissible programs under which there could be therapy programs where the students rap with one another, people with similar experience associate together and they have the proper kind of inspirational leadership in the schools maybe leading them away from drug use and the like? Do you feel that programs like that would be of any help in dealing with the drug problem in the schools? Will each of you answer. Start with the gentleman on my left.

Mr. KIRLEY. Yes: I believe it would be of great help.

Chairman PEPPER. The next officer.

Mr. HEONISCH. I believe it would be a help.

Mr. GRIFFIN. Undoubtedly.

Mr. SHUEMAKE. Yes.

Mr. HENSON. I would go along with most of that but I think like in other studies, when they have spent $750 million a year to combat drug abuse, it is not being spent in the right direction. If you are going to hire qualified personnel, hire an ex-hype who is cleaned up. You can't hire somebody out of the University of Maryland who thinks he knows drugs and narcotics. The only way they are going to learn is from people who have cleaned up themselves.

Chairman PEPPER. My question presupposes in the pretherapy program there would be young people with whom they would rap who had had drug experiences similar to the participants, who were knowledgeable in the subject.

We have heard in Chicago, you might say a compliment to the knowledge, the experts, that these students know all about drugs. Do you find that to be true?

Mr. HENSON. Yes, sir.

Chairman PEPPER. They are very knowledgeable. I had in mind that would be the use of people who are knowledgeable in the program.

Mr. HENSON. Yes, sir.

Chairman PEPPER. Well, thank you very much.

Mr. WALDIE. I have heard as part of the rumors that surround this whole problem, much of what we hear may not be factual. I understand that in certain areas of the country the preference of drugs of the type you have described is in all of the school systems, elementary as well as secondary. All of your testimony has been directed at the presence of drugs in the secondary school system, high schools. What about the elementary school system, is there any pattern of drug use in San Francisco schools and drug sales in the elementary schools?

Mr. HEONISCH. None has come to our attention recently. On occasion a grammar school teacher has called us and said they found a certain amount of pills on a student. Normally it turns out to be Darvon that has been taken from the medicine cabinet. We have had no evidence of any type of problem in the grammar schools. The junior high schools, yes; this seems to be where the kids start.

Chairman PEPPER. At what age do students normally start in junior high school?

Mr. HEONISCH. Normally, it starts around the age of 13.

Mr. WALDIE. Would the gentleman from Oakland comment on that?

Mr. HENSON. I have arrested people whose younger brothers used bennies or younger brothers smoked grass, 9 or 10 years old. We haven't had a report I know of in the juvenile narcotics of anybody in the sixth, seventh, or eighth grade, but I am sure it is happening.

Mr. WALDIE. As far as you people are concerned you are not aware of any traffic taking place in the elementary school?

Mr. HEONISCH. I am not.

Mr. WALDIE. That is very much contrary to the information we have. Our information may be incorrect, or it may be that you are missing part of the picture in this area. I would appreciate it if you would examine your records so that you could respond to that question with perhaps greater conviction as to whether or not you have any indication of drug traffic in the elementary schools in San Francisco as well as Oakland, and would you provide to the committee what indications there are, and if there are none, what is the experience of your respective offices?

(The information requested was not available at time of printing.)

Mr. EDWARDS. May I ask one question?

Chairman PEPPER. Yes, sir.

Mr. EDWARDS. Mr. Waldie and Mr. Murphy know much more about the situation in Southeast Asia than I do. I have only been there once and they have been there a number of times and made an exhaustive study. I wish one of the witnesses would answer this or make an observation about what several generals and high officials told me in Vietnam, and that was they made their biggest mistake when heroin started to become a real problem with the Armed Forces in Vietnam by grouping all drugs together, by saying the drugs are all bad, stay

away from all drugs. They said they found they immediately lost their credibility because actually the problem was other than all drugs. It was a heroin problem. Probably they don't even test for marihuana in any drug clinic in the United States. It is my understanding from experts in the field that marihauana is a zero problem as far as rehabilitation of drug addiction is concerned. There is no such thing, apparently, as an addict except in narcotics.

It seems to me most of the testimony today has been lumping drugs together. Is that the proper approach?

Mr. HENSON. I don't believe it should be lumped together. Marihuana is classified as a narcotic with different penalties set for it on judgment. Seconal being one of the most addicting drugs, probably more than heroin, but the medical side effects are a lot different. It isn't fair to categorize marihuana smoking with heroin, it is not fair. What the courts are handing today for possession of, sale of marihuana, especially by juveniles, is a slap on the wrist and out the door. It is probation. On an adult on second offense you will get 6 months to a year, that is about it. On heroin addicts on second or third offense, perhaps you will get a jail sentence but mostly the biggest problem lies in the courts not sentencing to a year or 2 years. The problem shouldn't lie with the sentence. It is a sickness, it isn't a crime, we prosecute it as a crime but there is help needed. I believe that is why the committee is here.

Chairman PEPPER. Gentlemen, we thank you very much. We commend the zeal and dedication with which your police department is trying to do something about this problem.

The committee will take a 5-minute recess.

(A brief recess was taken.)

Chairman PEPPER. The meeting will come to order, please.

We are glad to have back today as a witness Dr. Joel Fort, who made a very able presentation to this committee when we were here in 1969. Mr. Counsel, we would be glad to have you call Dr. Fort.

Mr. PHILLIPS. I believe you have a prepared statement you would like to read, Dr. Fort.

STATEMENT OF DR. JOEL FORT, FOUNDER, FORT HELP, A NATIONAL CENTER FOR SOLVING SPECIAL SOCIAL AND HEALTH PROBLEMS, SAN FRANCISCO, CALIF.

Dr. FORT. Yes, sir.

Mr. PHILLIPS. Would you please proceed?

Dr. FORT. Yes, sir. I plan, as I indicated, to diverse from this in a few places and condense it in the interest of time.

Thank you, Mr. Chairman and Mr. Phillips.

I have divided my presentation into two sections, one, on what is going on in the schools in regard to drug uses and two, and I think more importantly, what is going on with drug education and public policy.

Chairman PEPPER. Excuse me just a minute. Will you give a little bit of your own background and qualifications before you make your presentation?

Dr. FORT. All right. I began my interest in the drug field more than 20 years ago while still in medical school, continued that with 2 years of full-time work in the Federal Narcotics Hospital in Lexing-

ton, Ky.; have directed and developed alcoholism programs; served as a consultant for World Health Organization studying drug use and abuse in 16 Asian countries and in 1963, I believe it was, I was the first to bring out the significance of the Southeast Asian traffic in heroin. to little avail, unfortunately. I taught university courses since 1962 that deal with drug problems and related social problems; have consulted with or worked with the United Nations Division of Narcotic Drugs for 13 months; started the first city drug program in America here in San Francisco in 1965, and have trained probably more than 1,000 teachers over the years in courses I have given at the University of California extension having to do with both drug and sex education; a regular lecturer and consultant in schools, primary, secondary, and college level around the country; deeply involved in a private nonprofit program here in San Francisco that treats the full range of drug problems from alcohol to heroin; have written extensively, as you know, a number of books, many articles, including the most recent one in the scientific journal known as "Playboy" that appeared last month called "The Drug Explosion" and the main point of that was this drug culture and American culture have now become one and the same rather than being two separate things; and then I am very involved in proposition 19, which I plan to comment on. That is the whole issue of how the law should intervene and what role it plays in dealing with private behavior.

Chairman PEPPER. Will you give us your local address?

Dr. FORT. It is 199 10th Street. This is the address of our center for solving social and health problems.

Mr. PHILLIPS. You may proceed.

Dr. FORT. Firstly, what is the problem, I think, is where we should start. Now we often hear very incomplete kinds of information which are based on one experience or one person's observations rather than comprehensive or objective surveys of what is happening.

Secondly, we are confused because most people talking about drugs use what I call one-dimensional viewing with the alarm out of context approach, an approach that can make playing tennis seem like the most pathological thing in the world, or taking aspirin or drinking coffee to be extremely harmful.

My point is not that we do not need to pay serious attention to problems such as heroin addiction but rather the broader picture has been ignored while we often concentrate on one small part of the total picture.

Now, to use that as a background, when we talk about drug use in the schools the most commonly used drugs in our schools are alcohol and tobacco.

I was astounded that none of the police officers expressed any concern about this massive violation of existing drug laws because for people under 21 or 18 almost all use or possession of the drugs, alcohol and tobacco represents a willful, deliberate violation of the criminal law, so those are the two most extensive patterns of drug use, the two most extensive illegal patterns of drug use in the schools. Marihuana is a significant but distant third. It certainly should be part of our concern.

Following after that in extent of use and abuse are the barbiturates and amphetamines, related kinds of drugs, many of them sold over the

counter, such as Compoz, a whole range of things that people can buy as easily as they care to make a trip to the grocery store.

And then following these in popularity, that is, in extent of use, are the LSD-type drugs or LSD itself, mescaline, peyote, psilocybin, and then, of course, heroin.

We fail to distinguish generally the use of the drug from the abuse. Any of us might be concerned by any use whatsoever of alcohol, tobacco, or marihuana by a 13-year-old or 15-year-old, or whatever, but that is clearly a different matter, the occasional use or the one-time use of it, than the heavy use we can objectively call abuse or the instance of addicting drugs, such as alcohol, barbiturates, or heroin, called drug addiction.

So I would like for us to begin to see this thing in a better perspective than we have so far.

Drug abuse, I think, can be described in two ways: One is a simple definition to the effect that it is excessive use of any drug that measurably impairs health, social, job, or educational functioning.

Another common way of dealing with it that I have evolved over the years is to use a concept of hard drug. We all hear this concept tossed around but rarely do we bother to define it. So I have taken pains to try to define it.

I think death and disability, anybody would agree, is a hard effect no matter what the drug is that we are talking about. Psychosis is another hard effect. Addiction is a hard effect. So then we begin to look at which drugs are involved in these three major dimensions of hardness and we see that the two hardest drugs again are alcohol and tobacco in that they kill and disable far more people than all other drugs put together, including young people in the schools, not simply older people. They are part of the continuum. As one begins their drug use which may later kill them, in the case of tobacco usually while they are a teenager in elementary school.

If we look at that criterion we are also concerned about overdoses, and that was brought out in earlier testimony. I agree completely that it is a major problem that people are overdosing on heroin or other narcotics. I feel we should go beyond that. I think it is an even greater problem that people are overdosing on barbiturates and related kinds of drugs. Twenty thousand people a year die accidently or deliberately from OD's on sleeping pills, hypnotic drugs, and certainly I am also concerned about the greater number of overdoses from alcohol intoxication and deaths from that as from heroin overdoses.

My point, in case I have not communicated it yet, is that it is a moral and rational person and no society expresses concern and takes action against all unnecessary and preventable death, accident, psychosis, and addiction, whether it comes from a drug considered good for business or bad for business, the drug used by those people over there or drugs used by us. That this concern may be broader in Federal legislation and Federal priorities than it is presently.

I think the biggest thing, however, that has been ignored is the roots of the problem. It is very proper to talk about branches or symptoms and we often get more attention for that, particularly the more we sensationalize it. An example is the talk about drugs in the schools. Certainly we should express horror about the massive use and abuse of this whole range of drugs, reds, yellow jackets, tobacco, alcohol,

marihuana, heroin, by young schoolchildren, and it does begin in elementary school with many of them here in San Francisco and everywhere else in the country, and simply a reflection of what you are looking at or how you look at it when you conclude that there is no use and no abuse of drugs in elementary school or junior high school.

Mr. PHILLIPS. Do you take the position or do you look at drug abuse in elementary schools as either nonexistent or existent depending on how you look at it?

Dr. FORT. Yes. First, it requires that you define what drugs are.

Mr. PHILLIPS. Assuming that we have general agreement on what a drug is.

Dr. FORT. Then you assume that the whole problem is in the high school, I am saying an enforcement agency that assumes that, then doesn't pay any attention to what is going on in the elementary school, they then conclude there is no problem.

Mr. PHILLIPS. Wouldn't it be fair to say—I think we had some indications from the prior interviews and also this testimony here—that the reason that the police officers don't do more in high schools is it is hard for them to get police officers who look like high school students? Thus, it is almost impossible to get a police officer who looks like a grammar school student?

Dr. FORT. That is obviously true.

Mr. PHILLIPS. Well, believe it or not, Dr. Fort, we have had a number of cities we have visited, Chicago for one and Miami for another, where they didn't have any undercover officers at all, even in the high schools and they maintained they could not recruit people who were young enough to do the job. I think the police department's knowledge of what is happening in grammar school is restricted by the fact they don't have people who can function in that area very, very well and I think there are cities here in the bay area that indicate the seventh and eighth graders are using.

Dr. FORT. Yes, sir.

Mr. PHILLIPS. Do you know of any evaluations or studies that have been made in San Francisco or Alameda Counties?

Dr. FORT. Yes, sir; definitely there have been surveys. I have done surveys myself that I brought to the committee's attention as far back as the last hearing here in San Francisco that included Alameda County schools, San Francisco schools. There have been studies done by the Department of Criminology of the University of California at Berkeley on drug use in Oakland that included elementary school use. That was 4 years ago.

Mr. PHILLIPS. In the 4-year period will you say that drug abuse has become more serious in high schools and grammar schools here in the Bay area?

Dr. FORT. Yes, sir: it definitely has. There is more use of more drugs, including more risky ones, than there was 4 years ago, and a certain segment of that use is definitely properly called "drug abuse." or if you define drug abuse as any illegal drug use, almost all of that use is a problem.

Mr. PHILLIPS. Could you tell us in the period of time between the last time you were with the committee and the present time what, if anything, has been done about it by the authorities here that has either contributed to the growth or at least failed to inhibit the growth of it?

Dr. FORT. Yes; I think I can tell you that.

With your permission I would like to spend about 5 minutes more completing the broader presentation.

Mr. PHILLIPS. I am sorry.

Dr. FORT. Because the answer to that question follows upon some of the points I am going to raise and I will try to do it as hurriedly as possible.

The point I was making at the time Mr. Phillips asked me that important question is that the roots of the problem are not looked at at all. In addition to expressing horror about why young people are under the influence or taking these drugs in schools, we should ask why millions of young people or tens of thousands in San Francisco, Alameda, Contra Costa County prefer to be under the influence of a potent and often risky chemical rather than turning on to the educational experience. That is a more complicated question I grant you, but drug use can never be understood apart from the social context in which it occurs. And it reflects a great deal about America's educational increasing bureaucrazation of the overcrowding, the irrelevance of much of the curriculum and so on and so forth that must be examined if we are going to solve the drug problem. Drug education historically began with the temperance worker who went into the school and held up a clear glass of alchohol and dropped a worm in it and the worm shriveled up, and he said that will happen to you if you use alcohol. That is the first model of drug education, the first example of the scare technique in a one-dimensional way. That was then followed by a pattern that continues to this day of the drug policeman, the narcotic officer, saying similar things about other kinds of drugs.

Third, the ex-addict. I am well aware from the comments you may have made that I am going against the grain in questioning the validity of the ex-addict as the drug educational expert, but let me tell you why I question that. That person often goes into a classroom in a Brooks Brothers suit drawing down $12,000 to $15,000 a year from the community agency and says to the class if you use drugs, lumping them together indiscriminately, as Congressman Edwards brought out is often the problem, saying if you use drugs you are going to end up dead on the streets like I obviously did. There is some obvious inconsistency, in other words, in this kind of approach. But most of all, we are extremely naive to accept the assumption that you must have attempted suicide in order to treat a suicidal person, that you had to have a baby in order to deliver a pregnancy, that you had to be a narcotic addict in order to work with heroin addicts. Even if that were true, being a heroin addict or ex-user of LSD in no way makes you an expert on alcohol, tobacco, marihuana, or pharmacology, sociology, education, or other very key factors. Naturally, we want to find some simple way of dealing with it, if we can, but I am saying that because we have accepted these simple approaches we have dramatically failed. Drug education has really not been tried and all the things I have mentioned have been counterproductive, its been soft on drugs, has bred far more drug use rather than diminishing the problem.

Congress, I think, failed to understand it when you passed legislation a few years back defining drugs in a very incomplete way and saying education means educated about the evils of drugs.

Now, if that approach would work, not a single American would be smoking tobacco today, not a single American would be using alcohol, none of them would be using marihuana, because all young

people were told if they so much as looked at a marihuana cigarette they would become a street heroin addict within 24 hours and be raping and pillaging.

This phony line approach has been one of the major reasons for the escalation and the use and abuse of drugs, and young people will not accept it from anybody. It is not correct that they won't listen to an older person; it is certainly correct they will listen to nobody who talks about one drug in isolation or only the pathology of that drug without talking about the broader picture. And the most important thing a drug educator should do and could do is present alternative values and not demythologizing drugs and you can't go across, sometimes dangerous as some drugs have been exaggerated, so have benefits been experienced too, from drugs, and getting across quite honestly what we get out of a drug experience, whether that be alcohol, marihuana, or sleeping pills, depends on our own personality, character, mood, and expectations, rather than on the magical properties of the chemical. Meaning that no drug makes an ignoramus into a genius, no drugs solve school or family problems, no drug is totally harmless, none are necessary for human life, and none will rebuild neighborhoods. So the truth about drugs is a much more independent prospect than we usually talk about.

Mr. WALDIE. Let me interrupt, and I interrupt with the preface that, knowing you personally, and noting of your work over the years, I consider you clearly one of the most knowledgeable authorities in the United States on this. You have been engaged in it longer than most and you have engaged in the level, you have been able to observe more clearly than most, but one thing that I don't understand and seek to understand and get to know, with no help at all, was a theme I think you reiterated that the type of education relative to drug abuse has been inaccurate and, therefore, has been in part responsible for the increase of drug abuse.

Let me ask why drug abuse other than alcohol and tobacco has been minimal in this country compared to what it now is, by that, at this time the knowledge that heroin use as confined together, while confined together, is not considered as society's problem until recently, drug abuse had never grown to the proportion it now has. Even with that fifth educational process, what change in recent years has caused the spread of drug abuse to the proportion it now has? What has occurred in this society different than that which existed and kept drug abuse confined to alcohol, tobacco, and the two together?

Dr. FORT. I understand your question. We differ firstly in our interpretation of how quickly the phenomena happened. It is my belief that this has been slowly growing for decades, that it has been a steady increase, that we have become increasingly aware of it in the last decade, but all this time it has been building up and in part, it has been building up because of increasing production and overproduction of all kinds of pills, barbiturates, and amphetamines. In part it has been building up because of the massive advertising and deceitful promotion of the benefits to be gained from alcohol and tobacco, and pill use, equating drug use with sexual pleasure, eternal youth, happiness, et cetera. In part it has because of this counterproductive drug education. I will say specifically, what I was referring to there. If you say something in all good faith at a given

time that is later found out to be untrue, then the students in the classroom come to disbelieve anything that is said about that particular drug even by a more knowledgeable and more honest person.

Secondly and more dangerously, they come to disbelieve even what is told them about other drugs such as barbiturates and amphetamines and heroin, even when it is said honestly about them; and then at the final level they come to equate quite falsely the risks of all of these substances. They in effect lump it together in the same way that other people lump drugs together without making important distinctions. So that, I think, has been an important contributing factor and the other people doing drug education have likewise failed to communicate the fuller picture of alternative values.

Another factor, without making this too long an answer, is simply what has been going on in the society.

It is my belief that drug use and abuse reflect or are a barometric of the society. Insofar as people are bored, alienated, as their institutions become increasingly fragmented and bureaucratized and they feel more impotent, they turn more and more to chemicals, legal and illegal, for symptomatic relief, and that to me has always been the main danger of the drug culture because there is an inverse relationship, as I see it, between constructive social involvement and social change, and depending upon chemicals to deal with all of your problems.

So, I don't see this as an abrupt escalation in the last few years, I think it is steadily rising, it has become more and more visible and we have become more and more sensitized to it at the time of Vietnam, for instance, where so many soldiers sent over there became involved in marihuana and heroin as a direct consequence of the war. We became more sensitized to it because more white middle-class young people, as you pointed out, are now becoming involved with it, but its not a totally new phenomena, its been steadily developing for this combination of reasons, as I see it.

Mr. WALDIE. Thank you.

Mr. PHILLIPS. I tend to disagree with you on the gradual increase. It seems to me it has accelerated rapidly in the last few years. As the chairman pointed out, a thousand heroin addicts in 1969, 560,000 in 1971. Now, some of this may be attributable to better ways of measuring the system, but everywhere we go there seems to be a substantial increase, a substantial increase of people experimenting. I think this is possible because of the availability of drugs. I don't think its just a gradual increase. I think there is something different about it.

Dr. FORT. I think there is a substantial increase, too, but the figures you mentioned don't show, I don't think, prove your point. There always has been incompleteness and misrepresentation of statistics, particularly at budget time when people come before your committee and other committees. There is a tendency to walk a tightrope between showing how much you have accomplished in a given agency and showing how enormous the problem has grown, so you need more money and more personnel to deal with. I think that has disported the reality of it, and I talk specifically about heroin addiction statistics.

I long ago wrote about and publicly requested the official estimates of the Government if there were only 44,125 heroin addicts in the United States. That was an absurd figure at that time. There were at

least 100,000 in the United States at the time they were claiming in the 1960's there were 44,000, and on the basis of extrapolation of California figures, which were far more precise, I am sure Congressman Waldie reads the studies in the State legislature, that to me, particularly tracked down and used far fuller sources of information and measuring devices than the Federal Bureau of Narcotics had used. California at that time had 15,000 by this measure as compared to the Federal Bureau measure of 7,000; so there were at least 100,000 then.

If you start out assuming there were 140,000 in 1960, then you come to the conclusion the increase has been——

Mr. PHILLIPS. I agree the statistics are not that complete. But there are drug addicts who have middle-class families and white families. people in suburbs who have drug problems in their families, and none of this existed 10 or 15 years ago—certainly not even 5 years ago, so in the last 5 years all of us here who knew about the drug problem now have families, or friends, or know children who are involved in this drug habit. I think there has been a really rapid change. I disagree with you; it has not been gradual.

Dr. FORT. It can be both. There can be a steady increase in a phenomenon with experts with that and I don't see that the two are incompatible. I agree with you more people are aware of it now but it's entirely incorrect to say it wasn't happening before.

When I was at Lexington in 1955, I treated, in addition to many ghetto people, a significant number, certainly less than other groups of people, but a significant number of doctors, nurses, white middle-class, young people in their 20's, from New York, Chicago, California, and elsewhere. It is not a totally new phenomenon. It has become more extensive and more visible, but not brand new.

Chairman PEPPER. Doctor, I recall when we were here in 1969 I met at lunch one day a professor in one of the California universities, I don't recall which one it was, who had written some books in the drug field and he expressed the opinion that the modern drug craze that swept the country started on the campus of one of the large California universities around 1965, or somewhere along there.

Would you say that there has been anything like a rapid acceleration since that time?

Dr. FORT. Yes: there has been a rapid acceleration of the phenomenon within the last 10 years, but its been steadily growing all along and certainly it has accelerated. My point was it wasn't going along quiescent with there being no problem at all and then all of a sudden there is an enormous problem. I disagree entirely with that person's interpretation or the naivete that is reflected in suggesting a society of 200 million people can suddenly be turned on by one or two people at some university in California to this massive use and abuse of drugs. It's a drastic oversimplification and I think a dangerous one because it moves us away from understanding all of these, I think, more persuasive routes I was talking about earlier.

Chairman PEPPER. Would it be accurate to say that it did first become conspicuous on the campuses in the colleges and universities of the country?

Dr. FORT. It would be accurate to say that marihuana use first became conspicuous there, not accurate to say that heroin use or addiction became conspicuous there, or barbiturates. I would say reds, Seconal

capsules came out of high schools much more than colleges, and out of dropouts, street use of the drugs rather than among college students or older Americans. There are different patterns with different drugs, again illustrating the problem from lumping them all together and thinking of them just as the drug problem.

A few more remarks if I may and then I will return to those questions about what the schools can do.

As I have implied, the solution cannot be found in any one way such as passing one law or electing a particular person to office or some other things that we have accepted in the past. The many levels that I would recommend you concentrate on, and I know some of you already are in some of them, are first, reducing the overavailibility of these drugs and the overpromotion of them, and that requires different measures depending on which drug it is. With heroin it requires stop talking about it and starting acting, and when I was with the U.N. and when I visited opium fields in Thailand in 1963 and in neighboring countries, a thousand tons of opium per year were being produced then, and I am sure it is far more. For all of the years since then it has been claimed that the main source is Turkey and the problem will go away because the Turkish Government has agreed to cooperate. That is totally phony and very harmful. Even today with growing recognition of the trafficking from Southeast Asia, almost nothing is being done about it and I find it incredible, too, that this is true, despite the fact that I, since 1963, and you can reach far more people, have been pointing this out in the last few years; so I would say reducing the availability of that drug from Southeast Asia; reducing the availability of barbiturates and amphetamines and other potent pharmaceuticals as they come out by the ton.

Chairman PEPPER. Let me interrupt you there. How many amphetamines do you think are medically needed by the people of this country?

Dr. FORT. None whatsoever. I think this society could get along without amphetamines at all.

Chairman PEPPER. We had medical testimony before our committee to the effect that narcolepsy and hyperkinesia are really rare diseases, and other than obesity, trying to reduce overweight, that there is no medical need for amphetamines. These doctors testified that a few thousand, some of them said a few hundreds, would be all that would be needed to meet the real medical needs of the country.

Dr. FORT. That is true if you stick to narcolepsy and other very rare conditions. If you need it at all, you could do it with maybe 10, 20, or 50 pounds a year. If you bring in obesity that is an entirely different question. I consider it totally improper to use these drugs in the treatment of overweight and they are certainly not necessary and I would not see that as a justification for their continued production. With other drugs I think the problem lies in reducing——

Mr. PHILLIPS. Before you leave that point; we came across substantial evidence of overproduction, and this committee has been successful in getting amphetamine production cut back 82 percent.

Dr. FORT. Yes, I think that is an extremely important accomplishment.

Mr. PHILLIPS. But I was disappointed to hear that reds, Mexican reds and M. & M. reds, are now coming in from Mexico. Apparently

they are being manufactured there, thus all our efforts to cut back the American production will have little effect. Has that been your experience here, that there are amphetamines coming in from Mexico?

Dr. FORT. Amphetamines and barbiturates come in from Mexico, some of that remain, I believe, and I have been told by people who have been involved in it, it involves continuation but less so of transshipment from American companies plus what you point out, that new production by chemical and pharmaceutical laboratories in Mexico. And that is to me a very good illustration to the point I am making that I can't count on anything to solve the problem. Reducing the production and availability by itself in this country is an important step, but it's not going to solve it by itself. Simultaneously, we have to do a lot of other things, including interventions with governments, such as Mexico, South Vietnam, Thailand, that are significantly involved in various kinds of drug traffic. And the point I was coming to is we also should try to reduce the pressure that exists in American society to use chemicals for every pain problem or trouble and for every human relationship; and the greatest pressure today comes from the $2 million a day spent by the alcohol and tobacco industry in the United States alone. And it's ludicrous to me that the National Institute of Mental Health will spend taxpayers money to put on a commercial, which is questionable anyway, about a star basketball player completing some great play and turning to the audience and saying, "When I turn on I do it on the field; don't use drugs."

Immediately after that comes a beer commercial showing a man and woman getting with it simply through the use of this particular drug. That is the way we sell and promote drugs all the time and it is very inconsistent and hypocritical to permit the advertising of pills, alcohol, and tobacco, whether it is called a cigar, when it is actually a cigarette in brown paper, or called something else, that is contributing to the drug-ridden society. Along with this, I think we will restore credibility and bring about rational priorities if we begin to distinguish between the personal use of a drug which we may well continue to disapprove of, but distinguish between a private behavior and the trafficking in a drug or antisocial conduct, and that is the concept of decriminalization.

My twin crusades over the years in this field have been, (1) to move the society beyond drugs to other values; and (2) to get the State out of people's living rooms where they are engaging in private consensual behavior and decriminalization of the private use of marihuana, for example, would be a very major step forward in assigning rational priorities. I believe it was wrong in the first place to use the criminal law to coerce virtue or morality and to give up on the possibility of the family, the church, the school, and the political processes as sources or models of human living and of morality. This has not worked. It did not work with alcohol, it is not working with marihuana, it doesn't work in general with private behavior.

Mr. PHILLIPS. Would you extend the logic of that position to include amphetamines, barbiturates, heroin, and cocaine?

Dr. FORT. Yes, sir; I would. But I wouldn't give them as high a priority. But to illustrate what I mean, so hopefully there is no misunderstanding, I would extend my logic to mean that we have been very harmed by treating the heroin addicts as criminal instead of from the beginning approaching it through rehabilitation and prevention.

The concentration always should have been on the pusher, and particularly the major sources of supply outside of the United States. That, I think, is in no way being permissive or soft on a particular phenomenon but rather assigning rational and strict priorities that would be more effective. In this State, we, of the six States where it was attempted, are the only ones that succeeded in getting such a proposition on the ballot which will decriminalize the personal use of marihuana and bring about these different kinds of priorities. That is proposition 19. I stress this to you because law reform I see as one part of the total pattern. I am not saying that law reform is going to solve the problem by itself, but I think distinctions between use and selling, between private conducts such as use of alcohol in your home and drunken driving are very important distinctions for the criminal law to make and will end the hypocrisy and communications gap, increase the success of police and courts in dealing with violence and crimes against property and more serious drug problems.

Finally, on the school question. The fact that so much drug use and abuse is going on in our schools along with, by the way, vandalism by the hundreds of millions of dollars each year, promiscuity, truancy, dropping out, the whole range of things, along with this drug picture are going on in American schools. I think it's a massive indictment of San Francisco's education, and wherever else it is taking place, of American education, and particularly of the administration, not the teachers and not so much the students, but the administration including the local school board, principals, and superintendents. If we are ever going to solve problems we need to introduce an accountability. If we keep diffusing everything, saying no one is responsible, nothing is ever going to be done, and I am as astounded, as I think some of you were, the teachers, but more importantly principals and superintendents and school boards are just allowing indiscriminate use of alcohol, tobacco, marihuana, barbiturates, heroin, and LSD in San Francisco schools, and I think they must be held accountable for that. It really shouldn't be the police that are blamed for it, and that would be part of the solution as well. Along with for the users counseling, not by his present school counselor, who is untrained in this particular area, but by specially trained persons starting most likely or logically with school nurses who have some kind of background that is relevant, but who would in addition need specialized training in this, and secondly, having in the community a wide range of programs that would be responsive to the needs of the drug users or abusers and will communicate alternative kinds of values.

The Federal effort, I think, should include an examination of the literature and audiovisual material being produced by the National Institute of Mental Health, by the so-called Special Action Office, by the Office of Education, and by the military. All of these people are presently involved in drug education and attempt at preventive efforts. There is a tremendous amount of ways in efficiency, duplication, and most of all there is no coherent philosophy of what the goal is, what drugs are they worried about, what are they doing to get people to stop using that drug, what alternative values are they presenting, what priorities or assumptions are built into the system; and I think your committee would be the ideal one to deal with that.

That is all I want to say.

Chairman PEPPER. Doctor, do you agree that in getting people, young people, particularly students, off of the drug abuse that one of the most effective techniques in therapy is the inspirational type of appeal such as you find in service centers?

Dr. FORT. I would say that is an effective technique. If I had to give priorities to what I think would be the best of all, it would be to make going to school a mind expanding experience for young people which can compete with the alleged properties of drugs.

Chairman PEPPER. You spoke about a while ago a change of sense of values, making the educational process a desirable one.

Dr. FORT. That is right.

Chairman PEPPER. This obviously requires modification and modernization of the curriculum?

Dr. FORT. Exactly.

Chairman PEPPER. Also a reexamination of the personnel who are doing the teaching?

Dr. FORT. Exactly.

Chairman PEPPER. And the counselors and the like. In other words, do you agree with the thesis that we can in the school system itself do much with proper funding aid and encouragement to prevent the beginning of drug abuse and to induce those who are already committed to it to desist from it?

Dr. FORT. I agree with that very strongly, but I don't think it would take as much money as people might assume. I believe an enormous amount of money is already being spent in the Federal Government and from local taxpayers for the schools, and that enough money is already there. What is needed is a restructuring and revitalization of the educational process, rethinking as you pointed out, of the curriculum and of the teaching methods, and that wouldn't specifically require more money. You could, in fact, save money because maybe half of the budget now goes to so-called administration rather than being reflected in direct help either to educating or counseling students.

Chairman PEPPER. Well, have you observed that a great deal of the effort that is being presently applied, where it is applied, is more or less in the scare category, trying to frighten the students against the use of drugs?

Dr. FORT. More than that, it's tokenism, it's an attempt to present an image doing something, I think very analogous to the Federal Government's approach to present an image that the drug problem in America will be solved by putting all heroin addicts on methadone maintenance. In other words, throughout the picture, locally and federally, we distort what is really going on and accept all kinds of simple pseudosolutions; but the school would be the place to start, I agree with that entirely.

Chairman PEPPER. There are some who would say you ought not to consider trying to set up a program in the schools; that is the wrong place for it. You should try to set up agencies outside of the schools, in the communities. One would naturally contemplate all of the facilities that have to be provided, the personnel that have got to be trained and made available, and the like, and relatively unavailability at the present time, as Mr. Edwards told us this morning.

Dr. FORT. That is exactly right.

Chairman PEPPER. For example, we found out in the schools of New York, Chicago, and Miami that the main thing they did when they

discover a student abusing drugs was to suspend him, tell the parents about it and send the student home. Well then, what are the parents going to do? Where are the facilities available; they are out of school and they are out of contact with their curriculum and the like?

Dr. FORT. That is right.

Chairman PEPPER. Mr. Waldie.

Mr. WALDIE. I yield to Mr. Murphy.

Mr. MURPHY. Thank you.

Doctor, I agree with most of your testimony here today, especially with the idea that there can be something done by the Congress with these foreign countries that grow opium. I know the Foreign Affairs Committee, of which I am a member, has passed an amendment to the Foreign Assistance Act which would cut off all aid to Thailand because of their lack of cooperation.

Dr. FORT. Good.

Mr. MURPHY. I am happy you agree with that sort of approach.

Dr. FORT. I certainly do.

Mr. MURPHY. Part of your testimony raises some questions in my own mind with regard to the legalization of marihuana—and you kind of go up the scale—amphetamines, and maybe to cocaine. I equate that with this philosophy, especially in New York, of the methadone clinics. What we really now have, the latest statistics that come out of New York, is that one out of every two deaths from overdose in New York now are on the methadone level.

Dr. FORT. That is correct.

Mr. MURPHY. And I am afraid that if we move to this legalization, this decriminalizing that you referred to, of these drugs we will run into a problem like we are running into with the methadone program in New York. Maybe I don't see the difference.

Dr. FORT. Maybe. May I try? I share your concern and let me tell you the way I am using these words so we can be talking about the same thing.

To me legalization means what we do with alcohol and tobacco. Production, distribution, advertising, are all legal and the drug is massively available. Decriminalization means to me that the users of the drug, in this instance marihuana, would no longer be dealt with through the criminal law but would concentrate on it through education, prevention, and positive alternatives; but criminal penalties would remain for sale, or trafficking, or for any antisocial conduct, whatever we call those things.

I want you to see that I am not talking in anyway about legalizing, even at this point. I am not talking about legalizing marihuana. In fact, I think decriminalizing is probably the only alternative to the drive toward legalization of this drug and will help to keep us away from following the alcohol and tobacco model. I am not in any way suggesting that we should legalize and do what we have done with alcohol or tobacco with cocaine, heroin, or whatever. In fact, I am suggesting the opposite. That we give our entire priority to the sale and trafficking in those drugs and to antisocial conduct and deal with the private use of the drug through express disapproval, through education, building in honest programs in the schools that will use the kind of philosophy described earlier, and through a whole range of other things that I don't want to take the committee's time to get

into and repeat what I have already said. I want you to understand the distinction.

I have been thinking what I would call for is legalized treatment of all heroin addicts.

We have in this State, and there are in some other States, ridiculous restrictions on doctors treating addiction, which only drives them further into the street traffic and makes it impossible to present an alternative. But I am in no way suggesting we should distribute or allow the distribution, I would like to eliminate it entirely, in fact.

Mr. MURPHY. I am interested in your comments specifically on methadone treatment.

Dr. FORT. We have at our center here in San Francisco the only private self-supporting methadone maintenance program in California. It is also, as far as I know, the only one that stresses addiction is a social disease and not a metabolic disease, and the importance of that point is that when you tell people they have a metabolic disease order and make it analogous with diabetes and insulin you communicate to them the hopelessness of their condition and the supposed need to take methadone the rest of their life from some Government-financed program; and, finally, in our program we stress that the methadone should be presented as part of comprehensive services, not in isolation as a panacea but along with vocational counseling, job development, social work services, individual and group therapy, and that the person make a commitment to get off of methadone as quickly as possible rather than building in the idea that they will have to take it indefinitely.

But I have always been very cautious about methadone. I think it is being overpromoted by the Federal Government presently. Maybe this will summarize my point of view on it.

Suppose we put every heroin addict in America on methadone maintenance. It is my belief that since we would have done nothing to deal with the plant roots of it in Thailand and South Vietnam or the social roots of it in our country, we would be producing new heroin addicts as fast as we put old ones on methadone maintenance, and we can never keep up with it and pretty soon we would have 35-million people or more on it with a life-long dependency on 100-percent pure narcotics methadone. So. I think it should be used very selectively and with discretion rather than being overpromoted by a lot of people in our society, as is going on today.

Mr. MURPHY. Thank you, Doctor.

Chairman PEPPER. Mr. Winn?

Mr. WINN. Thank you, Mr. Chairman. I just have one question.

In your statement, on page 2, the last paragraph, you said it is time to introduce honesty into drug education and disregard approaches that have not worked.

You have been talking about a philosophy from a technical standpoint, and you heard the testimony this morning by the officers and you have heard basically the same thing in the other cities, that there is a shortage of good educational material.

Dr. FORT. That is true.

Mr WINN. Whether it be films, slides, pamphlets that are available, or specially called meetings. For instance, in the past in communities, people or the PTA would call a meeting to talk about drugs and drug

problems, to make the parents aware of it, and six or seven people show up in a school where there are 2,000 students.

Dr. FORT. There is tremendous apathy.

Mr. WINN. Apathy on the subject. From a technical standpoint, not a philosophical standpoint. How can we improve that and how can we, as a legislative body, make recommendations along that line?

Dr. FORT. First of all, I would devote some time and energy of your committee to a meticulous and aggressive evaluation of the philosophical goals and programs of people presently in the Federal Government who are doing drug education and prevention, and who are training others to do it. In other words, evaluation which would not per se be an expensive th' .g. Then I would seek to work out in an imaginative way methods that would reach the greatest number of people, and I think particularly of television. I think you could reach with enough advanced promotion and information far more millions of people of all backgrounds, though, if we devoted the creative energy and devotion to this topic that we devote to promoting the use of alcohol or tobacco or buying the right deodorant or toothpaste, that we are not doing this in a very efficient or creative way, nor do we have as yet any consensus on what the goals should be.

My goal is to try to move the society beyond their dependency on this whole range of drugs. I don't mean by that all or none. I mean a relative movement for as many people as possible, and within that I would say a very specific goal that I would hope everybody could accept is that if they are going to use any drug, that such use should be as selective and discriminate as possible, and I think that value can certainly be communicated in any drug education program.

Mr. WINN. Don't you agree, though, that the experts, and let's say that there are experts in the field, as there have to be——

Dr. FORT. Certainly.

Mr. WINN (continuing). Are kind of like economists, you can line them up and split them right down the middle on what they say is the way best to handle the problems in the economy?

I have been on this committee 4 years now and I have found that the problems and the opinions of the experts vary greatly on what we should do as far as maintenance is concerned, and education.

Dr. FORT. That is right.

Mr. WINN. I don't know who it is who can make the final decision on which group of the guys are the right guys or wrong guys.

Dr. FORT. I agree with your implication, it is very confusing. I remember Congressman Waldie years ago, when I was up once in his office, asked which expert are we supposed to listen to, and I have never forgotten that, and the only answer I have to it, which I was helped to arrive at through his questioning, is that we must teach people to think for themselves so that at least they know what context they are talking about, what distinctions, if any, they are making between use and abuse, how they are defining abuse, how they are defining what the problem is, and then what philosophy or vision or life are they building into the goals they are articulating for a drug education or drug prevention program, and then under our system of government you would decide what one to build into legislation.

Mr. WINN. Let me see if you agree on two statements that I will make. We have a whale of a drug problem in this country?

Dr. FORT. I agree with that completely.

Mr. WINN. If you were sitting here as a Member of Congress and you were asked to vote on a bill to legalize marihuana, would you vote yes or no?

Dr. FORT. I would vote "No" on that.

Mr. WINN. I don't believe it was clear in your first part of your testimony.

Dr. FORT. But to make very clear what I am saying, if you asked me to question, if I were sitting here and were asked to vote to stop making criminals out of the person who uses marihuana in private, I would definitely vote for that bill, which I see as a completely different issue than legalization.

Mr. WINN. I understand that.

Dr. FORT. Thank you.

Mr. WALDIE. I want to ask you several questions along this same line.

We have in our society, and I think your statement emphasizes it, it ought to be emphasized, the worst drug in our society is alcohol; that is the one that is abused and the most common and that is the one that creates the most tragic economic and personal loss in society.

Dr. FORT. That is correct.

Mr. WALDIE. The second one is tobacco. We use both drugs and they are abused. I do it because they are legal and because the system of distribution and the availability of it is there and I was raised in a society that ascribed great values to these, and I suppose that is partly why I have picked up both of those drug habits.

I know you concur that the introduction of another drug habit into our society would not be constructive, and that is why you oppose legalization of marihuana. I presume that is the major reason.

I wonder if the tendency toward a greater use or greater prevalence of that third drug in our society would not be enhanced by permitting private use without any sanctions.

Do they thereby create a broader market, i. ll I am asking. But you still curtail distribution, but you are going to say if they succeed in distributing it no consequences would fall, ailays a party who i using it, and I understand the argument and I concur in it that the criminal penalty that is assessed against the users are far more destructive of whatever we are attempting to constructively do for that user than the use of marihuana.

But on the overall problem of another drug being introduced into American society as a dependency crutch, do we not expand that probability by decriminalizing use; do we not make the market larger for the distributors who have been able to fulfill the market pretty well now even with the penalties that are assessed against selling? Would you comment on that?

Dr. FORT. Yes, sir. First, I think it is a point that the long-term consequences is certainly a point about which reasonable men can differ, and I would not in any way say that I can prophesize or make a prophecy of all of the possible consequences and I would say, however, that the way I arrive at my position, and arrived at it many years ago, is by weighing in a kind of human cost benefit analysis the potential harm or risk of the use of marihuana versus the demonstrated harmfulness and destructiveness in terms of use of tax money

tying up the courts, destruction of individual lives by our present system of indiscriminate criminalization.

Secondly, I would say that it is not introducing a new drug into the society—decriminalization would not do that. The reality of American life is, and I consider I am fortunate, that many millions of Americans of various ages and background have used and are already using marihuana and it is very persuasive in the society.

Mr. WALDIE. I accept that, but would decriminalizing use hasten that expansion of the availability of this third drug to American society?

Dr. FORT. My honest opinion on it is if it were done in isolation it would probably accelerate the use of marihuana, but I would hope it would not be done in isolation. If it did accelerate the use of marihuana I believe it would not accelerate it significantly more than is happening anyway with our present head in the sand ineffective destructive approach, and even if that does occur it would more than outweigh in this balance I spoke of earlier. It is a lesser of two evils, a choice we are often faced with. Even if it happened I think it would be a lesser evil than continuing the barbaric systems we have now.

Mr. WALDIE. Will it not be an inevitable, if you decriminalize use, that you will inevitably legitimatize distribution?

Dr. FORT. No.

Mr. WALDIE. Is there not just a basic unfairness for a citizen told by his Government if you can get this stuff, that is illegal, use it, but we are going to do our damnest to prevent you from getting it. Isn't it grossly unjust for a Government to say that it is a fair system?

Dr. FORT. Here is what I think the Government would be saying. It won't be the Government, it would be the people who vote on proposition 19 in November. I think most of them would be saying I don't particularly approve of your using marihuana and I would prefer that you don't use it and I am not going to plan to use it myself, but I approve less of the State entering into my bedroom and living room and destroying me in the name of saving me. I think that is what they would be saying and that is what we try to make clear in the proposition; and, secondly, our proposition gets around the possible dilemma you raise by permitting an individual to cultivate their own personal supply of marihuana. They would have no need, therefore, for tobacco in this illicit traffic or have any association with sellers. The prohibitions against alcohol with all of the tragic consequences of that would have been far worse if the users of alcohol had been labeled a criminal by the Federal and State laws instead of doing exactly what proposition 19 would seek to do, saying that we disapprove as a society of alcohol but we are not going to make you a criminal for your personal belief, we are going to try to stop the traffic.

That distinction has a long historical heritage in the United States, it is not really a new distinction, and I think our problems will be made far less if we do that with marihuana.

Mr. WALDIE. I have no further questions.

Chairman PEPPER. Doctor, when we held our first hearing in September 1969 in Boston, one of our witnesses was the chief justice of the Superior Court of Massachusetts, Judge Tauro, and dealing with this question of were we generally considering the context of legalization of marihuana, Judge Tauro took the position that he could

severely reduce the criminal penalty. He didn't suggest that it be eliminated, but that it should be relatively minor for the first use of marihuana. He pointed out that in the State of Massachusetts, at that time, fo the possession of marihuana the law required the court to give the person found guilty a sentence of from 2 to 10 years.

Dr. FORT. That is right.

Chairman PEPPER. And I think we found here in California, in San Francisco, at our hearing, I believe the California law provided for a penitentiary sentence.

Dr. FORT. One to 10 years.

Chairman PEPPER. That is what I thought. I asked if anybody knew of any case where anybody was actually sentenced to a penitentiary sentence and some witness said they knew of one. Judge Tauro strongly recommended that the sentence that could be imposed for the possession of marihuana be very sharply reduced.

Then when we held hearings later on at Omaha, Nebr., and we found that the Legislature of Nebraska had provided 1 week's incarceration in jail, not in a prison but in jail, a local jail, for a person found to be in possession of marihuana, for the first offense. I believe they did provide a year for the second offense. They didn't completely eliminate the penalty, but they reduced it to a very low penalty. But Judge Tauro was, I thought, very convincing on one other point that he made. He said he would be reluctant to see the use of marihuana legalized because of the greater availability of marihuana compared to alcohol.

For example, in the audience are a number of people and it may well be that a number of people present here today may take a drink of one sort of another before the end of the day, but I doubt very seriously if you would find anybody in this room with a bottle in their pocket, with any alcohol in their pocket, because the nature of that is such that you generally take it at home or someone else's home or a public place or the like; whereas with marihuana all you have to do is drop a cigarette in your pocket or put one in your handbag. Judge Tauro thought the likelihood of use would increase because of the increased availability, the readiness at which it might be made available.

Then we had at Lincoln, Nebr., when we had the hearings there, a highway patrol officer testified about the effect of taking marihuana from the individual. He said, by the way, that marihuana grows around the university there, around the State prison. We went out and looked at the growth of it. It may not be as good a quality as you get in some places, but it can be found. This officer had recently, before he testified, arrested a student at the University of Nebraska who had a very serious automobile accident, and he asked him why. The student said, "I don't know why I did it. I just misjudged the distance and also I misread the signal." He had smoked a marihuana cigarette as he drove.

So, we went back to Boston and we had a Harvard medical professor on the stand and he testified that the smoking of a marihuana cigarette did not impair the reflex of a muscle or a nerve, it did not slow down the process or reaction. When the brain sent the stimulus it reacted as promptly after the subject took the cigarette or marihuana cigarette, as before. I knew the headline would go out that

a Harvard medical professor said you can drive an automobile without your ablity to do so being impaired by smoking marihuana.

So I asked the doctor. I said. "Doctor. would you and your family like to ride in an automobile being driven by someone who was smoking marihuana cigarettes?"

He said, "I didn't say that at all. No, I wouldn't. I didn't say it wouldn't affect the judgment of the individual. I just said my test in my laboratory. my limited test, showed that after you smoke the marihuana cigarette you could respond to a signal, the nerves and your muscles would respond as alertly and as readily as before."

So, I merely wanted to bring out that, as Mr. Waldie has intimated, that the increased availability of marihuana raises serious questions.

Judge Tauro mentioned one other thing. He said. regardless of how bad it is. the alcohol culture is already fastened upon our society. We tried to change it and it didn't work. There is no prospect of that being changed in the foreseeable future so we have to assume it is there.

Dr. FORT. Can I respond very briefly? I realize the lateness of the hour and the usual practice of adjourning at this time. so I will just take a few seconds on that.

First, on the alcohol culture, I find it an unacceptable attitude to say that because it has always been there and because it is legal and because it is good for business we can't do anything about it. My view is that certainly prohibition did not work and should never be contemplated again as the way of handling it, but that does not mean to me that nothing can or should be done, and I have mentioned here today a number of more selective and discriminating measures that could be taken and to the advertising of drugs in an attempt to reduce the availability, higher taxation most of all presenting the people the idea that they can at least sometimes have a good time relative to other human beings turned on to the warmth and character of another person without having a drink in their hand or a cigarecte in their mouth.

Now, about the marihuana thing. I think it puts in a kind of popularity, it is already massively available and we have a situation where there is enormous popularity and growing nonenforcement of law in the same way as we have handled the illegal use of alcohol and tobacco by people under 21 or 18.

So, we don't have an ideal situation. We have a less than perfect work and less than perfect situation. It is very complicated and in balance I think it will be far better to stop making criminals out of the persons and to approach it in all of these different dimensions that I have talked about instead of continuing the same old system with its hypocracy and irrationality.

I wanted to make one final point just before you adjourn, and that is to suggest a radical idea to you as Congressmen, that problems aren't solved simply by money, that too much money has already been appropriated for drug programs. As has been pointed out by several of you, there aren't enough trained people, people who have worked in this field for enough years to know what to do with the money. Everybody is getting into the act now. I think we start off with the false concept that it is a psychiatric problem and turn it over to mind bureaucrats instead of realizing it is a complex social problem that is better dealt with in a very intradisciplinary broader approach, not particularly

touched or related to American psychiatry and the training of most psychiatrists.

So, what I am suggesting is that most of the money is going for highly paid administrators, for buildings, and for materials, and only a fraction of it, a smaller fraction, is going into direct help to people, and then generally and in a kind of assembly line operation with no standards or values, no techniques of evaluation built into it, and it is time to stop spending more and more money and to concentrate on quality rather than quantity.

Chairman PEPPER. Just one last inquiry. We have a treatment center in Fort Lauderdale. Fla., just above Miami, called "Seed." I am not saying it is perfect in every respect, but it has been operated by a man who is not a professional man; he was formerly an alcoholic who was in the theater.

Dr. FORT. Yes, I have met him.

Chairman PEPPER. Well, now, I have been up there twice and several members of this committee who are here with me today were there the last time we were up there. We saw 200 or 300 of these young people out in a large barnlike structure because he didn't have luxurious facilities for his establishment. But these young people were eager, bright-eyed; they got up and gave their testimony about what they had done; what sort of a project they were engaged in; they sang songs; they rapped, as it were, with one other; and they had the support that comes from mutuality of experience and the like. This fellow some way or other was able to inspire them to make them want to be better and do better when they got out of there.

Dr. FORT. That is right.

Chairman PEPPER. There are some who say if the fellow wants that kind of institution and doesn't have enough psychiatrists and psychologists around with proper degrees and all, that it is a failure.

Do you agree?

Dr. FORT. No, sir. I think we need to develop expertness and get away from the belief that, because I have been a drug user and drug addict I know everything about the subject, and greater arrogance because I went to medical school or trained in treatment of neurotic women I am an expert in treating drug abuse. That is totally irrelevant to the field, and the person you are talking about represents what is most needed, a committed, concerned person who is able to relate as a human being with other people who are trying to help, and that doesn't require degrees. It requires a degree of humanity that is far more important.

Chairman PEPPER. Some of us went out to Red Wing, Minn., to a correction institution housing young people and they had group therapy there dealing with young people who were serious law offenders. The head of this institution told us that the best man he had on those grounds was a felon that ran the shoe shop because he knew how to appeal to the young people.

Now, the last comment is this: If we could find that type of trained personnel to go into the schools and work with the students and could bring them to a sense of awareness of the wonderful life that they have a chance to live, can you imagine the possibilities that it might even reach the whole curriculum and the whole school experience of these students.

Dr. FORT. It would definitely be desirable if along with that you reformed the schools so that they actually did the things this charismatic person would speak about. It would be very detrimental if such a person came in and aroused expectations and the same old boredom and monotony continued to exist in the school system.

Chairman PEPPER. I thoroughly agree, that is the reason that the approach that this committee is considering right now is through the school system, through the elementary and secondary program, to try to stimulate the environment of the whole curriculum, the hopeful experience of this.

Dr. FORT. One simple thing that could be done that wouldn't cost hardly any money would be to make schools available after hours. They are enormously expensive facilities, all kinds of shops, recreational facilities. The buildings are there, why not open them up on the weekends and nights for people to use.

Chairman PEPPER. We found in Chicago one of the principals was doing that very thing, letting the schoolchildren who have problems come in in the evening and use the school.

Thank you very much.

Dr. FORT. One final thing. When you make grants I would like to recommend to you that you try to make them as flexible as possible because when you give the money through State and then local bureaucracy it gets so diluted by the time it gets out to private innovative programs it is almost not worth having, and the more flexibility you can build into it, the less money it will take in the long run rather than siphoning it off to the very inefficient system that is operating now.

Chairman PEPPER. The committee will take a recess until 2:30.

(Whereupon, at 1:25 p.m., the committee recessed to reconvene at 2:30 p.m., the same day.)

(Dr. Fort's prepared statement follows:)

PREPARED STATEMENT OF DR. JOEL FORT, FOUNDER, FORT HELP, A NATIONAL CENTER FOR SOLVING SPECIAL SOCIAL AND HEALTH PROBLEMS, SAN FRANCISCO, CALIF.

DRUG USE IN THE SCHOOLS

Over the 20 years I have made mind-altering drug use and abuse a major focus of my writing, consulting, and public health work, in addition to treating thousands with drug problems I have conducted surveys in numerous school districts, lectured at high schools and colleges, and trained (in University of California courses) more than a thousand teachers to do drug (and sex) education. No field of American life with the possible exception of foreign policy has been more pervaded by ignorance and fear or more dominated by viewers with alarm and sensation-seekers than the drug scene. To put the matter in context so that we may understand the real problems, the most widely used and abused mind-altering drugs used in our schools are alcohol and nicotine (tobacco cigarettes); and these are also by far the most commonly used illegal drugs since their possession by those under 18 or 21 is against the law. These are generally the first drugs used for non-medical purposes the use often beginning in junior high school and sometimes elementary school and by the last two years of high school involving some 75% of male and female students (and drop-outs). Marijuana is a significant but distant third in popularity and illegality although first in publicity, having been at least tried by roughly 50% by 12th grade and continuing to be used, mostly intermittently and moderately by at least half that number. especially those who had previously been taught by the tobacco industry and adult example, the acceptability of smoking. Barbiturates and amphetamines or their equivalents such as Quaalude, Compoz, etc. rank next in frequency of use, followed by heroin and LSD-type drugs. Most of this is use of a drug, whether we are speaking of alcohol, marijuana, or something else and only a fraction is

abuse, meaning excessive use that measurably impairs health or social and vocational functioning.

We should properly be concerned about tens of millions of young (and even greater numbers of older) Americans joining the drug culture which is now equivalent to American culture, and preferring to be under the influence of potent chemicals, legal and illegal, but even more we need to wonder about the roots of discontent and alienation in the schools and other bureaucracies recognizing that the more we make education a mind-expanding experience the less likely people are to turn to chemicals for their alleged properties of mind-expansion. In my spontaneous testimony before the Committee I will expand on the reasons for the massive increase in the use and abuse of drugs by our society, the failure of our present approaches, and how we can actually solve the many drug problems.

DRUG "EDUCATION" AND PUBLIC POLICY

Denying or ignoring the situation until it becomes critical, responding with hypocrisy or one-dimensional scare techniques, or passing a law against it have been the major United States approaches to alleged or actual drug problems in the schools or elsewhere. With but token exceptions proper drug education has not been tried and we have had massive and counter-productive (soft on drugs) drug miseducation: from the $2,000,000 daily spent by the alcohol, tobacco, and pill industries to push drug use and equate it with sexual pleasure, youthfulness, and happiness; in the past from temperance workers, and presently from drug policemen and ex-addicts totally untrained in the relevant disciplines of education, social sciences, pharmacology, etc. and telling horror stories out-of-context (scare tactics); sometimes from overworked classroom teachers of physical education, English, or biology who know little about drugs; and from highly expensive (to the taxpayer) audio-visual materials or TV commercials prepared by the National Institute of Mental Health or the so-called Special Action Office for Drug Abuse. Typically such commercials show a star quarterback or end completing a brilliant play and then saying, "when I shoot I do it on the field, don't use drugs." This is then followed by a beer commercial or a "cigar" commercial proclaiming the benefits of drug use.

It is time to introduce honesty into drug education and discard approaches that have not worked and in fact have been harmful. Any one drug should be talked about only in the context of all drugs from alcohol to heroin, and in the context of the society in which drugs are used. Beginning in elementary school, objective, factual, comprehensive drug information should be presented by a specially trained classroom teacher over a period of weeks or months each year with increasing sophistication. Participatory democracy, i.e., student involvement, is a much-needed reform since attitudes and beliefs must be confronted in an atmosphere of mutual trust and respect rather than a formal didactic presentation. Such programs are doomed to failure if the teacher is an advocate of alcohol, tobacco, or marijuana use, or perhaps shows in their own behavior in the school that they cannot get through the day without a cigarette. Consistency between what adults preach and practice, and the importance of role models for children have been much neglected. Moving the society including the young beyond drugs is one important goal of drug education and prevention, without condemning, labeling (head, freak, fiend, junkie, etc.), or criminalizing the user; and as part of this, helping to make what drug use does occur as selective and discriminating as possible rather than the present indiscriminate situation. Basic to this goal is demythologizing and deglorifying drugs by communicating that insofar as a drug sometimes brings pleasure, its effect is based mainly on the underlying personality and mood of the user rather than on any magical properties of alcohol or marijuana; that no drug including caffeine or aspirin is totally harmless, none is necessary for human life, none will make one sexually or intellectually competent, and none will solve family, school, or social problems. Additionally schools must begin to teach thinking—the use of logic and reason; and inner-directedness or independence in order to resist the blandishments of the drug pushers in the alcohol, tobacco, and heroin industries and peer pressures.

If a person feels in their own life there is no hope but dope whether that be alcohol, pot, or pills they are much more likely to use or abuse a drug than if they have available many alternative sources of hope, pleasure, and meaning. Surely rather than destroying people through the criminal law in the name of saving them, or lying to them, we can compete in the marketplace with positive values and positive alternatives starting in the schools. Then we can transform the ethic or drug advocates, legal and illegal, to one that calls us to: Turn on to life,

Tune in to knowledge and feeling, and Drop in to changing and improving our institutions and society. Finally, to solve the drug problems in the schools we must reduce the overproduction of heroin (from Saigon, etc.), pharmaceuticals, tobacco, etc. and their over-prescribing for adults and children with so-called behavior disorders; and we must restore credibility and rational priorities by decriminalizing private drug use as we are doing in California with Proposition 19. This will end the most destructive aspect of the drug problem by no longer making criminals out of people for their personal behavior. This will help police, save millions of dollars, and reduce drug abuse.

AFTERNOON SESSION

Chairman PEPPER. The committee will come to order, please.

We continue the hearings which we began this morning on drugs in the schools. For those who are here for the first time, the House Select Committee on Crime started in 1969 an investigation of the general problem of crime in the United States. We were here and had hearings in this ceremonial courtroom the latter part of 1969 dealing with the subject of drugs in general because we found out that about 50 percent of the amount of crime in this country was related to drug use. Now, we are engaged in another phase of that inquiry, drugs in the schools.

Our first hearing was in New York City, our second in Miami, Fla., our third just last week in Chicago, and this is our fourth. After this we will hold a hearing the latter part of next week in Kansas City, Kans.

We heard an interesting group of witnesses this morning. I am sure we will hear a very interesting group of witnesses this afternoon.

Mr. Counsel, will you call the first witness?

Mr. PHILLIPS. The first two witnesses this afternoon are Mrs. Alice M. Murphy and Mrs. Kathryn M. McNeil.

Thank you very much for coming today, ladies. One of the most tragic facets of the drug addicition is it brings death to too many people and it is specially regretful and regretting when it happens to young people. The committee really appreciates your coming forward to tell us about the experiences you people have had personally with the drug addiction problem.

Mrs. Murphy, could you tell us what your situation was with drug abuse?

STATEMENTS OF ALICE M. MURPHY, SAN FRANCISCO, CALIF., AND KATHRYN M. McNEIL, DALY CITY, CALIF., PARENTS WHOSE CHILDREN DIED OF DRUG OVERDOSES

Mrs. MURPHY. My 18-year-old son was found dead of heroin last November and it was a shock to us. We knew he had had problems before, he was a rebel, but while it may seem that we were certainly not indifferent, but I personally have been very ignorant about many things.

I recall when he was in grammar school in San Mateo County he was involved with sniffing glue. Apparently it was not difficult to get. This was new to me.

Mr. PHILLIPS. You say even in grammar school?

Mrs. MURPHY. In the eighth grade. This is not, however, associated with the school. This was pretty prevalent. It was in Westlake District, Daly City, a small community just outside of San Francisco. It had

nothing to do with the school but his associates apparently at that age were also involved. It didn't get out of hand apparently because it was checked.

Mr. PHILLIPS. Did there come a time when he went to other schools?

Mrs. MURPHY. Yes.

Mr. PHILLIPS. Tell us about that, please.

Mrs. MURPHY. Shortly after we discovered this we discussed it with the authorities in San Mateo County. Unfortunately, his father died quite suddenly and our son came through the eighth grade without problem, without incident. Then, because I had no other man in the family, I thought I would put him into a boarding school across the Bay with the Christian Brothers where he would have good educational possibility and also be able to live with other men around who would guide him. He lasted about 6 months. There was no drug problem but he was a rebel.

Mr. PHILLIPS. He didn't get along too well at that school and he left there.

Mrs. MURPHY. He didn't like authority to tell him what to do and I think this probably is not unusual with many young people. I can only speak from my own experience. I think people with this problem very often need some kind of a crutch and maybe this was his problem, I don't know. But he lasted about 6 months. He snapped back at one of the Brothers and they asked me to withdraw him and I did. So, then he came to San Francisco where I was in the meantime living, and he had problems almost right from the beginning. Whether he was specially adept at picking up the wrong group, I don't know. Soon after we discovered that he was drinking beer. The police said, when he was picked up for attempted theft, they found needle marks on his arm; so I know it has to have gone back to that time.

Mr. PHILLIPS. How old was he then, Mrs. Murphy?

Mrs. MURPHY. This is 4 years ago—about 14.

Mr. PHILLIPS. He was 14 years of age?

Mrs. MURPHY. Yes.

Mr. PHILLIPS. He was going to junior high school here in the San Francisco Bay area?

Mrs. MURPHY. Yes.

Mr. PHILLIPS. And this is the first time that you noticed that he had heroin addiction or anything to do with needles?

Mrs. MURPHY. Yes; I didn't know what it was. I didn't know that he had these marks on his arm because at that age you don't wash their hands and face and you rather presume that if he is sleepy or dopey he didn't get enough sleep or there is too much this and too much that. Our apparent apathy, I think, really often stems from ignorance. I was not aware of what he was doing. I was not losing money. He hadn't taken any money; although I couldn't afford to give him large allowances—we never had with our children—we kept small amounts for them to learn how to manage, and apparently the other three children had learned.

Mr. PHILLIPS. Do you know where he was obtaining the money?

Mrs. MURPHY. No; I don't. The only thing I can assume, if he had been stealing, that was the answer, I guess. I don't know.

Mr. PHILLIPS. And was he involved with other boys in school?

Mrs. MURPHY. Yes, he was; but I never knew who his friends were because I was working, and this is why I thought the solution of a residence school would have been so helpful.

Mr. PHILLIPS. Do you know that he received any drug education or whether he received any counseling for the problem that he manifested?

Mrs. MURPHY. This I don't know. I very much doubt it because I might have heard about it. I do know some schools had a program. I had a younger daughter who was a student in one of the private schools for girls and when she was a senior they had quite a program. They invited the parents to come and participate. It was an enlightening program—it was new to me—dealing with dope, heroin; and at the break I heard many parents say, "This is an awful kind of program to give to us, we don't need this here." I didn't know whether they did or not, I had no problem in my home at that time, but someone must have mentioned it to the police officer who was controlling the program and he came back in the second period and said, "Yes, you do have it here, right in this school." This was a surprise to me. I think many times parents seem apathetic, they don't seem to realize the impact of this. I didn't until I was hit in the head with it.

Mr. PHILLIPS. I think, Mrs. Murphy, that you reflect probably the views of most parents in this country, that they don't realize what is happening to their children. Their children keep it secret from them. They do it with their friends, sometimes in schools, sometimes in the vicinity of other places they spend their time, and rarely do they leave any evidence around for their parents to observe.

I think this story you have told us today is one that we have heard in Miami, in New York, and in Chicago.

Mrs. MURPHY. I don't think we are so naive not to realize its existence is pretty close to us.

Mr. PHILLIPS. Could you tell us what happened to your son after his 14th year?

Mrs. MURPHY. He was about, let's see, I guess the first semester—no, the second semester—in the junior high school; when they arrested him they found these marks, and we had to admit he was out of control, parental control. I had, as I say, no one to turn to within our immediate family and so when they asked what should be done I asked the authorities, and it was a terribly shocking thing for him to hear and for me to have to say, but I did ask if they would keep him under their jurisdiction at the San Mateo Log Cabin, feeling that there were possibilities for education, maybe not so much advancement, but at least he would be there and occupied. As it happened he was skipping school. He had a good mind and I think after you have missed enough classes and you are not prepared to answer, then you miss more. Whether it is pride or false pride, I don't know, but they did take him to Log Cabin and it was probably the best thing in the world that ever happened to him at that time.

He came out looking well, having gained weight, having slept and eaten correctly and good passing grades for the work he had done there.

He was dismissed around the first of December and there was no room for him in the school, they said, until the end of the following

January, and that is when our problem started. He had nothing to do but fall right back in the same pattern in which he had found himself before.

We were new in the neighborhood. We had been burned out of our home in San Mateo County and I knew no one here and when he would not be home at night, sometimes until 2 in the morning, I wouldn't know where to call, I wouldn't know any of his friends or their relatives.

Mr. PHILLIPS. You knew of no facility at all that would be available to treat someone?

Mrs. MURPHY. I didn't realize what it was. When he came out of Log Cabin they said he had no drug problem. When he was found last November the coroner said that he had one needle mark in his arm. They said he had taken heroin but he never knew what hit him, it was that strong. So I can only assume in the meantime there was not a drug problem. It was more of a rebellion.

Mr. PHILLIPS. And he had gone through a number of schools?

Mrs. MURPHY. Five.

Mr. PHILLIPS. To your knowledge he never received any counseling.

Mrs. MURPHY. I think that at the last school that he attended, a local school, they were most anxious to help him but I think he just didn't cooperate. I think he might have been helped, and with their helping him and probably making me a little sharper on the situation, perhaps we could have accomplished something.

Mr. PHILLIPS. Mrs. McNeil, would you tell us about the tragedy that occurred in your life as a result of drugs?

Mrs. MCNEIL. It all happened when my daughter was 18 years old and 8 months, when she was found dead. I had no problems with her at all through grammar school and junior high. Eventually, she got into high school and this is where they have these mod classes, class for 2 hours and free the remainder of the day, and she had a lot of spare time on her hands where she didn't know what to do and it was boring, so apparently she was without area identification. The school allowed anyone on the school grounds so this is how the drug problem started in the school and she got on to some reds and other kinds of barbiturates.

Mr. PHILLIPS. How did you find she had gotten onto reds?

Mrs. MCNEIL. She told me herself she had experienced it.

Mr. PHILLIPS. Do you know where she got the drugs?

Mrs. MCNEIL. She would not tell me the name, they would never tell you the name, but she said some people came by with them and they use their lunch money for it, and this kind of thing.

Mr. PHILLIPS. You were telling us, essentially, that your daughter was about 14 or 15 when she first became involved with reds.

Mrs. MCNEIL. Yes, she was about 15.

Mr. PHILLIPS. And she went to school here in this area?

Mrs. MCNEIL. At Serramonte High in San Mateo County.

Mr. PHILLIPS. And could you tell me how you first learned that she was using reds?

Mrs. MCNEIL. Well, the school called me because at that time I was raising my little brother, too. I had lost my mother, and my daughter was 3 weeks older than my brother, I had the two of them together.

The school called and told me I had to come to the school and pick my brother up who was real high and they had to let him out in the back area so that the area kids wouldn't see him. When we got home we all hashed it out, asked how they got it, why were they using it and this kind of thing.

Mr. PHILLIPS. Would you tell us what the children told you about where they got the drugs?

Mrs. MCNEIL. These guys who come on the campus and they would sell it to them and if they didn't have the money they could sell it, too, and make money to supply their needs.

Mr. PHILLIPS. The kids were given the opportunity to sell drugs themselves on the campus?

Mrs. MCNEIL. Yes.

