A COMPREHENSIVE ANALYSIS AND DESCRIPTIVE STUDY OF DRUG ABUSE IN THE COUNTY OF OAKLAND

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A COMPREHENSIVE ANALYSIS AND DESCRIPTIVE STUDY OF DRUG ABUSE IN THE COUNTY OF OAKLAND

By

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INTRODUCTION

Professional opinion about drug abuse is changing. What has for years been regarded as a criminal-physical problem, appears to be emerging as a socio-mental problem. To control drug misuse, much more must be known about the attitudes and motivational roots of the problem.

The abuse of narcotics, depressants, tranquilizers, stimulants and hallucinogins is on the increase, with, according to some Federal reports, over 22,000,000 persons involved in the abuse of drugs in the United States today.[1]

Misinformation contrary to available scientific knowledge has made the problem difficult to deal with, especially at the juvenile level of education. The effectiveness of prevention, control and treatment of a public health problem is in ratio to the degree of public understanding. Interest at present in the problem is much aroused.

Respect for all drugs must be engendered through every available channel to people of all ages. Members of society must be motivated to determine for themselves

that the social structure and its problems are not changed for the better when its members retreat from their problems by the use of various drugs. These drugs may temporarily alleviate the problems of the individual, but the causes of these problems still remain, and thus are ever present.

It is the purpose of the researcher to present a picture of how drug misuse has spread to the local community striking at the heart of our society, its youth. The study will focus its attention on the youthful offender from a standpoint of the judiciary, law enforcement and education, and concern itself with defining the problem, its extent, and who is involved. It will then offer some practical suggestions to assist in developing programs to curb the misuse of drugs.

CHAPTER I

THE RESEARCH PROBLEM

A HISTORICAL OVERVIEW

No subject in the past few years has aroused more general interest, created a greater demand for information, or caused more widespread concern than drug abuse. However, the problem has existed for many years. Almost thirty-five hundred years before Christ, marijuana was well known to the Chinese. Opium was in widespread use by the Egyptians fifteen hundred years before Christ.[2]

In North America drug abuse has a long history.

> By the eighteenth century American colonists used opium extensively as a therapeutic agent, and addiction was a widespread problem. Morphine and codeine were introduced to cure people from addiction, thus compounding the problem because these substances were equally addicting.[3]

By the nineteenth and early twentieth century many other substances were abused, including cocaine, bromides, chloral and chloroform. Heroin was introduced as a cure for morphine addiction, again without the realization that

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[2]Louis Relin, Narcotic and Drug Addiction (Chicago: Budlong Press, 1968), p. 3.

[3]Roy Smith, "The Ups-The Downs," Michigan Health, (Fall, 1968), 2.

it too was addicting. Little research was carried on as to the effects of these various drugs and to their side effects before they were put into use. Ether was being sniffed by college students, much like today's students using marijuana, long before it was known to be an anesthetic. The most popular mood modifier of this time was nitrous oxide, known as laughing gas. People thought then that its use would offer enormous insights and universal truths, similar to present day proponents of LSD.[4]

Legal Control

> The first formal recognition of the problem and attempt to control drug traffic on an international level took place in the early years of the twentieth century. In 1908, President Theodore Roosevelt of the United States called together the representatives of thirteen governments: Austria, Hungary, China, France, Germany, Great Britain, Italy, Japan, Persia, Protugal, the Netherlands, Russia, Siam and the United States. These thirteen governments formed the International Opium Commission of 1909.[5]

From this Commission several resolutions were forthcoming which were not binding on the members, but recommended the gradual suppression of the practice of smoking opium, taking into account the problems encountered in the several countries while they were doing so. It was also agreed

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[4]David Solomon (ed.), LSD--The Conscious Expanding Drug (New York: G. P. Putnam, Berkley Publishing Corporation, 1968), pp. 11-28).

[5]International Drug Abuse Manual--A Guide (Philadelphia: Smith Kline & French Laboratories, 1969), p. 37.

that these same countries would take appropriate action to suspend the international shipping of opium from their ports. It was apparent that more strong action must take place, and thus in 1911 the Hague Conference was held and in 1912 the International Opium Conference.[6] From this conference stemmed the controls on narcotics that made it a matter of international law. Treaties which were to follow contained the basic principles of these controls. An international exchange of narcotic traffic information was set up with the Dutch Ministry of Foreign Affairs as the focal agency for directing the use of this information.

In 1914 the Harrison Act was passed in the United States which made the dispensing of narcotics illegal, except for physicians and pharmacists. In 1919 outpatient treatment for drug abuse patients was established by several local health departments throughout the country, which were soon forced to close due to local resentment against them.[8] This is a similar reaction being encountered by authorities today in setting up half-way houses for drug abuser clientele.[9]

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[6] Ibid., p. 38.

[7] Ibid.

[8] Smith, op. cit., p. 3.

[9] "Drug Treatment Center Distresses Neighbors," Capital Press, April 9, 1971.

The League of Nations was established in 1920 and called for international cooperation in the war on the traffic of narcotics.

In 1923 Federal clinics were established throughout the United States, and once again strong opposition to their existence forced their closing. There was little, if any, support from state and local authorities, including the American Medical Association. With the unsuccessful treatment centers closed, those who were abusing drugs turned to illegal sources for help in ever increasing numbers.

In 1924 and 1925 a conference of thirty-six countries was held in Geneva (International Opium Conference) to set limits on the amount of narcotics that could legally be manufactured and distributed for medicinal and scientific purposes.

The purposes of the International Opium Conference of 1924 and 1925 could not be solidified, and the United States withdrew from the Conference.[10] China also withdrew since some countries refused to declare opium smoking illegal and also refused suppression of its use. Subsequent action by the remaining members of the Conference proved to be very weak in nature.

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[10] International Drug Abuse Manual--A Guide, p. 38.

Public opinion against the abuse of drugs and drug traffic brought about a conference in Geneva in 1931 to establish tighter controls on drug traffic. The Limitation Convention of 1931 applied controls to all phases between the manufacturing and consumption of drugs on a worldwide basis. Thus for the first time, an industry was regulated in accordance with worldwide plan based on the voluntary cooperation of interested nations.[11]

In 1946 the Economic and Social Council of the United Nations established the Commission on Narcotic Drugs, which was the successor to the League (which had disbanded) and controls were shifted to the United Nations and The World Health Organization's Opium Advisory Committee. In 1948 synthetic drugs, designated by the World Health Organization were included under the narcotic control of the United Nations.[12]

In 1953 an Opium Protocol was adopted, thus making nine different treaties governing the international control of narcotic drugs. Three International Organizations, charged with narcotic control, existed. Thus in 1961, in order to alleviate the complicated legal situation that had developed over the years, a Single Convention on

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[11] Ibid., p. 40.

[12] Ibid., p. 41.

Narcotic Drugs was adopted. It replaced all other treaties, except certain phases of the 1936 Convention.[13]

The legal council of the United Nations holds that psychotropic drugs (barbiturates, amphetamines and hallucinogens such as LSD) are not under the 1961 controls. Since their abuse has been much on the increase, a new treaty is being drafted for the specific purpose of their control.[14]

Halting the illegal traffic in drugs is essentially a world-wide problem. If the manufacture and distribution of drugs could be limited to only the amounts needed for research and medicinal purposes, the manifold problems could be lessened. Since 1908, as noted, through compacts with various countries, efforts at international control of various drugs and narcotics has been attempted with some success in limiting the source of drugs and narcotics. However, there are many loopholes in the international suppression of illicit drug traffic. In many countries there are inadequate laws against the use or selling of drugs and narcotics, and when they do have the laws they are poorly enforced. These same countries produce the greatest amount of plants from which the drugs are derived. In some of these countries, the use of opium is tolerated

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[13]Ibid., p. 42.

[14]Ibid., p. 45.

much the same as the United States tolerates alcohol and its abuse. This is not to say these countries do not try to limit exports and production, but in many cases to no avail. Four times as much opium is produced annually than is needed for medicinal and research purposes.[15]

As has been stated, the United Nations has many agencies which administer what are voluntary controls on the growth and production of drug materials in the countries that are producing it. Both the Drug Supervisory Body and the Permanent Control Opium Board have made extensive studies of the need for drugs throughout the world. Their authority for these actions is vested in the several treaties they are armed with, and they encourage countries to produce only what is needed for legal purposes. The World Health Organization disseminates information and medical-health standards to all countries. Even though there has been a slow and awkward development in the organizational control of drug traffic, a certain amount of success is apparent. Some countries have banned opium altogether, and others have refused to ship to countries that are not controlling their illegal traffic and thus are potential trans-shipment points in illicit drug traffic.

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[15]Jules Saltman, What We Can Do About Drug Abuse (New York, Public Affairs Committee Pamphlet #390, 1968), p. 16.

The United States has vested in the Bureau of Narcotics, under the Treasury Department, and the Customs Bureau the responsibility of enforcing its laws as pertain to illegal drug traffic.[16]

The aforementioned Harrison Act of 1914, which has been amended several times since its passage, has been the Bureau's chief enforcement authorization in the control of drug traffic. Many changes have been made giving the Bureau more power to act and stricter penalties have also been put into effect (Boggs, 1951 and Boggs-Danield, 1956). Due to certain restrictions imposed the judiciary has had little recourse in sentencing some who in their estimation would be more properly confined to hospital care. Because of this, the Advisory Council of Judges of the National Council on Crime and Delinquency has strongly proposed the discarding of mandatory sentencing.[17]

Due to the increase in drug abuse, and criticisms that have been aimed at existing legislation, much legislation has been and is being considered in the field of drug abuse. In 1965 many bills were before Congress, most of

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[16]Drug Abuse--A Manual for Law Enforcement (Philadelphia: Smith Kline & French Laboratories, 1968), p. 32; and Norman W. Houser, Drugs, Facts on Their Use and Abuse (Glenview, Illinois: Scott, Foresman & Company, 1969), p. 38.

[17]John W. Oliver, Drugs and Youth--Chapter 22 (Springfield, Illinois: C. C. Thomas, 1969), p. 229.

them aimed at lessening the restrictions as regards the disposition of drug abusers.

