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ABSTRACT

This document contains seven papers from the ninth World Conference of Therapeutic Communities that provide an international perspective on the therapeutic community (TC) movement as it is today. Papers include: (1) "What's Happening on an International Level" (William B. O'Brien); (2) "Therapeutic Communities of America" (David Mactas); (3) "Historical Influences and Evolution of Current Therapeutics in Europe" (Erik Broekaert and Catherine Rooryck); (4) "The TC in Latin America" (Juan Alberto Yaria); (5) "News from the Asian-Pacific Region" (Roy Johnston); (6) "The Future of the TC" (Mitchell Rosenthal); and (7) "Substance Abuse Awareness in California" (Chauncey Veatch, III). (NB)

CHAPTER 2

INTERNATIONAL PERSPECTIVES

WHAT'S HAPPENING ON AN INTERNATIONAL LEVEL

Msgr. William B. O'Brien

President
World Federation of Therapeutic Communities

Let me first say it is good to be here in San Francisco at the Ninth World Conference of Therapeutic Communities.

As I stand before you this morning and look out on this most impressive and esteemed audience, I can't help thinking about the man who was killed in a recent flash flood. He made his way to heaven, and at the Pearly Gates he was asked to give his case history, to tell the story of how he died and came to heaven. This he obligingly did. St. Peter thought the story so interesting that he asked the new arrival if he would agree to give a seminar for the other angels in heaven, telling them all about the flood and his demise.

The newly arrived resident of heaven was very much flattered and he immediately accepted the invitation to tell all about the flood. As he flew away to prepare for his talk on this devastating flood, a kind young angel tugged at the sleeve of his robe and said, "Sir, I think there's something I ought to tell you. When you give the seminar on the flood, Noah will be in the audience."

My point is that I'm somewhat disconcerted at being up here talking before such an imposing group of experts in the field as yourselves--all of you Noahs, so to speak! But that is what makes a World Conference of Therapeutic Communities so stimulating: the fact that it attracts the leaders in the field from around the world and provides a forum where ideas, knowledge, and the latest research can be shared and discussed as we steadfastly endeavor to refine our skills.

I would like to take time now to express my sincere gratitude and appreciation to Alfonso Acampora, Executive Director of our host program, Walden House, who has done a truly outstanding job of organizing this conference. It has been well documented that in the history of San Francisco there have been two major turning points: one was the Great Earthquake of 1906 and the other was the arrival of Alfonso Acampora from New York. To this day there is still heated discussion as to which event holds greater significance. But there is no doubt in our minds. We know it was Alfonso's arrival, and San Francisco has never been quite the same since.

For many years following the Great Earthquake the people of the Bay Area would date their lives from "before the earthquake" or "after the earthquake." Well, I am certain that this Ninth World Conference, under the leadership of Alfonso, will also have tremendous impact, but a very positive one. Its tremors will be felt around the world as, years from now, in looking back on the therapeutic community movement, we will date it from "before the Ninth World Conference" or "after the Ninth World conference."

Seeing so many friends and respected colleagues who have traveled great distances to be here gives one a feeling of great joy and satisfaction. As members of the therapeutic community movement, we are in many ways an extended family. In this spirit, and on behalf of the World Federation of Therapeutic Communities, I would like to welcome you to our ninth annual family reunion. As with most family reunions, God knows, we have our share of differences. But this is healthy, as we share ideas and feelings in the open and honest atmosphere unique to the therapeutic community. Our family ties are strong and responsive to the needs of our members, and this portends well for the future of the movement.

As we gather here in San Francisco at the foot of the Golden Gate Bridge, on the eve of its 50th anniversary, it is fitting that the theme of this Ninth World Conference is Bridging Services. When the Golden Gate bridge was completed in 1937, no body of water as wide or as deep as that strait had ever before been bridged. To be contended with were the physical problems of stretching a span across a deep four-mile wide body of water with treacherous currents in a region subject to high winds and possible earthquakes. After nearly five decades this bridge remains one of the world's greatest engineering achievements.

No less remarkable than the bridge itself were the men who designed it. Single mindedly they struggled against vested interests, interference from government departments, insufficient funds, shoddy workmanship, corruption, ignorance, and more than anything, the enormous technical problems of the crossing itself, risking their health and wearing themselves out. It sounds an awful lot like the struggles of today's therapeutic community directors, doesn't it?

Similar to the engineers and builders of the Golden Gate Bridge, we in the therapeutic community movement today are faced with the challenge of constructing a bridge between services and effectively spanning the treacherous currents and rising tides of substance abuse and despair which threaten to engulf our young--our most precious resource. Indeed, whether it's the streets of San Francisco, California or the back roads of Sao Paolo, Brazil, in cities and countries around the world, in tragic and unrelenting fashion, we are losing our children to substance abuse.

We continually read reports of increased substance abuse, rising teenage suicides, pervasive despair and alienation. The only decline reported in substance abuse in recent years has been in the age of the victims. In ever more increasing numbers youngsters are entering our treatment programs as young as 9 and 10 years of age. It is clear the substance abuse has become an insidious threat to our young around the world. In Italy, Ireland, Brazil, Argentina, Sweden, the Asian Pacific Region and countries around the glove, the recurring theme focuses on the plight of our young caught in the vortex of substance abuse swirling through our societies. In the United States, the Surgeon General recently reported that since 1905 American life expectancy has improved for every age category except one: 15 to 24 year olds. The death rate among this group has actually increased over the last twenty years, primarily due to substance abuse. The extent to which our youth are abusing substances is staggering. The highest drug use rate is among 18 to 25 year olds, and 12 to 17 year olds have the second highest rate. Reports have cited children as young as 9 and 10 saving their lunch money to buy a wide variety of drugs that are as accessible on street corners as ice cream and candy. This is not unique to the United States, however. It is seen throughout the world.

The present scourge of drug abuse is now compounded by the brutal fact that the incidence of AIDS (Acquired Immune Deficiency Syndrome) among intravenous drug abusers has been growing geometrically in recent months. Indeed, this group will soon surpass homosexuals as being most at risk to contract this deadly disease. In New York, for example, AIDS is now the second leading cause of death for women between the age of 30 and 34. These female AIDS victims are all either drug abusers or have had sexual contact with drug users.

It is clear that substance abuse is eating away at the very essence of our societies--the family. It is not merely a chemical problem, but a deeply human crisis. The therapeutic community is in the unique position to examine the mental and emotional forces that are shaping young lives around the world and plan appropriate intervention. Our children are yearning for a sense of direction and the therapeutic community is singularly qualified to provide it.

There is no doubt that the therapeutic community is one of the most potent treatment modalities in helping individuals achieve change. The elimination of the symptom, be it substance abuse or other disorders, is only part of the treatment and help. We achieve change as a result of meeting the needs of individuals by providing the necessary services. The greatest need is a sense of community, a sense of belonging, and this is what the therapeutic community provides as it effectively deals with the pains of modern man-loneliness and alienation. The key, then, is that the therapeutic community deals with root causes rather than merely treating symptoms.