Mr. PHILLIPS. And the things that these two children were using were reds and——

Mrs. MCNEIL. Yes; I am sure they had heroin, not heroin but had marihuana. They called it some sort of lids, like that. They told me all about that, too.

Mr. PHILLIPS. Did it get progressively worse?

Mrs. MCNEIL. Well, no, it didn't get to heroin yet, but as far as the other barbiturates they were taking them and continuously we would tell them don't take it, it will do this to you and that and they eventually got off but then I don't know what happened. Sometimes they have all of these kind of idle times and they don't know what to do with themselves, they get tired of studying all the time rather than idle around the schoolground, they had gone to a smoke pit, that was built for the Serramonte school which they allowed them to even smoke without supervision, so if they smoke cigarettes they might as well smoke anything else. How would they know and the school officials would care less.

Mr. PHILLIPS. Do you think the school authorities couldn't care less?

Mrs. MCNEIL. This is my feeling.

Mr. PHILLIPS. Do you know what caused the final overdose?

Mrs. MCNEIL. No; I don't, because my daughter went to work that day and she was supposed to come home that night and we put in an all-points bulletin for her. Apparently she was just a victim of circumstances because she had told me before that these people had approached her to be one of these girls on the street and she said, "Mom, I will never do that." Once in a while if you don't do what the pushers/pimps tell you to do they go and kill you off. I have had experiences from others, from other friends, where they have had these girls in a room. They had them there for several days and won't let them out, even blindfold them, and they are out of school and school does not notify the parents. If you don't have a friend that will call your parents you never know where your child is. As far as the school is concerned I think it should be really a crackdown on the top authorities in the schools to get to the families. I think the families with children in the schools should be closely related so they can know what is going on. As a matter of fact, nowadays the schools are not really too concerned about the kids that are in the schools as much as they should be.

Mr. PHILLIPS. How old was your daughter when she died?

Mrs. McNeil. 18 years, 8 months, 5 days.

Mr. Phillips. How did you discover your daughter?

Mrs. McNeil. It was about October 22 when I found out exactly where she was. They put it in a local Negro newspaper and her picture was in there and this is how I found out. All the time we were looking for her and the police did not know, San Mateo County Police were not closely associated with the San Francisco Police so this is why they did not know.

Mr. Phillips. She died here in San Francisco?

Mrs. McNeil. Yes.

Mr. Phillips. And you were looking for her in San Mateo?

Mrs. McNeil. We put an all points out in San Francisco and San Mateo, supposedly.

Mr. Phillips. And then the police advised you she had died?

Mrs. McNeil. No; not the police, the newspaper, that is how I found out. I called the Daly City Police Department and reported her being found.

Chairman Pepper. She had gotten into the use of drugs?

Mrs. McNeil. Yes.

Chairman Pepper. Mr. Waldie.

Mr. Waldie. No questions.

Chairman Pepper. Mr. Winn.

Mr. Winn. First I would like to ask, I am not familiar with the San Mateo Log Cabin, Mrs. Murphy, you referred to that, what is it?

Mrs. Murphy. It is a facility for San Francisco youth, in the youth authority, juvenile court.

Mr. Winn. Juvenile court?

Mrs. Murphy. Yes; and I don't know the basis on what they make their selection but they do have a number of boys going down there. It is divided into two sections. I cannot think of the name of the other facility just over the hill—up to junior high—and these are for high-school-aged boys.

Mr. Winn. These are just boys?

Mrs. Murphy. Just boys.

Mr. Winn. Do they have a similar facility for girls, that you know of?

Mrs. Murphy. I don't know.

Mr. Winn. You mentioned that your son, I believe you said, at times he appeared in your words "sleepy and dopey."

Mrs. Murphy. Just a few times.

Mr. Winn. Just a few times?

Mrs. Murphy. Yes; if it was a matter of a long period I would have been inclined to ask the doctor.

Mr. Winn. It probably wasn't too much different than a lot of teenagers that are growing fast, how they react.

Mrs. Murphy. That is the way I felt at that time.

Mr. Winn. Sleepy a lot of the time.

Mrs. Murphy. I thought perhaps that might be it. At that age he had grown 5 inches in the last 3 years.

Mr. Winn. Did you ever find that he wanted to discuss this with you in any way whatsoever?

Mrs. Murphy. No.

Mr. WINN. None whatsoever?

Mrs. MURPHY. Not at all.

Mr. WINN. When he was a 12-, 13-, 14-year-old, in that age category, how was his attendance in school?

Mrs. MURPHY. It was satisfactory.

Mr. WINN. Pretty good?

Mrs. MURPHY. Yes.

Mr. WINN. Would it be possible that you might not know what his attendance was at school?

I am not talking about you, I mean all parents.

Mrs. MURPHY. I am inclined to believe this particular school, which was a Catholic parochial school, would probably have left us no cause, as has been the case in many instances. Their standing waiting list is so long if you don't fit into their program—they are fair, they will give you every possible chance. I don't mean that—but I think if they felt we were indifferent to a situation they might ask us to withdraw. But there seemed to be no problem there, or in residence there was no problem. But after he came back and started into the junior high school, the last half of the junior high school, is where I noticed it.

Mr. WINN. Did he ever bring any of his friends home with him?

Mrs. MURPHY. No. He had one or two friends, just acquaintances, and those are the only people I ever could identify in the street. But I have never seen any of them since his death. That isn't unusual, of course, as they get older, in the last year their pattern of life changes and many have cars.

Mr. WINN. I was thinking about prior to that. It seems that kids run around, boys particularly, in groups of three, four, five, and they usually go to somebody's house afterward to eat.

Mrs. MURPHY. Yes. I wanted to make my home available for them because I felt if they needed, a lot of them are waivering at the time, I didn't think it was drugs, and maybe it was not, but I think that some of the children lived in the projects and there wasn't enough room for them to all congregate there. I tried to encourage them to come up. While we certainly had no large quarters at least we had the things that we thought would attract them—stereo and a library—and the possibility of talking things over with them so I would know, first, who his friends are.

Mr. WINN. You had a home, not an apartment?

Mrs. MURPHY. We had a flat, an upper flat now.

Mr. WINN. You also mentioned the fact the San Mateo Log Cabin released him the first of December.

Mrs. MURPHY. Yes.

Mr. WINN. Because there wasn't any more room and they had a full house?

Mrs. MURPHY. It wasn't so much that. I think they were thinking in terms of the young people coming out and keeping face. They said it wouldn't be fair to have them come at this stage of the game when the term was almost over. They said the other student body members might say, "Where did they come from?"

Mr. WINN. You thought he showed improvement when he was at the Log Cabin?

Mrs. MURPHY. Definitely.

Mr. WINN. And looked better?

Mrs. MURPHY. And personal care and personal interest from the gentlemen down there.

Mr. WINN. Was his attitude toward you better?

Mrs. MURPHY. He had been resentful in the beginning and rebellious, and this I could understand and expected, but it was much better when he returned home.

Mr. WINN. I think basically what you have told the committee this morning is that you were almost 100 percent unaware of what was going on until it was probably too late. I don't think that part of your case is too much different from what we have heard in other cities, because we are firmly convinced that most parents don't know what is going on. As one of the officers said this morning, and I believe you were here, parents don't know anything about the language, they don't know what kids are talking about, and there is a definite communication gap certainly in this field if not the difference in age brackets, and sometimes rebellious feelings and the combination of everything makes it pretty tough.

We appreciate your appearing here this morning. We know it is not easy, but it can be helpful to some other family.

Chairman PEPPER. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

I would like to direct my question to both ladies, especially Mrs. McNeil.

Did your daughter at any time indicate to you, other than that she was on reds, that she was using any other form of narcotics?

Mrs. MCNEIL. She informed me she had experienced heroin, heroin addiction before.

Mr. MURPHY. Did she ever express to you the idea she would like to consult with somebody at school and talk over whatever problems she had?

Mrs. MCNEIL. Yes, she had.

Mr. MURPHY. Was there somebody for her to talk to at this chool?

Mrs. MCNEIL. Yes, there was a counselor to talk to.

Mr. MURPHY. Did she in fact talk to the counselor?

Mrs. MCNEIL. Yes, we both did.

Mr. MURPHY. What was your experience? Would you describe your conversation with the counselor?

Mrs. MCNEIL. Well, it consisted of her being unable to get to work part time and go to school part time and this would help her to get funds for clothes and for whatever she wanted to do without having to sell drugs, and to get away from the crowd that she was associated with.

Mr. MURPHY. Did the counselor oblige in fixing her schedule so she could work part time?

Mrs. MCNEIL. No, I am afraid not.

Mr. MURPHY. Did not?

Mrs. MCNEIL. No.

Mr. MURPHY. Did you appeal to the counselor yourself at school?

Mrs. MCNEIL. Yes, and I also went to the personnel office and was given about 47 different positions, jobs that the kids could go from different schools on 4–4 plan. This man had this many positions open and I personally went to the school and told the school counselor this and she didn't follow through at all.

Mr. MURPHY. Thank you, Mr. Chairman.

Chairman PEPPER. Ladies, you share with us tragedy that many other parents have experienced in the country. In my district one of the wealthiest men there lost his son at 18 years of age after he had been put in all of the places he knew. A mother testified there that her son, under the influence of drugs, strangled her 5-year-old daughter in a locked bedroom. She couldn't get to the child before she died. She almost cried to the committee, "Why didn't somebody help me?" So I wonder. You didn't find any particular help in the schools, did you; they didn't seem to have any program to deal with this kind of a problem. did they?

Mrs. MCNEIL. No.

Mrs. MURPHY. I did find at this high school in San Francisco they were anxious to help him. I don't know that they were so aware it was a drug-oriented problem. I think they felt he was just skipping school because he didn't want to come to school.

Chairman PEPPER. That may derive from the fact that the teachers and the supervisors are generally, like so many of the parents, not very well schooled in the drug problem.

Mrs. MURPHY. Perhaps they don't recognize it.

Chairman PEPPER. What about you, Mrs. McNeil, you didn't get any help either, to speak of, in the schools?

Mrs. MCNEIL. No. Like I said, they probably weren't aware of it either, or what course to take.

Chairman PEPPER. What facilities or what assistance did you find available in the community to help when this problem developed? Was there any community facility which you felt you were able to turn to that offered any hope of help?

Mrs. MURPHY. No, I didn't, because at the time that my son was in and out of the school and playing truant I thought it was just that I didn't realize that he had come into a drug situation again until the coroner called me. Up to that point I felt it was just a rebellion in having lost so much school: "I am going to make it up, all right, I am going to do it." How can you do this? How can you get a job, as he wanted to do, when you are not equipped, you have no credentials. Even if you have credentials if you have no training what good would this do? I couldn't get that across to him.

Chairman PEPPER. Mrs. McNeil, what would your answer be? Did you find any facility or assistance available in the community to you?

Mrs. MCNEIL. There was a very limited amount of assistance that I could get. I had to call the various hospitals and they referred me to institutions and things like that. That was about all. But they had no facilities available because it was only for adults. They didn't have anything available for young adults.

Chairman PEPPER. So, in the schools you didn't find a full awareness of the real problem of the young people, and outside of the school you didn't find available facilities to give you any material help.

Mrs. MURPHY. I wouldn't say they weren't available. It was just - was not aware of my need for them, I guess.

Mrs. MCNEIL. I checked them out.

Chairman PEPPER. She didn't generally find them available; you didn't know because you didn't inquire.

Looking back upon this tragic memory that you have. have you any suggestions as to what could have been done to have saved this young man and this young lady from the tragic end that befell them? Mrs. McNeil?

Mrs. McNeil. Yes; I think, first, there should have been more security on the school grounds, more awareness of a child in and out of school. togetherness with the parent and the school. more education-wise. Talking to the parents and teaching them what goes on in the home should be one accord like this, otherwise they get confused and——

Chairman Pepper. Then if I may interrupt, you spoke about the restlessness that came from idleness.

Mrs. McNeil. Yes. (See additional material received for the record.)

Chairman Pepper. There could have been a fuller use of her time while she was in school?

Mrs. McNeil. Yes; they had a marginal school where you go to school at 8 and you are free from 9 to 11, and this gives them too much time to do nothing and there is no transportation from school to home until the bus transports them home at 3 p.m.

Chairman Pepper. The school didn't have any program for them?

Mrs. McNeil. No.

Chairman Pepper. Mrs. Murphy, what would you say could have been done that might have saved your son?

Mrs. Murphy. Well, I think, perhaps, that we might have persons on the faculty who are more personally aware and who are strong enough to take a stand on it. I realize that the fear of threat and reprisal can be pretty potent in the schools.

Mr. Edwards. What the lady said a moment ago, I think, is very important. It has to do with this area around here in California where we have required many schools to be condemned because of earthquake danger, with no facilities and no money to rebuild them. And so we have literally hundreds of schools in northern and southern California on double sessions, which means that the children are free with nothing to do hours and hours every day, and apparently with no effort to give them something interesting and challenging during these off hours.

Chairman Pepper. Well, thank you very much.

Anything else, Mrs. Murphy, you would care to suggest?

Mrs. Murphy. Nothing that I can think of right now. Tonight I will think of all of the things I might have said.

Chairman Pepper. Well, we wish to thank you both very much. I know you were here this morning and we are sorry that we had to delay you so long, but we do appreciate your coming and we feel that your testimony will be valuable to others. Thank you very much.

(The following was subsequently received from Mrs. McNeil:)

ADDITIONAL STATEMENT OF KATHRYN M. McNEIL

My continued suggestions as to what could have been done to save others from this tragic situation:

I think the Federal Government should take dramatic steps to employ person/persons interested in the drug abuse program, awareness of what steps to take to give assistance to the communities, counties and states and facilities quarters in the various schools, preferably High Schools and Junior College and to give assistance where needed at all times. Take an individual interest in each student. There should be area identification on all school grounds to prevent any outsiders

from loitering around the schools. The schools should be opened some nights during the week for consultation with both parents/teachers as well as with a student with a problem. The Superintendent of schools should never allow a smoking pit to be built at the schools and student should not be allowed to misuse or indulge in unlawful acts around the school campus as they are allowed to do today. They should have a program instituted to include the ambitious students for furthering their education whereby job information, tutoring services could be one of the major interest. There should not ever be a modual program instituted in High Schools. With these suggestions taken under consideration, I feel that the drug situation in the schools would become a rare situation.

Mr. PHILLIPS. The next witness, Mr. Chairman, is Dr. George Loquvam, director of the Institute of Forensic Sciences in Oakland, Calif.

Doctor, could you tell us what your occupation is and how you came to know about drug abuse, things of that nature?

STATEMENT OF DR. GEORGE S. LOQUVAM, DIRECTOR, INSTITUTE OF FORENSIC SCIENCES, OAKLAND, CALIF.

Dr. LOQUVAM. Yes. I am a forensic pathologist in Alameda County. I am the director of the Institute of Forensic Sciences in Oakland and we have a contract with the coroner or Alameda County to perform all of his medical-legal autopsies. We have been doing this since 1951, so, of course, all of the unexplained deaths in Alameda County my institute handles.

Mr. PHILLIPS. Could you tell us, Doctor, what you found in recent years in relation to drug deaths in Alameda County?

Dr. LOQUVAM. I was asked to present to this committee the material that I could gather out of the coroner's office so I picked 5 years, 1967 through 1971; and in order to put this in some kind of context for you people to understand, I used the total autopsies that we performed and I have some charts here.

In Alameda from 1967 to 1971 we had a total of 8,250. We had a total of 8,253 autopsies. Of those, 4.1 percent of them were teenagers, and I was told to restrict this to the 13 to 19 age group, which totaled 342.

Of these 342, we had 8 percent that died what we could call a natural death, some diseased process, heart disease, something that can be readily explained on a natural basis; and 92 percent were unnatural.

Now, obviously we are dealing with a very healthy population when you only have 8 percent natural deaths, so let's look at the unnaturals.

Teenagers: Vehicular accidents of all types, now, anyway a vehicle is involved except an airplane, motorcycles, bicycles, scooters, automobiles, 51 percent of our total died in some type of vehicular accident. And 16 percent of these had alcohol involved. That means alcohol from 0.05 to as high as 0.3. These figures don't really mean much until you realize that one of these kids 19 was driving a van back from Livermore in the south end of the county. He had eight people in the van. He drove it off the road and killed all of the people in it, nine of them, and he had a blood alcohol of 0.29. So there is sort of an iceberg here until you look into what these things mean in relation to the 51 percent.

Barbiturates were involved in 7 percent. This may be a passenger or it may be a driver. If one of them was injured and he stayed too long

in the hospital, obviously our barbiturate level would be of no value. These are only the people that died immediately.

Then we had Seconal, barbs, from 0.2 to 1.2 milligrams percent.

The second category are the gunshot suicides, and this is 6 percent of our total unnaturals. Once again the same thing: 16 percent of these kids had alcohol, 11 percent had barbiturates in their bloodstream.

The third category is the gunshot homicides, which accounts for 10 percent. Ten percent had alcohol involved, 7 percent had bariturates involved, and 3 percent had amphetamines involved.

The direct drug deaths other than these gunshots and automobiles, 15 percent were direct drug deaths, directly related to drug; 5 percent of these intravenous narcotism, 7 percent being barbiturate overdose. Four, narcotism when we have the capital kid with the tracks or without the tracks, to see if they are sniffing, skin popping, to see if they are popping it that way, or mainlining we take blood, liver, kidney, bile, and lung, we do more fine determinations on blood, and on the bile and on the liver, we think in distribution between tissues we can tell how soon death occurred after a shot because of blood levels and lung levels.

The other drugs involved were 3 percent and these went from everything, Darvon, airplane glue, chloral hydrate, trichloroethane, and I have had added in here LSD by history. The reason I say history, nobody can analyze for LSD out of a biological system. With careful investigation by the police and coroners' deputies these kids had been known to have had or been on a bad trip. Most of these came out of Berkeley. They usually died by jumping.

Then we have a whole bunch of other unnatural deaths to make up the 18 percent. These varied from drowning down to stabbing, homicide, and blunt injury.

That takes care of the numbers of cases that we see at our coroner's office over the last 5 years.

Chairman PEPPER. Would you just summarize that now for us?

Dr. LOQUVAM. There were 342 total teenage deaths in a 5-year period, 1967 to 1971 and 15 percent of them were direct drug deaths.

Mr. PHILLIPS. And there were some drug-related deaths.

Dr. LOQUVAM. There were a large number of drug-related deaths, where the drug in and of its own didn't cause the death but may have lead to the accident that produced other deaths.

Mr. PHILLIPS. We come to about 85 people over that period of time.

Dr. LOQUVAM. No; it is close to about 50.

Chairman PEPPER. Beg your pardon?

Dr. LOQUVAM. Closer to 50 direct or indirect drug-related deaths.

Chairman PEPPER. The total number was 342?

Dr. LOQUVAM. Yes.

Chairman PEPPER. And about 18 percent were drug related; 15 percent narcotism and barbiturates overdose, and 3 percent other drugs.

Dr. LOQUVAM. Yes.

Chairman PEPPER. Then what was the alcohol percentage?

Dr. LOQUVAM. I didn't break it by alcohol in and of itself. Here we have alcohol in vehicular, alcohol in gunshot, and alcohol in gunshot homicide.

Chairman PEPPER. Well if you were to make a statement based upon that study as to how many deaths were primarily due to alcohol, where

you might say the proximate cause was alcohol, would you just estimate roughly?

Dr. LOQUVAM. Well, I can't say that alcohol would be the proximate cause here because I don't know, so if I have to exclude these then we are down to alcohol involved in the accidents and that was 25. Out of 161 total had alcohol to a level that in my opinion most probably contributed to the individual's death.

Chairman PEPPER. So the largest single contributing cause appears to be in the drug field.

Dr. LOQUVAM. Yes; it does.

Mr. PHILLIPS. Doctor, you found not only heroin being a killer, I take it, but some other drugs as well?

Dr. LOQUVAM. Barbiturates are the next greatest. You see my institution does all of the blood, breath, and urine alcohol determinations for all of the law enforcing agencies in Alameda County. In the first 4 months of 1972 we had 42 cases of people driving vehicles in which we isolated PCP, the peace pill, out of their urine. Of these, 22 were teenagers. 32 of the total of 42 came from one community in Alameda County, and they found the guy that was making them. He was turning out the peace pills in that community. Again, 32 of the 42 came from that community and 22 of the 42 were teenagers, and they had been stopped by the police because of driving error, and we isolated this out of their urine. There are many little side faces of this drug problem, it is not only the dead ones, it is——

Mr. PHILLIPS. People are dying in California of heroin and barbiturates mainly, and any other drugs.

Dr. LOQUVAM. Those are the chief ones in my experience. We have had no methadone deaths in Alameda County. There has only been about, I think, four methadone deaths in the whole State. This is easily explainable. We don't have any good methadone programs really of any large volume and what ones are here are probably controlling their methadone dispersal pretty well. New York, as you know, has a fantastic problem because of the looseness of the control and the number of people.

Mr. PHILLIPS. And Miami has the same problem.

Dr. LOQUVAM. Yes. You know, strictly from an academic standpoint, I am interested in knowing distribution of drugs because these things keep changing in our own community. Our Seco-barbiturate deaths are dropping off. In 1967 our amphetamine drivers were 10 times ahead of the amphetamines. Now they have reversed themselves. Our total heroin deaths in Alameda dropped significantly in 1971 and I think this is when they had the big hullabaloo down in Mexico at the border to stop stuff coming across. We had a marked drop in heroin deaths in 1971.

Now in 1972 they are just taking off again, it is going to be bigger than any year we have had.

Mr. PHILLIPS. 1972 is going to be the largest year in Alameda County?

Dr. LOQUVAM. Yes. I am only looking from 1967 through 1972, but we have plotted these in my laboratory. In 1971 they had a marked drop and now 1972 is going up.

Mr. EDWARDS. How many teenage heroin deaths did you have in 1971 and how many will you have in 1972?

Dr. LOQUVAM. You will have to wait 1 second because I didn't break it down that way. We had eight category IV narcotisms in 1971.

Mr. EDWARDS. And you will have more in 1972?

Dr. LOQUVAM. Yes. I am sorry, I didn't figure 1972. I wanted to take a 5-year period.

Mr. EDWARDS. The reason I asked this is there is a formula used by some people that can estimate the total population by the number of deaths. Now can you prognosticate or extend an estimate of how many heroin addict teenagers there are from the number of deaths?

Dr. LOQUVAM. No. I know some people use a judge factor and I don't ascribe to it.

Mr. EDWARDS. The testimony this morning indicated that heroin addiction, or heroin use in the schools of Alameda County, or at least in Oakland, was not a serious problem.

Dr. LOQUVAM. I have no way of——

Mr. EDWARDS. Almost no problem.

Dr. LOQUVAM. I have no way of judging this. I am not competent to do so.

Mr. EDWARDS. How many heroin deaths were there in 1971 in Alameda County?

Dr. LOQUVAM. All I have are the figures as I was asked of the teenagers. I don't have them in the back of my head.

Mr. EDWARDS. We do have estimates of the number.

Dr. LOQUVAM. I have the exact numbers for everybody but I was asked only for teenagers so those are the only figures I brought. I am sorry.

Mr. WALDIE. Doctor, the New York City equivalent of your office coroner testified to an astronomical number of heroin deaths in New York City, but he also said that those were undercounted, that there are a number of deaths, he believed, that are heroin attributable deaths, or drug-overdose deaths, that never get reported as such.

Is there such a possibility in Alameda County?

Dr. LOQUVAM. Yes, and I have excluded these from my totals. These are the kids with hepatitis, the kids with other infections that die because of infected needles, infected stuff that they are using, and we recognize these and these are heroin deaths. But when I am talking of a heroin death, I have found it in the bloodstream and in the bile and I am talking of an actual figure.

Now, one distinction in New York, they don't even do a morphine determination, they do a quinine because all morphine, heroin in New York City is cut with quinine. This is ridiculous, I think; they are either missing a lot or a lot of people are taking quinine or quinidine or something.

Mr. WALDIE. But in terms at least of Alameda County, you believe those that have used heroin, and it is in their bloodstreams and their death has been a result of overdose or attributable to that use, at least they are allied.

Dr. LOQUVAM. Yes.

Mr. WALDIE. The figure would be only less than the actual figure because there is a possibility of another group from infections, from the use of the instruments by which they insert the drug.

Dr. LOQUVAM. Yes: and I don't include those in my heroin deaths because I hadn't isolated heroin.

Mr. WALDIE. Would you have any estimate as to how much inflated that then would cause those figures to be? The figures are disturbing enough as they are.

Dr. LOQUVAM. I really don't think too much, Mr. Waldie, I really don't. Five a year maybe, three a year. I am guessing, but somewhere in there.

Mr. WALDIE. How long have you been coroner, Doctor?

Dr. LOQUVAM. I am not the coroner. I have been doing the coroner medical-legal cases since 1951.

Mr. WALDIE. Were there instances of heroin overdose in those years?

Dr. LOQUVAM. I am sure there were, but we weren't competent to isolate it and identify it. You see, we didn't have the technical know-how to do a blood——

Mr. WALDIE. When did that competency come on the scene?

Dr. LOQUVAM. 1968, real well.

Mr. WALDIE. Actually these figures really only cover the years which there has been any competency to identify.

Dr. LOQUVAM. Oh, yes, indeed, 1967 on up; and back in 1967 I had to have 400 cc. of blood before I could do it. Now we can do it on 5 cc. So you can see our competency is getting better.

Mr. WALDIE. Thank you.

Mr. WINN. Does the coroner have the authority to perform an autopsy in Alameda?

Dr. LOQUVAM. In California any unclaimed body, any body that has not been physically attended by a physician for 10 days, any homicide, suicide, industrial accident or other accident, is automatically a coroner's case. Then the coroner can decide, or if he has a forensic pathologist, will decide which cases will be autopsied to truly ascertain the cause of death.

Mr. WINN. It is his choice?

Dr. LOQUVAM. Yes.

Mr. WINN. Could the parents block it if they absolutely so desired?

Dr. LOQUVAM. No.

Mr. WINN. They can't do that in California?

Dr. LOQUVAM. No.

Mr. WINN. We have been informed in some States the parent can, or other people can, block an autopsy, thereby the figures could be very misleading and the coroner, of course, would not know whether this was a death attributable to the overdose of drugs or what it might be.

Dr. LOQUVAM. That is true.

Mr. WINN. Until we get more States on a basic conformity, we really can't pay too much attention to any national figures.

Dr. LOQUVAM. That is true, and then think how many little communities do not have any laboratory facilities and a child is killed in an automobile accident and there is no alcohol, there is no barb, there is no work done.

Mr. WINN. When we look at the statistics and we see them presented and hear about them, we are probably seeing statistics that are much lower than the actual facts. I don't know whether they would be much lower.

Dr. LOQUVAM. I have no basis to make an opinion. All I can go on is what I know in my own community and I know there are many communities that do none of the things we are doing.

Mr. WINN. If many communities don't do the things you are doing, then they have no way of adding to the statistical information, accurately at all.

Dr. LOQUVAM. That is right.

Chairman PEPPER. I hope it is not an improvement. I know we have a large number of young people here this afternoon and I know that they are leaving now, a good many of them are leaving.

I would like to ask the doctor a question, if I might, before all of these young people leave.

Dr. Halpern, who is the medical examiner for New York City, who evidently has had the largest experience of any doctor, I believe, in the country in autopsies on those who died from suspicion of heroin relation, testified before our committee in New York that he regarded it as an inaccuracy to say, when we see that anybody has died from heroin, that it is an overdose. He says, according to his experience, if you took the same quality and the same quantity of heroin over a period of time and you got no unfavorable reaction, still the next dose might prove to be fatal.

Would you give us your opinion that it might just happen in a peculiar way that nature reacts and might produce a fatality. Would you care to make any comment?

Dr. LOQUVAM. Certainly, I can't help but agree with Dr. Halpern. No. 1, we don't know why an individual dies of heroin. Nobody has ever explained this physiologically to anybody's satisfaction. We have the individual that is accustomed to taking his two or three shots a day and all of a sudden he dies with the needle still hanging in the vein. You can't make me believe this is overdose. Something has happened. Whether it is an anaphalactic reaction, I don't maintain it.

Chairman PEPPER. Something seems to paralyze the basal ganglia in the brain that paralyzes the involuntary processes of the body.

Dr. LOQUVAM. They certainly have respiratory failure, they get the typical white foam in their mouth. You open their larynx and it is full of white foam. It is a cardio respiratory type of death, but the exact mechanism I don't know and I don't think anybody does.

Mr. WINN. I was following up on this, whether the coroners have the authority, in trying to figure out if we are going to get any real accurate statistics. Your charts refer only to accidental deaths, don't they?

Dr. LAQUVAM. No, mine refer to all teenage unnatural deaths over a 5-year period block even down into automobile, gunshot, suicide, gunshot homicide, directly related to drugs, category IV, narcotism and barbiturate overdoses, and the other rare overdoses.

Mr. WINN. All right, if a teenager died and the parents had the doctor come out and declare this person, this child, dead, would there be any way that the coroner's office would ever have an opportunity to conduct an autopsy?

Dr. LOQUVAM. Yes; this is well stopped. No. 1, if the doctor hasn't seen the patient within 10 days he knows by law he cannot sign a death certificate.

Mr. WINN. If he hasn't seen the patient?

Dr. LOQUVAM. If he hasn't physically seen the patient within 10 days, and that doesn't mean a telephone call or the mother meeting him on the street and saying Susie doesn't feel well. This means physically seeing him within 10 days, he knows he can't sign it and he won't sign it; therefore, it automatically comes to a coroner's office in California.

Mr. WINN. That is not true in other States in the country, is it?

Dr. LOQUVAM. No.

Mr. WINN. That is my point. What I am saying again is that it is possible in the statistics that we read, that some patients in cahoots with the family physician, or however you want to put it, are covering up the fact that some of these young people are dying from overdose or from other implications dealing with drugs, and we may never know about and never see any statistics.

Dr. LOQUVAM. I think this is entirely true in some parts of the country.

Mr. WINN. There is no way to judge and it probably wouldn't be fair to ask you what percentage of teenage deaths in the Nation might be in that catagory, because that would probably take a fantastic amount of research and then I doubt then you could ever come up with an accurate figure.

Dr. LOQUVAM. It would just be a guess.

Mr. WINN. On No. 5, Darvon, airplane glue, all of them to my knowledge, and correct me if I am wrong, are purchasable across the counter.

Dr. LOQUVAM. Darvon is not. Chloral hydrates——

Mr. WINN. Darvon isn't?

Dr. LOQUVAM. No, that is a prescription drug. Chloral hydrates and trichlorethane, neither one of these can be purchased across the counter.

Mr. WINN. There are a great many adults taking Darvon.

Dr. LOQUVAM. Yes.

Mr. WINN. Any they can be swiped out of a medicine cabinet.

Dr. LOQUVAM. Yes. You said purchased.

Mr. WINN. I did, but I was thinking how easy they are to get.

Dr. LOQUVAM. Really, I didn't list all of them here. This chart could go on another page. These are isolated.

Mr. WINN. Those are the main ones?

Dr. LOQUVAM. Those are the main two or three.

Mr. WINN. Could we safely say that about half of the other drugs in that 3 percent could be easily purchasable across the counter?

Dr. LOQUVAM. I hate to make a statement like that when I really don't know.

Mr. WINN. We are trying to get a better understanding of the problem for any possible legislation. Thank you very much.

Mr. MURPHY. No questions.

Mr. EDWARDS. No questions.

Mr. WALDIE. I have one more. If I understand you, you broke down the figures in terms of teenage deaths, that would be age 19 and below, attributable to those causes.

Could you give us some indication of the total deaths attributable to the use of heroin, excluding alcohol for the moment?

Dr. LOQUVAM. Once again in teenagers, teenagers only?

Mr. WALDIE. Excluding teenagers.

Dr. LOQUVAM. The total picture?

Mr. WALDIE. Is there some picture; is teenage death the predominant death from the use of this drug?

Dr. LOQUVAM. No; if I had gone up to age 25 I would have added another 12 or 15 percent. Our highest incidences is between 21 and 25.

Mr. WALDIE. They are the highest?

Dr. LOQUVAM. Yes; they were teenagers 2 years ago.

Mr. WALDIE. To what category were teenage deaths attributable to the use of heroin for example?

Dr. LOQUVAM. We had one 13-year-old. From each end, 13 to 19.

Mr. WALDIE. Thank you.

Chairman PEPPER. We want to thank you very much. You are doing splendid work and we wish we had more public servants like you.

(The following statement was received for the record:)

STATEMENT BY ROGER HOFFMAN, COORDINATOR, SAN FRANCISCO COORDINATING COUNCIL ON DRUG ABUSE

The San Francisco Coordinating Council on Drug Abuse is coordinating the efforts of over 80 public and private organizations that are making specific attempts to reduce the abuse of drugs in San Francisco. The Council provides a community forum where organizations offering drug abuse treatment, prevention, education, research and law enforcement services can come together to discuss issues, define problems, set goals and priorities and recommend action to solve drug related problems. One of the major objectives of the Coordinating Council is to prepare a comprehensive Drug Abuse Plan for the City and County of San Francisco that can be used as a guideline for action in reducing drug abuse.

The Coordinating Council has had two years of experience in trying to define and seek the solutions to problems related to drug abuse in San Francisco. As a result of these efforts, the Council recognizes drug abuse among school-aged youth to be one particular form of self-destructive behavior with which youth decide to become involved.

Other forms of self-destructive behavior include gang activity, suicide, vandalism and various other forms of juvenile delinquency. In seeking to define the problem, the Council had to consider why young people choose these forms of self-destructive behavior. A further search reveals the overall problem: there are too few positive, non-chemical activities that youth can choose from that provide alternatives to drug abuse. An important dimension to this problem is that the opportunities to make choices that affect the lives of individual youth are limited because of the decision-making restrictions placed on youth by adults. It would seem then, that if a wider variety of constructive activities were available to youth and if youth were allowed to make many of the decisions that are presently made for them by adults, the tendency for youth to make self-destructive choices such as abusing drugs would diminish.

Perhaps the most important activity that youth are not allowed to participate in is the decision-making process that directly affects their lives. As a result of adult laws, traditions, and social mores, youth as a group are essentially powerless in the sense that they are not allowed to decide for themselves how their lives should be. Most of the decisions that affect the lives of youth are made for them by adults. Adults tell them they have to go to school, they have to take certain courses, they have to be in by curfew, etc. The assumption has been that youth are not capable of making their own decisions. However, if responsible decision-making is one of the most important things a maturing individual needs to learn, the only way to learn decision-making is to make decisions. Youth involvement in personal and community decision-making can not only be a positive activity—an alternative to drug abuse and other forms of non-productive behavior, but it would enable youth to develop other types of alternative activities that would directly affect their lives.

The following conditions exist in San Francisco that not only limit the positive activities with which youth can become involved, but also limit the

decision-making power of youth. All of these factors contribute to the existence of drug abuse among youth in San Francisco because they limit the number of positive, non-chemical activities from which youth can choose.

Comprehensive youth planning does not exist in San Francisco

There are many organizations in San Francisco that are attempting to meet the needs of youth. However, these services are fragmented and un-coordinated. Comprehensive planning needs o exist to determine gaps in services, set priorities, provide for un-met needs and evaluate existing services. An important aspect of comprehensive youth planning should be youth advocacy whereby, the professional planners and social workers are organized to articulate the interests and needs of youth to City and State governments as well as other policy-making entities. Youth under 18 must be represented on the Board of the planning body to make the efforts to youth. Youth know best the problems of youth.

Many cities have organized Youth Service Bureaus in an attempt to coordinate and consolidate youth services. Youth Service Bureaus are coordinated youth needs service centers—*centralized facilities* where youth can go to have a wide variety of needs met and to which other agencies such as the Juvenile Court, social service agencies, etc., can make referrals. San Francisco has no such coordinated, centralized facility.

Few alternatives exist to Juvenile Court for diversion of delinquency tendency arrests and misdemeanors

In 1967, the President's Crime Commission concluded that ". . . delinquency is not so much an act of individual deviancy as a pattern produced by a multitude of pervasive societal influences well beyond the reach of the actions of any judge, probation officer, correctional counselor or psychiatrist."[1] It suggested that the most effective countermeasures to delinquent behavior lie outside the Juvenile Justice System.

Many young people are arrested for offenses that are not considered crimes if the offenders were adults such as truancy, running away from home, curfew violations, and being beyond control of parents—offenses categorized as "delinquent tendencies" (referred to in California as "601 cases"—those prosecuted under Section 601 of the California Welfare and Institutions Code). In 1971, delinquent tendency arrests accounted for 24% of all petitions filed for boys and 70% for girls. In our complex society, types of adolescent "misbehavior" labeled as delinquent tendencies or categorized as misdemeanors are often more normal than abnormal; yet, numberless laws blankets these acts within official jurisdiction. But advancing recognition of the evils flowing out of the labeling process, and concern over our low rehabilitation batting average, make us pause and look for new directions. The use of authority may be destructive as well as constructive. If young people who commit nonserious offenses need any ongoing services, these can frequently be provided as well or better by non-court agencies.[2] By diverting youth charged with *all* 601 offences, certain misdemeanors and first offenses out of the Juvenile Justice System, a wide variety of community-based alternatives become available to which youth can be referred that can meet the specific needs of youth. The legal mechanism in California for diversion is Section 653 of the California Welfare and Institutions Code which allows the probation officer to reject the officialization of a child's offense or status.

The diversion of *all cases* referred to the Court for drug use and possession should be considered. Assistance to drug abusers can best be provided by the wide variety of treatment programs that exist in San Francisco. A law currently pending in the California Legislature (Senate Bill 714—the Campbell-Moretti-Deukmejian Drug Abuse Treatment Act), which stands an excellent chance of passing in the fall, would enable the adult Court to divert drug cases out of Criminal Court and into community treatment programs. Since the Juvenile Court already has the enabling legislation to divert *any* offenses from the Juvenile Justice System (Section 653 previously cited) it should more frequently apply this section and divert cases of drug use and possession. The use of diversion allows the young person (along with the probation officer) to decide with which community-based program he or she wishes to become involved.

Few educational alternatives exist

The young people who abuse drugs most are the ones who need a wide range

[1] Rubin, *Law as an Agent of Delinquency Prevention*, U.S. Department of Health, Education and Welfare, Youth Development and Delinquency Prevention Administration (1971).
[2] Ibid.

of educational activities and opportunities. The conventional approach to education does not seem to work for them. Many are impatient, have a low level of motivation and lack self-confidence. These youth need specialized instruction to improve their self-image and level of motivation. An alternative of this type, Opportunity High School, now exists as part of the Unified School District; but, more alternatives need to be developed. To go further, the laws and regulations that require mandatory education and mandatory courses need to be seriously examined. These laws limit the choices available to youth for constructive decision-making.

Youth have very little influence in the determination of school policy

To facilitate education, students need to be thought of as participants and not merely recipients of the educational process. The 1971 White House Conference on Youth brought young people together from all over the country to make recommendations to public officials. The following recommendations were made regarding student participation in educational policy development:

America's democratic system is rooted in the belief that all citizens who are affected by the system should have a voice in deciding how the system is to be set up. This concept of a representative democracy has not been universally accepted in our Nation's educational institutions. As students on all levels become increasingly socially and politically aware, the time has come to give students a voice in the policy and governance of their educational system.

Beginning with the secondary level, students should participate in educational decisions and student governance. They should also participate in broad-based policy decisions by having representatives on educational and governing boards at all levels and in governmental agencies. Special efforts must be made to include racial and ethnic minorities, students in vocational and non-academic concentrations, and other students who, for various reasons, traditionally tend not to be involved in educational governance. As members of the community, they should be indispensable participants in sound decision-making. In those instances where students are not voting members, steps should be taken to move toward giving them voting representation.

Government at all levels should support student participation and should include students on all of its educational boards. State, county, and local governmental agencies should have student representation. High school students should be represented on boards of education. The legal regulations and guidelines for all Federal, state, and local programs that have impact on students and youth should reflect the above principle of participation.[3]

Effective drug education is lacking in private and parochial schools

The San Francisco Unified School District has a very comprehensive drug education program. Their approach is to ". . . discourage the irresponsible use and abuse of drugs by helping youth develop satisfying and constructive interests and ways of living that are preferable alternatives." They believe that ". . . all youth can be trusted to make reasonable and responsible decisions and choices when given opportunities to explore the many facets of complex problems under competent direction." Drug abuse is seen as ". . . a symptom, not a cause. of maladjustive behavior."[4]

These approaches, properly applied, will be effective because they recognize the decision-making potential of youth. However, the private and parochial schools do not have access to such approaches. Steps need to be taken that would enable private and parochial schools to provide this type of drug education.

Funds allocated for drug education in the public schools are minimal

To maximize the effectiveness of the Unified School District's drug education program, more funds need to be allocated specifically for drug education. This fiscal year, $86,000 has been allocated for drug resource teachers, administrators and materials. With approximately 80,000 youth attending schools, only $1 per student per year is spent on drug education. The high priority need for drug education is not reflected in the amount of money allocated for such education.

Relatively little drug education exists for youth not attending school

There are a number of young people in San Francisco that attend school only part-time or not at all; thus, they have little exposure to drug abuse education. It

[3] Report of the White House Conference on Youth (1971).
[4] Master Plan of Instruction about Drugs and Hazardous Substances, San Francisco Unified School District (1971–72).

should be the responsibility of the various community-based drug treatment and crisis intervention programs in San Francisco to provide drug education to youth not attending school.

Students do not have access to drug counseling in the schools

Drug education is important as a measure to prevent drug abuse, but services also need to be provided to youth who are currently abusing drugs and need help. The present program in the public schools is generally thought to have its effect on those young people with a moderate to low risk of later drug abuse. Services need to be provided for "high risk" students who are abusing drugs or have a high potential to do so. The School District does not currently provide specialized drug counseling for youth who need immediate help while in school. From 1969 to 1971, however, the School District in partnership with the Department of Public Health instituted a program in certain high schools called the "Crash Pad" program. Professional mental health counselors were allowed to set up drop-in centers within the high schools to provide drug counseling services. If a student chose to seek help, it was immediately available. Programs such as this need to continue on an ongoing basis. Students should be consulted when decisions are made about the specific services to be provided.

The San Francisco Coordinating Council on Drug Abuse is prepared not only to work with youth to provide an array of constructive and exciting non-chemical alternatives, but also to help change the existing laws, institutions and values that limit the decison-making power of youth to determine what these alternatives should be.

Mr. PHILLIPS. The next group of witnesses is a group of probation officers who work with children after they have gone through their criminal justice process and have been involved in drugs. Ken Moresi, Edgar Kendall, Eskew Young, and Armond Pelissetti, would you please come forward?

Mr. Chairman, Mr. Nolde is prepared to question these particular witnesses.

Mr. NOLDE. Mr. Young, you are a probation officer for Alameda County and you are in the special drug unit; is that correct?

STATEMENTS BY PANEL OF PROBATION OFFICERS: ESKEW YOUNG, JR., ALAMEDA COUNTY, CALIF.; ARMOND PELISSETTI, INTAKE DIVISION, JUVENILE COURT, SAN FRANCISCO, CALIF.; KENNETH MORESI AND EDGAR KENDALL, ALAMEDA COUNTY, CALIF.

Mr. YOUNG. Yes.

Mr. NOLDE. And all of your cases deal with drug offenses, I take it.

Mr. YOUNG. That is true.

Mr. NOLDE. Could you tell the committee the extent of drug use among our youngsters in this area, as you have seen it through your caseload, your dealings with these youngsters?

Mr. YOUNG. Well, I work with adults.

Mr. NOLDE. Let me modify that a little. I realize your position, you see the young adults and you have had some experience in dealing with them. Looking at their records, could you tell me the extent of drug use along the way with your case?

Mr. YOUNG. As I said, I deal with adults that are involved in the use of narcotics, heroin, barbiturates, a whole range of drugs. It has been my experience when we do what we call a background report within the court report and start checking as to the type of drugs that these people have used, almost without exception, it has been my experience to have found that marihuana and barbiturate use has started in the schools. Sometimes at age 14. Is that what you were after?

Mr. NOLDE. Yes. And how does that progress, if there is such a progression?

Mr. YOUNG. Dealing strictly with my caseload, often it moves up to where they are involved in the so-called hard drug, heroin. Most of my caseload, I would say 45 percent of it, are people that are using heroin and the other percentages vary from the amphetamines and the barbiturates.

Chairman PEPPER. Counsel was asking what percentage. What is the age group of those people?

Mr. NOLDE. How early?

Mr. YOUNG. My age group, the people that I supervise, run from 18 through 48. The majority of them are between, I'd say, 18 and say 27. A great majority are below 30.

Mr. NOLDE. How early would you say many of your cases get into drugs; how old would you say they would be?

Mr. YOUNG. In junior high school and high school, 14, 15, 16 years old.

Mr. NOLDE. Can you tell us a little bit more about the types of drugs and how they really get into it, how they progress.

Mr. YOUNG. I think, and it has been said here before, the majority of them have started off with marihuana. I think what happens is somewhat in contradiction to prior testimony. The reason that we don't see too much heroin in the schools in contrast to other drugs is because of the price. I think someone mentioned allowances. I think that most kids, especially in the ghetto area, don't have that amount of money, at least in the school situation, to be that involved in the purchase of heroin. They can come up with a dollar or so for barbiturates or the marihuana. The ones that do graduate into the heroin scene, my experience indicates they usually supported this habit through illegal activities—burglaries or some type of theft.

Mr. NOLDE. So you would say that they would start on marihuana and progress perhaps to the pills and barbiturates, then on to something else, up to and including heroin, until they ultimately find a drug of their choice.

Mr. YOUNG. Yes.

Mr. NOLDE. To which they stick. And would you say most every one of your cases has gone through that sort of progression?

Mr. YOUNG. That is the general pattern.

Mr. NOLDE. What is your caseload, by the way?

Mr. YOUNG. About 100.

Mr. NOLDE. I assume that is really much more than you feel would be ideal?

Mr. YOUNG. Right, it should be a lot lower than that.

Mr. NOLDE. Do you have some ideas as to what can be done about this problem, particularly in looking at the youngsters?

Mr. YOUNG. Well, I think we were talking about this before we got here. I think Dr. Fort kind of summed up some of my ideas. I can't see how we can put the entire responsibility on the schools or police department or law enforcement. I think it is going to require the efforts of all of these different agencies and institutions. In addition, it is my feeling at this point that I don't think we really know what to do. I think we are kind of searching and investigating and I don't believe that we have come up with the answers. Also, from what I have

seen, the only programs that have, at least to my way of thinking, been effective are programs like Synanon and in our area another called GROUP. These are residential programs where the people that use drugs are isolated. I am very skeptical. I think that what is needed is probably more research. Not only research as to the people that are using drugs and why, but perhaps we should go into schools and start checking out the kids that don't use drugs and try to figure out why it is they can be in a drug setting and refuse to participate. So I feel that it is just as Dr. Fort says. It requires a total effort and we need much more knowledge than we have now.

Mr. NOLDE. Do you have ideas on different treatment or at least different types of drug abusers?

Mr. YOUNG. Yes. Well, again this ties in with my personal experience with people that are on probation, and incidentally I have been doing this for 10 years. I have had a caseload involving narcotics and dangerous drugs. What I observed is that the drug abusers who are on amphetamines, and I think as the chairman said, back in 1967, 1969, this was quite extensive. What I noticed then, when I would ask why is it that you would choose or select this particular type of drug? The response I would get is that it enables me to rap. What they meant by that is to reach out, to be more responsive to their peers. In contrast, when I put the same question to people on heroin I found they tried to solve their problems of not being able to get involved by using a drug that prevented personal involvement.

Mr. NOLDE. In other words, they were sort of stepping back.

Mr. YOUNG. Right.

Mr. NOLDE. Copping out, so to speak.

Mr. YOUNG. This suggested to me that perhaps there is a different method of treatment that may be required for those individuals involved in different types of drugs.

In addition to that, with the hallucinogenics or psychedelics, again this is my personal experience, I found that most of the people that I have had, and especially people that have gone to college, were searching for identity, trying to find out who "I am," where "I am going," what is "reality." I have noticed when many of them did stop using this particular drug they were usually involved in some religious type of activity as a solution to their personal problems.

Mr. NOLDE. And did you have thought on research on the college level?

Mr. YOUNG. Yes; we talked about this earlier because they are some of the things that apply to what happened this morning. Now, very seldom have I seen a black drug user who uses LSD or psychedelics, for whatever this is worth. I think that this might tie in with the reality things I said about kids in the middle class and upper classes, the things that they are searching for. So this research thing that I have in mind, I think this is why we need more of it in order to solve some of these problems that have been brought out during the hearing.

It is very complex and you can't involve the schools or the probation department or law enforcement. I think a total picture is required.

Mr. PHILLIPS. Do you think there are adequate facilities in the schools now to try to head off a kid getting into trouble before he gets arrested for a serious matter and comes to your attention?

Mr. YOUNG. Well, again, I am not at that level but from where I am I would have to say no, because I am still getting them as adults.

Mr. PHILLIPS. Are there any facilities you are aware of in the schools that could intervene when a boy starts to become a dropout, become a drug problem in the school; any facility at all in Alameda County where you can intervene?

We heard women testify that children died and no one seemed to be able to address the problem.

Mr. YOUNG. I think Mr. Kendall can respond to that better than I can. He is in the juvenile division.

From my standpoint of supervision on treatment, there really isn't that much. I think, as the two ladies pointed out, there is not that much in the community when you need treatment or help for the people that are using drugs. There is very little in the community in the way of assistance or what is available. Often there is a long waiting list or with the methadone maintenance program the addict will have to pay from $10, from $15 to $16, and often they don't have this money. It is like something there and it really isn't there. So I think that is what those two ladies experienced.

Mr. NOLDE. Thank you. Mr. Pelissetti, you are a probation officer for the San Francisco Probation Department. I take it you are in the intake section.

Mr. PELISSETTI. That is correct.

Mr. NOLDE. You screen all of the new drug cases coming in?

Mr. PELISSETTI. Yes, sir.

Mr. NOLDE. Can you give us some idea what the extent of drug use is among school-age youngsters?

Mr. PELISSETTI. To break it down into the different categories, marihuana is nationally the highest usage. I would say our San Francisco kids have got to be at the 80-percent usage level. By that I don't mean constant usage, such as everyday, I mean from one to three times a week. I realize that is a high figure, however, and I would believe approximately 95 percent of our children, ages 12 to 18, try it once.

With regards to the use of reds, secobarbital, which volumewise are the second highest used drugs, I would say about one-third of our teenage children are using them with frequency. The age of starting I would say is at the junior high school level, some at the elementary level, around the seventh grade. May I qualify this early starting period. I have noticed the San Francisco kids seem to start by glue sniffing and other so-called garbage items that they can take out of their parents' cabinets at home. They try to get high on aspirin, they get high on Darvon, diet pills, and so on. In fact, many have no knowledge what they are getting high on. Many of the younger children, who are not so intelligent, will take anything that they come across.

I think what we have to fight for and do, is to define the cause. Why at the point of the seventh, eighth, and ninth grade level, aside from making the excuse that it's a fad, why at this time do children start using drugs? I think the reason was covered in prior testimony regarding public advertisements. The thoughts with regard to avoiding pain, feeling good, and forgetting your troubles seems to be a Madison Avenue version of the "American Dream." It is a hard sell.

Mr. NOLDE. How old are these youngsters? I assume the cases you are dealing with are all youngsters?

Mr. PELISSETTI. Yes, sir; the youngsters I deal with range between ages 10 and 18.

Mr. NOLDE. How young are they when they start getting into drugs?

Mr. PELISSETTI. I have seen many cases starting in at about the 11-year-old level, mostly glue sniffing. I would say in 1968–69 we were getting approximately 100 referrals a year on glue sniffing alone. It was a fad at that time. It was the so-called t. ing to do. The stores in San Francisco for a great period of time afterward were selling glue, airplane glue, et cetera, to children only under supervision of parents. Some of the stores were. Most were very hard to control.

There aren't that many kids using glue anymore, too many know that it does cause brain damage. I wish to clarify one of the points that Sergeant Heonisch made today, which I thought was not really clear. I don't think he meant to say that there is no drug usage in elementary schools or junior high schools. I believe he meant to say there is very little of it reported at the elementary school level, especially in the parochial schools. I believe this is handled between teacher and parent.

With regard to the junior high level, some cases are reported to the police. In high school many cases.

Mr. NOLDE. How widespread is it, how available are drugs at school?

Mr. PELISSETTI. In San Francisco, the availability of drugs, in my opinion, is such that any teenagers in any school, and especially junior high school or senior high school, can get any drug in the amount of time it takes the seller to either go to his locker or to his car to get it. Odds are the pusher will be able to reach in his pocket and furnish the buyer anything ranging from heroin all the way down to marihuana. The only delays that exist are in the bulk sale; when somebody has a lot of money and wants to buy in volume he is going to have to wait perhaps a whole hour.

Mr. NOLDE. A maximum of 1 hour, in other words?

Mr. PELISSETTI. Yes, sir.

Mr. NOLDE. To buy any drug whatsoever?

Mr. PELISSETTI. I would say so. I don't want to be a prophet of doom, but if teenagers have the money they can buy anything they want at any time; it doesn't take much time at all; even to make a contact in a school where the buyer is not known.

Mr. NOLDE. And that is up to and including heroin?

Mr. PELISSETTI. Absolutely; either on the school campus or off the school campuses the time factor depends solely on where the seller has the drugs stashed.

Mr. NOLDE. Are these youngsters getting any sort of guidance or help from the schools, or otherwise?

Mr. PELISSETTI. Let's put it this way: If they are, it's failing in San Francisco, it's failing miserably. With few exceptions I would say the counseling programs in San Francisco schools are failing. I don't believe the counselors are trained to teach our kids about drugs. I think it started much too late. Programs start probably at junior high school level in San Francisco. The counseling seems to be taking mild effect somewhere between the last year of junior high school and the first year of senior high school. I believe it's too late at this point. Many children emerging from the initial, shall we say, the

"awareness years," third, fourth, fifth, sixth grades. have been misadvised by many of the elementary teachers regarding the effects of drugs.

When children graduate to the junior high school. where these drugs are much more available and they have already been told that they are going to either die or have brain damage from the use of marihuana, and then a counselor or teacher tells them heroin can lead to death, they just put one together with the other and they don't believe it. There is a big "unbelievability gap."

Mr. NOLDE. Thank you. Mr. Moresi. you are the senior probation officer in the Alameda County special drug unit, which you head. In your case the people working for you deal exclusively in drug cases involving juveniles.

Mr. MORESI. Juveniles and adults.

Mr. NOLDE. Would you tell the committee about the drug index you have set up?

Mr. MORESI. This particular unit, the intensive supervision unit within the probation department, has been in operation now for about 18 months. Part of the program of operation involved fairly intensive training for deputies in the unit even though for the most part they were experienced deputies and experienced in drug abuse. As part of the training we have developed what we call our drug index and it's our attempt really to do a number of things. Basically, what it boils down to is that we are individualizing the information that we are getting, our cases as they come into the unit for supervision. We have developed five drug indexes. One for opiates, on for stimulates, one for sedatives, one for psychedelics and one for marihuana.

Based on the questions asked in the drug index, such things as frequency of use. the amount of use, the effect it has on the person using the drug, the number of withdrawals that they have experienced, and several other items as they apply to the particular indexes, and then a secondary index which we call a progress national index which includes things like employment, education history, family stability, alternative relationships the person makes and generally keeps, their motivation for change. We are able to get a fairly concrete and fairly individualized picture of the individual and their drug abuse or drug use patterns.

It's been said many times, and I know you have heard it many times, each individual uses drugs for different reasons and uses them in different ways and, of course, they will respond to different kinds of treatment.

So, in effect, by gaining this information on an individualized basis we then can hopefully make the best use of the community resources and the resources that we have in developing a treatment plan for the individual.

Mr. NOLDE. In other words, you seem to identify the heaviest problems and give them the maximum intervention and the maximum forms of treatment?

Mr. MORESI. That is right.

Mr. NOLDE. Then down on a scale?

Mr. MORESI. Yes, sir; that is true. One of the difficulties in that respect is if you are dealing with someone and if they, for example, talk your language and if there are certain things about the person that you identify with, you may tend being human to have a halo effect, diminish really the kind of drug problem they have and not provide really the kind of service they need. But taking a look at all of the factors involved you can start off and not be 180° out with the treatment plan that you are talking about.

If you have a hard-core heroin addict then probably we are talking immediately about regular drug testing, certainly, and perhaps, we are going to make a referral to a residential treatment program or a methadone maintenance program if those things are available to us at this time.

Mr. NOLDE. What is your opinion of the overall drug use in the community among youngsters in terms of trends?

Mr. MORESI. I think the overall number of young people, and young adults for that matter, that are using drugs is clearly increasing in our experience.

Mr. NOLDE. What kind of drugs?

Mr. MORESI. With youngsters, with school-age people, primarily barbiturates and pills and in that sense many of them use marihuana as well. But I think that most of them probably do not abuse marihuana as they abuse the pills and barbiturates.

Mr. NOLDE. Pills and barbiturates are the choice?

Mr. MORESI. They seem to be and they present a very serious medical problem in that sense as well. With young adults I think we continue to see the abuse and misuse of barbiturates and amphetamines but also I think we are seeing a greater incidence in the use of experimentation with heroin.

I might also add there is a relatively new drug on the scene we are seeing more and more of in Alameda County and that is PCP.

Chairman PEPPER. What is that like?

Mr. MORESI. Phencyclidine is manufactured for limited purposes as an animal tranquilizer. The effects of phencyclidine are essentially to block out the muscle feedback that you get; in other words, if I hold my arm up this way the muscle tension and so forth tells me my arm is there. Phencyclidine will block out that sort of sensor or return and I lose sense of body image, sense of where I am and who I am and that sort of thing. It's a dangerous drug in that way.

M. NOLDE. Can you give us the estimate of percentage of youngsters coming through the Alameda County Probation Department who are involved in drugs?

Mr. MORESI. This is who have used at any time or those who have a problem?

Mr. NOLDE. Both.

Mr. MORESI. I would venture a guess, and they are really both guesses, but those that use drugs or have used any form of drugs at any time, probably in excess of 90 percent. Those that have a problem with drugs, serious problem, probably in the range of maybe 20 percent, 25 percent, something like that.

Mr. NOLDE. Thank you, Mr. Moresi.

Mr. Kendall, you are also a probation officer in the Alameda County Probation Department and you have responsibility for strictly drug

cases with a large number of juveniles in that caseload. What is your idea of the facilities that are available to help these kids with their drug problems, and the extent of drug use as you have seen it?

Mr. KENDALL. Well, I don't think it's fair to blame the schools for lack of counseling programs available. As we all know, schools are largely financed by the whim of the voter and most of the schools, at least the urban schools, are operating on budgets that are rather outdated. I think that they would like to do more than they have done. I feel that there are some schools even with lack of funds that are getting private financing for their programs out of foundation grants and the like. One school district I know of is negotiating with the local counseling center to provide alternative counseling for drug problems which I think is a good answer. It's a stopgap answer, perhaps.

I do feel that the answer to drugs in the schools isn't going to be by posting strong-arm monitors in the halls or just by providing a drug counselor to talk to kids about drugs. As Dr. Fort indicated earlier, I think that what is needed is a complete reform not only in curriculum but in teaching methods and perhaps even in the structure of schools.

I think school has to be a place that kids go to get turned on, not on drugs but on to education.

Mr. NOLDE. They are not finding that interest in the schools today?

Mr. KENDALL. Right. I think the education we are offering them is of the 1920's. They are finding out what the seven products of Argentina are.

Mr. NOLDE. How widespread do you think the use of drugs is among school-age youngsters?

Mr. KENDALL. In, I think, tracing it up through the schools. I don't see much of it in grammar schools. I hear of isolated incidents of kids using drugs, mostly marihuana or reds, Seconal in grammar school, but by and large it hasn't become a major problem there yet. But starting with the seventh grade, junior high school or middle school, that is where we really begin to see it happening, I would say around 13, 14 years of age. Mostly, I think, the greatest drug abused is barbiturates, and this is seen most of the way through high school.

As somebody said earlier today, everybody has a drug of choice, they like barbiturates, or amphetamines, or whatever. Some like PCP. Marihuana seems to be fairly commonly used by most of the drug users of my acquaintance.

I haven't seen a great deal of heroin used by school kids. Some do what we call chipping, use it on occasion but don't use it heavily. Where I have seen it used heavily is after they graduate from high school. As they get out into society and are unable to find a place for themselves, they fall into the routine of shooting heroin.

Mr. NOLDE. Thank you, Mr. Kendall. I have no further questions, Mr. Chairman.

Mr. WINN. I would like to ask a question that may be a little tough to answer. I am going to ask Mr. Young first, but I would like to hear from all of you.

Mr. Young, in your case do you counsel mostly blacks or do they point you that way?

Mr. YOUNG. No; I counsel whatever person I happen to receive; it is not broken down to any particular race.

Mr. WINN. If the young person on probation would know that if they were black and they knew you were available, do you think that they would rather talk to you than any of the other three?

Mr. YOUNG. I have heard some of them say that. They expressed that desire, but I don't think that is what it really is. I think that what is really needed, and initially that may have been a problem, whether the person is black or white, or of some other ethnic background. What is the importance of establishing a relationship? When something significant is developed between the two individuals, and I think that it can, the racial thing is not that important.

Mr. WINN. The reason I asked that is we had hearings in New York and we had some individuals from Attica prison come down and they testified that they wanted more black guards and the Spanish-speaking people wanted more guards and supervisors who were Spanish speaking. We spent quite a bit of time trying to figure out if that really was going to serve the purpose that they thought that it would. I just wondered if the same thing might carry over in the work that you four gentlemen are doing?

Mr. YOUNG. I think now what I see, I think what it does. I think they are saying they want someone who understands what their problems are. For example, when we are talking about the schools, I think when we speak of the schools in the Oakland area, say Skyline High School, it's a different cultural background from some school, say, in the central part of Oakland.

Mr. WINN. We are not familiar with the area.

Mr. YOUNG. For example, that is where, say, there is more wealth in the Skyline district.

Mr. WINN. Higher income?

Mr. YOUNG. Right. So I am using this as race. If there is a black person from a poor neighborhood and you got a probation officer who has no feeling and doesn't understand this. I think that is what they are getting at. So if some person had that ability and that knowledge, that information, I think he can work with them.

Mr. WINN. Who makes the assignments to you gentlemen?

Mr. YOUNG. The senior D.P.O., like Mr. Moresi here.

Mr. WINN. How do you decide, do you have any criteria?

Mr. MORESI. Criteria, yes. Generally, I know the deputies in the unit, I know them quite well. Often we don't have enough information about a particular case as it comes in, however, to make the most appropriate assignment at that time. By and large what we have is the court report information plus whatever the investigator may call and tell me about a particular case. In fact, the investigator may suggest someone in the unit for assignment. Once we make the assignment it is not an irrevocable, irrefutable thing, however, and if it turns out that this particular deputy can't, or feels he can't, work best with the case then they will come and let me know and we will transfer the case to someone we think may be better suited.

Mr. WINN. I didn't hear the last.

Mr. MORESI. After working with a case for a period of time if the particular deputy feels he cannot——

Mr. WINN. He asks to be transferred. What about the young person involved, can they ask for a transfer?

Mr. MORESI. They can ask for a transfer as the adults can as well, and they will always have a hearing on the matter. Sometimes I view

the request for transfer as a manipulation on the part of the young person involved. They feel the probation officer is putting too much pressure on them.

Mr. WINN. Let's take a case that seems to be so prevalent, that we hear about and we have heard about several of them today, of a rebellious young man in and out of school. We have heard this in every city we have gone to. And he finally comes to you and you know that much background because he's been in and out of three or four or five or six or seven schools and nobody can handle him, the parent can't handle him, or the school authority. How would you screen this guy and how would you assign him, based on what criteria?

Mr. MORESI. Well, if we just have the information recording his rebelliousness and don't know too much about his drug abuse and this is the only thing we are keying on——

Mr. WINN. Don't know too much about what?

Mr. MORESI. Drug use or abuse, and this is all we are keying on, is the rebelliousness, I might be inclined to give the case to Mr. Kendall who tends to have an awful lot of patience, who will go way out of the way to work with an individual to meet him more than halfway, who can tolerate, I think, a considerable amount of rebelliousness and has a lot of patience in that respect. So based on that limited information, that is what I would probably do.

Mr. WINN. Do you gentlemen counsel with girls, too?

Mr. MORESI. Mr. Kendall does. He may wish to comment.

Mr. WINN. Do you have women counselors, too, separate ones that deal mostly with girls and women?

Mr. MORESI. Traditionally in the probation department women probation officers have supervised women probationers. That is changing and has been changing over the past few years.

Mr. Kendall supervises some girls and I think one adult woman. We have one woman in our drug unit who supervises primarily women, but some of the male adults, male probation officers, with adult male caseloads also supervise women where we think that the matching of that particular case with that deputy is more appropriate regardless of the sex of the individuals involved.

Mr. WINN. Do you find the whole problem of a woman or girl not being able to talk to her father and so she can talk to you as if you were her father?

Mr. KENDALL. Well, I hate to generalize.

Mr. WINN. That may be kind of far fetched.

Mr. KENDALL. Yes, I think often I have filled a father role. It's difficult to generalize unless one has a lot of specifics about a case.

Mr. WINN. Can you tell by the way they talk to you?

Mr. KENDALL. Yes; I think so.

Mr. WINN. You can spot it pretty fast if they want someone to talk to?

Mr. KENDALL. I think it's really easy to tell when a girl needs somebody, especially a father type, that they can relate to.

Mr. WINN. Do most of the young people criticize their parents somewhere in their conversation with you?

Mr. KENDALL. Almost always.

Mr. WINN. Both parents?

Mr. KENDALL. Yes, both parents.

Mr. WINN. Sooner or later both parents?

Mr. KENDALL. Many of my kids have only one parent present in the family and may not even know the other parent well at all and are rather neutral.

Mr. YOUNG. I would like to respond to that. I would like to make another statement. We have two drug units. For example, Mr. Moresi and Mr. Kendall, they are in one which is composed of six persons, six other deputy probation officers, and I am in the other unit. We have 12 people that are concentrating on combating drug abuse.

Now, in response to your question that you asked about parents, again I am speaking of adults, after they get to me. Looking back historically, what preceded the man before I got him, in his relationships with his parents. What I have noticed, and this might also apply to other crimes, but I am tying it in with drug abuse. I would say almost without exception, all these persons that are on drugs—too bad Dr. Fort isn't here now, maybe he could respond to this—there usually is over indulgence by the mother. By some other person, if he doesn't have a mother. I kind of got that feeling about the mother that testified here, with Mrs. Murphy. I believe this type of indulgence is not knowing what the child is doing, not knowing his peers, not knowing where he is and letting him get away with misconduct by not correcting him and giving in to his desires, is the pattern seen in the parental supervision of drug abuses.

I feel this has something to do with the child's drug use. If he wants something he gets it. The drugs act as a substitute for the type of things that he isn't getting or getting in the wrong way from either the parents or someone acting as parents.

I think all of us DPO's would testify to this. Usually when they marry it's a woman that is filling the same kind of role the parent did. One of the things that I try to use in the treatment process is if the person has a wife like that, is to get her to change her mode of dealing with him where she is no longer indulgent. Often this has helped the drug abuser to straighten up somewhat.

Mr. WINN. Don't you think though—and I thought your answer would be that most of them mentioned their parents or criticized the parents—don't you think that is an easy out? In some cases it's probably very true. This is the basic reason for their problem, one of both parents, or not having one parent. On the other hand, don't you think it's an easy out because they don't want to say, "I was wrong. I was wrong all the way. I did it because my peers were doing it and I thought it was the great thing to do"?

Mr. YOUNG. I think we are getting now into methods of treatment and my response to that is what I try to do is deal with what is going on now and try to make the person responsible for where he is at this moment.

Mr. WINN. I am glad you picked that up. What you are talking about, where do we go from here, forward, and don't let's go too far back.

Mr. YOUNG. Because I can't do anything about what happened.

Mr. WINN. You can't do anything about that. I am sorry I took so long on that.

Chairman PEPPER. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

I am certainly not happy to hear your testimony but I am happy to hear that we have four gentlemen here who are in great contrast to the four gentle- we had this morning. I think I understand the program and w going on in your community.

Mr. Young g back to this business of the overindulgence, I don't want to ma this a course in social studies but one of the things we are hearing from the youngsters in the schools is that there is no discipline and what they would like from their teachers and superiors is a line which they know they cannot cross; especially in Miami we heard this. A criticism of the teachers, who won't discipline the kids at all. The youngsters seem to be looking for some direction through discipline and they don't seem to be receiving it.

I wonder if you would agree with that?

Mr. YOUNG. Well, I think when they talk about these treatment methods and the ones that have been successful, like in the residential programs. Well that is precisely what goes on there. There are rules that are set down, people are required to respond in a responsible way and it's expected.

Mr. MURPHY. Synanon?

Mr. YOUNG. Synanon.

Mr. MURPHY. All the programs that I have looked into and investigated and had any insight into, the director of the program is usually a no-nonsense guy. That is why I suggested earlier, and it seems to be one of the recommendations at least I will come up with when this committee meets, that when you have someone on a peer level going into the school and giving instructions on the drug scene, you can't condition that person. Someone who is using drugs is pretty sharp and they will start conditioning somebody, and especially an older person who might not have had that experience. They won't know the lies and they won't know the tricks. One of the things that someone who is responsible and who has had a history of using drugs, will know is when he is being conditioned because he will say to the individual: "Listen, I tried that stuff, don't give me any of that, you are not being strong, you are not finding yourself, you are not being true with yourself." This is why I would like to see, as the fruits of these committee hearings around the country, a recommendation that school boards incorporate in their programs, along with their counselors, graduates of these various programs such as Synanon, Gateway, Seed, so that you have someone who is not easily conditioned. You fellows probably heard all the stories from A to Z and you know when you are getting conned and you know when you aren't. It's an automatic response. What would you think of a program like that?