To this point, little has been said about the illegal traffic of barbiturates, tranquilizers, and amphetamines specifically. Fifty per cent of the total production of these drugs comes from well known and established drug firms in the United States. Only a small portion of the illegal traffic is produced by the criminal element. There are various reasons why the above takes place, but careless accounting of materials seems to be the major factor in this illegal traffic (i.e., failure to identify customer, discarding of large quantities of samples, etc.). Until the enactment of the Durham-Humphrey Law of 1951, there were no Federal controls governing barbiturates though some states had begun to deal with the problem on their own. In 1965, with the passage of the Harris-Dodd Act, controls were enacted that required the keeping of records by drug handlers, limiting the time of prescriptions, and gave the agents of the Food and Drug Administration full police powers and charged them with enforcing the law. Some states still do not try to control amphetamines and tranquilizers. A uniform State Barbiturate Code has been drafted, but only a few states have adopted it.

Marijuana (Cannibis Sativa), though a hallucinogen, is classified as a narcotic according to law. Hashish, a

derivative of the Cannibis plant, has been used by India and Eastern countries for many years. Compared to these countries, its introduction into the United States has been relatively recent. In the 1920's it was used a great deal by musicians and their followers.[18] The musicians felt it helped them to be more expressive in their presentations. Since the 1920's, and especially after World War II, its use has become much more widespread and has reached age levels that alcohol had not previously made any significant inroads (use to any degree by elementary school children). The growth and sale of this product is forbidden by both federal and state laws in the United States. Once again, due to the severity of restrictions as regards disposition of cases, the public in general and officials specifically are clamoring for reduced restrictions and penalties (changing from felony classification to misdemeanor).

The mind changing or expanding-sensation drugs have also come on the United States scene in recent years extensively. One of the leaders in this category being LSD (D-lysergic acid diethylamide).

The main danger in hallucinogen usage is the unpredictable results to the individual user. According to Dr. Donald B. Louria, Chairman of the New York County

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[18]Saltman, op. cit., p. 6.

Medical Society, LSD is the most dangerous drug abused in today's society.[19] Dr. James F. Goddard of the Food and Drug Administration seems to concur with Dr. Louria completely and revealed his concern by sending letters of warning to over two thousand colleges in the United States to this effect.[20]

Other hallucinogens, such as peyote, mescaline, psilocybin (which come from a cactus grown in and around Mexico), and substance from morning glory seeds and mushrooms are being used and abused.

The misuse of alcohol, of a certainty, must be included in this overview. There are estimated to be over six million alcoholics in the United States. The effects of alcohol usage and abusages have long been a concern of society and many programs have been inaugurated to curb this problem.[21]

In recent United States history, tranquilizers are another form of drugs being abused. They are not narcotic, nor a barbiturate, but sedatives that are used to calm one's nerves. Properly used by prescription, as so many other medicinal drugs, they are of importance to mankind.

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[19] Ibid., p. 10.

[20] Ibid.

[21] Jay Cross, A Guide to the Community Control of Alcoholism (New York: American Publishers Health Association, 1968), pp. 1-3.

Yet many, according to the American Medical Society, are addicting. Though there are laws governing their use, due to some of the aforementioned reasons for availability of drugs to the individual who actively seeks them, the laws, though helping to curb the illicit traffic in these drugs to a high degree in many instances, have proved ineffective in others.

The last materials to be taken into consideration in this overview are the so-called deliriants such as glue, with toluene, lighter fluid, cans of compressed chemicals, gasoline and thinner materials among others.[22] Though in use for many years in the United States for the purpose which they were originally produced, concern for their abuse has come about only recently to any large degree. Possibly due to the ease of procurement, they have affected much lower age levels in our society, including elementary school children. Many respiratory, kidney and liver ailments have been attributed to their usage, by sniffing mainly. Deaths have been noted in the community under study.

INTRODUCTION OF THE PROBLEM

There exists in Michigan and more locally, Oakland County, a growing concern on the part of responsible

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[22] Teaching About Drugs: A Curriculum Guide (Washington, D.C.: American School Health Association, Pharmaceutical Manufacturers Association, 1970), p. 165.

members of said society in these areas as regards the flagrant use and abuse of drugs. Much of the evidence that has brought about this concern has been depicted on local radio and television stations, as well as magazines and newspapers. Frequent referral by the media as to persons dying, causing accidents, thieving, committing burglaries as a result of the use of drugs of various types to excess has finally aroused the public to try to seek a solution to the growing problem and to provide ways of dealing with the problem when it was defined.

Thus it was that the writer set out to gain as much insight into the problem from a threefold standpoint: education, law enforcement and judicial dispensation. Many blind alleys were entered as factual information was hard to accumulate for an individual. It became apparent that the researcher had to confine his data collecting to the three areas he was already involved in, and thus more readily able to acquire the needed information.

STATEMENT OF THE PROBLEM

The purpose of this thesis is to establish a position as to the following:

1. To determine the extent of drug use and abuse in the County of Oakland.
2. To determine the frequency of drug abuse.
3. To determine the types of drugs abused.
4. To determine the age and sex of known abusers.

5. To determine the disposition of cases of drug abuse by various agencies already in existence, with emphasis towards the judicial, enforcement, and educational institutions.

6. To determine reasons for the misuse of drugs.

7. To determine what programs, if any, exist at the county level for dealing with the problem.

8. To determine a course of action.

A descriptive study is presented of the problem of drug abuse in Oakland County, involving the years from 1967 to 1969. Since there had been no prior study in this area, practices and policies as to their present status are emphasized.

This study identifies the types of drugs being misused, the age of the persons involved and their sex. It delves into the various types of persons involved, from their family and social backgrounds, to the basic makeup of the individuals themselves. The study tries to categorize those who misuse drugs into types as far as frequency of their participation, from the experimenter, who once tried it, to see what it was like, to the frequent user who may have become habituated to the drug use. The study probes some of the reasons most often given for the misuse of drugs. It identifies the procedures followed by those who are trying to cope with the problem, and gives some indication as to the success or failure of past and present practices. The study deals with the extent of

the problem, and some of those most likely to become involved. A presentation is made of some alternatives to present methods, from education to mental and physical, medical and psychiatric treatment, and community involvement towards a future insight to aid and assist those not so fortunate as to have achieved a happy and fulfilled life through acceptance of all that life has to offer, the "downs" as well as the "ups," without the use of chemical aids.

HYPOTHESES

1. Are drug misuse contacts increasing in the county?
2. Are more males than females involved?
3. Is drug misuse by the youthful offender socio-economically effected?
4. Is drug misuse to the point of fostering criminal tendencies placed at the age range of 15 to 21?
5. Is the drug abuse problem a sociological and psychological problem as opposed to a legal problem?
6. Is the age that one begins the misuse of drugs of various types pre-teen and early teen?
7. Are marijuana and alcohol the most abused drugs?

DEFINITION OF TERMS

Included in this portion of the research are terms important to this study. Some of the terms are associated with the drug problem directly, while others are closely related to drug abuse, and misuse problems.

Drug--a substance used as a medicine, or in making medicines; a narcotic substance or preparation.

Drug Addiction--a state of being addicted; habituation.

Addict--one who is addicted to a habit.

Drug Use--the using of drugs for medicinal purposes, legally.

Drug Abuse--the using of drugs, to a degree not medically prescribed.

Drug Misuse--the using of drugs for other than medicinal reasons and medically prescribed.

Drug Experimenter--one who experiments with various forms of drugs and deleriants on a hardly-ever basis.

Drug Occasional User--one who uses drugs for other than medicinal reasons on a once or twice a month basis.

Drug Frequent User--one who uses drugs for other than medicinal reasons on a basis of once a week or more.

Non-User--one who never takes drugs or deleriants of any kind except for medicinal purposes.

Drug Traffic--the sale and/or movement of traffic from one point to another of drugs.

Chloral--a colorless oily aldehyde--CCl_3CHO having a pungent odor obtained by the action of chlorine on alcohol, used in making chloral hydrate, used to produce sleep.

Deliriant--that which induces a state of delirium.

Pot--marijuana.

OVERVIEW OF THE LITERATURE

Multiple sources have been explored to insure a thorough understanding and awareness of the studies which have been completed by interested and learned persons dealing with the various phases of the problem of drug misuse. Several books have been read in the past two years relevant to the research area. Selected professional periodicals and journals have been studied along with all pamphlets and literature available from the International Narcotics Law Enforcement Association, The Michigan Special House Committee on Narcotics, The United States Department of Health, Education and Welfare, Health Services and Mental Health Administration, National Institute of Mental Health, various publications of Smith Kline and French Laboratories and the Bureau of Narcotic and Dangerous Drugs, United States Department of Justice.

In a recent survey by Louis Harris, large numbers of Americans report that literally millions of their friends and relations are using drugs that they feel are dangerous. The special survey on the use of legal and illegal drugs shows substantial public concern over the effects of tranquilizers and sleeping pills as well as such drugs as marijuana, LSD and heroin. For the survey, a cross-section of U.S. adults was extended to include a probability sample of all those over 16.

Nearly 15 million people (10 per cent of the estimated 148 million Americans 16 years of age and over) say someone "close to them" uses marijuana. Among teenagers, the proportion is 28 per cent. And 31 per cent of college students say either they or some close friend uses "pot."

While more than seven in ten of the general public feel marijuana is dangerous, only a bare majority of college students (56 per cent) agree.

One in 10 persons report they know someone who has used LSD, while an indicated 4.4 million persons (3 per cent of the 16 and over population) have intimate connections with someone who has tried the hallucinogenic drug. Concentration of usage among teenagers rises to 13 per cent and to 17 per cent among college students.

An overwhelming 89 per cent of the public believes LSD is "dangerous," a view shared by 87 per cent of teenagers and 83 per cent of college students.

One person in 20 reports knowing someone who has tried heroin. A nearly unanimous 97 per cent of the public polled sees heroin as "dangerous."

The survey also reveals substantial numbers of Americans feel drugs legally prescribed by doctors may be dangerous.

A projected total of 16 million people (11 per cent) know someone "close to them" who takes pep pills, although 73 per cent feel they are dangerous drugs. Familiarity with usage rises to 30 per cent among college students.

A sizable 41 million Americans (28 per cent of the sample) are intimately acquainted with someone who takes sleeping pills. The incidence rises to 34 per cent in the most affluent segments of society, those earning $15,000 or more a year income. Among college students it goes to 38 per cent.

Some 55 million people (37 per cent) report they know someone well who makes use of tranquilizers. The heaviest concentration can be found among the 30-49 age group and among those earning $15,000 and over, with 44 per cent reporting usage.

Despite these figures, 41 per cent of the entire public feels tranquilizers are "dangerous" drugs.[23]

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[23]Louis Harris, "The Harris Survey, The Detroit News, February 22, 1970.