As President of the World Federation of Therapeutic Communities, I have traveled extensively around the world visiting program, and I am pleased to report that I was reassured by what I saw. One cannot help but be deeply impressed by the basic strength of our movement. That strength is reflected in the individual programs, in their dynamic development and, above all, in their dedicated staff.

In people like Lars Bremberg and the outstanding job he and his lovely bride, Helena, are doing in leading the TC movement in Scandinavia. In Sweden alone, Vallmotorp and Daytop, the two sister foundations, have a total of 300 beds located in seven different houses and are still expanding. A short-term treatment program will be opening in October, and Lars is now overseeing the training and development of TC staff in Thailand.

In the Pacific, Roy Johnston has been tirelessly and generously working on behalf of the TC movement as President of the recently established Asian/Pacific Federation of Therapeutic Communities.

In Ireland, we have seen the growth and expansion of Coolemine under the leadership of Jim Comberton and Tom McGarry. Our congratulations also go to Jim on his recent election to the Presidency of the European Federation of Therapeutic Communities.

In England, Phoenix House, under the creative leadership of David Tomlinson, now has centers across Great Britain offering 150 treatment beds with age range of 18 to 25 years. They were recently honored by a visit from Prince Charles.

In Italy, the programs of Il Centro Di Solidarieta continue to thrive and flourish under the dedicated leadership of Don Mario Picchi and Juan Corelli. In October there will be the formal dedication of their new center in Rome. In northern Italy we have witnessed the miracle of Avanzini! Msgr. Avanzini has done a truly remarkable job in developing and directing a thriving, vital TC in Verona. He recently acquired an abandoned airport, and on this site he will soon be opening what has been described as a modern day "boys town." The World Federation can now boast its very own "Father Flanagan!" Fortunate indeed are the young boys and girls of Verona.

In South America, through the dedicated work of Juan Alberto Yaria and Miguel Angel Bianucci of Argentina, the Latin American Federation of Therapeutic Communities was recently created, and this bodes well for the movement.

Under the expert guidance of Peter Vamos, Portage has experienced tremendous growth and is Canada's largest drug-free treatment program.

Here in the United States, the Therapeutic Communities of America has thrived and reached new heights of achievement under the leadership of its President, David Mactas. Its member programs throughout this country are setting a new standard of excellence which makes us all very proud.

I apologize that, due to obvious time constraints, I have been able to name but a few of the many individuals and programs generously giving of themselves and contributing so much to the therapeutic community movement. I wish I had more time to name all of you, but you know who you are. And so, to all of you, for recognizing the problems as well as the potential with which we are faced, I salute you.

At this time I would also like to make a special salute to our dear friend and respected colleague, Harry Sholl, who recently passed away after a long illness. As Co-founder and President of Gateway House Foundation in Chicago, Harry guided that program to international prominence. He was responsible for the establishment of Therapeutic Communities of America and served as the founding President. Harry was also Co-founder and Treasurer of the World Federation of Therapeutic Communities. Harry, like no other man, attracted and engaged the love, affection, and respect of all of us. He awakened in each of us a sense of dedication, love and excellence that we will always treasure. Full of wisdom, wit and a great sense of humor, Harry was a generous and loving man, a true humanist who will remain a shining example for all of us.

The therapeutic community movement is now on the threshold of a new era. We have the global membership essential for a global approach to substance abuse and related disorders. We must not fail to play our roles effectively. As the theme of this Ninth World Conference indicates, the role of the therapeutic community should be bridging services. Let us make the therapeutic community the bridge that connects the community, the authorities, the professionals, the law, the families and the addict himself. As a bridge, the therapeutic community can bring people closer together and facilitate movement and development by shortening distances and crossing barriers to communication. As with a bridge, the therapeutic community can represent the perfect blending of science and art as it spans the troubled waters of despair, isolation and alienation and leads the way
to the much sought after love, support, fraternal concern and, indeed, family where one can grow and flourish. As the bridge leads to the discovery of new lands, the TC, as stated by Pope John Paul II at last year's conference, can "lead to the discovery of human dignity."

Today governments around the world continue to be content with the question, "What?" in terms of the youth equation, "What drugs? What crime?" and answer with simplistic but politically attractive responses to this complex issue. The therapeutic community or "healing family" speaks to the all-important question, "Why? Why do you take drugs? Why do you act irresponsibly?" It thereby moves the central focus from symptom to root cause, from the drug to the person opting for the drug, and from the crime to the person electing to violate society's code.

It is to this causal "why?" of substance abuse that we as treatment leaders should address ourselves this week in a concerted effort to initiate programs of meaningful action for all concerned. I look forward in the days ahead to discussing this question with you as we share our views and mutual concerns. Let us use this

Ninth World Conference as the opportunity to build the bridges that will conquer the void of despair and loneliness, and bring order out of chaos. Let it be the bridge that will facilitate communication where we all can learn and grow and come away with new ideas.

As the "healing family," the therapeutic community has the healing power to foster the transformation of our lost, alienated youth into responsible, caring, productive individuals impelled to help others find the same happiness. It is in the therapeutic community that a true revolution of the spirit takes place, and we must never lose this. Rather than being discouraged by substance abuse and related disorders of our young, we have the opportunity to accept the challenge it presents. as our host program for this conference is Walden House, it seems only fitting to recall the words of Henry David Thoreau in Walden, "If one advances confidently in the direction of his ideas, and endeavors to live the life which he has imagines, he will meet with a success unexpected in common hours." With this in mind, together this week, let us advance in the direction of our dreams in our quest for a relevant, dynamic and vital TC.

Let our time together be the time of improvement. Let us promote the concept of the therapeutic community and develop the resources of our programs throughout the world. Let us work together in the spirit of union, harmony and, indeed, love as we become the builders of bridges between man and his potential and span new heights and breadths in the historic and ongoing journey of the TC movement.

THERAPEUTIC COMMUNITIES OF AMERICA

David J. Mactas

President
Therapeutic Communities of America

The Ninth World Conference of Therapeutic Communities will be a memorable event. It is another chapter in the evolution of the therapeutic community. The tradition has been set.

That the TC movement continues to gain impetus is owed not only to the effectiveness of the model. Tenure, as well, is a most significant variable. As programs approach the 20 year milestone, so, too, do legions of treatment professionals. The opportunity to work in so dynamic an environment, and collaborate with residents toward maximization of human potential, fuels staff enthusiasm while affirming the TC as an exciting and uplifting career choice.

At the time of the First World Conference in Sweden, many of us in the U.S. were bound by a common agenda--survival. Today, given a foundation built on success, our agendas are testimony to diversity and sophistication. However, as we continue to carve our niche in the human service arena, we are often called upon to summon the strength derived from struggles past. While we enjoy more pervasive acceptance, "complacency" is a word not found in our glossary. We are innovative and resourceful, yet adaptive and accountable.