Mr. YOUNG. I think that is an excellent idea. I think you do need a combination of someone who has been through the drug abuse situation plus someone on the other side who can relate to the kids.

Mr. MURPHY. Thank you, gentlemen; I appreciate your testimony.

Mr. BLOMMER. I would like to ask you a question. I think you were here this morning when Dr. Fort made a great point of saying that alcohol is by far the biggest drug problem we have in the United States.

I wonder if you think that is true among young people?

Mr. PELISSETTI. I have noticed in the last few months, that alcohol has been on the upswing. I would say that marihuana with regards

to the minors, the 13- through 18-year-old group, is most frequently used. However, I am seeing a swing now, not so much in San Francisco but in Marin County and other suburban areas, back to the alcohol: so I would say yes, alcohol is a definite problem. I see a lot of mixture of wines or beer and reds, and that is dangerous.

Mr. BLOMMER. I was going to say isn't that especially dangerous to mix barbiturates and alcohol?

Mr. PELISSETTI. Absolutely. Most of the kids realize this.

Mr. BLOMMER. They do realize it?

Mr. PELISSETTI. Yes, sir.

Mr. PHILLIPS. They do it anyway.

Mr. PELISSETTI. I find it absolutely amazing. Another danger existing in San Francisco is the modest availability of poisonous psychedelics and amphetamines. There is so much poison going around, so much cutting of these drugs with arsenic, et cetera, that kids don't really trust the "buy," especially the psychedelics. They usually learn this through experience and not from someone else. Every once in a while they see a convulsion in the hallway at school, more often than not they swing away from the psychedelics because of bad trips and from getting absolute poison in their system from making bad buys. Thus, many kids mix barbiturates with alcohol to experience what they used to get from psychedelics.

Mr. WINN. I wanted to ask one more question and I didn't want to ask it while Mrs. McNeil was here.

What happens when you get a case like that. From her testimony I gathered that she had had several conversations with her daughter about her daughter's drug problem and she was aware of it and the daughter admitted starting on marihuana and trips on her wine. I am sure that Mrs. McNeil didn't know quite how to handle it other than normal parental admonishment that it's not right and it's wrong and you ought to quit it.

What does a normal parent do in that case, using her example, just what you heard and what we heard, without any background? I am sure she didn't know anything about drugs. Other than the parental love what else could she do?

Mr. MORESI. This is the most difficult question I think most parents face, and partly their response is one of almost willing to deny the problem on occasion or at least wanting to minimize the seriousness of it and hope it's like the first time your kid takes something out of the store when he is 5 years old. You hope if you take it back and so forth he won't do it again. But I really think that, as has been probably demonstrated to you gentlemen over and over again, this is part of the educational process that I think has to go on outside of the schools for the parents. At that stage the kids are so much affected by their peer group and so much inclined to follow what their friends are doing, a parental admonishment simply is not going to be adequate and as soon as teacher or parent learns of a drug problem they really need to pull out all of the stops and investigate the situation as thoroughly as possible; and given the limit types of the treatment resources that are presently available, at least make every effort to seek treatment through a doctor. Presently at least in the Bay area, there are a number of crisis information programs where at least if you call up you can get the name and address of some drug programs or some

physicians that are knowledgeable about drugs and follow up from that standpoint.

Mr. WINN. It seemed, by what we heard, that she did try to the best of her ability. She went to the school, went to a job placement bureau and got a list of jobs. She also told the other side of the story where the daughter had the list and didn't follow up on it. That daughter didn't seem like she was about to go out and get a job; she seemed to be enjoying the free time, which I am sure a lot of the students do. It's a real problem for a mother, and I gather, too, that she was raising two children practically by herself. I don't have the background on the woman, but that is a real problem. She didn't know where to go and when she went to the school they didn't help her.

Mr. MORESI. Apparently, she didn't get much mileage out of the school counselor. We don't know what went on in that discussion with the school counselor, how much information she gave the counselor and so forth. Frequently it's the case in discussing a problem with the parents they will minimize it with us, too, so we don't get a complete picture always, at least immediately, of the nature of the problem.

Mr. WINN. The odds are, particularly in the mother's case—well, I suppose the father's, too—they are going to protect the drug users.

Mr. YOUNG. I think something else comes up: I think we are talking about two things. We are talking about where can you go for help, then when you have an individual and the help is available, will the individual accept it. I think perhaps that might have happened with the lady's daughter. I know I have experienced that. There are times you can refer the drug abuser but usually he is not motivated. One of our biggest problems is trying to get the person motivated to seek the help.

Mr. WINN. The girl died when she was 18. At that age that girl is pretty much running her own show.

Mr. YOUNG. Yes, sir.

Mr. WINN. And the parents are almost helpless, aren't they?

Mr. YOUNG. Right.

Mr. WINN. Thank you, Mr. Chairman.

Chairman PEPPER. Mr. Kendall, I understood you to say, what I believe very strongly, that you believe that a great deal can be done in the schools if they have the funding and if they develop the imagination and try to bring the proper personnel into the picture to prevent drug abuse by the young people and to turn them off after they have started on it. You do believe that is possible?

Mr. KENDALL. Yes, sir.

Chairman PEPPER. The kind of curriculum that would be exciting to them. In other words, I understand you to suggest that the kind of curriculum, the kind of school atmosphere and program which might turn the students who are accustomed to drug abuse off of drug abuse, might also turn those students and the other students on to education and the like?

Mr. KENDALL. Right. There are lots of things that schools are experimenting with, especially in Oakland at this [illegible], not necessarily in the field of drug education but teaching techniques that are really beginning to pay some dividends.

But also I do want to give a plug for the Oakland public schools in that they have a drug education coordinator who has, during the past

year, developed a curriculum packet for the K through six grades where he atempted to infuse the drug education into a general curriculum type of approach rather than make it a special drug education program. I am not totally familiar with it but it sounds like a good approach to me.

Chairman PEPPER. That is creative thinking in the field of how to deal with the problem?

Mr. KENDALL. Yes; and now the same person is working on a curriculum packet for the advanced grades.

Chairman PEPPER. Very good. Do you agree, Mr. Pelissetti?

Mr. PELISSETTI. Yes, sir; I do agree. I would like to add only that I feel that it's important that there is a coordination. Any dealings with regard to the drug abuse program with the kids has got to be one that is realistic. No. 1; No. 2, has got to be one that is followed through all the way up the line. In other words, these drug problems are first discovered either at home and even more usually at school. From that point, somewhere along the line, law enforcement enters in, whether it is the police department or whether it is the probation department. One of the things we are fighting for, or at least we might as well start trying to do, is to coordinate the activities of the school with the police and the probation so that we can establish some honest trust with the kids. This is going to be a monumental task but I think this is where the solution lies because I don't think we will be attacking the effect anymore—the effect of the drugs—I think we will get to where we should be; into the cause why they are taking them.

Chairman PEPPER. We had a very interesting bit of testimony in Chicago from the deputy to the State's attorney in Cook County, apparently in the case of teenage arrests that had some relationship to drugs, relatively minor offenses, where they would have them come in on Saturday mornings, they would give counseling to them, they have group meetings, have people there to talk to them. They carry that on for quite a period of time keeping them under the general supervision of the court, and that way they have been able to prevent most of these people from getting involved again in drug offenses or drug-related offenses one way or the other. We had another case where the police had a unit of its own where they would do the same thing; try to help those who came into the custody of the law in the early stages of their lives, to try to help them to find a way to get out of it.

Mr. PELISSETTI. This is what I was speaking of when I was talking of the realistic approach, the manner of dealing with the kids. Once they have been referred to the legal system, it seems to me that you can attract more flies with honey than you can with vinegar; if the kids feel they are going to receive help they will open up, and I find this especially true when I can talk unofficially with the kid who is referred in for a theft crime. Usually I can detect that he is stealing to buy drugs. If I can put that crime aside momentarily, whether I am going to bring him to court or not, and make him aware of this, then say "OK, let's discuss this drug problem," it works.

Chairman PEPPER. Mr. Young, do you want to add anything in this general area?

Mr. YOUNG. Well. I agree with what you said and I somewhat disagree. I would draw some exceptions. I don't think we can put, and perhaps you weren't doing this, all of the schools in the same category. This is why I say this. I think from what I have said and heard. kids will turn on to drugs for many different reasons and when I use the situation at Skyline High School, I think what might work in that school as to educational programs, would not work elsewhere, especially in a ghetto school. So when you say create some imaginative new programs, that is really a big statement. I am not sure at this point if we really know what that is.

Chairman PEPPER. Maybe we don't. Maybe that is what we are looking for. It's the job of somebody to try to help them find what is the real meaning of life.

Mr. YOUNG. That is what I think is going on. I agree. I think if there was some other way to turn on other than drugs I think perhaps they would do that. But I think you have a better chance with the innovations and the imaginative approach in dealing with the middle-class schools and upper-class schools rather than the ghetto schools.

Chairman PEPPER. Isn't it obvious that, as you gentlemen have suggested, all of these various things have to be related; we have to have the whole spectrum covered. Of course, we need to do more in the home. We can do more. I feel a great deal more, than we are doing in the schools. The school has the child for several hours, 5 days a week, and the parents are usually too busy with one thing or another. So the schools, with all of their personnel and facilities and potential, seem to me to be an area where a great deal of good can be done. Then, of course, there is a great community outside for the cases where there will have to be medical care, perhaps where some drugs will have to be used such as in detoxification programs and then the law aspect of it, the probation. You gentlemen represent one of the most important aspects of the whole correctional problem, having enough properly trained probation officers. You gentlemen seem to exhibit a very high quality of competence and understanding which is so greatly needed in this critical area over the country. They have caseloads of 125, 150. I know in Washington they said that the secretary of the probation officer called up oftentimes the person that is on probation and said now your probation officer has his eye on you, he is watching you and all. But, anyway, all of these agencies, the community, the schools, and law enforcement officials have to work together. Each one has its own enlightened part to play.

Mr. Moresi, anything you would like to add in this area?

Mr. MORESI. No: I think it's all been said really and quite well. I agree with what Mr. Young just said, in essence, there has to be modifications from school to school and so forth.

Chairman PEPPER. Yes, of course; it will be up to the school. I am not talking about the Government telling the schools what to do. I am simply thinking that given the means to experiment they will find one thing works and at some other schools another thing works, but the best will gradually emerge from the educational knowledge of the educators of the country and it will begin to be followed. I don't mean to hand them down any script. I mean simply give them the money to try to work out the best kind of program that they can devise.

Mr. WALDIE. I am never convinced when I hear someone say that the answer is to change schools so you can turn on the school and don't have to turn to drugs. I guess that is the answer to a more perfect society, too, we don't have to turn on with alcohol, we can turn on with whatever we are confronted with in life. But that doesn't really give me much conformity. We aren't going to make much progress in that direction watching the statistics.

I am puzzled, and there was an allusion to it but we have never pursued it, is there a hands-off attitude when selling and traffic in narcotics is taking place on a school campus, secondary and elementary, that for some reason or another there is a sanctity to those premises that limits law enforcement? There would be no such restrictions or sanctity if it were taking place in a movie theater where the young congregated, or a drive-in where the young congregated. The law enforcement people would quickly exercise to the extent they could their authority.

It seems to me, parents ought to be assured that when their child goes to a school that every effort is being made, at least, that that child will not be exposed to the traffic of drugs within the school system.

I am not personally convinced that those assurances can be given now. There seem to be a tolerance that I detect that when it takes place on the school campus that it's the responsibility of the school administrators and not a problem so much of law enforcement but a problem of education. Their problem is alone where it's a problem of education, but when they are dealing on the school campus, when they are used as agents for those off the campus, then it's not a problem of education, it's a problem of law enforcement. It seems to me that someone ought to be assured that maximum efforts are being made to prevent that by the tools of law enforcement on the campuses just as you would prevent it at the local drive-in, or local movie theater, or the local gaming high school parlor, or whatever it might be.

Do I gather from the conversations that you have engaged in with members of the committee as well as from other witnesses here today that there is an invisible line that restrains law enforcement from actively seeking to curtail the traffic of drugs on the campuses of the schools in Alameda County? I have been told that your drug unit didn't even go on the campuses. I have been told they are so busy on the street they can't get on the campus. I am curious. Is that in fact the case or, in fact, is there a policy that says the campuses are different than elsewhere and, therefore, we only go on the campus when full cooperation is extended and if it is not we don't go there even if we are aware dealing is taking place on the campus to the degree that is discernible to everyone in the community?

Would any of you comment. Is there a hidden restraint or is there a feeling that drug dealings on the campus should be more or less within the purview of law enforcement than drug dealing elsewhere in the community?

Mr. MORESI. It's been my experience in discussing the drug problem on the campus with certain members of the Oakland Police Department they do not feel any restriction about their role on campus. I think they feel they have as much responsibility to police campuses as they do any other area.

Mr. WALDIE. Let me stop you there. One of you said in 5 minutes you could take $100 and buy any drug anywhere on any school cam-

pus in this community. If that is so, do I gather that it's hopeless to try to stop dealing on the campuses; it's either hopeless or no one is doing anything else about it, or if they are doing something about it they are not able to stop it.

Is the latter the case?

Mr. MORESI. I think there are a fairly large number of young people that deal in drugs and I am thinking primarily of drugs like marihuana or barbiturates and not so much heroin. I think the police, by and large, are trying to focus not on the relatively small pusher on the school campus but trying to get the guys supplying the drugs to these particular pushers.

Mr. WALDIE. But they are not succeeding at all and that big pusher doesn't reach my child; it's that relatively small pusher that reaches my child. If my child goes to that school I have some control, not enough, over where else he goes, but I have no control over that school. He has to go there, and I don't get any hope or any encouragement from anyone saying that the problem is soluble. That statement is thrown out at every committee hearing we have: That you can buy as much drugs as you want, of any quantity and any type on up to heroin—which was a statement made by one of you, I think, Mr. Pelissetti made it today—in a moment's notice on any campus in the areas under your surveillance.

If that is the case, either law enforcement is lax for some reason, or the problem is beyond law enforcement.

Is there any middle ground that I have overlooked between these two extremes?

Mr. KENDALL. I don't think you are going to be able to eradicate pushing drugs on campus. Or even if you could, if your child wanted drugs he is going to get them off of campus.

Mr. WALDIE. I am not even talking about eradication. We are not describing eradication: we are talking about control: $100 in 5 minutes to permit you to buy any kind of drug you want is far beyond the problem of eradication.

Is anything being done to control the access and the availability of drugs on the campuses, if that is an accurate description; or is that an exaggeration?

Mr. PELISSETTI. With regards to the knowledge I have on this subject, through speaking to the kids and police officers and teachers, the way I look at it is it's not a problem that cannot be solved. I think that there are two approaches that can be taken. One, we are going to have to change the philosophy that obviously exists in the school now, of teachers and counselors keeping hands off the kids on their sales.

Mr. WALDIE. Is that a philosophy that exists in the schools?

Mr. PELISSETTI. Yes.

Mr. WALDIE. And does that philosophy extend to the point where they don't cooperate with law enforcement officials?

Mr. PELISSETTI. I would not say that. I think the reason for the philosophy—I guess I am using the wrong word—the policy, is to keep hands off and the reason for that is fear.

Mr. WALDIE. What about law enforcement officials, what keeps them from bringing that matter under control, if it's that widespread?

Mr. PELISSETTI. With regard to the junior and senior high school level, mainly the fact that you can't find too many 21-year-old police officers that can pass for teenagers. Every now and then you can.

Mr. WALDIE. If that is the conclusion, then you end up as one of the two alternatives that it seems insoluble.

Mr. PELISSETTI. I believe not. I believe that we can start to solve the problem by instituting a policy to cut back the amount of sales and dealings on the school. This policy must enlist our good teenagers and it must be made rigid.

Mr. WALDIE. Make it what?

Mr. PELISSETTI. Make it rigid. When someone is selling in school it would have to be a rigid policy when you are caught you are going to be referred to the police and on upward. You can perhaps make that punitive or you can perhaps make that more of a discussion situation. There are ways of coordinating this.

Mr. WALDIE. Is that the way they have been doing that in the past, the discussion situation?

Mr. PELISSETTI. Well, in San Francisco no plan has been adopted. There is no consistency. Leadership is missing for numerous reasons.

Mr. WALDIE. You concur that it hasn't worked, whatever we have been doing in the past?

Mr. PELISSETTI. Absolutely.

Mr. WALDIE. So whatever we have been doing in the past has been insufficient. What this committee wants to know is what can we do in the future to better the situation, and once we have that in mind we can determine what the Federal role is.

I have not yet heard anyone suggest anything I could put my hand on as to what we could do except make the experience in the schools so exciting that you turned on with the school curriculum rather than drugs, and that doesn't give me much to put my hand in.

Can you give me concrete examples in your experience of what you think we could do to stop the traffic in drugs that takes place on the campus?

Mr. PELISSETTI. I believe that if we can institute a program whereby we are not talking about only punitive measures with the kids, where we can develop the situation where when someone is either observed by a teacher or another student, the name is passed on, the person is contacted, that there can be a counseling, a full discussion, and an attempt to find the reason why this person is selling, or using, or both.

(The following was subsequently received in further response to Mr. Waldie's question:)

HOW TO STOP TRAFFIC IN DRUGS THAT TAKES PLACE ON THE CAMPUS?

In San Francisco, as in most cities in the United States, there must be the following: *Resources*, namely people who know and understand the drug problem. There must be leadership over these people. There must be sufficient money available to allow these people to continue working a consistent program. The program must be rigid, constantly reviewed for implementation or change when any aspect starts to fail.

In the national picture: There is a sufficient amount of money being spent at this time. The reason why this money seems not to be enough is because it is going in too many different directions. Many people and organizations receiving funds or grants make very good use—MANY DO NOT. There is little follow-up, no centralization of results from these programs.

In San Francisco: Here the problem goes somewhat unchecked because of the above reasons personified. There are few people with even minimal training. There is no central office where information can be handled and given out. There are many crisis clinics, programs, and hospitals able to handle problems, however even within these organizations there exists a lack of trust and Communications.

San Francisco could be assisted greatly by a program aimed directly at the schools with the School Dept., Police Dept. and Probation Department working

hand in hand to reach the user/seller—if there is the proper leader, the man able to make a cohesive unit with these departments. It will take a "salesman" to present this to the kids and be accepted. Once the trust factor is established with the kids the drug problem will be more than vulnerable. It can be defeated. I have made this proposal within my department, to my Chief; he is enthusiastic and feels that it can work, however I feel the chance of this being established in San Francisco is slim because we lack funding. This idea is not original—to a small degree it exists in many cities, however no one has tried to concentrate the efforts. Community relations divisions of Police and Probation Departments are finding some success, but limited because they don't coordinate their individual activities. They don't share their successes and failures, they waste much time and money and frustrate their dedicated personnel on failures that could have been avoided if they had compared notes with other departments and cities. Goals must be defined, both immediate and long range—funding must be assured—control need not be gaged to successes immediately, it must grasp the knowledge gained by the worker, digested, and the master plan changed according to individual success. The result will be a successful program which will include all aspects of the problem, both Cause and Effect.

ARMOND PELISSETTI,
Probation Officer—San Francisco.

Mr. WALDIE. That isn't being done?

Mr. PELISSETTI. No, sir.

Mr. WALDIE. Is it not done because of lack of resources?

Mr. PELISSETTI. Numerous reasons: fear of retaliation, no student trust, lack of resources, and many more.

Mr. WALDIE. You mean fear of physical retaliation?

Mr. PELISSETTI. Physical retaliation, damage to teacher's personal property. This sort of thing exists. It's more or less hands off at that point. It would be foolishness on the part of one teacher out of a hundred to go up and say listen, "I am going to save you, come and tell me why you are using drugs." If you are going to have an effective unit in the school, you must have the kids instructed in the class as to what the purpose of this unit is, and if they want aid that they can receive full aid from this unit.

Mr. WALDIE. At this point it's a law enforcement problem, isn't it?

Mr. PELISSETTI. Yes; I believe it has to be.

Mr. WALDIE. Whatever the causes are, whatever the causes of the deterioration and condition at this point, it's a law enforcement problem, it seems to me, less than an educational problem.

Mr. PELISSETTI. It's a combination. Law enforcement, teamed with education must fight the deterioration of the youngster and the family structure which exhibits itself in the abuse of drugs.

Mr. WALDIE. That is the motivation for the user, but I am talking about the dealer. That dealer is on campus to earn extra money, and from what my own youngsters tell me the primary motivation of the people they know on their campuses that are peddling drugs is to earn money. They are not hooked, they are earning money and they are trying to increase their allowance by selling drugs, and they are getting it from somebody, which is a concern of law enforcement. But it does seem to me that if kids were selling drugs on the corner, and were identifiably selling drugs on the corner, you would arrest many. But you don't arrest them in the schools. I gather you cannot infiltrate as a student or undercover agent. I didn't know what the reason is. But there seems to be greater sanctity from law enforcement on the campuses than almost anywhere else in the community. Am I correct in that from what I have heard. At first I would have had trouble finding out where to buy drugs in San Francisco, but now, from what you have

told me I could go to any school campus and buy them, they are so identifiable. But if I weren't familiar with the community I wouldn't know what neighborhood to go to. I suppose there are some neighborhoods just as accessible for drugs as the campus. But on the campus—unless you exaggerated in your comments and I want to ask you again—in 5 minutes for $100 you can buy on any campus in San Francisco any drugs you want; is that correct?

Mr. PELISSETTI. You don't even have to go into a $100 amount.

Mr. WALDIE. I mean you could buy with $100 a variety of every drug that is available on any campus in San Francisco?

Mr. PELISSETTI. Surely. I don't feel that is an exaggeration in the least.

Mr. WALDIE. As the counsel said, I don't think it's an exaggeration either. It was demonstrated by one of our own people in Chicago. There is a breakdown somewhere and I know because everything is so bad everyone turns to this stuff. But either you can stop dealing on the campus by arresting people that are dealing, or we have to shrug our shoulders and look for societal solutions which are general in their measurements; and I haven't heard anyone tell me what we can do on the campuses to stop dealing in drugs.

What do we do to stop dealing in drugs beyond trying to stop the guy that wants to buy it. His problem is one problem. What do we do to stop it being sold on the campus, or can you stop it being sold?

Mr. PELISSETTI. Yes, you can; but not with one simple answer. You employ a program with combined efforts of parents, teachers, counselors, probation officers, police, and the kids themselves.

Mr. WALDIE. Maybe I am asking the wrong people. I will ask others.

Mr. PELISSETTI. I would respond a little bit, I know the Oakland Police Department in the last year or so has something of a policy at least to focus on the pusher and not to be as concerned about arresting kids for using only. So they are making an effort in that area. They have limited manpower, I know that, so they are trying at least to marshal and focus the manpower they have on the pusher. This is insufficient. Both pusher and user must be identified, contacted, and dealt with. The way to solve the problem is to attack it without reservations—all aspects of it; on and off campus both.

Mr. WALDIE. The business of expelling a kid who is dealing is a tragedy for that kid, but it's an equal tragedy to let that kid remain on campus and continue dealing, if there is no way of controlling him.

The only reason I mentioned the Oakland people is we were visited by their narcotic juvenile people that were here this morning. You may have been here, perhaps not. They didn't go on campuses, but they worked in the street because they have too much to do on the street. I suppose that only means one thing. Given the manpower and the resources they could do the job that they perceive needs to be done, which would include campuses. And that the problem in San Francisco may be the problem throughout the country, that there are not sufficient resources allocated to it. Certainly if you have a caseload of 100 people there are not sufficient resources allocated to your end of this problem. With 100 people as a caseload for probation work, that seems to me to be an incredible amount of people that you can skim over. I don't want you to get into that really because probation

isn't the function of this committee. I really want to know what do we do about stopping the dealing in the schools?

Mr. YOUNG. The thoughts I have on that. I think that you are talking about prevention in a certain area and I think in the school setting you are talking about education. I think that is where the conflict is. The school authorities are thinking if we want to educate we have to have the trust of the students that are involved.

All right now, for example, I am against having police officers on the school campus because I think it does just what has gone on there. I think the kids will hesitate to come forth and talk about it when they do have a drug problem. So I think we have to ascertain what it is we want to do. This is what Dr. Fort says. What are the goals? Maybe we will have to put up with having pushers and the guys that are dealing until we get the educational means of teaching kids or at least inducing them to stay away from drugs.

(The following was subsequently received for the record:)

COUNTY OF ALAMEDA HUMAN RESOURCES AGENCY,
Oakland, Calif., October 12, 1972.

HON. CLAUDE PEPPER,
Chairman, Select Committee on Crime, House of Representatives, Congress of the United States, Washington, D.C.

DEAR SIR: During the testimony before the House Select Committee on Crime, the Honorable Jerome R. Waldie asked specifically how could police action be used on the school campuses to thwart or apprehend the drug pushers.

I would like to present the following ideas for the committee's consideration.

The main problem with having police on the school campuses to deal primarily with drug pushers is trying to overcome the general lack of confidence and rapport that the students, some teachers and many parents have for law enforcement. To get around this obstacle, I make the following suggestions.

At the elementary school level, there should be a person designated with a title that denotes *protection* or *help* for the students. This person or persons should not only be knowledgeable about narcotics and dangerous drugs and their impact on the user and the community, but also this person should have added responsibilities in the area of student protection, health, safety, etc. This person should have the power or authority to effect a peace officer's arrest on campus.

Establishing a program in the elementary school as outlined above would accustom the children to seeing and, hopefully, accepting this person as one who is there to *help* and *protect* them from whatever source. This person would have contact with the students in areas other than drugs. I believe this would augment the person's effectiveness. He would not be seen just as the "Narc".

Regarding drugs, his primary emphasis would be prevention and education as to drug abuse and would include soliciting the students' aid in keeping drugs off the campus.

This same individual would work with the parents, the P.T.A., and other school community organizations in his role of *student protection.*

It is important that the individual that assumes these responsibilities be given a title or designation that clearly shows he is on campus to protect or aid the students.

As I said during the hearing, there are no easy answers to this drug problem, but we have to keep trying.

Sincerely,

ESKEW YOUNG, JR.
Deputy Probation Officer II.

Mr. WALDIE. The difficulty is we have been operating on that thesis and everything shows the parameter of the curve going up and nothing shows it coming down. I know you lose the confidence of the kids if they think a narc officer is on the campus, but I think it is equally bad to lose kids to narcotics that they purchase on the campus when the presence of a narcotic officer on a campus would stop the dealing, or di-

minish it, or slow it down. It would be a worthwhile loss in some confidence, I think, a great deal of lack of confidence in kids that don't deal with narcotics knowing it's prevalent in the school. I don't know how much opportunity you have to talk to kids who don't use narcotics but see it being sold on a campus, and there is a failure of morals on their part that is permitted to continue on the campus and they are not enthusiastic about it.

I used to think, as has been said, that the educational function requires confidence of the students, and the policemen on the campus would limit that confidence. But those were in the days when everybody said we have the answers, which is to educate people and tell them how bad this is and they will stay away from it. I don't see that answer working at this point. I am willing to almost conclude—I am willing to conclude—we have hit a crisis stage and we had better start moving to a law enforcement approach while we are working on the long-range solution.

Mr. YOUNG. I think if you look historically, the things you are saying about this in the areas where they are now, there was law enforcement and it didn't work then.

Mr. WALDIE. Was there law enforcement?

Mr. YOUNG. In the ghetto before it moved out into areas where it is now, they were doing these things, busting people, but it didn't stop the drug abuse.

Mr. WALDIE. Were they busting them for use?

Mr. YOUNG. For both.

Mr. WALDIE. I am not suggesting busting for use, busting for dealing in the ghetto where there is much dealing. I assume most of that dealing was on the streets.

Mr. YOUNG. Yes, most of it would be on the street but there were activities in school where drugs were being sold. The answer to it is exactly what Dr. Fort says, to dry up the source where they can't get the drugs.

Mr. WALDIE. If we could dry up the source, clearly that would be the answer but we have been trying to dry up the source since the beginning of time and the source gets larger and you don't dry up the source by making it legal.

Mr. YOUNG. I think we are right back to what I said in the beginning; that we are asking for some tough solutions and I don't think we know what they are yet.

Mr. WALDIE. We don't; I am the first to concede that, and the deeper we get into it the more readily I am willing to concede that we don't know the answer. We have been found daring and the problems have gotten worse, but one thing that I see is that there is a hesitancy to consider the campus as an area in which law enforcement should really be applied.

I know in one of the communities the committee went there was hostility toward the police on campus, period. Maybe it was justified, I don't know. It was not an inner-city school with the kind of hostility that is a cultural thing because of the grievances in the past. It was not that basis, it was a hostility based on other things.

Mr. YOUNG. Maybe you could deal with that by having someone who represented the schools to go into the school communities and talk with the parents, and in this way see how they felt about having

a police officer come on the campus, because this is probably where the reluctance is. It probably comes from the parents, and they could put pressure on the school administrators.

Mr. KENDALL. In 1966 in Oakland the Oakland schools had a policy—this is early in the surge of drugs—the Oakland school had a policy of suspending any student caught in possession of or selling drugs. The police were invited on campus. Kids were referred through the police channels to the probation department and all we saw was a great big increase in the sale of drugs. I don't think it is possible to stop it.

Mr. WALDIE. That may be. That was the two alternatives I posed. I may opt for the first alternative but we don't have the solution, we don't know what it is, and at this point all we can conclude is that there is nothing that we have found that can stop it and it is going to increase. That is essentially what you are suggesting?

Mr. KENDALL. I am not suggesting that necessarily.

Mr. WALDIE. I am not saying you approve it but that is the situation as you see it.

Mr. KENDALL. I am not saying it is going to increase. I am saying it may not get any greater if we institute certain controls such as counseling and reform of the education program and try a variety of programs outside of school, alternative programs in the community, outside counseling programs. I think there has to be a total effort.

Mr. WALDIE. I gather you do not think that police activities on the campus should be engaged in.

Mr. KENDALL. I think they should be used with great discretion. I think the kids react strongly to police on campus. I think in some cases it is absolutely necessary but it should be used with discretion.

Chairman PEPPER. Well, thank you very much. We appreciate this valuable contribution that you made to our hearings. Thank you all very much. We will now take a 5-minute recess for the convenience of the reporter.

(A brief recess was taken.)

Chairman PEPPER. The committee will come to order, please.

Mr. Counsel, will you present the next witness?

Mr. PHILLIPS. The next witness is John Luce, who is associated in his presentation with Dr. Seymour M. Farber. Dr. Farber is dean of the Continuing Education in Health Sciences at the University of California. Mr. Luce is an extension specialist in continuing education and health sciences.

Mr. WALDIE. Mr. Luce, would you please give Dr. Farber my regards, and my regrets that he was not able to be here. If he is as much an expert in this field as I presume he is, as he was when he did my surgery, we are in good hands.

STATEMENT OF JOHN LUCE, EXTENSION SPECIALIST, CONTINUING EDUCATION IN HEALTH SCIENCES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CALIF.

Mr. LUCE. I will be happy to.

Chairman PEPPER. We have heard good reports of Dr. Farber and of you, Mr. Luce, and we are very pleased to have you.

Mr. PHILLIPS. Mr. Luce is also an author in this area. I believe you have written a book about drugs.

Mr. LUCE. I wrote a book about the Haight-Ashbury Clinic with its medical director, David Smith.

Mr. PHILLIPS. You have a prepared statement, a joint statement of Dr. Farber and yourself. Would you please highlight it or do you want to deliver it?

Mr. LUCE. No, I have no desire to deliver it and I am sure you have no desire to hear it.

Mr. PHILLIPS. I have read it and it is succinct and very effective.

Mr. LUCE. Well, I think the basic idea is that just as the problem of what to do about drugs exists in every area and so it does in medicine and as one of our activities we worked for a number of years with school districts in trying to get drug programs started, particularly in some of the smaller States in the country, and since that early activity, which has been pretty well bureaucratized and institutionalized about this point we are focusing more and more on the education of physicians.

I think part of the entire drug-abuse problem has been caused by the medical and drug profession and I really think that they help set a climate of opinion where people do try to medicate themselves whether with heroin or sedatives and I think at this time the medical profession hasn't had much experience with dealing with drug users. We have found a tremendous demand for information and we put on symposia and various programs for the medical profession as well as others to inform them about drugs and the message in our statement is that the medical profession is not very well informed, that drug abuse and alcoholism is not taught in the health science curriculum as a rule and I think that reflects not necessarily a backwardness but a tardiness on the part of the medical profession among others to become involved in drug abuse.

Mr. PHILLIPS. I think you are exactly right on that. I think the medical profession and psychiatric profession, the legal profession, educational profession have really not attacked the problem the way they should have. We have left the problem to the ex-addict to cure himself and cure others. The thing has been neglected by many facets of the Government, by the health departments, by educational departments, by the hospital departments, and I think that the statistics that you have in your report alarmingly show that even under the best programs the problem continues to grow. I think the statistics that you have included in your report show a substantial percentage of increase in the use of barbiturates, amphetamines, and other drugs in schools. It is the only such report I have seen in the entire country. San Mateo County is to be congratulated on their keeping of these statistics. It is the only place in the country that has a 5-year record and it is the only governmental entity that does it annually, and the statistics unfortunately indicate that the problem is growing.

Is there any program that you are aware of in San Mateo County to combat this type of drug abuse in the schools?

Mr. LUCE. No; no more so than any other county I know of.

Mr. PHILLIPS. They have a good statistician.

Mr. LUCE. You have heard testimony to the point I don't believe drug education can work because I don't believe drugs are used by people that are most rational, and appealing to them on that level there is a certain section you are never going to reach.

Mr. PHILLIPS. One question I was going to put to Dr. Fort this morning, but I now ask you. If you had your choice, or you were forced to make the unhappy choice, of putting money in counseling or money in drug education, which would you put it in?

Mr. LUCE. I would put it in counseling.

Mr. PHILLIPS. I am reaching that conclusion myself.

Mr. LUCE. I really do believe, as a medical student and I have that orientation, that drugs are used for symptom relief by children as well as their parents and that until they can be looked at that way and until there is an alternate form of therapy I think people are going to use them.

In Haight-Ashbury, where I worked for 5 years now, that is not the tip of the iceberg although it is compared with that, it is the bottom of the barrel, it is a cesspool, people who can't make it elsewhere, and those people are very disturbed. Most of them who I have dealt with as a counselor, I think, are probably better off on drugs than without them. I think there are many potential suicides there, many people who really even might go to more criminal activity if they weren't on drugs than if they were. That is not to say they shouldn't be policed by any means but it is to say they are sick people. I have been working at the county hospital and I have a ward with 25 people in it and there is not one who is not an alcoholic or drug abuser. Most of them are multiple and that is certainly the pattern we see in Haight-Ashbury, multiple-drug abuse. High school students in San Mateo are more particular and they have more money and they are not habituated at drug use, but the end of the road is multiple addiction and abuse.

Mr. PHILLIPS. And you are seeing that at a lower age level than it was a few years back?

Mr. LUCE. Yes, sir; but that is true of everything in society, isn't it?

Mr. PHILLIPS. I have no other questions.

Chairman PEPPER. Mr. Waldie.

Mr. WALDIE. I have no questions.

Chairman PEPPER. Mr. Blommer.

Mr. BLOMMER. Mr. Luce, I have a question that maybe you can address yourself to. The witnesses that preceded you were obviously expert in their area and I thought trying to give their best evidence to this committee. One of them said he believed that 80 percent of the students in all of the high schools were regularly using marihuana and 30 percent were regularly using barbiturates. Now, that is not at all what your statistics show. Someone, either you or the previous gentleman, is wrong. That is a problem for any committee. I think it was pointed out this morning we have to listen to some experts and that man was an expert and he said 80 percent. Your statistics say less. What do you perceive as the problem?

Mr. LUCE. Well, the problem is that I don't think you can get accurate statistics about something that is an illegal activity, one in which it is good to boast about among some people and with other people its a matter of standard course to lie about in the course of understanding or underreporting.

I don't think statistics are ever going to be anywhere near exact in this field, or any other field of illegal activity.

Mr. BLOMMER. When I talk to some of these young drug abusers they seem to me to think that what they do is done by everyone. When

you say how many students in your school use marihuana, they say everyone, and I wonder if experts in the field of probation, who see the kids in trouble maybe. I don't mean to say——

Mr. LUCE. I know what you are saying.

Mr. BLOMMER. They feel that way?

Mr. LUCE. Sure. I think that that is one of the problems with drugs, as Mr. Waldie said. You have the example of making the turn on the schools and everybody will turn off. Its so cliche, and one of the cliches is that very often of over-reporting with adolescents and I think much underreporting in such other areas such as the pathologist, I think, quite importantly showed that drug deaths, drug-related deaths are not reported correctly.

Mr. BLOMMER. I have no other questions. Mr. Chairman.

Chairman PEPPER. Mr. Luce, I believe you said you have been a consultant to educational institutions.

Mr. LUCE. Yes, sir; in Idaho, Utah, and Nebraska.

Chairman PEPPER. Were those colleges, universities?

Mr. LUCE. No.

Chairman PEPPER. Secondary schools?

Mr. LUCE. In 1970, the Office of Education started putting money into the States to develop drug abuse programs and most of the money was used by the larger States, such as California, in already existing drug programs, whereas the smaller States used the money to create teams and send them out to various places to learn about drugs and we taught a group of them in San Francisco so there were secondary and primary school administrators on a State level. They then went back and created drug programs in their States.

Chairman PEPPER. We have a drug abuse education program, maybe that is the one you are talking about. I believe 65 million Federal dollars were made available. That is supposed to be primarily to educate the students relative to drugs, is it not?

Mr. LUCE. Well, at the stage of the game when I became involved in 1970 the money was to educate administrators who would then educate teachers who would then educate students, so I came in at a different level. Yes, I suppose the money is used for students now.

Chairman PEPPER. Suppose you were called by an individual secondary school, let's say a high school, and you were requested as a consultant to advise that school, and suppose they had some money to put in any reasonable program, and you were asked by the school authorities to advise them as to the best kind of program they could put in to deal with the problem of drug abuse in that school, a problem which they had discovered to exist there. What in general would be the advice you would give them?

Mr. LUCE. I would start with the assumption I said earlier, I don't think drug education is ever going to reach a certain group of people. It hasn't with alcohol, it hasn't with tobacco, and I don't think it will with drugs. I think, however, you can try for the best and you can particularly try to deal with the peer-group pressure which is certainly a very important factor.

Chairman PEPPER. The peer pressure?

Mr. LUCE. Well, I think two things happen in school. I think No. 1, the classes are so large that they lose the real model of the teacher, which I think has always been very important, and should be more im-

portant today with families breaking up. If I were really going to use money I would use it to improve the student-teacher ratio. That is a general impression of mine. Since most schools won't do that, my advice would be to start with the assumption it's not going to reach everybody and, therefore, counseling is a good place to put your money. But again if you want education, that it should be education that begins very early, that does not focus on drugs per se so but deals with the organisms and that you at some point, perhaps in the fourth or fifth grade, which is, I think, the time right now when kids are starting to become involved with drugs, that there should be the groundwork created so that people know a little more about their bodies and hopefully have little more respect for them and the drugs are introduced as a fact of life along with medications which is, I think, where they belong. As I said, not isolated, not treated with any kind of scare technique, but put in some kind of perspective.

Again, all the best you can do, I think, is rationally explain what drugs do and use the facts at your disposal which I think make an impression on a sixth grader to show statistically what happens to people who use drugs. But I don't think you can do anything more than that and I don't think education is going to do more than convince those people who didn't take that much convincing in the first place.

Hopefully, you can knock the props out from under the experts among the students who think they know all of the answers on drugs, but that is undercutting their influence on their peers more than it really is educating the goal desired.

Chairman PEPPER. I suppose it would be well also to do what one could do to educate the parents in the significance of drug use and abuse.

Mr. LUCE. Yes.

Chairman PEPPER. And to learn more facts about it.

Mr. LUCE. Certainly. But again within the idea that education is limited, that it is of limited value, I think, in a problem like this.

Chairman PEPPER. You referred to peer pressure. The hearings that we have had and the investigations and visits we have made have indicated to, I think, most of us, that the most effective programs to deal with drug abuse are peer therapy programs where the students apparently rap with one another, where they have the right kind of inspirational leadership, which seems to get them more or less back on the track.

Is that your experience?

Mr. LUCE. I think dollar for dollar they are the most effective. In terms of yield per unit type, I think intensive psychotherapy is the most effective technique with most young people if you can afford it or have the clinic, given the tools at your disposal. Methadone is the most effective thing in the world if you are measuring the number of people who go back on drugs. It doesn't do anything, I think, for their enjoyment and for their happiness, but if your objective is to get them off drugs, I think that is very effective and probably even cheaper. Second to that, I think the peer-group programs certainly are.

Chairman PEPPER. Well, now, these peer pressure, peer-group programs that I know about exist outside of the schools. Some enterprising individuals or group sets them up, or some community sets them up, and they are usually private or semiprivately operated. Do you

think it would be possible to establish something like these peer-therapy programs in the schools if you had the right kind of leadership? Couldn't they be installed there?

Mr. LUCE. Well, I think it might be possible but the dynamics of the peer-group-therapy thing is quite different than what I think really happens in the peer group. In the groups, lets call them, is that some people want to reform themselves and the best way they can do it is by reforming others. There are religious overtones to a lot of these groups that don't work very well within the school setting. It just doesn't grow organically in the vernacular at school. It usually will take an ex-addict, as you have mentioned, or some kids who get together and decide they want to turn their friends on to natural foods or religion or whatever and the spontaneity of it and the fact a person is using that method to retain his own hold to convert others, I think, is very essential to the programs themselves.

Chairman PEPPER. Couldn't that all be done under the general aegis of the schools; it doesn't necessarily have to be done even in the daytime, for that matter. We found in Chicago one school principal was having meetings at night for dropouts, students that were having problems. Couldn't leaders be found to guide and lead that kind of program under the general direction of the schools?

Mr. LUCE. Certainly, just as free clinics can be started by public health departments. but I think an important thing is they are always done with enough license to let the situation develop itself.

It's a rule in schools, I am sure, I can't say it's a rule, but I am sure it very often happens in schools, the person that the students turn to is not the counselor but the teacher they happen to like and respect and again it reenforces the idea if it's programed into the school it doesn't necessarily work and very often it doesn't have as good a chance to survive as if somebody takes it upon himself or herself to develop it. So I think the best thing the school can do is provide the resources and certainly condone the effort and the facilities as best they can. but to direct it or try to create it out of a vacuum. I have seen this done many times and it hasn't worked. You say OK kids, here is a raproom, rap, and the kids say see you later, and I think understandably it would happen to us.

Chairman PEPPER. The school could either let them come in the evening or they could rent a building somewhere and, as you say, encourage, get the right kind of leadership for them, and guide, and help it along.

Mr. LUCE. I think some school systems have done this with great success, such as Berkeley.

Chairman PEPPER. Most of the schools don't have the money. In Chicago they said. "We don't have the money. We may have to close down several of our schools in December because we don't have the money." They don't have a single drug counselor in one of the schools of Chicago. They are trying to find money so they can train 200 teachers out of all of the thousands there are in the Chicago school system in knowledge of drugs. They don't have the money to do these things.

If we start out now to get money from the Congress to set up outside the school system enough institutions properly staffed and with proper facilities and the like to take care of all the students that need this

special assistance, it would take from now to kingdom come to ever get Congress to pass the program because you would have to deal with hundreds, if not thousands, of programs and special action agencies not accelerating too rapidly in getting things done and go institution by institution. If we can work through the school system by letting them do what they can with the personnel they have got and the facilities they have got, and let them put what they have to put outside of the schools, we can get money in one bill, if the Congress is sufficiently impressed by this program and thinks this is the best kind of program that can be developed. The money to be distributed in an administrative way to the schools of the country.

It just seems to me that there is not a single answer but at least a great deal can be accomplished in working through the schools and helping them to find the best way. It will take more law enforcement, I think, as Mr. Waldie has suggested. Some of the school boards don't even have a firm policy that their principals, supervisors, and teachers have to report incidents of drug abuse. In New York, when we had our hearing there, they were not even requiring the school authorities to report the students whom they observed to be addicts to the health authorities as the law required. When we turned the spotlight on it they did begin to require it after that. So a lot has to be done, and it seems to me that within the school system there is much that can be done in this area. Do you agree?

Mr. LUCE. I agree with that. I just want to emphasize though, that I think a lot of these things happen by themselves and either in spite of our efforts or I don't think entirely because of them. I think the death of a few rock stars every year does more to decrease heroin abuse among some kids than any amount of money could ever accomplish and in the years that I have been working in this field I have seen so many well-intended efforts that just haven't happened because the students haven't initiated them. It's a very difficult situation to be in.

Chairman PEPPER. The whole problem is difficult, isn't it?

Mr. LUCE. Yes, sir.

Chairman PEPPER. Everywhere you turn you see a door with the word "enigma" almost written on it.

Thank you very much. Any other questions?

Mr. WALDIE. I think your emphasis in the statement that you and Dr. Farber have presented here on the problem of alcoholism is an excellent emphasis, not only in the adult society but it would seem to me to be way out in front in terms of drug abuse, drugs of choice, but in the statistics from San Mateo County alcohol abuse is really the most prevalent drug on the campus today.

Mr. LUCE. Yes, sir; I am sure that is true. I know it's true in all of the communities that I have ever visited.

Mr. WALDIE. I am sure it is, too. We get concerned, and properly so, over the hard drugs, which are more exotic and have more dramatic and traumatic effects, but I suspect in the long run there is certainly

nothing more dramatic or exotic or deplorable than alcoholism once abuse occurs, and I think the tolerance of our society with that drug and its consequences makes it more difficult certainly to address the prevalence of other drugs moving into this society.

I wasn't aware that we had no curriculum apparently involving alcoholism. I am aware in my own youngster's school back in Maryland of drug abuse programs that, apparently my youngsters are typical, that are effective. They seem to respond and they start them young.

Mr. LUCE. Are you speaking of educational programs?

Mr. WALDIE. Yes; at 8, 9, and 10 years old they started on drug abuse, or drug programs, describing much as you did the consequences to the body of an individual to the drug abuse, but not alcohol. There was little attention to alcohol though some, but little attention to it, and I don't recall all the years of my life in the California school system of some years ago, when these other drugs were not prevalent on the scene but alcohol clearly was. I recall not a single course on alcoholism and the consequences of abuse of that drug and I am pleased then to see that emphasis in your statement because we can get carried away with these other drugs and still let that drug which is the most destructive of our society continue unabated.

Chairman PEPPER. Well, thank you very much, Mr. Luce. We appreciate your appearance and are sorry you had to wait so long.

Mr. LUCE. It was interesting.

(The joint prepared statement of Mr. Luce and Dr. Farber follows:)

PREPARED STATEMENT OF DR. SEYMOUR M. FARBER, DEAN, CONTINUING EDUCATION IN HEALTH SCIENCES, AND JOHN LUCE, EXTENSION SPECIALIST, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CALIF.

As the members of the Select Committee on Crime are doubtless aware, the use and abuse of illegal psychoactive chemicals are common, if now universal, among young people in America today. This is particularly true in urban centers like San Francisco, whose Haight-Ashbury district has long served as a barometer for reading changes in drug-taking habits among the young. Yet it is also true in our outlying suburban counties, whose teenage residents once had to seek drugs in the city but now can find these substances closer to home.

One such county, San Mateo, lies directly to the south of San Francisco. A lovely, quiet place, San Mateo county in recent years has witnessed a rise in youthful drug use and abuse which, although not atypical, is nevertheless unacceptable.

This rise is reflected in a five-year series of surveys of junior and senior high school students in San Mateo county. This series was conducted by the San Mateo county Department of Health and Welfare with the support of Public Health Service Grant 2 RO1 MH20058-02. Comparing standardized rates of just one category, that of female and male high school seniors, it reveals that:

in 1968, 71.1 percent of females and 76.5 percent of males had used alcohol at least once, while in 1972 these percentages were 83.2 and 87.5 respectively;

in 1968, 31.9 percent of females and 44.6 percent of males had used marijuana, while in 1972 these figures were 53.0 and 60.8 respectively;

in 1968, 16.1 percent of females and 20.5 percent of males had used amphetamines, while in 1972 the figures were 24.4 and 25.8 respectively; and finally,

in 1971, the first year studied, 2.2 percent of females and 5.9 percent of

males had used heroin, while in 1972 the figures were 2.7 and 4.6 respectively. On first glance at these statistics, it may appear that heroin use among male high school seniors actually declined over the 1971–1972 period. But as the authors of the San Mateo study are quick to point out, heroin use was probably under-reported in 1972. Furthermore, the surveys significantly underrate the extent of drug use and abuse among all young people because they are limited to those who attend school—something which m[illegible]re confirmed abusers cease to do.

As the authors also underline, *any* use of heroin among [illegible]nool students is a cause for great concern. Yet what concerns us most [illegible]e fact that the use of all kinds of drugs has increased among youth pe[illegible] in recent years. Many factors account for this, and perhaps someday we [illegible]derstand why and in what order widespread chemical consumption rises [illegible]ils on the tides of human history. Yet in the meantime we must operate [illegible]hin the known probability that drug use and abuse, among young and ol[illegible]e, will continue to characterize our technological society for quite some tim[illegible].

Many individuals and organizations are attempting to alte[illegible]least stabilize this situation. Among them are those of us in the Department of Continuing Education at the University of California, San Francisco, and the Diane Linkletter Fund. Founded over twenty years ago to meet the educational needs of practicing physicians and other health professionals, the Department of Continuing Education has presented a variety of programs on alcoholism and other forms of drug use and abuse, including a national heroin symposium in 1971. We are presently planning our largest effort yet, a two-part symposium and workshop for persons active in drug abuse treatment, research, education and social policy. Scheduled for February of next year, its title is DRUG ABUSE: 1973.

The Diane Linkletter Fund was established three years ago by Mr. and Mrs. Art Linkletter in memory of their daughter and is administered by the Department of Continuing Education. It was originally devoted to producing educational materials about drugs and in assisting educators and community leaders in many states in planning drug abuse prevention programs. Today, however, some of the functions of the Diane Linkletter Fund and other private groups have been assumed by public agencies. This has left us free to concentrate on a long neglected area: the training and involvement of physicians and other health professionals in the drug abuse field.

That such involvement has been neglected is reflected in the fact that a relatively small number of health professionals participate in the dozens of programs on drug abuse presented by the Department of Continuing Education. Indeed, the priorities in major disease entities have not included alcoholism and other chemical dependencies. Furthermore, it is only recently that instruction in these problems has begun to receive the necessary emphasis in American medical schools.

There are many reasons for this: alcoholism and drug abuse have only recently been classified as medical, rather than legal problems, for example, and working in drug abuse has long been considered of low status in professional fields. Yet equally important has been the lack of public support for professional education and training programs. Today the situation is changing: the National Institute on Alcohol Abuse and Alcoholism and the President's Special Action Office for Drug Abuse Prevention has been established. Drug abuse has also become an issue in some of the current political campaigns. Yet drug abuse must be regarded as more than a campaign issue. Bearing in mind the probability that drugs will continue to be with us, we must make a long-term commitment to stimulate and support the drug abuse prevention field.

The Diane Linkletter Fund is fulfilling this commitment by working with the California Medical Association and other groups to insure that professional students are trained to deal with alcohol and drug abuse from undergraduate through p[illegible]graduate school. And the Department of Continuing Education is intensifying its efforts to reach practicing professionals as well as community leaders. The members of the Select Committee on Crime can aid us in this effort by sponsoring and backing programs aimed at making alcoholism and drug abuse an important part of all education.

In doing this, they will help guarantee that some of the best students, including health professionals, in our country join the fight against dangerous drugs. We believe that all America will benefit, including the young people who in increasing numbers are becoming involved with drugs today.

PRELIMINARY REPORT, 1972, SAN MATEO COUNTY, CALIF., SURVEILLANCE OF STUDENT DRUG USE—ALCOHOLIC BEVERAGES, AMPHETAMINES, BARBITURATES, HEROIN, LSD, MARIHUANA, TOBACCO

TRENDS SHOWN IN FIVE ANNUAL SURVEYS IN LEVELS OF USE REPORTED BY JUNIOR AND SENIOR HIGH SCHOOL STUDENTS

Between the 1971 and 1972 studies, the general trends of rates of drug use appeared to be upward. There were exceptions to this, and the increases were usually less than those between the 1970 and 1971 studies.

The all-over pattern of drug use—that males have higher rates than females and that the rates of use increase with class—held true as in the previous four studies. It is interesting to note that if the 1971 rate is subtracted from that of 1972, many more positive increases and fewer negative decreases were shown in the female rate than in those of males. This could indicate that for future years the rates for females will show less difference from the rates for males than has occurred in years past. The pattern of increase and decrease of rates between junior and senior high schools were consistent.

It is now possible to distinguish different trends among the different drugs surveyed.

Alcohol usage was again up, as had been demonstrated in each of the successive studies. This was true for both males and females. It should be noted that the senior class reported forty percent of the males and twenty-five percent of the females as using alcohol fifty occasions or more. *Tobacco usage*, after an apparent decrease, has started to edge back up again. This particular observation could be an important finding of the studies.

Marijuana rates showed a moderate up-trend. Rates although higher for juniors and seniors, levelled off in the freshman and sophomore classes.

LSD appeared to be levelling off. also, particularly among boys.

Amphetamines showed a moderate up-trend. It is interesting to note that rates were lower among freshmen boys this year.

Barbiturates showed a very definite downward trend. This finding does not agree with the popular opinion that "1972 was the year for barbiturates". However, the down-trend was so pervasive throughout all classes, sexes and levels that it is difficult to dispute.

The most important figure in this study is the rate of heroin usage. *Any* use of heroin among high school students is a cause for the gravest concern. It should be pointed out that a problem is much easier to control when only a small proportion of students are involved. Although the two problems are entirely different in many ways, it should be recalled that the use of marijuana among middle-class high school students in San Mateo County was almost unknown ten years ago. It should also be mentioned that there were reservations about the possibility of a few "wise guy" answers distorting the 1971 survey rates for heroin use. Corroborative evidence from other sources in the schools gave evidence that the figure was *reasonably* in line. In 1972, after examining all survey forms in which heroin was indicated, it is our opinion that any deviation from the true level this year would be toward under-reporting. It should also be pointed out that a high school survey does not pick up as high a rate as the one which would include those persons of the same age who were outside the school system. This is based upon the empirical observation that dropping out of school and heroin usage appear to be associated.

Each survey has shown many write-ins regarding other drugs. These drugs may be ones actually used by the student, or ones he wishes to bring to attention. The overwhelming write-in in the 1972 survey was cocaine.

It is possible to contruct *standardized rates* for the high schools using equal populations for each of the eight class-sex groups. This eliminates the possibility of rates being distorted because proportions of high or low risk class-sex groups change between years. For example a school with a large population of senior males could have a rate several points higher than one with a large proportion of freshman females, even though each individual class-sex rate was the same.

STANDARIZED RATES OF USE, SENIOR HIGH SCHOOLS ONLY, 1968–72

	Any use during past year (date of survey)					10 times—During past year (date of survey)					50+ usage (date of survey)		
	1968	1969	1970	1971	1972	1968	1969	1970	1971	1972	1970	1971	1972
Alcoholic beverages	65.4	72.5	73.9	75.8	80.8	25.4	33.8	35.6	43.6	49.1	15.6	22.4	25.1
Tobacco	55.8	54.8	52.6	54.4	55.5	35.4	35.9	34.2	36.0	36.2	27.0	28.8	28.7
Marihuana	31.9	39.5	42.0	49.7	51.0	17.5	24.4	26.3	32.9	34.5	15.9	21.2	21.8
LSD	10.5	14.7	13.9	15.4	15.6	3.8	5.9	4.8	5.0	4.7	1.6	2.1	1.7
Amphetamines	16.1	20.3	19.5	23.3	23.6	6.0	8.0	7.0	9.4	9.7	2.8	4.0	4.1
Barbiturates	NA	NA	15.5	17.8	14.8	NA	NA	5.2	6.2	4.6	2.2	2.6	2.0
Heroin	NA	NA	NA	3.5	3.2	NA	NA	NA	1.6	1.2	NA	1.1	.9

[Percent of each grade reporting the use of the above substances "at least once during the past year", "10 or more times during the past year" and "50 or more times during the past year". Males and females]

	Any use during past year (year of survey)					Used 10 or more times during year (year of survey)					50 + usage (year of survey)		
	1968	1969	1970	1971	1972	1968	1969	1970	1971	1972	1970	1971	1972
Alcoholic beverages—Males:													
7th grade	NA	52.3	49.0	55.1	58.5	NA	10.9	11.7	16.4	19.8	NA	NA	NA
8th grade	NA	60.2	61.4	68.0	70.5	NA	18.3	22.6	30.6	33 4	NA	NA	NA
Freshman	61.0	66.3	66.1	74.0	75.8	21.4	26.8	26.4	36.2	39 1	11.3	17.6	17 6
Sophomore	64.5	75.2	76.8	76.5	81.7	24.7	36.8	38.9	45.0	50.0	18.0	24.4	28 3
Junior	70.7	78.9	79.2	82.4	84.0	35.6	43.5	45.9	54.7	56.5	23.4	32.3	33.0
Senior	76.5	81.7	80.6	83.6	87.5	41.6	52.6	49.9	59 3	66.0	26.9	36.9	39.8
Alcoholic beverages—Females:													
7th grade	NA	38.4	42.0	43.0	49.6	NA	8.2	6.7	10.7	13.9	NA	NA	NA
8th grade	NA	50.6	53.8	63.4	67.1	NA	16.2	15 0	22.7	27.7	NA	NA	NA
Freshman	52.0	63.2	62.6	68.3	73.7	13.4	20.9	20.9	30.8	35 5	6.5	12.8	14.5
Sophomore	60.1	67.4	73.3	74.1	79.5	15.1	25.0	31.2	38.9	44.0	12.3	17.4	19 3
Junior	67.4	71.4	76.0	78.4	80 9	24.0	30 4	35.0	41.5	49 5	12.9	19 3	23 4
Senior	71.1	75.7	76.7	79.1	83.2	27.0	34.3	36.6	42.5	52.5	13.1	18.5	25.1
Tobacco—Males:													
7th grade	NA	43 6	38.2	41.6	42.2	NA	17.4	12.3	15.8	16.1	NA	NA	NA
8th grade	NA	51.0	51.0	50.1	51.8	NA	25.5	23.6	25 7	29 2	NA	NA	NA
Freshman	57.1	51.2	49.9	54.4	55 5	34.0	31.2	29.4	32.5	31.7	22.8	24.6	22 9
Sophomore	54.3	50.1	51.4	51 1	54.4	34.6	33.7	33.5	33.0	34 8	27.2	26.8	27.8
Junior	56.7	55.0	50.5	54 6	53.1	39 4	38.7	34.9	38 3	35 7	28.9	31.6	29 1
Senior	58.3	58.1	52.1	53.5	54.5	41.5	42.1	36.7	37 7	37.1	30.7	31.3	31.3
Tobacco—Females:													
7th grade	NA	39.8	34.0	36.0	37.5	NA	14.0	11.9	14.3	16.4	NA	NA	NA
8th grade	NA	50.1	44.9	49.0	52.9	NA	25.3	21.4	26 3	30.0	NA	NA	NA
Freshman	52.0	56.1	52.1	56.2	57.7	27.3	31.3	29.5	33.7	34 5	20 2	23.6	24.7
Sophomore	55.4	55.5	57.0	56.3	58.3	34.0	32.7	36.9	37.7	39.3	23.1	30.1	30.4
Junior	57.4	54.8	54.8	55.6	55.0	35.4	37.5	35 4	38.7	37.5	27.6	31.8	31.1
Senior	55.1	57.5	52.7	53.7	55.1	36.7	39.7	37.3	36.4	33.1	30.6	30.4	31.9
Marihuana—Males:													
7th grade	NA	10.9	9.9	17.6	17.2	NA	4.1	2.7	5.3	5.8	NA	NA	NA
8th grade	NA	23.9	22.5	29.1	33 3	NA	11.6	10.3	14.6	17.2	NA	NA	NA
Freshman	26.8	34.9	34.1	44.4	43.9	14.3	20.2	19.6	26 1	26.8	11.5	17.2	15.9
Sophomore	32.3	41.7	45.5	49.7	51.9	18.1	25.7	29.3	33.3	36.8	19 6	23 2	25 5
Junior	36.9	45.5	48.9	57.9	58.0	22.5	30.3	34 1	42.3	41.2	23 5	30 2	28.2
Senior	44.6	50.1	50 9	59.1	60.8	25.6	33.9	34.2	43.7	45 0	22.0	32 3	31 7
Marihuana—Females:													
7th grade	NA	10.7	7.2	12.6	13.2	NA	1.7	1.4	4.1	4.6	NA	NA	NA
8th grade	NA	21.8	16.6	25.8	29.2	NA	7.4	6.9	12 4	14.1	NA	NA	NA
Freshman	22.9	31.8	31.9	40.5	39 0	10.6	18.0	16 2	23 3	23 0	7 2	11.6	12.5
Sophomore	28.1	35.5	42.1	48 1	49.3	14.9	21.2	26.6	31.1	32 2	14 1	17.0	19.1
Junior	31.7	38 3	42.6	49 6	52.4	16.7	23 2	26.2	32.6	35.7	14.4	19.3	20 7
Senior	31.9	38.0	40 3	48.3	53 0	17.4	22 3	24.1	30.6	35 5	15 0	18 5	20.4

NA—Information not available.

Number of responses	1968		1969		1970		1971		1972	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
7th grade	NA	NA	530	523	2,268	2,356	2,619	2,777	2,765	2,871
8th grade	NA	NA	553	597	2,215	2,166	2,638	2,762	2,698	2,855
Freshman	2,349	2,526	3,129	3,156	3,161	3,378	3,084	3,220	2,629	2,787
Sophomore	2,332	2,473	2,826	2,920	3,183	3,053	2,804	2,821	2,453	2,329
Junior	2,064	2,205	2,579	2,850	3,019	3,004	3,037	2,982	2,296	2,264
Senior	1,799	1,892	2,034	2,287	2,352	2,632	2,467	2,363	2,043	1,901

NA—Information not available.

[Percent of each grade reporting the use of the above substances "at least once during the past year", "10 or more times during the past year" and "50 or more times during the past year". Males and females]

	Any use during past year (year of survey)					Used 10 or more times during year (year of survey)					50+ usage (year of survey)		
	1968	1969	1970	1971	1972	1968	1969	1970	1971	1972	1970	1971	1972
LSD—Males:													
7th grade	NA	2.8	1.3	2.7	2.7	NA	0.2	0.2	0.9	0.8	NA	NA	NA
8th grade	NA	8.7	4.9	6.2	7.1	NA	2.4	.9	2.0	2.0	NA	NA	NA
Freshman	8.1	11.0	10.9	12.5	12.2	2.6	4.5	4.3	4.4	3.7	2.0	2.0	1.3
Sophomore	11.1	16.9	16.4	16.1	17.6	4.2	7.2	6.1	5.9	6.0	2.0	2.7	2.3
Junior	14.6	19.2	18.5	21.2	18.0	5.7	8.5	7.3	8.6	6.0	2.6	3.9	2.2
Senior	16.6	23.0	17.4	21.1	21.2	6.6	10.5	6.9	7.3	7.2	2.6	3.4	2.8
LSD—Females:													
7th grade	NA	2.1	.9	2.3	2.5	NA	.4	.1	.3	.5	NA	NA	NA
8th grade	NA	6.0	4.0	6.3	6.4	NA	1.3	.8	1.3	1.6	NA	NA	NA
Freshman	6.9	11.2	9.2	11.7	12.0	1.9	3.5	2.2	3.0	3.0	.7	1.0	1.1
Sophomore	8.3	12.8	15.0	13.6	14.5	2.5	4.4	4.8	4.1	4.3	1.4	1.4	1.4
Junior	9.2	13.0	12.4	15.0	15.4	3.6	4.6	3.3	3.9	4.0	.8	1.4	1.3
Senior	9.4	10.8	11.7	12.1	13.7	3.3	3.7	3.2	3.0	3.5	.7	1.0	1.2

Amphetamines—Males:													
7th grade	NA	5.1	3.7	5.3	5 2	NA	1.7	.6	1.3	1.4	NA	NA	NA
8th grade	NA	11.8	9.5	10.9	12.0	NA	3.4	2.8	3.5	3.4	NA	NA	NA
Freshman	12.0	14.9	13.8	17.9	16.9	4.0	5.0	4.2	6.3	5.3	1.9	2.9	2.3
Sophomore	15.8	19.1	18.5	19.5	22 8	5.6	7.2	6.0	7.0	8.5	2.6	3.0	3.6
Junior	17 9	22.1	20.7	24 6	21.8	7.0	9 5	8.2	10.7	9.2	3.9	4.9	3.6
Senior	20.5	25.7	18.8	27.0	25.8	8 5	11.5	7.2	10.9	10.9	3.3	5.6	5.4
Amphetamines—Females:													
7th grade	NA	5 9	2.8	5.9	6.1	NA	1.1	.4	1.3	1.4	NA	NA	NA
8th grade	NA	10 4	8.2	13.2	14.6	NA	1.5	2.1	3.0	4.7	NA	NA	NA
Freshman	12.9	19.5	17.3	22.5	21.7	3.7	6.3	5.4	7.6	8.5	1.6	2.5	3.1
Sophomore	16.1	20.1	24.4	26.8	27.4	6.1	8.3	9 4	11.0	11 1	3.6	4.0	4.5
Junior	17.1	21.5	22.3	25.5	28.1	6.4	8 1	8.3	11.2	12.5	2.9	4.6	5.3
Senior	16.1	19.8	19.9	22.8	24.4	6.7	8.2	7.5	10.4	11.4	2.4	4.3	4.9
Barbiturates—Males:													
7th grade	NA	NA	3.4	5.9	5.1	NA	NA	.5	1 2	1.2	NA	NA	NA
8th grade	NA	NA	9.6	11.0	10 7	NA	NA	2.3	3.7	3.0	NA	NA	NA
Freshman	NA	NA	12.5	16 8	11.9	NA	NA	3.9	5.4	3.2	1.8	2.6	1.4
Sophomore	NA	NA	16.6	16.8	16.0	NA	NA	4.8	5.7	5.5	2.3	2.2	2.8
Junior	NA	NA	17.3	19.8	14.7	NA	NA	6 5	7.7	5.1	3 6	3.8	2.2
Senior	NA	NA	14.3	18.6	15.4	NA	NA	5.1	7.3	5.8	2.4	3.7	2.8
Barbiturates—Females:													
7th grade	NA	NA	3.1	5.4	4.8	NA	NA	.4	1.0	.8	NA	NA	NA
8th grade	NA	NA	7.7	12.3	11.1	NA	NA	2.1	3.6	2.7	NA	NA	NA
Freshman	NA	NA	14.5	18.0	13.7	NA	NA	4.6	5 3	3.5	1.5	1.5	1 3
Sophomore	NA	NA	20.3	19.2	17.2	NA	NA	7.7	6.2	5.3	3.0	2.3	1.9
Junior	NA	NA	15.0	17 9	15.6	NA	NA	4.5	6.8	4.5	1.7	2 7	2.0
Senior	NA	NA	13.7	15.0	14.1	NA	NA	4.4	5.3	4.0	1.3	2.2	1.4
Heroin—Males:													
Freshman	NA	NA	NA	3.7	2.7	NA	NA	NA	1.8	1.1	NA	1.4	.7
Sophomore	NA	NA	NA	3.9	4.0	NA	NA	NA	1 8	1.7	NA	1.4	1 2
Junior	NA	NA	NA	4.9	3.8	NA	NA	NA	2.4	1.7	NA	1.8	1.2
Senior	NA	NA	NA	5.9	4.6	NA	NA	NA	3.0	1.6	NA	2.0	1.2
Heroin—Females:													
Freshman	NA	NA	NA	1.9	2.3	NA	NA	NA	.6	.9	NA	.5	.7
Sophomore	NA	NA	NA	2.0	2.6	NA	NA	NA	.8	.8	NA	.5	.5
Junior	NA	NA	NA	3.3	2.9	NA	NA	NA	1.1	1.1	NA	.7	.7
Senior	NA	NA	NA	2.6	2.7	NA	NA	NA	1.1	1.0	NA	.6	.6

NA—Information not available.

The small form reproduced here has, over five years, produced a staggering abundance of analyzable data. This was planned in 1968 when the original rules were set up for the San Mateo survey of student drug use. The sole objective of the survey was to find out the level of use of several substances by students. This was to be done with the utmost respect for the student. the schools, and the districts. There was no need to ask any question which did not directly fulfill the objective. There should be no moral or emotional overtone. It was particularly important to use as little as possible of the student's time for administration. Confidentiality was of utmost concern. During five annual repetitions of the survey with approximately 150,000 completed responses, not a single individual has been identifiable.

When the 1968 survey was planned, the possibility of producing data comparable over several years was built into the design. This has made it possible to develop the only large-scale series of historical data on the spread of use of specific drugs through a student population which is available nationally.