Drug Dependence in Michigan, a recent publication by the Michigan House of Representatives, reports of a study carried out by the House Special Committee on Narcotics and by the Sub-Committee on Alcoholism Programs of the House Committee on Liquor Control of the Seventy-fourth Legislature. The basic findings of this study are as follows:

1. That the underlying causes of drug dependency and drug abuse are closely and intimately related to the wide-spread and far-reaching spiritual malaise that afflicts our entire society.

2. That the attitude of society and the governmental agencies through which society acts may be fairly characterized as one of vengence and vindictiveness toward the drug dependent person who is treated as an evil person.

3. That the primary agents our society has chosen to deal with drug dependent persons and the illicit drug traffic have been remarkably unsuccessful, particularly in failing to quash to any significant degree drug sales.

4. Illicit drug use and sales are rising among all sectors of the population, not just the young. All forms of drug abuse and the corresponding crimes against persons and property are also rising.

5. Alcohol is the drug which is the subject of the greatest abuse in our society and alcohol dependent persons far outnumber those persons dependent on all other

drugs. This observation holds true for every age group and every socio-economic class and every religion.[24]

Respect for Drugs, a manual developed by the College of Pharmaceutical Sciences at Columbia University and edited by Jack E. Gross, Director of Project PFD, gave the practicing pharmacist the means of bridging the educational gap and extending themselves into the areas of professional pharmaceutical services. The lessons contained in the manual were to assist pharmacists in becoming Therapy Advisors or Drug Consultants, utilizing their professional knowledge in a way that had not been practiced previously. Through this manual, they were encouraged to participate in community programs of drug control. The materials presented are valuable to the educator, professional, and law enforcement personnel as well as all other agencies interested in this aspect of the problem of drug use and misuse.[25]

A Guide to the Community Control of Alcoholism, by Jay N. Cross, M.P.H. 1968, provides the basic information from which appropriate decisions can be made concerning community alcoholism program content. In general, principles

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[24]Richard A. Bogg, Susan D. Russell and Roy G. Smith, Drug Dependence in Michigan (Lansing: Michigan Department of Health, 1969), pp. ii, iii.

[25]Jack E. Gross (ed.), Respect for Drugs (New York: College of Pharmaceutical Science, Columbia University, 1968), p. 2.

of program development are presented rather than descriptions of specific services and activities. It provides a useful summary of current knowledge about alcoholism and alcohol problems.[26]

From these many sources a basis in law as well as social philosophy, and a thorough understanding of the depth of the problem has pervaded the thoughts of the writer throughout this research. A more knowledgeable handling of the topic has resulted.

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[26]Jay Cross, A Guide to the Community Control of Alcoholism (New York, American Publishers Health Association, 1968), p. 73.

CHAPTER II

THE METHODOLOGY

The gathering of data to support conclusions of this study is only as valid and reliable as the methodology. This part of the study describes in detail the nature and scope of the methodology used.

INSTRUMENTATION

Two instruments were constructed to collect, by written questionnaire, data for this study. One set of questionnaires was sent to the forty-seven law enforcement agencies of Oakland County, and to the judicial branches of government in the county. Specific questions of age, sex, types of drugs used, and disposition of cases of drug misuse were used. Answers to questions of general nature were solicited pertaining to the reasons for involvement, what programs were in present existence and effect in the institutional framework to ameliorate the situation, and what programs would enforcement personnel and judicial officials suggest and recommend.

All agencies of law enforcement were contacted by phone prior to the mailing of the questionnaires informing

them of the survey and that they would be receiving the questionnaire, and their participation would be greatly appreciated. Twenty-two of the agencies were contacted personally for interview by the writer. The instruments were mailed under the auspices of the newly formed County Drug Abuse Committee, of which the writer became a member; first as a member of the law enforcement sub-committee, and later chairing that committee. This same instrument was sent to the following County institutions: social agencies, churches, druggists, public, and medical. Reference will be made to these other agencies, though the main institutions to be dealt with, as indicated earlier, are education (junior and senior high students), the judiciary, and law enforcement.

The instrument for the judicial and law enforcement agencies was devised and categorized on the following basis:

1. Type of institution--State, County, City, Village and Township.
2. Total drug abuse contacts--1967, 1968, 1969.
3. Age of the abuser--less than 10 to 21 and over.
4. Sex--male or female
5. Types of drugs abused--numbered in order of popularity:

marijuana	stimulants (amphetamines)
LSD - DMT	tranquilizers
mescaline	deleriants (glue, lighter fluid)
barbiturates	other_____
heroin	

6. Disposition of abusers:

court	social agencies (counseling)
school counselor	medical doctor
psychiatrist	hospitalization
clergy	other_____
warning (talked to abuser)	

7. Involvement reasons given.

8. What happened to the youths as result of involvement.

9. What programs are now in effect within your institutional framework aimed at amelioration of the drug abuse problem.

10. What programs would your agency like to see put into effect.

11. General remarks and suggestions.

DATA COLLECTION

As stated before, the questionnaires were mailed to forty-seven law enforcement agencies in Oakland County. The rates of return (sixty per cent) were considered sufficient in quantity, quality, geographics, socio-economic, and according to population distribution for a valid analysis. When the questionnaires were collected, the writer had an opportunity to interview the officials at the different departments, thus gathering additional information not readily receivable by the questionnaire.

A separate instrument was constructed for the study of the problem at the junior and high school level. It was a questionnaire consisting of twenty-five questions which dealt with the following areas of concern:

1. Questions dealing with drug use.
2. Self-study questions.
3. Description of family make-up.
4. Socio-economic background.
5. Specific drugs used.
6. Questions dealing with the sociological and psychological aspects of their involvement with drugs.

The types of questions and answers and the manner with which the survey was conducted were such as to guarantee the anonymity of the testee.

The survey was conducted with two junior high schools, 7-9th grades, and two senior high schools 10-12th grades, in the county area being researched. Their selection was made to represent a cross-section of the total districts in the county from a socio-economic standpoint, as well as population and geographic location, rural and urban.

The second set of questions aforementioned were specifically formulated to be used by the researcher in acquiring information from the student population in the county. This portion of the research was separate and apart from the Drug Abuse Committee, and had been started prior to the formation of the committee. This instrument was devised and categorized on the following basis:

1. The age of the student being surveyed.
2. Sex--male or female.
3. Present grade--7 through 12.
4. Present grade average--A to E.
5. With whom living.
6. Amount of church attendance during past year.
7. Dating frequency.
8. First experience with drug misuse.
9. Questions with frequency of use.
10. Questions concerning materials used (drugs, alcohol, deleriants, etc.)
11. How the subject would describe himself--physically, mentally.
12. Questions regarding social status.
13. Questions regarding school extra-curricular activities.
14. Number of times expelled or suspended.
15. Questions dealing with area in which subject resides.
16. Subjects family income (estimated).
17. Questions regarding family relationship (father, mother, brothers and sisters).

PRESENTATION OF DATA

The four schools used in this study (two senior high schools and two junior high schools) were chosen according to their geographic and socio-economic areas to represent a sampling of the school population in the County of Oakland. These classifications were arrived at by the use of Bressers

Cross Street Index[27] and the Talus Report, 1968.[28] The questions were given to 245 junior high students, and 275 senior high students. These samplings represented as much as time would allow, the population of the twenty-eight districts in the county. The socio-economic and educational factors were determined by the questionnaire instrument and the following figures.

	Rating	Property Value	Disposable Income
Highest Wealth Zone	A	$37,500 & over	$15,500 & over
Medium High	B	30,000	12,500
Medium	C	22,000	9,500
Medium-low	D	17,000	6,500
Low	E	13,000 & less	5,500 & less

	Income	Mean Education
High School A	$12,500 & over	12 - 15 years
High School B	9,500-10,500	9 - 12 years
Junior High C	12,500 & over	12 - 15 years
Junior High D	9,500-10,500	9 - 12 years

The income was based only on the head of the household, not including income from working mothers. The mean education was also that of the head of the household. Schools B and D are in less populated areas with some farming with medium to medium-low income whereas A and C are predominantly urbanized medium-high to high income areas.

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[27] Bresser's Oakland County Cross Index (Detroit: Walter Bresser & Sons, 1967-69), p. 4.

[28] TALUS (Detroit Regional Transportation and Land Use Study), 1968, pp. 3-9.

STATISTICS

Table I represents the first phase of the study as to the number of drug users, other than for medical reasons, in the schools surveyed. As can be seen, School A[1] has a drug using population of 35%; School C[1] has a drug using population of 33%; School B[2] has a drug using population of 21%; and School D[2] a drug using population of 19%. According to these figures, schools in more populated areas with a higher socio-economic factor tend to have a higher rate of drug users.

TABLE I

FREQUENCY OF DRUG USERS BY SCHOOL

School	N	Non-Users	Users	% Users
A[1]	135	88	47	35
B[2]	140	111	29	21
C[1]	125	84	41	33
D[2]	120	97	23	19

The second phase of the study deals with the frequency of drug use by the sampling. At the high school level, 69 per cent of the drug users fall into the categories of experimentation or that of the occasional user, whereas 35 per cent are frequent users. At the junior high level of use, 76 per cent fell into the categories of

experimentation and occasional users, with 22 per cent listed as frequent users.

TABLE II

FREQUENCY OF DRUG USE

Type of User	High School		Junior High School	
	N	%	N	%
Experimenter	35	47	29	45
Occasional User	16	22	20	31
Frequent User	26	35	14	22

Table III compares School A with another high school with similar suburbia aspects and socio-economic factors. As can be seen, percentage rankings are quite similar, with little significant difference in the distribution of frequency of use of drugs by the students in each school. Neither is there any appreciable differences in the extent of use.

Table IV concerns the type of drugs, other than alcohol and deliriants, being used in the four schools under study. As can be seen from the table, marijuana ranks the highest in usage by both junior and senior high users. Amphetamines also are high in usage, followed by

TABLE III

COMPARISON OF DRUG USE BETWEEN HIGH SCHOOL A AND ANOTHER HIGH SCHOOL Z WITH SIMILAR FACTORS

Non-Users		Experimenter		Occasional User		Frequent User	
N	%	N	%	N	%	N	%
88	65	20	15	8	6	19	14
104	68	19	12	11	7	19	12

TABLE IV

TYPES OF DRUGS BEING USED JUNIOR AND SENIOR HIGH

Types of Drugs	Senior High		Junior High	
	N	%	N	%
Marijuana	65	84	48	77
Amphetamine	42	55	29	46
Barbiturate	15	19	17	27
Heroin, Morphine, Cocaine	9	12	11	17
LSD, DMT, Mescaline	30	39	24	38

LSD-DMT. Barbiturates, heroin, and morphine and derivatives are much less in use.