In light of the diversity of TCA member agencies, it is indeed difficult to assess the "state of the art." So many of us have applied our expertise to new areas and have dramatically expanded our repertoire. Perhaps therein lies a common thread--the incorporation of new constituencies into our continuum of services.

Among those "new" groups served are impaired physicians, those convicted of driving while intoxicated, and substance abusers in the work setting. The development of such programs is testimony to a growing acknowledgment that our agencies have been underutilized resources. Growth and development in such pursuits serve to strengthen our status in the human service arena. Moreover, with such sophistication comes greater understanding and acceptance for our primary focus--the therapeutic community.

We have learned that sound business management principles and humane administration are not mutually exclusive. Rather, they are complementary. A not-for-profit designation does not suggest that expenses must exceed revenues. A growing fund balance helps to insure organizational stability, not necessarily the trappings of the profit motive.

Enhancement of the TC lexicon reflects development. Investment strategies, property management and computer technology are among those areas with which we have become increasingly concerned. Such concepts and language augment, rather than replace, that which is traditional and functional in the TC. Greater confidence in the efficacy of the TC model has created a less insular contingent of professionals which recognized alternative resources. It should be noted that this trend can be seen in our respective staffing patterns and roster of consultants. Such development, it is suggested, poses no threat to the character, integrity, spirit or effectiveness of the TC. It is built on the bedrock of a humane and exciting model responsible for the reclamation of countless lives.

The TCA credentialing and accreditation process has certified almost 200 direct care staff as of this writing. Nationally acclaimed for its comprehensiveness, this initiative acknowledges professionalism and competence while reinforcing a sense of community among colleagues throughout North America.

This Ninth World Conference affords a global perspective. It is an opportunity to embrace old friends, make new friends, and to celebrate the memories of those who have passed in body, but whose spirits fuel our continued commitment.

Harry Sholl, TCA's founding president, is no longer with us. However, all of us who were privileged to know him will be forever buoyed by the inspiration he instilled. The entire TC community, world wide, has been touched by his deeds and goodness. We all mourn his loss.

That San Francisco is the present venue for our conference is of particular interest. Devastated by the earthquake and fire of 1906, it is a city which, consistent with the self-help concept recognized its capacity to heal its own wounds and rose again to regain its splendor, its uniqueness and its character. It is, to be sure, an environment conducive to personal growth and enlightenment.

On behalf of Therapeutic Communities of America, I am honored to welcome our good friends and colleagues. As in years past, I am confident that our week together will be fun, informative, and, ultimately, will serve to re-affirm our sense of mission.

TCA NEWS
Spring, 1986 THERAPEUTIC COMMUNITIES of AMERICA Vol. 7, No. 2

TCA PRESIDENT TESTIFIES IN WASHINGTON

TCA President David Mactas, accompanied by Richard Pruss, chairman of TCA's Federal Oversight Task Force, attended a hearing before the U.S. House of Representatives Subcommittee on Crime of the Committee of the Judiciary on H.R. 526 and H.R. 2954, relating to Narcotics Assistance and Controlled Substances Penalties, held in Washington, D.C., on March 13.

In testimony presented to the Subcommittee, Mactas reminded the members that substance abuse problems persist and that in 1984, according to Attorney General Edwin Meese, "... there was an increase in the illicit use of all dangerous drugs," while appropriations for treatment continue to shrink.

Stressing the economy and efficacy of the therapeutic community, the difficulties arising from increased cost of treatment, the need for additional programs for adolescents and the elderly, and the high incidence of AIDS among intravenous drug abusers, Mactas' testimony in support of H.R. 526 praised the Rangel bill as an "important piece of legislation... (that) represents great scholarship, insight and sensitivity."

"There has long been a sense of competition between those who enforce and those who treat—as if we're fighting different enemies," Mactas said. "H.R. 526 ... at last proposes a collaboration ... (and) would authorize federal funds for 1986-1990 to assist the states, based upon the extent of the drug problem."

HOST AGENCY: ABRAXAS

The Abraxas Foundation is pleased to welcome the TCA membership to America's Number One City. According to Rand-McNally's *Places Rated Almanac*, Pittsburgh tops the list of the nation's "most livable" cities. We are proud that Abraxas, as one of many fine human service agencies in this area, has played a part in enhancing the quality of life for over two million residents of the Pittsburgh region.

Abraxas is a private, nonprofit corporation, with a history that goes back to 1973 when juvenile and adult courts in Pennsylvania were struggling with the dilemma of rapidly increasing numbers of young drug and alcohol offenders.

A remote woodland site, a former Civilian Conservation Corps camp in the 1930s and Job Corps Center in the 1960s, was identified as a place where a treatment center could be developed to serve as an alternative to incarceration. A proposal was submitted and accepted and a program was launched as a pilot project of the Governor's Council on Drug and Alcohol Abuse (now the Office of Drug and Alcohol Programs of the Pennsylvania Department of Health). It was the only such project in the state; and Abraxas continues to be the only private agency to receive direct state support, a very small part now of our overall budget.

Supported primarily by fee-for-service contracts with the courts and child welfare agencies, and with the additional support of private sector donors who help to subsidize our costs and enable us to keep our fees

New Abraxas Dorm

low and therefore attractive to financially hard-pressed county agencies, Abraxas has grown and expanded over the years and currently offers a wide range of substance abuse treatment and rehabilitation services.

HISTORICAL INFLUENCES AND EVOLUTION OF CURRENT THERAPEUTICS IN EUROPE

Dr. Erik Broekaert and Catherine Rooryck, M.A.

European Federation of Therapeutic Communities
Gent, Belgium

To understand the essence of the present day European therapeutic communities, one has to start from a historical perspective on the treatment of people with problems. History shows how an evolution took place in psychiatric institutions from religious inspired care to a medical-scientific approach. Later on, the human reactions against psychiatry led to the development of the TC.

During previous conferences, lecturers frequently referred to relations between TCs and the early Christian concept. Mowrer (1) discussed how the intrinsic value of the Christian faith was transferred during group meetings where the members publicly confessed to release themselves from guilt. This process was called exomologesis. This Christian-Jewish tradition and its influence by Hellenism was brought to Europe by Arabs via Byzantium and Spain. Studious monks investigated the old texts in the scriptoria of their monasteries. Through their exegesis, they prepared the way for the flourishing of the Catholic Church. This exegesis tried to better understand God, and the deeper, worthy nature of things. Exaggerated politicizing of the religious life in the 17th century led to a rising protestantism that wanted to draw on early Christian experience. This caused violent reactions. Although Catholic orders, such as the one of Vincentius a Paulo, tried to ameliorate the fate of people, protestant reactions arose in the bosom of the church. It is known how Quakers and the Swiss reformed church (Zwingli), were of great impact on the development of the TC (2). The Swiss reformed church served as a source of inspiration for the Buchmann and Oxford groups (3), which prepared the movement of Alcoholics Anonymous, and later Synanon (4). The Quakers prepared for the medical evolution in psychiatry. It is no secret that the "moral treatment" started with Dr. Tuke (5), who was inspired by the Great founders of his movement: William Penn and Margaret Fall (6). In Cunningham, England, they started the humane treatment of prisoners, adults and children incarcerated in the deepest jails.