Surveys through 1970 were tabulated manually by PTA volunteers and Research and Statistics staff. A PHS grant—NIMH RO1 2005S–01 made it possible to add computer analysis to the 1971 survey. Evidence of strong positive correlations between use level- for *all* pairs of substances have been shown. As a student's use of any drug increases, his probability of using another drug more frequently also increases. Pearson product moment correlations produce positive values of .17 to .90. Considering the large numbers of observations available for each class-sex correlation calculated, a value of .08 either positive or negative could be considered significant at the 1% level.

THIS REPORT WAS MADE BY: ☐ FRESHMAN ☐ SOPHOMORE ☐ JUNIOR ☐ SENIOR ☐ MALE ☐ FEMALE

I have used (during the past 12 months)—	Never	Once or twice	3 to 9	10 to 49	50 or more
Tobacco					
LSD					
Marihuana					
Alcoholic beverages					
Heroin					
Amphetamines (meth, speed, bennies, pep pills, etc)					
Barbiturates (downers, reds, blues, yellow jackets)					
Anything else you would like to name or say?					

Note: More information about this survey on the back of this form.

At this point absolutely no data is available which could allow a statement to be made that the use of any drug tends to precede the use of any other drug.

The statement that persons who use LSD tend to avoid the use of alcohol is examined in the following table. An arbitrary differentiation of "significant use" is based upon many comments written on the survey forms over the past five years. "You have to try it once to get them off your back." For alcohol, "no use" or "up to nine times" would appear to take in a limited amount of occasion drinking such as New Year's, weddings, and other celebrations, often indicated as parentally condoned. For LSD, "no use" or "once or twice" would cover the single experiment, or LSD administered without the knowledge of the recipient.

1971 SAN MATEO SURVEILLANCE OF STUDENT DRUG USE—2 LEVELS OF ALCOHOL USE ASSOCIATED WITH 2 LEVELS OF LSD USE

Level of alcohol use over past 12 months as reported by student in 1971 surveillance	Boys				Girls			
	Total number of responses	Not more than twice (number)	3 times or more		Total number of responses	Not more than twice (number)	3 times or more	
			Number	Percent			Number	Percent
7th grade, total	2,619	2,581	38	1.4	2,777	2,758	19	0.7
Not more than 9 times	2,190	2,182	8	.4	2,481	2,477	4	.2
10 or more times	429	399	30	7.0	296	281	15	5.1
8 grade, total	2,637	2,549	88	3.3	2,787	2,711	76	2.7
Not more than 9 times	1,831	1,813	18	1.0	2,156	2,134	22	1.0
10 or more times	806	736	70	8.7	631	577	54	8.6
Freshman, total	3,077	2,830	247	8.0	3,220	3,013	207	6.4
Not more than 9 times	1,962	1,911	51	2.6	2,230	2,185	45	2.0
10 or more times	1,115	919	196	17.6	990	828	162	16.4
Sophomore, total	2,804	2,501	303	10.8	2,821	2,601	220	7.8
Not more than 9 times	1,541	1,494	47	3.0	1,718	1,675	43	2.5
10 or more times	1,263	1,007	256	20.3	1,103	926	177	16.0
Junior, total	3,037	2,584	453	14.9	2,971	2,714	257	8.7
Not more than 9 times	1,377	1,316	61	4.4	1,747	1,705	42	2.4
10 or more times	1,660	1,268	392	23.6	1,224	1,009	215	17.6
Senior, total	2,491	2,154	337	13.5	2,363	2,204	159	6.7
Not more than 9 times	1,023	975	48	4.7	1,358	1,325	33	2.4
10 or more times	1,468	1,179	289	19.7	1,005	879	126	12.5

The 1972 survey was funded in part by PHS Grant 2 RO1 MH20058-02. Additional copies of this release are available as long as the supply lasts. They may be obtained by sending a stamped self-addressed envelope to Mrs. Lilian Blackford, Health and Welfare Statistician, San Mateo County Department of Health and Welfare, 225—37th Avenue, San Mateo, California 94403. Requests for permission to reprint all or part of the material should be sent to the same address.

Chairman PEPPER. The committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 5:30 p.m., the committee was adjourned, to convene at 10 a.m., on Friday, September 29, 1972.)

DRUGS IN OUR SCHOOLS

FRIDAY, SEPTEMBER 29, 1972

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CRIME,
San Francisco, Calif.

The committee met, pursuant to notice at 10:15 a.m., in the Ceremonial Courtroom, U.S. District Court, 450 Golden Gate Avenue, San Francisco, Calif., Hon. Claude Pepper (chairman) presiding.

Present: Representatives Pepper, Waldie, and Murphy.

Also present: Joseph A. Phillips, chief counsel; Michael W. Blommer, associate chief counsel; Chris Nolde, associate counsel; Barry S. Berger, assistant counsel; and Leroy Bedell, hearings officer.

Chairman PEPPER. The committee will come to order, please.

I have a telephone message from Congressman Don Edwards who was able to be with us yesterday and make a valuable contribution to our hearings, expressing regret that he had to go to San Jose today to keep some commitments he had previously made there, and regrets it very much that he couldn't be with us today. Congressman Waldie is delivering an address the early part of the morning at the University of Berkeley and he asked us to go ahead and he will be here in a little while.

I would like to comply with a request that came to me to read into the record a letter from Dr. George Pickett, director of the County of San Mateo Department of Public Health and Welfare. The letter is dated September 29 and addressed to me as chairman of this committee. It reads as follows:

DEAR CONGRESSMAN PEPPER: Yesterday we learned that your committee was in San Francisco and were informed that one of your concerns is the drug abuse activity in schools and the effectiveness of programs to combat this serious problem. Unfortunately, on such short notice I have not been able to prepare an appropriate presentation, or to appear before your committee. Mr. Gerald Day, chairman of our San Mateo County Board of Supervisors, is well-known for his interest in drug abuse programs and would have liked to have discussed this matter with you and members of your committee. He would like to prepare a formal document for submission at a later date.

Well, we have notified Dr. Pickett we will be very pleased to have for the record this document. The letter continues:

It is no surprise to you that drug abuse has become one of the most significant problems in suburban America. Much of what is known about this problem has been developed by research work in San Mateo County. The level of concern is high. Competence of the school personnel, health workers, and citizens input is high, but suburban America does not attract national attention, concern, or money. Priorities are such that the urban centers with high density of population and the concentration of statistics indicating poverty and crime attract most of the money for combating significant social problems. The large suburban counties are not able to obtain the dollar resources necessary to mount the

kind of programs needed. It is our hope that the priorities that are used for the distribution of grant money will be reexamined so that the availability of help will be better related to need.

Very truly yours,

GEORGE PICKETT, M.D.,
MPF Director.

We are pleased to receive this letter from Dr. Pickett.

(Mr. Day's statement, previously referred to, was not received in time for printing.)

Chairman PEPPER. Mr. Counsel, will you call the first witness?

Mr. PHILLIPS. Yes, Mr. Chairman, the first panel of witnesses today is a group of high-school-age students who have been involved seriously in the drug problem that confronts the Nation.

First. Miss Susan Norvall and Miss Laura Mayer. Would you come forward, please, girls? Would you sit in those two seats.

Also, James Sullivan and Paul Lopez, would you come forward and take seats, gentlemen. Also William Strickland and James Griffin.

Jim, I think we will start with you if you don't mind. Would you take a microphone.

Chairman PEPPER. May I ask each of you if you will remember when you begin to speak to pull the microphones close in front of you so that everyone can hear, please.

Mr. PHILLIPS. Jim, how old you are?

STATEMENTS BY JAMES SULLIVAN, LAURA MAYER, PAUL LOPEZ, SUSAN NORVALL, JAMES GRIFFIN, AND WILLIAM STRICKLAND, CALIFORNIA HIGH SCHOOL STUDENTS

Mr. SULLIVAN. I am 18 years old.

Mr. PHILLIPS. And could you tell us where you have resided most of your life?

Mr. SULLIVAN. In Palo Alto, Calif.

Mr. PHILLIPS. Tell us when you first got involved in drugs, how old you were?

Mr. SULLIVAN. About 14 years old, 13.

Mr. PHILLIPS. 13 or 14 years old?

Mr. SULLIVAN. Yes, sir.

Mr. PHILLIPS. How did that happen, what got you involved?

Mr. SULLIVAN. How was I involved?

Mr. PHILLIPS. How did it come about.

Mr. SULLIVAN. Well, I lost interest in the things I was doing, like baseball activities, school, related things like that, so like other people around me were doing things like getting high and stuff like that, I saw more interest, seemed more interested in what they were doing so I kind of wanted to see what they were doing so I started getting involved, kind of like an acceptance, I guess, or something I could relate to. It was easy to do. I didn't have to put out anything for it. It was fairly easy to get involved.

Mr. PHILLIPS. What drugs were available when you were in the seventh and eighth grades?

Mr. SULLIVAN. The only stuff I really looked for was grass and maybe some barbiturates, but I mostly used grass and alcohol. I first started out on alcohol, really. I was just getting into drinking pretty heavily then and from then on it kind of led to other things.

Mr. PHILLIPS. What it did lead to, what other things did it led to?
Mr. SULLIVAN. Well, eventually it led to cocaine. I had an addiction to cocaine for a little while.
Mr. PHILLIPS. And did you get involved in junior high school with acid and mescaline?
Mr. SULLIVAN. Yes, sir; I did; just in some sales, and just helping my friends out, things like that.
Mr. PHILLIPS. Did there come a time when you actually got involved with coke, selling coke?
Mr. SULLIVAN. Yes, there did.
Mr. PHILLIPS. Could you tell us how that occurred?
Mr. SULLIVAN. Well, the element was more when I came into high school. Everyone else had graduated from dope and stuff like that into coke, a little heroin, small amounts, but mostly coke and I was into some of the lesser things in high school like grass and booze and stuff like that. I saw what the other people were doing and kind of wanted to do what they were doing, coke. I got involved. I knew a few people that were using it and pretty soon I was doing it, too. Then I got to know their contacts and from then on I got pretty heavily involved.
Mr. PHILLIPS. And you got very heavily involved in coke?
Mr. SULLIVAN. Yes, sir.
Mr. PHILLIPS. And you were taking it yourself?
Mr. SULLIVAN. Yes, sir.
Mr. PHILLIPS. Coke is an expensive drug, is it not?
Mr. SULLIVAN. Yes, sir.
Mr. PHILLIPS. Can you tell us what the price of coke would be in a high school in Palo Alto?
Mr. SULLIVAN. When it filters down from ounces it goes for approximately $1,000, $975, $900, depending on quality, but it goes down to like nickel bags, like $5 worth, which are very small amounts, and it just may be one or two highs but it goes like grams, quarter-ounces, half-ounces, whatever, how much money you have. They will make certain weight for you.
Mr. PHILLIPS. Did you ultimately buy large amounts of cocaine?
Mr. SULLIVAN. Yes, I did.
Mr. PHILLIPS. And what was the largest amount of cocaine you ever bought?
Mr. SULLIVAN. Half an ounce.
Mr. PHILLIPS. And how much would you pay for that?
Mr. SULLIVAN. $400.
Mr. PHILLIPS. And where would you get the $400 to pay for the half ounce?
Mr. SULLIVAN. Well, I would sell. I knew the people who were selling it and I knew people who were buying it themselves, so I could get high quality coke for other people and I would get money out of it.
Mr. PHILLIPS. Resell it?
Mr. SULLIVAN. Yes, sir.
Mr. PHILLIPS. You would buy it for $400 and then you would buy it for other people who were selling and other people who were using?
Mr. SULLIVAN. Yes, sir.
Mr. PHILLIPS. The people you were selling to, who were they?

Mr. SULLIVAN. In high school? In the junior high school I didn't go down there because I didn't like the people. But the people in the high school I could kind of relate to them and I could sell it to them.

Mr. PHILLIPS. Were there many sellers of cocaine and other drugs in high school?

Mr. SULLIVAN. Many fellows do it?

Mr. PHILLIPS. Yes.

Mr. SULLIVAN. Yes, they do; quite a few.

Mr. PHILLIPS. And how about the people who were buying it, were a lot of kids involved in the various drugs at Palo Alto?

Mr. SULLIVAN. Yes, sir; quite a few people were involved in using drugs in Palo Alto.

Mr. PHILLIPS. Where did your connection get his drugs?

Mr. SULLIVAN. Well, he just explained to me a little bit about how he got it. He got it over, his friends would, I guess he called it a St. Kate type of thing. He would give them a certain percentage for bringing it over from Peru in the sails. He would have them bring it over and he would give them a percentage of what he sold.

Mr. PHILLIPS. In other words, they would bring the material in from Peru for your contact?

Mr. SULLIVAN. Right; say that again.

Mr. PHILLIPS. How did the material get from Peru to your contact?

Mr. SULLIVAN. I can't really say, but he explained to me, he said he concealed it in candy boxes, covered with chocolate. He explained that to me, but I really never saw the candy boxes or anything.

Mr. PHILLIPS. Now, did you see the chocolate on top of the coke?

Mr. SULLIVAN. Yes, we chipped it off. I helped him clear it off.

Mr. PHILLIPS. Describe the quality of the cocaine that you were receiving from this man.

Mr. SULLIVAN. Well, it was the best around. There was none better. I got an uncut from my contact, so he said. It was uncut, and I would sell it to people for high prices and they could cut it up which would be like mixed in lactose or sugar or whatever they had. It looked like just mixing it in so they could sell more and get more money.

Mr. PHILLIPS. How much could you sell in a day in the school if you worked at it?

Mr. SULLIVAN. If I really worked at it I could sell over a thousand dollars worth; but I never worked at it.

Mr. PHILLIPS. You would take it yourself as well?

Mr. SULLIVAN. Yes, sir; I was.

Mr. PHILLIPS. Could you tell us whether the teachers were involved with drugs at all in that school?

Mr. SULLIVAN. I am not really positive they were involved in it but they knew about it, I am sure they did, a number of them. A few of my teachers, I would go into the classes and they would know I would be high but they just kind of wouldn't talk to me or something, kind of shied me off.

Mr. PHILLIPS. And do you know that any teachers were using marihuana or any other drugs?

Mr. SULLIVAN. Yes; I would come in contact with one that did use it and I knew of three that did use marihuana but I didn't know about the other ones. They acted like maybe they might have used it but I really can't say if they have, but I knew.

Mr. PHILLIPS. Do you have an idea about the percentage of children, high school students, who were into drugs at Palo Alto?

Mr. SULLIVAN. In the high school I would say 90 percent, but in junior high school I would say it went down to about 70, 65, but at least over half in all schools.

Mr. PHILLIPS. When you were selling cocaine, you were selling other drugs as well from time to time?

Mr. SULLIVAN. No, I could set up deals but I wouldn't sell it myself.

Mr. PHILLIPS. Did you take precautions so that you wouldn't be caught?

Mr. SULLIVAN. Yes, I did.

Mr. PHILLIPS. Could you tell us a little about that?

Mr. SULLIVAN. Well, I kept my grades up in school, you know, high grades, and my appearance was—I never had hair longer than about the middle of my neck and I would avoid situations that would bring myself to get busted. I would see guys at school and they would have real long hair and real modern-style clothes and kind of shaggy looking and I would always see them hassled by cops. Cops would see that kind of thing, typical drug user, bad element, and I could see somebody like me, typical high school kid, he is all right, like that. I would avoid all sorts of stuff.

Mr. PHILLIPS. So you never really got hassled at all until the time that you were caught selling to——

Mr. SULLIVAN. No, I was never hassled at all.

Mr. PHILLIPS. How long had you been selling before you were finally caught?

Mr. SULLIVAN. Altogether, about 2 years.

Mr. PHILLIPS. And you had been selling in the same school or other schools?

Mr. SULLIVAN. One school.

Mr. PHILLIPS. And did the kids from other schools come over to your school to make purchases?

Mr. SULLIVAN. Yes.

Mr. PHILLIPS. Tell us a little about that.

Mr. SULLIVAN. They would come over and try to buy my stuff but I wouldn't sell to them because I didn't know them, and even if somebody else vouched for them and said they are all right I never really wanted to do that because I didn't know the person personally myself. I was talking with some of them about the drugs in the other schools and they said yes, everybody is doing it, everybody has their stuff, their stash, whatever you want to call it.

Mr. PHILLIPS. Congressman Murphy would like to ask how many kids in your school were actually involved with drugs.

Mr. SULLIVAN. I really can't say any specific number but 90 percent is all I can really say. The other 10 percent were actually people that were involved in police activities. We call them junior narcs or whatever you want to call them, just guys that were exploring into the policeman-type thing, or just people that had their heads on pretty well that really didn't need it.

Mr. PHILLIPS. A small minority of 10 percent or so, as you call them, were police types?

Mr. SULLIVAN. Yes, sir; right. There was nobody, really; I mean nobody that I knew actually went around with those people because

we couldn't trust them because we didn't know where they were really at.

Mr. PHILLIPS. I am going to get back to you and you can tell us a little bit about the program you got involved with and how you got straightened out.

Mr. SULLIVAN. OK.

Mr. PHILLIPS. Laura would be second.

Miss MA[illegible]. Pardon me?

Mr. PHILLIPS. Do you want to testify second?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. Could you tell us how old you are?

Miss MAYER. 16.

Mr. PHILLIPS. And where have you lived in California?

Miss MAYER. Mostly in Marin County, over in San Rafael, Corte Madera, Canfield, and a few times in San Francisco.

Mr. PHILLIPS. You have lived pretty much in this general area of San Francisco, the bay area, practically all your life?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. All your 16 years?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. Could you tell us what high school you went to?

Miss MAYER. Went to San Rafael High, Washington, and Redwood.

Mr. PHILLIPS. And could you tell us what the situation was in relation to drugs at San Rafael?

Miss MAYER. I felt that there were more drugs at San Rafael than the other schools in Marin County. I would say that there was quite a few people using drugs there, too.

Mr. PHILLIPS. Could you tell us what type of drugs they were using?

Miss MAYER. I guess grass, hash, amphetamines, heroin, cocaine, everything.

Mr. PHILLIPS. Speed?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. All of those drugs were available at San Rafael?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. And who was selling them?

Miss MAYER. Mostly I noticed that older kids, you know, that weren't in high school were coming around to the school and selling there. Some people in high school also.

Mr. PHILLIPS. Could you tell me whether you ever got involved in using drugs yourself?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. And could you tell us how you got involved and what you got involved with?

Miss MAYER. Mostly, if I recall, was with my mother and then with my friends, and I got involved with grass first, hash, speed, mescaline, and acid.

Mr. PHILLIPS. How old were you when you first got involved?

Miss MAYER. I guess 12 or 13.

Mr. PHILLIPS. Did you receive any drug education at all in the schools you went to?

Miss MAYER. I didn't but there was drug education. A small part of one of the classes was for drug education.

Mr. PHILLIPS. Did you go to school when you were loaded on drugs and really under the influence?

Miss MAYER. Yes.

Mr. PHILLIPS. Could you tell us what the teachers' reaction was to that?

Miss MAYER. I feel that some of the teachers knew that I was loaded but they didn't say anything to me. My counselor didn't say anything to me, either. And I usually went to the classes that I thought I could get away with it and didn't go to the other ones.

Mr. PHILLIPS. Did anybody give you any help at all at that stage?

Miss MAYER. At schools?

Mr. PHILLIPS. Yes.

Miss MAYER. No.

Mr. PHILLIPS. And do you think that if someone had intervened earlier in your drug use that you might have avoided some of the difficulties that you had?

Miss MAYER. That is really hard to say. I know at that time I wasn't ready to accept anything, any help from anyone, because I wasn't ready to look at where I was at really.

Mr. PHILLIPS. Did you finally get very, very sick from being involved with these drugs?

Miss MAYER. Well, yes.

Mr. PHILLIPS. You tell us about that.

Miss MAYER. I was using, you know, speed. I was using a lot to get by the everyday things that I did and I ended up getting busted, and going to the hospital and withdrawing from it because it was really heavy. I couldn't do it by myself.

Mr. PHILLIPS. And you were committed to a program; is that correct?

Miss MAYER. Yes, sir.

Mr. PHILLIPS. Paul, could you tell us how old you are and how long you have lived here in California?

Mr. LOPEZ. I am 17 right now and did you ask when I first got mixed up with drugs?

Mr. PHILLIPS. Yes.

Mr. LOPEZ. I was about 14 years old when I first started taking drugs. I was going to Peterson High School and I just was drinking a lot at first. I never wanted to go to school, so I got behind in school and they put me into a continuation and I was with all my friends, and they said there was a lot of reds and weeds going around all over the place so I told them I was going to buy some. I bought some and I told them I was going to take three. It was a big thing then and I never had saw any kind of drug until I got there.

Mr. PHILLIPS. And the first time you got drugs at all was in high school?

Mr. LOPEZ. Yes, right.

Mr. PHILLIPS. Did you start with reds?

Mr. LOPEZ. Yes, sir.

Mr. PHILLIPS. How many reds did you start with and did it progress?

Mr. LOPEZ. The first time I took reds was three and it started getting bigger and bigger, because it is going to affect me very much and I kept on taking them and got really put into it.

Mr. PHILLIPS. You kept getting more and more involved with reds. Could you tell us whether other kids in the junior high or high school were using drugs?

Mr. LOPEZ. All of them. All of them were using drugs.

Mr. PHILLIPS. What type of drugs were they using?

Mr. LOPEZ. Acid, mescaline, coke, speed, weed, reds, bennies, everything.

Mr. PHILLIPS. Heroin?

Mr. LOPEZ. Some of them were using heroin.

Mr. PHILLIPS. And how old were they, Paul?

Mr. LOPEZ. About 17 or 18 years old.

Mr. PHILLIPS. Now, did there come a time when you really got very heavily hooked on reds?

Mr. LOPEZ. Not exactly physically, but mentally I was hooked on them.

Mr. PHILLIPS. Where did you get the money to buy these drugs?

Mr. LOPEZ. Burglarizing, lied to my parents, manipulating my relatives into giving money, burning people, selling it.

Mr. PHILLIPS. What type of drugs were you selling, Paul?

Mr. LOPEZ. Mainly reds.

Mr. PHILLIPS. And how many crimes would you say you got involved in over a period of a year or two to buy these drugs?

Mr. LOPEZ. About nine to 11 times.

Mr. PHILLIPS. Nine to 11 burglaries?

Mr. LOPEZ. Burglaries, I never. Well I have been in a lot of burglaries but I never got caught and the first burglary I ever got caught for I got sent up for it.

Mr. PHILLIPS. You were caught in a number of different things, auto theft, grand theft, and things of that nature?

Mr. LOPEZ. Yes, sir.

Mr. PHILLIPS. But essentially you got away with a lot of the ones you pulled?

Mr. LOPEZ. Yes.

Mr. PHILLIPS. One of the things I think you told me, Paul, as we talked before coming here, was that once you got involved with drugs the only time you went to school was to get drugs?

Mr. LOPEZ. Right.

Mr. PHILLIPS. Could you explain that further?

Mr. LOPEZ. Well, sometimes the town where I live would be dry and I would be dry and, well, you won't get stoned except for on booze or something the day before, and you say you want some dope and really everybody had dope in school. As soon as I walked into school everybody knew when I came to school I was going to buy something so they always used to come up to me and ask if I wanted to buy some, and right away I would be buying them and I would be loaded in school and get kicked out of school. People were just always loaded, they were never loose, always to keep it quiet, but me, I was one of the loose ones around there and I just went over there to party.

Mr. PHILLIPS. So, in other words, if you needed drugs and couldn't get them locally, the best place to get them was at school?

Mr. LOPEZ. Right.

Mr. PHILLIPS. Paul, could you tell us whether you turned on your friends and got other people involved?

Mr. LOPEZ. I turned on practically everybody I hung around with. Some of my friends were really getting good grades in school and doing good. They respected their parents, short hair, and stuff like that. They looked really good. And once I turned them on to a couple of reds or turned them on to weed everything starting changing. They want more money and at night when we don't have any money they want to go hit a house or something and trade it for some dope. I never really wanted money, I always wanted dope. To me dope was a big thing.

Mr. PHILLIPS. Now, could you tell us a little about the drug education program that you saw?

Mr. LOPEZ. Which one?

Mr. PHILLIPS. Any of them that you did see. Do you think they were effective or ineffective?

Mr. LOPEZ. I don't think they are effective in a way where people come there all over the place to talk about drugs like they wanted to bring up some kind of a counseling. To put in some money for counseling where people get together and try to get each other off drugs or something. Well, my opinion about that is I don't think that really works because I have been through a lot of counselings and I was free, that is when I was free. I mean that is when I was in the outs and I went to counseling, it never did me any good.

But to be put in an institution and to think about what you have done wrong, it gives you time to think about what you have done wrong. It really works, because you live in there and put yourself together in a place like that if you really want to change.

Mr. PHILLIPS. Paul, do you have any suggestions about what could be done to avoid other kids getting into drugs?

Mr. LOPEZ. If they could get jobs or have some activities and really have something good that they don't want to be loose, a lot of this drug problem would end. There are hardly any jobs. People walk the streets burglarizing for money.

Mr. PHILLIPS. And part of the reason that some of these young people get into drugs is there is nothing else to do?

Mr. LOPEZ. That is right, nothing to do.

Mr. PHILLIPS. Sue, perhaps you could be our next witness. How old are you?

Miss NORVALL. I am 18.

Mr. PHILLIPS. And could you tell us how long you have lived in California and whereabouts in California you have lived?

Miss NORVALL. In San Mateo County all my life.

Mr. PHILLIPS. And could you tell us what schools you went to?

Miss NORVALL. I started going to Hillsdale and I went there for my freshman and part of my sophomore year, then I went to Peninsula Continuation for 2 years, and the last school I went to was Girls Day Care in Redwood City.

Mr. PHILLIPS. When did you first get involved with drugs?

Miss NORVALL. In junior high school, just smoking grass.

Mr. PHILLIPS. And did it become more serious?

Miss NORVALL. Oh, yes. I quit smoking grass and I started taking psychedelics and barbiturates, and then I started doing speed when I was in Hillsdale and then heroin when I went to Continuation.

Mr. PHILLIPS. How old were you when you went to Continuation, Sue?

Miss NORVALL. Oh, 16 or 17.

Mr. PHILLIPS. You started using heroin and getting heavily involved with speed when you were 16 or 17?

Miss NORVALL. Yes, sir; speed when I was 15 and stuff when I was 16.

Mr. PHILLIPS. Can you tell us, Sue, how you got the money to buy these drugs?

Miss NORVALL. Well, it started with forgery and then I got busted for that and quit doing that, except for once in a while, and stealing mostly, just burglaries sometimes. My boy friend helped a lot.

Mr. PHILLIPS. You say your boy friend and you got involved in burglaries and things of that nature?

Miss NORVALL. Yes; we were partners.

Mr. PHILLIPS. And what would you burglarize?

Miss NORVALL. Houses.

Mr. PHILLIPS. What would you take?

Miss NORVALL. Oh, TV's. We hit a lot of hospitals and places, too, for typewriters, wheelchairs, things like that.

Mr. PHILLIPS. Then what would you do with the televisions, typewriters, and wheelchairs that you got?

Miss NORVALL. Sell them.

Mr. PHILLIPS. Who would you sell them to, what kind of person?

Miss NORVALL. Well, I am not going to mention any names.

Mr. PHILLIPS. No, I am not interested in names, just the shops and places.

Miss NORVALL. There were a few shops and some individual people.

Mr. PHILLIPS. How much would you get for a typewriter?

Miss NORVALL. A typewriter, $40, and then after we had sold a lot of them the price would go down and we would try and think of something else.

Mr. PHILLIPS. When the price went down on typewriters you started stealing other things?

Miss NORVALL. Yes, sir.

Mr. PHILLIPS. Give us, Sue, some estimate of the number of crimes that you were involved in.

Miss NORVALL. The numbers?

Mr. PHILLIPS. Yes. If you can. I know it is hard. Just a rough guess.

Miss NORVALL. I have no idea. I was not aware of what I was doing. I don't remember.

Mr. PHILLIPS. Up to a hundred, at least?

Miss NORVALL. One hundred, more than that. I was into dope for a long time.

Mr. PHILLIPS. You were into dope for this entire period, and really didn't know what you were doing?

Miss NORVALL. I knew what I was doing, I am responsible for what I did, but it wasn't a big thing to me so I don't remember it. It is a very hazy period of just exactly what I ripped off. I didn't keep track of that. It wasn't important to me just as long as I got the money.

Mr. PHILLIPS. We will come back to you, Sue, I am sure.

Jim, you are a student here in the San Francisco area and you haven't gotten involved to any degree in drugs yourself; is that correct?

Mr. GRIFFIN. That is true.

Mr. PHILLIPS. Could you tell us, Jim, what school you go to?
Mr. GRIFFIN. I go to Reardon High School, San Francisco.
Mr. PHILLIPS. How old are you?
Mr. GRIFFIN. 17; I am a senior.
Mr. PHILLIPS. Tell us essentially how you see the drug scene in your school.
Mr. GRIFFIN. There was a lot last year. I have never seen heroin, but anything you wanted to get you could get it, like weed. There must have been all kinds of, like, 10 guys 1 day they could get you a lid any time you wanted and bennies and reds, just about everything.
Mr. PHILLIPS. You could get bennies, reds; could you get mescaline, acid, and things of that nature?
Mr. GRIFFIN. Yes, sir.
Mr. PHILLIPS. Could you get coke?
Mr. GRIFFIN. Yes.
Mr. PHILLIPS. And this was relatively easy in school; is that correct?
Mr. GRIFFIN. Yes. They would approach you and ask you if you wanted it.
Mr. PHILLIPS. Could you speak a little louder, please?
Mr. GRIFFIN. They would approach you, the people that wanted to sell it would approach you and if you wanted to buy it you could buy it, and if you said no they would come back another time and ask if you wanted to.
Mr. PHILLIPS. Tell us what your estimate is of the number of seniors in your school who might be involved with these drugs.
Mr. GRIFFIN. I think not that many students are into heavy stuff, but I would say 85 to 95 percent have smoked grass.
Mr. PHILLIPS. About 85 to 95 percent would be smoking grass?
Mr. GRIFFIN. Yes, sir.
Mr. PHILLIPS. How about kids who are into heavier things, do you have any estimate on that?
Mr. GRIFFIN. I would say about 35 percent.
Mr. PHILLIPS. What would those kids be taking?
Mr. GRIFFIN. I think it would be the senior division.
When you are a freshman, you got out of grammar school, you are not into that yet and once you start it is a thing you do. You drop some reds or bennies and you go to a game and you are really active and you want to participate so you take a couple of bennies, six or something, and you just do it. Then you take some reds to get ready for school. It is a lot easier to go loaded than it is to go straight.
Mr. PHILLIPS. Could you tell us something about the people who are peddling the drugs in the schools? What type of things are they peddling and what type of people are they?
Mr. GRIFFIN. They are pretty average people.
Mr. PHILLIPS. Just students?
Mr. GRIFFIN. Just students. At Reardon you can't have the long hair but it can touch your collar and you get those kind of people.
Mr. PHILLIPS. And are they selling, in addition to dope, other things?
Mr. GRIFFIN. Yes.
Mr. PHILLIPS. Will you give us an example of that?

Mr. GRIFFIN. Parts of cars and sometimes if someone has ripped off a gun you could get a gun.

Mr. PHILLIPS. In other words, you could buy guns or tires or something that had been stolen from someplace else; is that correct?

Mr. GRIFFIN. Yes, sir.

Mr. PHILLIPS. And the fellow who was dealing dope was dealing in those other stolen things as well?

Mr. GRIFFIN. Not mainly. There was other people that usually did that because I think the person that deals in dope just wanted to deal in dope and that is all. That is the only thing he was concerned with. At Reardon there is not that many. Once you get in there and have been there for 4 years you know everyone and you know all the time. So you know you can, if you have got burned before, say if you sold them something and got in a little trouble, you never go near them again, so they know the people they can sell it to and who not to sell it to.

Mr. PHILLIPS. I see. So there is a knowledge among the groups who are at school who you can buy good stuff from and who you can buy bad stuff from?

Mr. GRIFFIN. Yes.

Mr. PHILLIPS. Do you have a girl friend who got involved more seriously with drugs?

Mr. GRIFFIN. Yes.

Mr. PHILLIPS. Can you tell us a little bit about that?

Mr. GRIFFIN. Well, she started out smoking weed and then she went to a little higher, a little higher and it began to get really bad. So I don't date her any more. She tries one thing and then after that doesn't stimulate her any more or satisfy her any more she would go to something else.

Mr. PHILLIPS. Could you tell us the things that she went through, if you know?

Mr. GRIFFIN. Grass, mescaline, acid, bennies. She never touched reds at all.

Mr. PHILLIPS. How about THC?

Mr. GRIFFIN. Yes.

Mr. PHILLIPS. How about cocaine?

Mr. GRIFFIN. I think once.

Mr. PHILLIPS. Did she go to a Catholic girls school here in San Francisco?

Mr. GRIFFIN. Yes, sir.

Mr. PHILLIPS. And your school is also a private parochial school?

Mr. GRIFFIN. Yes; all boys.

Mr. PHILLIPS. Can you tell us why, in your estimate, young people get involved in drugs?

Mr. GRIFFIN. Its the thing to do. When you are at a party or something and someone fires up a joint and you want to smoke it and you get hassled at home sometimes, you have to be in at a certain time and at school they get on your back if you miss a class, and when you are not your normal self then, say, if you take something it is a lot easier to take because it doesn't really hit you hard. You can sit there and it won't even affect you no matter what they say.

Mr. PHILLIPS. Is it easy to get drugs, Jim?

Mr. GRIFFIN. Yes.

Mr. PHILLIPS. Can you contrast it to beer? Is it easier to get drugs than it is to get beer?

Mr. GRIFFIN. Yes, it is quite easy. I think beer you can almost buy it anywhere in San Francisco, if you find a store, same as if you find a dealer, and if you find a good dealer then it is just like a store, you can keep going to him until he gets busted.

Mr. PHILLIPS. How about pills, are they as easy to get as beer?

Mr. GRIFFIN. I think weed is a lot easier to get. Nowadays people will be turning you on to it without charging you at all, a couple joints here and there, but never a lid. I think weed is a lot easier to get than beer.

Mr. PHILLIPS. Can you tell us where the sales of these drugs are taking place among the high-school-aged kids?

Mr. GRIFFIN. I would say outside the school. They usually keep it in the car. They don't bring it into the school because it is a lot easier to go outside because there is no chance of getting busted. You can do it behind a tree or in a car and if you say do it in the cafeteria or in the halls you don't know who might be watching down the hall. A student might be watching down the hall and he might say something to a teacher. Just in joking, but outside you know who is there and you know the kids all around you, so it is a lot easier to do it outside, a lot more casual.

Mr. PHILLIPS. Thanks very much.

Bill, you have gotten here late, perhaps we can have a few words with you.

Tell us how old you are?

Mr. STRICKLAND. I am 19, as of yesterday.

Mr. PHILLIPS. As of yesterday. Congratulations and I hope that your next 19 years are happier than your first 19.

Mr. STRICKLAND. I hope so, thank you.

Mr. PHILLIPS. Could you tell us where you have lived here in California?

Mr. STRICKLAND. I have lived in California all my life—Bay area.

Mr. PHILLIPS. Could you tell us whether you have gone to the schools here?

Mr. STRICKLAND. Yes, sir; I have gone to school in Oakland. That is the first place I started to school, in Oakland. We moved to San Leandro and I had lots of problems in San Leandro so I went to Hanna Boys Center in California and that was back in 1965. Then when I got out of there I started in St. Elizabeths in Oakland and that is when the drug problem started.

Mr. PHILLIPS. Tell us how you got involved with drugs and what type of drugs you got involved with.

Mr. STRICKLAND. I started out smoking marihuana. It was mostly out of curiosity and the fact that I wanted to be with the hep people, I wanted to be accepted for what they wanted me to be instead of what I wanted to be and, therefore, I started doing what they were doing in drugs and I found it quite fun, I thought.

Mr. PHILLIPS. Did you progress from marihuana to other things?

Mr. STRICKLAND. Yes; I have gone from marihuana. I started out on marihuana and went to LSD. I have done heroin. I never really had any problem with heroin. I don't have a desire for it like some people do.

But the main drug I had a problem with was PCP, a tranquilizer for animals. I liked it a lot and, therefore, it became a problem.

Mr. PHILLIPS. And before you did that did you also try reds, hash, and beans as you call them?

Mr. STRICKLAND. Yes, sir.

Mr PHILLIPS. What are beans?

Mr. STRICKLAND. Beans, Methedrine, and amphetamines, uppers, they just get you wired.

Mr. PHILLIPS. Bennies or beans, you use the term "beans"?

Mr. STRICKLAND. Yes, sir.

Mr. PHILLIPS. Could you tell us who was using drugs in Marin High School, the one you spent some time in; what type of kid?

Mr. STRICKLAND. Mostly the majority of the kids were using drugs. The athletes, the sports-minded people, weren't into drugs, but now they are. When I was there they really weren't but I can see how the incoming of heroin is becoming a problem and it wasn't then. Then the main thing was marihuana, reds, bennies, and now things are getting heavy.

Mr. PHILLIPS. Could you give us some estimate of the people who are involved at Marina?

Mr. STRICKLAND. I would say, well, the majority of the students were. I would say about 60 or 70 percent. I was aware of the fact there were even a number of teachers that were into drugs and it was pretty widespread all over.

Mr. PHILLIPS. Can you tell us where the buys take place in the schools?

Mr. STRICKLAND. Mostly in the bathroom. They would meet in the bathroom. I will sell you what you want to buy. We would set it up on the lunch field, anywhere if the coast was clear and classrooms, anywhere, anywhere the person could get ahold of it. Out in front of the school, before school started.

Mr. PHILLIPS. Give us some estimate of kids in that school who might be into heroin or cocaine.

Mr. STRICKLAND. An estimate of how many people? When I was there, right now there is probably about 25 percent at the most. That is well known. Not 25 percent. I would say about at the most 10 percent, but it is coming in fast—surprisingly, too.

Mr. PHILLIPS. You got pretty heavily into PCP?

Mr. STRICKLAND. Yes, sir.

Mr. PHILLIPS. And you were using it how regularly?

Mr. STRICKLAND. As often as possible. For my habit I would steal from my mother. I would rip off bars, especially I liked bars because I always knew there would be at least some money in there, a cigarette machine, et cetera. I was using it every day heavilf.

Mr. PHILLIPS. How many places did you rip off?

Mr. STRICKLAND. I can estimate it is pretty close to 200 different breaking-and-entering crimes.

Mr. PHILLIPS. That is over a couple of years?

Mr. STRICKLAND. Yes, a period of a lot of years.

Mr. PHILLIPS. Could you tell us whether you ever got into dealing yourself?

Mr. STRICKLAND. Every time I tried to deal I would end up in the hole, moneywise. I would never come up with enough money be-

cause I would usually use too much of the profits that I would be making if I would sell. So, I would have a younger person sell for me and I would give him something on the side so he would take care of it for me.

Mr. PHILLIPS. What was the teachers' reaction to the drug scene?

Mr. STRICKLAND. Their attitude was like either two ways: They looked at it, they either didn't want to get involved, or they had too much on their hands to get involved or they would take you to the office. Their outlook on it, I would say their attitudes toward it, was they didn't want to get involved.

Mr. PHILLIPS. Did you receive any drug counseling in the school?

Mr. STRICKLAND. No, I didn't have any drug counseling. At one time we did have one seminar that I remember and it was led by a detective on the narcotic squad from the town I lived in. There were no drug education classes. That is about all I can remember.

Mr. PHILLIPS. Thank you very much.

I have no other questions at this time.

Chairman PEPPER. Mr. Murphy?

Mr. MURPHY. Thank you, Mr. Chairman.

Bill, getting into your particular habit, your own personal case, what turned you on to drugs?

Mr. STRICKLAND. What was it that I was attracted to about it?

Mr. MURPHY. Yes; was it the fact your other friends were doing it?

Mr. STRICKLAND. That and the fact that there was something missing. It was out of boredom and Jesus was missing in my life and I filled that up with drugs. I filled that up with drugs. I filled that gap between me and God with drugs and I became dependent upon them to be happy—happiness.

Mr. MURPHY. Now, if you were asked your recommendations—and I am going to ask all of the young people at the table—if you were asked your recommendations on what school authorities could do to help youngsters such as yourselves that are coming along after you and are now facing the same problem, what would you describe as a meaningful program in the schools that could be of some help to you?

Mr. STRICKLAND. I would say if the teachers would just get more involved with the students, more of a look, they would keep more of a watch on their students, it would be a lot more helpful and the students would see where they are wrong, because a lot of them don't get punished when they should get punished.

Mr. MURPHY. This is an interesting comment because I have heard this comment in every city this committee has traveled to, that youngsters such as yourselves have indicated to this committee that there is such a total lack of discipline in our schools that there is really no definite lines and thereby no direction for the student and that the teachers really don't care. If you get the lesson you get it, and if you don't you don't. At 3:15 they are a mile away from the school and they only worry about the next day when you come back. A lot of teachers worry about the ramification of getting involved, in chastising the student, or reporting the student to the principal or whatever authority he has to report to. But they are scared to. There is really a lack of communication between the school authority, through the teacher and the student.

Mr. STRICKLAND. Right, there is.

Mr. MURPHY. Now, what about a qualified counselor in the school and maybe a graduate of some program like Synanon? I think Synanon is your program out here in California, and Gateway Houses in Chicago, the Seed in Miami, some graduates such as yourselves, if you kick the habit, go in with the counselor into the school and talk to the students.

Do you think that would be effective?

Mr. STRICKLAND. Truthfully and honestly, no. I have gone through group therapy programs. I have gone through a Synanon-oriented program and I went back to the same thing I was doing before I went in the program. I am saying it is wrong. For instance, I went in the Christian drug program and found that happiness was missing and that is why I took drugs and now I have found happiness and don't need drugs and don't need any false concepts to be happy.

Mr. MURPHY. Mr. Sullivan, I ask you the same questions: What turned you on, and what would be effective, in your estimation, in school to help prevent the youngsters from using drugs?

Mr. SULLIVAN. That is a tough question.

Mr. MURPHY. I know it is a tough question. That is exactly why this committee is going from city to city; we are puzzled by it, too. We have some recommendations but we are not sure we have the answer, and when we go back to the Congress in Washington we want to make recommendations and fund meaningful programs. We don't want to throw any money down the drain. We would like to have the students, people like yourselves, tell us. We can get doctors in here, older people that have never had experiences with drugs, and they can make all the recommendations in the world, but if it isn't reaching the student, then we have failed. We have a responsibility and that is why we are here. We want your opinion.

Mr. SULLIVAN. The only thing I can really say is when I first started getting into it, I was really looking for an identity; to identify with the people that were doing the drug-type thing because they were having the fun. It looked to me if they were having the fun and I was somewhat bored with my life—just the same things for 13 years.

Mr. MURPHY. How did you get off of it then? What change took place in your life that you were able to kick this habit?

Mr. SULLIVAN. Well, just finding myself, I mean doing things on my own without help or the hindrance of a drug because before I needed them. Like he said, every day you have to have it, every day, because without it you won't be able to really survive, I guess, and finding myself, just kind of reality, just as that is what really made myself, just to say I really don't want that any more for myself. What is best for me is to do the things I wanted to do that I really feel good doing, where something actually comes out of it.

Mr. MURPHY. Tell me this As you started your high school career, if some adult or somebody maybe the same age level as you were able to sit down and talk with you and give you some direction, or talk over some of the problems of why you had no identity, would you have listened?

Mr. SULLIVAN. No; I wouldn't have. I think the only time I actually would have had some chance was in the seventh grade when I first got into the environment of the junior high school thing where you have to be tough and all this type of stuff. You have to be "Mr. Big

Stuff." You see the guys in the higher classes doing these things, and what they are doing is the thing to do.

Mr. MURPHY. In other words, you think if the treatment is to be effective at all it must get to——

Mr. SULLIVAN. Has to start early.

Mr. MURPHY. Early in the academic career, at the grammar school level.

Mr. SULLIVAN. I think that would be great. For myself, I went to a parochial school for 6 years and I really didn't have any experience with the people that I lived near or the people in my own district or anything because the school was out of the district and I knew the people there. Then when I got into the district I was unprepared for what really came.

Mr. MURPHY. Sue. I ask you the same question: Could somebody have helped you had they been able to identify with you and talk to you at an earlier age?

Miss NORVALL. Well, if I had been open to wanting to change, yes; it would have been nice to have someone to talk to.

Mr. MURPHY. Some of the youngsters that we talked to say when a counselor, who is of a different age generation than the student is, comes in to talk the kids end up lying to the counselor and telling him things that they think the counselor wants to hear. But, especially in Miami, the youngsters told us if somebody came in that had made the same mistakes they had, had been on the drug scene like they were, they couldn't lie to him or her because they would pick up the lines and they would tell them, "I told those same stories."

Miss NORVALL. I don't think it is the age. It is someone that you can relate to. They don't necessarily have to be through what you have been through as long as you maybe get a feeling that they are concerned. That is all it takes.

Mr. MURPHY. In other words, the feeling that they are really concerned about your future or your problems.

Miss NORVALL. Yes; and if they are being honest and wanting to help you. If you trust a person it doesn't matter how old they are.

Mr. MURPHY. You mentioned the fact that your boy friend was helping you pay for your habit. Was he committing crimes, too?

Miss NORVALL. Oh, yes; we were helping each other. We were partners, you know. It was on an equal basis. It wasn't me more than him, or him more than me.

Mr. MURPHY. How much would you spend a day to support your habit at its worst time?

Miss NORVALL. I never had a large habit. Between us, maybe $40.

Mr. MURPHY. A day?

Miss NORVALL. Between us.

Mr. MURPHY. A day?

Miss NORVALL. Yes. This is for both of us, and he did have a larger habit than I did. It was a psychological thing more than the physical.

Mr. MURPHY. How about the rest of your students, were they spending that much money, too, in high school?

Miss NORVALL. At the time I was doing heroin I wasn't going to school. I was enrolled at Continuation, but I rarely went unless I was clean. I rarely went.

Mr. MURPHY. How did you get away with a situation like that if you were enrolled in classes and you weren't attending classes? how would you get credit?

Miss NORVALL. I wouldn't get credits.

Mr. MURPHY. Would the school authorities——

Miss NORVALL. Finally, they did.

Mr. MURPHY. Did they come after you?

Miss NORVALL. Yes; and I was put in a girls' day care school.

Mr. MURPHY. How about the young lady on your left, Laura.

Laura, if somebody had taken an interest in you earlier in your life, how could they have done it? What would you recommend that the schools do to help you, the youngsters?

Miss MAYER. I feel, first of all, that the classes should be smaller and that is the same thing as the teacher being able to relate to the students.

Mr. MURPHY. In other words, what you are saying is that the teachers do not relate to the individual students and thereby he loses identification, he doesn't think anybody cares about him; is that what you are saying?

Miss MAYER. That is how I feel. I did lose my identity. I felt like a number instead of a human being, and that is pretty bad, and I feel they have a voucher system in Santa Clara County which is going to a school of your choice for 1 year, and that leaves the schools that have good programs, more people will go to. Less people will go to the schools that don't have a good program. I feel that this is something that would be good, you know.

Mr. MURPHY. Do you think there is too much freedom in the schools today as far as the student is concerned?

Miss MAYER. I don't think so. I don't think that there is really enough freedom. You are 16 and you want to do something, but yet you can't learn what you want to learn. You are getting thrown things.

Mr. MURPHY. In other words you say the curriculum is not meaningful.

Miss MAYER. That is right. But I still think there is freedom, a lot of freedom. There should be.

Mr. MURPHY. Paul, what would you describe as an effective program in the high school that might have prevented you from turning to drugs?

Mr. LOPEZ. I don't think there was anything that could affect me to not take drugs. What I thought would help me, as soon as I started they should have sent me up a long time ago.

Mr. MURPHY. They should have been sterner with you?

Mr. LOPEZ. I should have got sent up a long time ago.

Mr. MURPHY. In other words, you feel the courts or whatever you were brought before, were too lenient?

Mr. LOPEZ. Yes; because they have tried programs for me. I have been in a lot of programs and none of them ever worked. This was the first time I ever took some dope and I liked it. I don't think there was anything that could have stopped me.

Mr. MURPHY. What was your habit costing you, at its worst, a day?

Mr. LOPEZ. My worst habit?

Mr. MURPHY. How much would it cost you a day to maintain that habit at its worst period.

Mr. LOPEZ. About $5. Just taking reds.

Mr. MURPHY. You were just on the reds; right?

Mr. LOPEZ. Right.

Mr. MURPHY. How about the young man next to you, Jim.

You weren't involved in drugs, Jim?

Mr. GRIFFIN. Not at all.

Mr. MURPHY. Do you think that there could be meaningful programs instituted in the schools, a combination of counselor and graduates of synanon programs to help the students?

Mr. GRIFFIN. Well, at Reardon right now if a teacher catches, if your eyes are red they will take you in the office and they will question you and if you are loaded he will bust you for it. And there are people that get away with it and I have heard many times, like counselors, people go to them and they will say yes, I am taking dope and all this, and sometimes they do turn them in. That is what they are not supposed to do. If they can set something up where someone your own age can do something for you, I think that would help out a lot. But someone older, you know, there is really no reason to go to them unless you really have a problem, and that is where it has to be stopped, before you get the problem.

Mr. MURPHY. I want to thank you young people for appearing here today. Mr. Chairman, that is all the questions I have.

Chairman PEPPER. Mr. Nolde.

Mr. NOLDE. Sue, how old were you when you first started into drugs?

Miss NORVALL. 13.

Mr. NOLDE. And what grade were you in?

Miss NORVALL. Eighth.

Mr. NOLDE. Why did you get into drugs, basically?

Miss NORVALL. Well, at that time I wasn't strong enough with myself. Other people could easily influence me, and I wanted to be with my friends. They were happy, they seemed, and so I did. I wasn't happy with myself though. I can't say that I personally don't think anyone else has that much of an influence on me that would start me using it. It was me.

Mr. NOLDE. Did you see your friends using drugs?

Miss NORWALL. Yes.

Mr. NOLDE. And did you notice any changes in them?

Miss NORWALL. They seemed happier.

Mr. NOLDE. And you weren't happy?

Miss NORWALL. I wanted to be with them. No, I wasn't happy.

Mr. NOLDE. So you used drugs?

Miss NORWALL. Yes.

Mr. NOLDE. To get happy.

Miss NORVALL. Well—

Mr. NOLDE. When you went in the ninth grade you got into the psychedelics and then the barbiturates and then speed and finally the heroin?

Miss NORVALL. Yes, sir.

Mr. NOLDE. How old were you when you finally got to heroin?

Miss NORVALL. 16.

Mr. NOLDE. And how long did you use it?

Miss NORVALL. Two years.

Mr. NOLDE. Was it available around the high school where you were, the last one?

Miss NORVALL. I didn't get it at high schools.

Mr. NOLDE. But did you see it around there?

Miss NORVALL. Yes; I saw it.

Mr. NOLDE. What school?

Miss NORVALL. I was using it so I often had it with me.

Mr. NOLDE. And what school was that?

Miss NORVALL. Continuation.

Mr. NOLDE. Laura, you have testified that you could buy any kind of drugs you wanted in school, including barbiturates, marihuana, hash, peyote, speed, coke, and heroin; And that you sold drugs in school. What school was that?

Miss MAYER. Did I what?

Mr. NOLDE. You sold drugs in school?

Miss MAYER. Yes; at Redwood High School.

Mr. NOLDE. And was your mother using drugs?

Miss MAYER. Yes.

Mr. NOLDE. What happened in your own situation with her?

Miss MAYER. I was living with her until about 2 years ago and I got busted for running away and truancy and they found out she was using also and took custody away from her.

Mr. NOLDE. Did she turn you on to drugs?

Miss MAYER. Yes; the first time.

Mr. NOLDE. How did that happen, or what kinds of drugs?

Miss MAYER. Marihuana.

Mr. NOLDE. Anything else?

Miss MAYER. Yes; well, after grass you know, hash, mescaline, acid, and speed.

Mr. NOLDE. Did you have any place to turn to at school for help?

Miss MAYER. Not at school, because I wasn't going very much.

Mr. NOLDE. Do you have some feelings about how the schools could be improved?

Miss MAYER. Yes. Like I said before, making the classes smaller which would help a lot, I think, and having someone from the outside to come in that knows something about drug and talk maybe, that has been through a program or done something in the line of drugs, drug abuse, and talk to the people and show concern.

Mr. NOLDE. Bill, could you estimate the percentage of your classmates that were into some form of drugs?

Mr. STRICKLAND. The percentage of classmates was about 60 percent.

Mr. NOLDE. And what percentage of those were into the psychedelics, reds, and speed?

Mr. STRICKLAND. About 30 percent.

Mr. NOLDE. About 30 percent?

Mr. STRICKLAND. About 30 to 40 percent went to reds and psychedelics. Mostly it was just marihuana.

Mr. NOLDE. Were any of the teachers using drugs?

Mr. STRICKLAND. Yes; it was brought to the students' attention at a couple of parties where I became aware that a couple of teachers had smoked marihuana. They were at the party and they did participate in the use of the drug.

Mr. NOLDE. You saw that yourself?

Mr. STRICKLAND. No, my friend saw it. He smoked it with them in the bathroom.

Mr. NOLDE. In the bathroom?

Mr. STRICKLAND. In the bathroom of the house.

Mr. NOLDE. No further questions, Mr. Chairman.

Chairman PEPPER. I would like to ask each one of you young people to give—if you don't mind doing so, if you do, of course, you will not do so—I would like to ask you, starting with you, Bill, a little bit about your own family situation.

Mr. STRICKLAND. Sure. Well, my family situation right now——

Chairman PEPPER. When you got into drugs.

Mr. STRICKLAND. I had been getting in trouble all my life.

Chairman PEPPER. Were your father and mother living together?

Mr. STRICKLAND. Up until I was 15 they lived together, then they got a divorce and I think it was because of me.

Chairman PEPPER. Did you live with one or the other of them thereafter?

Mr. STRICKLAND. My mom.

Chairman PEPPER. Go ahead now; did your mother work?

Mr. STRICKLAND. She worked. She tried to keep us going as best as possible.

Chairman PEPPER. Did you have any brothers or sisters?

Mr. STRICKLAND. Three sisters, and two of them were married and me and my younger sister living at home with my mom. I was incorrigible. I was beyond control of my parents, and they tried and I think it was because of me that the divorce did take place. Family conditions were not as family conditions should have been. The rules weren't enforced. Unless I yielded to the rules, I am not going to perform. I didn't want to be and I rebelled. I was a rebellious child and I caused lots of commotion everywhere I went, the streets, my own block. Not one of the parents of the children that I liked to run around with would let their child play with me because they thought I would influence them because I was a terrorizer and it was probably my fault that my family situation was as it was and did break up.

Chairman PEPPER. Would you fight or what was it? Why was it they called you a terror?

Mr. STRICKLAND. At 9 years old I would break into my next door neighbor's house. I knew they had a jar of money. I would steal that and go buy candy and stuff with it and I used to sniff glue when I was young and I used to break into my next door neighbor's home to get money to buy glue and I would sniff spray paint and I was an outrageous child and it was because of me that my family did break up, I am sure. But now I think that things are getting back together, all of a sudden things are going for the better.

Chairman PEPPER. You have had a religious experience since that time?

Mr. STRICKLAND. Religious experience?

Chairman PEPPER. Yes.

Mr. STRICKLAND. Yes, sir; I have. People would call it a religious experience. That is what they would call it.

Chairman PEPPER. Did you have any religious association, did you go to any kind of Sunday school or church during the time that you were a so-called terror?

Mr STRICKLAND. Yes; when I was very young, 6 and 7, my dad used to make me go to Sunday school all the time and I didn't get anything out of it. I didn't even listen to them. I used to rebel against that even. And then I was in a Catholic-run institution, but it had no bearing on my life because my drug problem didn't start until I got out of the Catholic institution.

It was up until the time of, it has been almost a year now when I realized that I couldn't make it any more and I tried and I have been through programs and nothing helped me and I realized that I couldn't do it on my own. I had too many problems. I had done too much harm to everybody and the only way I could see I was doing the harm was through the love of other people trying to help me or I wouldn't have been aware of what I was doing. I knew I couldn't go on any more; I couldn't make it; I was at the bottom. I tried suicide a couple of times and I saw no hope in my life until I got down on my knees and then my life changed. That is all I can say. I am born again. I am a different person. People see me today, my old friends, and they don't know it is the same Bill Strickland. They say that is far out, man, look where he is coming from.

People used to talk to me like I talk to people now and I would say to the guy, this guy is really weird, what is he talking about, and it wasn't real to me. I didn't know I was missing all of this happiness and truth in life. I didn't really see until I asked God to show me. People still don't believe; they have to find out on their own. I did and God showed me and I do have a new life and I am happy. I have a purpose in life.

Chairman PEPPER. That is a very exciting story, Bill. You are such a big handsome fellow, it looks like you have so much to live for. We are all grateful that you found yourself. You can help others, too.

Mr. STRICKLAND. I am trying.

Chairman PEPPER. Just one last question. What seemed to be the trouble with you the time before you found yourself, you just didn't fit in, or you didn't understand what it was all about, or what?

Mr. STRICKLAND. Right. I was confused about life and I tried to figure out what life was all about. Now that I look at my life I see I myself was putting on an act in front of my friends to be accepted. I wanted to be what they wanted me to be instead of what Bill Strickland wanted to be.

Chairman PEPPER. Let me ask you young people this. You are all in the teenage group. I am much older than you, of course. I grew up in a relatively stable society where you went to Sunday school and church, and back in those days they didn't question seriously whether there was a God or not. There were people that were called agnostics but they were way off somewhere from the area in which I grew up. I wonder if you are not going through a period when maybe the sense of values are changing and you see it written up on the front pages of magazines, "Is there a God?" What are the standards, what are the varieties of life. what are the things, what is true. and the like. Your elders are not too sure nowadays about a lot of things. You have to come up through an age of experimentation and I imagine many of you are confused about what are the values of life, what are the real values that you can tie to, is it really worth while to work hard and study hard and make good grades and go out and get a job and marry

and have a family and work most of your life. Is that a worthwhile way to spend your life? Do you ask questions like that, Bill?

Mr. STRICKLAND. I remember in my life as I was growing, and I was getting more and more depressed with my drug problem, I thought a job would be the answer. I thought settling down and having a family would be the answer. But that is why I really hit bottom. I got that job and I said well, I was happy, too. I was real happy. I am not going to be the way I used to be. But I was only fooling myself because I didn't have the willpower to change. It was like I had plugged into a drug scene and this drug just drained all of my power and I was dependent upon that to be happy and until that cord was cut, I was depending upon drugs to have peace in my life and to have happiness. It was all phoney—the job and the money wasn't the happiness I wanted; it was contentment inside. Knowing what I was doing was right. That is the only way I have been able to be happy, by knowing what I am doing is right.

Chairman PEPPER. Jim, will you comment on these things that I have said?

Mr. SULLIVAN. Like about my family situation?

Chairman PEPPER. Yes.

Mr. SULLIVAN. When I was going to a grammar school I kind of had a thing where I was doing it. I didn't really want to be there; it was all right. I didn't experience anything else, any of the different type situations, so I was content, the parochial situation.

Chairman PEPPER. Were you living with your parents?

Mr. SULLIVAN. Yes, I was.

Chairman PEPPER. Bill, what sort of work was your father engaged in?

Mr. STRICKLAND. My father made very good money. He used to be a truckdriver; now he has a job where he sits and checks the trucks when they come in.

Chairman PEPPER. What does your father do?

Mr. SULLIVAN. He is an airline mechanic for United Air Lines.

Chairman PEPPER. Go ahead.

Mr. SULLIVAN. I got like into the junior high school into the different elements and I kind of kept this thing up where I could keep my parents pleased by getting all right grades, C grades, and come home when they wanted me to and I was leading a life of just getting more and more involved. When I would go home I would be just the good guy again and kind of showing them I am doing good in school and I come home and they couldn't really say anything and I know they really wanted to but they didn't want to.

Chairman PEPPER. Did you think your parents recognized that you were developing a drug problem?

Mr. SULLIVAN. They knew I had used it off and on but they didn't know I was in it as heavily as I was.

Chairman PEPPER. One of the things we have to consider in any recommendations that we will make is that the drug training programs that we recommend would include also giving information to the parents about recognizing the drug problem and having an understandable knowledge of it.

Do you think that would be desirable?

Mr. SULLIVAN. Yes; I think it would. I came in contact with a program when I was in the juvenile hall in San Jose where they took parents through. I can't remember what police station it was. They showed them what this smelled like and looked like and what the symptoms were, just like grass or coke sniffers, constantly running noses or just kind of droopy eyed or something, just showing them what to look for.

If the child is like I say, coming home at the right time and doing all right in school you still suspect something. If the parents had something to look for because they haven't had any experience with it, like I am sure all kids now days could spot out somebody who is using it or selling it just almost right away, just looking, I would say.

Chairman PEPPER. Jim, when you began to find you were getting deeper and deeper into the drug problem, your intelligence must have advised you that you were getting involved in crime, that you could be sent to prison. Did it concern you? Why did you allow yourself to drift into that?

Mr. SULLIVAN. Well, I felt like I was important, people needed me like they needed my drug. I thought they really needed me and I felt like I was serving some purpose. I really didn't realize that people were just using me for what I had, and not as a person. I didn't really get to know any real people. I didn't know anybody.

Chairman PEPPER. Did you have any ambitions at that time as to what you wanted to be when you grew up?

Mr. SULLIVAN. No; none at all.

Chairman PEPPER. You were not thinking about the future?

Mr. SULLIVAN. No.

Chairman PEPPER. Were you, as Bill Strickland, sort of mixed up about sense of values and the like?

Mr. SULLIVAN. I really didn't even think about values. I didn't have any values, none at all.

Chairman PEPPER. Incidentally, did you find any hesitation on the part of the teachers or the school authorities in recognizing your drug use and in reporting you? I mean any hesitation on their part attributable to the fact that (1) they might be sued by your parents if they reported you as a drug abuser and (2) there might be some physical attack upon the one who did that by the student who was reported?

Mr. SULLIVAN. I think the majority of my teachers didn't really want to see as long as I was in the classroom, if I was there and I didn't cause any problems in the classroom, teachers were satisfied. I mean, as long as I didn't cause any problems. It is really like as long as you are here it is all right; I don't care what shape you come in as long as you can maintain, which I did, and I didn't have any problem at all.

Chairman PEPPER. How did you get back? You seem now to be back into mature control of yourself. What happened?

Mr. SULLIVAN. Getting arrested and getting sent up. I am getting out pretty soon, about a week or two; but I have been in this ranch for 6 months now and I believe I have really found myself. I don't need to impress other people; I don't need to do the things I used to do because I am relying more on myself. I am going on to college; I have got my high school diploma; and just finding myself. I think, is the whole thing.

Chairman PEPPER. Well, now, the two of you have already spoken—you and Bill. You found yourself. Bill is 19 and you are 18?

Mr. SULLIVAN. Right.

Chairman PEPPER. You found yourself before it was too late; you still have got your youth and your health to enjoy. Have you known of any fellow students who have lost their lives in automobile accidents while they have been under the influence of drugs, or died from taking heroin or any use of drugs? Have any of your friends lost their lives because of drugs?

Mr. SULLIVAN. Yes; I know of one and I almost lost my life once in an automobile accident when I was under the influence.

Chairman PEPPER. And these crimes that you all committed. I imagine you must have had a number of hair-breadth escapes. Didn't you run the risk of being shot or being hurt by the people whom you were robbing or burglarizing? You always are running a risk, I would think, in those circumstances. What I am getting at is a lot of the students just say, "This is the period in my life—I will go through it. It is a great experience." If you decided you will come out all right, there is nothing serious; but a lot of them don't come out all right; they don't change quite soon enough?

Mr. SULLIVAN. I think one of the things I used to think about—it always happens to somebody else; it is not going to happen to me.

Chairman PEPPER. That's right.

Mr. SULLIVAN. But when it does it is a little late and the next time, say, well, I will make sure to avoid that next time and then get right back into the same thing.

Chairman PEPPER. Sue, you are a lively young lady with so much assurance of happiness in your life. What family background did you have when you got into involvement with drugs?

Miss NORVALL. My family cares a great deal for me.

Chairman PEPPER. Are your father and mother living together?

Miss NORVALL. Yes; they live together.

Chairman PEPPER. What does your father do?

Miss NORVALL. He is a hardware salesman. My mother is a dress saleslady. She sells dresses.

Chairman PEPPER. Do you have brothers and sisters?

Miss NORVALL. I have an older brother and he is straight; always has been.

Chairman PEPPER. How would you account for the fact that you got so deeply involved in this drug situation?

Miss NORVALL. Well, I didn't care about myself; I do now, though, and I am learning to care for myself more every day.

Chairman PEPPER. But you feel that you had to go through that rather hazardous experience that you have encountered in order to find yourself, is that it? At least you had to do that?

Miss NORVALL. No; I probably wouldn't have had to go through that, but I did. I don't regret it.

Chairman PEPPER. Have you had any friends who have lost their lives while they were involved with drugs or liquor?

Miss NORVALL. Oh, yes.

Chairman PEPPER. They didn't come through, did they?

Miss NORVALL. No, but that happens. That is part of life. I care for them. Some people have to do it; at least I care.

Chairman PEPPER. In many respects, I think this is the finest young generation we have ever had; they are the healthiest, the strongest, the largest. I think they are probably on the whole more keenly intelligent, probably more idealistic than any generation we have ever had and basically they come out all right; but is there any way they can find themselves without having to go through some of the gruesome experiences that drugs are leading them through?

Miss NORVALL. Yes, sir. I know of a lot of help, you know, that I have seen people—well, I know how it was with me. There is a lot of people around pushing their trips on me, telling me, well, maybe this is how it should be; this is how it was for me. You have to do it this way. Well, everyone has to find their own way to do things and they just have to feel that is right. What may be right for one person is not right for the other. This all comes from within you. You feel this. This is not a religious thing that I am talking about, though.

Chairman PEPPER. I know. Did you find among your teachers those who inspired you in the schools that you have attended?

Miss NORVALL. In Continuation school, yes; I had a lot of help and a lot of care. It helped a lot in Continuation because the school was very small and there was a lot of individual training and the teachers there are a lot more aware of what is happening with younger people than in regular, larger schools.

Chairman PEPPER. So you agree with Laura that if we could reduce the size of classes and give more personal attention to the students it would be helpful to them?

Miss NORVALL. That helps, yes; I think that is necessary and has to be that way. But also in a continuation school the schedule, the way the classes are set up, you can learn from them, learn about yourself more than maybe learning about mathematics or English, really unnecessary subjects, when what you should be learning about is yourself and other people.

Chairman PEPPER. In other words, you think that improvements may be made in the curriculum in the schools today?

Miss Norvall. Yes, sir.

Chairman PEPPER. Well, I am hopeful that this tragedy that we are having in the schools may lead to the stimulation of the school authorities, the educational leaders of the country, to reconsider and reevaluate the curriculum so they can make the curriculum more exciting, more meaningful, in terms of life, and more desiring, more challenging to the students. I don't know whether that will be possible or not, but it seems to me everyone is groping in that direction.

Laura, you told us about your mother having influenced your first use of drugs. Were your father and mother living together?

Miss MAYER. They divorced when I was, I guess, 9 or 10. My father is a schoolteacher and he lives here in San Francisco.

Chairman PEPPER. Well, now, would you just tell me again why you got into this use of drugs? Were you mixed up and you wanted to do the popular thing? You wanted to experience the thrill of it, or what?

Miss MAYER. I was very curious and also my friends were just getting into it and I wanted to do what they were doing, to be accepted again. You know, I didn't have myself, too; I didn't understand myself either. I had a lot of living to do, and I did it the hard way.

Chairman PEPPER. You didn't find much in the schools to suggest anything much to you about yourself, did you?

Miss MAYER. It is more—you know—academic things instead of people.

Chairman PEPPER. Well, I had the fortunate experience when I was in a small high school in east Alabama of having a high school principal who had the genius of inspiration. He took a small school and from that school so many boys and girls went on to college and universities all over the country and many of them made what many considered successes in life and most of us like to acknowledge our indebtedness to the inspiration of this man, that principal, who awakened our awareness to the great world outside and the invitation and the challenge of it and the like. I wish we had more inspirational teachers like that.

Did you find many inspirational teachers in your experience?

Miss MAYER. Yes, I guess I have met a few. That more or less works in the way they taught; they were, you know, without the books. They do teach us something from their experience, or relating things that they have done. Yes, I have met a few.

Chairman PEPPER. Paul, what was your family background at the time you got into drugs?

Mr. LOPEZ. My father was a junkie and my mother was a religious person. She used to go to church all the time and they used to make me go to church. My father used to be pushing heroin all the time and he just got out of prison about 2 days ago and, well, with me and my father, we always used to fight: we were forever fighting and we never got along and I never respected my mother. I always came home when I wanted and stayed out whenever I wanted to. But before, when my father used to work and before he became a junkie and started dealing, I was one of those good goodies, getting haircuts and getting really good grades in school and doing real good. But then when he got sent up and my mother and father started arguing a lot, everything just slipped out of my mind, nobody told me what to do anymore.

Chairman PEPPER. Paul, you sort of had a bad beginning, didn't you? What about now? Do you think you have found yourself? You are a fine, handsome young man. Do you think you have found some objective in life now?

Mr. LOPEZ. Yes, I have been to the ranch program; it took me a while to get used to something like that. I have been in it for 11 months and I was one of these "dinks" as they call them over there and I said while I am there I might as well learn something. We have counseling over there and there is a work school; there is everything over there. It is just like a ranch.