Table V investigates the use by students in grades seven through twelve of drugs, alcohol, and deliriants. Alcohol included beer and wine. Interpreting these percentages it is apparent that the use of alcohol in various

forms is much more extensive than either drugs or deliriants in all classes. Drugs seem to be more used by the upper classmen of each type of school. Though deliriants are used, the extent is not as high in the high school as other substances. Usage at the seventh grade level indicates an ease of acquiring the material for sniffing. They have not made their contacts for acquisition of other substances to any large degree. Once again, it can be noted as to the comparative aspects of drug use between the top class of junior high (9) and senior high (12).

TABLE V

MISUSE OF DRUGS BY GRADES--ALL FOUR SCHOOLS

Grade	N	Drugs		Alcohol		Deliriants	
		N	%	N	%	N	%
7	75	9	12	34	45	12	16
8	83	12	15	46	56	10	12
9	87	28	32	56	65	17	20
10	83	12	14	42	51	12	15
11	92	18	20	59	64	9	10
12	100	37	37	72	72	18	18

Table VI investigates the comparison of the three types of drug misusers with student non-users at the senior high level. Use of Chi Square was made. Probability levels are shown for significant differences. NS stands for non-significance.

TABLE VI

DIFFERENCE BETWEEN NON DRUG USERS AND THE THREE TYPES OF USERS--HIGH SCHOOL

Variables	Experimenters (N=35)	Occasional Users (N=16)	Frequent Users (N-26)
Sex	NS	NS	.05
Grade in School	NS	NS	.10
Grade Mark	NS	NS	.01
Live with	.01	.01	.01
Church Attendance	NS	NS	.05
Dating Frequency	.01	.10	.01
Self Confidence	NS	NS	.01
Extra Curricular Activities	NS	NS	.01
School Suspension	.01	.05	.01

Table VII presents the results of the drug using population at the junior high level as compared with the non-using population. As in the high school survey, differences show up between the different types of drug users.

TABLE VII

DIFFERENCE BETWEEN NON DRUG USERS AND THE THREE TYPES OF USERS--JUNIOR HIGH

Variables	Experimenters (N=29)	Occasional Users (N=20	Frequent Users (N=14)
Sex	.05	NS	.01
Grade in School	NS	.05	.05
Grade Mark	.01	.01	.01
Live With	.05	NS	NS
Church Attendance	NS	NS	NS
Dating Frequency	.01	.01	.05
Self Confidence	NS	NS	NS
Extra Curricular Activities	NS	.05	.01
School Suspension	.05	.01	.01

Table VIII deals with the description of the types of drugs used by age and sex as reported by the law enforcement agencies of Oakland County answering the survey. Ages ten through twenty-one were broken down to indicate the sex of the drug misuser, the total number of users and the particular drug being misused.

Table IX is the assessment of the total drug abuse contacts of the 60 per cent of the law enforcement agencies answering the survey, for the years 1967, 1968 and 1969. All age groups are shown. A definite increase

TABLE VIII

DISTRIBUTION OF TYPES OF DRUGS USED BY AGE AND SEX
LAW ENFORCEMENT, 1969

Age	Sex		N	Marij.	Amph.	Barb.	Mesc. DMT. LSD	Deler.	Heroin	Tranq.	Cough Syrup
	M	F									
10	5	1	6		1			2			3
11	12	2	14	2	3	2		6			1
12	15	2	17	5	5	2		5			
13	16	3	19	9	3	3		4			
14	30	5	35	18	9	2	4	1	1		
15	32	6	38	26	6		6				
16	47	8	55	31	2	3	12	1	6		
17	66	13	79	43	6	4	12	2	12		
18	64	12	76	45	9	7	5	5	4	1	
19	66	15	81	43	10	8	6	7	3	4	
20	62	11	73	44	12	10	4	2	1		
21	66	14	80	48	15	2	9	3	3		

in usage contacts appeared from the 73 contacts made by law enforcement agencies in 1967 to the 601 contacts in 1969

TABLE IX

OAKLAND COUNTY LAW ENFORCEMENT AGENCIES
TOTAL DRUG ABUSE CONTACTS
(60% ANSWERING SURVEY)

Year	All Ages Number of Contacts
1967	73
1968	286
1969	601

Table X assesses the disposition of drug misuse cases for 1969 by law enforcement agencies reporting in the survey. Of the 601 total contacts, 374 were referred to court, 37 to social agencies, 4 to medical doctors, 12 to psychiatrists, 16 for hospitalization, 7 referred to clergy, 88 were warned and released, 54 cases are pending, and 9 were released to their parents.

Table XI deals with six law enforcement agencies reporting a cross section of the total county agencies and also a cross section of the population and socio-economic factors. Departments A, B and C are from the urbanized upper median income bracket. Departments D, E and F represent a cross section of the county in the more rural, less populated areas with a medium to lower-medium income.

TABLE X

LAW ENFORCEMENT DISPOSITION OF 1969 CASES
OF MISUSE OF DRUGS

Disposition	Number
Court Disposition	374
Social Agencies	37
Medical Doctors	4
Psychiatrists	12
Hospitalization	16
Clergy	7
Warned and Released	88
Pending	54
Released to Parents	9
TOTAL	601

TABLE XI

SIX LAW ENFORCEMENT AGENCIES
TOTAL CONTACTS, ALL AGES

Department	1967	1968	1969
A	19	76	243
B	19	58	90
C	3	39	68
D	0	3	17
E	3	12	25
F	0	1	5

Table XII deals with Departments A, B and C and the types of area they represent as regards the distribution of materials used in drug misuse primarily by youths 17 years of age and under. Types of abused materials are marijuana, amphetamines, barbiturates, LSD-DMT, mescaline, heroin and deleriants. Once again these three departments represent the upper medium income groups.

TABLE XII

THREE LAW ENFORCEMENT AGENCIES
DRUG MISUSE CONTACTS, 1969

Drug	Department		
	A	B	C
Number, 17 and under	84	34	44
Marijuana	42	19	23
Amphetamines	9	6	5
Barbiturates	5	2	3
LSD, DMT, Mescaline	8	4	6
Heroin	8	2	4
Deleriants	12	1	3
Number, 18 and over	159	56	24

Table XIII deals with Departments D, E and F and the types of area they represent as regards to the distribution of materials used in drug misuse primarily by youths 17 years of age and under. The types of abused

materials are the same as used in Table XII. These three departments represent a rural, some farming, less populated medium to lower-medium income zones.

TABLE XIII

THREE LAW ENFORCEMENT AGENCIES
DRUG MISUSE CONTACTS, 1969

Drug	Department		
	D	E	F
Number, 17 and under	11	16	4
Marijuana	2	6	3
Amphetamines	4	4	
Barbiturates		1	
LSD, DMT, Mescaline	2	2	1
Heroin	1	1	
Deleriants	2	2	
Number, 18 and over	6	9	1

Figure 1 is a graph of the total drug abuse referrals made to the probate court, juvenile division, of Oakland County for the years 1967, 1968, and 1969. The information shown by the graph deals with both sex and the number of referrals.

Figure 2 is another graph indicating, in another fashion from Figure 1, the same information as to the

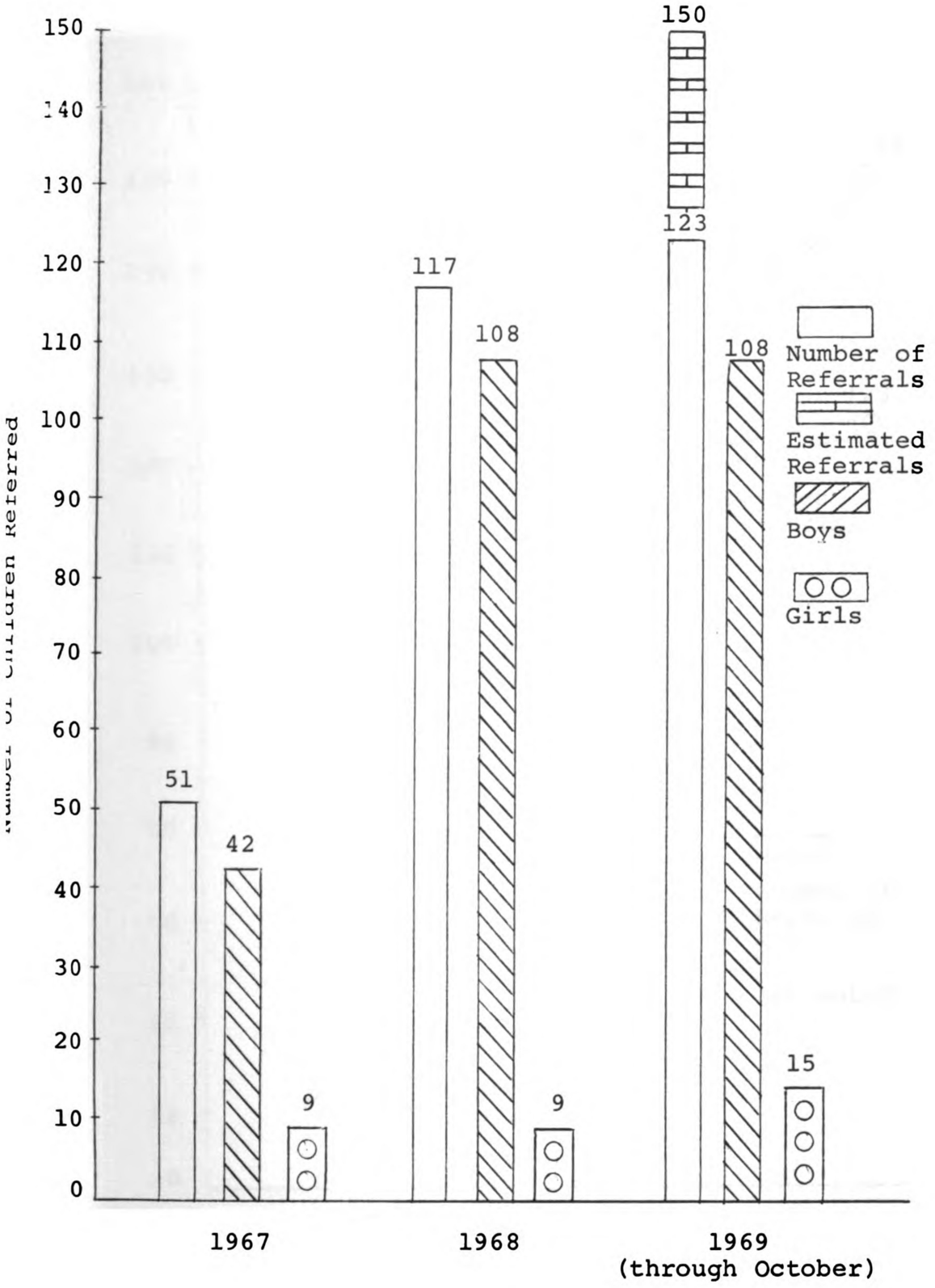

Figure 1. Probate Court: Juvenile Division, Drug Abuse Referrals.