Through Dr. Tuke, this "moral treatment" influenced the great French psychiatrist Pinel (7) who, in La Salpetriere in Paris, unchained the psychiatric patients. He served as an example to the famous psychiatrist of Ghent, Dr. Guislain (8), whose institution became a model of humane psychiatric care in Europe. These Quakers left England for Philadelphia. There is a connection between "the guidance" they experienced during their prayers and the present known therapeutic methods.

France became the center of the scientific world, and 19th century science expanded. It is remarkable how this scientific interference led to the finding of a close attachment between the care for adult and young handicapped people and the problems of the psychiatric patient. After the revolutionary work in La Salpetrier, Pinel had an astonishing influence on Dr. Itard (9), who was looking for an appropriate education for "the Wild Boy of Aveyron," found naked in the woods. Science tried to resolve the problem whether he was mentally disturbed, deaf, or socially neglected, since he couldn't speak, read or write, walked on hands and feet and uttered bestial sounds. In this scientific approach, Itaard associated with Abbe de L'Epee (10), who developed the sign language for deaf mutes. "The Wild Boy of Aveyron" was treated with the method for the deaf, and a close connection between problems of children with handicaps and the totality of the social life was proven. Itard's disciple Seguin (11) took a revolutionary position. He considered idiocy as a developmental disturbance and thus treatable. The mentally handicapped were considered as having a typical way of being. They could be developed through work, dedication and understanding.

This way of thinking led to an optimistic scientific view on the possibilities of treatment. This scientific evolution in Europe was further inspired by Freud (12), who was a neurologist and a disciple of Charcot (13). Freud was well informed on French psychiatry. Starting from a materialistic-scientific point of view, he discovered the importance of the intra-psychic component. He was strongly influenced by hypnosis and mesmerism. Like the Essenes and Christ, Freud was also of Jewish origin. Freud's disciple Jung (14) broadened the revolutionary heads of Freud with the universal-symbolic component. He denied dualism and looked for the unity within contradiction as the essence of treatment. Because of World War II, European psychiatrists and educators, well aware of the psychoanalytical theories, fled to the United States. There they laid the foundation of the existential-humanistic psychology. Out of their reaction against the medicated psychiatric hospital, the TC movement grew.

All this led to some remarkable present day tendencies within the European TC:

* Analytical psychotherapy lacks structuralizing influences. For this reason affiliation to a more social-educational way of handling predominates. Living together becomes the starting point of moral consciousness. Conflicts which rise in daily life situations form the basis of therapeutic encounter.

* Social life has to contend with serious economic problems. These go hand in hand with the multi-nationalizing of concerns. All this leads to a conservative-liberal policy and a tendency for "survival of the fittest." In the social sector innovative solutions are designed to combine creativity and cost effectiveness.

* The uncertainty involving the struggle for life leads to a tendency of sectarianism and radicalizing of minority groups. The lack of personal security is replaced by the certainty of the guru, in whose warm hands one can experience the security of love, or by politically engaged action groups.

* Because of the socio-economic decline, the inhabitants of the TC become materially more neglected and aggressive. Consequently, the treatment becomes more disciplined and profound. This gives a chance to realize the revolutionary TC ideology through school and education.

Summarizing, we can say that therapies in Europe are becoming replaced by educational action which stresses human individuality. The client or resident is considered as part of a dynamic family. This move towards restoring values also finds its reflection in the social structure. They become more conservative and postulate the struggle for life. Certainty is looked for in small minority groups of sectarian or political nature. All this is reflected with scientific research which switches from an objective to an engaged subjective approach. Maybe the solution lies in the humanistic expedition of Tijl Uilenspiegel who continually amazes the world by his fight for freedom and creative solution (16).

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THE THERAPEUTIC COMMUNITY IN LATIN AMERICA

Dr. Juan Alberto Yaria

Gradiva Therapeutic Community
Buenos Aires, Argentina

Gradiva Therapeutic Community was born in Buenos Aires, Argentina in 1972 as a new and different approach to solve psychiatric and psychological problems. Institutional psychiatry in our country has usually been very strong, so our project was not very warmly welcomed as there was some distrust and skepticism. Besides, our name had to be changed under the 1976-1983 political regime. During that period our facility was not a therapeutic community but a psychiatric clinic, otherwise the government would have closed the premises. Anyway, community therapy was practiced inside. There is no doubt these res trictions reduced our possibilities of development, though thanks to the 1984 Rome Congress a more dynamic drive was introduced.

This is a pathognomonic fact of what happened to the therapeutic community in Argentina and still is happening in many parts of South America. A proper analysis of our development should include historical circumstances of our peoples and their leadership, both in the political and medical fields where there is reluctance to accept changes as proposed by the therapeutic community.

However, our task was fulfilled. College support movements were created at Universidad del Salvador and Universidad de Belgrano. Assistance was given to new therapeutic communities in other Argentine cities (Rosario, Tucuman, Jujuy) and South American nations (Uruguay, Peru, Brazil, Bolivia and Paraguay).

After 13 years we feel our experience, our ideas and our particular views on the therapeutic community should be shared. The presence of Brian Madden, Charles Devlin, H. Gissen and A. Acampora last June has been a very positive contribution which we deeply appreciate. We believe we deserve some credit for the long way we had to come in our attempt to devise a therapeutic praxis. There is a background. In the same way as one person's name shows his or her parents' choice, the name Gradiva bears the trademark of S. Freud. Not the Freud you criticize, but the Freud we understand. He who teaches us that it is through language than an individual's problem should be deciphered. For us this involves family language, as he who comes to us is subject to family power, be it because of excess or shortage of such power.

Power with a victim, and at the same time a victim who supplements the victimizer, playing the role assigned by the latter. This is the major problem of he who comes to the consulting room. As a paradox, the victimizer is also a victim of the other.

Gradiva, a work by Freud we have taken up as our emblem and badge, outlines different areas suitable for an approach to the therapeutic community.

Language Analysis

From this standpoint, the therapeutic community is an area for symbolization of conflicts in a family group the outcome of which is the consulting person. An area for symbolization means that all the group activities are connected by an axis, which is dialogue. The subject is exposed to confrontation, but a confrontation where intersubject sanctions are the key. Resorting to dialogue (etymologically the link between language and reason) is tantamount to reviving the ancient Socratic method where questioning leads to truth.