Chairman PEPPER. There is activity; they keep you occupied?

Mr. LOPEZ. All the time.

Chairman PEPPER. Did you all find any idle time in the schools? Didn't you find a little bit of idle time in the schools, most of you?

Mr. LOPEZ. I did.

Chairman PEPPER. Jim, you were fortunate to stay out of involvement in the drug situation. Do you attribute that to your family? What was your family background?

Mr. GRIFFIN. My father died 10 years ago and we moved out here from Philadelphia. I am a Catholic and I guess that is the way I was

brought up. But I would like to say one thing about how you said tell the parents, inform the parents, about drugs.

Well, how many parents nowadays do you think would—Catholic or Protestant or whatever—would accept it if you went up to them and said your son is using drugs? Would they accept it? They would rather forget about it; that can't be my son.

Chairman PEPPER. In other words, they wouldn't want to learn very much about it; they would rather forget about it?

Mr. GRIFFIN. True. If the neighborhood found out about it or my next door neighbor—his son takes drugs—they wouldn't want that; they would rather keep it under the rug.

Chairman PEPPER. In Miami we heard a witness who is a former Federal judge tell about his daughter being addicted to drugs, a teenager, and after she came back from one of these programs, which had done her a great deal of good, and he was talking to his friends about their children who were associates of his daughter. He knew that these children of this friend of his were using drugs. But these friends just sympathized with him about how tragic it was about his little daughter. He didn't tell them that their children were as deeply involved. But, as you said, they didn't want to recognize it, either.

We appreciate you all coming and we wish the best of everything for you in the years ahead.

Thank you very much.

(A brief recess was taken.)

Chairman PEPPER. The committee will come to order, please.

Mr. Counsel, will you call the next witness.

Mr. PHILLIPS. The next witness is Rinna Flohr.

Perhaps you could tell us what your title and function is, Miss Flohr.

STATEMENT OF RINNA B. FLOHR, ASSISTANT DIRECTOR, DIVISION FOR SPECIAL PROBLEMS, DEPARTMENT OF PUBLIC HEALTH, SAN FRANCISCO, CALIF.

Miss FLOHR. I am a psychiatric social worker with the department of public health community mental health services, with the center for special problems, and I was the coordinator of a program called "Crash Pad Program" in the San Francisco school system during the years 1969 through the end of 1971.

Mr. PHILLIPS. Could you tell us what the crash pad program in the San Francisco schools was, and what happened to it?

Miss FLOHR. Yes, the crash pad program in San Francisco schools system was an attempt to design a partnership between the department of public health and the school system to meet the emergent drug crisis that was evident in the schools at that time.

At that time, the top administration of both the school department and the health department's mental health services recognized the increasing drug problem and decided that existing manpower in the schools was insufficient to deal effectively with it. More services and more manpower were needed. Since there were reports of drug overdosing, students falling in the stairwells, vomiting, looting, and incurring injury to each other through violence, it was suggested that the personnel needed should be health personnel, medical personnel,

or psychiatric personnel. So a partnership was formed; four teams of mental health professionals with ex-addict counselors were assembled from staff employed by the health department and a program was established to be operated within four high schools in San Francisco. In each of these four schools, the programs developed by the teams reflected the specific needs of the school and the neighborhood in which it was located. Consequently, the programs designed were very different in each school.

This is a short summary of the statement I have prepared.

Mr. PHILLIPS. We have your statement and we will incorporate that entire statement in the record. It is a very, very well prepared and thorough statement.

Miss FLOHR. Thank you.

Mr. PHILLIPS. The idea essentially was to introduce medical personnel and experts into the school system to treat the drug problem directly at hand?

Miss FLOHR. Right.

Mr. PHILLIPS. And would you tell us why the program failed or why it was discontinued?

Miss FLOHR. Well the program was discontinued for many reasons. One is that when you bring outsiders into a school system you create problems along with doing that. First of all, you create problems of different orientations between health professionals that were not used to working within the framework of a school and school personnel. For example, we were concerned with insuring confidentiality in order to encourage students to utilize the services we set up. This meant allowing kids to be present during class hours in a treatment facility without teachers or anybody else knowing they were attending these crash pads. Problems resulted from this: Conflict between health and school personnel was heightened; some students abused the crash pads by cutting class and stating that they were attending the crash pad program.

Another reason that these programs were discontinued was finances and space. The program had no actual funds. It functioned primarily with borrowed staff from the health department and borrowed space from the school district. Space needs within the schools grew and the need to return personnel to the health department grew. New funds were not made available to continue this program.

The health department needed staff and staff had to be deployed back to it. I think funds for more personnel are sadly needed in this area.

Mr. PHILLIPS. Do you believe it is a desirable program that schools should have treatment and counseling facilities in the schools which are available to the students who are there?

Miss FLOHR. Yes, sir; we supplied approximately 14,000 hours of therapy sessions and counseling that were fully utilized in the schools. I believe that if you make it available there, that it will be utilized.

Mr. PHILLIPS. And it is not there any longer and it's been discontinued?

Miss FLOHR. That is correct.

Mr. PHILLIPS. Thank you, Miss Flohr. I have no other questions.

Chairman PEPPER. Miss Flohr, have you any recommendations to make to this committee as to what other innovations should be made in the schools today in dealing with the drug problem?

Miss FLOHR. I have a list of summary recommendations that grew out of my work which I would like to read into the record.

Chairman PEPPER. We will be glad to have you do that.

Miss FLOHR. Drug education and prevention efforts in the schools are excellent. The materials developed, seminars offered, and the staff development and training provided were of excellent quality with regard to content. However, even the most excellent curriculum and materials are totally useless if teachers are not familiar with them and do not know how to use them.

Some attention should be given to whether or not teachers are attending training sessions set up to instruct them how to utilize these materials. Materials that are developed are not available in large quantity. There needs to be more copies of the materials that do exist so that they can be circulated and utilized simultaneously rather than sequentially. The San Francisco schools' drug abuse teaching curriculum program was recognized by NIH as a very good program and printed by them for general distribution. However, additional very good films and teaching materials have been developed which can't get distributed because money to duplicate these materials and to make these things accessible is often cut from budgets when reviewed. If you don't have teachers learning what the curriculum is and getting comfortable with the materials, the best materials won't be useful.

Chairman PEPPER. You think it would be desirable to provide a program of education in drugs and drug abuse for the teachers?

Miss FLOHR. Certainly, and this has been going on but it hasn't been well attended.

Chairman PEPPER. Probably not well funded either.

Miss FLOHR. That is right.

Funding the lectures is not the only problem involved with teacher training: The problem is time as well. Teachers' days are fully scheduled. Often when training seminars are given they are given on weekends or after school. Teachers are asked to put in their free time to come and improve their skills. Teachers have approximately one free period a day. It is unfair to expect them to use that free period to learn. In addition, if they spend their free period learning, then they have no time to use what they have learned with the kids.

Chairman PEPPER. If they had adequate funding, the teachers could simply stay a longer period and be paid for the time they were spending learning about this problem?

Miss FLOHR. That is right; and if there were more teachers they wouldn't have to carry as large a teaching load and they could have less periods a day.

Most drug-abuse education takes place in the classroom. Since absenteeism from school is high and cutting class is common, students who are absent from class do not receive the benefits of this education. In many instances, it is exactly this group of absentee children who are abusing drugs and needing the benefits of some extra help.

Drug-abuse education is not enough. Those children who currently are abusing some drugs may benefit from educational services, but also need medical and psychological counseling services to help them break a pattern of self-destructive behavior.

Once the crisis atmosphere was ameliorated, many school personnel demonstrated that they could relate to a young drug abuser in a helpful way when they were given adequate training.

However, it also became clear that possessing the capability of helping the drug abuser meant four things: (1) having the knowledge; (2) having the ability to apply that knowledge; (3) having the ability to assess when to apply that knowledge; and (4) having the time to apply it.

Drug education and teacher training seminars saw to it that many individuals had the knowledge but many did not know when to apply it, how to assess when to use it, and many just didn't have the time.

The shortage of staff adequately trained to assess when to apply existing skills is what lead to a feeling of panic and what created the initial drug crisis atmosphere.

It was clear that the projected frequency of medical emergencies and drug overdoses had been greatly exaggerated. This exaggeration was a symptom of the panic school personnel were experiencing when faced with situations in great quantity.

Mr. PHILLIPS. Excuse me. Could you tell us whether or not the health department here in San Francisco maintains any records indicating overdoses which are not fatal?

Miss FLOHR. I am not aware of such records. Dr. Curry would be a better person to ask.

Mr. PHILLIPS. I have been asking the department and they say they don't have any.

In addition, do you know whether the schools keep any records of overdoses?

Miss FLOHR. I believe the schools do keep records because every time a referral is made to a hospital or emergency facility it is recorded.

Mr. PHILLIPS. It is reported to whom?

Miss FLOHR. It is recorded on the record, the child's record and I think a list is kept.

Mr. PHILLIPS. I don't think they have been accumulated. Do you know if they have been accumulated?

Miss FLOHR. I don't know.

Mr. PHILLIPS. Do you know if any survey of the San Francisco school system has been conducted to determine the extent of drug abuse in the system?

Miss FLOHR. I believe so. Several surveys have been conducted both by the police department in their efforts and the school department.

Mr. PHILLIPS. Have you ever seen the results of those surveys?

Miss FLOHR. No.

Mr. PHILLIPS. Well, would you not be advised of the extent of the drug problem by these surveys?

Miss FLOHR. Yes.

Mr. PHILLIPS. But you have never been so advised.

How do you account for the fact a survey exists indicating drug abuse in the school and has never been brought to your attention?

Miss FLOHR. I think there is a lack of coordination of effort in this city.

Mr. PHILLIPS. We have also been told by the State officials involved in the treatment and rehabilitation programs that are available in San Francisco that those programs are totally disorganized and "fragmented." I think was the word used. Would that be your description of them?

Miss FLOHR. I think the programs are fragmented, and recently an organization known as the San Francisco Coordinating Council on Drug Abuse has been applying for money under CCCJ to begin to coordinate these efforts and pull them together so that we are not overlapping and duplicating efforts and fragmenting services.

Mr. PHILLIPS. And it is pretty disorganized right now?

Miss FLOHR. Yes.

Mr. PHILLIPS. Thank you.

Miss FLOHR. I think the shortage of time rather than the shortage of talent proved to be the one most crucial drawback in the school's efforts. Nurses were forced to resort to provide bandaid treatment rather than the intensive treatment which they were quite capable of providing.

Counseling staff was beridden with huge caseloads, 300 to 500 cases each, and mounds of paperwork surrounding course material, student curriculum, class transfers, et cetera. Though adequately trained, they had little time to offer the more psychiatrically oriented guidance or help. Schools had only one social worker who was kept so busy making referrals out that she had no time to offer any psychotherapeutic services within the school herself.

Chairman PEPPER. Excuse me. Did the schools have in addition to what you called the social worker, a drug counselor?

Miss FLOHR. Yes, they did. Each school had a drug resource teacher that was well trained as to the materials, curriculum materials that were available and it was the resource teacher's responsibility to work with the other teachers in the school around these drug issues. We did work very closely with the drug resource teachers from the drug education department.

Chairman PEPPER. Is that still going on?

Miss FLOHR. Yes, that is going on. I want to also point out that I heard recently that the board of education denied Mr. Huber, who is the person that has organized the drug education effort and has done some outstanding work in this area, his position was rejected and I think this is a very serious problem because the incidence of drug abuse from reports of other people that I have heard here and other places have not really gone down in the schools and not only has the crash pad program and the health department efforts been eliminated from the schools, but now the outstanding drug education program is seriously threatened.

I feel that funds ought to be appropriated and earmarked specifically for counseling and drug abuse services so that schools may apply directly for these funds. I feel if they are not earmarked that they might get thrown into the general fund and I am sure you are aware there is a philosophical kind of debate going on as to what the priorities are in the schools. Basic education is certainly the first priority, but from where I sat and from what I saw, if a child was disturbed and agitated and confused and intoxicated he could not benefit from the most excellent educational courses. So something has to be offered besides education so that a child can utilize the facilities that we have in our educational system.

Mr. PHILLIPS. I think the chairman asked you whether or not they have a drug counselor in the school and I think you said yes. Isn't the person you have described as a drug counselor really a person who is in the educational program?

Miss FLOHR. Yes, that is correct.

Mr. PHILLIPS. And his main purpose is education; it is not really counseling the children at all.

Miss FLOHR. Right, he does that though as well because he has become known as the person that is most knowledgeable in the school in the area of drugs.

Mr. PHILLIPS. Does he have any time; doesn't he carry a teaching burden as well?

Miss FLOHR. I believe his teaching burden has been lessened and he has more time. Mr. Huber could respond to that better.

Mr. PHILLIPS. Fine, thank you.

Miss FLOHR. As an outsider I feel that the board of education has not been extremely supportive of these services. I have spoken with Dr. Richard Robins, who is the director of special education and pupil services, and his feeling as an insider is quite different. He feels that the board of education has been extremely supportive of these ancillary treatment services in the schools, that in spite of budgetary cuts they have not cut back counseling services in the schools and that they have reduced, made an effort to reduce the caseload of each counselor. I think what this says is that if the schools had more money to allow them to develop services, at least in San Francisco, it would be well utilized, the attitudes are favorable and positive.

I think also, that administrative accountability needs to be sought by clearly defining who are the people in charge of programs. One difficulty in our program was that there was ongoing confusion as to who was responsible for running the program and when a problem came up the responsibility and resultant blame was shifted back and

forth unproductively between the health department and the school department. If money was directly available to the schools, schools could contract out for services with health departments, if they desired, develop their own services, or contract out with private facilities who were offering good programs. This mechanism would clarify who has the administrative responsibility.

Interest on the State level such as is shown by your committee on the Federal level needs to be cultivated and encouraged so that licensing of institutions and school personnel and so that legislation and the allocation of funds that are provided federally reflect the quality sought and the concerns raised here.

Mr. PHILLIPS. On that point, Miss Flohr, we have been advised the Governor's office has a gentleman assigned going around to the various school districts in this State to tell these school administrators they have a drug problem in their schools.

Miss FLOHR. Yes, sir.

Mr. PHILLIPS. These administrators throughout the State are reluctant to admit they do have the problem. Has that come to your attention?

Miss FLOHR. Yes. In setting up our program, a typical way of dealing with the drug problem was to expel a child and, therefore, the school could say they had no problem. But the child had the problem. I think that this raises another reason why I feel that services should not be housed within the actual school facility but located nearby: What happens to the child after 3 o'clock when school ends? Who is responsible for them when the personnel has to leave, the janitor is no longer on duty, and the school gets locked up?

Mr. PHILLIPS. Maybe the school shouldn't get locked up at 3 o'clock.

Miss FLOHR. Maybe not. But whatever facility is provided, it should be available 24 hours.

Mr. PHILLIPS. I agree. Please go on.

Miss FLOHR. I think, basically, I have presented my major concerns.

Mr. PHILLIPS. Thank you very, very much for those concerns.

Chairman PEPPER. Mr. Murphy.

Mr. MURPHY. No questions.

Chairman PEPPER. Mr. Waldie has just arived. I am sure he is sorry that he was unable to hear your full statement, but he will read it in the record, Miss Flohr. I just told him you made an excellent statement here.

Miss FLOHR. Thank you.

Chairman PEPPER. Any questions?

Mr. WALDIE. No.

Chairman PEPPER. Well, Miss Flohr, thank you very much. You have great knowledge of this subject and you have made some valuable contributions to it. We thank you.

Mr. PHILLIPS. I understand you have been nominated for office here as coordinator.

Miss FLOHR. I have been nominated as president of the Coordinating Council on Drug Abuse.

Mr. PHILLIPS. Good luck in your nomination.

Miss FLOHR. Thank you.

Chairman PEPPER. We are pleased to hear that.

Miss FLOHR. Thank you.

(Miss Flohr's prepared statement follows:)

THE SAN FRANCISCO SCHOOL CRASH PAD PROGRAM. 1968–71. BY RINNA FLOHR, A.C.S.W., CENTER FOR SPECIAL PROBLEMS, CITY AND COUNTY OF SAN FRANCISCO. DEPARTMENT OF PUBLIC HEALTH, COMMUNITY MENTAL HEALTH SERVICES

When there is an epidemic the community responds. Initially attempts to control the spread of an epidemic are made through existing structures. When these seem inadequate, others are formed, in the interim, a familiar phenomenon occurs—Panic. Mass panic creates a crisis.

In 1969–1970, the San Francisco Unified School District found itself in the midst of a drug crisis. In an attempt to meet the challenge presented, the San Francisco Unified School District and the San Francisco Department of Public Health, Community Mental Health Services, redefined their relationship. Together, they conceived of a new partnership and a new structure to meet the problem created by the availability of dangerous drugs with the school system. This structure became known as a "Crash Pad" and this effort known as "The San Francisco School Crash Pad Program".

The attempt to define new services was not easy within a climate of crisis and urgency. Reportedly young people were overdosing in school, falling down stairwells and in the halls from intoxication, over-crowding the nurse's office, becoming unpredictably enraged in classrooms, starting fights in lunchrooms, severely cutting classes, vomiting, looting, and resorting to violence. In attempts to intervene and control the situation, rules were enforced, new rules were delineated, and privileges were revoked. Irrespective of the rules, the offenses continued and the ultimatums were nervously issued.

Nervously issued, because it was clear that the number of rules and restrictions already far outnumbered the availability of resources for their enforcement. Rules had been used as deterrents; when they were transgressed, the showdown was avoided and new rules were employed to act as hopeful alternatives. It was clear that a showdown was not wanted, but as ultimatums were distributed, it was equally clear that a showdown was eminent. The Hall Patrols and the Door Guards took their jobs more seriously. Students could not pass through the halls at odd times without having their signed passes on which the time had been clearly stamped, carefully checked. Classrooms were locked at the bell and students who were tardy preferred to cut class altogether rather than face the embarrassment and stigma of seeking entrance to the "learning vaults", as they became known.

Unable to enter class and not allowed to roam the halls without a pass the students experienced the excitement of danger. Should he get caught, he knew that the penalties would be far more serious than the consequences of entering class ten minutes late. But, entering a locked classroom was a mortifying experience, definite to occur. Truant, nervous, seeking a place to hide and something to calm him and occupy his time for the remaining twenty minutes before the next bell, drugs or mischief seemed an easy answer. Mischief provided an outlet for anxieties and drugs provided relief from them in the form of sedation.

It was disheartening for all to discover that in the effort to tighten controls and eliminate the problem of drugs in the schools, anxiety levels continued to rise, staff morale continued to decline, and more drug use seemed to be occurring.

In the fall of 1969, the top administration of the San Francisco Unified School District and the San Francisco Department of Mental Health, Community Mental Health Services, met and reviewed the problem at hand. Attempts to deal with the problems within the Board of Education were not seen as sufficient. The drug problem kept spreading and growing. Reportedly, more children needed help than there were trained staff within the existing school system to offer it. It was decided that personnel would be drawn from the existing Mental Health Services to provide a team of mental health professionals for each of four schools in the San Francisco School System. It was felt that the composition of the staff of the Crash Pad should consist primarily of medical and psychiatric personnel.

No funds were allocated for the program, but that which was needed was cooperatively provided by either Community Mental Health Services or the San Francisco Unified School District. Community Mental Health Services agreed to provide staff and the Board of Education agreed to provide space and whatever else they could in the way of furnishings and equipment within their facilities.

The four teams were selected, four high schools were decided upon, and a series of lectures were offered to the Public Health Staff that would be working within the schools. These lectures centered around working with adolescents, pharmacology of drug abuse, sociology of drug abuse, and an understanding of the school

system. Role-playing was used as a training technique and the staff began to feel equipped to enter the schools.

The first job of the treatment teams was to define with the administration, the teachers, the students, the parents, and the medical and counseling staff, those problems that were unique to the neighborhood in which the school was located and to that particular school regarding drug abuse.

DEFINITION OF THE PROBLEM

Everyone agreed there was a drug crisis, but no one agreed what the definition of that drug problem and that crisis was.

As we began to talk about what the problem was in each of the schools, we began to discover that it was defined differently in each school. Not only was it defined differently in each school, but, different groups within the schools had different ideas as to what was meant when we said there was indeed a drug problem. For example, to the teachers, "drug problem" related to a student's classroom behavior: If the student was sleeping through class or belligerent in class, that was the drug problem. To the administrator, the drug problem referred to more legal aspects, for example: In one school, the administrator was getting calls from the community saying that during school hours, the kids are leaving the campus and smoking marijuana or taking drugs on their property. To the students, the concern about the drug problem was that they were getting in trouble with the school authorities. Their concern was not with the dangers of the drugs they were taking, but rather with the problems of getting caught. To the parents, the concern about the drug problem was the dangers the drugs presented and the exposure their kids had to other kids who were using drugs. Parents felt it was the school's responsibility to make the school a safe place for their child to be. Their concern was the control of other children and the control of the use of drugs on school grounds.

To our staff, drugs were not the problem at all, but merely a symptom of other more underlying problems, be they the educational system itself or the personal psychological problems of the individual using the drugs.

As we began to define the differences in the perceptions of this problem, we realized that these differences added to the confusion and to the crisis situation. We had been told that the primary problem relating to drugs in the schools was a medical problem. Administrators had told us that kids were in medical crisis with drugs on school grounds, and for this reason, it was felt that there was a need for a medical team.

After being in the schools for a while with medical staff, we began to realize that this was not the case at all. At most, there were one or two medical problems a week. In the nine months in which we were in the schools, there were only five medical emergencies per school. In all these instances, the regular emergency procedures used routinely by the schools were adequate to deal with the problem. No special services were necessary within the schools themselves. In fact, it was felt that the hospital was a better place to deal with the problem of drug overdose. A great number of kids appeared to be on drugs during the school day, but most of these kids did not get into medically emergent situations. Why then was the problem translated into medical terms?

Perhaps the explanation can be found in the fact that school personnel were extremely concerned with being able to tell whether or not a child was using drugs. This meant, teachers and administrators wanted to know how to diagnose.

When asked why diagnosis seemed to be so important, the following situation was offered as explanation. One gym teacher was reported to have had a class in which there were girls who preferred to sit and talk with each other about their dates, boyfriends, and so forth, rather than taking part in physical activities. Deciding that she had had enough of one girl's malingering, she forced the girl, who had claimed she didn't feel well, to jump on a trampoline. This girl jumped on the trampoline despite protest, missed it, cracked her head, and sued the school. This girl was stoned on barbiturates. The result of this was that teachers were extremely concerned about telling whether or not a child was on drugs. In addition to this, teachers were constantly being placed in the position of wondering whether a child's poor grades or poor attention span were due to the teacher's inadequacy in teaching, the child's individual interest and personal problems, or due to an external factor, such as a drug, which, if eliminated, would enable the student to secure better grades and succeed in school.

Administrators, deans of girls and boys were constantly confronted with students who had been acting out in the lunchrooms or halls. Their concern was whether or not that child was under the influence of a chemical substance which was affecting his reasoning powers and his self-control or whether that child was intentionally being disruptive. There was an implied message that if an individual was under the influence of drugs, he should be and would be handled differently than if he was not. This implication needed to be examined quite carefully.

The medical profession was advancing the idea that drug abuses is a sickness. The judicial view was that drug abuse is a crime. School personnel were caught in the bind of deciding whether an individual who is abusing drugs is sick or is a criminal, whether he can help his behavior or cannot. We found that we became involved with helping school staff make up their minds as to where they stood on this issue. In addition, we discovered that the mere presence of medical personnel and psychiatrically-trained personnel on the school grounds alleviated school staff from feeling the burden of having to diagnose, and thereby decreased their sense of helplessness and their sense of panic when confronted with a drug abusing individual. This helped greatly to decrease the crisis atmosphere within the school system, and teacher's self-confidence was increased.

Over the next nine months, teachers learned that they could assess functioning and make appropriate referrals when an individual was not functioning appropriately. It was not important to determine whether a student was on drugs; it was important to determine whether a student was capable of functioning in the class. These simple guidelines and these simple statements seemed to alleviate much of the discomfort among the school personnel with drug users. Just by virtue of health personnel being present and available in the schools helping them to clarify their responsibilities in relation to the drug problem, much of the panic about drugs in the schools disappeared. Prior to this, every incident that happened in school, be it racial tension, theft, cherry bomb explosions in the garbage cans of the lunchrooms, or whatever, was attributed to drugs on campus. Drugs became the "scapegoat" for any source of trouble. This, however, changed as we began to work in the schools. Our being there enabled school personnel to focus on the more crucial problems of learning.

HOW WE ACTUALLY WORKED

Each of the four school programs developed quite apart from each other and ended up with very different structures and organizations. Each of these structures can be seen as a distinct Crash Pad model.

Structure No. One.—"The Lounge"

In this school, the primary concern was the legal and community problem created by kids taking drugs off school grounds during school hours. Neighbors of the schools complained frequently of kids smoking marijuana on their lawns and feared arrest for allowing this to occur on their property. Shopkeepers complained of pilfering, crowding, and illegal drug usage on their property. The major concern of this particular school was to contain those kids who were using and abusing drugs to school property. They felt the best way to do this would be to have a place on school grounds that was attractive enough to draw in the kids who were using drugs. Their hope was that kids would prefer to use drugs in this room rather than off school grounds. In effect, the school opened itself to some severe criticism as it was seen, by some, as condoning the use of drugs on school grounds by providing a room where drug use was tolerated. But in another sense, the school hoped that by attracting kids to one room labeled a "Crash Pad", there would be a certain degree of control of the problem. In addition, they felt that if this room was staffed by mental health personnel and medical personnel, that kids could develop relationships and good rapport with these individuals, and hopefully, would begin to explore alternatives to drug abuse.

This, of course, worked. Many students brought their drug usage to this room and many students began to question their drug abuse. But at the same time as this was happening, serious questions were being raised as to the ethics of providing such a facility on school grounds.

Structure No. Two.—Might be called "The Therapy Model"

In this school, it was felt by health staff that if a child was intoxicated, he was not in the frame of mind to think clearly about reasonable alternatives about his life. Group therapy was set up and participation in the group was not allowed if the child was intoxicated that day. The group experience capitalized on peer-group pressure, and acceptance into the group was seen as the first success in ridding oneself of drug abuse. Therapeutically, this program, of all four that were developed, had the most success.

Administratively, however, this program met severest criticism by the school administration. The principal felt that this approach did not alleviate the problem of what to do with those individuals who were intoxicated, since this program screened out those individuals who were intoxicated that day. In addition, he felt that those students who could meet this criterion ought to be in class, rather than participating in group therapy.

Structure No. Three.—"The Counseling Model"

In this particular school, it was felt that the problem of drugs could be handled effectively by the personnel that were already there in the school. The problem simply was that there was not enough time and not enough personnel to deal with the increased problem of drugs in the school. Therefore, our staff was seen as and encouraged to become an arm of the existing counseling department, providing one-to-one counseling services and group psychotherapy.

Structure No. Four.—"Crisis Intervention, information and education model"

In this school, the Crash Pad team related itself to the nurse's office, the drug resource teachers, and the administration, providing consultation and service as needed. The following services were developed:

First: The development of ongoing educational units on drugs with various departments, such as Civics, English, Psychology, Art and Dance.

Second: Crisis Intervention Services were offered through the nurse's office where Crash Pad staff provided evaluation, detoxification, and diagnostic interpretative services.

Third: Intensive ongoing one-to-one therapy was offered through referrals working closely with the school social worker and the guidance department staff.

Fourth: Staff development and training sessions were offered in conjunction with the drug resource teachers. The object of these training sessions was to develop student group leaders, train teachers, and to offer further in-service training for the staff of the Crash Pad itself.

Fifth: Health education around drug abuse was offered teachers, administrators, counselors, and students in conjunction with the San Francisco Unified School District's Health Education Department. The Health Education Department also developed a library of teaching aids, films, articles, and slides.

In addition, the drug resource teachers, displayed posters and other educational materials in the showcases of the school's halls. Health personnel were often called upon to review the contents of these materials for accuracy. In addition, drug abuse resource teachers often called upon the treatment team personnel to speak in classes and participate in programs as resource individuals on drug abuse.

Sixth: The provision of psychiatric consultation services to counseling, nursing, and teaching personnel were a regular part of the Crash Pad team's activities.

Seventh: Student staff members received credit for conducting rap groups and discussion groups for other students about life-styles and attitudes about drug use in today's society. These groups were often used by students in a positive way to gain acceptance by their peers. Their knowledge of the drug scene could be put to productive use as a group discussion leader where they would get recognition from their peers, rather than gaining that recognition by abusing drugs and being a leader in that sense.

Eighth: Staff provided a liaison between the students who was using drugs and the teacher who expelled him from her class, between the teacher and the administration, between the student and the administration, between the parent and the administration, and between the student and the parent.

Ninth: A group for parents was operated but participation quickly dwindled.

Tenth: An adult education course was developed on drug abuse to be offered through the adult school aimed at reaching parents who would not accept therapy, but would need a place to discuss their anxieties, concerns, myths and

problems about drugs, as well as a place to get factual information about drugs. their affects, treatment programs, and resources available in the city of San Francisco. Some effort was made to involve the P.T.A. by a presentation made at their meeting; but P.T.A. participation was rather poor and this did not prove to be a successful means of reaching the parent population.

WHAT WE ACTUALLY SAW

Approximately fifteen (15) individuals were seen each day on an evaluative or crisis basis, as follows:

1. Approximately three (3) students were seen in the Nurse's office requiring approximately two (2) hours contact each for a total of six 6) hours per day.
2) Approximately seven (7) students were seen around authority points in the school requiring approximately fifteen (15) minutes contact each for a total of one (1) hour and forty-five (45) minutes per day per school.
3. Approximately five (5) students were seen by teachers and others requiring approximately two (2) hours contact each (one hour was spent in direct contact with the student and approximately one hour was spent in follow-up) for a total of ten (10) hours per day per school.

Therefore. approximately seventy-two (72) hours were spent with students on an emergent basis per day throughout the four schools, totaling three-hundred and sixty (360) hours per week. Several of these students remained in treatment throughout the year and utilized regularly scheduled therapy hours.

In addition, many students needing intervention services, repeatedly needed them.

Approximately five (5) out of every fifteen (15) new contacts remained in some form of treatment with the Crash Pad staff.

Approximately two (2) groups per school per week were offered on an ongoing basis varying in participation from five (5) to ten (10) students per session with a session lasting approximately one (1) hour.

In terms of patient hours per year, approximately fourteen-thousand two-hundred and eighty (14,280) patient hours were offered and utilized, as follows:

1. Eighty (80) hours for group therapy per week;
2. Three-hundred and sixty (360) hours crisis intervention evaluation per week;
3. Thirty-six (36) hours for individual therapy per week.

Four-hundred and seventy-six (476) patient hours per week, × 30 weeks in a school year, totaling 14,280 patient hours per year.

Only twenty-five (25) overdoses were recorded over nine (9) months of operation.

However, two (2) to three (3) cases per school per week required some sort of medical assessment or intervention related to drug abuse.

DRUG USAGE

Most of the drugs used in the schools in those nine months in which we were there were barbiturates and marijuana. We were beginning, however, to see the use of heroin and cocaine. The use of hallucinogens in the schools was down. Their use seemed to be primarily by upper middle-class individuals. Many of the students who had used halliucinogens stopped; and heroin use began to be seen in the upper middle-class populations. Recently, we have seen a shift from barbiturate abuse to a growing use of alcohol and alcohol in combination with other drugs in the schools.

GROUPINGS

Basically, we saw the emergence of three groups of kids in the schools. These individuals grouped themselves primarily by where they came for help with their drug problem. For example: We had one group that whenever they got in trouble with drugs, came to the nurse's office for help (Group 1). Another group of kids got in trouble with drugs and were found by either the Dean of Girls, Dean of Boys, the Principal, the Hall Patrole, or the police, on campul (Group 2). The third group got in trouble with drugs and were found most often by their teachers (Group 3).

We began to look at these populations and realized that there were a very interesting phenomenon occurring. Why was it that whenever a kid got in trouble, he seemed to always get in trouble in the same place? There was very little crossing over, and we began to look at the groups more closely. What we found was very interesting.

In Group 1, we discovered the following things:

1. There was usually an absence of a male from the family.
2. The student coming to the office was usually a middle child.
3. There was report of some friction in the family, and in particular, friction with the mother.
4. The mother usually worked.
5. There was a history of many absences from school due to illnesses; and prior to the drug epidemic, this child was often in the nurse's office with complaints about other physical ailments. Since the drug abuse epidemic, complaints of other ailments diminished and drug abuse became the physical disability which brought this student to the nurse's office.
6. This group usually was female and used drugs chronically.
7. These students rarely got in severe difficulty with drugs, for they were familiar with what the drugs did to them and knew how to titrate their own dosage.
8. These students would maintain a "high" with the drugs by taking them at various intervals throughout the day.
9. It was our feeling that these students were looking for a substitute mother, and that the nurse was the likely figure in the school to act in this capacity. Unforcunately, the nurse's schedule was so busy, she rarely had time to fill this role the child was seeking. Instead, the child often met further rejection from this substitute mother, and the problem was compounded. The shortage of nursing personnel in the schools is critical. A nurse who must relate to the general health care and needs of two-thousand (2,000) students and possibly more if she covers more than one school in a week, cannot be expected to offer more than "bandaid" therapy, nor can she risk getting involved in a long discussion with a child who's resistances are down and defenses are high, and who is emotionally vulnerable.

Rather than engaging in conservation with the intoxicated student, the nurse has learned the most efficient way to deal with the problem is to usher the child in, have them lie down, make a mental assessment of the child's situation, probe slightly, but do not offend the child by accusing him of taking drugs, accept a child's explanation of his lack of coordination and sleepiness on the surface, but consider suspecting drug abuse, keep the child calm and relaxed, induce vomiting if drug abuse is suspected within the last half hour, check medical records, inform the Dean of Girls, who in turn will notify parents that medical treatment is being administered on their child, respect the privacy of the individual by providing a screen around the child so that he is isolated from the gazes of others entering the nurse's station, monitor vital signs and make appropriate medical referral.

The soundness of this approach (stated in No. 9 above) gets lost if we look at if from the student's perspective.

SITUATION

School day, morning, second period class, Algebra, test scheduled, student unprepared, nervous, didn't study because of fight with Mother that developed over housekeeping responsibilities and student's poor grades. Student called "stupid" and "good-for-nothing" during argument, student refuses, in that case, to do any chores or any studying. Disheartened, rejected, unprepared, student takes reds for the "high", the rebellion, the self-assertion, the sedation, and starts off the a.m. the same way, dropping a red approximately every half hour in order to stay "high". Test this period, escape sought, he drops more reds, loses coordination, appears drunk and tired, appears at nurse's office: Student: I don't feel too well.

NURSE (Eyeing the student's muscular sluggish coordination.) What's the matter?

STUDENT. Nothing, I'm just tired.

NURSE. (Mentally surmising drug ingestion and deciding against comment.) Well, why don't you lie down till you feel better? (Nurse indicates cot, gets blanket, then goes to Medical Records.)

STUDENT. (Thinking to herself.) I wonder if the nurse thinks I'm on drugs? I wonder if she cares? (Calling out to nurse, testing.) . . . I bet you think I'm on drugs!

NURSE. (Defensively.) No, why should I think that? (At this point the nurse returns to her record room, some phone dailing is heard, something is mumbled. Audible to the student is only the student's name and a few phrases which make little sense.)

STUDENT. (Anxiety level rising, feels she has gotten herself in a situation without a pay-off. Drug effects are deepening, creating additional anxiety; emotional liability sets in. The student feels alone, unwanted, unhappy, sorry she is in the nurse's office; begins to cry . . . At that moment the door opens and the Dean of Girls enters sternly.)

DEAN OF GIRLS. Hello, Marg, what's the problem this time?

STUDENT. (Cries loudly, turning away.)

DEAN OF GIRLS. Don't turn away when I'm speaking to you—You know I have to call your mother.

STUDENT. (Happy inwardly that mother will be called; hopes mother will come and take care of her; left-over anger at mother leaves her glad, too, that mother will be interrupted from work because of her.)

DEAN OF GIRLS. (Phoning mother.) . . Mrs. 'X', your daughter has been using drugs again. We can't keep her here. You'd better come and get her.

Mother-daughter situation aggravated, mother perceives school as telling her she's a "bad" mother because her daughter is in trouble again. Mother has already started out with bad feeling toward daughter carried over from last night. Mother must humiliate herself before her employer to get excused or must lose a half day's work and hurt her employment record in order to pick up daughter. Mother, angry, humiliated, frustrated enters school, sees daughter and starts yelling embarassing things at daughter in front of Dean of Girls, nurse, and other students waiting in the nurse's office.

Resistance lowered, emotionally liable, daughter attempts to save face while mother seeks to demonstrate that she is a "good" mother to the school authorities and will not tolerate this behavior from her daughter.

A situation, which innocently started as a means of escaping a test and winning some mothering and acceptance, ended up more agitated than before and aggravated the situation between mother and daughter, rather than served to diminish the strain and ameliorate the tensions between them.

The availability of trained staff to recognize the dynamics of this situation and others similar to it, and remedy it by apportioning as much time as necessary to the student, encouraging discussion of problems, calling the parent to reassure the parent that the child is in competent hands and is receiving medical attention, rather than reprimanding the parent and demanding that the parent drop what she is doing and come to school to claim her problem child, appeared to have an effect on:

1. Child's future drug use;
2. Parent-Child relationship;
3. Child getting counsel and/or psychiatric help;
4. Child doing better in school;
5. Child's sexual acting-out; and
6. Child's running away from home.

The most characteristic things about Group 2 (page 19) are the following:

1. All had problems with authority figures. Adolescent testing of authority is quite normal. Adolescent bragging and boasting is also quite normal.
2. This population was predominantly male with a reputation among fellow students for being a sizeable drug user (friends claim he takes reds, and that is no big deal).
3. Tends to brag more about drugs than they actually take.
4. Tends to challenge authority with drug issues since drugs are the "in" thing.
5. Points of conflict emerge around Door Guards usually when others are around to see an argument progress. Investment is winning the argument is high since it earns notches of esteem from friends.
6. Logically, actual drug usage is low so clarity of thinking is present. It is not uncommon to fake being "high".
7. Sometimes, this is the student who is engaged in pushing drugs. Nevertheless, he rarely takes them. (Cronies think otherwise)
8. Are often loud, boisterous, and frequently bully others.

Removing authoritarian individuals from positions of Door Guards and lunchroom monitors, and replacing them with unauthoritarian older staff, alleviated the problem of public conflicts. By simultaneously providing a place in the Crash Pad where these students could compete productively and with peer acceptance as a leader, the need to prove oneself in other less productive ways, such as bragging about drug use or pushing drugs, diminished.

The most characteristic things about Group 3 (page 19) are the following:

1. They were usually good students (A-B average), discovered by teachers primarily because they were coming to class regularly rather than cutting class. Consequently, the teacher knew them well and could easily detect minute changes in their behavior.

2. Teachers were often much more accurate in assessing early stages of drugs ingestion in this group than the Public Health Crash Pad team professionals, and, oddly enough, this group presented the most risk in terms of medical emergencies. The explanation of this is evident.

i. This group was most ignorant at the drug scene and tended to believe rumored dosages, and to take uncut, pure drugs in large quantities without first building tolerance to them.

ii. This group tended to use drugs around serious emotional situations in their lives as suicide gestures.

One situation from this group stands out vividly. This situation demonstrates one element of the confusion surrounding the recklessness and ignorance of the drug scene: Absenteeism in the class was high. After several warnings and several ultimatums, one teacher decided it was time to follow through on some of the threats promised if students continued to cut class. Harrassed, and upset, this teacher laid down the law, "The next person absent or tardy to this class will have to go speak to the dean before they are allowed to enter this class again." This teacher gave herself no leeway. The following day, a student who was known as "teacher's pet" was unavoidably late to class. This student prided himself on the fact that he was never late and always in good attendance; his grades were excellent. This morning, prior to class, his girlfriend stopped him in the hall and informed him that she no longer wanted to go with him and that she was going with someone else.

It is important to remember that the school is a social setting as well as an institution of learning, and that it is within the social setting that the storm and sress of adolescence is being experienced every day. It is not appropriate to think of the student as a passive receptacle of great ideas and factual material. School is a social institution within which students prepare themselves to participate as adults in the wider community.

Entering class ten minutes, distraught about the loss of his girlfriend, this student becomes the first test case of the strength of the teacher's ultimatum. Despite his student's excellent attendance record, this teacher felt obligated to demonstrate to other class participants the seriousness of the rule she had laid down the day before; and this student was sent to the dean.

Agitated and upset by this incident, this student sought help from a guidance staff member he liked. He could see through the glass that the counselor was talking with two students known on campus as drug abusers. The conversation seemed serious, so he waited patiently until the period bell rang. Then, he left to go to class, only to return and find the same two kids now in heated conversation with "his" guidance counselor. He waited around a bit, then knocked on the door. The guidance counselor came to the door and apologized for being busy and asked him to come back once more at mid-period.

He was not heard from again until his friend came running into the nurse's office saying that he had fallen down the stairs. At this point the counselor got up, raced out in the hall, and discovered the student had taken drugs and inadvertently overdosed.

The saddest part of this story is not that the student had overdosed, but rather, that this student had called out for help and his was not recognized until the cry had reached crisis proportion. In addition, the non-verbal message transmitted to the student was that "drugs were better at getting attention than people".

THE END OF A PROGRAM

At the close of the 1971 school year, the Crash Pad Program in the San Francisco School System officially ended. Staff was deployed back to the Department of Public Health, Community Mental Health Services, and space was reallocated to additional classrooms. Budgets were cut and schools had to reassess priorities. Several schools had to be closed because they were not earthquake-proof and there was a critical shortage of space.

Mandatory integration of the schools diverted administrative attention from solving the drug problem to solving racial problems. Since the crisis atmosphere had diminished, even though drug abuse was still a problem in the schools, school staff felt confident they could adequately deal with the drug abusing students and the Crash Pads became extinct.

The ongoing drug education effort offered by the San Francisco Unified School Districts' Health Education Department seemed an appropriate means to continually renew teachers' confidence and keep them in touch with the changing drug scene. In addition, our experience had demonstrated that medical emergent situations were not common, and that existing school personnel could, if they had the time, adequately determine whether there was a need for medical attention.

With the closing of the Crash Pad Program in the schools, accessibility to medical personnel again becomes a problem. There was, and continues to be, a serious shortage of nurses, psychology, social work, and counseling personnel in the upper grades. Existing mechanisms for handling the few overdose emergencies a year had proved sufficient, and no other mechanism had to be established.

SUMMARY AND RECOMMENDATION

1. Drug Education and Prevention efforts in the schools are excellent. The materials developed, seminars offered, and the staff development and training provided were of excellent quality with regard to content. However, even the most excellent curriculum and materials are totally useless if teachers are not familiar with them and do not know how to use them. Some attention should be given to whether or not teachers are attending training sessions set up to instruct them how to utilize these materials.

2. Most Drug Abuse Education takes place in the classroom. Since absenteeism from school is high and cutting class is common, these students who are absent from class do not receive the benefits of this education. In many instances, it is exactly this group of absentee children who are abusing drugs and needing the benefits of some extra help.

3. Drug Abuse Education is not enough. Those children who currently are abusing some drugs may benefit from educational services, but also need medical and psychological counseling services to help them break a pattern of self-destructive behavior.

4. Once the crisis atmosphere was ameliorated many school personnel demonstrated that they could relate to a young drug abuser in a helpful way when they were given adequate training.

5. However, it also became clear that possessing the capability of helping the drug abuser meant four things:

i. Having the knowledge;
ii. Having the ability to *apply* that knowledge;
iii. Having the ability to *assess* when to *apply that knowledge;*
iv. Having the *time* to apply it.

Drug Education and teacher seminars saw to it that many individuals had the knowledge Special training aimed at drug resource teachers, counseling personnel, and pupil services personnel saw to it that individuals had the ability to apply that knowledge. Fewer people developed that ability to assess when to apply that knowledge, and it was in this area that Crash Pad staff was most helpful. Almost no one, except Crash Pad staff, had the time within the school to apply their knowledge.

6. The shortage of staff adequately trained to assess when to apply existing skills is what lead to a feeling of panic and what created the initial drug crisis atmosphere.

7. It was clear that the projected frequency of medical emergencies and drug overdoses had been greatly exaggerated. This exageration was a symptom of the panic school personnel were experiencing when faced with situations in great quantity that where new to them and threatened their security. The provision of medical consultation and referrals rather than direct medical services, proved to be what was used even when direct medical services were available.

8. The existing mechanism for handling emergencies was adequate. No special system needed to be developed for drug overdoses.

9. The shortage of time rather than the shortage of talent proved to be one of the most crucial draw-backs of the schools' efforts in the area of drug abuse. Nurses were forced to resort to provide "Bandaid treatment" rather than intensive treatment which they could quite capably provide. Counseling staff was beridden with huge case loads (300 to 500 cases each) and mounds of paper work surrounding course material, student curriculum, class transfers, etc. Though adequately trained, they had little time to offer the more psychiatrically-oriented

guidance or help. Schools had only one social worker who was kept so busy making referrals out that she had no time to offer any psychotherapeutic services within the school herself, let alone participate in the types of services Crash Pad staff was able to provide.

10. The availability of trained personnel within the schools with time to get involved is perhaps the single most important need the school is facing. Teachers had essentially one free period a day. Those who cared, used that period to learn about the drug scene. Unfortunately, when they used this face period to learn, they did not have any more free time to apply that knowledge they had acquired.

11. When funds were short, priorities were set. Schools chose to use available monies to meet the basic educational needs of children. Counseling, nursing, psychological, social work, and drug treatment services are seen as ancillary to the education program. When something had to go, these services usually went first. These services should not be seen as an extra or luxury item. To the addicted or drug abusing child, the absence of these services interferes with his basic education.

12. Even more than before, health care services should be linked to the schools. Busing has forced the child to travel away from his home health district to an area where services are not available to him with his family after three o'clock (3:00) p.m., since health districts and school districts no longer coincide. In addition, a student should not have to leave school to improve his ability to participate in school.

13. Schools are social environments as well as learning factories. Many students come to school primarily to be with other students rather than primarily to learn subjects. Places such as Rap Groups should be provided so that students can explore and improve their social acquaintances and social functioning. Providing a place within the schools to work on peer interaction and relations may greatly reduce the need to seek peer acceptance through preparation in the drug or other subcultures.

14. When psychiatrically-oriented services were made available to students, they were utilized. When the Crash Pad Program terminated, 14,280 hours of individual attention were terminated too.

(The following letter was received for the record from Miss Flohr:)

JAMES LICK JUNIOR HIGH SCHOOL,
SAN FRANCISCO UNIFIED SCHOOL DISTRICT,
San Francisco, Calif., October 4, 1972.

Miss R. FLOHR,
Center for Special Problems,
San Francisco, Calif.

DEAR MISS FLOHR: It is my understanding that you will be making a report to a House of Representatives Committee on the subject of drug abuse. As you know, during the past from years 1968–1972, I have served as Supervisor of Counseling and Guidance for the San Francisco Unified School District. On the basis of my observations, the need for a very comprehensive program of education, orientation, and school counseling is great.

It has been my observation that our schools are in desperate need of adequate funds so that we can do the following:

(1) Provide *all* of our teachers with sufficient information and training so as to be able to identify problems and deal with emergencies.

(2) Provide counselors with necessary training and additional time to do preventative work and to help orient teachers.

(3) Provide sufficient curriculum materials so that important information can reach all students in a fashion which meets the sophistication of the times.

Otherwise, I see a need to do a better job of coordinating community and agency services intent on dealing with drug abuse problems. It is my impression that our services are fractured and that there is a lack of communication between public and private services. It has been unfortunate, too, that the fine efforts of the special Police Department program under Inspector Herb Lee have suffered so much because of a ridiculously low budget.

Sincerely yours,

JAMES HAMROCK, *Principal.*

Chairman PEPPER. Call the next witness, Mr. Counsel.

Mr. PHILLIPS. The next witnesses are Detective Stephen Hardy and Mrs. Marsha Scott, who are conducting an educational program here in the schools.

Would you please come forward.

I see you brought another gentleman with you.

STATEMENTS OF STEPHEN HARDY, PATROLMAN, AND MARSHA SCOTT, REHABILITATION WORKER, JUVENILE BUREAU, YOUTH PROGRAM, POLICE DEPARTMENT, SAN FRANCISCO, CALIF., ACCOMPANIED BY LEONARD WOOLFOLK, INSPECTOR

Mr. HARDY. The third gentleman is Inspector Leonard Woolfolk who works in our program with us also.

Mr. PHILLIPS. Thank you for coming, Detective, could you tell us, essentially, what the purpose of your program is and how you conduct it.

Mr. HARDY. We are working on a Federal grant with the police youth program out of the juvenile bureau. Our program is strictly educative. We start with the fourth grade students and work right up through the 12th grade and also civic adult groups as they request our services. Our attempt is to make the people we speak to aware of, first off, who is going to turn them on to drugs; and second, and most importantly, the heavy price that they are going to have to pay should they choose to fall into this line.

Mr. PHILLIPS. Who is the person that turns someone on to drugs, a teenager?

Mr. HARDY. Their best friend or, as you heard earlier this morning, a parent; always a close friend. There is some misapprehension among some young people and parents alike that they think that it is going to be some gentleman standing on the corner with a big trenchcoat and a hat pulled down over his eyes. Human nature is such that a person isn't going to take something from someone they don't know, first off, unless they are a fool. So we try to stress the point to them that it is going to be their very best friend, because in the first place that is who they are going to be with when this type of thing will fall into their presence.

Mr. PHILLIPS. The other point you make is you try to emphasize to them the difficulties, the hardships, the tragedies that accompany drug use.

Mr. HARDY. Yes.

Mr. PHILLIPS. And you yourself have personally experienced that tragedy by a member of your family. Tell us about that.

Mr. HARDY. I have a 25-year-old brother who is an ex-heroin addict currently on the methadone maintenance program. He became involved with drugs first off in high school, approximately, I would say, at 15 years old.

Mr. PHILLIPS. Would that be here in the San Francisco area?

Mr. HARDY. Yes. Out in the Sunset district, a so-called white middle-class area—and progressed. He was one that started with marihuana and progressed to pills and hallucinogenics and eventually to heroin.

Mr. PHILLIPS. And essentially that experience with your brother

and the tragedies that have occurred there have given you added incentive to succeed with this program?

Mr. HARDY. Yes. I think that in a program like this, especially nowadays with kids, I can, unequivocally, with the fourth graders being sophisticated and knowledgeable as they are. A program of this type must be dealt with in a realistic way because if you are not truthful with people they turn you off like that, and you might as well pack up and leave.

Mr. PHILLIPS. Do you find that youngsters in the lower grades are into drugs, or talking about drugs?

Mr. HARDY. Yes; most definitely. The first year of our program we intended to impact specifically fourth, fifth, and sixth grade, because there is a high proliferance of experimentation with both marihuana and pills, either barbiturates or amphetamines by the children, getting them either from friends or their parents' medicine chest.

Mr. PHILLIPS. In the fourth, fifth, and sixth grades?

Mr. HARDY. Yes; and this is where we initially were impacting and from there, of course, we have gone to the junior high, senior high schools ahead of schedule just because of the seriousness of the problem, and the heavy demand for our services.

Mr. PHILLIPS. I am going to ask Marsha to tell us a little bit about herself.

Could you tell us, please, a little about your background, how you got into the drug scene?

Mrs. SCOTT. I got into the drug scene and my part in the program is going out to the schools. The fact is that I am an ex-heroin addict and I used and was hooked on heroin for 7 years. My particular family background is that I am an only child from a fairly wealthy family. I started using drugs when I was 20. However, I had no drug education whatsoever in grammar school or high school and I attribute this ignorance of drugs to my getting so deeply involved that I didn't start on grass, I started right out on heroin, because a guy who I married was a heroin addict and I was totally unaware. Had I had some drug education or had been able to recognize the symptoms of drug addiction, or even any type of drug use, I feel I wouldn't have had and wasted the 7 years of my life that I did.

This is why I believe very much in the program of having an ex-addict or someone who had used or even being used as a counselor in the schools to talk to students because they can relate to someone who has used drugs.

Mr. PHILLIPS. You talk to school groups and you have talked to parent groups. Can you tell us, essentially, what you tell them, what is the message that you bring to these people in this program?

Mrs. SCOTT. The message I bring to the students is I don't go out and use the words "don't use drugs," because when you tell somebody not to use drugs, you are making a big mistake. If they want to and have in mind that they intend to they are going to do it no matter what you say. So my message is give them briefly a rundown on the background, my criminal record, and I am considered a hard-core criminal addict. Tell them that here is what happens, you do this and this is what you can expect. If you want to go out and abuse drugs that is your thing but be prepared to either go to jail, go to prison, die, or get yourself killed. There is only one way and that is down all the way,

as long as you are involved in drugs, no matter what it might be, barbiturates, speed, amphetamines, heroin, cocaine, whatever.

Mr. PHILLIPS. You tell them a little about your own experience; you say that at 20 you came from a very good family, financially, and had never been involved with drugs.

Mrs. SCOTT. Right.

Mr. PHILLIPS. What happened to you as a result of the drugs that came into your life.

Mrs. SCOTT. I started using because I wanted to be with my husband. I loved him very much and it was a matter of time once I found out he was an addict. I came and went for about 5 months, unable to make any type of decision, and finally upon moving back the last time I decided to go ahead and try it. I did try. It took about a year to lose everything that we had. I used for 3 straight weeks, decided not to use, then I got sick. I thought I had the flu. And he brought it to my realism that I was hooked on heroin.

After getting hooked on heroin I used speed, barbiturates, acid, coke. I was the type of person that once I started I just kept using and I ended up with hepatitis four times in 1 year. Coming out of the hospital they told me if I got it again I would die, which certainly didn't stop me. To support my $100- to $150-a-day habit before he went into the penitentiary, we started out with burglary, went till tapping and then to robbery and we got busted pulling a robbery across the Bay. He went to the penitentiary and I was left out there with a $150-a-day habit not knowing how I was going to support it. At one time I remember telling myself, should I ever entertain the thought of becoming a prostitute I would rather be dead, because I didn't want to get involved in this. And I might add that 99½ percent of the young ladies who become involved in narcotics, and I mean any type of addicting narcotics, end up out on the street as a prostitute.

When my husband went to the penitentiary, I went down and talked to a girl who worked on the street. It took about an hour to give me a rundown on what was going on and in 1 hour I had a new profession. I was a professional narcotics prostitute. I only planned to do this a couple of months to make enough money to buy enough stuff to deal and support my habit this way. That 2 months turned into 2 years and for the next 2 years I worked out on the street and went to jail regularly, caught a sales conviction for heroin and got 5 to life in the State penitentiary.

Mr. PHILLIPS. Can you tell us a little about the people, the other girls, kids out on the street who got into drugs and prostitution?

Mrs. SCOTT. Right.

Mr. PHILLIPS. How old were they?

Mrs. SCOTT. I was going to tell you that. In my time of working out on the street the youngest lady I ever worked with was 12. She was also a prostitute and went right into prostitution. She had never committed a burglary or anything like that but she was turned on by her brother who was a heroin dealer from New York. She ran away. He gave her a dealer's habit.

Of course, when her habit got so big and she was using up a lot of dope, he put her out on her own on the street. So rather than staying in New York, she came out here and we lived together for about 6 months, worked together on the street, and to this day, as far as I know,

she is still out there working. When I got out of jail in April I got on the methadone program and have been for the last 15 months and I have been totally clean in the 15 months, and I wanted to get involved with a drug program because we do have a drug problem and I care about seeing these young kids get out of drugs. I didn't want to get a job just to make the money. Not only young women, but young men prostitute themselves for dope. There is nothing they won't do. And I don't care what any dope fiend says when he first starts out, "I won't do this and I won't do that," there isn't anything that you won't resort to to get that one bag of dope to make you well.

Mr. PHILLIPS. Detective Hardy, you and Marsha have another associate in your program and you actually go into the classrooms and with teachers and tell them essentially what Marsha has said and display some films. I think the film that you showed me was a very, very effective one. I don't know what effect it has on the kids, but the kids in the film, many of them died.

Mr. HARDY. Yes; the film you are speaking of is called "11:59 Last Minute To Choose," which was filmed entirely in the Bay area, in the Haight-Asbury, at Mission Emergency Hospital and up in Mendocino State Hospital. It is a very realistic film.

Our presentations are done with me in uniform because we are associating the uniform with our program and Marsha. In this film there is only one person of all of the young people you see in it, who are all under 21 years of age, who has not fallen back into drug use of some type. Several of the participants of the film have died of overdoses themselves. It is a pretty gruesome, but I think very effective film because it shows young people from all walks of life and the Lord only knows that the problem is all over America now. There is no delineation to a class or specific type of people that you can definitely associate drugs or addiction with. I think this film is the most effective visual aid I have seen to this point. What we do is show the film and then I will speak a few moments relating my experiences and my views from a law-enforcement standpoint, then Marsha will speak and we will have a discussion, question-an-answer period, after that.

Mr. PHILLIPS. I would like to ask you both to comment on the question-and-answer period. I think you have both told me that kids, after they see the program, will come up and ask for help; is that correct?

Mr. HARDY. Yes; we have had several experiences with that. The one that I recall was from last spring. There were two of them. Last spring semester where we went out to a high school in San Francisco and a 15-year-old girl, who was a sophmore, sort of sat through the lecture with her head bowed and after the class was over she came up to Marsha and it seemed that her boy friend, who was a junior, 16 years old, was an addict and convinced her to fix junk with him the day before we were making our presentation. During that day he went out and bought his stuff, fixed himself, was to meet her later on after school. In the meantime he overdosed and killed himself and the chances are this young lady wouldn't have been there the next day to see our presentation had he been able to fix her at the same time he had himself.

Mr. PHILLIPS. Detective, would it be fair to say from your experiences that the heroin problem is in the schools and it goes down to as young as 14 and 15 years old?

Mr. HARDY. I would say right now most definitely. I am afraid if it continues on, that you are going to find a higher percentage of junior high students becoming involved with heroin. The problem is just growing like wildfire and one of the biggest problems that we have, both Marsha and myself, is convincing adults just how serious this problem is, and that includes teachers as well as parents, all along the line. You can just draw the line straight across.

Mr. PHILLIPS. Marsha, would you comment on the reaction that the children have after the program is over; what they say to you and what their reaction is to it?

Mrs. SCOTT. I might relate a shocking experience to people. At a very prominent parochial school, fifth graders we had talked to. A girl came up after class and asked could she please speak to me outside, a very mature fifth-grade girl. We stepped outside and she said I have something I would like to tell you and I said yes, and she said my brother, his name is so an so, is a heroin dealer and he has fixed me with heroin twice, and she wondered what should she do, you know, after she had heard me speak. She said it scared her to death. And not only had she shot heroin but she also helped him cut it with lactose. She helped him sift it, bag it up and made sales to the door, and this just literally knocked me off my feet. You know, a fifth grader, only 10 years old, and here she is wondering at 10 years old. She hasn't even begun to live and has already had her body injected with one of the heaviest narcotics and all I could see for her and told her if she stuck around and continued to be there when she was 12 she would find herself out on the street with a habit and she just almost broke down in tears. It really scared her to death to think this could really happen to her and she saw people fixing and she knew all of the terms, she knew them right down to—in order to know about using junk you have to know, and you can tell by listening to a kid talking, talking about bagging up, cutting it with lactose, making $20 and $30 "bag ballons," selling half pieces, knowing how much is in a piece and half piece, a quarter of a piece, and she just knew what was happening right down the line. This is really shocking.

Mr. PHILLIPS. And she was a girl from a good school?

Mrs. SCOTT. A Catholic prominent parochial school.

Mr. PHILLIPS. Could you tell us what would be the socioeconomic and racial composition of that particular school, or that girl?

Mrs. SCOTT. She was white.

Mr. PHILLIPS. And the people who went there were affluent?

Mrs. SCOTT. Majority white.

Mr. HARDY. I might further add a lot of times these questions aren't directed to us until either the teacher or an adult authority in charge has left; then the person questions us.

Mr. PHILLIPS. We had the same indication. We had young men testifying from Purdue University, that has a pharmacology program, and they went to the high schools and talked to the kids all over Indiana and Illinois and they felt that when the teachers stayed in the room they got no response; the kids didn't talk to them. But if the teacher left, they got a much more candid and refreshing exchange from the student body. So I guess you are having the same problem.

Mr. HARDY. Yes, sir.

Mr. PHILLIPS. I don't know why teachers don't want to know the facts.

Mr. HARDY. To me the biggest crime is the fact that these kids feel that they can't confide or trust in any particular teacher. I think that something has to be done to inform or educate teachers to being aware of what is involved here.

Mrs. SCOTT. I have put myself in the place of a child being frustrated, not having parents that you can talk to, having teachers that you can't relate to, and having a drug counselor in the school who is too busy and doesn't have the time and is really not into it. The kid feels, well, he has read it in a book but has never really been out there, and this is where I feel that bringing a rehab graduate from some kind of program into the schools where kids know that person does know what is happening and will come out and open up to them.

Mr. PHILLIPS. One other thing that you mentioned to me and that is the extent of the parent's knowledge of what is going on with some of these kids, and some of the points you made with these parents when you talked to them about their first knowledge of their child being involved with drugs. Tell that to the committee.

Mrs. SCOTT. You mean where you go out and talk to the parents and tell them about the communication between them and their child. Say a child would like to come to the parents and if he comes, say he finally gets up the nerve and feels he has trust in his parents and he comes up to them and says, "Dad, you know," this is a son and father, and the son says, "You know, I have smoked grass and I want to tell you." Well, the first thing the father does is knock him down, locks him up or takes him up to the youth guidance center and locks him up. And this is a very, very bad reaction. A parent should be taught that if his child cares about him enough and has the trust to come up and open up and openly admit the use of narcotics, this father or mother should take advantage of this by sitting down and asking why, not just jumping down their throats and saying my child is an addict. When the kid says I have smoked grass and the father and mother say you are going to die or you are going to become addicted, they are throwing out the fact that a fifth grader knows is not the truth.

Mr. PHILLIPS. The other point I think you made is you told me of an incident where the mother first learned of a daughter's addiction when she received a call from the coroner's office. Will you tell us about that?

Mrs. SCOTT. Yes, sir. Let's say at the end of a conversation or at a talk and you kind of see people kind of looking at each other and the parents, they are thinking, "Well that is not my problem, that doesn't happen in my home," and I tell them, "You know, you really can't get the full impact, it really won't hit you until some time in the middle of the night when your child is out or some day in the afternoon you are vacuuming your house and you get a call on the telephone and they say, 'Do you have a daughter or son by the name of so and so?' and you say, 'Yes,' and they say, 'Well, we have a heroin overdose case down here which is carrying identification, possibly your daughter, or your son; could you please come down and identify the body?' " Then it reaches down into their guts and tears their heart out because it falls in their backyard and then they realize that they have a problem.

Mr. PHILLIPS. Thank you very much. I have no other questions, Mr. Chairman.

Chairman PEPPER. Mr. Waldie.

Mr. WALDIE. I don't think I understand, Madam, what motivated you to get off of drugs.

Mrs. SCOTT. I got out of jail a year ago April and I had done time, over a 2-year period, prostitution time, and I got out of jail thinking and looking back on what happened to me. I had a child by a first young marriage. I had lost custody of that child with a robbery arrest and the fact that I had been to two State hospitals in the drug programs, and that was brought out in court, and I lost custody immediately of my boy.

I saw that the only way I was going was down and I had reached bottom, as low as a young woman could go in her life, and thinking that this was really the end.

I had tried every program that was made available to an addict and I just didn't succeed. The only one I hadn't tried was the methadone program and I felt maybe I had one more chance. At this point I was ready to either commit suicide or get off of drugs. I was willing to give up my life should I not be able to get on a methadone program immediately.

Mr. WALDIE. Why had you not tried methadone before?

Mrs. SCOTT. Methadone, for those of you who don't know, is a synthetic narcotic and it is a habit-forming drug. I figured all those years that I was using, why substitute one habit for another. Maybe that was an excuse, but that is how I rationalized it. Then when it was the only program left, I felt maybe it wouldn't be so bad going down and getting a bottle of orange juice every day and at least being able to live a normal life. I did go down there and I did get on it and I have been clean since.

But wanting to get off, from within myself, along with the methadone, I think is what has kept me clean. My talking and caring about narcotics, about the abuse of narcotics. Every day I talk about it. It's a constant reminder of the hate and the gutter life you live when you do fall back.

Mr. WALDIE. When you have an incident like the 10-year-old that came up to you and told you she had been fixed by her brother and her brother was dealing and she was participating, what do you do at that point?

Mrs. SCOTT. You mean myself inside?

Mr. WALDIE. No.

Mrs. SCOTT. As far as like catching the brother——

Mr. WALDIE. Well, whatever you do. Do you follow up that child; do you find out if anything is being done for that child; or do you assume that your role is concluded once you have listened to the child and then go to another school?

Mrs. SCOTT. Well, my job is to talk about drug abuse, not to go out and chase down the abuser, and possibly cause harm in the family. Our number is left with the school should that child want to call me and talk to me personally.

Mr. WALDIE. But is there anything that ought to be done to assist that 10-year-old? That 10-year-old, as you seem to perceive, is right on

the brink, and may have crossed over the brink of an enormously tragic step.

Mrs. SCOTT. Definitely.

Mr. WALDIE. She came to you for help, I presume, and it would seem to me that, if I understand you, no help is given the child; the child then is left there; and if the child pursues it further, you will talk to her. But is anyone alerted that that child is in need of help?

Mrs. SCOTT. No. Like I have felt, we should have been able to follow up on the children where they come down and talk; but the money, we don't have those kinds of funds.

Mr. WALDIE. Am I incorrect in believing that is a very big deficiency in the program?

Mrs. SCOTT. Very big, yes.

Mr. WALDIE. How often do you find people that come to you for that kind of help?

Mrs. Scott. I have had people when I first started on the program. I gave out my number to young people who wanted to call me. I was being called day and night and had to have my phone number changed and mentioned could we get some type of private counseling with myself.

Mr. WALDIE. It just seems to me if your program is succeeding, and it might very well be, it certainly has succeeded enough, at least there are instances where youngsters are giving you their confidence, that that doesn't do much for this youngster who gives you confidence and asks for help and then that is the end of it.

Mr. HARDY. We have in several cases been able to refer either the student or the person asking us to an agency within the city for further help.

Mr. WALDIE. Well, why only several cases? Here is a 10-year-old child. I can't think of a set of circumstances that would be more distressing to hear, or a child that needs more assistance than that child, and yet nothing went beyond the conversation the child had with you. I assume that child was asking for help—she was talking to you, but I guess what she was really doing was asking for help—and I gather your program affords no opportunity for giving that help to that child.

Mrs. SCOTT. Right. Our program is not set up in a way where we could, like Steve said, we can refer but we are not set up to handle——

Mr. WALDIE. What is wrong, when a child of that nature comes up to you with that problem, with telling the drug counselor in that school? Is there something that you believe would destroy the program if those confidences were revealed?

Mrs. SCOTT. Definitely.

Mr. WALDIE. Well, does whatever mitigates against telling the drug counselor about that, because it might jeopardize the program, don't you then come up with a dilemma, you jeopardize that child. The child obviously has no confidence in the drug counselor or the child would have been to the drug counselor. What happens to that child is what I am trying to find out. That child is right in the middle, isn't it? That 10-year-old, described as you have described it, came to you for help, and I don't see you gave that child any help, except to tell that child what happened to you, and that was perhaps some help.

Mrs. SCOTT. Well, I gave my number personally to her to call me so we could talk, but I left that open to her to do that. Now, once it gets around that people are confiding and you are giving up those confidences in this program, nobody will ever open up. Hopefully, we are opening up a new door to drug education whereby we can have this thing that you are talking about, where we can have the followup counseling without giving up the program as my being a snitch, because once that gets around you might as well forget it. The kids will not even listen.

Mr. WALDIE. I can understand how that would destroy the whole basic concept of the program but there has to be something between not helping a 10-year-old, that came to you asking for help, and turning them over to the authorities. There just has to be something between that and there is nothing that I have heard you describe between that.

I can gather the program would have enormous value to those not in the dilemma of the 10-year-old. The 10-year-old is there and that 10-year-old might proceed further and that 10-year-old, it seemed to me, came to you for help, as I presume a number of children do; but the program seems to have a major gap as there is no way you can help them without getting the reputation of being a snitch. And that ought not to be the case.

Mr. HARDY. That is right.

Mr. WALDIE. Do you have any idea of what happened to the 10-year-old?

Mrs. SCOTT. No, we haven't been back to the school again this year.

Mr. WALDIE. Don't you think that is a bad thing?

Mrs. SCOTT. Well, if the kid says what can I do and you refer them, what more can we do?

Mr. WALDIE. That kid wasn't referred?

Mrs. SCOTT. I gave her my number to call me.

Mr. WALDIE. But she never called?

Mrs. SCOTT. No.

Mr. WALDIE. I have no further questions.

Chairman PEPPER. I would like to ask both of you what more could be done, if you had adequate funding in the schools, themselves, to prevent drug abuse by the students and to get the students off of it who do get hooked?

Mr. HARDY. I think first off, developing a creditable enough program within each school, and I am including junior highs and elementaries, that would facilitate students feeling free to talk to someone about their problem and being able to be counseled, and to have this followed through on; not just a 2-month or 3-month period but a continual, continuum type of situation. The problem here is in developing the meaningful, creditable program with people into it enough that they are going to make the effort to do the job, because these people will not open up to anyone that they feel that they cannot trust.