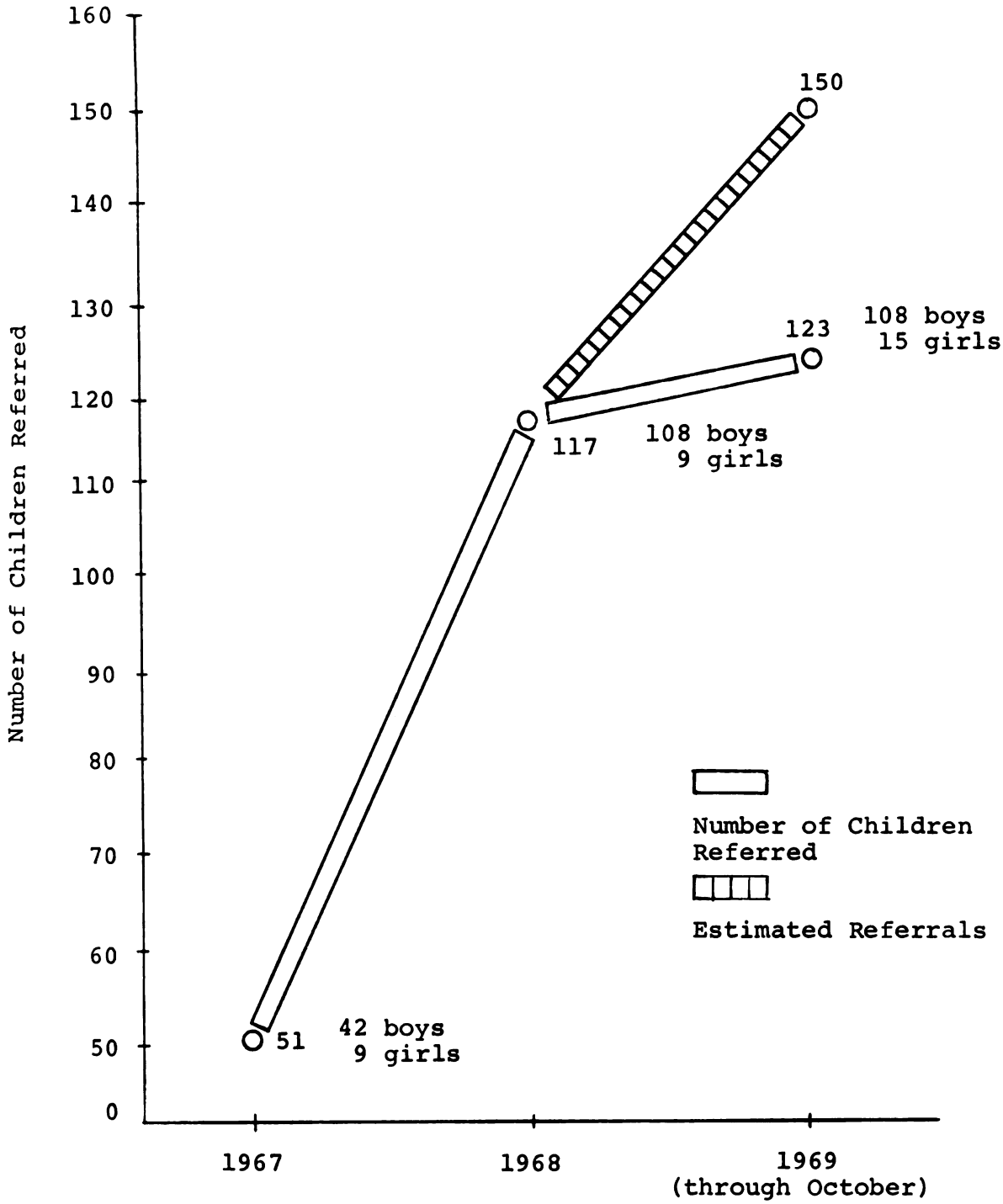

Figure 2. Probate Court: Juvenile Division, Drug Abuse Referrals.

number of males and females referred to this court for 1967, 1968, and 1969.

Figure 3 is from the Probate Court, Mental Health Division. The graph depicts the number of referrals to this division and the sex of these referrals for the years shown. Also noted in this graph are the estimated number of referrals for the same years.

Figure 4 indicates similar information as Figure 3 as to the number of referrals and number of estimated referrals to the Mental Health Division of the Probate Court and the sex of said referrals for the years 1967, 1968, and 1969.

Table XIV is the Circuit Court assessment for 1967 showing the number of referrals, the sex and age of those referrals. The distribution of the types of drugs misused are shown. The charges brought against these misusers were in the following categories: unlawful use of narcotics, possession of narcotics, fraudulent obtaining of narcotics, possession of heroin, possession of marijuana, and possession of dangerous drugs.

Table XV is the Circuit Court assessment for 1968 showing the number, age, and sex of drug misusers. Charges brought against these persons were: unlawful use of narcotics, possession of narcotics, fraudulent obtaining of narcotics, possession of dangerous drugs, attempted possession of narcotics, violation of hypnotic drug act.

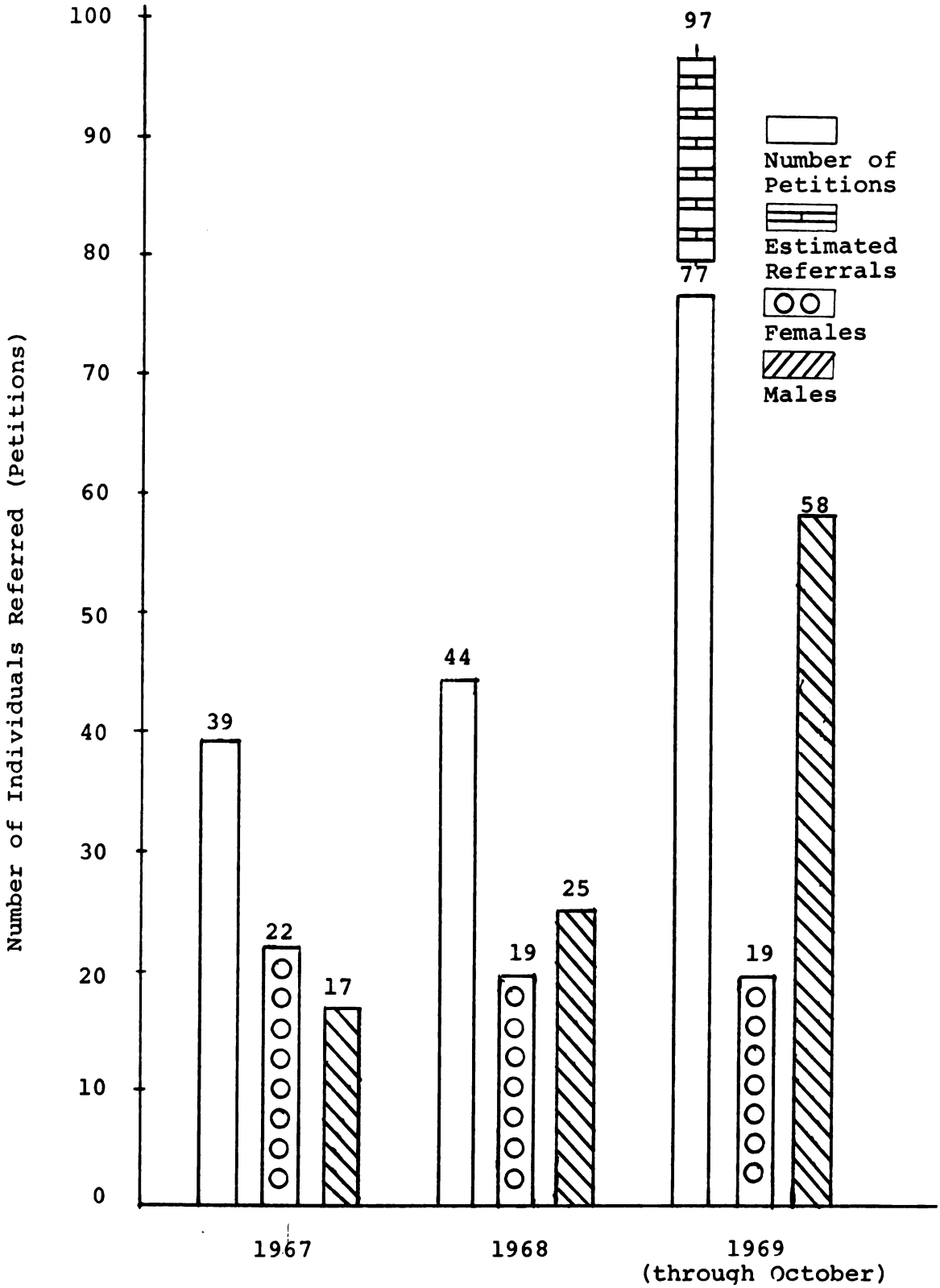

Figure 3. Probate Court: Mental Health Division, Drug Abuse Petitions.