The therapeutic community as an area for symbolization has a very deep meaning for us, as it involves not only a broad theoretical background based upon L. Strauss" structuralism and modern linguistic theory from Saussure to Chomsky, but also because the whole community can be defined as a "symbolic organization" where all members take part every day in "symbolic rituals" which make therapeutic culture and tradition. Gatherings and meetings of different character, groups seeking a varied scope of goals; but the most important aspect is "listening and dialogue," the foundations of the whole work.

The ancient Greeks have taught us that human problems are solved, brought over to awareness, or tolerated by speaking them out. Language was for them immanent and transcendental at the same time, emerging from subjectivity, belonging to no one. It is what modern linguistics calls the place of the Other (of everyone and no one). It is in dialogue that different interaction parties will find their borders. Language

draws the line dividing what is possible from what is impossible. Omnipotence yields ground in favor of intersubject sanction and confrontation.

Symbolizing every human relation in the community gradually enables the subject, without his becoming aware of it, to be different, regarding himself, the others and the environment. From this standpoint the therapeutic achievement would be being different, being capable of being different. This differentiation, as already stated, would be gradual, coming in three stages which serve as the basis for growth:

* sexual differentiation (awareness of a sex)
* generational differentiation (overcoming sick dependence on parents and designing a vital project)
* social identity-founding differentiation (the field of concrete social praxis).

The participation democracy emphasized by M. Jones is for us the application of language. Dissent, conflict and ensuing results, confrontation and interpretation are stages as a consequence of the symbolic "machinery" which makes a man a man.

We are different from behavioral therapeutic communities. Language brings us closer to a subject's history; he will have to find out--if he is willing to--his place in that history, and its connection with parents' history.

We are different from projects of therapeutic community resorting only to the subject's will and behavioral reformation. We believe that these are only good intentions ignoring the deep and complex fabrics of a person's disorders.

In a therapeutic community truth can be made more or less evident through language. Quoting the ancient Greeks in this sense, truth is alethea, that is, permanent questioning. Different sets of activities and elaboration beyond factual activities create links for permanent questioning. It is with the Other that I get involved; or whom I fight: it is through the Other that I ask myself questions.

A therapeutic community must create the framework suitable for questioning. Those who come to the therapeutic community do so conveying full responses (e.g. a closed omnipotence posed by addicts); task groups will bring the subject within the scope of questioning. In the end, behind his human problem the question will stand, "Who am I as a person?" This question will put man closer to his being, which in turn can only be conquered from the "listening to" as posed by Martin Heidegger. Listening and questioning become the media conveying a history which makes sense, where a solid project will be built. The institutional staff is the ground where listening and questioning will first become the foundation for a sound therapeutic project. The whole community participates in a joint task which I called the field of "symbolic efficiency" in a 1982 book, *Psychotherapeutic Approach to Psychosis*. "a passage from thing to symbol and from symbol to symbol." Such a path involves a discovery to get rid of the limited scope of literate and concrete matters, to be able to travel across a new dimension of meaning, questioning what has happened. Restoring symbolic capabilities--that is what is secured. The actual freedom and independence comes from differentiation, passing from dependent immediacy to mediation through the long road of symbolization where community mates are the agents.

The community is a framework for symbolization where a democratic environment produces every signal processed within; the community framework and the group rules will bring the symbolization goals closer. In a non-democratic environment deprived of rules, and without a proper framework nothing can have a meaning. A therapeutic community can only be significant for itself as well as for its members provided it creates the suitable framework for double sense-to be able to approach reality as an equivocal entity doing away with the slavery resulting from the viewpoint that considers reality as unequivocal. An organic framework makes it possible to achieve double sense; so the therapeutic community can be described as the restoration of a living dialogue within a legal framework. Stemming from such a legal and legitimate context, dialogue yields positive results.

The therapeutic community itself is a social criticism, giving priority to dialogue as opposed to narcissistic microsubjects posed by social forces. It gives priority to the binding capacity of meaning, listening and questioning, against the purest answers of mass culture. It generates links and relations where equivocal elements develop against unequivocal lecturing by the Master.

The Therapeutic Community as Family Environment

For us the disturbed individual is a mockery of alienating family life. It is a distorted portrait. The truth appears absurd, since truth can be shown through absurdity. The identified patientis showing what others cannot see of themselves, their truth as in a negative film. His human problem is made in the family. He becomes a scapegoat of a significant relationship pattern and at the same time is an observer of that pattern, expressing them all and protecting them all so no one could penetrate that pattern.

He is a product of several generations of conflict, finding it symbolization in him. Varying interface effects of characters and roles can be observed in family life. Up to a certain extent characters play a role which imposes restrictions on subjectivity, as in the case of father or mother roles. We often observe parents deserting their roles, posing the question of parenthood and its awareness. This brings about the masculine-feminine elements and the question of characters unable to take up human-supporting roles in technological society families.

This is paramount in the case of the character of the father and his relation to the role of father in cases of addiction. Tracing two etymological origins of the term family we find: a) famulus, group of slaves, offspring and servants to a Master; b) a femore, linked to a structure, to an order, as for the ancient femur was an indication of physical order of the body. This two-fold dimension of family poses two assets showing at the consulting room: one the one hand, all-embracing power where the disturbed individual is a clearcut example of pathological slavery; on the other hand, the structural condition of a subject. No human relationship will ever occur where there is no family. Our therapeutic community is a family community. For Gradiva, family is a part of a three-stage therapeutic process:

* a primary-group gathering
* a multi-family gathering, and at the same time
* active participation in institutional therapeutic moments.

The Therapeutic Community as a Criticism to Power

We see power as a narcissistic structure contrary to the proper use of authority as proposed by the therapeutic community, which implies group operation based upon the Law, parting with a notion of power concentrated in one hand. Authority is a result of a covenant. Narcissistic power is based on bribery and obedience to avoid dying or going insane.

Pinel setting madmen free, Freud releasing neurotics from the prison of the unconscious, and above all, M. Jones showing traditional medical power brutality connected to institutions operating as prison camps. After that Bateson bringing a twin-link as a power combination by a victim and victimizer. From that imaginary "prison camp" picking the mother-child relation as a model--though it could be applicable to any human relation where contradiction occurs--the only way out is counter-violence, or else meta-communication. The twin-link acts as a narcissistic trap where symbolization fails to offer a way out.

The therapeutic community as an environment for symbolization and as a treatment unit for the whole family poses a criticism toward the alienating power system. Describing the human problem as family and social crisis, working permanently with authority transference and shared responsibility, we seek to rescue the subject from slavery. And we paraphrase Spinoza, "One finds out he is a slave in the first place, then understands his slavery, and finds himself free in the end, once his needs are comprehended."

In short, our Community functions as a symbolization framework with a family strategy leading to decoding power relations inherent to human problems.

There is no way to describe in this presentation three other aspects supplementing those already stated:

* the Community as a labor community
* the Community as a play community
* preventive aspects of the Community

In the face of an impersonal world prone to anonymity, a world where affective shortcomings and narcissistic escape often generate margination, addiction and schizoid affective cutoff in the technological clockwork society, therapeutic communities will grow in number as they are a response to human needs.