Chairman PEPPER. In other words, you have got to have the right kind of people to carry on these programs.

Mr. HARDY. Yes, sir.

Chairman PEPPER. Now, you and Marsha were going into the schools. Did you find adequate programs to deal with this problem in the schools that you visited?

Mr. HARDY. I haven't to this point. A couple of the high schools are attempting to develop programs that I think will eventually be very creditable, but the problem here is the majority of teachers call us and they say to me we have to give them this education, we have to teach them something about this during the school year, and you would be a much better person to be able to do it than I would. This is the general reaction when we are asked out to the schoools.

Chairman PEPPER. In other words, it's a duty that has to be done and will you come and do it.

Mr. HARDY. Yes, sir. I feel that our program has a place in the schools but I also feel that teachers have even a bigger part because they are in contact with the students day in and day out and they are sort of pawning this duty off right now.

Chairman PEPPER. Well now, I share Mr. Waldie's expressed concern about the 10-year-old girl. She was fighting a deadly enemy there that was almost about to grasp her and she didn't apparently feel she could turn to her family to save her from it, at least she hadn't done so. Apparently, there was nobody in the school. It would seem to me that there might have been a teacher, if there had been an adequate program in the school, teachers that were knowledgeable and able to communicate, so that Marsha could have in confidence given the name of this little girl to such a teacher or such a drug counselor and then in a tactful way they could have found an opportunity to have talked to this girl and found the boy, the brother, and if need be go to the family and work the thing out someway to have given some help to this child that was pleading for help. But the system—you had a role to play but you didn't think it included further help—but the system was leaving that little child helpless to grapple with this enemy that was about to grasp her; wasn't it?

Mrs. SCOTT. Right.

Mr. HARDY. The problem is right now the system for the most part refuses to acknowledge that there is a serious drug problem and this is where we really bump our heads against the wall.

Chairman PEPPER. Well, we find that all over. The general authorities don't like to admit it; they want to brush it under the rug.

Marsha, have you any suggestion as to what kind of programs could be installed in the schools that would be helpful in preventing addiction or use of drugs by the students, or that would help them get off of it once they are hooked?

Mrs. SCOTT. I think, as I mentioned to Mr. Phillips, they should have a reputable drug counselor. I don't know what type of degree they have to have to be a drug counselor, but along with this counselor should be someone who is a graduate of some type of drug program or rehab work such as myself who has been there, working together and being able to have this trust in them so if a child feels that they are coming under the drug and they see danger, they want help, and they want help now, they can go there. How many kids, if they think they are going to get sentences to youth guidance center, are going to come in and confide in somebody; its not going to happen, you won't have a kid tell you anything, it doesn't happen. If they think they can come in and tell you and honestly get help, see, you can make a big mistake of going to the parents and saying your child, don't get excited, but your child has shot heroin. Boom, my child is a drug addict. We had better lock him up.

And keep him away from the drugs. You have right there, at the age of maybe 10 or 13 years old, you have that kid locked up and you have him in cold storage. He is going to hate everybody around him and may be using drugs for what they did to him when he was honest enough to come out and say something.

Chairman PEPPER. Would you say that an adequate educational program should also, as far as possible, include the education of the parents in dealing with drugs?

Mrs. SCOTT. Right, definitely; most definitely.

Mr. PHILLIPS. Maybe the inspector could give us his views.

Mr. WOOLFOLK. Sitting here listening to my colleagues talk, reflecting over some of the things I have personally been confronted with since going into the schools, I think having an adequate staff of counselors and rehabilitation workers isn't going to be very successful unless there is an atmosphere within the school itself that will allow the students a feeling of thinking that there is someone who has some concern. Just having two people who are there specifically to deal with those particular problems and not having the other teachers within the school, not having the administrative staff, the principal himself being concerned about what is going on, to me it seems that particular program is doomed to failure because the students are not going to have enough confidence in the program to go to the people who are there for their benefit and seek their help.

I have talked very recently with a lot of adult groups. I have talked to employee groups in the Federal Government, city government, and some other agencies. Most of the people are having a concern about the drug problem once you present it to them. Most of them don't know how to go about trying to do something about it. What should they do once they are confronted with it? In many cases, this is my own personal opinion, but a lot of the young people who become involved in drugs do so because there is no semblance of communication in the home between young persons and the parents. A lot of the young people are afraid to go to the parents and confide in them the kinds of things that are happening, the kinds of things that they are involved with. Maybe they are not even experimenting with the drugs yet but they are in an environment where its very prevalent. Some young people, and they have communicated this in many instances, have a desire to go to their parents and talk about it. Parents don't have any knowledge whatsoever. It is unfortunate that in most cases most of the parents that I have talked to have less knowledge about drugs than have their fourth and fifth grade kids who are in school.

Mr. PHILLIPS. What do you think can be done to correct that, if anything?

Mr. WOOLFOLK. Well, I think there has to be an intensified program for parents, because it is a difficult thing when you try to force something on people. They tend to turn off on it. How one would go about getting out this information to them, and whether they would be receptive to it, is a difficult thing.

Mr. PHILLIPS. Thank you, Inspector.

I don't have any more questions, Mr. Chairman.

Chairman PEPPER. Mr. Waldie?

Mr. WALDIE. Yes. May I ask the inspector one question? Maybe it is not within your realm of responsibility.

I have listened to a number of programs the police authorities and the probation authorities have instituted to attempt to help out in a situation similar to what you have described today; but I have not been able to get clear in my mind what is being done relative to a campus where you know dealing is taking place, visibly openly. Everybody is aware of who is dealing.

There are attempts, apparently, on the street, to stop the source from coming to the student dealers, but what is the best program you have seen, in your own experience, of excising that student dealer from the campus, or is there any program of which you are aware, or is there attention to that aspect of it? The attention seems to be—and I think it is properly directed—on informing youngsters as to what they may be confronting; but what happens when they don't buy that story and dealing is still very prevalent, very obvious? Everybody knows about it; what is then done?

Mr. WOOLFOLK. In San Francisco, and I can only relate to San Francisco, the narcotics investigative detail here does deal with those kinds of problems. One of the unfortunate things about this is that the narcotics people cannot go into the school and try and deal with the problem that exists there unless they are invited in by the school administration.

In many cases the school administration will not admit that they have a problem; consequently, if you don't have a problem, why do anything about it? Why do something about something that doesn't exist? So they say that they don't have a problem; therefore, they can't get the necessary people who can deal with the problem to come into the schools and do something about it.

Mr. WALDIE. Is that common?

Mr. WOOLFOLK. Fairly common.

Mr. WALDIE. Now, tell me what happens, though, with the administration that recognizes that there is a problem? Then what is the best method of dealing, of handling the student dealer that everybody knows is a dealer?

Mr. WOOLFOLK. I believe they had testimony on this yesterday. You have a number of undercover people who work in all facets of the drug world.

Mr. WALDIE. Is that the only way you can get at it, because they say, therefore, you can't get at the junior high school or the grammar school because you can't get an undercover person in there?

Mr. WOOLFOLK. Well, that creates a problem also because in many cases you may find young people within the junior high school who would be very reliable informers. There is a problem once there have been arrests made in a junior high school. Going into court, identifying the person who was the informer. It is a very tough decision from a police standpoint because in most cases the police department tries not to involve the young person to such an extent that there are going to be repercussions. It is difficult at the enforcement level when you get down to the junior high and elementary schools.

Mr. WALDIE. I can understand that the law enforcement officers find themselves in a difficult situation.

What schools have developed a means of handling that, within the school without the law enforcement people, that you believe might be on the right track; or have any of them?

Mr. WOOLFOLK. I can't think of any schools offhand in San Francisco.

Mr. WALDIE. How would you generally describe the San Francisco school system in terms of its awareness of the extent of the problem of drug use in the school system? Is it good? Is it mediocre? Or is it poor?

Mr. WOOLFOLK. I can't say specifically about all schools. I can say that at the school board level they did have a person—they had a person, I think Rinna Flohr talked about—Mr. Gene Huber, who was in charge of family health, which included drug abuse; and they were making some effort to try to deal with the problems that they knew existed in the schools.

The problem that they had was in coordinating or communicating to the people at the school level that the problem existed. In most schools they had a person designated as resource teacher; however, in many cases the person designated resource teacher had no formalized program in that school.

Mr. WALDIE. Well, I gather what you are concluding is that the system is not handling the problem well, in your view?

Mr. WOOLFOLK. No; it is not.

Mr. HARDY. Could I respond? There is one high school that we started working with last semester—Mission High School—that, I think, is making strides. This is a school that has gone to an unstructured type of situation due to a high incidence of cutting and they have two people out there who are attempting to work fairly extensively—more so than I have seen at any other school—with this problem.

They teach it as part of the family life but they deal quite specifically with drugs, and I think with the type of students going to this school that I would see some meaningful results. We are scheduled to go before nine classes this year out there and we went before four last semester.

I would have to agree with Len that it is so far inadequate what they are attempting to do; there is so much more that needs to be done for any type of results to come and it is so rampant, the dealing and selling within the schools, that possibly just education, and strictly education, is going to be the ultimate answer.

Mr. WALDIE. Thank you.

Chairman PEPPER. Well, thank you very much. We appreciate your coming.

Mr. WOOLFOLK. Thank you for having us.

Mr. PHILLIPS. Mr. Chairman, we have Mrs. Richard Bailey, president of the California Congress of Parent and Teachers Association, District 28; Mrs. J. P. Gessini, and Mrs. Joseph McDonald who are PTA health officials.

Ladies, would you please come forward?

Mrs. Bailey, you are from PTA District 28. Could you tell us briefly what location in California that is?

STATEMENT OF BETTY BAILEY, PRESIDENT, CALIFORNIA CONGRESS OF PTA, DISTRICT 28; ACCOMPANIED BY CAROLINE GESSINI, HEALTH EDUCATION; AND LOIS McDONALD, HEALTH DIRECTOR

Mrs. BAILEY. Good afternoon. It has been a long wait.

Mr. PHILLIPS. I am sorry.

Mrs. BAILEY. We have missed lunch but we have had an interesting morning listening to testimony and we only hope for the PTA that we can make a contribution today.

The 28th District is a district within the California PTA made up of Emeryville, Oakland, and San Leandro. We represent about 19,000, or a little better, membership within the 28th District and I am its president for a 2-year period.

Mr. PHILLIPS. Mrs. Gessini, you have been the woman in the PTA who has been most active in drug programs?

Mrs. GESSINI. Yes, sir.

Mr. PHILLIPS. Mrs. McDonald, you also have been active in the health area of the PTA program?

Mrs. MCDONALD. Yes, sir.

Mr. PHILLIPS. Would you ladies comment, please, on the issue of whether or not school administrators in your particular area are aware of the drug problem and are doing anything effectively about it. Could we start with Mrs. Bailey?

Mrs. BAILEY. We learned of our invitation just 2 days ago, Mr. Phillips, and had a spot check and I would briefly state that our administrators are deeply concerned and interested in fulfilling their obligation as educators, and we as parents within the community have an awareness and a concern of the drug problem.

Mr. PHILLIPS. Would you comment on that?

Mrs. GESSINI. I would say essentially the same thing; maybe some of the administrators are threatened by the problem and afraid to admit it, but they are aware and they are trying to do something about it.

Mr. PHILLIPS. When you say they are threatened, isn't it the case at least some of these administrators in your district are really unreceptive to doing anything about the problem?

Mrs. GESSINI. Maybe a couple are; yes, sir.

Mr. PHILIPS. And how do you view the drug problem in your particular community?

Mrs. GESSINI. We do have a drug problem in our particular community; it certainly hasn't decreased. In fact, with our drug abuse program we find we are treating more and treating more heroin addicts.

Mr. PHILLIPS. Is that at the teenage levels?

Mrs. GESSINI. Yes.

Mr. PHILLIPS. Is your particular community a rather affluent one here in California?

Mrs. GESSINI. Yes, sir.

Mr. PHILLIPS. Are you finding more and younger people being involved with heroin?

Mrs. GESSINI. Yes, sir.

Mr. PHILLIPS. What essentially has your school system done about it?

Mrs. GESSINI. Our district and the district administrators have been most cooperative, as has been our school board, and many suggestions have been brought up about it.

We have a parent drug education committee meeting and last year we had a student education committee and a faculty who all worked together and the suggestions that we have come up with, too, as far as curriculum and recommendations toward implementing cooperation

in the schools or implementing curriculum in the schools, have been accepted and supported by the school board and the district administrators. There has been some hesitancy in the on-site administration.

Mr. PHILLIPS. You say there is some hesitancy where?

Mrs. GESSINI. On the school site.

Mr. PHILLIPS. On the sites. Some of the principals maintain they don't have a drug problem?

Mrs. GESSINI. No; they don't say that they don't have a drug problem; but where it has been suggested and highly recommended that a specifically trained, qualified counselor in drug abuse be or a drug cadre—be supplied on campus, some of them reluctantly have said that they do have counselors on campus and these counselors should be able to take care of the problem; but these counselors are not trained to handle these sort of things.

Mr. PHILLIPS. Do you believe these counselors are adequate to handle the problem?

Mrs. GESSINI. No.

Mr. PHILLIPS. Have you any suggestions for what you believe the parents would want done in relation to the drug problems in your school?

Mrs. GESSINI. Well, I think, first of all, one of the critical issues is parent education, and parent education in the primary grades. I know that last year we initiated a program that was sponsored both by our community drug program and the schools. It was called "Dope on Dope for Parents," but this was threatening.

We have had to change this to, "Stop, Look, and Listen," but it was a drug information program for parents and also a communications workshop. These were held in very small groups—seven to eight parents, couples—led by a leader and a coleader where the drug problem was discussed, drug information was given to them, and then communications skills.

Mr. PHILLIPS. I am asking you what do you think should be done?

Mrs. GESSINI. I think they should be continued but I also think the parent education in the primary grades is critical.

Mr. PHILLIPS. In relation to children, what should be done?

Mrs. GESSINI. The drug education should be—curriculum should be implemented—K through 12—but my concerns are in who is educating the children; the teachers, what kind of training they are getting; how comfortable they are; what talents do they have for passing this information on to the children. I don't believe that every teacher is able to do this and I think that funds are needed to train them.

Mr. PHILLIPS. Do you believe that you need drug counselors in your schools?

Mrs. GESSINI. Absolutely.

Mr. PHILLIPS. Mrs. McDonald, could you just give us your comments on what you think parents feel should be done about the problem?

Mrs. MCDONALD. Well, I agree I think one thing we need is parent education, as you have heard from others here; but as you commented, when we are sitting back there the problem we have had with elementary school children's parents is the fact that they say "Well, we

have no problem; my child isn't going to get involved, so we can't."

We have had these meetings or we have had a type of parent education. You can't get them to come; they feel they don't have this problem.

Mr. PHILLIPS. And you find that is contrary to fact in many, many cases?

Mrs. MCDONALD. We all feel that it is and I think it has been proven that it is. For someone who has, say, a fourth- or fifth-grade child maybe they don't have a problem at this stage and maybe they never will. We hope that they won't; but their child will soon be in junior high and I think that they should become better informed of what is going on.

Mr. PHILLIPS. Mrs. Bailey, do you have any suggestions for what should be done in your schools?

Mrs. BAILEY. We would appeal to this committee to go back to Washington, D.C., and promote funds that we can, through the school-site principal, implement health education program, K through 12, that come in the curriculum and start as early as possible.

As we listened to the testimony today, perhaps the preschool program should be introduced to our topic today; and we certainly would make the second appeal to you gentlemen that we need help on the school sites with some sort of person who is drug oriented, educated. Of course, the principals here feel that they must make the choice so that it does fit in with their particular community and their particular problems; so we would appeal for the two: Health education including drugs and the many other social problems that we face in schools and communities, K through 12; and also some help on the secondary level.

In doing the spot check, we find that it is money and most of our answers through the mass media say perhaps it isn't money; perhaps it isn't this but from Oakland, Emeryville, and San Leandro our superintendents feel the need of more funds. If directed I feel these two appeals we make today will be felt.

Mr. WALDIE. I agree. The only functions the Federal Government, I think, responsibly plays in providing some assistance toward solutions to this problem are revenues and perhaps a level of consciousness on the part of the Congress as to the extent of the problem as well as increasing the level of consciousness of the problem on the part of the people.

I gather your impressions are in your school system there is an adequate level of consciousness of the problem among the administrators?

Mrs. BAILEY. Yes.

Mr. WALDIE. No one dissents from that view or has dissented; am I correct in that?

Mrs. MCDONALD. I think we do have some administrators that feel the problem is not as great today as it was a year or two ago. I think Mrs. Gessini will agree with me on that; but we feel that the problem hasn't lessened; it is just that the students that are taking drugs are smarter; they are not having as many school incidents, actually.

Mr. WALDIE. There seems to also be a problem in the level of consciousness of the seriousness of the problem on the part of the parents?

Mrs. McDonald. Very much so; much more so than by the school administrators.

Mr. Waldie. That has not been in any way met; and then, if I may say so, there is another level of consciousness that is deficient and that is on the part of the politicians that have to provide the money, whether they be school board members, State legislators or Federal Congressmen, Governors, or Presidents. There is a great fad in talking about the urgency and crisis of drugs in America but it is rarely followed up with much commitment in terms of resources.

I have no further comments, Mr. Chairman.

Chairman Pepper. I am very glad to hear you ladies relate what you have said here today about calling for more funds to meet this problem, because obviously that is the great need all over the country. We need a lot of other things, but you have to have the money before you can do most of the other things. Singularly enough, there has not, to my way of thinking, been very much demand upon the Congress for legislation in this particular field.

This committee initiated these inquiries into the question of drugs in the school and I believe we are the only committee of the Congress that initiated such an investigation. Due to the initiative that came from the State of New York by an investigative reporter for one of the networks, two members of the committee brought this reporter to Washington, D.C. He told us about the commentaries that he had made and appalling situations in the New York City schools. We discussed the matter and due to the general feeling that we had that we knew something about the drug problem, because we had many hearings on that, and this new evidence about the penetration of it into the schools, we committed ourselves to start the hearings in New York where we found a deplorable situation. Some described it as appalling. The prevalence of drug abuse wasn't realized, apparently, by many people.

The school board didn't have any very clearly defined policy about dealing with it. They were not even requiring observance by the school principals and teachers of the law that required reporting of instances of discovered drug abuse among the students to the medical authorities.

There was hostility in some of the schools to the police sending undercover agents into the schools to help with the problem. Sometimes the identity of the undercover agent was disclosed by some of the school authorities or by teachers; so right away we ran full tilt into the gravity of this problem. The next hearing was in Miami, where I live, and a member of a school board there described the problem as epidemic. The top three members of the administrative staff of the Dade County School Board were all off on vacation; they didn't have time to come and testify about the problem. It appeared that the county authorities had called upon the school authorities to make a survey. Most of the school authorities don't know the gravity of the problem because most of them haven't had adequate surveys to determine what was the gravity of the problems in the schools and the county school board authorities declined a request of the county authorities that they have a survey because they just sort of wanted to sweep the problem under the rug.

We found a comparable situation in Chicago, a great city like that. They did not have one single drug counselor in the schools of

the city of Chicago and they were struggling to find the money in the face of the possibility some of their schools might have to close in December because of a general shortage of funds. They were struggling to find the money so they could give drug training to just 200 teachers out of the thousands employed.

They said they did not have the money to do the programs.

So if parent-teacher associations over the country become aroused about this matter and call upon the Congress, as Mr. Waldie said, upon the Governors, and the State legislators, to put the money out and give these educational authorities the opportunity to devise innovative programs and get health authorities to cooperate with them and the police authorities to cooperate with them, I am sure that we believe that you can do these things in this country.

We don't accept the impossible here in America very readily, especially where the matter involved is something as precious as the children of this country. We are delighted to have you ladies come here with the strong presentation that you have made today and we hope you will feel that it is possible and desirable to contact others at the national level.

Don't you have a national parent-teachers association?

Mrs. BAILEY. Yes; we do.

Chairman PEPPER. Well, I think it would be very helpful if they would let Congress hear from them and know that people in the country want help in this area.

Mrs. BAILEY. Mr. Pepper, may I make a comment?

Chairman PEPPER. Yes.

Mrs. BAILEY. We are merely scratching the surface and as adults we are merely trying to play catchup. Our kids are way ahead of us. It was something that you and I did not do in our generation. Our youngsters are very well informed and, as parents and teachers, we are trying to catch up; we are trying to work on a problem. Curriculums are being formulated now; we are in the process in East Bay of this, of reaching, of helping, but it is an overwhelming problem all over our country if not the world; is this correct?

Chairman PEPPER. Yes; it is a very difficult problem, a very grave problem. There is no doubt about that, but your organization is perhaps better qualified than any other to arouse the kind of public opinion that is most likely to get something effectively done.

Thank you very much, ladies and gentlemen.

The committee will take a recess until 2:15 p.m.

(Whereupon, at 1:30 p.m., the hearing was recessed, to reconvene at 2:15 p.m. this date.)

AFTERNOON SESSION

Chairman PEPPER. The committee will come to order.

Will you call the next witness?

Mr. PHILLIPS. Our next witness is Dr. Marcus Foster, who is superintendent of schools for the Oakland school district here in California.

Dr. Foster has been superintendent of schools in this particular district for a period of 3 years and is one of the outstanding educators in the country. With him is a staff associate, Mr. Robert Newell, who is in charge of their drug education programs.

Chairman PEPPER. We are very glad to have you with us.

STATEMENT OF DR. MARCUS A. FOST[illegible] SUPERINTENDENT, OAKLAND UNIFIED SCHOOL DISTRI[illegible]AND, CALIF., ACCOMPANIED BY ROBERT NEWELL, DI[illegible]RUG EDUCATION

Dr. FOSTER. Thank you.

Mr. PHILLIPS. We would like to ha[illegible]rvations about the scope of the problem of drug abuse in [illegible]ere in California.

Dr. FOSTER. Yes, sir. We know that we [illegible]rious problem with the abuse of drugs but when one tries to get absolute numbers it becomes difficult.

We had the juvenile arrest statistics examined for Oakland in relationship to narcotics abuse—marihuana, opiates, dangerous drugs, liquor laws, drunkenness—and we did not include traffic violations.

For the year 1970, the total arrests through 17 years of age was 687 and the year 1971, when we have the complete data, the numbe of arrests was 378; and for this year so far, through June, we have 234.

What I am saying is that when one begins to try to get figures it becomes difficult, only looking at the top of the iceberg. Children who abuse drugs are much more sophisticated in the use of them; you don't see as many arrests as in previous years. But Oakland is concerned enough about the problem that we sought to hire a person who would devote full time to drug education.

This problem, as you know, is a serious problem that involves all the community and if it is going to be resolved it will take total community resources in a coordinated effort to resolve the problem. The school is one agency that has the concern and the responsibility, but we have to work with police and other agencies across the community as well as hospitals and all the rest. But the school does have a serious role to play since the school is in continuous contact with youth, probably over a longer period than any other agency.

So we did hire a drug educator coordinator to examine our problem, to develop the kind of information that would be necessary to equip teachers to recognize and make referrals of children who are abusing drugs.

We see it as a problem that education begins at kindergarten right through to the time the children leave school and ours, then, is a comprehensive program to have information, one that gets at the causes: and Mr. Newell, who came to us, was supported in his first year and a half by a grant from the Department of Public Health, State of California, and that was a grant of $49,000.

As that grant ran out, although our budget is woefully inadequate to perform all of the needed services to deliver quality education—and drug education is an aspect of quality education—and as we see our diminishing budgets dwindling even further as priorities, national priorities drain off resources into other areas. then drug education is one of the areas of responsibility of the school that suffers.

But despite our already inadequate budget, we invested general purpose money in Mr. Newell and his office in order to keep it operating.

I would then have Mr. Newell, if it meets your pleasure, describe the kind of program that he has been able to develop in Oakland and give you a sense of some of the things we are doing in the area of drug education.

Mr. PHILLIPS. Will you briefly summarize what you have been doing in relation to drug education? We have your curriculum and reports but if you would summarize that it would be appreciated.

Mr. NEWELL. Basically, we feel that the role of the school has to be in the area of prevention; primary responsibility for prevention seemingly to us starts in preschool and we are working with preschool teachers right now and kindergarten and elementary grades. The secondary responsibility of the schools seems to be in the area of treatment in cooperation with community agencies, which we do, be that police, probation, mental health services, the hospital agencies that are providing services to children.

Mr. PHILLIPS. Mr. Newell, if I could interrupt you—you say the first step you take is in prevention, which you regard as pretty much part of the educational curriculum.

Can you tell us how many teachers in the Oakland system have been adequately prepared to teach drug education in the schools?

Mr. NEWELL. Yes, sir. Bear with me a minute.

Mr. PHILLIPS. Give me an estimate; it doesn't have to be the exact number.

Mr. NEWELL. In the neighborhood of 500 teachers; all the nurses, 15 counselors, 250 clerical personnel, and approximately 60 administrators.

Mr. PHILLIPS. You say there are 500 teachers who have received some drug education?

Mr. NEWELL. 500; there are 3,000 teachers in the system.

Mr. PHILLIPS. 3,000 teachers in the system and 500 of the 3,000 have received some type of training.

Mr. NEWELL. From 10 to 50 hours.

Mr. PHILLIPS. And how do they receive the 10 to 50 hours?

Mr. NEWELL. Through inservice instruction conducted after school, on Saturday, weekends, et cetera.

Mr. PHILLIPS. And you say it is 10 hours?

Mr. NEWELL. Anywhere from 10 to 50 hours. Some teachers don't want to invest more than 10 or 20 hours and so we have a variety of offerings; some teachers want an overview course of 10 hours. Such teachers aren't interested in a very intensive program and we run 50-hour courses during the summer.

Mr. PHILLIPS. Are these voluntary courses?

Mr. NEWELL. Yes, sir.

Mr. PHILLIPS. A teacher on his own time has to go to these particular courses?

Mr. NEWELL. Yes, sir.

Mr. PHILLIPS. Who conducts the courses?

Mr. NEWELL. I facilitate the instruction along with a number of community agencies—the police, probation department, treatment and rehabilitation personnel, methadone maintenance people—whoever operates in the community.

Mr. PHILLIPS. You get guest lecturers to come in and talk to the particular groups?

Mr. NEWELL. Yes, sir.

Mr. PHILLIPS. Are they conducted downtown in headquarters?

Mr. NEWELL. Oakland has been divided into three regions and they are conducted in each of three regions, so the teacher doesn't have to travel so far.

Mr. PHILLIPS. I suppose it would be fair to say that these 500 who have attended are the highly motivated people who have volunteered their own time?

Mr. NEWELL. Yes.

Mr. PHILLIPS. And the 2,500 who haven't attended are probably less highly motivated?

Dr. FOSTER. One has to understand that we have the funds to hire just one person to give attention to this and even if the 3,000 came, we would not have the resources to provide the education they needed.

Mr. Newell is the only person that devotes full time to this in our system, so I wouldn't want to let the implication stand that the teachers who did not arrive in service courses did not come because of lack of interest. Part of it is we just do not have the resources to provide the number of experts to do the kind of job that is needed in a system the size of Oakland.

Mr. WALDIE. May I also intrude at this moment? I think the accomplishment that you have related—500 out of 3,000—is an amazing accomplishment in view of what we have been hearing elsewhere.

It is the most vigorous program we have heard.

Mr. PHILLIPS. In Chicago, we have 200 people who had less education than that and they had something like 11,000 teachers.

Dr. FOSTER. Another amazing aspect that indicates the concern of teachers in this day and age, where you have to pay teachers to take courses—that is because of the union and the teachers' asserting their rights, to which I have no objection—but these people came voluntarily and the only inducement was they could in conjunction with one of the colleges, California State, they could get half a credit; but we did not have to pay the teachers to have them come to take the course.

Chairman PEPPER. I want to join in commending these 500 teachers who, on their own time, came in to take these courses.

Mr. PHILLIPS. Is there some financial advantage to the teacher in taking the course?

Dr. FOSTER. No; in that those that need the credit can get a half, inservice, get credit from the college.

Mr. PHILLIPS. This is an advancement toward higher wages?

Dr. FOSTER. Yes, sir.

Mr. NEWELL. As an extension in instruction or for California State College, Pomona State, St. Mary's whatever—I can offer in effect to teachers a unit of credit for $6 which ordinarily would cost them anywhere from $15 to $20; and we in the Oakland public schools pick up the instructional costs.

Mr. PHILLIPS. I see. In addition, when they get the additional inservice credits, they are entitled to higher pay in some States.

Mr. NEWELL. On a limited basis they can only get so many inservice units which will go toward increased salary increment.

Mr. PHILLIPS. Could you tell us about the type of teachers who are attending the courses you are giving—young, old, male female?

Mr. NEWELL. The entire elementary, junior high, and secondary teachers; we have offered specific inservice just for elementary and secondary teachers, also in hopes that that would be an inducement so that the secondary teachers wouldn't feel they are getting something that was for elementary teachers only. We have tried to attempt to tailor it to the needs of those teachers.

Mr. PHILLIPS. Do you have anybody in the school who is described as a drug counselor, someone who is counseling children?

Mr. NEWELL. The general counselor at the secondary school has that role.

Mr. PHILLIPS. Really? Is that really his role or is he a counselor?

Mr. NEWELL. He is a counselor to handle all kinds of problems; drugs happen to be one.

Mr. PHILLIPS. Is he educated in any special way? The reason I asked that question is we have had testimony from children, we have had testimony from all over the country, that there isn't anybody in the school who is really aware, knowledgeable, about drugs, who would lend a sympathetic ear to the child who is manifesting a drug problem.

Would you comment on that?

Mr. NEWELL. The sympathetic ear, I think, although it may not carry the professional credential, that is what we are trying to do in teacher inservice with nurses and so on. We feel that hopefully students will identify with someone in the school, though it may not have the official title of counselor, to whom they can go and talk and confide and get some help and receive some help; and if not receiving help then we provide a directory of services to every school so that that individual can refer that student for help to any one of a number of community agencies.

Dr. FOSTER. One of the aims of Mr. Newell's program is to have at each school site a person identified who will be responsible for drug education in that school. When you have limited personnel then you have to multiply that person as many times as you can.

Mr. PHILLIPS. We have heard that repeatedly, Dr. Foster, throughout the country and each one seemed to have adopted the program that the first system we have to have is to have a teacher in each school who has some background who becomes a resource leader, as they describe it, for the school. That person in that school becomes the focus of all other teachers' questions, and a person who can advise about what films are available, what plans are available, what lesson plans should be adopted; then we find out that that person goes back into the school and is assigned a full-time load of teaching the seventh grade or fourth grade and has little or no time for the drug resource activity.

Has that been your experience here?

Dr. FOSTER. Yes; certainly that is our experience because in the last 3 years we have had to close out 200 teaching positions. In California you must present a balanced budget; it is illegal to do as some agencies do—deficit spending. One must have a balanced budget and we have to eliminate teaching positions so we do not have the luxury of freeing up teachers: it is not really a luxury; it is a necessity, to free people to give them the time to do this.

What we have to do is identify a teacher or a responsible person in each school and initially just to receive the material that comes in and be responsible for it, instead of putting it into the teacher's mailbox, at a faculty meeting explain the material until Mr. Newell can get there and conduct a workshop.

We have 90 schools he has to get around to visit and it is just impossible as a one-man gang.

Mr. PHILLIPS. I suppose it is almost impossible then, with those financial limitations, to do anything further to counsel or treat some child who is manifesting a drug problem?

Dr. FOSTER. Yes, sir; this is the reason I place emphasis on our program, which stresses prevention. We do not see ourselves here as a treatment program, as a treatment agency.

Mr. PHILLIPS. Assuming that you had the money for some minimum amount of treatment, counseling, some after-school counseling and group therapy, guided by additional employees of the education department, people who would report to you but would have special talents in the area of drug abuse, special training in group leadership, and things of that nature, do you see that the school board could, or school authorities could, operate a program like that to the benefit of the children?

Dr. FOSTER. Certainly; we would be very pleased to expand our regular guidance offerings to include heavier concentration on this particular problem. The matter of prevention is the key. I don't want to say that we would back away from an opportunity to engage in some treatment, some aspect of treatment, but we just don't have the resources to do that.

Mr. PHILLIPS. I think so many children are so far into drug use and abuse that prevention is no longer acceptable for a large portion of these children; I think we are going to have to do more with treatment and we have talked to some of the treatment people here. Treatment facilities are fragmented and disorganized and our sole hope perhaps is that the schools will start to take up some of that slack and give it guidance.

Dr. FOSTER. When we talk about treating causes we are talking about dealing with boredom, dealing with negative self-image, the things that drive youngsters into the abuse of drugs: and when you begin to talk about giving children an opportunity to succeed, to develop an exciting curriculum that captures their interest, you are talking about our general, basic program, which over the years has been cut back consistently.

We have seen in the last 15 years the State's contribution to local education dwindle from 50 percent to less than 25 percent. During that same period local taxes in Oakland have not been raised since 1958 for general-purpose school budget; and then we see nationally the efforts instead of being massive so that they have impact on the problems, those Federal resources come in strict categorical ways so that one can't use them to attack any other problems but the limited amount that the focus is on.

For example, we have 40 percent of our 60,000 children on AFDC and manifesting all of the deleterious effects that poverty brings, and we have 13.2 percent of our budget in State and Federal projects, we are able to reap less than a third of that 40 percent with programs that help to offset the deleterious effects of slum living and poverty. So I see drug abuse as part of that total picture of inadequate education: education that is unfunded.

Mr. PHILLIPS. I would point out that I suppose you can survive in life being a poor speller and not know too much about geography; you can't survive in life as a drug addict. I think that perhaps we

are going to have to use more of our funds, the ones that are available and perhaps the ones that Congress will make available, for this drug problem.

Dr. FOSTER. I would say this: If you have a poor speller, one who is unable to deal quantitatively with the math problems that confront us in our highly technological society, you are going to have a drug abuser; and that is where so many people fail to see that connection.

Mr. PHILLIPS. I am a very poor speller.

Dr. FOSTER. But you also are chief counsel for this committee; but if you had not the opportunity to succeed at something, if you didn't have the kind of schooling that would prepare you to do the things that you are able to accomplish, then that is what drives people into the abuse of drugs. I am saying that it is impossible to separate the two—quality education and drug education and drug abuse; they are so intertwined and interrelated. If we are able to give children a sense of their personal potency, a sense of their own power, so they have a good feeling about themselves, we are not going to have a drug abuser.

Mr. WALDIE. May I interrupt you a moment?

I find myself in substantial agreement with what you have said but I don't fully understand the parameters of the problem in the Oakland school system.

Can you identify for me the numbers of drug abusers that have come to your attention, and I presume surveys have been made of the Oakland school system?

Let me not presume. Have surveys been made of the Oakland school system of the number of drug abusers, the drugs they are abusing and the grades in which the abuse is occurring?

Mr. NEWELL. No.

Mr. WALDIE. That surprises me because I have been impressed by this program that you set up. I am wondering if the effectiveness of the program isn't limited by not being able to identify the extent of the problem; and I only make this comment because you are not unique as a school system in that regard. Thus far in the San Francisco Bay area the only school system that apparently has made any in-depth study of the extent of the problem with which they are confronted is the San Mateo school system; they have had a 5-year study that has produced some, I think, information that makes a program such as you have set up here a more meaningful program. Can you tell me why no such surveys have been made in this school system?

Mr. NEWELL. Yes, sir; in a focus on prevention, a survey—this is a personal opinion—to me represents a number of things. It represents if we identify 60 percent of the student body is using drugs, and that is a high figure—that is not what Oakland's figures are, I'm sure.

Mr. WALDIE. Why do you say that is a high figure?

Mr. NEWELL. Because I firmly believe that the majority of students are not taking drugs. And that is by far and away past the majority figure.

Mr. WALDIE. Well, I hope that is absolutely correct.

That assumption, it seems to me, ought to be demonstrable; but go ahead.

Mr. NEWELL. And the other 40 percent of the students realize that perhaps 60 percent of the student body are taking drugs, and because

of a lot of factors that 40 percent may be saying to the 60 percent, "Gee, I didn't realize 60 percent of the students are taking drugs; maybe I am missing out on something."

San Mateo, incidentally, has done an exceedingly remarkable job in the survey; however, a friend of mine in San Mateo has indicated the rumor went around school for the last survey, which is presently being taken, that they were going to put narcotics agents undercover in the event there was an increase in the use of drugs and word spread, "Don't indicate you are using drugs if you are."

What I am saying is there is a lot underneath the surface of the iceberg or the water of the iceberg and it is very difficult to tell by survey. I would rather personally go to the school and ask students, "Are you or are you not using drugs and why"; and I found without exception students will reveal that kind of information and give me perhaps an indication of the kind of drugs, when bad drugs come in, so that we can indicate that they are bad drugs—Mexican reds, et cetera.

Mr. WALDIE. Would the approach that you have outlined in your program be any different were 60 percent of the student body using drugs?

Dr. FOSTER. Let me deal with that. We are stressing a preventive program. If one does a survey and the survey says 60 percent are using drugs, that has nothing to do with the programmatic response one makes. Every child needs to know that drugs can be abused. The kindergarten child needs to know to stay healthy. Sometimes we use drugs and in a constructive way. Our program is not seen as part of crisis education, although there is a drug crisis; but it is good education for all children.

Mr. WALDIE. Well—but, Doctor, and I don't find disagreement with that aspect of the drug program; I think a drug program has to attack all phases of the problem—but if in fact you are at a crisis stage, prevention is only part of the approach and I would suspect suppression would be another part of the approach. You may not be at a crisis stage where suppression is a major part of your program, but I wanted to get into a determination as to whether that is so.

Your public health director in Alameda County estimated, if I understand correctly, 10,000 heroin addicts in Alameda County; which seems to me to be enormously high, but those were his figures. If I assume that is accurate, I would assume the drug problem in the schools reflecting the community problem would be an equally disturbing problem, and I assume it is, and I would want to know what is being done in the way of suppression.

I think your prevention program is extremely effective; as well as any we have heard in going around the country. Just the fact that you have trained 500 teachers, particularly voluntarily, when there are no resources, you have overcome that gap in a very substantial and commendable way.

But what is being done in terms of suppression if, in fact, we are at a crisis stage?

Dr. FOSTER. When you say "suppression," I assume you mean cooperation with the police in order to detect drug use and all of that?

Mr. WALDIE. That may be part of the suppression program. You alluded to suppression in this program. I noticed there is a reference to a procedure that you follow that the administrator may, and only

the administrator may, call in the police and he then can only do that under certain conditions; so suppression is a part, apparently, of this program. But I just don't understand why an identification of the extent of the problem cannot be empirically set forth; neither do I understand why an attempt to do so has not been made, although I have been told that the reason you don't do that is because you don't believe in the results that you might obtain as they might be misleading. That is one reason for not doing it.

A second reason might be that you would create hostility on the campus. Are those conclusions validly stated by me as to what you believe is the reason for not surveying?

Dr. FOSTER. No; part of it. Given limited resources, one can spend those resources making surveys or one can spend those resources devising strategy to educate and prevent. We have opted to spend our money not in sophisticated surveys that say here are these many children. We are saying let's assume that there are a number of children.

Mr. WALDIE. What have you assumed then? Let me start from that point.

Dr. FOSTER. Our assumption is that every child needs some education about drugs.

Mr. WALDIE. What is your assumption as to the extent of the problem that confronts you? What is your assumption as to the extent of drug abusers in the Oakland school system?

Dr. FOSTER. I can only refer to my opening comments when we had the police give us their figures on juvenile arrests for the last several years, which included arrests for narcotics violation—violation of narcotics laws, including marihuana, opiates, dangerous drugs, drunkenness, and those arrests up to the age of 17 for 1970 and this is not on-campus arrests; these are all juveniles in Oakland; through 1970 it came to 687; in 1971 it decreased to 378, and this year it is decreasing further.

Mr. WALDIE. That doesn't give much direction, it doesn't seem to me, Doctor. I would think this sort of a program, for example, would have to know what drug is being abused most commonly in the Oakland school system and what changes in drug use proclivities are being demonstrated by an institutional study. If heroin is now coming onto the scene, that would seem to me to be a most meaningful thing to understand. If it is amphetamines being abused or barbiturates or alcohol, it would occur to me that this program would be oriented in different directions if you knew that. I gather you don't know that.

Dr. FOSTER. And I would say, sir, you leaped to an assumption that is not based on fact.

Mr. NEWELL. Basically, we see our program as being comprehensive in an instructional manner for kindergarten through 12th-grade students. We recognize that marihuana and barbiturates are basically the drugs that are being used and/or abused in the schools; but at the same time we recognize that alcohol and tobacco are probably the most dangerous of the drugs; and so our focus includes the entire spectrum of drugs. We feel that every student by the time he is through the fifth grade needs basic information about all of the drugs; from that point on the students' empirical information may transcend anything the teacher may tell him, so our focus is on a different aspect.

Mr. WALDIE. If you have the resources. would you find a study of what the situation is in the Oakland school system related to drug abuse of value?

Dr. FOSTER. When we are dealing with a serious human problem all data we can get about that problem would be useful.

Mr. WALDIE. If you had the resources such a study would then be of value?

Dr. FOSTER. We would want to use that with other information that we can gather.

Mr. WALDIE. Of course; but I do gather the lack of that information is a handicap that you would overcome had you the resources?

Dr. FOSTER. Yes; but it would not materially change our emphasis and focus on the K through 12 informational, instructional prevention approach because we see that as part of quality education.

Mr. WALDIE. Would there be any other approach that might be dictated if the information indicated that you were at a crisis stage, or would that still be the approach you would maintain?

Dr. FOSTER. If you are in a school system with 60.000 people and deep in the midst of a crisis, you can't hide it; it manifests itself; and we deal with it as it manifests itself. If there is a concentration or outbreak or use of drugs that exceeds what has been the pattern heretofore, the police are alerted to it, the principals, supervisors, our counselors—that information becomes available.

I wouldn't want to have you feel that one has to have someone come in and do a statistical survey to know what is going on in a school. As a high school principal you are aware of the slightest day-to-day changes in the student body and its population, and drug abuse when it becomes excessive manifests itself. I don't know of any who have had the experience of being a high school principal or junior high principal——.

Mr. PHILLIPS. How does it manifest itself? Does it manifest itself in absenteeism?

Dr. FOSTER. It might be absenteeism.

Mr. PHILLIPS. Dropouts?

Dr. FOSTER. A kind of listlessness on the part of students.

Mr. PHILLIPS. There is absenteeism in your schools?

Dr. FOSTER. Certainly.

Mr. PHILLIPS. And substantially absenteeism is a problem; isn't it?

Dr. FOSTER. Any core city has; I don't know any that doesn't have some problem, but we are proud to say in Oakland in the first year of our administration we reduced unexcused absentees at the secondary level 34 percent and the elementary level 21 percent; and that is being maintained.

Mr. PHILLIPS. What is your absenteeism now?

Dr. FOSTER. I haven't looked at the figures. We have been in school 10 days.

Mr. PHILLIPS. For the last term?

Dr. FOSTER. I don't have the figures on it.

Mr. PHILLIPS. Can you tell us?

Mr. NEWELL. Unexcused absences, 8.9 percent.

Mr. WALDIE. If the doctor says he doesn't be' that the school system in Oakland has reached a crisis stage, I .ccept that and I presume that is your belief?

Dr. FOSTER. I believe that if 10 children are abusing drugs in their lives, that becomes a crisis; I don't believe in waiting for a critical mass to develop and say now we have the crisis. If 20 children, two children, are abusing drugs, I consider it a crisis.

Mr. WALDIE. Right. Let me put it this way. You do not believe there is anything occuring in the Oakland school system that would cause any departure or addition to the program that you presently are implementing?

Dr. FOSTER. Given the resources——

Mr. WALDIE. I am not saying given the resources.

Dr. FOSTER. This is totally inadequate.

Mr. WALDIE. What we are trying to find out, Doctor, as a congressional committee, is the extent of the problem. We know that the resources are deficient; we know that that is given in any situation, but particularly in education and particularly in California, resources are never sufficient to do the basic things that have to be done; but it is potentially possible, conceivable, that Congress, if they are sufficiently motivated, can assist in this area? I gather from what you tell me that you believe that this sort of a program will meet the problem you have; you would like to have it enriched with more instructors and more resources, but the problem is really an educational problem and the problem is not really any greater than that at this moment?

Dr. FOSTER. Yes; I would say that it is an educational problem. I don't see it as a problem for stationing undercover agents on campus.

Mr. WALDIE. Let me get into that because we have a different philosophy from school district to school district, and I don't know which is right.

Is it believed undercover agents on the campus are destructive to the educational process to the point where they should not be permitted?

Dr. FOSTER. Yes, sir.

Mr. WALDIE. And so they are not permitted on the Oakland schools campuses?

Dr. FOSTER. We cooperate with the police; we don't have them because no one has come forward with a suggestion that we have the kind of situation where it would be useful.

Mr. WALDIE. All right; but no one knows, do they?

Dr. FOSTER. The point that seems to be alluding us is that if your problem is of sufficient magnitude that it becomes disruptive to the educative process, you know that you can't hide it. In the days of student unrest, when campuses had riots and walkouts, no one had to have a survey to find out how many children were involved in it; the school was automatically disrupted the minute the unrest burst forth.

Mr. WALDIE. We haven't hit that point, obviously.

Tell me, Doctor, why you believe that undercover agents on campus are destructive of the educative process?

Dr. FOSTER. It is a special kind of approach that is antithetical to life in a democracy. We are dealing in a school setting with a problem that can be, we feel, handled through educational processes.

Mr. WALDIE. Can you handle the dealer on the campus through educational processes?

Dr. FOSTER. We have the local police that deal with that.

Mr. WALDIE. Do you call them onto the campus?

Dr. FOSTER. When we need to. When we need to, and they conduct a surveillance and these youngsters who are selling, they not only sell at school, they also sell in the community. The police come and tell us we want to see so and so because we know he is selling and they tell us about it.

Mr. WALDIE. Do they come on the campus only at their initiative?

Dr. FOSTER. If we need to, we send for them.

Mr. WALDIE. Have you ever done that?

Dr. FOSTER. Oh, yes; definitely.

Mr. WALDIE. When you identify a dealer, do you call the police?

Dr. FOSTER. Definitely.

Mr. WALDIE. All right. You are the first one I have heard say that in the campus community so far.

Dr. FOSTER. Definitely.

Mr. WALDIE. When a dealer is identified on the school campus, the police are called in?

Dr. FOSTER. Definitely. The youngster is arrested. He is breaking the law in a most serious way, not only affecting himself but his peers.

Mr. WALDIE. I would think that were so and yet I am uncertain enough in this field that I don't make any hard and fast conclusions: but other educators have not indicated that is the practice and the Oakland police that were here yesterday were ambiguous on the point because I asked them if they, in fact, did any of their work on the campus. They said, "No"; they are too busy on the streets to get onto the campus, was their reason. They didn't suggest there was a hostile attitude on the campus; they said they were too busy on the street.

Dr. FOSTER. That is the point I was making. They identify these fellows because they sell in the neighborhood and if they have to make an arrest and they know the child is going to be at school, we cooperate and have that child.

Mr. WALDIE. I think that your idea of preferring to call the police onto the campus when you have identified the dealer is a better situation than the undercover agent, although some police practices may be difficult. You have identified the dealer; I don't see how unless you are willing to testify this is a dealer. I guess you could do that?

Dr. FOSTER. We have nonteaching assistants that are sophisticated themselves in the matter of drug abuse. Every one of our schools has campus aides, as they are called, and they are alert to the problem and they have good working relationships with the police.

Mr. WALDIE. What is that program? I would be interested in that.

Dr. FOSTER. This antedates my coming to Oakland, but my understanding is it probably grew out of the days of student unrest and activism when they felt they had to have adult supervision of playgrounds and in places where students congregate in less than a regularly supervised classroom situation; so the remains of that now would be found in the campus aides in halls, people who walk through the halls. We still have some of that and that is another reason, and there the role of this person is supportive of the student and it doesn't smack of the kind of police state where I am going to catch you doing something. They are alert for the people who come from off the campuses, these older youth out of school, and these people know the students of that school and they are identified, those as they come onto the campus to conduct illegal activities.

Mr. NEWELL. The schools called the police on seven specific occasions that I am aware of last year for selling and possession of drugs.

Mr. WALDIE. That is where I got lost. I didn't understand the policy. I think I do now. Also, I think I approve of it.

I have no further questions.

Mr. PHILLIPS. I have no other questions.

Chairman PEPPER. Appropos of the point that you were just discussing with Mr. Waldie, would the teachers, the school principals, and the assistants on the school premises, if they saw or reasonably could have seen a violation—a sale or something that looked like a violation of the law—would they report that to the principal or to the police?

Mr. NEWELL. Yes.

Dr. FOSTER. The first responsibility would be to report it to the principal. The principal is in charge of the operation of this school and it would be his judgment as to whether it would be indicated that a——

Chairman PEPPER. But the teachers—we have had testimony that the teachers will turn the other way a lot of times to keep from seeing a student who seems to be under the influence of drugs, or maybe to avoid seeing a sale or transaction because, first, they might get sued by the parents if they report that a child was engaged in some sort of illegal activity or drug abuse; and, second, they might be fearful of some personal attack that would be made upon them.

Have you had any experience with that?

Dr. FOSTER. When you have 3,000 teachers I am sure in that number you find the kind of people that are found in the general population, who don't want to get involved in things and in order to avoid being involved would look the other way. But I would say the large majority, most of our teachers, are conscientious about their work and about the safety and care of children and would report such activity.

Chairman PEPPER. Is there a directive from you as superintendent and through you from the school board that they do that?

Dr. FOSTER. Yes; and further, the law in California deals specifically with attacks upon teachers and what not. It makes it illegal for a principal or any other school employee to try to persuade a person who has been attacked not to reveal the information. You understand that sometimes in the teacher fraternity some schools are more concerned about the reputation of the school rather than the safety of the student in terms of turning over the lawbreaker, and in order to keep the name of the school out of the paper there is a tendency sometimes, to avoid that publicity by not reporting it. We say, definitely, if you do this it is a disservice to the student; it is a mistake in kindness to avoid that real obligation of getting medical help for the child. Frequently that child is turned over to his own doctor.

Chairman PEPPER. We found in our hearing in New York that the school authorities, the principals and the teachers, were not complying with the law which required that any instance, where it was discovered that a student was abusing drugs, should be reported to the medical authorities of New York City. There were a number of reports that were made after we held our hearings there and called public attention to it; then the school board evidently sent out a directive and they

began to require those reports. They were not making those reports at all.

Doctor, let me get some perspective, if I may. You have said you have 3,000 or 3,500 teachers in the Oakland school system?

Dr. FOSTER. 3,000.

Chairman PEPPER. You have 60,000 students——

Dr. FOSTER. That's right.

Chairman PEPPER. What is your annual budget?

Dr. FOSTER. We have a total budget of about $90 million; but in the general purpose budget, that is where you hire your teachers and all, we have about $46 million.

Chairman PEPPER. Well, now, please tell me how much money are you spending and how many people are you employing in your whole program in your Oakland school system for the prevention of drug abuse among your 60,000 students and in your program to try to get off of drugs those who are using them in your school system?

Dr. FOSTER. Yes; the grant that brought Mr. Newell to us was $49,000.

Chairman PEPPER. Where did you get that?

Dr. FOSTER. That was from the Department of Public Health, State of California. When that grant ran out, we took out of the general purpose budget sufficient funds to pay Mr. Newell's salary and the salary of his secretary: that is $27,000.

Chairman PEPPER. So that is the amount that you are spending on the program?

Dr. FOSTER. There are all kinds of inkind support and what not—the reproduction of some of these materials.

Chairman PEPPER. Are you getting any Federal money?

Dr. FOSTER. No.

Chairman PEPPER. So that is the budget that you are working on with a 60,000-student load here in respect to the drug problem?

Dr. FOSTER. Yes, sir; and we say it is totally inadequate.

Chairman PEPPER. Now, Doctor, let me ask you this: Just suppose this Congress were to do what this committee will hopefully do, and we will try to get it to do, I anticipate, and that is make sufficient money available to you to put on the kind of program that you as an educator would think would be the best. What do you think you could do toward prevention and correction of drug abuse in your Oakland school system? What sort of a program would you innovate if you had the money to do it?

Dr. FOSTER. I would first want to thank Mr. Waldie for his comment about what we have been able to accomplish with so little.

Chairman PEPPER. I join Mr. Waldie in the commendation. I think you are one of the most knowledgeable and one of the most concerned authorities that we have found, as Mr. Waldie has indicated, in the area. We commend you.

Dr. FOSTER. Thank you.

The next step would be to have in each of our regions, the three decentralized regions. a person who would be the counterpart of Mr. Newell. He would then be the citywide, districtwide, director of the effort within each region, each region comprised of about 20,000 youngsters; and then each one of those directors in the region would have

staff. Currently the only staff that Mr. Newell has is his one secretary, but we would have a staff to those people that would intensify.

Chairman PEPPER. Don't you think you would at least have to have one person in each school?

Dr. FOSTER. I am coming to that. We could intensify our educational effort and those regional drug educators would then begin to develop in each school, in each school site, a responsible person who would be identified. We would go at it with the zeal that some people are trying to identify draft counselors in each school and you had to put a sign up, "This is a draft counselor"; but we would have these people very knowledgeable about drug education and they would be at the school site. Then we would want to go beyond that and in terms of the materials that we have, the cross-age teaching where all of the children would be working with the younger children. There are a number of activities, but part of that key would be to improve the general educational program so that we could begin to develop students who can read, write, and count and have a high opinion of themselves and chances of the future; and that would all go into our drug educational program. It would take place in the general educational program.

Chairman PEPPER. Doctor, we had a medical doctor in the Chicago system testify last week that most of the dropouts were academic failures in the schools; maybe they were not academically disposed or inclined; maybe the curriculum didn't adapt to them. They said in the city of Chicago they had 12,000 dropouts last year and we know that the dropout is almost inevitably headed for juvenile court. The juvenile judges tell us about 50 percent of those who come through the juvenile court wind up before very long in the penal institutions of the country. So the dropout is a very serious problem.

Do you have any problem with dropouts here?

Dr. FOSTER. Yes, sir; and fortunately we do have some title VIII money coming into Oakland for dropout prevention.

Chairman PEPPER. In other words, that is an area, too, where innovative curricula is necessary.

Dr. FOSTER. Yes, sir.

Chairman PEPPER. I know in my State of Florida, except in one county, vocational education has not been available in our public schools until the 10th grade. The dropouts have nearly all dropped out by that time, it seems to me.

You were talking about innovative programs and in trying to inspire students to find schools meaningful. We have had witnesses right here who said they took drugs in order to keep from being bored.

Dr. FOSTER. Yes, sir.

Chairman PEPPER. In the schools.

Dr. FOSTER. Then I dwell on a point you made, our concept of career education K through 12 endeavor and youngsters in the kindergarten when they talk about neighborhood helpers, and what not, begin to look at vocational alternatives and understand decisionmaking; how that forecloses—if you make one decision it forecloses one. We see our alternative model. We have a program that is an employer-based educational program; we started this year with 50 children; we hope to extend that to a thousand. What we have failed to recognize in the past is that children have a variety of cognitive styles and we have tried to

fit them all into one type of approach to develop, and what we are saying is that we know that the styles of learning are varied and we make no qualitative judgment as to whether this style is better or not, it just manifest as human beings relearned in different ways so we have this model that is going on with 50 children now taking education in stride. We have another model where we call it Renaissance School where the youngsters are focusing in a kind of less structured environment, centering on art as one of the major interests.

We are opening a school, we haven't named it yet. whether it is going to be Galileo, but it is up at the Showboy Science Center where we have a planetarium and a group of youngsters will be learning there.

We have some 7,000 of our children taking all or part of their education in the real world of work in the science laboratories and in industry and commercial establishments. So what I am saying, sir, is that we have to recognize and we are trying to act on that recognition that we cannot force children into the same traditional educational model that seemed to fit ages ago and it really didn't fit then, but our dropouts were less noticeable because they could be absorbed into a less technical society but now children out of school without skills are not employable, automation has wiped out the succession of jobs that led from the helper up to the skilled mechanics, they have to come with skills. and if you send them out without skills you pile up what is called social dynamite we have seen explode in the cities around the country.

Chairman PEPPER. You are vindicating the confidence that I have had that if we give the schools the money you educators, and you seem to be one of the most enlightened educators I have met in our public schools systems, you educators by experimentation and by innovation can discover and develop programs that will come to grips effectively, perhaps not perfectly, but effectively with this problem.

Now, there are some people who have told us—some people in high places in Washington in the drug program look with a jaundiced eye on any effort on the part of this committee to get Federal money to help you educators try to do something about a problem within your school; not outside of the schools but in your schools, with your own students—they say the only thing you school people should do, if one gets too obstreperous, they can have him arrested on the campus, dismiss him, turn him over to the community, let somebody else set up a system to deal with him.

Who is better qualified to develop the kind of imaginative. interesting, challenging, and innovative programs than you educators?

Do you feel that if you are given the moneys, that the school system, the educators of this country, can do a great deal toward the prevention and the correction of drug abuse?

Dr. FOSTER. I do indeed think that, sir, and I think society rightfully looks to the schools during times of crisis; Sputnik went up and the schools were the place that became the focus and the focus of our problem, not turning out our scientists. We see more and more things added to the school and society is correct in that because we are in continuous and prolonged contact with youth. And while we didn't want to be at the posture that we can solve it as an institution working alone, but we say we have a heavy responsibility for what happens to youth and responsibility for coordinating the efforts of other youth-

serving agencies, so the impact in the way that serves the best interest of that youngster.

Chairman PEPPER. Do you have all of what we call the intramural athletic events and activities that you would like to have on your campuses?

Dr. FOSTER. We have the interscholastic program. If we were given resources we would expand the intramural program where the youngster who is not going to be good enough to make the varsity could have the joy of competition and developing an interest, what might be a lifelong interest in tennis and he may never be ready to go on the tournament circuit but for his personal satisfaction. So we would like to expand that. But one of the first areas you begin to cut when your budget begins to shrink are those areas that people see as not being the essential curriculum areas and you begin to cut off some art and some music and cut back on your athletic program and you chop away and it becomes a kind of masochistic endeavor of taking off an arm and leg and trying to still survive, and our programs, especially the cities, sir, are so meager that it is amazing how they are able to meet the children that we do serve effectively. We know from looking at scores that tie in with poverty and school achievement is so close that in Oakland the correlation is 0.89, that is if you rate the school and use AFDC as an indicator of poverty schools, with the highest concentration of poverty are the schools that have the lowest in terms of academic achievement.

I just say it is immoral that we doom a child to a life of lower achievement because he was born poor. Our society has to understand that the dollars that come to us are like trying to dip the ocean dry with a teaspoon. We are going at moving this problem with a little shovel and broom. We need a massive steam shovel to begin to move it. Our dollar income of 13.2 percent equals about $3 million. It translates into that kind of money and that we don't reach the needs of a third of the children who don't begin to address themselves and, as you know, the title I moneys are add-on funds. So if your basic program is inadequate to begin with and then you add on a little pittance and say this is going to solve all of the deleterious effect of slum living, it is an exercise in futility. But despite that we have begun to see some breakthroughs in Oakland.

When you say to people who are not in education that one of the first goals we set was to achieve 1 year's growth for a year's instruction, that seems very modest. But for the poor, for the alienated, for the population heretofore that has not been reached, it is the breakthrough—just to get a year for a year. And yet in some of our schools it would be, to be precise Woodrow Wilson, our children, this is a slum school, poor school, they are achieving 3 month's growth for every month in school. It flies in the face of the kind of data that we here developed when they say the poor people may even be genetically inferior. I am concerned about the drug abuse and drug education but I am concerned about education in toto, and you are right, sir, if you are booked on dope you are doomed to a kind of dead end life, but I would submit in this highly technical society if you leave school without skills you are doomed to a dead end.

Chairman PEPPER. And society is going to have to pay for them out there beyond the school; they will be in the prisons, in the courts,

they will be committing crimes, they will be on welfare, unemployment compensation, and the like, unless we are going to dispose of them on a hillside and, like the Spartans, let them die.

Dr. FOSTER. Exactly.

Chairman PEPPER. Well, Doctor, I thank you. We may want you to come up to Washington and be a witness before the Education and Labor Committee that will also be dealing with this matter.

Dr. FOSTER. I am encouraged by the reaction of you who are on this select committee and by the questions posed by your counsel; I am actually encouraged. Working out in the vineyards can get lonely and sometimes discouraging.

Chairman PEPPER. Well, thank you very much. We appreciate your coming, Doctor; it is an inspiration and encouragement to hear you.

(The following material was received from Mr. Newell:)

EVALUATION OF OAKLAND PUBLIC SCHOOLS DRUG EDUCATION PROJECT, JANUARY 1, 1971, TO JUNE 30, 1972, ROBERT NEWELL, DIRECTOR

(EVALUATED BY: WILLIAM CARL THOMAS, COORDINATOR, CONTINUING EDUCATION, CALIFORNIA STATE UNIVERSITY, HAYWARD, AND JOHN JOGI, DIRECTOR, ACCESS INFORMATION CENTER, CONTRA COSTA COUNTY SCHOOLS)

Introduction

This is not a typical evaluation report. A conclusive and specific evaluation of a program dealing with behavioral attitudes which reflect complex systems of motivations and causes presents insuperable difficulties. The response by the Oakland Public Schools to the drug abuse crisis in 1970 required immediate and decisive action. There was not time to research effective programs or to develop experimental knowledge through observation of a "pilot project" which represented a "typical" school in Oakland. Even the assumption that a typical school can be identified in an urban population is highly questionable. Further the evaluation of the Oakland Drug Education Project was limited by:

1. The difficulty of identifying viable criteria for measuring attitudinal changes relating to drug use.

2. The difficulty of identifying specific data concerning drug use, particularly for drugs other than heroin. Even the incidence of heroin users who are arrested or who report for treatment is an unreliable source of data.

3. The limitations of the time period of the evaluation report (18 months) which do not allow for accuracy in observing the behavioral changes resulting specifically from an educational program.

The problem was stated by Superintendent Benbow in a proposal dated February 13, 1970 to the Comprehensive Health Planning Council of Alameda County as follows:

The Oakland Public Schools, as all large urban schools, are faced with the overwhelming problem of increased numbers of student drug abusers and experimenters and no money for personnel to provide assistance to students or even to know what services and education should be provided.

There are approximately 64,000 students enrolled in the Oakland Public Schools, 12,500 of these students are in the senior high schools—grades 10–12.

There is no planned coordinated program of counselling or instruction in drug abuse for these students. The administration, faculties, parents and the students themselves are well aware of this problem and concerned citizens are constantly making demands for action.

During this 1969–70 school year, many fragmented drug education programs are being conducted by earnest and dedicated faculties in various elementary and secondary schools. A drug abuse education resource manual was developed during a 1969 summer workshop and was distributed to all secondary schools.

Subsequent to the submission of the proposal the program was funded as the education component of the Alameda County Comprehensive Drug Abuse Program. A director, Mr. Robert Newell, and a full-time executive secretary, Mrs. Gloria Bailey, were employed. This evaluation report covers the activities of the project from January, 1971 through June 30, 1972.

Scope of the evaluation

In view of the parameters established by the above considerations this evaluation of the Oakland Public Schools Drug Education Program will be concerned with the following:

1. A statement of the philosophy and methodology of the Project and a summary description of the typical activities of the Director during the period of the evaluation.
2. The activity response of the Project to the stated objectives, primary and secondary, of the original proposal as refined by the Director and approved by the School Board subsequent to funding.
3. A description of the inservice training program, and a statistical analysis of the effectiveness of the regional and city-wide training workshops.
4. Summary and conclusions.

PART I.—A STATEMENT OF THE PHILOSOPHY AND METHODOLOGY OF THE PROJECT AND A SUMMARY DESCRIPTION OF THE TYPICAL ACTIVITIES OF THE DIRECTOR DURING THE PERIOD OF THE EVALUATION

I. PHILOSOPHY AND ACTIVITY SUMMARY OF THE PROJECT

In a memorandum to the Superintendent's office dated February 3, 1971 the Director outlined his perspective of the role of the school in resopnding to the problems of drug abuse.

One of the problems in designing drug education programs in schools has been the lack of an overall plan and attempts to attack the situation globally instead of specifically and systematically. The following outline represents a tentative plan which will provide a basis for discussion regarding what can be reasonably expected to be accomplished.

I. The School's Roles
- A. Primary Responsibility
  - 1. Prevention
    - (a) Focus on causes
    - (b) Begin at kindergarten
    - (c) Conceptual approach to include:
      - 1. cognitive information
      - 2. affective relationships
    - (d) Reverse peer pressure
- B. Secondary Shared Responsibility
  - 1. Working with the symptoms
    - (a) Treatment, rehabilitation, correction, intervention
    - (b) Cooperative planning and implementation with the community.

II. Conceptual Framework
- A. Provide sound factual information
- B. Develop attitudes that lead to sound decisions
  - 1. Working with the symptoms
- C. Conceptual development from K–12
- D. Total Health Education as a vehicle
  - 1. Ten concept areas such as, (1) drug use and misuse, (2) environmental health hazards, (3) mental-emotional health, etc.

III. Involvement Groups
- A. Students
- B. Teachers
- C. Nurses, Counselors, Principals, etc.
- D. Parents
- E. Community Groups

The above outline makes clear that drug education is concerned with the whole person (cognitive, affective, and psycho-motor) making decisions about drugs in the community settling as well as the school environment. Thus prevention is not only concerned with the communication of information about drugs but with more complex elements in the affective domains such as decision making, communication skills, value clarification, and alternatives to drug use. The development of the project in the evaluative period supported this assumption with an added emphasis on enhancing self-esteem as a critical factor in arresting drug abuse.

Emerging from these definitions of the schools primary and secondary responsibilities, the Director identified the following program objectives as the long-range task of the Project:

I. Staff inservice (nurse, teacher, administrator, etc.).

II. Development and publication of curriculum materials for a K–12 grade program which will focus on causes, attitudinal change, and place an emphasis on the individual and his interpersonal relations.

III. Identification and training of resource people in each Region to provide ongoing assistance to teachers and schools in program development and implementation.

IV. Publication of reference material about the history, nature, effects and related information on the psycho-active drugs.

V. Review and possible revision of administrative policies and guidelines.

VI. Identification of contact persons in each school.

VII. Preview and purchase procedures for instructional materials.

VIII. Workshops in group process for counselors and psychologists.

The Director then proposed the following time table and activities to accomplish the above objectives.

STAFF INSERVICE

I. K–6 Personnel
   A. Workshops in each Region; Spring 1971
II. K–12 Personnel
   A. 3-Week Summer Workshop, June 22 to July 14
III. 7–12 Personnel
   A. Fall 1971
IV. Nurses
   A. Recognizing Symptoms and Treatment Procedures; April 1971
V. Counselors and Psychologists
   A. Group Process Workshop; May 1971
VI. Administrators
   A. Orientation; May 1971
   B. Administrative Policy and Procedure; Fall 1971
VII. Resource Personnel (3 Health Educators)
   A. Training at Drug Training Center, Cal-State; May 1971

CURRICULUM

I. Writing Workshops: May 1971
II. Publication Dates; Fall 1971
   A. Reference—Psycho-active Drugs; May 1971
   B. K–6 Curriculum; Fall 1971
   C. 7–12 Curriculum; Spring 1972

RESOURCE PERSONNEL AND RESIDUAL

I. Health Educators
   A. One in each Region
II. Drug Contact Person
   A. One in each school
III. Pupil Personnel Services
   A. Future Workshops conducted by trained staff
IV. Alameda County Drug Education Office
   A. Consultation
   B. Program Implementation
   C. Workshops
V. U.C. Medical School
   A. Pharmacy Students

A careful survey of the over-all accomplishments of the Project through June, 1972 established the fact that with only one exception all of the above program activities were planned and implemented in the time period stated. The one exception is the development of a 7–12 curriculum guide, scheduled for the Spring of 1972. This objective is now in process and is expected to be completed in the Fall of 1972.

In an educational area as complex as drug abuse prevention and in an institutional setting such as the school the above accomplishments of the Drug Education Office are to be commended.

The task of the Director as he stated it (see page 10) was three fold:

1. A program which is preventive in nature.
2. A program which will give teachers some basic tools with which to work.
3. A program containing a residual effect which will last after the project is finished.

The staff inservice accomplishments, the development of K–6 curriculum guidelines, and the beginning of the identification of resource and residual personnel indicate the task is being accomplished.

Also supportive of the degree to which the Oakland Public Schools Drug Education Project was active in the pursuit of its goals is the following summary of random samples of the Directors activities taken from reports to the Superintendent for the period January 1971 through June 1972. These illustrate the widespread involvement of the director in the drug educational process both in school and community settings. The director of an effective drug program must function in the areas of coordination, public relations, community representation, curriculum development, teaching. administration, inservice training, parent education, and education innovation.

CALENDAR OF IMPORTANT EVENTS 1971–72 DRUG EDUCATION OFFICE

1971

February: Nurses Meeting (Hunter Hall) 45 Nurses. Presentation to 45 teachers-administrators at U.C. Davis (meeting at Lodi, California) re drug education. Participated in panel discussion at Clawson School re drug abuse.

April: Presentation—Redwood Heights PTA & Dads Club. Presentation—Allan Temple Baptist Church, Oakland—drug symposium. Presentation to Board of Education. Presentation—Crocker Highlands PTA. Nurses Inservice—Hunter Hall 1:30–4:00.