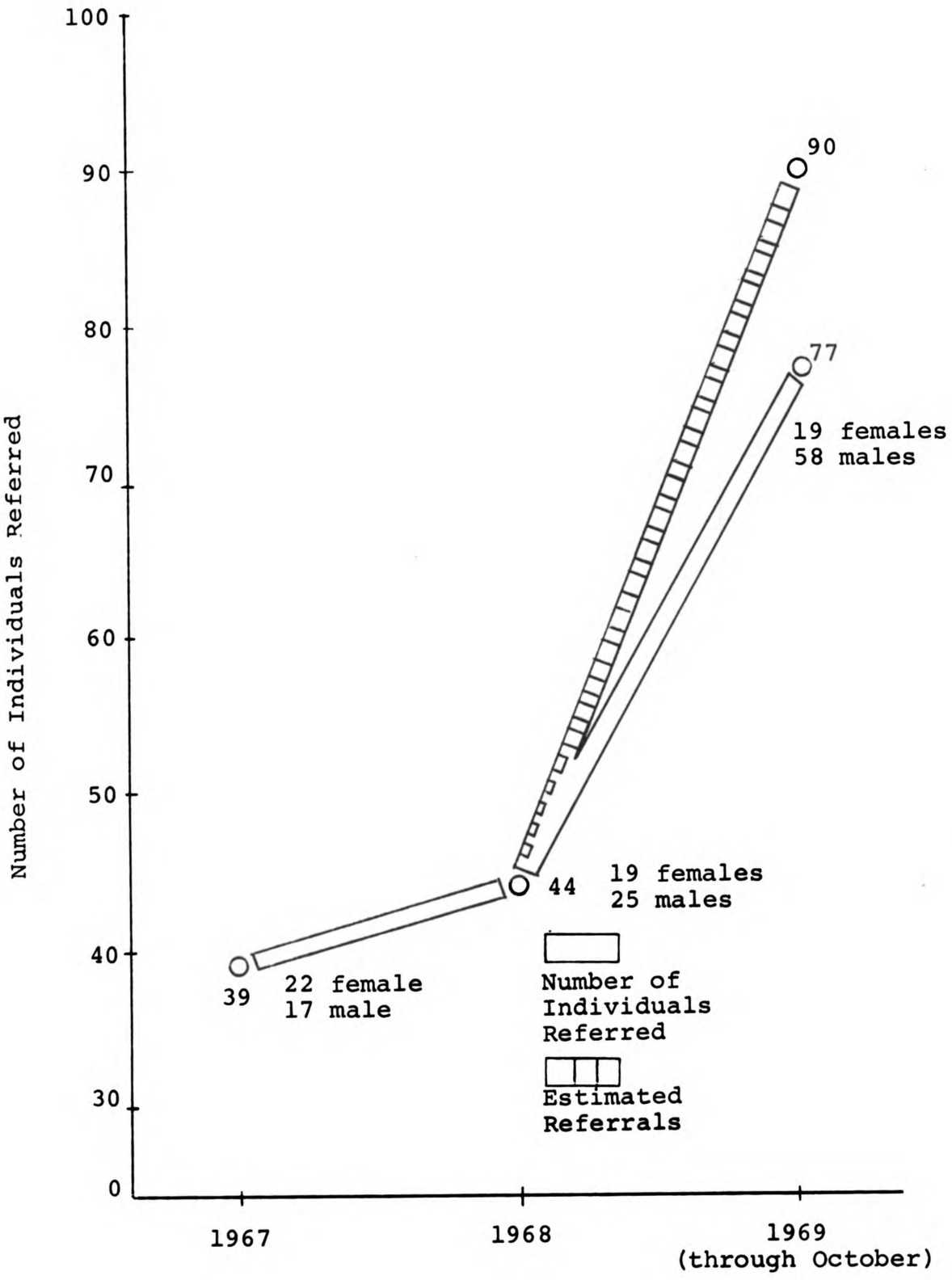

Figure 4. Probate Court: Mental Health Division, Drug Abuse Petitions.

TABLE XIV

CIRCUIT COURT ASSESSMENT, 1967

Age	Sex		Unlawful Use of Narcotics	Possession of Narcotics	Fraudulent Obtaining Narcotics	Possession of Heroin	Possession of Marijuana	Poss. Danger. Drugs
	F	M						
17-21	1	5	1	5				
22-30	0	2		2				
31-40	0	3	2		1			
41-50	0	2		1		1		
51-60	1	1	1	1				
TOTALS	2	13	4	9	1	1		

TABLE XV

CIRCUIT COURT ASSESSMENT, 1968

Age	Sex		Unlawful Use Narc.	Poss. of Narc.	Fraud. Obtain. Narc.	Poss. Heroin	Poss. Marij.	Poss. Danger. Drugs	Attempt. Poss. Narc.	Viol. of Hypnot. Drug Act
	F	M								
17-21	3	20	4	10	1		5		2	1
22-30	1	12	5	5	1		1		1	
31-40	0	4	3						1	
41-50	1	2	1	1				1		
51-60	0	0	—	—	—		—	—	—	—
TOTALS	5	38	13	16	2		6	1	4	1

TABLE XVI

CIRCUIT COURT ASSESSMENT, 1969

Age	Sex		Unlawful Use Narc.	Poss. of Narc.	Poss. of Heroin	Poss. of Marij.	Poss. of Danger. Drugs	Attempt. Posses. Narc.	Viol. Hypnot. Drug Act	Sale of Narc.	Sale of Hal. Drugs
	F	M									
17-21	8	81	23	43	1	5	3	4	1	3	6
22-30	3	35	15	15			1	5	2		
31-40	1	3		2					2		
41-50	1	4	1	2				2			
51-60	0	3	2						1		
TOTALS	13	126	41	62	1	5	4	11	6	3	6

Table XVI (p. 47) is the Circuit Court assessment for 1969 showing the number of misusers of drugs, by age and sex. It shows the distribution of the cases according to the various charges brought against them. The charges were: unlawful use of narcotics, possession of narcotics, possession of heroin, possession of marijuana, possession of dangerous drugs, attempted possession of narcotics, violation of hypnotic drug act, sale of narcotics, and sale of hallucinogenic drugs.

Table XVII is the Probate Court, Mental Health Division, assessment of the cases of drug misuse for the years 1967, 1968, and 1969 by age and sex.

TABLE XVII

PROBATE COURT MENTAL HEALTH DIVISION
CASES OF DRUG MISUSE

Age	1967		1968		1969	
	Male	Female	Male	Female	Male	Female
Under 17	0	0	0	1	4	3
17-21	5	1	14	7	30	7
Over 21	12	21	11	11	24	9
TOTALS	17	22	25	19	58	19

Table XVIII is the juvenile and circuit courts assessment for drug misuse contacts for 1967, 1968, and 1969 indicating the number of abusers for each year and the sex of these abusers. As shown by this table the male users for these three years was 82 per cent of the total, the female users 18 per cent.

TABLE XVIII

JUVENILE AND CIRCUIT COURTS
DRUG MISUSE CONTACTS

Year	Number	Male	Female
1967	105	72	33
1968	204	171	33
1969	374	322	52
Per Cent		82	18

DATA ANALYSIS AND INTERPRETATION

Interpretation of Information of Schools Surveyed

The amount and frequency of the misuse of drugs in the schools from the data collected is extensive. If one were to project the figures received in the sampling to the total county junior high and high school population,

105,882 in 1969,[29] it would indicate that 23,294 or 22 per cent of the school students have used or are using marijuana in one form or another. Alcohol, including beer and wine, has been or is being used by 62,740 students, or 59 per cent. Amphetamines are running third in the usage of the three.

The frequency of users seems greater in the more populated, higher socio-economic areas than in the rural middle to lower-middle class areas according to Table I. It also appears from Tables VI through XVIII that males are more involved in drug misuse than females.

As shown in Table II those experimenting at the junior high level rank close to the experimenters at the senior high level. The occasional user at the junior high level is slightly higher, with the frequent user at the junior high level less than the senior high level ranking of frequent users. One could speculate as to the probability of the high school having an increase in frequent users when this 22 per cent reaches the eleventh and twelfth grades, where a tendency towards peer grouping takes place in the frequent user category as shown later.

Table III shows a comparison between School A and another high school Z in the county. Both schools were located in the upper medium income area with similar higher

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[29]Statement by Secretary, Oakland Schools, personal interview, March 12, 1971.

population and geographic factors. Percentage rankings were quite similar with little significant difference in the distribution of frequency of use of drugs by the students in either school. There was no appreciable difference in the extent of use either. The figures for high school Z were compiled in a previous survey and noted in the drug abuse committee study.[30]

Table IV depicts the kinds of drugs other than alcohol and deliriants being used in the four schools surveyed. Marijuana ranks highest in usage in all schools followed by amphetamines. This table indicates a lower rate of usage of barbiturates, heroin and morphine by all schools, than marijuana and amphetamines. LSD, DMT and mescaline ranked third in usage.

Table V indicates that the frequent users tend to be a homogeneous group in that they are mostly upper classmen of their particular schools. Frequent users tend to form a group where drugs are the accepted thing and play an essential part in the way they live. As Dr. Ralph Rabinovitch, of Hawthorne Center, stated during an interview with the writer: "These people are a part of a subculture that is with us today, and most likely will be for years to come."[31] Due to this in group feeling, the aspect

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[30]Oakland County Drug Abuse Committee Unpublished Report, 1970, p. 41.

[31]Statement by Dr. Ralph Rabinovitc, Director of Hawthorne Center, personal interview, February 24, 1970.

of self-confidence is heightened due to the favorable sanctions of their peers.

The use of alcohol and deliriants was explained in Table V. The use of deliriants did not seem to be a great deal more in one class than another. It is a problem of serious proportions since there have been several deaths reported in the County in the past three years that are directly attributed by the authorities to the inhaling of these fumes. However, only a small number of the total tested indicated a steady use of these materials. Alcohol, on the other hand, is used a great deal (usually in beer or wine form) by a large number of students, both junior and senior high levels. There could be various reasons for this, such as noted by the students in the self-reporting survey. One of the most common reasons they gave for preferring alcohol was that their parents used it quite often and didn't seem to get into too much difficulty, and that if their parents can do it, why can't they. They see what they want to see, read what they want to read, and hear what they want to hear--the severity of alcohol abuse statistics not withstanding.