NEWS FROM THE ASIAN PACIFIC REGION

Roy Johnston

President
Asian Pacific Federation of Therapeutic Communities

I bring you greetings from the Pan Pacific area, from our regional federation within WFTC--the Asian Pacific Federation of Therapeutic Communities. We extend to all of you, our sisters and brothers met here in San Francisco, and particularly to Alfonso Acampora and his team who have brought together this wonderful meeting, our best wishes for a successful and memorable World Conference the influences of which will chain out from this place to the extension, growth and strength of the TC movement right around the world.

As we extend to you these greetings, we ask you to focus on the region. As we do so we remind you than on the Pacific rim and up into Southeast Asia we have a zone of tremendous potential, of potential wealth, of great numbers in people, and of varying stages in development, both economically and politically.

Truly it has been said that our region is tomorrow's world, tomorrow's world center as the focus shifts from the old and the not so old to the new.

For this reason alone, the region is important. But from our own specific viewpoint, the very factors which make it the center of tomorrow are those which bring the plague of addiction to chemical substances.

And so we have within the region the Tragic Triangle. There is no way, except to those who are unprincipled, that it can be termed "golden." We have also the problems of the Peripatetic Pill, which somehow for the same "golden" reasons finds its way into the region from the tragic overruns of the pharmaceutical companies of Europe, American and Japan. And we have alcohol, long resident in the area, but brought new refinements by way of scotch, the juniper and the powerful pervading influences of the media.

Like elsewhere on this planet, we thus have within our region a population many of whom are potentiated to addictive substances, who have the ready wherewithal to meet that biochemical urge, and health and hospital systems not equipped in knowledge or training or even the will to understand the problem, let alone deal with it.

Thus it is significant and of interest to us all that many thousands of kilometers away from the formal and pioneering influences of men like Maxwell, Jones, Bridges, O'Brien and Deidrich, and with no knowledge of their profound influences in their own geographic areas, TCs were being established as an innovative response to a plague of addiction that was beyond both the capacity and the comprehension of the established health systems to cope with.

We have since in our region, thanks to the selfless international work, the many thousands of kilometers of numb-bum travel, of William O'Brien and lately Lars Bremberg, knitted into and gained much from the world-wide brotherhood and support of WFTC. And we are the better for that.

I am stressing these elements of origin in and from our region for we here, where establishment systems in many of our parts cannot so readily or easily be put in their proper perspective, have seen the need to remind ourselves constantly that the TC is an innovative response, that it stands taller and more effective away from systems which, seeing its success, have a yen to climb back onto its mode, and there are dangers in that.

To say we have special problems in our region is not to say we are alone in that. But we see the need for reminder of our innovative origin and what that meant at the time of innovation to be constantly before us.

Having with some delicacy and diplomacy traversed these important points, of which we shall say no more, what's going on in our region?

From Nepal across to Sri Lanka, through Thailand, Malaysia, Brunei, to Indonesia, the Philippines, Guam, Hong Kong, Japan, Australia, New Zealand and the South Pacific Islands of Fiji, Cook, Samoa--within this broad and populous region the TC movement is nurturing out well.

From within the Philippines with DARE, from within Malaysia with Pusat Pertolongan and the communities of Malaysia Cares, from within Thailand with Rebirth, from within SARDA in Hong Kong, from within New Zealand with Kahanui and Aspell and Johnston, has been the core of growth. In Nepal, in Sri Lanka, in Guam, in Australia, Indonesia are nurturings which will grow.

In this past year since our Rome Conference, the events which have been at the forefront have been the work of Pusat Pertolongan in Ipoh, Northern Malaysia, where the first Malaysian National Conference on Alcohol Problems was pioneered by Yakob Scholer.

Likewise in Selangor, Malaysia, we have established contact with the quite remarkable and purely innovative TC response Malaysia Cares with it Rumah Cahaya (for men) and Rumah Kepercayaan (for women) communities for those with drug problems. Pusat Care was established in January, 1980.

In Brunei we have opened up a continuing dialogue with the Director General of Health and Education on drug problems which are concerning that area and we have contact with colleagues there.

With United Nations and ILO representatives in the region we have established close working relationships which will enable the extension of the TC concept, particularly in areas where rigid authoritarian approaches have been dominant.

As we leave this Conference we go to Khatmandu in Nepal to an NGOs Conference where, thanks to Pio Abarro and the Colombo Plan, we will discuss TC extension.

But most important of all developments in the region, at this vital formative stage as we move forward, has been the great support and encouragement of the Council of Social Welfare of Thailand, which under royal patronage has helped provide a setting into which is being established a Pan Pacific Regional Training Institute for TC staff.

This project owes its present incipient existence to many elements of support: to the Swedish government, which is granting generous financial support; to WFTC through is International Development Committee, which provided the co-ordinating mechanism along with APTCs own channels; and lastly, but by no means least, to Lars Bremberg and his Swedish Valmotorp - Daytop TC systems which are providing the skills and the manpower for the establishment of the Institute which we would like to see called the Dag Hammersjold APTC Institute.

Lars Bremberg and his team are well suited to this challenging task. First, they have what we have seen from experience is essential: a long established TC system operating in their home country and a lack of colonialist tendencies for which there is no room in the region. They themselves have a highly developed and operational Training Institute. They are backed in their country by a government which has a genuine social concern for drug problems in the countries of our region.

Last, but by no means least, Bangkok, Thailand which ten years ago staged the international conference out of which WFTC was born, looks forward to the 11th World Conference at Bangkok in January, 1988.

Those, my friends, in brief, are the thought from and report on our Asian Pacific Federation, very much an integral part of our parent WFTC to which we say a warm public thank you, particularly to William O'Brien and Lars Bremberg.

THE FUTURE OF THE THERAPEUTIC COMMUNITY

Mitchell S. Rosenthal, M.D.

President
Phoenix House Foundation
New York

I am delighted for this opportunity to address the Ninth World Conference of Therapeutic Communities. And the issue I choose to raise today may be perceived quite differently by participants from the United States and those from other parts of the world. That issue is the simple matter of our survival, the future of the American TC, the role we are to play tomorrow in the treatment of substance abuse, if indeed there is a role for us in the constellation of treatment services now taking shape.

Because we have been, for so long, at the very center of drug abuse treatment in this country, it is not unreasonable for us to have assumed that we would remain there. But the 20 or more years during which we have been at the center of things does not give us squatter' rights. And a relatively low level of concern about our future is more an expression of our relative isolation within the world of social and health care service providers that it is a realistic reflection of confidence in our future.

There have been, to be sure, great changes in therapeutic communities since we first began working with drug abusers. But there have been even greater changes in the nature of drug abuse, in the perception of drug abuse and in the universe of drug dependent Americans who are and will become candidates for treatment.