May: Principals Inservice Meetings—Hunter Hall. Curriculum Development Committee meetings (workshops) Grades 7–12. Region II 10-Hour Overview Workshop—Bret Harte. Region III 10-Hour Overview Workshop—Skyline. Group Process Workshops. Presentation to PTA at Emerson.

June: Group Process Workshops. Region I 10-Hour Overview Workshop—Lincoln. Drug Education Workshop—Lincoln School 3-weeks.

September: Psychoactive Guide, "Straight Dope" distributed to K–6 teachers and others upon request. Presentation—"Black Counseling Program"—U.C. Berkeley.

October: 20-Hour Drug Education Workshop—Fruitvale School. Nurses Meeting—Hunter Hall. Presentation—PTA—Fremont High School. Skyline High School Minimum Day Program. Presentation to PTA—Piedmont. Presentation to PTA—Fruitvale.

November: Presentation to PTA—Glenview. Co-sponsored program, Conference for Administrators, "Strategies for Meeting the Pressures of Change." Mini-Grant application work started (final application made in Spring 1972—we were awarded the grant—training to start this Fall).

December: Phase II of the Drug Education Project written and submitted. Administrative Guideline Committee—First meeting. Met each month through April 1972. Final proposal completed in May, 1972.

1972

January: Planning Meeting and Presentation—Lazear, Faculty Meeting—Inservice—Glenview School. Administrative Guideline Committee Meeting. Lazear Workshop Inservice (4 meetings of total faculty). Nurses Inservice—Hunter Hall.

February: Howard School Assembly of 5–6 graders. Glenview School Parent/Teacher Workshop. Nurses Inservice. Presentation—Burbank/Burckhalter Schools. Presentation—Golden Gate Parents Club-Teacher Inservice. Presentation—McClymonds High School "What's Happening."

March: Large packet of information to all School Nurses re drugs and etc. Presentation Howard School PTA. Presentation—Prescott Follow-Through Program. Presentation—Parker PTA. Workshop at Oakland Tech High in area of drugs. Guest speaker—Westlake Jr. High. Speaker—Roosevelt Jr. High. Resource person at Student Leadership Conference—Roosevelt. Presentation—Maxwell Park School.

April: Drug Education Workshop at Martin Luther King, Jr. Elementary. Drug Education Workshop at Skyline High School. Presentation—Grand Lake Kiwanis Club. Presentation—Munck School. Faculty Inservice—Hoover Jr. High "What's Happening." Curriculum Develop Workshop. Guest speaker—Contra Costa County Administrators. Valuing Presentation—Adult Day School. Guest speaker—State Department of Education at a drug education wor hop for nurses (Redwood City). Presentation—Frick Jr. High "What's H. pening." Administrative Guideline Committee meeting.

May: Guest speaker—Golden Gate School. Guest speaker—West Oakland Health Center. Classified (clerical) Employees Drug Education Workshop—Hunter Hall. "7-Ring Circus"—connected with Drug Education Workshop. Guest speaker—"Oakland High Twelve." Master Plan presentation—Bella Vista School.

June 14: First meeting of Central Committee on Drugs and Narcotics (newly appointed committee, set up by R. Newell).

PART II.—THE ACTIVITY RESPONSE OF THE PROJECT TO THE STATED OBJECTIVES, OF THE ORIGINAL PROPOSAL, AS REFINED BY THE DIRECTOR AND SUBSEQUENTLY APPROVED BY THE OAKLAND PUBLIC SCHOOL BOARD OF EDUCATION

The primary objectives and secondary objectives of the *original proposal* (February 13, 1970) were stated as follows:

PRIMARY OBJECTIVE

To increase the knowledge of pupils, parents, and school staff regarding the use and abuse of drugs in order to assist in the reduction of the incidence of drug abuse among students in the Oakland Public Schools.

SECONDARY OBJECTIVES

1. To provide a varied educational program in the Oakland Public Schools to meet the needs of all students—the non user, the experimenter, the drug user and drug abuser.
2. To provide parents and school staff members with information regarding drug abuse that will enable them to work more effectively with young people.
3. To develop a health instruction framework and program on drug abuse and attitude change from grades Kindergarten-12.
4. To prepare trained personnel from various disciplines and varying backgrounds and experiences in group work and health instruction skills to implement a drug education program in the schools.
5. To develop over-all policies and procedures for identification, referral or care of drug abusers.

Upon the establishment of the Drug Education Office, the Director responded on February 7, 1971 to the above Primary and Secondary objectives as follows:

"After one reads the Primary and Secondary Objectives of the Drug Education Project, and also realizes the difficult situation existing in many schools, there could be a tendency to attempt plugging all the holes in the dike at once. This approach, in an attempt to satisfy immediate needs, would be doomed to failure. Due to the time limitations of the project, it appears the most effective and efficient use of time and money would be to embark on a plan which in its initial phase at least contains three elements:

1. a program which is preventive in nature.
2. a program which will give teachers some basic tools with which to work.
3. a program containing a residual effect which will last after the project is finished.

"During this initial phase, attempts will be made to research and evaluate urban programs dealing with the realities as they exist, particularly at the high school level. It is hoped that in this way, information, suggestions and input can be more meaningful and not based on desperation."

Subsequently he restated the objectives in a report to the Superintendent and to the Board of Education on April 13, 1971. (The restated objectives are repeated below and the degree to which they were implemental by the Drug Education Project is indicated.)

ACTIVITY OBJECTIVE I

Staff inservice

1.1 K–6 Personnel

10-hour overview courses	Attendance
Region I (June 1, 3, 5, 1971)	34
Region II (May 11, 13, 16, 1971)	24
Region III (May 18, 20, 22, 1971)	22

1.2 K–12 Personnel

50-hour in-depth courses; all regions (June 22–July 14, 1971)	117
30-hour classroom techniques course (April 4–May 13, 1972) K–6—72; 7–12—30	102
Building inservice for faculty (4 schools)	82
20-hour secondary overview (October 12–31, 1971) (5 of 51 attending were K–6)	51
30-hour in-depth training K–12 (April 4–May 23, 1972) K–6—38; 7–12—35; special personnel—21	94
1.3 Nurses: 2-day overview first aid, (January 26 and February 1, 1972) (43 out of a possible 54 nurses attended)	43
1.4 Counselors and psychologists; 15-hour group process workshops (May 6–June 9, 1971)	17
1.5 Classified (clerical) inservice program (May 10–11, 1972)	250
1.6 Inservice for principals (May 5 and May 12, 1971) K–6—40, and 7–12—15	55
1.7 Resource personnel: 3 health educators; 1 week full time at Drug Training Center, Cal State at Hayward	3

In addition to the above training programs developed and conducted by the Project the Director was influential in the involvement of an undetermined number of school personnel in other training opportunities offered by the Alameda County Drug Education Program, California State University at Hayward, St. Mary's College, and the University of California at Berkeley.

ACTIVITY OBJECTIVE II

Development and publication of curriculum materials for a K–12 grade program which will focus on causes, attitudinal changes, and place an emphasis on the individual and his interpersonal relations.

2.1 September 10, 1971—"STRAIGHT DOPE" a guide containing basic information on Psycho-active drugs sent to each elementary school teacher and to secondary (7–12) school principals who requested copies for their teachers. The precise number of copies sent cannot be determined but the estimate is "many." Numerous copies of the 53-page guide have been sold (at $.00) to schools outside the Oakland Public School District. See copy accompanying this report.

2.2 December 15, 1971—The K–6 Drug Education Curriculum Guide "ITS IN YOUR HANDS" was completed and mailed to each elementary school teacher and to administrative personnel. See copy accompanying this report.

2.3 The 7–12 Drug Education Curriculum Guide is now in process of development and will be completed in the Fall of 1972.

ACTIVITY OBJECTIVE III

Identification and training of resource people in each Region to provide ongoing assistance to teachers and schools in program development and implementation.

3.1 Three health educators were trained with 60 hours of district inservice training and one week full time training at the California State University Hayward Drug Training Center.

3.2 At least one teacher was trained and identified in each school as a possible resource person for local building implementation of drug education programs.

ACTIVITY OBJECTIVE IV

Publication of reference material about the history, nature, effects and related information on the psycho-active drugs.

(See Activity Objective II on above.)

ACTIVITY OBJECTIVE V

Review and possible revision of administrative policies and guidelines.

5.1 Administrative Guideline Committee was formed with 35 members on December 6, 1971. Monthly meetings were held each month through April.

The final draft proposal which appears on the following pages was completed on May 9, 1972 and has not yet been reviewed or adopted by the Board of Education.

ACTIVITY OBJECTIVE VI

Identification of contract persons in each school.

75% completed.

ACTIVITY OBJECTIVE VII

Preview and purchase procedures for instructional materials.

This activity has been continuous as a part of each workshop. The purchase of any substantive amounts of materials has been limited by budget considerations. A large part of the available funds were used for the development and printing of the curriculum guides (K–6) and the manual on psycho-active drugs. (See Activity Objective No. II.)

OAKLAND PUBLIC SCHOOLS,
EDUCATION DEVELOPMENT AND SERVICES OFFICE OF DRUG EDUCATION,
May 9, 1972.

To: Edward Cockrum, Associate Superintendent, and Robert Blackburn, Deputy Superintendent.
From: Robert Newell, Coordinator.
Subject: Draft of Proposed Administrative Guidelines for Drug Abuse.

PROPOSED PROCEDURES FOR CONTROLLING DRUG ABUSE AND FOR ASSISTING PUPILS INVOLVED IN SUCH ACTIVITIES

Foreword

The abuse of drugs is a social problem for which there are no simple approaches nor solutions. In the areas of prevention, treatment and control, parents, the schools, and the community must focus their efforts on the causative factors of drug abuse. It is imperative that we all work cooperatively if we hope to reduce the number of pupils who become involved in drug abuse activities.

Each pupil's case should be considered on an individual basis, and every attempt should be made to keep students in school. Emphasis should be placed upon providing alternatives to punitive measures for students who seek help in coping with drug problems. Each administrator is encouraged to develop more specific procedures in his school to implement the general outline provided here.

I. STAFF PROCEDURES AND RESPONSIBILITIES

Teachers as well as other school personnel are in a strategic position to observe pupil behavior. When any member of a school staff has good cause to be concerned about a student's drug abuse activities, he should report such information to the school administrator. Permitting a student to "sleep it off" or ignoring someone having difficulty may be detrimental to the health and welfare of that individual.

II. NURSING PROCEDURE

A. Students who are suspected of being under the influence of a drug, but who are able to function in the school setting.

1. Consult with the principal or his designate and follow the procedure set up within the school.

B. Students who demonstrate abnormal behavior and/or who are unable to function normally in a classroom situation, but whose vital signs are not indicative of any immediate danger.

1. Notify the principal or his designated representative.
2. Make every effort to notify the parent and manage as any emergency situation.
3. If the parent cannot be reached, refer to the principal or his designate for follow-up decisions.

C. Students who are unconscious or from whom little or no response can be elicited command life saving procedures.

1. Call the ambulance following the established routine.
2. Notify the principal and request assistance of another adult; manage as any emergency situation.
3. Make every effort to reach the parent.
4. Although it is important to determine the type of drug and amount taken. this inquiry should follow steps 1, 2 and 3.

D. Reporting

1. Follow the usual procedure for reporting serious accidents or sudden illness to the Superintendent's office and Health Services.
2. Reporting to the police is solely the responsibility of the principal of the school or his designate.

III. ADMINISTRATIVE PROCEDURES

Guidelines

Utilizing the good judgement of the administrator in charge, each instance of drug abuse should be handled in an individual manner, taking all factors into consideration before making final recommendations or decisions.

Procedures

A. Administrators should notify parents or guardians of any drug abuse activities.

B. Administrators are requested to cooperate with school nurses in emergency situations; e.g., life saving procedures and calling the ambulance.

C. Case studies

An administrative case study will be made on each student charged with drug abuse activities. This study will utilize medical help, pupil personnel services, and conferences with parents and other relevant persons or agencies to make a determination as to the action to be taken.

D. Alternatives

Alternative lines of action in handling cases could include:

1. Continuance of the student in school:
   (*a*) If the administrator is satisfied that the student's presence is not inimicable to the welfare of other students and is also in his best interest.
   (*b*) Dependent upon the student's following recommended medical or psychiatric therapy.
   (*c*) If the student follows stipulated conditions of school probation.
2. Placement in a home study program.
3. Referral to the counselling center for individual or group therapy.
4. Major adjustment of student's school program to involve work experience, or other school placement.
5. Suspension.
6. Recommended expulsion with referral to the Discipline Hearing Panel.
7. Reporting to Police

   Administrators may notify the Community Relations and Youth Division of the Oakland Police Department when:

   1. It is in the best interest of the student and/or the school.
   2. The student is in possession of restricted dangerous drugs.
   3. The student is engaged in the sale of restricted dangerous drugs.

ACTIVITY OBJECTIVE VIII

Workshops in group process for counselors and psychologists.

These workshops were held on May 6, 19. 26, June 2, 9, 1971. Seventeen counsellors and psychologists participated, led by an instructor from California State University at Hayward. Two typical evaluative statements follow.

"I feel certain the renewal of counselling 'role' and behaviors resensitized me to the extent that my individual appointments with students improved. Also I am even more determined to get groups going in the Fall. Involving teachers and parents will also be a part of my '71–72 GOALS. We expect to have a volunteer center that will include Drug and DRAFT, etc. counseling. It is my hope that Counsellors here will be appropriately involved with that program rather than isolated from these volunteers.

"I'm sorry my previous commitments this summer prevent my attending the Drug Workshop, however, I will welcome any involvement in the Fall."

"Our counselling department at Fremont will attempt to set-up a group process program for '71–72 school year. I feel that these workshops were invaluable to me in that I will probably spearhead the group process activity at our school.

"My personal and professional attitude toward group process is rapidly changing from neutral to positive. My ignorance led me to place little importance on group theory and practice but the workshop has helped me to realize that I have not tapped this communications technique previously and that it holds a high potential for helping adults and students relate to mutual problems in an understanding mode of activity.

"Thank you for the excellent opportunity to learn."

Six evaluative statements related to this workshop were measured on a scale from 1 to 5 with the following results

	Average response
1. The relevancy of presentations to my professional role was	4.4
2. On the average, the quality of presentation was	4.3
3. My individual involvement during the workshops was	3.8
4. What I learned from my involvement with the group (my peers) was	4.1
5. Concerning the subject area of this workshop, I feel	3.8
6. Concerning the implementation of the subject area, I feel	3.8

PART III.—A DESCRIPTION OF THE INSERVICE TRAINING PROGRAM, AND A STATISTICAL ANALYSIS OF THE EFFECTIVENESS OF THE REGIONAL AND CITY-WIDE TRAINING WORKSHOPS

PART III—INSERVICE TRAINING DESCRIPTION AND STATISTICAL ANALYSIS

3.0 Scope of the evaluation of the inservice program

This portion of the evaluation addresses itself to the 70-hour regional workshops held in the spring of 1971 and to the 50-hour summer workshop of the same year. No attempt has been made to evaluate other workshops similar in content since the sample evaluated is substantial enough to appraise the effectiveness of the training program. The inservice workshops are related to the primary objective and to Activity Objective Number 1. Other components of the program (e.g. the development of instructional frameworks or the administrative guidelines) require separate evaluations when completed and field-tested.

The inservice training for which data is available consisted of the workshops mentioned above and involved a total of 191 participants.

The available data examined for preparation of this report consists of participant responses to questionnaires and to pre and post information inventories given at the three-week summer workshop in 1971.

3.1 Description of the 10-hour overview workshop

To assure broad district-wide participation in the drug education workshops, one 8-day (10-hour) overview workshop for teachers and special personnel was held for each of the three regions in the Oakland Public Schools District. All elementary schools (K–6) were encouraged to attend. District credit or one quarter unit of credit through California State University at Hayward was offered.

The purpose of these workshops was to provide an overview of drug education materials and methods to increase the confidence level of the elementary teacher and provide motivation for further training to increase classroom competence. The elements emphasized in the 10-hour session were:

1. Information about drugs and the laws relating to drugs.
2. Pharmacology.
3. Communication skills.
4. Decision making through value clarification.
5. Alternatives to drugs.
6. Self-esteem and drugs.
7. First-aid (crisis intervention).

It was further hoped that the limited introduction of the teacher in the 10-hour workshop would lead to participation in the 3-week in-depth workshop to be held in the summer of 1971.

3.2 Description of the 3-week-in-depth drug education workshop

The 3-week summer workshop was held for all teachers (K–12) and special personnel throughout the district. The stated goals for the workshop were:

1. To provide exposure in the various dimensions of drug education, including both the cognitive and affective domain.
2. To have the participants recognize and understand that drug problems are symptomatic, and that effective drug education must:
   (*a*) be preventive
   (*b*) focus on causes
   (*c*) be a continuous process beginning in Kindergarten
   (*d*) give opportunities for students to make meaningful decisions
   (*e*) help clarify values
   (*f*) provide positive alternatives
3. To inform, motivate, and begin to develop some of the skills necessary to provide effective instruction in the classroom.

The implementation of these objectives is indicated by the overview of the workshop on the following page.

DRUG EDUCATION WORKSHOP SCHEDULE—JUNE 22–JULY 14, BOB NEWELL, COORDINATOR

OAKLAND PUPIL SCHOOLS, DIVISION OF EDUCATIONAL DEVELOPMENT AND SERVICES, OFFICE OF DRUG EDUCATION

Materials Preview: 1:00–1:30 p.m.
Time: 1:30–5:00 p.m.
Place: Lincoln School Auditorium (11th and Alice Sts., Oakland)
Tues. June 22
- 1:30 Registration-Introduction
- 2:00 Pre-Test—Carl Thomas
- 2:30 Overview and Pharmacology—Dr. Feinglass

Wed. June 23
- 1:30 Tobacco—Dr. John Williams
- 2:30 Alcohol—Dr. Winslow Rouse
- 3:30 A/V Evaluation

Thurs. June 24
- 1:30 United Pittsburgh—Charlie Weaver
- 2:30 Street Drugs—Charlie Weaver
- 3:30 Solano Laboratories—Dr. Shulgin

Fri. June 25
- 1:30: Panel
  1. Dr. Jess Bromley
  2. Fred Duda
  3. John Alves—of "Group"
  4. Judge
- 2:45 Small Groups
- 3:45 Report Back

Mon. June 28
- 1:30 Role of School—Don McCune
- 3:30 Role of School
  1. Alternatives
  2. Curriculum Overview

Tues. June 20—Carl Thomas
- 1:30:
  1. Valuing
  2. Communicating
  3. Group Dynamics

Wed. June 30—Carl Thomas
- 1:30:
  1. Valuing
  2. Communicating
  3. Group Dynamics

Thurs. July 1—Jeff Muller
- 1:30: Role of the Teacher
  1. Decisions
  2. Alternatives
  3. Classroom Environment

Tues. July 6—Tom Swaffer
1:30: Curriculum Development
1. K-3
2. 4-6
3. 7-9
4. 10-12
Wed. July 7—Jack Danielson
1:30: Communication Skills
Thurs. July 8—Jack Danielson
1:30 Communication Skills
Fri. July 9—Options
Mon. July 12—Dr. Roger Smith—Marin Open House
1:30 Community Approach
1. Prevention
2. Treatment
3. Rehabilitation
Tues. July 13
1:30 Alameda County Comprehensive Drug Abuse P...
1. Health
A. Counseling—Vince Parlette
2. Education—Orie Jackson
3. Probation—Ken Moresi
4. Law Enforcement—Al Bucher
3:00 Floating Rap Sessions
Wed. July 14
1:30:
Role Playing—Dr. Feinglass
"Policies & Procedures"
3:30—Carl Thomas
Post-Test
Wrap-Up
Evaluation

3.3 Description of evaluation instruments used and analysis

3.3.1 To measure the level of information related to drug use and increase in that level of knowledge, pre-workshop and post-workshop tests were given which were based on the State of California Drug Education Drug Information Tests. (See copy on the following page.)

3.3.2 To measure the value of the workshop components an instrument was devised to measure participant response to the following questions involving nine phases of the workshop experience. In addition participants were asked to make constructive suggestions for future workshops and to note observed changes in attitudes or competencies.

The information inventory (3.3.1) was given only in the 3-week summer workshop since it was assumed that no appreciable change could be measured in a 10-hour workshop. It was further assumed that since the major emphasis of the workshop was in the affective area with a minimal emphasis on cognitive content, that positive changes in this area would be small. Comparison of pre and post test scores on the information test supported this assumption. (See below.)

3.4 Summary of the information inventory (3.3.1)

Number taking pre and post tests	82
Total number of items	25
Total possible correct responses	2050
Total errors pre-test	896
Average errors pre-test	10.9
Total correct responses pre-test	1164
Average correct pre-test	14.1
Total errors post-test	645
Average errors post-test	7.9
Total correct responses post-test	1405
Average number correct responses post-test	17.1
Difference between correct responses pre- and post-test	241

DRUG PHARMACOLOGY TEST

Please circle, on a separate sheet, the letter that indicates your answer to each of the questions listed below.

1. In the U.S., the most commonly abused drug listed below is:
   a. cocaine
   b. heroin
   c. codeine
   d. marihuana
   e. LSD
2. One of the known active ingredients in marihuana that has been extracted and synthesized is:
   a. psilocybin
   b. DMT
   c. lysergic acid diethylamide
   d. THC—tetrahydra cannabinol
   e. STP
3. Which of the following is not a psychedelic drug:
   a. THC
   b. LSD
   c. STP
   d. IRT
   e. DMT
4. Tolerance to drugs refers to the fact that:
   a. decreasing amounts of the drugs are necessary to obtain the desired effects
   b. increasing amount of the drug are necessary to obtain the desired effects
   c. no matter how large a dose, one can never obtain the original effect
   d. none of the above
5. The effects of cocaine are much like those of a:
   a. stimulant
   b. depressant
   c. narcotic
6. Studies of the effects of marihuana tentatively indicate that:
   a. heart rate and pulse rate go down
   b. subtle personality changes may result from chronic use
   c. both a and b are true
7. Which of the following is not usually a symptom of heroin withdrawal:
   a. death
   b. nausea, chills, prostration
   c. anxiety
   d. cramps, vomiting and weight loss
8. If an individual told you he had in his medicine cabinet secobarbitol (Seconal), chlordiazepoxide (Librium), and meprobamate (Equanil), one could say that he had a fair number of:
   b. sedatives
   c. narcotics
   d. hallucinogens
9. Which of the following is true of alcohol and barbiturates:
   a. both are general stimulants
   b. barbiturates inhibit the effects of alcohol
   c. alcohol potentiates the effects of barbiturates
   d. their effects are completely different; both drugs may be used in treating LSD psychosis
10. Chronic use of "speed" can lead to:
    a. cardiovascular involvement
    b. malnutrition
    c. paranoid psychosis
    d. all of the above
    e. only a and b of the above
11. The drug which according to its users, allows one to experience death is:
    a. marihuana
    b. heroin
    c. "smack"
    d. LSD

12. Which of the following drugs does not usually produce hallucinations:
    a. LSD
    b. DMT
    c. psilocybin
    d. phenobarbitol
    e. mescaline
13. The effects of marihuana may include:
    a. sedation and relief from anxiety
    b. disinhibition and excitement
    c. perceptual changes
    d. all of the above
    e. only a and b of the above
14. Which drug does *not* generally have the same effects as the others:
    a. hash
    b. crystals
    c. speed
    d. methamphetamine
    e. bennies
15. The "rushes" refers to:
    a. The New York Subway System
    b. the first few moments following an IV dose of speed
    c. a series of LSD flashbacks
    d. convulsions due to an O.D. of barbiturates
16. Which of the following is considered to be relatively safe to inhale:
    a. tuolene
    b. propane
    c. benzene
    d. butanol
    e. none of the above
17. Dependence on hallucinogens such as LSD includes:
    a. psychological dependence
    b. physical dependence
    c. tolerance
    d. all of the above
18. Dependence on barbiturates includes:
    a. psychological dependence
    b. physical dependence
    c. withdrawal can produce convulsions and death
    d. all of the above
    e. only b and c of the above
19. Dependence on heroin includes:
    a. physical dependence
    b. psychological dependence
    c. drug withdrawal produces an adverse physical reaction
    d. tolerance
    e. all of the above
    f. only a and c of the above
20. Death in human beings using LSD usually has been the result of:
    a. overdose
    b. suicide or accident
    c. organic damage caused by the drug
21. Death from heroin overdose usually is due to:
    a. liver damage
    b. respiratory depression
    c. Cerebral hemorrhage
22. The potent parts of the hemp plant (Cannabis Sativa) are found:
    a. in the stems only
    b. on the male plant
    c. on the female plant
    d. on both the male and female plants
23. Which of the following substances is most frequently found to be implicated in childhood poisoning:
    a. insecticides
    b. aspirin
    c. solvents, such as, gasoline, glues and thinners
    d. sleeping pills
    e. diet pills
    f. alcohol

24. Which of the following is considered to be a likely result of LSD usage:
    a. death
    b. extensive chromosomal and genetic damage
    c. disorganization and personality change
    d. permanent insanity
25. We are exposed to many chemicals whose:
    a. toxicity in general is unknown
    b. mechanism of action is unknown
    c. toxicity and action are completely understood
    d. both a and b are correct

Average difference in number of errors pre and post test	3.0
Average difference in number of correct responses pre and post test	3.0
Percent of increase of total correct responses	20.7
67 participants or 81.7% increased information from pre to post test	
5 participants or 6.1% maintained their original number of correct responses	
10 or 12.2% decreased the correct number of responses from pre to post test	

The above data seems to support the assumption that level of drug knowledge of the typical teacher in Oakland Public Schools is low and continued emphasis on basic drug information needs to be made. The development of the resource guide with basic information about psycho-active drugs was a response on the part of the project to this need.

3.5 Summary of the Questionnaire on Workshop Components and Methodology

The following questions were asked:

1. Were the focus and objectives of this workshop or class unclear or clear?
2. Was relevancy of what was presented to your teaching task low or high?
3. On the average, was the quality of presentation uninteresting or interesting?
4. Was the relationship of the presentations to one another poor or high?
5. Was your individual involvement during the session very little or very active.
6. Was what you learned from your involvement with the class group (your peers) of little value or very valuable?
7. Were the handouts of little value or very valuable?
8. Concerning teaching the subject area of this class, do you feel much less confident or much more confident?
9. Concerning teaching the subject area of this class, do you feel much less competent or much more competent?
10. Please write on the other side of the sheet any constructive comments and suggestions for class improvement. Please note any observable changes in your own attitudes or learning.

The following chart summarizes the average responses from participants in the regional workshops (10-hour K–6) and the summer workshop (50-hour K–12) to each of the above questions. The response was measured on a scale from 1 (low) to 5 (high).

10-HOUR OVERVIEW

Question	Region I, 27 participating	Region II, 22 participating	Region III, 21 participating	Average of total	Summer, 104 participating (all regions)
1	4.5	4.0	4.1	4.2	4.2
2	3.3	3.8	3.9	3.6	3.6
3	4.3	4.5	4.6	4.5	4.0
4	4.3	4.0	4.3	4.2	3.9
5	3.5	3.4	3.4	3.4	4.0
6	3.5	3.5	3.7	3.6	4.0
7	4.1	3.6	4.4	4.0	4.2
8	3.9	3.7	3.9	3.8	4.0
9	3.7	3.6	3.7	3.7	4.0
Total	3.9	3.8	4.0	3.9	4.0

It is apparent that the workshop training with an average response of 3.9 for the regional workshops and a 4.0 rating for the in-depth district workshop was considered to be effective and profitable by the participants. A large number of constructive suggestions for workshop improvement, made in response to

question 10. were noted by the Director and were implemented in subesquent training programs.

Of significance to this evaluation is the response to the request for observable changes in attitude or knowledge competence. The responses are categorized in a general manner as follows:

1. Increase in desire to relate more personally with students	9
2. Increase in insight into students attitude toward teachers	5
3. Increase in drug knowledge (cognitive)	15
4. Increase in appreciation for direct contact with addicts	6
5. Increase in appreciation of affective education (valuing)	19
6. Increase in appreciation of group approach in counseling to drug education	6
7. Increase in desire to work with parents and community	5
8. Increase in knowledge of new classroom strategies	2
9. Increase in confidence in teaching drug education	4
10. Increase in understanding of kids' "life style"	3
11. Increase of communication skills	9

PART IV.—SUMMARY AND CONCLUSIONS

SUMMARY AND CONCLUSIONS

The preceding description of the activities and the analysis of the training program leads to the following conclusions.

1. The response of the Project to the primary objective "To increase the knowledge of pupils, parents, and school staff regarding the use and abuse of drugs in order to assist in the reduction of drug abuse among students in the Oakland Public Schools."

Recognizing the limitations upon the valuation process indicated in the Introduction (page 1) the Oakland Public Schools Drug Education Project must be given an exceptionally high rating for developing a framework and foundation for a long-range drug education program that should almost immediately "increase the knowledge of students, parents and staff regarding the use and abuse of drugs."

In the evaluation period 836 teachers, nurses, counsellors, administrators and other Oakland Public School personnel received some form of drug education training that increased their knowledge regarding drug use and abuse. Evaluation of the training programs was consistently high (4.0) with a wide range of training areas covered. This training was dispersed throughout the school district so that each Region now has resource and contact people capable of further developing effective drug education programs at the building level.

The development and distribution of the K–6 Drug Education Curriculum offers further assurance of an expected increase of knowledge. The use of this guide in the context of the training provided in the workshops assures a more than adequate foundation for drug education program development. The reduction of drug use as a result of preventive education can only be determined in years to come. However, the effective beginnings of an educational program provided by the Oakland Drug Education Project should have a decisive impact on the incidence of drug abuse in the future.

2. The Mini Grant

A most significant indication of the effectiveness of the Project was the approval by the U.S. Office of Health Education and Welfare of an application for funding for the training of a community-school team to assist the schools of Oakland in the further development of community-wide drug education. This national recognition of the Oakland Drug Education Project is further evidence of a broadly based program which gives promise of increasing productivity.

Mr. PHILLIPS. Mr. Chairman, the next witnesses are Rev. Gordon McLean, Charles Alexander, Louis Gucinski, and Edward Stafford, who are all from Santa Clara and all very active in rehabilitation, the various rehabilitation programs in this county.

Could you tell us, Reverend McLean, how do you view the scope of drug abuse among our young people?

STATEMENTS BY REV. GORDON McLEAN, EXECUTIVE DIRECTOR, DRUG ABUSE INFORMATION SERVICE, SAN JOSE, CALIF.; EDWIN T. STAFFORD, JR., DIRECTOR, DRUG ABUSE PREVENTION PROGRAM. JUVENILE PROBATION DEPARTMENT, SANTA CLARA COUNTY, CALIF.; AND CHARLES D. ALEXANDER, ASSISTANT SUPERVISOR, AND LOUIS GUCINSKI, SUPERVISOR, WILLIAM F. JAMES BOYS RANCH, JUVENILE PROBATION DEPARTMENT, SANTA CLARA COUNTY, CALIF.

Reverend McLEAN. I submitted, Mr. Phillips, Mr. Chairman, a memorandum to your committee outlining many of the things that I had to share with you, but I perhaps could summarize them in a few minutes.

Mr. PHILLIPS. If you would, I think the chairman would prefer that we can incorporate your statement as part of your testimony, Reverend McLean.

Reverend McLEAN. Yes, sir.

As I have been following some of the testimony of the committee here, I am very interested in it because I am in the Drug Abuse Information Service, which is a private agency in the community providing education and counseling services to schools, to young people, in the State of California and out across the Nation, so we have had some contacts in dealings with it.

Several of the various officials that testified here pointed out the drug use among young people of high school age and there was some reference to the use of drugs among junior high school age and I feel that is a serious area that the committee needs to devote some attention to because our experience has been that we are seeing an increase in the use of drugs among junior high age young people and the younger high school students, while we are seeing a decline to some extent among some drug use in the older high school students and on the college level. The increase is among the younger high school students and very much into the junior high school level and this is an area——

Mr. PHILLIPS. I know your work carries you to many schools in your area.

Reverend McLEAN. And across the country.

Mr. PHILLIPS. And you have talked to many, many students, and have they advised how accessable drugs are in the schools?

Reverend McLEAN. Yes, sir; they have.

Mr. PHILLIPS. Just tell us what drugs are available in the high schools in your area.

Reverend McLEAN. Mr. Phillips was with me on the radio last Sunday night on a phone-in talk show for young people and we discussed this and really most young people will tell you any of the drugs they want to get are readily accessible on about any campus, and that is a pretty fair and accurate statement, and this has been the thing that we are seeing increase very much.

I am concerned about some of the areas of dealing with the problem, I think they need some attention, and I would like to take a few minutes to point some of those out.

First off, there has been considerable talk about police and school cooperation back and forth and as long as these two forces of the communities continue to look at each other with a great deal of mutual skepticism and suspicion, I think one of the strongest resources you have to combat the problem is effectively stymied. There is no reason why they need to be really at odds with each other and one of the most effective things that I think can happen in each community is for the law enforcement people, that means the sheriff's office, the police, perhaps the district attorney, the probation department and the school people, to sit down together and start to discuss their problem and instead of being very suspicious and antagonistic in their disciplines start to see where they can work with each other. We get all sorts of paranoid reactions when you talk about a policeman on campus but if there are drug sellers on campus then law enforcement belongs on campus.

I agree with you there are perhaps understandings that need to be reached about it and I have no quarrel about that. But I very much believe that we have got to deal with the problem effectively and when some educators in it, not all but some, say that we do not want to cooperate with law enforcement people, that we are going to handle the problem alone, that they are deceiving themselves, because as we just heard this afternoon from a very dedicated educator, the resources, financially and staffwise of the school district even like Oakland to start to deal with its problem, are pretty limited. And so that is step No. 1 that I think has to happen.

There has to be in community after community a realistic understanding between law enforcement and education and I think it can come about this way: I have had most police agencies that I have dealt with very interested in getting the young person who is using drugs some help. They are not anxious to bust that young person, they are anxious to bust the young person dealing drugs, and if a school can work out an arrangement whereby a young person who wants help can come to a counselor to be referred for that help and get that help, and the police will cooperate in it, I think you will find this will be universally their attitude. Where they want to be involved is with that young person on campus who is dealing and creating the problem for the educator and I think at this point they very much should be, and I think this is a very strong point that needs to be made.

Mr. WALDIE. May I interrupt you at this moment. Perhaps your group functions in this way. I had an experience at the inception of a program similar to yours, I suspect, in the city of Antioch, and at that time the only program Antioch had was a narcotics officer who was quickly identified among the young in the community as the narc, and made no progress at all toward help, and finally he, because he is a decent individual with some vision, was able to get the police department to be one of the mutual sponsors, openly, without any deceit, without any surreptitious moves of a drug clinic that would not be run by the police department at all but would be supported in the community as an asset to the community. There was immediate community hostility to the creation of a drug clinic. The police department supported the creation to get community support for it. Then that worked as a liaison between the police department and the schools. The schools could refer problems to the community resources

and the community resources had a sufficient relationship of mutual confidence with the police department that they pretty well let them decide how best to treat these people. And I didn't suggest that it was a solution to the drug problem that small community was confronting, but it darn well helped it.

In any event, is that the nature of your organization in the community?

Reverend McLEAN. Yes, sir; and I think that is a very realistic approach. Here where the different agencies are getting together to work together instead of being off saying we can't cooperate with them, we can't have anything to do with them, they have a different discipline.

Mr. WALDIE. And neither one can do it themselves.

Reverend McLEAN. That is right, and it is too bad that the police were here yesterday and the educators are here today, and the two never got to meet. The tragedy is that it isn't only in this room they didn't meet. Many of them haven't met where they should be meeting to work together to solve some of the problems, and I think, Mr. Waldie, what you pointed out is a very beautiful example of this and we have seen it done in many of the school districts in our county where the police have become cooperative, they have worked together, the police have provided some good education program. been available when they were needed; in turn the schools had a free hand to counsel young people who came for help and it becomes a good cooperative type of plan without mutual suspicion and recrimination and I think that is an important point.

Mr. PHILLIPS. Reverend McLean, in your prepared statement you address yourself to a community program for analysis of things that are brought in by parents; that is, chemical substances. Could you tell the committee about that?

Reverend McLEAN. Yes, sir. The sheriff's office in our county government in Santa Clara County, using the facilities of its crime laboratory, made available this service to parents who find some substance that they are not aware positively what it is; and they can take it to various designated drop points, get an identification number put on it and then call a county lab number that is well advertised in the county and get, 5 days later, a description as to whether it was just some harmless substance or whether it was a drug, without further information being given. They give the identification number, they are told what that substance was, and then the family may as it wishes proceed to get some counseling, help, whatever they want to do based on whatever it is has been found.

Mr. PHILLIPS. As parents find some substance in a pill or capsule or such, that appears to be a drug, in their child's possession or box or whatever it might be, they can then have this analyzed and determine whether he is using a drug?

Reverend McLEAN. Yes, sir; they can get this report anonymously. Just call in with a number and get that and use it for the basis of getting family counseling or confronting a youngster who denied any drug use, but here is the evidence. It is not the sole answer but it is certainly a very useful tool for a community to have available.

Mr. PHILLIPS. I think it is the only community in the country which has that; or am I mistaken?

Reverend McLEAN. I wouldn't know across the country, but as I have mentioned it in several other cities I found that is quite amazing, so it probably is a unique thing.

Mr. PHILLIPS. Mr. Stafford, you have a special program for young people after they are arrested, unfortunately. Will you tell the committee briefly about that program?

Mr. STAFFORD. Yes, sir; we have a program in the county juvenile probation department that is designed specifically for the first time offender. We try to avoid court but we have a threat to say either you go to our program or you go to court. The program is unique in that it requires parents and child involvement over a period of 6 weeks. They meet 2 hours a night once a week. Our purpose is to provide some information regarding the drug problem in our community.

Most parents will say, "Well, it is a first time offense, I am not going to worry about it," and that is really a serious risk as far as we are concerned. We try to provide some information to the parents as to what is going on in this particular county regarding drug abuse and the risks involved. We have youngsters who are addicts come in and talk to the people. Also, we have persons like Reverend McLean here, law enforcement people, people from the crime lab to talk about the drug problem. The unique part of our program is where we have parents and youngsters in small groups of about 12 or 15 but no child and his parent is in the same group. We encourage at this time communications skills and techniques, and discussing family problems. Our whole focus is not really on drugs per se but on people problems because our feeling is if you are able to work out the problems, the drug problem will go away, and this is where our whole focus is.

In another part of our program, we have youngsters and parents who are graduates of our program come back and colead with our probation staff in these groups and work with other youngsters.

Mr. PHILLIPS. I was thinking as you were sitting there that Reverend McLean represents the church and religious orientation, and perhaps part of our problems today are a result of failure of the churches to influence people; and then you have your educational process involved after someone gets arrested and Mr. Alexander, also sitting there, gets the fellow who really doesn't make it in that program and has had a serious history of either criminal activities or drug activity. Mr. Alexander. I guess, when society fails, you are our last resort.

Mr. ALEXANDER. Yes; we get a lot of rejects.

Mr. PHILLIPS. You do have some constructive ideas, I believe, and you have a constructive program at your ranch. Two of the gentlemen who were testifying here this morning, Paul Lopez and Jim Sullivan, have been through your program. Could you tell us essentially what you do with these young fellows when you get them?

Mr. ALEXANDER. Most of these are under the auspices of the juvenile department, probation department. Then they have been tried on these other programs and come to what we call our division, rehabilitation, so we are really the ones who are supposed to take care of all of the problems. OK, we failed, you treat him. Our program has a maximum population of 80 kids; 80 kids from all over.

Chairman PEPPER. They are in residence there?

Mr. ALEXANDER. Yes, sir; they are there for the whole time.

Mr. PHILLIPS. You have a ranch, a real ranch where the kids have jobs, education, and things of that nature?

Mr. ALEXANDER. Yes, sir.

Mr. PHILLIPS. You also have some type of philosophy of reestablishing values and reestablishing a young man's character?

Mr. ALEXANDER. Yes, sir.

Mr. PHILLIPS. Tell us about that.

Mr. ALEXANDER. That is the main thing we try and work on. He is there on a drug problem, but we don't emphasize the drug problem when we start with him. We find out what he has been doing, his movement, his life style and we stop it right there. We don't allow him to talk about drugs any more, that is not the problem as we see it. If we had to meet him legally we have never seen it, so when he gets to us we emphasize some of the dynamics that got him in trouble and that is what we start dealing with, how to handle peer groups and his own help. We teach him how to do that through regular hours, go to bed at a certain time and get up, and he works on the job and he has to do the things that he should have done outside in school. He has to go to school. If he doesn't do these things he doesn't get out. So it is an incentive for him to do these things to get himself out; and basically this is how it is lined up.

Chairman PEPPER. Excuse me just a moment. Are they restrained upon the premises of the ranch?

Mr. ALEXANDER. Yes, sir.

Chairman PEPPER. They are confined?

Mr. ALEXANDER. Yes, sir; but it is an open confinement. They can walk away whenever they feel like it. There are no locks, no fences. When they are out of our sight, we have them on jobs out of our sight, but they are not locked up or anything like that.

Mr. PHILLIPS. If they do walk off the reservation then it gets to be more serious?

Mr. ALEXANDER. Then the posse has to apprehend them.

Mr. PHILLIPS. So the wall is a rule rather than a fence.

Mr. ALEXANDER. We put the personal responsibility on the individual. We don't have any locks. We figure that he can walk away at any time but whatever he does the responsibility is on his shoulders, not on mine. We provide these things for him and he can either do them, accept them, or he can leave. When he does leave he has to pay whatever is going to be the consequence. The judge has already told him, obey the rules and regulations, so I am not going to punish him any more. He has been sent out there. So we line it up for him and set the program for him to get involved for his sake, not for our sake.

Chairman PEPPER. Is this a State program?

Mr. ALEXANDER. No.

Chairman PEPPER. Private?

Mr. ALEXANDER. No; it is run by the county, a county run program.

Mr. PHILLIPS. Mr. Gucinski, you, in a very brief conversation with me, summarized a series of goals and movements through the system. Could you just briefly describe those for the committee, please?

Mr. GUCINSKI. When a boy is adjudicated and comes to the ranch he is in what we call C section, where he stays approximately 1 month to make adjustment to that program. After a month has elapsed we are looking toward attitude change, his acceptance of the fact that he is

at the ranch, getting along with his fellowman, counseling program, which is both individual and group, and we also incorporate family counseling.

Mr. PHILLIPS. Your ratio of counselors to interns is 1 to 6?

Mr. GUCINSKI. One to seven in a capacity with 80 boys.

Mr. PHILLIPS. And you also have a girls' ranch?

Mr. GUCINSKI. Yes, sir; that accommodates 36.

We have emphasis when a boy first initially comes to the ranch, the boy, if he has been on drugs, he usually has lost many pounds. He comes out rather thin, somewhat weak both spiritually, emotionally, physically, so we work with the boy physically, hoping to be able to develop his body on a trampoline, on the unicycle, on the tightwire, on the rings, on the parallel bars, working with this boy physically at school as well as during his free time to try to have him take some pride in his body with the program that we have offered, a weight-development program.

We encourage the boys to engage in all physical activities of the program, cultural as well as social, so that the boy gains faith and trust not only in himself but in the gentlemen he is working with. As he gains confidence enough then we start moving the family group in and have family counseling and hope to have that boy involved with family counseling before he graduates. That would be a period of, average length of time, approximately 7 months.

Mr. PHILLIPS. Does he have a job while he is there and responsibilities to perform?

Mr. GUCINSKI. Yes, sir.

Mr. PHILLIPS. As he succeeds in those does he get higher responsibilities?

Mr. GUCINSKI. And he is promoted to B, to A, and then to home session and is expected to maintain.

Mr. PHILLIPS. Quite frankly, gentlemen, it is the first system I have heard about in the country which seems to have a proper ratio of personnel to people inside and a hope for the future for young people. So, I thank you for coming and I am impressed with what you have been trying to do with these youngsters.

Mr. GUCINSKI. Thank you, sir.

Chairman PEPPER. Mr. Waldie?

Mr. WALDIE. No questions. I am always bemused by the fact that there are so many different programs addressing the same problem and I suspect what it means—bemused is not the right word—I suspect it is that none of us really knows the answer and the answer may not be a monolithic answer, quite certain it is not, and a variety of approaches ought to be encouraged and yours is a constructive one and does seem to have had some good results.

Do you get any Federal funds at all for any of these programs?

Mr. STAFFORD. I might mention our particular program is the result of a program operated a year ago which was federally funded

Mr. WALDIE. A pilot program then evolved?

Mr. STAFFORD. A departmental program, yes.

Reverend MCLEAN. May I mention a couple of things briefly to you, Mr. Chairman, I think that are important to add here. As we are working in drug education a lot and working with the schools, there is a philosophy prevalent that if only we give young people the facts

on drugs educationally we will go a long way to solving the problem. This bothers me a great deal, because I am in classrooms and campuses with young people every day of the week and the thing that I find repeatedly is that the young people in the classroom setting there know more about the drugs than the people up front trying to tell them about it. We have to do something more as far as the value structure of a young person's life. You can spend millions of dollars, and not solve that problem, in education resources and treatment and everything you want to talk about.

I think a lot of it goes back to family relations, family structure, their own personal integrity, their own personal faith, their view of themselves and the world. It is a very practical reality as you are starting to deal with young people in drugs not only what they are taking but why they are taking, what is the view of these as individuals that makes them drug prone.

And as we start to work on those problems and perhaps more than a big governmental agency or even a big school system, those are things best attacked by smaller type of agencies with people who have commitment and belief in young people who can work with schools, community agencies, because they are dealing with those feelings and attitudes of young people.

As a private agency we have enjoyed a very harmonious working relationship with Mr. Stafford, Mr. Alexander, Mr. Gucinski, because they deal with public agencies that are open to this kind of approach and want to make it a part of their treatment and their dealings with young people, and it has been very effective. And one other thing I want to say briefly and quickly. I spent some time in Asia this summer because I wanted to see where all of our problem was getting a lot of its origin, as far as supplies go, and I left convinced that we are facing a flood of narcotics traffic directed at the United States and the very best efforts that have gone into it so far, and I do not belittle them, but the very best effort we have made so far is spooning out the ocean. The volume of drug supply centering in Hong Kong going through Manila and coming to the United States, the hundreds of millions of dollars of that in politically tied syndicates across the world, represent one of the greatest threats externally that this Nation has known.

And the statements that both major political leaders have made in recent weeks that we must cut off aid to Asian countries that deal in drugs to this country are strategic.

I think that is easier to say than it is to do. Because of alliances we have with other nations, because of defense commitments and because of the fact that many of the people across this world we look to for leadership and friends of ours are behind our back very much involved in dealing with the things that is one of the great threats to our country, and I hope, sir, as your committee probes the various facets of the problem that you will include consideration for the fact that we are dealing with a problem with international ramifications and the thin line of men that make up the Bureau of Narcotics and Dangerous Drugs and Bureau of Customs, I am sure they are doing the best they can. They are dedicated men, they need all of the help. We talk about money going somewhere. We need to give them help and start to really meet this problem. We are no way near meeting it.

Chairman PEPPER. We thoroughly agree with you, Reverend McLean. It has been a matter of great concern to this committee and we have done what we can to be helpful to those agencies in meeting this menace, this challenge and, as you say, we can anticipate that if the supply does dry up to a considerable extent; or altogether in Turkey, that it is going to come from other areas that will probably furnish a larger quantity even than Turkey was furnishing.

So there is not going to be any immediate drying up of the quantity of material coming into this country. We have got to try to do what we can to keep it out and at the same time do what we can to diminish the market in this country and to develop a program.

You gentlemen are a good illustration of the start of programs. The school authorities have their place and if we can just have enough programs and have some sort of liaison, some sort of coordination, there may be some that should be referred to the type of program that you have. We have a young man here this morning, Bill Strickland. He found his release in a religious experience and nothing else seemed to change his way of life, and now he has found himself and seems to be a young man of great promise for the future, great confidence as he approaches the future. The tragedy of it is that we didn't have enough anywhere, we didn't have enough programs in the schools, we don't have enough outside of the schools, we just don't have enough programs, period, to deal with anything like that adequately.

Reverend MCLEAN. I think, too, when it comes to Federal funding and money that Congress and the agencies allocate, that getting these funds to the people who need it and are doing the job is often a lesson in frustration. We have tried for various programs working in to apply for various Federal funds. The bureaucratic redtape necessary to get at that is unbelievable and we finally threw the whole thing out and said, well, we will do without it, and the experience is discouraging because millions of dollars are being spent and yet you start to perpetuating little bureaucratic machines but are not really being put where some of the action is.

Mr. Stafford's program was funded for 1 year, cut off. If the country wants to maintain one of the best programs it has got, it is going to have to do it itself. The resources that can be available to help Mr. Alexander and Mr. Gucinski to do some things that they need to do are not there. We as a private agency are really limited. We get calls from schools, from school districts, from parents, wanting us to help and we want to help. We are there to help; and if we had even some of these resources available——

Chairman PEPPER. Are you getting any Federal money?

Reverend MCLEAN. No, not a dime.

Mr. ALEXANDER. May I say something. In the whole deal today I was going to bring up something and I forgot—accountability. We have agencies who are doing jobs but they are not being held accountable. Nobody measures whether they are effective or not, and I think the Federal agency looks at not only their department but other departments who are proposing and saying they are doing things and they are not doing it. I think we should look at our own Food and Drug Administration because they are not restricting the amount of drugs that are being produced. I think you know they are making a huge profit, not only in the drugs that they are putting out, but also in the

advertisements that are behind it, which I think is feeding the problem, and very few people want to attack this area of control of money-making because the youngster that we are dealing with is an economic problem.

It is not just illicit, it is that people are making money from adults down to the other kids, and I am saying we should look at that and take some priorities in certain areas and stay on those priorities until we defeat them. I think we keep fragmentation if we get some groups and say this is where we are going and this is the timetable we are going to try and do it. I think we might make a lot more inroads.

Chairman PEPPER. You strike a sympathetic chord with this committee because we started some 2 years ago to try to get something done about amphetamines, one of the dangerous drugs that is being abused by the young people of the country today. We offered an amendment in the House, which we lost; we got it adopted in the Senate, and we lost it in the conference; but we kept on pushing and got the Department of Justice, which we had given authority to reduce the quota system of the amphetamines which was then at the level of 8 billion a year being produced and distributed in this country, when they didn't need but a few thousand at the outside.

Finally, the amount has now been reduced by 82 percent and we are trying to get further reduction. So far we have been giving consideration to going into barbiturates, that seem so far to be unregulated. They pour them out the way they used to pour amphetamines out, and yet nearly all of these young people that testified spoke about the prevalence of the use of barbiturates in the schools. And then now the ingenuity of the drug houses coming up with new things, and they are making human adaptation of some of these things that were designed for use with animals and the like.

So I think your suggestion is well taken, that we and others that have authority in the matter should look into it to get the Food and Drug Administration to advise us what is being permitted and then maybe some efforts should be made to get the appropriate committees of Congress to go in-depth into the quantities of the various drugs that are being distributed and to keep a watch on them because they will come up with some new ones from time to time.

Just one other thing. You know, I remember the CCC camps back in the early Roosevelt days and I thought they did a great deal of good for a lot of young men who I saw go off and come back stalwart, strong, confident young men. Your ranch sort of reminded me of that.

Would there be any possible use of that kind of thing on a large scale; would it be desirable?

Mr. ALEXANDER. If the attitude of the people changed toward institutionalization. They put us in the same bag as all institutions and that is one of the things that we are fighting that is really hurting the whole object, is people think institutionalizing is the worst thing that can happen. We are not running a correction institution to keep the people 5 or 10 years, we are talking about time to get the person out of the whole system, what caused him trouble, to get him built up enough to go back, and I think we have a lot of camps, a lot of ideas, but it is the attitude of America at this point toward institutionalization is really one of the difficulties of doing that and by us being in this field and everything suggests to people, because we are representative of

institutions and representative of the law, we are rejected because they feel we want to institutionalize everything.

We want to try deals that will work but it is just that we are not going back, we are saying let's amplify it.

Chairman PEPPER. Well, if we do get the whole gamut of what we know occupied by action undoubtedly we can do a lot more. Dr. Foster mentioned jobs. I remember very well a lady was doing some work for my wife. She spoke to my wife in private about her 14-year-old son and she said all the rest of her children were well behaved, this was causing her trouble all the time, and she said, "Mrs. Pepper, could you help him get a job? If I could get him a job I think maybe I could have better luck with him."

Mrs. Pepper helped him get a job and she didn't have so much trouble with the boy. So, as Dr. Foster said, part-time employment, and what can be done in the schools. We have often heard some innovative programs, in Chicago, particularly, where the State Attorney's Office of Cook County, when they come in on a drug-related arrest, they give special programs to them on Saturday, and they have the parents in and they have seminars with them and the like because they have got them, as you say, they have a little club over their heads. Some say after they have been in, the courts can send them on probation, and have some strings on them after that. Those programs are beginning to be developed now.

These peer therapy programs seem to be doing the best job in my area where they get these youngsters that are sent there by the courts or schools or who come voluntarily or sent by their parents. They get them in there, several hundreds of them, and they stay in the program from 10 o'clock in the morning until 10 o'clock in the evening and then they stay at the home of some parent whose child has been through the program. They don't go back home until they are discharged. And then they sing songs, and they rap together, and all that, and they have had phenomenal success.

But one thing about what you said a while ago, Reverend McLean. Some of these Federal administrators, they have got a pattern, they want you to have so many psychiatrists and so many psychologists and so many doctors of this, that, and the other, and they want so many reports filed.

They would rather have reports than cures, most of them, and if you don't have them they won't give you any money. That is one of the problems we are wrestling with. Getting them to recognize that in dealing with human beings, leadership, the capacity to challenge, to inspire, to excite young people to action, does not necessarily mean a man must have an educational degree. Some men have the genius of leadership, born with it. A man like Robert E. Lee or George Washington could ride up into the thick of battle and men would say go back and we will take it and they would die taking it, but they would take it to save the life of that man. He didn't order them to do it, they loved him; he had the genius of leadership and that is the kind of program that gets result.

Mr. STAFFORD. Could I make one comment?

This morning you raised a question of several people, as to what would you recommend as far as programs? I would like to comment that I think a theme should be made and that would be to encourage

mental fitness as well as physical fitness to help people develop the capacity to deal with whatever risk they may face in life. If you prepare people mentally, they will be able to deal with problems. If we don't, we are lost.

Chairman PEPPER. That is very good.

Reverend McLean, do you have any suggestions

Reverend MCLEAN. I think you have perhaps heard these things that communities across the Nation and counties could well do. We have seen on TV the last few night pictures of our institution for juveniles that were pretty sad and thus that is what the public image often is and yet you can go out to a ranch like these gentlemen have and see some real things being done that are vital and helping in changing the direction of young people's lives and then——

Mr. PHILLIPS. My staff was out there to see that and they reported it looked like a country club.

Reverend MCLEAN. It is a good place and it is too bad it gets lost in the shuffle of all of the bad things around the country, but perhaps we need to take a look at your own families at home and not always depend on somebody in the community going to solve it, and here we are back to a person's own personal faith, commitment, the type of thing that the young man told you about this morning, about the faith in the Lord that changed his life. That may get a little skepticism these days but it is hard to improve on.

Chairman PEPPER. It doesn't for me. I don't mean to make any show of it or anything, but I know that is one of the moving experiences in the live of many people and I was glad to hear this young man this morning stand up, a big strong, young man that he is, and say that is how he came to experience a new life, some sort of spiritual experience that he has had.

Anything else, gentlemen, to add?

Well, thank you all very much for your very knowledgeable and valuable contributions. We will adjourn until 10 o'clock tomorrow morning.

(Reverend McLean's prepared statement follows:)

PREPARED STATEMENT OF REV. GORDON MCLEAN, EXECUTIVE DIRECTOR, DRUG ABUSE INFORMATION SERVICE, INC., SAN JOSE, CALIF.

From our experience in daily contact with young people involved in the drug scene, we see several trends:

1. Less use of drugs among college students and older high school students. This can be attributed likely to the well documented and recognized ill effects from the use of opiates, amphetamines and barbiturates as well as the hallucinogens.

2. An increased drug use among younger high school students and into the junior high school age group where the desired message on drug effects has not been presented at all or, if presented, not done in a manner that will deter drug use.

3. A definite increase among a more drug oriented group of young people—small compared to the teenage population that could be described as experimenters, but quite a definite group in the sub-culture of youth—who are using heroin, cocaine and other hard narcotics.

Large expenditures of government and private funds, expanded services such as methadone clinics, and a variety of educational and counseling approaches to youth have all been tried with varying degrees of success. But drug involvement and use among our population still remains a serious problem.

As to young people specifically, several things are needed:

1. New approaches to community action in prevention, including dealing with the first time-user and experimenter.

Santa Clara County, San Jose, California is following one such plan. Young drug users are referred to a four week counseling program after an initial arrest has been made by police agencies or even through voluntary participation of families finding themselves with the problem. The juvenile probation department provides this alternative to formal court action and it involves one night a week with the parent and the youngster in a counseling/information program. Following a fact session with an expert, the group is broken up into smaller discussion units with parents in a different group than their own youngsters. This allows for some free discussion and frank exchanges between parents and youth that usually helps both. It seems to be much more effective than the usual probation procedures.

Further innovations in treatment are offered by the county to young drug users with the development of day care treatment centers providing education and counseling services but allowing the young person to return home at night and enabling the counselor to work with the family.

For those young people needing more intensive treatment to keep them from heavy delinquency and drug involvement, the county operates three rehabilitation centers—ranch-style, residential schools with counseling, recreation, education and work experience. The two boys ranches and the girls ranch are among the finest facilities of this type in the nation.

2. Innovative and contemporary educational tools need to be used in updating and implementing positive drug education programs.

Any such program must begin by educating the educators. Perhaps the saddest commentary on drug education is the student sitting in the classroom often knows more about drugs than the instructor. Up-to-date films, books and other visuals need to be developed for each level. Increasingly we are feeling drug education should not be an isolated unit taught for a period of days or weeks exclusively, but brought into each area of curriculum—social studies, chemistry, physical education, health, etc.

3. Community planning must draw on the resources of many areas for an effective program against drug abuse.

Where it has not been done (as in California by law), communities need a coordinated program involving education, law enforcement, probation, and private agencies for mutual cooperation, sharing of ideas, and working together. California has made good strides in this area under a state law requiring the County Supervisors to develop a county-wide plan for dealing with their local problems.

4. Monies that are available need to be put where they will accomplish the most good and not be bogged down in layers of bureaucracy and red tape.

Small, private agencies in the community are often doing some of the most vital and important jobs and yet it is all but impossible for many of them to get government help from funds provided while often new agencies are set up by government and red tape added at length. Money is wasted when there should be simple and straight forward procedures to get the help to the people doing the job.

As I toured Asia this past summer, I became convinced that drug use is not a problem for the American people to solve alone. With hundreds of thousands of dollars worth of narcotics coming to America from Asian countries, we must continue our efforts to stop that flow. We need to vastly increase the services, personnel and budget of agencies such as the Bureau of Narcotics and Dangerous Drugs, U.S. Customs, etc. for investigation, law enforcement training and cooperation across the world.

America must stop ignoring the dealing in drugs by political leaders in countries that are supposedly our friends, and it would be no small service if the Congress would serve notice that not one cent of aid or assistance will go to many of these Asian countries until we have every assurance and evidence they are taking genuine and effective anti-narcotic efforts within their own borders. Political expediency has too often caused us to look the other way while the trafficking went on. Reports from B.N.D.D. agents have been ignored to our shame and detriment.

Money alone is not the answer. Philippine local officials told American authorities, "You paid the Turks $35 million to burn their opium crops. The climate in our area is ideal for growing opium, but we're not growing it. Pay us $35 million and we won't even start growing it!" More than anything else this nation needs to be respected across the world, as distinguished from being thought of as "good guys". In no way should we lend our support to governments and peoples that will not meet their responsibilities in solving the drug problem.

(The following statement was received for the record:)

STATE :NT BY PERCY PINKNEY, EXECUTIVE DIRECTOR, COMMUNITY STREETWORK CENTER, SAN FRANCISCO, CALIF.

Good afternoon, Congressman Pepper and members of the House Crime Committee. I have come before you today to speak on what has been called the "drug problem" in our schools. This is a topic I am sure you have all heard much about in the past few days and in the past few years.

I think just about everyone will admit that many, many kids in our schools—in San Francisco, in San Rafael, in New York, in Miami and probably even in McComb, Mississippi—many young people in our schools are using some form of drugs or narcotics during school hours and after school hours. This is no surprise to me. and should be no surprise to anyone else. Certainly most people would admit that many kids are using drugs, so there is little reason to believe they would stop using drugs at 8:30 in the morning and start again at 3:00 in the afternoon.

We have a drug problem, certainly. But more than that, we have a school problem, we have a poverty problem, we have an economic problem, we have a job problem and we have a government problem. Just try hanging around our own Hunters Point community for a couple of weeks, living in one of those flea-bitten projects up on that hill, without any money, without a job, with a couple of food stamps in your pocket. I guarantee you'll probably start looking for some kind of dope yourself after a couple of weeks in Hunters Point, and you won't have to look far—that pusher man will find *you* with no trouble at all. You will want some way to stop seeing all that despair, all that poverty, all that ignorance. Then just remember that a whole lot of people in Hunters Point, in Harlem, in Watts and many other similar communities have to look at that scene every day all their lives. and you will begin to understand the "dope problem".

I think that when we get serious about solving all these other problems, and when we get serious about making our schools responsive to the needs and lives of the people in them, we will have taken a big step toward solving the drug problem. As long as kids are bored stiff by uninteresting school material they couldn't care less about, as long as we keep graduating large numbers of kids from high school who can't even read, we will have a drug problem in the schools—and that only takes into account those students who stay in school, not to mention the ones who drop out into the streets where the real dope scene is.

Also, I think the Government should quit worrying about the flow of marijuana into the country, and instead do something about the flow of heroin from Southeast Asia. If the FBI and the police would worry less about busting a few pot-heads in Golden Gate Park and more about curtailing the mass overproduction of amphetamines and barbiturates by our fine-upstanding drug manufacturers, we would begin to get a handle on the drug problem—since huge numbers of these pills find their way into the black market with the full knowledge of the manufacturers.

I think when this country really gets serious about the rest of its problems, the drug problem will cease to be a problem and will become a medical and psychological symptom which will be dealt with effectively with medical and psychological treatments.

Thank you, and good afternoon.

(Whereupon, at 4:05 p.m., the committee adjourned, to reconvene at 10 a.m., Saturday, September 30, 1972.)

DRUGS IN OUR SCHOOLS

SATURDAY, SEPTEMBER 30, 1972

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CRIME,
San Francisco, Calif.

The committee met, pursuant to notice at 10:25 a.m., in the Ceremonial Courtroom, U.S. District Court, 450 Golden Gate Avenue, San Francisco, Calif., the Honorable Claude Pepper (chairman) presiding.

Present: Representatives Pepper and Waldie.

Also present: Joseph A. Phillips, chief counsel; Michael W. Blommer, associate chief counsel; Chris Nolde, associate counsel; and Leroy Bedell, hearings officer.

Chairman PEPPER. The committee will come to order please.

Mr. Counsel will you call our first witnesses, please.

Mr. PHILLIPS. Yes, Mr. Chairman. The first panel of witnesses today is the principal executive officials of the San Francisco School District. Mr. George Chinn, president of the school board; Dr. Morena, new superintendent of schools; and with him is a member of his staff, Mr. Eugene Huber, who is in charge of the drug education programs in that school system.

Thank you very much for coming, gentlemen; we are happy to have you with us.

Chairman PEPPER. We are very pleased to have you here, gentlemen, and we know you will make a valuable contribution to the effort of this committee to learn what the Federal Government can do that will help you school authorities in dealing with this problem of drug abuse that we have found so prevalent in the schools of this country, even down into the elementary school.

Let me just say one word. I noticed in the paper this morning that one of the young ladies who testified here yesterday as a witness, who had been an abuser of drugs in schools, made the comment, I suppose not unexpected from a young person, that hearings such as this committee was conducting were ridiculous because all we wanted to do was pass some laws to put more young people in jail.

Well, we are sorry that even one young lady got such an erroneous impression of the attitude of this committee. We do not have any authority, in the first place, to recommend legislation to put anybody in jail because that kind of offense would be a State offense and not a Federal offense, ordinarily. What we are trying to do is to get the Federal Government to provide money and guidelines, perhaps, and other forms of aid to the school authorities to help the schools and, of course, we are interested in programs outside of the schools; but we consider that the action is in the schools.

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What we want to do is to help the schools to deal with this problem, not by putting somebody in jail or even suspending them from school, but trying to save the students from falling into the tragedy of drug abuse in the schools.

I just want to make the statement that the young lady, unfortunately, misinterpreted our effort.

Gentlemen, you may proceed in your statement. You know, of course, your distinguished Representative, Jerome Waldie, who is so vitally concerned about this matter, was responsible for our committee coming here to this area to learn what we could from those best able to inform us, and so he is following with the keenest interest what evidence we develop here. It is an honor to have him as the ranking member of the committee where he has made such a magnificent contribution to the effort we have been making to do something about the whole problem of crime in this country and now particularly with this phase of drugs in the schools.

STATEMENTS OF DR. STEVEN P. MORENA, SUPERINTENDENT, SAN FRANCISCO UNIFIED SCHOOL DISTRICT, CALIF.; ACCOMPANIED BY EUGENE C. HUBER, CHAIRMAN, HEALTH EDUATION PROGRAMS; AND GEORGE Y. CHINN, PRESIDENT, BOARD OF EDUCATION

Dr. MORENA. Thank you, Chairman Pepper, members of the committee. I would like to preface my rather general statement with another statement and that is that my tenure in office has been for 4 weeks and so obviously the statement is somewhat general.

Mr. Chinn, the president of our board, was just recently appointed president of the board and so with your kind indulgence I have asked Mr. Huber to come in since he is currently without title operating as the chairman of our health education program which, of course, includes drug abuse.

One cannot look for "a solution" to drug abuse, because drug abuse is not a single problem. The reality of the situation in which we as a large metropolitan area find ourselves is that drug abuse is a social problem as serious among adults as it is among youth. If we are to attempt to develop common solutions in one program, we risk emphasizing the impractical or overlooking the effective. If we try to isolate a single approach as "the solution," we will find a lack of acceptance by many who need help. The recognition of such a dilemma forces a school district such as San Francisco Unified to try to develop an educational program which will assist each individual to find those solutions which are uniquely acceptable.

If we were asked to state a simple measurable objective which could indicate a succesful program, reducing consumer demand for chemical crutches would be the answer. The current demand for drugs reflects many segments of society that have accepted the Madison Avenue propaganda that discomfort is readily alleviated by drinking, smoking, or indiscriminately using substances which quickly induce or delay sleep, which stimulate or depress appetite, which mask fatigue or relieve pain, reduce tension, boost confidence and make troubles seem to disappear while they give you sex appeal.

In addition to the legal "big sell," we have to be aware of the demand fostered by peer pressure and current slogans as "Try It, You'll Like It." A decrease in the demand for the legal, nonprescriptive as well as the illegal mood modifying chemical substances, will automatically result in a reduction in the supply. The reduction in supply, as well as demand, is readily measurable.

A partnership, the combined force of all the generations working together, is required if this objective is to be achieved. Such a partnership requires free, open, and honest communication between parents and children, teachers and pupils, and mutual respect for viewpoints which may differ. Adults must, if necessary, take the initial step to form that partnership with an alienated generation. Before we lose any more of the most talented and promising young people the world has ever known, we must bridge that intergenerational communications gap by finding areas in which agreement is most likely. Rational individuals, regardless of age, will accept the following:

1. A drug used discriminately as prescribed is helpful; the same drug used indiscriminately, excessively, or to mask a problem is harmful. Drugs, per se, are not the problem. The critical issue is how and why they are used.

2. All drugs and many nonpharmaceutical substances are potentially dangerous, some much more so than others.

3. The drugs most commonly abused by youth and adults alike are alcohol and nicotine. Excessive drinking and smoking trigger and complicate more mental and physical illnesses and accidents, cause more premature deaths and lead to greater family disorganization than do all other licit and illicit drugs combined.

4. Legal controls cannot eliminate curiosity, deter the unscrupulous from taking small risks for big profits, nor remove from the face of the earth all substances capable of altering man's perception of reality.

5. Laws and law enforcement alone cannot solve the problems associated with drug abuse. Children should be taught to respect the law, and we must do all we can to help them understand its limitations. Each of us must be aware of personal responsibilities in an imperfect system.

6. Drugs are so readily available and peer pressures so great that at some time all children and adults are faced with making a decision whether to use them or not. No school, no neighborhood, no family, no child is immune. Users and pushers act, look like, and are average people of all ages, and often cannot be identified even by trained observers or those with personal drug experience.

7. Individuals at highest risk are those who find it difficult to cope with stress. Drug abuse in the ghetto, long a problem of social unconcern, is now surpassed in seriousness in middle class, affluent neighborhoods. Traditionally a predominantly male problem, drug dependency is today increasing among girls and women.

8. Children will be better able to make responsible, less emotional, decisions about drug experimentation if they are insulated prior to the time they are forced by circumstances to make a decision. Information which is credible to them and which can be supported by scientific data is most important. Where proof is not yet available, each child must be given opportunities to assess the risks and consider the consequences of experimentation with substances not yet objectively understood.