It is apparent too that alcohol is one of the least expensive materials and that at the same time easy to come by. There is another factor that must be considered. The writer interviewed many officers from various departments as to the use of alcohol by the young people encountered

in their jurisdictions, and has accompanied county and local enforcement officers in their work, thus witnessing what is taking place in this regard. The police in the county have let up on efforts to apprehend teenagers for using beer and wine. They have admitted a preference on their part for the youngsters to use these substances as opposed to the use of drugs. This does not mean they are turning their heads when they observe the use of alcohol, but rather that there is not a concerted effort to arrest the alcohol users. Beer parties, grassers, and the like are merely disbanded by the officers and the youths sent on their way. Thus it is that the young people noted it was much easier to use alcohol without being apprehended than when they are caught using drugs. Since this study was made other research indicated users of alcohol materials were also inclined to use marijuana.[32]

Table VI shows the comparison of the three types of drug misusers with student non-users at the senior high level, using Chi Square. Probability levels are shown for significant differences. "NS" stands for non-significance. The table indicates that the types of drug users differ significantly from the non-user as to who they live with. The user does not live with both parents, in dating frequency the user seems to date more frequently, and the

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[32]Bogg, Smith and Russell, op. cit., p. 156.

user is more susceptable to expulsion or suspension from school according to the findings. The reader should also note that the frequent user differs from the non-user not only in the aforementioned variables but significantly in the following variables in order from the chart: sex, the frequent user more often being male; grade, the frequent user being in a higher grade; grade marks, the frequent user having lower grades; church attendance, the frequent user attending less often; confidence, having a higher degree of confidence; school activities, the frequent user tending to not be involved in extra-curricular activities. From the above, the frequent user apparently has a behavior pattern unlike that of the non-user, or even the occasional user and the experimenter.

Table VII presents the results of the drug using population at the junior high level as compared with the non-using population. As in the high school survey, differences show up between the different types of drug users. The sex ratios show a predominance of males in the experimenter-frequent user area, but little difference in the occasional user. Grade in school is not significant with experimenters but is for the occasional and frequent users. The grade mark is significant in all three types. As for who they live with, the experimenter shows a tendency to live less often with one or both parents, whereas the other two types show no significance. As in

the high school table, dating frequency is increased on the part of drug users or non-users. Unlike the high school, the frequent user at the junior high level shows no significant variation from the non-user as regards self-confidence. In extra-curricular activities there was no significant difference between the experimenter and the non-user. However, there was an appreciable difference between the occasional user, the frequent user and the non-user. As in the high school survey all three types tended to be more susceptible to suspension from school as a result of their use of drugs than the non-user.

A theory quite applicable to this writer's findings in his research is that drug users tend to be those students who do not feel a part of the society or community in which they find themselves, in or out of school. This applies to both the junior and senior high school students. This pattern was shown in the previous tables, where the frequent drug users were involved in the higher suspension rates from school, lower grades, and fewer extra-curricular activities. These same differences correlated with the frequency of drug use at both levels of education.

The problem, therefore, seems to be one for a certain number of those students who either cannot or will not adapt to the established norms of the society in which they live, and thus attempt to form their own societies, which, as stated before, sanction the misuse of drugs. It

is a need for everyone to feel a part of the whole, especially while young and constantly searching for meaningful values. Thus it is necessary for those who are able in society, through whatever means available, to foster programs that these young people can relate to in a manner which will satisfy their most innate need, that of belonging without the misusing of drugs.

Interpretation of Results from Law Enforcement and Judicial Survey

The instrument sent to the municipal, county, and state law enforcement agencies of Oakland County resulted in a response from approximately 60 per cent of the agencies. Forty per cent were reluctant to furnish the desired information due to their desire to maintain their contacts with drugs/narcotics in a confidential manner.

As stated previously, telephone notification preceded the questionnaire, and when the writer had an opportunity to converse with involved officials as to the extent of the problem in their given areas he did so. He also had an opportunity to discuss the problem with several judges in the county area, who also received and answered the questionnaires.

That drug misuse contacts are on the increase generally throughout the county, is attested to by the following information.

Data compiled from the juvenile and mental health division of the probate court, and the circuit court, along with the information from several law enforcement agencies bears this out. In 1967, Table IX indicates 73 contacts by the police with drug misusers. In 1968, there was an increase of 213 cases in the number of contacts. From 1968 to 1969, an increase of 315 occurred, or 528 more than in 1967. The population of the county increased from 865,000 in 1967 to 920,000 in 1969.

At the same time, the probate court, juvenile and mental health division, indicated an increase of contacts with drug abusers, Figures 1, 2, 3 and 4, as follows: 1967, 90 cases of drug misuse; 1968, 161 cases, 1969, 235 cases. The circuit court indicated for the same period of time the following: 1967, 15 cases of drug misuse; 1968, 43 cases; and 1969, 139 cases (Tables XIV, XV, and XVI). Thus, those drug abuse contacts reaching court action numbered 105 in 1967, 204 in 1968, and 374 cases in 1969 (Table XVIII). It can be noted here that of these cases, 118 or 18 per cent were females, and 565 or 82 per cent were males (Table XVIII). This preponderance of males to female usage is borne out in the educational survey and the table of cases of 60 per cent of the agencies for law enforcement of the county which returned the questionnaire.

It is apparent from Tables XI, XII, and XIII that there is a relationship between the amount of drug abuse and the socio-economic area which a particular law enforcement agency serves. Though there is a certain amount of contact with transient subjects, it appears that more drug misuse takes place in the more urbanized upper-middle income areas than in the less populated rural middle to lower-middle income areas. This corroborates the educational survey.

There is also an indication from Table VIII that ages 14 and 17 are peak phases of various drug using groups, suggesting a peer relationship which condones the use of various drugs similar to the education analysis. Since 13-15 is the mean age of ninth graders at the junior high level, and 16 to 18 for senior high, the three agencies surveyed tend to corroborate each others figures to some degree. As noted by law enforcement agencies, some of the reasons given by drug abusers when contacted by them were those of disenchantment with their present life, a wish to be with the "in group" of their peers, and general rebellion against parental influence. Several indicated an interest in the profit involved in selling.

An assumption that drug misuse to the level of fostering criminal action is placed at the age range of 15 to 21 is partially attested to by court Tables XIV, XV, XVI and XVII. In every graph and table, 17 to 21 is the

highest incident range of contact with the courts. Tables XIV, XV, and XVI show the highest rate of contact with the circuit court at 17-21. Agency officials stated that certain crimes were committed while under the influence of certain drugs, such as breaking and enterings, larcenies, auto thefts, and high speed chases. It was also stated that some of these crimes were committed while not necessarily under the influence, but to acquire materials to sell in order to buy their particular type of drug. Time would not permit a detailed check of the records to corroborate this information both on the part of the writer and that of the police officials and the courts. It was also apparent that the type of data in writing needed by the researcher was not any longer available for the previous years of 1967 and 1968 since these records numbered in the thousands, and in some cases inaccurate and incomplete records had been kept.

The assumption that the misuse of drugs is a part of a sub-culture in our society is attested to by both the educational and law enforcement reports and tables, and in the interviews with selected officials, such as Dr. Rabinovitch of Hawthorne Center. He stated that if this were a 3 per cent sub-culture, then society would have to learn to live with that 3 per cent accepting it for what it is, a manifesting of deviancy upon the part of certain peoples who cannot or will not attempt to accept the social

norms that are presently in existence in their given household, community, and total environment. Their way is not to constructively work toward the attainment of new goals in the present structure, but rather to band together, formulating their own concepts and standards and literally ignoring any others. The fact that in so doing, they tend to clash with existing standards is of little consequence even to the point of breaking the law, which they feel is unjust in most all respects.

Thus, at the Center, due to Dr. Rabinovitch's firm beliefs, those who have and are misusing drugs are told from the outset if they want help they will get it. In getting that help they must meet and accept rules laid down by the Center. They use no drugs, except in rare cases where the staff doctor recommends it. Hair must be trimmed and bodily hygiene is rigidly enforced. Schedules of classes, both vocational and academic, are followed specifically. These are but a few of the ways in which enrollees at the Center must conform. They are informed what each person entering the Center is expected to do, and not to plan to stay if this is not their intention, as the Center has neither the time, space or money for providing a temporary home for those experiencing a bad trip and are merely seeking relief for their condition. Young people are cut off from parental influence for a time in order for the Center to have its fullest affect on

them. Dr. Rabinovitch estimates little can be done for anyone in a stay short of one year in duration. He would not attempt to give any statistics as to the rate of recidivism or the percentage of success or failures achieved by the Center.[33]

Over these years surveyed and previous years by other reports, it is apparent that the most common disposition of abusers by law enforcement agencies is court action (Table IX). For many years the problem of the misuse of drugs has been placed squarely in the hands of law enforcement personnel to deal and cope with as best they could. It is apparent from the continued increase of usage and the number of contacts by various community agencies, that the methods used by enforcement agencies have not been highly successful. Very little has been done in the area of prevention of drug misuse, but rather the emphasis has been on apprehension. Some have felt that in apprehending those who sell and use drugs illegally, they have curbed immeasurably its use by the rest of the society. As the data shows, this has not been the case. Even law enforcement agencies admit that when they bottle up the source by these methods at one point, it springs forth from some other point.

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[33]Statement by Dr. Ralph Rabinovitch, Director of Hawthorne Center, personal interview, February 24, 1970.

The courts on the other hand, have tried various methods of disposition, such as psychiatric aid, probation, and protective services with some success. However, the courts time and money are limited. There must be found a way of reaching the drug misuser other than law enforcement and court action. Though these two must be an integral part of any on-going program, other sources of assistance must be found in order to get at the sociological, mental roots of the problem.

In the closing part of this study, the writer will propose some possible programs for consideration.

CHAPTER III

DRUG MISUSE PROGRAM DEVELOPMENT
COUNTY CENTRAL AND LOCAL
COMMUNITY LEVEL

In the county structure lies the services available for the needs of the people in the community, and the effectiveness of these services depends entirely on how well the existing agencies meet these needs. To prevent overlapping of policies and procedures on the part of these agencies, effective organization must take place. This involves the cohesion of different aspects of various agencies into a system through which authority, coordination and control may be exercised. Probably the two most important aspects of organization of a community drug abuse program are coordination and leadership. In acquiring these, all interest groups in the community should be involved, such as educational, enforcement, medical, judicial and other community agencies, professional workers and organizations.

GOALS AND OBJECTIVES: THE COUNTY CENTRAL PROGRAM

The county should establish and develop a total service program to deal effectively with the problem of drug abuse in the county. The program should be so comprehensive in nature that it would provide diagnosis and treatment of individuals abusing the use of drugs and narcotics. It should also serve as a drug and narcotic training source for the county that will be supported by on-going research to determine the program's effectiveness as well as program coordination for the county. Pursuant to enabling each community of the county to develop drug abuse activities, a network of facilities and programs should be encouraged for community development. These community programs would be coordinated and assisted by the Central County Activities.

The purpose of this plan is to provide a conceptual model for facility and program development in drug use control activities at the county level.