As you know, the therapeutic community for drug abusers emerged during the 1960s as a self-help alternative to more conventional and less helpful means of treating drug dependency. It shared its name with those therapeutic communities that had been started more than a decade before in certain British psychiatric hospitals. But a name was just about all it shared with them. It had roots in far more ancient forms of communal healing, and its most immediate progenitor was Alcoholics Anonymous.

The point, of course, is that TCs evolved almost independently of the medical and mental health mainstreams, although not without the participation of a good many medical and mental health professionals. Nevertheless, we were outsiders. And that gave us the freedom to innovate, to experiment and to discover methods that worked. It allowed us to create communities that were truly "therapeutic"--caring communities that permitted long-term humanistic and psychodynamic involvement with clients, communities that provided a 24-hour-a-day context for learning and for change.

We were not given this opportunity because the medical and mental health establishments were convinced we could do a better job. We were given our chance because most doctors, psychiatrists, psychologists and social workers just didn't care. Some had been frustrated by their own attempts to deal with addiction while others were put off by both the nature of the patients and the nature of the problem. Drug addicts (in those days that meant heroin addicts and little else) were not patients many doctors cared to see. They were poor and generally disadvantaged. They had social, emotional and economic deficits. They were perceived as criminals, and many were indeed criminals. And they were considered incurable.

As for the problem of drug abuse, that was clearly becoming a crisis. But it was not a crisis most health care professionals recognized as medical. It was considered a social crisis, and what most troubled both the public and its political leaders was the spread of addict crime, not the spread of addiction.

Therapeutic communities were one of the ways in which certain communities responded to this crisis, a crisis many expected to be short-lived. It was felt that when the crisis passed, then TCs would dry up along with the public funding that supported them.

Only it didn't work out that way. The crisis persisted. Instead of blowing away, TCs proliferated. They grew in size, scope and sophistication. And the question today is, "Have they grown enough, matured enough, to survive a wholly different perception of drug abuse and the drug abuse crisis?"

We have had 20 years to show what we can do. And in that time, we have put together an astounding record of accomplishments:

* We have proven that drug abuse is curable.

* We have shown that "drug free" treatment is not only the most desirable model, but the most predictably effective as well.

* We have established the efficacy of the self-help dynamic and its vital significance to substance abuse treatment.

* We have demonstrated the important role that ex-abuser clinicians play in the treatment process.

Now this clearly should be enough to establish therapeutic communities as an essential component of whatever constellation of treatment services are developed in this country. But we cannot assume that it will be enough. Indeed, I suspect that it most likely will not be.

The reason lies in what else was happening during the 20 or more years during which the therapeutic communities were showing what they could do. Drug use grew from the relatively negligible levels of the early sixties to involve more than 50 million Americans by the end of the seventies. That is 50 million who have used drugs and more than 20 million who use them regularly. During this period, drugs spread across our country to communities of all sizes and all levels of society. Indeed, drugs are now more readily found in upper income homes than in lower income homes, and drug use is more prevalent in affluent suburbs than in the central city.

There has been, in recent years, great growth in what is misguidedly called "recreational" drug use and a shift from marijuana to more potent and dangerous drugs. More than 20 million Americans now have used cocaine. More than five million use it regularly. And an estimated five thousand new users try the drug each day.

Right now, we are seeing the greatest increases in drug use occurring within the workforce. The young men and women who were students when marijuana first moved into the schools and onto the campuses have come crowding into business and industry. They are our most "drug experienced" citizens -- the Americans most "at risk" of drug abuse because two out of three have already used drugs.

These young workers have been coming into the job market for more than a decade and a half. Researchers are now finding that one out of five male workers age 18 to 24 is a "problem" drug user whose productivity is 30 percent below par. Among working men 25 to 34, one in eight is a problem drug user. The work forces become increasingly vulnerable to drugs at its composition continues to change as more young "at risk" workers are hired and more older, low-risk workers retire.

The new "at risk" workers are the baby boomers, members of that oversized and much-named generation that was yesterday's "counterculture" and today's "yuppies." More significantly, they are today's parents as well. As this first drug-vulnerable generation ages, we can expect to see more adult drug abuse. At the same time, we can expect youthful abuse to persist and reach even higher levels as more children of drug-using parents reach adolescence.

Drug abuse is now a mainstream problem, and mainstream institutions are beginning to respond to it. It is no longer society's outcasts who are the victims, but society itself -- men and women with careers and homes, family physicians and health care insurance.

As more and more family physicians start looking for signs of drug abuse among their patients, more will find them. Even six years ago, in a University of California study, 150 consecutive general medical patients, making their visit to a practitioner, were screened for alcohol and drug abuse. The study found that more than 11 percent were using psychoactive drugs other than alcohol.

What will private practitioners do once they start automatically checking for indications of drug abuse? Where will they send their drug-abusing patients? This is today's doctor's dilemma. The reason, I suspect, that more physicians aren't on the lookout for drug abuse is that they aren't too sure what they should when they find it.

Industry, too, has a dilemma. A growing and already substantial portion of the workforce is composed of drug abusers. Much has been written of late about how industry is attempting to identify them. Urine testing has become a "hot" issue for the press, civil libertarians, and labor negotiations. But the most difficult question, that has yet to be satisfactorily addressed, is, "Where will industry send its drug-troubled workers for treatment?"

Ours is a supply and demand economy. A new (and new kind) of demand for drug abuse treatment is being answered by a rapidly-growing supply of treatment alternatives. Most of them are from the medical and mental health mainstream, many of them private, for-profit, high-cost and covered by health insurance.

What we are seeing in certain areas, most notably in that major city just down the coast from here, is drug abuse treatment as a growth industry. What should rightly concern us is how much of the treatment now becoming available is designed to respond to considerations other than patient need, to career demands and the prejudices of employers, to health care coverage and distinctions of class.

Now I am not for a second suggesting that there is anything inappropriate in this sudden diversion of the medical and mental health mainstream. Their new interest in drug abuse is a legitimate response to growing patient needs. We may, of course, find it ironic that drug abuse has finally achieved unchallenged recognition as a medical problem now that mainstream patients are its victims. We certainly should be quick to condemn those opportunistic practitioners who are now bringing what we know to be ineffective and inappropriate treatment into what has become, to some degree, a seller's market.

But our chief concern must be to determine what role therapeutic communities are to play in this new treatment environment. This is not necessarily an issue of concern to our European colleagues. Indeed, we may well look to some of them for guidance. For the most part, their TCs have tended to enjoy strong linkage to established medicine and mental health.

I believe that we in America have two choices. The first is to restrict ourselves to the treatment of our "traditional" clients. The trouble with this is that most of us have long since moved away from our initial client base to treat a variety of drug abusers. It is one of the ways in which therapeutic communities have matured -- demonstrating the capacity to adapt treatment methods to new client populations, dealing with adolescents, for example, and treating working men and women.