9. The best protection any individual, young or old, has against becoming dependent on drugs is self-understanding, self-respect, self-responsibility, and an acceptance of one's own assets and liabilities. A favorable self-image is more easily acquired in a home and school environment where youth are loved, wanted, and respected; where they know they are free to express their feelings without fear of punishment; and, where they can discuss with interested adults alternative ways of dealing with the frustrations they feel.

10. The first responsibility of the school is preventive education. The target group are pupils who are in the mainstream of society. The secondary responsibility is intervention, or providing assistance for students whose experimentation with drugs is a dissatisfying experience. Youth who abuse drugs to the extent that they need extensive therapy or rehabilitatio must be aided by agencies other than the school.

Mr. PHILLIPS. Perhaps I might interrupt you at this stage because I think you have just stated the policy of the school board, the policy of the school system. Essentially, you say that that policy as to the major function of the school system is preventive education, and you say that treatment and rehabilitation of a child who is abusing drugs is not the function of the school system but the function of some other agency. I think that I have a philosophical difference with that proposition.

I would like to ask you at this stage what you view is the responsibility of the school system for that child who is becoming involved with drugs; he is experimenting with drugs, he is using drugs two or three times a week, he is buying in school, he is becoming a difficulty there, he may be absent on occasion, but the problem manifests itself to the school system. What do you think is the responsibility of the school system in that situation?

Dr. MORENA. I can give you a brief response and I would like to have Mr. Huber also respond.

Mr. PHILLIPS. Thank you.

Dr. MORENA. Upon identification, and we are assuming that the individual has been identified, that we do have social agencies to whom we can direct for treatment.

Mr. PHILLIPS. Do we really have those, Doctor?

Dr. MORENA. Do we really have them? Yes, I feel we do. The extent to which we are able to use them may be another question.

Mr. PHILLIPS. We are told by the principal officials here in the State government that the treatment and rehabilitation systems here are fragmented and disorganized, that is in San Francisco and in other counties; that there are very, very few resources here for a child to receive treatment and rehabilitation. They feel that their efforts have to be substantially intensified before we are going to have resources to send the child to, and what I am afraid you are saying, and perhaps it is an overstatement of the case, that we see a child drowning in the school system, at least what the Government sees, we are putting a buck slip on the child saying buck him over to another agency, let him drown, and I don't see that the school system should take that position. I think, perhaps, they should take a broader position.

Dr. MORENA. Yes. I don't know to which extent this individual is involved and perhaps we might be a little more specific; I am not too

sure. We do have counseling staff, we can make preliminary assessments of this individual that is identified and I think at this point we can provide some sort of help for that individual. But in terms of therapeutic help, I think as far as an individual that has abused and needs medical treatment, perhaps that is within the purview of our organization.

Would you mind if I deferred part of this to Mr. Huber?

Mr. PHILLIPS. It is a policy problem and I think Mr. Chinn might have some observations about it.

As I understand, Mr. Huber's responsibility is for conducting the educational program. This is a policy decision on behalf of boards of education and the principal executive officers of the school system and it is the policy I am directing my question to.

Is that an enlightened form of progressive policy or is it one that should be reevaluated especially with a new superintendent and a new——

Dr. MORENA. The whole area has to be reevaluated, I will agree with you; and I feel somewhat frustrated that I am not very precise in my answer because I am not aware of exactly what is available. I do know counseling is available and we have a fine counseling staff.

Mr. PHILLIPS. I do not know whether that is accurate or not, "you do have a counseling staff." Do you have a drug counseling staff?

Dr. MORENA. No, we do not have a specific drug counseling staff.

Mr. PHILLIPS. Are the counselors that you do have conversant, knowledgeable, trained in the drug abuse area?

Dr. MORENA. I would have to defer that.

Mr. HUBER. May I use this microphone?

Mr. PHILLIPS. Yes.

Mr. HUBER. Actually the policy of the San Francisco Unified School District is that when a student is recognized as needing help because of drug problems, we try to carry it as a counseling problem; that is, referring to another agency is a last resort, not a first step. We try to carry it on as an internal counseling problem of the school itself to do what we can for the student.

Now in each of our secondary schools we do have a teacher who is called the drug resource teacher. Unfortunately this teacher has but one period a day and that is all that has been provided, but we have such a person on the school site.

Mr. PHILLIPS. We have had that repeatedly told us throughout the country, that you do have a drug resource teacher in each school. That drug resource teacher may or may not have some substantial training, but essentially the function of that teacher is to provide information to other teachers, to provide resources to other teachers, films and booklets, and the function of that teacher is in no way, unless it is an added function, adopted by the teacher to aid the child. Is that correct; he is not there to counsel?

Mr. HUBER. The primary function in originally setting up this person was for that reason, the coordinator for the program. In most of our schools, and I think this is a credit to the people who have been selected for that particular job, they have gone out of their way to involve themselves with young people. Now this is not true in 100 percent of the schools, I must admit that, but I would say that more than half of our teachers are really dedicated individuals who spend

voluntary time in community agencies and we have many of them in San Francisco, not as many as we need, but probably more than other cities like us.

I know you have heard from some of the people yesterday, for example, people at Walden House. We work very closely with people at Walden House.

Mr. PHILLIPS. Walden House, I think, has 60 residents; but we heard testimony yesterday that, even if it is grossly exaggerated, 60 percent of the kids are experimenting with drugs. Let's assume only 10 percent are. Ten percent of your school system would be 6,000 and we have 60 in Walden House. That is the best program here.

Mr. HUBER. What I am saying is there are agencies and we should pattern more after agencies like Walden House.

Mr. PHILLIPS. You say let's have some other agency somewhere else.

Mr. HUBER. Only as a last resort, when we really feel we can't handle it ourselves. We do need good counselors. Again we don't have enough.

Mr. PHILLIPS. Do you feel that the counselor system is adequate to sustain the burden of new drug counseling?

Mr. HUBER. No.

Mr. PHILLIPS. Probably?

Mr. HUBER. No, not as it stands right now. We have people We have in-service courses that are offered. We don't have enough time to reach all of the people we feel should be reached. This is part of the statement that is included in what I have to offer.

Mr. PHILLIPS. Perhaps you would want to continue.

Dr. MORENA. I think perhaps after Gene makes his statement some of these might be a little more specific. I do agree with you we do not have adequate provision for counseling and specifically no designation as a drug counselor.

The program of instruction directed toward reducing the demand and thereby preventing misuse of hazardous substances by the citizens of San Francisco is in reality a partnership project. The pupils and teachers in our schools, the parents and community representatives in our city are striving:

1. To help youth understand the values systems and motivations which underlie the use, misuse, and abuse of hazardous substances;

2. To provide opportunities for young people to examine critically a wide range of factual information and expert opinion, and to develop criteria and responsibility for decisionmaking, and finally;

3. To discourage the experimental and recreational use of drugs and hazardous substances by helping youth develop satisfying and constructive interests and life styles as preferable alternatives.

I think when this is extended, by what Mr. Huber says, there will be a little more meaning to these statements.

Mr. PHILLIPS. Mr. Huber, do you want to briefly describe your educational program?

If you have a prepared text, we will certainly include that in the record; and if you could summarize that for us, perhaps we could then question you about it.

Mr. HUBER. This in terms of quantity is perhaps impressive and I suspect it has a great deal of quality to it as well.

As a part of the prepared statement I make reference to the National Clearinghouse on Drug Abuse Information which accepted our program in 1970 as one of the eight or nine model programs throughout the United States.

Mr. PHILLIPS. The model education program?

Mr. HUBER. Yes, sir: for other communities to use in developing their curriculum materials.

The master program as far as San Francisco is concerned sets up minimum requirements as far as instruction in the classroom is concerned and at the present time our educational organization primarily can through three schools, separate buildings, intermediate, four through six grades, separate buildings, junior high school seven to nine, senior high school 10 to 12. In each of the grade levels there are minimums of required hours. I can't guarantee all teachers are carrying out what are supposed to be minimum education.

Mr. PHILLIPS. How many of your teachers are prepared to teach those courses, and how have they been prepared?

Mr. HUBER. I did not bring with me the figures as far as inservice courses.

Mr. PHILLIPS. Approximately how many?

Mr. HUBER. I would suspect at least 20 percent of our teachers have actually actively enrolled in inservice courses.

In addition to that, because of some Federal dollars which were made available to us through the Emergency Employment Act last October and November, we have established at our elementary level, and this is where we feel the emphasis should be, we have established seven zones. Because of the integration pattern we have in San Francisco we have seven zones. Each of those zones has a team made up of one teacher and two paraprofessionals who go from school to school not to work with kids but to work with teachers, because we feel that these Federal dollars are not going to be with us more than this and next year and if we had these people working with children, when they leave we will be back where we were. We have these people and call them resource teachers. They go from school to school to try to involve teachers to get involved with kids in doing things.

Now this doesn't mean giving lectures about drugs; it means getting kids involved in learning how to enjoy going to school so that they have something with which to make a comparison if they have an enjoyable experience with drugs.

Now, I am blowing my top here but we feel——

Mr. PHILLIPS. It is better than blowing pot.

Mr. HUBER. Some kids disagree. We certainly feel that there are many youngsters in San Francisco, and I know throughout the Nation, who really don't enjoy school, obviously. They don't enjoy their homes either, and when they experiment with drugs, for whatever reason, it may be they find for the first time an enjoyable experience.

Chairman PEPPER. May I interrupt you. Apropos of what you have just said, I received what I thought was shocking information last night from a teacher I happened to meet, whom I know, from the Daly schools. I guess that is not part of San Francisco, it is further down the Bay.

Mr. HUBER. San Mateo County.

Chairman PEPPER. In the eighth grade there were three classes of 16 students each who had the reading grade of 0 to 2.3. In other words, in the eighth grade. three classes of 16 each who were between kindergarten and the third grade in their reading ability.

Then in the seventh and eighth grade, she told me, there were four classes of 25 each with a reading grade level of 3 to 5. They were in the seventh and eighth grades and had a reading ability between the third and the fifth grade.

Now, what are schoolchildren like that going to find of interest? I saw on TV a student, a young lady. They asked her about her school: did she have a drug problem? She said, "No, the problem in our school is reading and pregnancy." And from the hearings that we have had in New York, Miami, and Chicago, and now here, in the last few weeks, I am just beginning to be aware of the fact that we have got a real crisis in education in this country, and we are going to have to pay for it.

How can a child pass the eighth grade with that kind of a reading capacity? They must have just been passed year after year. We heard this in New York in the black and Puerto Rican areas. the children there don't pay any attention to classes; they walk in and out; they insult the teacher if the teacher tries to require any discipline of them. They pass them. They have nothing else to do; they just pass them.

What are they going to do in this society of ours when they get out of that school, eventually. A lot of them will drop out. Chicago had 12,000 dropouts last year. I don't know how many you had here in your area. But it seems to me that we have got a very serious situation altogether.

Students have testified here at this hearing that they took drugs to keep from being bored. Well, maybe some of them didn't have the capacity to get anything out of it and maybe the curriculum wasn't quite as exciting as it should have been.

What would you say to that?

Mr. HUBER. I certainly don't disagree that changes have to be made in education, obviously.

A couple of years ago I made a statement before the National Education Association Convention here in San Francisco that while drugs have had some pretty negative effects as far as individual students are concerned, I suspect that drug abuse has had some relatively positive effects as fa. as educational processes are concerned, because we have suddenly realized that we don't teach subjects, we teach children, and we have to realize changes must be made and they have to be made pretty soon.

Chairman PEPPER. And the kind of program that we are thinking about would be a program that would enrich the whole curriculum; that is exactly what we are talking about. to help you to be innovative and experimental and challenging in the presentation of education.

Mr. HUBER. If I had an educational goal, if there were some magic way I could put this into operation, what I would like to guarantee is that every student has one enjoyable experience in school every day and I think he would come back.

I don't know if you play golf or not. I do. I am not a very good golfer. I shoot maybe 113, something like that, and 110 of those shots are pretty poor and I get three good ones and it is the three good ones

that make me come back next week: and I suspect if young people have enjoyable experiences in school they are willing to forget the bum shots and come back for the three good drives.

This Federal program that we call EDAP, elementary drug abuse program, these are really dedicated people, they are paraprofessionals, some with college degrees who couldn't get jobs other places and work as paraprofessionals with us. Eight of them are certificated by the State of California. So dollarwise their salaries are a little bit higher. But they are so involved in getting other people to enjoy going to school, and you know there are subliminal messages we are giving these kids. We involve them, for example, in taking pictures and the pictures happened to be about antismoking or antibeer drinking by adolescents, or what have you, and the emphasis is on the pictures but the underlying message is the abuse of substances, and we try to get those substances which fit into the world of that particular age level.

For example, our primary kids really aren't concerned about heroin, they hear it, but it really is not one of their concerns. They are much more concerned about antismoking. They are home telling mom and pop to try to lay off. They are concerned about alcohol, as most of us are. At our intermediate level, four-to-six level, is where we put more emphasis on substances. We certainly go into all of the drug classifications. We feel that at the time these students finish the sixth grade they should be aware of the pharmacology of drugs, at least appropriate for their level of understanding. But by the time he gets into the junior high school we are much more concerned that the emphasis as far as drug education is concerned be not on drugs but on personal motivation. What is it in our society that sort of pushes kids toward drug abuse?

Mr. PHILLIPS. I might interrupt you there.

It seems to me that we have heard programs and curriculum and we have read them from all over the country and they are just not successful. Maybe it is too soon to know whether they are successful or not. Maybe these educational programs take a decade before they have an influence. Maybe we have to wait for the kindergarten child now to get to high school before we know whether they are going to be effective or not. But as I see it, we are not being effective because we are getting more and more children, high school children and junior high school now, and even in the grammar schools, being involved with drugs; so the educational program is not working.

Mr. WALDIE. Let me interrupt because I want to cover much the same area.

Will you tell me how long your program has been in existence?

Mr. HUBER. This particular one is a revision from last year, which was based on a program that has been developed since October of 1968.

Mr. WALDIE. So at least since 1968?

Mr. HUBER. As far as this program is concerned. Now the concern about drugs in San Francisco is considerably older than that. This particular bit of information was written by Dr. Frances Todd, who was my colleague until her recent retirement. It is dated 1957. We in San Francisco have been aware of drug problems for a long, long time.

Mr. WALDIE. OK.

Mr. HUBER. We have been pleading since the late 1950's and early 1960's for help, and thank God you are finally here.

Mr. WALDIE. Let me stop you there a moment.

Has your concern resulted in the implementation of programs? I presume it has. Is there any manner by which we can receive a measurement as to the success of your concern, and has the drug problem in the San Francisco schools diminished during the years that your concern has been present and you have implemented that concern?

Mr. HUBER. If you say in the schools, I will say yes.

Mr. WALDIE. All right.

Mr. HUBER. The police department. Sergeant Hoenisch was here the other day.

Mr. WALDIE. Hold on. I presume your conclusion, in the schools, that the drug problem has diminished is supported by some surveys or quantitative measurements. Well, all right; have you had any such measurements or surveys? Can you tell me why you have not? Is there any reason why you have not resorted to demonstrating the success or failure of the programs that you have instituted?

Mr. HUBER. There are several reasons. Whether they are valid or not remains to be seen.

Mr. WALDIE. What are they?

Mr. HUBER. First of all, San Mateo County has for the past several years been running surveys on student abuse involvement, changing the trends, and so on. We feel that the students this close are pretty much images, that is not exact, I know, but nevertheless we are close enough that their problems are very close to our problems.

Mr. WALDIE. Well if that is the——

Mr. HUBER. That is one. Second, surveys are extremely expensive, time consuming, and of questionable value in terms of the kinds of answers that you get from students the first time they go through it.

Mr. WALDIE. Is it the expense?

Mr. HUBER. That is part of it. That is a very important part of it.

Mr. WALDIE. If you had the money would you conduct the surveys?

Mr. HUBER. Today I think a survey would be much more effective than it was 3 or 4 years ago and for this reason I suspect that young people, for example, the first survey that was done in San Mateo County, I am sure you are aware of it, was kids who answered questions, those few were bragging, others were suspicious, they didn't know what was going to happen if they answered, yes I have tried this, or yes I have tried that. I think they have found out after 3 or 4 years now, that is, three surveys that are completed, that there was no hassle as far as the kids were concerned who said, yes I have used this. I think they are much more prone now to give an honest answer, so I think a survey would be effective now in San Francisco, yes; but we don't have the dollars, there is no doubt about that.

Mr. WALDIE. You need the dollar for the survey and you would like the survey; is that accurate?

Mr. HUBER. Yes, sir; that would give us baseline figures with which we can make comparison in the figures.

Mr. WALDIE. Absent those figures you have concluded that the drug problem in the San Francisco school system has improved?

Mr. HUBER. Yes. This is subjective evaluation by people on the school site.

Mr. WALDIE. All right. But that subjective evaluation must have some foundation other than hunch.

Mr. HUBER. Yes, sir.

Mr. WALDIE. And will you tell me what this foundation is? Are there any criteria that support that subjective evaluation?

Mr. HUBER. I guess one can pick numbers that support his case. Certainly the police department feels that the arrest records as far as juvenile offenders in San Francisco is in the direction they would like to see. They would like to see it move in this direction faster, but they feel that the arrest figures in the San Francisco Police Department in terms of juvenile offenses, those published statistics, have improved.

Mr. WALDIE. The police department testified yesterday that any individual coming onto any campus in the San Francisco school system can buy any quantity and any type of drug within a 5-minute period of time if he had the money to purchase. If that is accurate and that represents an improvement of the situation that existed in the San Francisco school system, then the past must have been indescribable. Is that accurate?

Mr. HUBER. In view of the statements Dr. Morena was making if we can cut down the demand——

Mr. WALDIE. I am very well——

Mr. HUBER. Three years ago——

Mr. WALDIE. Let me interrupt.

Mr. HUBER. Kids were overdosing, they were buying and using on campus.

Chairman PEPPER. Will you allow Mr. Waldie to ask you the questions?

Mr. WALDIE. I don't want to interrupt you. I don't mean to be playing games with you and I am not criticizing what you are doing.

Mr. HUBER. I understand.

Mr. WALDIE. But I am really trying to find out if you know the extent of the problem within the San Francisco school system or if we know it. We get a lot of opinions and I personally am inclined at times to find it to be exaggerated, but I can't turn to anyone that can tell me those police officers that made that statement know what they are talking about; and I would like you to deny that that is so.

Can you go on any campus in the San Francisco school system, if you have sufficient money, and buy any quantity of drugs that you desire within that span of time?

Mr. HUBER. I would hesitate to say. It depends on what you mean by "on campus." Sometimes we are talking about different things. We had better define the limits. If you mean in the halls, I suspect that you can.

Mr. WALDIE. That you can?

Mr. HUBER. Not anytime you want or not as open as some people seem to think. If you go outside the school building, across the street, around the corner, then I say the marketplace is there.

Mr. WALDIE. Now, that then, essentially, is what the police told us. Is that an improvement over what was heretofore the situation in the San Francisco school system?

Mr. HUBER. As far as sales, probably not. As far as use, and this is what we should be concerned about, as far as the schools are concerned now, the demand and the use by kids on the school grounds is not as it was 2 or 3 years ago.

Mr. WALDIE. I understand you to say sales is a direct relation to the demand. If that is the condition of sales, demand is extremely high; is it not?

Mr. HUBER. Yes. This idea that people are not pushers anymore, they are dealers, they have more customers than they can handle.

Mr. WALDIE. If sales are as high as you have described them, demand is high to meet that need.

Mr. HUBER. Yes.

Mr. WALDIE. But you still conclude demand is less than it was heretofore in the San Francisco school system?

Mr. HUBER. No; that is not what I said. What I said was use on the school grounds so then we are not seeing the overt symptoms of drug abuse. We have to differentiate, too, between use and abuse.

Mr. WALDIE. All right.

Mr. HUBER. I am not saying that kids don't use drugs. I am certainly not saying that adults don't use drugs. We all do. When someone asks me what percentage of students I think use drugs I say 100 percent.

Mr. WALDIE. What are you saying then?

Mr. HUBER. I am saying that we are seeing less drug abuse now, so we have come a step. We are far from solving the problem but I think we are moving in the right direction. We are not seeing as many kids on the school grounds abusing drugs as we did a couple of years ago. We are still seeing tremendous amounts of drug use and misuse and we haven't solved the problem by a long shot, and I don't claim that we have, but I think we are moving in the direction toward solution. I just haven't found all of the answers yet, nor has anyone else.

Mr. WALDIE. No one in society has, and all that I am trying to establish as a member of this committee is the extent of the problem: and I find that very difficult.

I find authorities suggesting, as you have suggested, that we are making strides and the situation has improved in the 10 years that you have been attacking it in San Francisco, but then when the situation is described in terms of fact, that you can buy anything you want on the campus at any time, that does not seem to me a measure of improvement and I can't find, except in San Mateo, any school administration that has attempted to determine a measurement as to whether progress is being made or not. It's a subjective feeling and it's not a subjective feeling that gives me much comfort.

It doesn't give me much comfort to hear a policeman say you can get drugs any time, any place, any quantity, on any school campus in San Francisco, because I don't know that he is right, but neither do I find anybody able to refute that, and there is general acceptance that that is so. And if it's lack of money that restrains you from measuring the success or failure of your programs, then we ought to provide you those funds. But to suggest that these programs are in the right direction, there ought to be some means, since they have been in existence for some time, of measuring success or failure; and apparently there has been no effort to measure success or failure, just a gut feeling, as you describe it, that abuse is not occurring as frequently as in the past, though use is at the same level.

Mr. HUBER. Certainly there is an acceptance of drug use in our society.

Mr. WALDIE. You bet there is.

Mr. HUBER. That is the biggest problem we, as educators, have to overcome.

Mr. WALDIE. I am a user of two drugs myself. I use alcohol and I use tobacco and I abuse tobacco, I recognize that; but I sit on this committee and I just don't understand why we can't get more concrete facts as to the extent of it rather than these general propositions that its tearing the school system apart; and why we can't get some indication of the steps we have been taking really leading to some conclusions that are positive, or are we playing games with ourselves? It would seem to me if we are investing resources, as you are in the San Francisco school system, to attack this problem, that someone ought to be able to say those resources have had return; and there may be reasons why you don't measure, but none have ever given me a good reason yet, except they don't have the means to measure success or failure, or even to identify the extent of the problem.

The only school district in California we have come across so far in San Mateo that has made an effort, and it's been subject to some uncertainties as to the results, but at least the effort has been made to measure.

Mr. HUBER. This was the public health department, not the school district.

Mr. WALDIE. I didn't know that.

Mr. HUBER. County public health ran those surveys. The San Mateo District has 23 or 26 different school districts in the county and all of the districts except one participated.

Mr. WALDIE. Have you ever asked your county public health department to run similar surveys?

Mr. HUBER. No.

Mr. WALDIE. And that is because—when you smiled, I assume you thought that would be a fruitless request.

Mr. HUBER. Yes; in terms of dollars spent.

Mr. WALDIE. They don't have the money?

Mr. HUBER. We cooperate very closely in terms of training programs for teachers and even requests for presentation to students in terms of trying to prepare our students in the youth projects, for example, but in terms of asking them for dollars which would be necessary, we are talking about not only people but computer time and things like that, and that is where the expense really builds up. It's not something that we felt we could afford.

Mr. WALDIE. The Congress might be able to help, but I keep getting the answers, "Well, we don't have money, but in addition its very hard to survey," and I gather from the second part of the answer that there is not much enthusiasm or desire to measure the extent of the problem in the school system because of the adverse consequences publicly that might thereby ensue.

Am I unfair in that?

Dr. MORENA. I feel very strongly about this. We constantly ask for money and the way in which it's asked often is very important, but part and parcel of the request for money has got to be an opportunity to evaluate because people want to know what happens to their money.

Now, the amount of money spent in this district for drug information is a pittance. We can hardly staff the schools and give instruction in every class and along with that is the primary concern with reading

that you mentioned. As a district we are going to make that commitment in terms of reading because that may be the single satisfying experience an individual has to have, whether he knows it at the time or not, before he is going to succeed at any endeavor.

But I feel very strongly about money and in asking for it but I also feel very strongly with that money part of that package must include evaluative criteria to defend the use of this money, and I feel that if we had the kind of money we wouldn't be afraid to ask and to survey. It's just they are not putting money where it's needed, and when there is a priority it becomes this may be important in terms of a priority, drug abuse, reading, perhaps No. 1 then look at the budgets and find out where the money priority is.

Mr. WALDIE. We had the superintendent of the Oakland system over here yesterday and I have rarely heard a more persuasive presentation and more passionate one. But I came away with the conviction that his view on the matter—and I am wide open to my own views because I don't know the answers any more than anybody else—his view of the matter was drug abuse in the school system is only a symptom of an awful lot of other problems in the school system that require resources that have not been provided, and that if we start attacking the symptom without the cause we are not spending resources wisely.

I get a sense that that is about the direction you are coming to, also that Congress ought not to get overly excited about drug abuse—well, they ought to get excited about drug abuse—but they ought to convert resources to improving the educational system to prevent the climate that seems to foster drug experimentation in the school system.

If you had your choice between dollars to go in a reading program or dollars to go into expanding the sort of drug program, given the present situation, whatever that is, in the school system of San Francisco, what would your choice be?

Dr. MORENA. My choice would be reading.

Mr. WALDIE. Why?

Dr. MORENA. Because I think an individual has to have it as a base for any satisfying experience almost in any grade level.

Mr. WALDIE. The tragedy is that those choices have to be given.

Mr. HUBER. I disagree.

Dr. MORENA. With me?

Mr. HUBER. You have to choose between the two. I disagree with everyone. We put drug education into our reading program, we don't put drug education on the side. It's not a separate program, its very, very, very much integrated with ongoing programs, particularly at the elementary level, in what reading programs are going on, our art program, social studies, sciences.

Mr. WALDIE. I don't know if your drug program is worth a damn. I don't mean to criticize it. I just don't know. All I know is the situation, as described to me, in the San Francisco school system has not shown progress, is really deporable. It's deplorable in every school system in the land. I am not suggesting the San Francisco school system is unique. It's deplorable in Montgomery County, Md., where my youngsters go to school.

All I am saying is that unless there is some basis from which you can make judgments as to whether the program is having results it's very difficult to come to the conclusion that you, as the instigator of

the program, have come to, that it's the best of all possible programs, given the least resources available.

Dr. MORENA. May I add one thing because Gene and I are not in opposition. I think it's important. If I had to make the choice it would be reading and if we had that kind of money we have to remember that complete reading can include almost the complete gamut in terms of drug abuse, family education, whatever it is; but without this skill of being able to read it's extremely difficult for a student to have a satisfying experience in school.

Mr. WALDIE. Is there a correlation between a lack of reading skill and drug abuse? Can you tell me that?

Dr. MORENA. I can't give you that; I just don't know.

Mr. WALDIE. But we ought to know those things.

Dr. MORENA. That is correct. I agree with you, but I cannot answer that.

Mr. WALDIE. If that is a correlation that is discernible, you are dead right.

Chairman PEPPER. Would you add relevant to that, that there is a correlation between lack of reading skill and dropping out of school?

Mr. WALDIE. I am sure there is that correlation. Please don't construe the questions I have asked you as critical of the San Francisco school system, because they are questions that are pertinent, at least pertinent in my mind, that I have asked of all administrators.

I just get such general assumption about the nature of this problem, and generally their descriptions almost are hysteria. They may be right. But nobody except the San Mateo school system has presented some indications as to just trends at least, and I must say the figure in that system that interested me the most was that the drug abuse problem there is greater than alcohol and any of the other exotic drugs, which says something about the parents of our youngsers, myself included.

Mr. HUBER. May I add something in terms of survey?

During this past semester, spring, we tried very diligently to work with an organization in San Francisco, MOSVEDA, which is the educational arm of the Mission Rebel. They have some funds for educational programs in the community as well as assistance to the schools. And we worked very hard trying to set up a survey instrument which they felt could be used first on a pilot basis in a couple of schools and then organize it on a citywide basis for San Francisco.

We ran into a great many problems, one being with some of the educational code provisions which restrict us as to the kind of questions we can ask about attitudes and behavior, and you know in setting up a survey who wants to ask questions about did you smoke because your folks do. Technically we can't ask a kid if his folks smoke, not under the present educational code, without getting prior permission from the parents and showing them a survey and all the rest of the business. So it's not again the matter of dollars alone; there is a lot of redtape that is involved with setting up a districtwide survey, too, if you want to include those kind of questions.

For example, one of the major interests that MOSVEDA happened to have was ethnic orientation, particularly with, as you can surmise from their name, they were Latino-oriented and we had many objections because it would identify one particular group as being drug users when really what we were trying to find out was some of the things

we will find out about your cultural background which may help you to read, reach solutions to the problems that Latinos have.

Mr. WALDIE. Just one final question. In the Oakland school district their policy relative to drug offenses, that is, beyond the educational program, when they are dealing with a dealer or a user that has a medical problem, there was a stated policy that if an ambulance is required the nurse must go through a certain step and notify the parents and all that.

In the San Francisco school system have you had occasion to call ambulances for youngsters that are suffering drug problems?

Mr. HUBER. Yes. I don't know when the last instance was because I don't get reports from the public health department. I guess it would be easy enough to go and look them up.

The last one of any consequence I heard was more than a year ago at Mission High School.

I might add, for example, at Mission this time last year we had a class offered which we wanted to call "career health problems" or "critical health problems" and the counseling staff there decided to call it "drugs," instead, for whatever reason they had I am not sure, except that the major emphasis of that class was drugs, although we included other adolescent concerns, like pregnancy, venereal disease control, and particularly those absorbed with the drug scene, hepatitis, and so on. That was an elective course. There was one section last fall. This spring there were four sections. This fall there are nine sections. Mission High School uses the arena system where kids come in and sign up not only for the subject area but if possible the teacher that they would like to have for that class, and the kids have shown us they want these kinds of classes where we give them an opportunity, they select them, and I suspect that if nothing else it certainly shows us that the kids are interested in learning about drugs from other than personal use.

Mr. WALDIE. Thank you.

Chairman PEPPER. Gentlemen, I would like to talk money a little bit with you all. How many students do you have in the San Francisco school system?

Dr. MORENA. We have approximately 82,000.

Chairman PEPPER. Now, how much is your budget annually?

Dr. MORENA. For drugs?

Chairman PEPPER. No; your school budget.

Dr. MORENA. It was approximately $139 million and if you follow the record of San Francisco last year that is a figure that is rather difficult to be accurate on right now.

Chairman PEPPER. $139 million?

Dr. MORENA. Yes, sir.

Chairman PEPPER. How much are you getting from the Federal Government?

Dr. MORENA. I can't determine that at this time, Mr. Chairman.

Chairman PEPPER. Do you know, Mr. Huber?

Mr. HUBER. Not for the total school budget, I don't know. I do know how much we get for drug education, but not the total for drugs.

Chairman PEPPER. How much do you get for drug education?

Mr. HUBER. From the Federal Government, approximately $137,000, wasn't it; $135,520.

Chairman PEPPER. $135,000?

Mr. HUBER. That is under the Emergency Employment Act.

Chairman PEPPER. Emergency Employment Act?

Mr. HUBER. Yes, sir.

Chairman PEPPER. You mean to get jobs for the ones that are drug-oriented?

Mr. HUBER. Yes, sir.

Chairman PEPPER. What I am trying to get at is this: Let me take the program that we now have. We passed in Congress in the last few years two or three elementary and secondary education bills. Do you recall just how much money you are getting under this legislation to aid you in maintaining your educational programs, generally?

Dr. MORENA. No. As I said, I have been here a very short time and I wasn't aware that we would have to come in with budgetary items.

Chairman PEPPER. You don't recall, Mr. Huber?

Mr. HUBER. I know that we have several extensive Federal programs. I don't know what the dollar amounts are.

Chairman PEPPER. Well, now, one, I believe it was Dr. Foster who testified here yesterday and mentioned some disparaging aspects and I suspected a justified one, on the ground that these programs had to do with categorical grants, that program provided aid to a school that had a certain number of students who came from homes where the income was below a certain minimum level, and that presented problems.

Do you think that it would be better for the Federal funds to be generally available to you to allow you to use them in the best way you can in furtherance of your general educational programs?

Dr. MORENA. Yes, sir; I think each of the areas is different. I am quite sure we have a lot of common concerns with Dr. Foster but there may be a particular emphasis that we would want to take which the guidelines would not provide us.

We do have in terms of categorical aid, as you mentioned. I know we were just funded under ESAP for approximately $710,000. That figure I know, but that is categorical aid and there are a number of limitations, and so in a sense your categorizing the money and you also have to categorize the students; so it's not across the board, and I think restrictions do make it far more difficult.

Chairman PEPPER. I am not on the Education and Labor Committee, as I was for 14 years in the Senate, but I have been very much impressed that the Federal aid programs don't seem to be going over as much as I thought they were; don't seem to be giving as much help to you all; you don't seem to regard it a major item in your budget here, as much as I had hoped maybe you would.

Dr. MORENA. I wouldn't say that. I think it's a major item and I am sure that it's a great assistance. What I am saying is we just haven't gone far enough because we are talking about categorical aid that is limited somewhat to students. I am saying that is not true for problems like this. We can't categorize the students. If we want drug abuse aid we need money for it as we do for reading and anything else, and that must be across the board aid.

Chairman PEPPER. That was the last question in that series I was coming to.

We would like very much to have some kind of an estimate, the best that you can make. If you suppose we had the power to give you the

amount of money from the Federal Government that would aid you to establish the kind of a program that you would like to have in your school system here, which would favorably affect the drug use and abuse problem. have you any kind of an estimate as to how much—in a school system here of 82,000 students—you think you would need in addition to what you have already gotten from present sources to do the kind of job that you would like to have a chance to do?

Mr. HUBER. If I could just make a rough estimate, for example. In San Francisco we have roughly 130 schools, about 100 elementary and 30 secondary schools, some special schools, too, but basically 130. The figure brought to me. for example, was that for each 100 teachers we have to roughly estimate a million dollars in terms of salaries. fringe benefits, and what have you. With $1,030,000 we could provide one teacher in every school full time for counseling or coordinating drug programs. If we wanted to devote his time to just counseling I suspect we perhaps would not need that many at the primary level. But certainly for the intermediate. junior high, and senior high school, we should have at least one teacher full time on every school campus, and we are talking something in excess of a million dollars. That doesn't include training, that is just salaries.

Chairman PEPPER. That is just salaries?

Mr. HUBER. Yes, sir; that does not include training. And, incidentally, there aren't too many I don't think ask for money for things. We would much rather have our students develop their own things.

I wish you could see some of the instructional aids some of our kids have developed in the area of drugs that can be used for other students.

We feel that student involvement is really the important thing but in order to get student involvement we have to get teachers who are trained to involve kids, and when kids have problems which probably are not drug problems at first, there are other personal problems, and because they feel frustrations they turn to drugs and then they have that in addition; so we don't need drug counselors, what is needed is personal problem counselors for adolescents and preadolescents.

Chairman PEPPER. Who also have knowledge about drugs?

Mr. HUBER. Certain pharmacological information so they can lecture about drugs and then they can recognize when students have misinformation, and it's misinformation that gets young people in trouble. lack of information, they are frightened. Most kids are pretty normal people and if they don't know about something they avoid it. If they have misinformation about it I suspect they are much more likely to experiment.

Chairman PEPPER. That is for 130 schools. In Chicago we found that the school authorities told us they were trying to find money to have 200 schoolteachers that would have that general qualification in a school system where they had thousands of schoolteachers. They had 3 or 4 million population. I was just thinking, I believe there are about 52 million elementary and secondary students in the country.

If you were to apply that figure of yours to the Nation, can you make a rough calculation as to how much the total amount would be?

Mr. HUBER. Salaries will vary from school district to school district but roughly the figure that was quoted to me and I repeated was for each 100 teachers we are talking about a million dollars as far as salary

is concerned. Divide 100 into the number of teachers you think and multiply by one and that will tell you how many millions we need.

Dr. MORENA. I think it is fine to have one teacher in each school and we have about 130, but I think I would be a little more concerned with going a step beyond that to say whether in fact we have an individual responsibility for instruction; that is one. No. 2 would be an individual responsibility to handle the drug problem at any degree. So we have a drug counselor. Then No. 3, for the region or for the school department, we should have drug centers if we are going to provide the type of help that needs the removal of that individual from that school. So we can start with instruction for 1 million but then I would have to go far beyond that if we are really going to have a program that goes from one end to the other providing not only the instructional aspect, the counseling aspect, but perhaps the medical aspect, if that is necessary.

Chairman PEPPER. But even the larger catalog which you have just given us doesn't include Mr. Huber's very valuable suggestion a while ago that he would like to innovate the curriculum and——

Dr. MORENA. This is above that.

Chairman PEPPER. That would be in addition?

Dr. MORENA. In-service training providing teachers. That would be above that. This is something we really do not have now in terms of counselors for drugs.

Chairman PEPPER. In other words, you are saying that if we are really going to come to grips with this problem, in the many ways that we would need to do if we are going to do any effective good, its going to take a lot of money; isn't that correct?

Dr. MORENA. Absolutely.

Chairman PEPPER. It's a massive program.

Somebody told me the other day that this committee doesn't need to be concerned with this. This is a man high in the drug hierarchy in Washington. He said that we have already got a drug education program with $65 million a year the Federal Government is making available in a country of 200 million people. He thought that was all right, that was an adequate program.

Mr. HUBER. That is 32.5 cents a head per year.

Chairman PEPPER. There you are. So you can see how much that comes to. We know now what effects we are getting, that is in effect now and you can——

Mr. HUBER. May I quote something from the morning Chronicle, Saturday, September 30, 1972, San Francisco Chronicle. "U.S. Government, it's reported, spends about $? million a day on chemical and biological warfare." Give us 2 days.

Mr. WALDIE. We are spending $5 billion bombing North Vietnam this year; $5 billion since April of this year to bomb North Vietnam.

Chairman PEPPER. About $125 or $150 billion altogether there, and yet we can't teach the children to read or help them get off of drug abuse in the country.

Mr. PHILLIPS. I have two comments, Mr. Chairman. One is, Dr. Morena, I am happy and pleased. You are the first innovative superintendent we have talked to who's come forward with an idea an . a program and the way you presented it was forceful. I hope that you will carry it through.

The other point is: Was anything done before you got there to give the information about the problems to parents and to the citizens of San Francisco and the State legislature?

Dr. MORENA. I am really not aware.

Mr. PHILLIPS. The parents, I think, would support you. They would go for the extra tax money. I think the legislature would. But I don't think educators are bringing the problem geographically to the attention of their Representatives.

Dr. MORENA. Any more than the reading. No matter what the problem is.

Mr. PHILLIP. Everyone knows they have a teacher in the school. I don't think they know there is a drug problem in the school.

Dr. MORENA. I think the drug problem obviously is important—I am agreeing with you—but I think it is a matter of an entire district making a statement, not just an individual. I think our board members are as concerned about the problem as I am and whether it be reading or drug abuse, pregnancy or whatever it is, we as a group, as a district, have to make a statement and a commitment to a problem and that we are going to attend to it in this manner, then I think we will get the reaction you are referring to.

Mr. PHILLIPS. If you had the facts of the San Mateo survey which shows an increase in drugs and shows kids that are using them, if you brought these to the attention of the legislature, if you brought these facts to the attention of parents, you would have support for additional moneys.

Mr. Chinn. has the school board here ever discussed the drug problem in the schools and have they formulated any policies in relation to it?

Mr. CHINN. The answer is, "No, sir."

Mr. PHILLIPS. That is not unusual, Mr. Chinn.

Mr. CHINN. And I am being very frank and candid with you.

As I listen to the testimony today, the discussion going on, as I listen to the exchanges in the testimony being presented today, I do feel that the drug abuse problem has been almost neglected. I feel there is also a tremendous gap between those who hold the purse strings, who dictate national policy, have not stressed drug abuse as a national problem, have not kept time with what is happening in the rest of the Nation. We seem to go on what, if I may quote a saying that I have heard as a youngster, a Chinese saying, "We tend to shed tears only at the sight of a coffin," and this is the impression that has been given me.

I think a drug abuse program, by your presence here, I hope it will be a year round project, where when you give us money, and God knows how necessary money is in doing the effective job. I would like to see as a condition of your giving us money that you coordinate at the same time with the various districts throughout the Nation requiring us to give you periodic reports as to what is happening to the money and how the program is going on in each separate district. Then you would be in a better position to know how wisely those moneys are being spent, whether or not you are hitting toward the right direction and whether any particular locality or sector of the Nation is failing to do its job.

I feel that there is a gap there, there has been in the past, and I hope the result of this hearing would remedy this situation which I think is critical.

Mr. PHILLIPS. Thank you.

Mr. HUBER. I wonder if I might respond to one thing you said at the end about parents concern and tax dollars?

I suspect there is an analogy between young people and their parents in terms of behavior. We get kids in a classroom and we can sit and reason and talk pharmacology and motivation and what have you and this youngster says he is not going to use that stuff. He really means it in the classroom in the afternoon. But when he is in a car that evening with his friends, all of his reason is pushed aside and emotion determines his decision. We approach parents. The PTA's in San Francisco are unbelievable supportive, unbelievably so.

Mr. PHILLIPS. I think that is a good word. We have talked to the PTA. We talk to PTA's wherever we can, and they are supportive. What that means is they will support you but you are not giving them the programs that they want. They want more done and they will support you. The problem is that you haven't said we need a drug counselor in the school, we need the money and we are not getting it and we have a problem.

Mr. HUBER. We talk to parents and they agree, they don't disagree with us, but when November comes around and they walk into that voting booth and it says taxes will go up 10 cents, then all the reason goes out and emotion takes over and they push the "no" button.

Mr. PHILLIPS. Because you haven't educated them, you haven't told them about the problem. Most school districts hide it.

How many letters have you sent out to parents telling them you had a drug problem in the schools?

Mr. HUBER. Every semester we send out information about the family life education program.

Mr. PHILLIPS. That is a standard letter and you wouldn't by reading this see there is a drug problem in the schools.

Mr. HUBER. This is one of the vital areas. In our annual reports in the last 3 years we have put this as our No. 1 priority, drug education.

Chairman PEPPER. I don't know what the tax situation is here, but I know in my State. I live in Miami, we have a legal limitation upon the amount of ad valorem tax that can be imposed upon the real estate in the area, real and personal property in the area, and they nearly always are bumping up against the ceiling.

Now, if they are going to get more money they have to change the constitutional limitations or it's got to come from the State or the Federal Government, which have a wider latitude in the imposition of taxes.

What is your tax structure here. Do you get most of your revenue from ad valorem taxation?

Dr. MORENA. Yes. We haven't reached the tax limit yet so we are not quite in the predicament, for example, that Oakland is. However, the moment that you get close to it, as you well know, we have to become aware, and I think you make a very good point, Mr. Phillips, that we may tell the story on occasion and may be periodically, but I think really to get an effect it's got to be saturation and people have to

be aware over and over again precisely what it is we have to face in the schools, whatever the problem is.

Chairman PEPPER. Well, undoubtedly Mr. Phillips is right in suggesting at the State, the local, and the Federal level a greater awareness must be brought home to the people in authority of the gravity of this problem.

We started this inquiry on our own initiative; nobody asked us to make a study about the drug situation in the schools of this country. We got into it because of our being set up by the House of Representatives to investigate crime in the United States. We found out when we got into the inquiry in different parts of the country that about 50 percent of the violent crime in this country is drug related. So then we got into drugs because of its relationship to crimes.

We found that a whole new area of recruits into the army of drug addicts in this country is the area of the public schools, elementary and secondary schools, and so we were led to go into that. As I told the parents, teachers, ladies who were here yesterday, we, Congress, so far as I am aware, have not had any demand anywhere that Congress appropriate a sizable amount of money to do something really effective about this problem of drugs in the schools. I told these ladies that I hoped the Parent Teachers Associations of the country would make a real demand upon the Federal Government, upon the Congress. We are going to introduce legislation there that will provide large amounts for this purpose—$500 million is the figure that we are tentatively thinking about. We are only an investigative committee, but we have offered that before the Education and Labor Committee of the House. I appeared there last Tuesday in behalf of such a program and most of the members of our committee have concurred in the introduction of that bill. But now we have got to have public support

I don't recall any instance where the school authorities of this country, from the State level or whatever level it might be, have been calling on the Congress, "Why don't you help us with this drug problem."

I don't know of any demand that has come in from the country, from the school authorities, generally. I don't mean that you are neglectful, but I do think that greater appeal to those in authority by those who are concerned at the school level will be helpful in providing assistance to you.

Any further questions?

Mr. WALDIE. None.

Chairman PEPPER. Mr. Clunn, we are delighted to see a chairman of a school board that has your concern about these problems and your evidently forward look about the matter. The community is fortunate to have that sort of attitude at the top of their school system. Dr. Morena, we are glad to hear you today. You are going into a great adventure here and we wish you success. I hope we can be instrumental in providing some help to you.

Dr. MORENA. Thank you.

Chairman PEPPER. Mr. Huber, thank you very much. We hope that you will be able to get an improvement in your school system so that every student will find that one interesting new thing each day. I am sure if we can accomplish that, that we will diminish many of our ills.

(Mr. Huber's prepared statement follows:)

PREPARED STATEMENT OF EUGENE C. HUBER, CHAIRMAN, HEALTH EDUCATION PROGRAMS, SAN FRANCISCO UNIFIED SCHOOL DISTRICT, CALIF.

Recently I attended the hearings on The Delivery of Health Services and one of the physicians who testified made the following points:

1. About 1% of the U.S. population is too ill to get out of bed each morning and go to work. This does not include those who don't have jobs or those who don't want to get up; it refers only to those who are medically ill, and can't work.

2. Basically, then, 99% of the population on any given day may be classified as "not sick."

3. At the present time, it is estimated that 1% of the physicians in the United States devote their practice to preventive medicine.

4. This means that 1% of the medical effort is directed toward the prophylactic needs of 99% of the population while 99% of the national medical effort is devoted to the therapeutic needs of 1% of our population.

I believe these points are analogons to the current dilemma referred to as drug abuse.

We have over the past few years allocated tremendous numbers of dollars to law enforcement, treatment, and rehabilitation. I am not suggesting that these expenditures should be decreased, for they are desperately needed, now! But, if we are to have any hope of decreasing the continued need for such expenditures in the future, we must examine our current priorities and place more effort on keeping the non-drug-abuser from becoming an abuser. Is there anyone who feels that apprehension, confinement, treatment, and reorientation is less expensive than prevention?

Regardless of what figures you choose to accept, the fact remains that in the United States less than 50% of the citizens are abusing drugs and more than 50% are not. Who in this room would care to place a wager that the dollars budgeted for preventive education equal 50% of the total spent on trying to solve the problems of drug abuse?

Obviously the abuse of dangerous substances and the associated problems are not new nor is their recognition. The Food and Drug Act at the turn of the century and the Harrison Act of 1914 certainly indicate that we have been aware of the consequences of the indiscriminate use of opiates for more than 50 years. Yet, there are some who are just realizing that the old laws and the old methods of using scare techniques are no longer effective. There are those who have been pleading for help since the late 50's and early 60's.

The concerned people in San Francisco don't need a report from Columbia to tell us we have a drug problem with our young people. This is a sea port town; we have had our minority ghetto areas for a long time. The San Francisco statistics relating to alcoholics, to per capita consumption, and to the ratio of on sale and off sale outlets of alcoholic beverages to the population have made us aware of drug problems for years.

In 1957, Dr. Frances Todd, my colleague until her recent retirement, prepared this drug information resource manual for teachers in our district—that's 15 years ago. This book, also written by Dr. Todd, is entitled "Teaching Youth About Alcohol" and it's copyright date is 1964. We believe, whether you agree with us or not, that the number one problem is alcohol. But, please, let us not argue about substances, let us agree that our joint concern is for the youth of America. This manual is our bible—it represents the joint efforts of a great many people—students and teachers, parents and community representatives. Mrs. Joan Haskin, who is sitting in the audience, Dr. Todd, and I are primarily responsible for putting it together over the last few years. We are aware of the problem; we have been trying to do something, but with little help, small budgets, and no means of enforcing the use of the materials which have been developed. I do have a question of you. Where have you been for the last 10 years?

We have ideas; we have materials; what we need is some political clout which will make preventive education mandatory. We also need some dollars so that we can train our teachers to put these new materials and methods into operation.

Does this mean that we should throw out the traditional methods of education?—Of course not, for there are many of us who have found that the old ways worked—*for us*. It will probably work for some of the young people today as well. Remember, however, that the traditional methods were being used as drug abuse evolved into the national dilemma we have before us. Let me give an example. We too often hear the so called critic who tells us that all we have to do is inform each youngster what drugs will do to him and he won't use them. "It's against the law and it's dangerous—that should be enough." May I refer you to a question in the Kansas Journal of Medicine (July, 1967):

Question. Is knowledge of the actions and dangers of drugs an obvious and effective deterrent to their misuse?

Answer. No, addiction among physicians and nurses has increased over that of the general population. (A 1967 survey showed a 10 fold increase.)

The San Francisco Chronicle, February 5, 1972, made this statement, "Researchers say just about one out of every 100 doctors gets hooked on narcotics."

Is there a need to recite the cases of policemen, attorneys, business executives, and, yes, even school teachers, who have been arrested for drug law violations? These people were the recipients of traditional anti-drug education. While it worked for you and me, it didn't work for them—and it's not working for many of the young people in today's world.

What then should we do?—If I could answer that question, I'd bottle it. I do know this much, however; it took us more than 50 years to get into this mess and the schools should not be expected to get us out of it by the end of Easter vacation 1973.

What kind of a program should we have?—In my opinion we should not have "a" program, we should have many—one for every kid if necessary. I am sure that the program which may be good for San Francisco may not be good for Topeka. That which failed in Chipley, may succeed in Oakland.

What makes kids take drugs?—I'm not sure why each one experiments for the first time. It may be curiosity; it may be because of peer pressure; it may be for any one of 1000 reasons—including the fact that it was just there. But I am fairly certain why those who abuse drugs continue to do so. *IT FEELS GOOD.* Until we can accept the fact that drugs give people enjoyable experiences, we will be unable to make any headway in getting people to change the behavior they enjoy and of which we disapprove.

What, then, are we trying to do in the San Francisco School District?—We are trying to provide young people—in the primary grades especially—with enjoyable experiences in which they find success and satisfaction. The youngster—whether he be from a ghetto or an unhappy home in an affluent neighborhood—who finds his first truly enjoyable experience with drug experimentation is the student who exists as high risk, drug dependent probability. Another youngster from the same environment—but one who has had some involvement in activities which provide him with feelings of success, accomplishment, and self-satisfaction—is less likely to become dependent on chemicals. I am not saying this youngster will not use drugs. He may smoke, or use alcohol, or may have a different choice, but he probably will not be a drug abuser because he has alternatives from which to choose in order to feel good.

How do we evaluate our preventive program?—This is most difficult to answer, for it's almost like asking a cleric to evaluate his religious endeavors. I guess, if we waited 'til all the members of our respective congregations die, we could then count how many souls go to heaven or hell and which ones are not soiled by drugs.

In terms of our evaluations, we can offer little hard data. We *can* say this: in these schools where we feel the district program is being carried out, the over, symptoms of drug misuse and abuse are less visible than they were two or three years ago. I am certain our Police and Public Health Departments will substantiate this. In the last two days, two of our high schools have been prominently displayed in the news media. Thursday's Examiner discussed one school which, for the first time to the best of my knowledge, offered last semester one class with one teacher and 25 students involved in instruction related to drug abuse prevention.

The other school, covered on TV by channel 4, carries on an extensive program in which every student during his Sophomore Year participates in a thorough investigation of drugs and related problems of the adolescent. This school and its students have produced instructional aids for city-wide classroom use and have been outstanding in their youth-to-youth project. In another school, our 10th, 11th, and 12th grade students have planned and put into operation training classes for adults—parents, teachers, and administrators. But we can speak only for those school-age youngsters who attend our classes. We know there are those who should be in school and are not there because of drug-related problems. We can do nothing for those kids who do not come to the public schools. We have our hands full with trying in school to keep kids from misusing drugs out of school.

While we, as educators, feel confident that we can exert some influence on the near and distant future, the schools are unable to control the society of today which favors irresponsible use by youth and adults of mind-altering and escape-producing substances.

We are not trying to pass the buck, nor adroitly sidestep issues—a charge made against me in the recent past. We accept the responsibility for what we see as our duties.

Priority No. 1. Preventive education for the majority of youth who are still in the mainstream of society.

Priority No. 2. Intervention, counseling, and referral services to those whose experimentation with drugs has been a dissatisfying experience.

Priority No. 3. Assistance with therapy and rehabilitation when requested to do so by agencies, outside of the school, who are qualified to design individual programs for individual students.

Finally, this is not the first time that the San Francisco Unified School District has been investigated and evaluated by a federal level agency. The National Clearinghouse for Drug Abuse Information, in 1970, selected our program guidelines as one of the eight or nine throughout the country at that time to be reproduced and distributed as a model for other cities to use in developing their curriculum materials. We feel we have a better program today.

Gentlemen, thank you for listening to me.

Chairman PEPPER. These have been very valuable hearings that we have had again in this great city of San Francisco by the invitation of our distinguished member, Mr. Waldie. It's always a privilege for me, being from the great State of Florida, to have a chance to come to this great State of California and this magnificent city of San Francisco which I regard as one of the charming and delightful cities of the world. We were here in 1969 on the question of drugs generally, and what we learned here had a perceptible influence upon national policy in the reduction of the number of amphetamines. Since we were here we have had a part in reducing about 82 percent the number of amphetamines that are being manufactured in this country. So that hearing led to fruitful results, and we hope that this one will also.

I want to express public thanks to the presiding judge, the chief judge of the U.S. district court here, for his kindness and consideration in allowing us to use this very excellent ceremonial courtroom, and I want to thank all of the court officials and others who have cooperated with us, including the media and the citizenry in general. This concludes our hearings in San Francisco.

(The following material was received for the record:)

PLATFORM OF THE SAN FRANCISCO CLASSROOM TEACHERS ASSOCIATION

PREAMBLE

The San Francisco Classroom Teachers Association exists to advance the general welfare of the students, the schools and the profession, to strengthen cooperation between the teacher and community, to promote professional attitudes and ethical conduct among its members, to maintain the standards of the teaching profession, and to form a representative body capable of developing group opinion on professional matters and speaking with authority for the teachers.

To fulfill these purposes, the San Francisco Classroom Teachers Association adopts the following policies and goals:

Equal Educational Opportunity for All
Teacher Education and Professional Standards
Curriculum and Instruction
Evaluation of Education
Freedom to Teach
Adequate Facilities, Equipment and Materials
Adequate Financial Support
Organizational Framework
Professional Standards and Ethics
Employment Policies and Standards
Participation of Public Affairs
Integration
Negotiations with the School District

Local School Actions
Closure of Unsafe Schools
Teacher Student Relationships
Drug Education
International Understanding

1. *Equal Educational Opportunity for All.*—Educational opportunity for every individual to develop his full potential for responsible and useful citizenship and for intellectual, moral and spiritual growth.

a. A system of free, effective public education adapted to all with legal safeguards for the education of all individuals involved.

b. Maximum development of summer school programs, with voluntary attendance, to meet individual student needs for acceleration, enrichment, or remedial instruction.

c. Special provisions for the gifted, the physically handicapped, the mentally retarded and the emotionally disturbed pupils.

d. Measures designed to provide compensatory education for culturally deprived pupils.

e. A formal program of counseling and guidance in elementary and secondary schools to provide optimum development of every individual.

f. A comprehensive education for all, including the fine arts and vocational education.

2. *Teacher Education and Professional Standards.*—The services of a competent, professionally prepared teacher for every pupil.

a. Hiring practices which assure that fully certified teachers evidencing a basic competence in English will be placed in each classroom throughout the district and which eliminate the employment of those with sub-standard credentials based on less than the baccalaureate degree.

b. No evaluation policy for certificated personnel be accepted as satisfactory unless other methods than use of standardized test norms are employed to assess pupil progress.

c. No evaluation policy shall be acceptable unless it provides for:

(1) The achievement and maintenance of proper control and achievement and preservation of suitable learning environments shall be a responsibility allocated to central office and site administrative personnel.

(2) Reciprocal evaluation between classroom teachers and other certificated personnel regarding these two elements; and

(3) Consideration and proper weighting of mitigating circumstances and of the restrictions placed upon all certificated employees by factors which are beyond their power to establish or influence.

3. *Curriculum and Instruction.*—Establishment of policies and procedures that would involve teacher association participation in developing curriculum and improving instruction.

a. Provision by the Association of leadership in the initiation and development of curriculum.

b. Course of study adoption with the advice and involvement of the teacher association.

c. Provision for student participation in new curriculum development.

4. *Evaluation of Education.*—Teacher involvement in district evaluation programs, supplemented by state-financed periodic sampling of pupil progress.

a. Local selection of approved tests in both state and district evaluation programs. We oppose use of State imposed standardized test norms in assessing district, school, class, or individual pupil progress.

b. Full utilization by the district in planning educational policy of results of district evaluations, including followup studies of graduates.

5. *Freedom to Teach.*—Opportunity to teach without undue interruptions or improper restraint.

a. Elimination of classroom interruptions which divert the teacher from his basic job.

b. Minimization of assignments for supervision of out-of-class student activities unrelated to the educational activities of the school.

c. Relief from semi-custodial duties, policing duties and routine clerical tasks, including keeping the elementary school registrar.

d. Freedom to deal with controversial issues.

e. Class size to permit a quality education program with maximum class sizes established for each division with no provision for a plus factor.

(1) Elementary Division maximum class sizes of: (a) Kindergarten, 18 pupils per session; (b) Grades 1 and 2, 20 pupils per session; (c) Grade 3, 24 pupils per session; (d) Grades 4, 5 and 6, 30 pupils per session.

(e) Where 50% of the class is one year or more below level in standardized achievement tests, the maxima shall be reduced by 20%.

(f) Maxima for split grades shall be 10% below normal maxima for regular classes.

(g) Where both "(e)" and "(f)" apply, reductions shall be 30%.

(2) Secondary Division maximum class sizes of: (a) Academic subjects, except English, 30; (b) English, 25; (c) Physical Education, 37; (d) Industrial Arts including Mechanical Drawing and Homemaking, 24; (e) Other non-academic subjects, 28.

(f) Class size maxima for any student who scores one year below grade level on standardized achievement tests by subject shall be 20% below maxima class size.

(3) The above limits may be exceeded only upon teacher request for specialized or experimental instruction, which will enhance the educations programs. In such special situations, the following student contact hours formula will apply.

(a) Elementary: (1) 500 student contact hours per week, Kindergarten; (2) 600 student contact hours per week, Grades 1 & 2; (3) 625 student contact hours per week, Grade 3; (4) 750 student contact hours per week. Grades 4, 5 & 6.

(b) Secondary: (1) 750 student contact hours per week for all academic subjects (except English) and for commercial courses in the secondary schools, grades 7–12. (2) 625 student contact hours per week for English in the secondary schools, grades 7–12. (3) 700 student contact hours per week for non-academic subjects (exclusive of physical education) in the secondary schools, grades 7–12. (4) 925 student contact hours per week for physical education classes in the secondary schools, grades 7–12.

(c) In low-achieving classes, the maximum student contact hours shall be reduced by 20%.

(4) Number of students in classes for which special facilities must be provided, i.e., typewriters, office equipment, etc., shall not exceed the available facilities.

(5) Number of students in classes shall not exceed the seating facilities.

6. *Adequate Facilities, Equipment and Materials.*—Learning facilities appropriate in the educational needs of every pupil.

a. Safe, healthful, adequate and attractive schools, classrooms and play areas.

b. An individual desk or work area for every pupil and teacher.

c. Instructional materials, library and text books, laboratory, physical education, audio-visual and other equipment suited to the subject matter and grade level of each student.

d. Teacher involvement in school budgeting, plant planning and in the selection of instructional materials and equipment.

e. Adequate eye safety for every student.

(1) Provision for special item in the Superintendent's budget for safety equipment.

7. *Adequate Financial Support.*—An adequately financed program of public education at the local and state levels.

a. State Constitutional guarantees of:

(1) Support of the public schools as the state's first financial responsibility.

(2) The minimum amount per pupil which the state annually must place in the State School Fund for support of the public schools.

(3) The amount of the basic aid per pupil which the state must allocate each year to all school districts regardless of their assessed valuation per pupil.

(4) The minimum salary per year for a full-time fully-credentialed teacher.

b. Provision by the state of adequate additional funds to school districts to provide full and equal educational opportunity for all with special added provisions to meet urban needs.

c. Provision by the state for the excess costs of special education programs.

d. Financial assistance from the state to help finance school construction.

e. Continued state support of public schools from the General Fund of the state rather than from earmarked taxes.

f. Increased Federal support to help meet costs of school operations and construction, with allocation of such funds within the state to be determined by state and local districts and with attention to those districts providing special services to newly arriving immigrants.

g. Uniform assessment of all property subject to ad valorem taxes without regard to the agency fixing the valuation or the geographic location of the property.

h. Authority for determining amount of local taxes to be levied to finance current operations of school districts to be in hands of governing boards without statutory limitation.

i. Use of financial resources of the schools exclusively for school purposes.

j. Provision by the state of the necessary additional support to finance any additional functions assigned to the public schools.

k. Reimbursement by the state for loss of school taxes caused by removal of additional property from tax rolls by exemptions not heretofore authorized.

l. Assessment of wealth represented by possessory interests in personal property for school purposes.

m. Separation of school fiscal matters from city government.

8. *Organizational Framework.*—Effective organization control and administration of public education at all levels.

a. A qualified and adequately staffed State Department of Education with a broad program of leadership and service to local districts.

b. Elected non-partisan lay governing boards at the local level with responsibility for appointment of professionally qualified superintendent or executive officer.

c. A professionally prepared and competent administrative staff in every school.

d. Active and meaningful involvement of the community along with teachers in school and district operation to improve the education of youth. This involvement should commence in the early planning stages and avoid any semblance of superficiality which can generate community resentment.

e. Teacher development of clear guidelines and understandings of responsibilities outlining areas of decision-making and policy development established at all levels prior to community involvement.

9. *Professional Standards and Ethics.*—Promotion of professional standards, responsibility and ethical conduct by encouraging all members of the Association to adhere to the provisions of the Code of Ethics of the Education Profession.

10. *Employment Policies and Standards.*—Establishment of procedures affecting employment and guarantees of professional welfare of teachers.

a. Development and implementation of appropriate procedures within state law through which teacher organizations may work effectively with the school board and administrtion on questions of salaries, working conditions and school policies.

b. Development of sound written personnel policies specifying procedures for employment, promotion, in-service training, grievance processing and dismissal; for placement and advancement on the salary schedule; for assignment and transfer of teachers; and for other aspects of personnel practice.

c. Professional selection, promotion and payment of teachers and administrators solely on the basis of personal fitness and professional training and appropriate experience, without regard to race, color, religious creed, or national origin, or lawful political affiliation. An important factor in selection will be sensitivity to needs of all students.

d. A salary schedule designed to meet the needs of teachers and containing yearly and career increments, recognition of successful teaching and training and professional growth factors providing for doubling of beginning salary in not more than ten years and tripling at top of schedule. All teachers should be properly placed on the schedule on the basis of such factors. Professional service rendered on a part-time basis, such as in an evening program, class coverage, or for a special period of time such as summer school, should be compensated in direct proportion to placement on the salary schedule. Subjective ratings should not be used as a basis for determining salaries.

e. Sound evaluation procedures developed in cooperation with teacher organizations and which afford teachers periodic critique of performance and the opportunity for improvement and upgrading and which provide administrators the opportunity for evaluation of their performance by teachers.

f. Tenure laws and policies which both protect competent teachers against improper dismissal and provide for orderly dismissal of incompetent, unprofessional or other teachers who should be removed from service for specified causes. Tenure protection should cover employment but not position.

g. Provision of protection of teachers against common emergencies through sick, bereavement and other forms of leave.

h. A retirement system for teachers, without regard to sex, with provisions for service or disability retirement, without minimum or maximum compulsory retirement age. Provisions without cost of members of death and survivorship benefits. Cost of retirement allowances to be borne jointly by members, and employer, and with guaranteed benefits. System to remain an independent agency under an independent board and administered by an executive officer.

i. Reasonable, carefully defined work schedule for all teachers allowing a forty five minute minimum for a duty-free lunch period and a forty five minute minimum period during the school day for preparation, evaluation, conferences and other essential out-of-class duties.

j. Encouragement, through increased professional and sabbatical leaves, scholarships and salary increments, for teachers to maintain and improve professional competence.

k. Provision of opportunities which allow members of the profession to attend professional meetings with paid substitutes.

l. Seniority rights shall be fully protected.

11. *Participation of Public Affairs.*—Understanding and support of teachers' rights and responsibilities to participate fully in public affairs.

a. Informed active participation by teachers in the consideration of all legislation and especially that directly affecting public education.

b. Recognition of teachers' political rights and responsibilities, including the right to seek and hold public office.

c. Recognition of the right of teachers to join organizations of their own choosing.

12. *Integration.*—Basic to the position of the SFCTA, as reflected in the statements cited below, is the recognition of school integration as something more than the desegregation of racial and ethnic groups within the student population. True integration in education requires, among other things:

a. adequately planned and financed in-service training programs to prepare students and teachers, counselors and administrators, for integration prior to its implementation and to assist in the adjustment process once desegregation has begun.

b. An affirmative action personnel policy that wherever possible will bring about minority group representation throughout the district, in each school, and at all levels, substantially reflecting the racial and ethnic make-up of the local student body and the district pupil population.

c. Active community and teacher organization involvement at all levels and at all stages of the plans for continuing integration and in the formulation of educational policies and development of educational programs.

d. The inclusion of such quality education components as English as a second language (ESL)/bilingual instruction for all pupils in need of such classes and special educational programs for the gifted and deprived.

e. The inclusion of a full-time counseling program comprised of certificated and competent counselors balanced wherever possible in ethinic and racial characteristics with a counseling load limit to 250 counselees with adequate clerical help, facilities, equipment and supplies.

f. Avoidance of all plans, such as the so-called "Voucher Plan" under which education would be financed by grants to parents which could lead to racial, economic and social isolation of children and weaken or destroy the public system.

g. Recognizing that true school integration is more than a mixing of bodies but is not possible without first desegregating pupils, the Association supports only that transporting of pupils which is accompanied by measures designed to insure that quality education and true integration result.

13. *Negotiation with the School District*

a. The Representative Council is the source of authority for proposals made by chapter negotiators who may be advised by the Executive Board and may utilize chapter committees and other consultant help. Negotiators drawn from a chapter negotiating committee which shall be responsible to the Representative Council for negotiated agreements.

b. Prior to signed negotiated agreements going to the School Board for action, they shall be presented to the Representative Council for ratification.

c. When all reasonable attempts at resolving an impasse in negotiations have failed, the Association believes mediation, fact finding and arbitration are acceptable means for resolving differences. In addition, the Association does not discount the value that political action, concerted action or sanctions against

the district can play in resolving persistent disagreements. Though the Association believes that every effort should be made to avoid concerted action as a procedure for the resolution of impasse and that the above procedures should make concerted action u necessary, under conditions of severe stress causing deterioration of the educational program and when good faith attempts at resolution have been rejected by the District Governing Board, concerted action may become necessary.

14. *Local School Actions.*—The Association will support actions taken by a faculty majority at a building site not inconsistent with the program and policies of the Association. The Representative Council and/or Executive Board will approve requests of an individual school or schools before the Association takes a stand favoring such requests.

15. *Closure of Unsafe Schools.*—A school should be closed if an educational situation does not exist or if in the opinion of the faculty it is unsafe to keep a school open.

A school should be closed if 30% of the staff is missing, if serious disruption takes place, or if no educational program is possible. In applying these criteria, the safety of the children is to be given prime consideration.

16. *Teacher Student Relationships.*—Every student is entitled to learn. free from conduct by others which disrupt the teaching learning process.

a. Teacher and students are entitled to the rights due them as citizens of the United States, including those of reasonable due process. However, in carrying out due process in discipline matters, teachers are entitled to a non-adversary relationship with their students.

b. District discipline procedures must be just and clear and should involve teachers, students and parents in review and development.

c. Teachers must be provided with adequate means of parental contact.

d. When, in the judgment of the teacher, conduct by student(s) threatens the learning process, the teacher must have the authority to suspend the source of the disruption from the classroom and/or the school and should meet or confer with the student's parents or guardians at the student's return following suspension. The student shall not be returned to the classroom from which he was suspended without the concurrence of the teacher and the principal.

e. A learning Diagnostic Center should be maintained for the benefit of students having school difficulties. Discipline transfers to other regular schools without first referral to the Diagnostic Service Center should be prohibited.

f. Guidance services should provide a special school to receive discipline transfers with a flexible program voluntarily staffed by screened applicants.

g. Students should have a method of pursuing grievances and appealing suspensions and transfers.

17. *Drug Education.*—Maintenance of a continuing in-depth drug education program from elementary grades through high school based upon establishing dialogue between the student and the adult which provides information from sources the young people can trust is essential. It must be accompanied by and in and out of school remedial program backed by trained counselors capable of working with drug using students, their parents and teachers.

18. *International Understanding.*—Obligation of members of teaching profession to work for international understanding and to exercise right of freedom to teach about work of the United Nation and its agencies such as UNESCO and UNICEF.

(Whereupon at 11:40 a.m., the hearing adjourned, to reconvene Friday, October 6, 1972, entitled "Drugs in Our Schools, Kansas City, Kans.")