But are the changes we have made to accommodate a greater variety of clients sufficient to keep us near the center of the treatment scene? I am not convinced that they are. I do not believe that therapeutic communities can go it alone any longer. Had we not evolved independently of the medical and mental health mainstream, we probably could never have developed the treatment methods we did, methods which many in the mainstream are now eager to embrace. And we probably could not have demonstrated that drug abuse is curable. But, if we are not now prepared to work with more traditional medical and mental health professionals, then there is a good chance we will not survive the rationalization of drug abuse treatment services that is certain to follow the rapid expansion of the next few years.

How, then, do we prepare ourselves to work with and join the doctors and psychiatrists, psychologists and social workers whom many of us have considered hostile to therapeutic communities? We must recognize here how many professionals have long been involved in therapeutic community treatment and realize that these men and women became involved because they recognized what the TCs had to offer. More and more health and mental health care professionals are coming to realize that we may have something to teach them. But we will find too many unwilling to learn from us until we overcome some of the structural problems of our independent past.

I believe it is most important for TCs today to demystify TC treatment, to professionalize clinical practice and to start seeking more opportunities to collaborate with mainstream medical and mental health agencies. To demystify TC treatment we must recognize that what we have is a model and not a prescription. We are strong on description and weak on analysis. There is no broad conceptual framework that provides a basis for understanding the working of the therapeutic community. Indeed, there is no single, published codification of generally-accepted TC principles and practices. What does exist generally fails to reflect the more recent changes in TCs, the ways in which we are adapting to new client populations.

The lack of a solid conceptual basis for our work has meant almost total reliance on practical instruction for our clinicians and relatively little theoretical input in the training process. We have used what amounts to an apprentice system to train former clients to become skilled clinical workers.

Now, there are a great many virtues to the apprenticeship model. It is one that every profession initially employed. And it has worked amazingly well for TCs. It has made our former clients a source of strength and a means of renewal. But it has shortcomings, and these shortcomings become most evident when we attempt to modify our methods and adapt our programs. We simple ask too much of our ex-addict clinicians and give them too little. What is amazing to me is how rarely they disappoint us, how often they are able to struggle through to an intuitive understanding of questions they should be prepared to deal with conceptually.

We have made efforts to professionalize clinical practice. The credentialing program of our national TCA is a fine beginning. I am not arguing here for a more rigid kind of credentialism, the kind that would drive talented and dedicated clinicians from the field. I am asking that we broaden and deepen our approach to training, that we work together on ways of making true professionals, non-degreed professionals, of the men and women who are most responsible for our treatment successes.

I believe that we must undertake, over the next several years, the creation of new resources, including a body of material that will provide the solid conceptual language we need to describe ourselves, not only to our more traditional colleagues in medicine and mental health, but to ourselves as well and to our clinicians. We must start developing resources for training that will support the professionalization of clinical practice in the TC. I do not think we can accomplish any of this individually. I am convinced we must work together, pooling resources and sharing talents, to accomplish these tasks.

We have got to collaborate with each other to make it possible for us to collaborate with more doctors and psychiatrists, more psychologists and social workers. If we do not, if we are too proud to make the effort, if we are unwilling to share what we know with mainstream medicine and mental health, then it is entirely likely that they will attempt to use the methods we have developed without understanding them. They will attempt to use, as they already do, our TC-trained clinicians without understanding what they can contribute.

What will happen then to therapeutic communities? Well, my best guess is that we will become incidental to the main thrust of drug abuse treatment in this country and that patients will suffer as mainstream professionals struggle to learn for themselves what we have learned over the past twenty years. TCs would survive. But they would play a diminished role and contribute little to the further development of drug abuse treatment in America.

SUBSTANCE ABUSE AWARENESS IN CALIFORNIA

Chauncey Veatch III

Director
Department of Alcohol & Drug Abuse
State of California

I bring you greetings today from the governor of the state of California, George Deukmejian. He is unable to be here today and he regretted that because this community is very important to him. Very briefly, we have a proclamation from the Governor, and I'd like to wish you the very best as you take everything that you've learned at this conference back home as you prepare for next year's event in Sweden so that it can be as successful an event as the one here in San Francisco in the state of California in the United States.

From what I've been told, and listening to those of you who have been around, the Ninth World Conference is, perhaps, the most successful to date. We're very pleased about that. There are people from 21 countries here. There are over 500 participants. The conference started off on a positive note with a 10k Run for Recovery the very first day. And after I looked out and saw all of you here this morning, my eyes focused on the young people I see here in the very first row. When I see the young people that are here in San Francisco today, I think about how important they are for all of us because as we struggle on a daily basis to combat drug abuse, in many ways the young people represent a thread that cuts across the fabric of every society on this globe and one that we all feel so deeply about. I believe that we can make a difference today and in the days that follow so that the quality of life for our youth will be much greater than the quality of life that we have today.

There are many things that do come to my mind, but there's one thought that stands out above all others, and I'd like to share that and share the proclamation from George Deukmejian, the Governor of California. And that thought is about Robert Kennedy, who died in this state 8 years ago, who once said that too often we feel that there's nothing that one man or one woman can do against the array of the world's ills. But each time an individual stands up to fight injustice or poverty, you send out a ripple of hope, and those ripples cascade together forming a wave which overcomes the greatest walls of oppression.

Surely, all of us believe that the battle that we wage is as important as any battle in any society across this globe. I wish you continued success in your battle. Our thoughts and our prayers go with you as you leave this great city and go back to your homes. We hope that this has been a valuable conference for you. I'd like to thank Alfonso Acampora on behalf of the Governor and the people of the State of California.

I also see that the Monsignor is here, and I'm delighted to see him. I went to Notre Dame and our mascot is supposed to be the Fighting Irish. I always wondered why we had a redundant name for a mascot -- Fighting and Irish!

I'd like to present this proclamation firstly to Alfonso Acampora. I'd like to read the message from the Governor as I present this to you personally. The Text of Proclamation reads:

> "Whereas an estimated 1.5 million Californians are problem drinkers; and whereas as many as 90% of our youth have reportedly tried alcohol and 64% have reportedly experi- mented with illicit substances by their senior year of high school; whereas approximately 4,500 Californians died in 1984 as a result of alcohol and drug abuse; and whereas the cost to California for treatment, lost productivity, crime and property associated with alcohol and drug abuse is $17.7 million annually; and whereas the general public's awareness of the dangers of alcohol and drug abuse is necessary to combat this serious problem; whereas on September 1-6, 1985, San Francisco has the honor of host- ing the Ninth World Conference of Therapeutic Communities which would explore better ways to educate and treat and maximize the elimination of the problems inherent in chemical dependency and alcohol abuse among our youth and adults; now I therefore, George Deukmejian, Governor of the State of California, do hereby proclaim September 1-6 as Substance Abuse Awareness Week in California and encourage all citizens to join in an effort to reduce substance abuse."