Inherent in this plan is a concept that drug use is a symptom of social ills. As crime in the streets, need of medical care, housing, and employment, drug use control must be based on human needs. This plan proposes that the county create a high level staff to implement the skeletal plan and further design meaningful community programs to deal with community problems. The central

staff of the county will be designed to encourage coordinated community programs to deal with community problems. The county, it is recommended, would subsidize community programs that are developed to meet community needs. It is a known fact that the problems in one community are different from the problems in another community. It becomes most apparent that in dealing with social problems the community must be the doctor. If an appropriate community action program is developed with Awareness Houses, Hilltop Houses, Free Medical Clinics, or Huckleberry Houses (whichever most appropriately meets the community needs), a concentrated community drug caucus will be the banner under which people will unite to deal with community problems--one of which is drug abuse.

The initial operation of a program of this nature would parallel existing community action programs. This is necessary during initial activities in that the newly-created activities (of Awareness Houses, etc.) would bring new blood into the existing establishment and assist the existing institutions to become relevant to current social problems.

The unique method of financing has broad ramifications: if adequately implemented the state can reward counties with subsidies for county-wide action proposals; the county, in turn, can subsidize communities for program development. This approach would enable the community,

county, state and nation to address itself appropriately to the current social issues.

Lastly, this program cannot be detailed in full account--it must be detailed by each community. Additionally, it should be noted that there is no one program that meets all needs. Each program must have built-in alternatives. It is expected that with public involvement the drug activity programs will be sensitive to social needs. Methadone maintenance (at 40 milligrams a day for a highly addicted person at a cost of eight to ten cents per day) may be the answer to one problem, while RARE (Relatives for Addiction and Re-education) may furnish the solution to another.[34] Awareness--to what the problem is, and to what works in programming may be the key to drug use control activities. To this end the plan is developed.

THE COUNTY CENTRAL PLAN

The Facility: Physical Plant

The county should purchase, develop, lease, rent or coordinate the use of a comprehensive facility suitable to implement the total drug abuse abatement program. The facility will be so designed as to accommodate those individuals in the program who have been diagnosed as in-patients.

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[34]Oakland County Drug Abuse Committee Unpublished Report, 1970, p. 63.

It will provide resident accommodations suitable for short or long term occupancy, and a dining facility for meal preparation and food service for those in residence. Indoor and outdoor recreational facilities; areas for medical examinations and related non-surgical medical activities; and rooms suitable for use as educational classrooms should be provided.

The central facility will house the Drug Abuse Repository, as well as provide necessary office space for professional, para-professional and classified staff.

Physical Health Service

In conjunction with County Medical Health Services, a complete medical health service program would be available in the facility designated for drug use abatement. The medical health service should provide the following:

1. Complete health diagnostic service.
2. Complete prescriptive service necessary for this activity.
3. Complete health supervisory service necessary for this facility activity.

Mental Health Service

In conjunction to the activities of County Mental Health Services, the County Mental Health Division would provide the drug use abatement facility with a total mental health service program. The mental health service should provide the following:

1. Complete mental health diagnostic service.

2. Complete mental health prescriptive service, including medication, therapy, and prescribed guidance services.

3. Complete supervisory service of the related mental health programs designed for individuals in the drug use abatement program.

4. Emergency service facilities necessary for this service facility.

5. Complete health service supervisory service for the medical service related activity.

Client Induction

Individuals involved in the drug use abatement program would be identified through numerous sources. When appropriate:

1. The various courts in the county may assign individuals to the drug use abatement facility for diagnostic, treatment and educational programming.

2. Guardians may refer individuals to the drug use abatement program.

3. Individuals may refer themselves to the drug use abatement program.

4. Individuals may refer known drug abusers to the drug abatement program.

5. The referring of individuals to the drug abatement program is continually understood to be defined as a mutually agreed upon alternative to continued drug use.

Housing Facility

The facility designated as the center for the county-wide drug abatement program should accommodate

fifty individuals in appropriate facilities. The following guidelines are suggested in locating this facility.

1. The nature of individual housing in this facility is to be considered short range and exists primarily as a supportive service to evaluation processes.

2. The housing facility function will be to provide short range housing until the individual's diagnostic and prescriptive phase is complete.

3. As a support facility, the housing service will provide emergency housing to individuals at this time of crisis.

4. The continual nature of housing in this facility relates to an ongoing evaluation of the drug use problem in the county and the nature of program effectiveness in relation to housing service.

The Prescriptive Service Activity

The county drug abuse facility and program would provide a total prescriptive activity consistent within the recommendations of the Medical and Mental Health Services Recommendations and other staff consultants recommendations. Wherever possible the below listed services would be coordinated through the facility activities in conjunction to the existing staff providing this service in the community.

1. The drug abuse facility and programs will provide individual and group therapy treatment to all individuals identified for treatment.

2. The drug abuse facility and programs will provide group and individual guidance and counseling to all individuals identified for treatment.

3. The drug abuse facility and programs will provide educational programming and planning to all individuals identified for treatment. The high school programming will provide credit-course accessibility in conjunction to the high school district wherein the facility is located.

4. The facility and programs will provide physical activities to all individuals identified for treatment.

5. The facility and programs will provide cultural activities to all individuals identified for treatment.

6. The facility and programs will provide vocational and educational planning to all individuals identified for treatment.

7. The facility and programs will provide work experience programming to all individuals identified for treatment.

8. The facility and programs will provide supervised activity (probation life) to all individuals identified for treatment.

9. The drug abuse activity and programs will provide supportive life experience (family counseling) to all individuals identified for treatment.

10. The drug abuse activity and programs will provide school/college on-site experience to all individuals identified for treatment.

11. The drug abuse activity and programs will provide related supportive-exploratory experiences necessary for a meaningful life to all individuals identified for treatment.

Drug Use Control Repository Service

The county drug abuse facility and program would provide a complete Repository service to schools, agencies, clinics and organizations to assist in the development of

media collections pertaining to drug use control. The Repository service would be so structured as to enable existing libraries and media collection centers to provide this service consistent to the community needs in all areas of the county. The Repository service would include the following:

1. The establishment of complete bibliographic services to appropriate individuals, agencies and institutions.

2. Duplicating services necessary to provide materials to appropriate individuals, agencies and institutions pursuant to the community and/or institution request and needs.

3. The establishment of complete materials collections for "loan service" to appropriate individuals, agencies and institutions within the county area.

4. The availability of a Repository consultant to assist in the establishment of complete bibliographic and materials collection within established centers and necessary new-centers that may be created within the county area.

5. The creation of a mobile drug-lab consistent with Repository materials within the guidelines established by the various governmental agencies for the display and/or transportation of narcotics and drugs as media centers for the various communities and agencies within the county area under the control of the various police and/or governmental agencies as necessary for such media displays.

In-Service Training Programs and Facilities

The county drug abuse facility and program would provide a complete in-service training program and conference center pertaining to drug use control. This

in-service training program will be available to individuals, interested organizations and/or parents, educators, and other people involved in drug use control within the county area. The in-service training program would:

1. Enable parent groups and/or concerned citizens to be more totally aware of the drug use problems in the county.

2. Enable professional and experienced staff in drug use control to have conferences with professional staff in education and/or related services pertaining to drug use control.

3. The entire conference workshop programming to be supportive of the various needs and/or interests of committees and/or organizations dealing with drug use in the county.

Research Program and Activities

The county drug abuse facility and program would provide an on-going research program of activities pertaining to the effectiveness of the drug abuse facility and programs. The research program of activities would attempt to:

1. Determine the effectiveness and meaningfulness of diagnostic and prognostic service.

2. Determine and assess the effectiveness and meaningfulness of all treatment services.

3. Determine the effectiveness and meaningfulness of all repository service activities.

4. Determine the effectiveness and meaningfulness of in-service program activities.

Supportive Field Work Activities

The county drug abuse facility and program would provide a supportive operation of field-work activities and consultative services to various communities, school districts, agencies and operational activities pertaining to drug use control in the county. Various Task Forces would be:

1. Established as the need arises to provide services to schools, communities and/or agencies operative in the county pertaining to drug use.

2. Created from the operational staff of the drug abuse facility and programs to make necessary proposals for county and state-wide legislation and/or judicial action as the need arises.

3. Created of educators to develop educational program recommendations as the need arises pertaining to drug use control both on a county, state and national scene.

Program Adjustments

The entire structure of the county drug abuse facility and programs would be so structured that necessary adjustments could be made in all activities as the need arises and/or requests are forthcoming.

1. The appropriate advisory committees pertaining to drug abuse programming and/or facility operations would have continual feedback from the operations within the county and state to be supportive and responsive to needs as established as the program is operational.

2. The use of new information and/or proposals as the Governor's Report on Drug Abuse will

be incorporated into the programming to further facilitate the implementation of sound programming and facility use pertaining to drug abuse.[35]

Staff Need

To enable the most efficient use of existing professional, para-professional and classified staff in developing and operating a total drug use facility and program, every effort would be made to coordinate activities with existing agencies and programs within the county. Every effort would be made to:

1. Relate to the county medical offices and facilities to enable the most prudent and economic use of existing medical staff.
2. Use para-professionals where possible to assist in program and activity implementation.
3. Use classified staff, where possible, to assist professionals and para-professionals in program and activity design and implementation.
4. Use clients involved in drug use related programs where appropriate in program implementation and general operations.

Immediate Staff Procurement

To enable the immediate beginning of actual programs of drug abuse activities in the county, a Central Staff should be secured as soon as possible. The Central Staff should consist of the following:

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[35] For Your Information (Lansing, Michigan: Governor's Office of Drug Abuse).

1. An Executive Director
2. A Director of Program Planning
3. Clerical Support Staff as needed.

Facility Procurement

To enable the beginning of actual drug abuse programming, the county should establish a facility as an operational center for drug abuse activities. The facility would:

1. House the Central Staff of the drug abuse activity.
2. House individuals as identified in the preceding sections--The Facility through Staff Need.

Operational Programs

To establish a central county drug abuse activity and a network of community action programs the following would be proposed:

1. The county Board of Supervisors shall create a high level office to be primarily concerned with social problems in the county, with initial emphasis on drug abuse activity.
2. The county Board of Supervisors shall appoint an individual to the office with total responsibility to the Board of Supervisors for program design and implementation pertaining to the social problems assigned to the office responsibility.
3. The county Board of Supervisors shall approve the prerogatives of the office of social problems to appoint staff members to various positions, consistent with established procedures and within budget allocations approved by the Board of Supervisors.

4. To enable the office of social problems to begin active programs pertaining to drug use control, the Board of Supervisors should appropriate necessary funds to facilitate appropriate programs in a central facility, and in the participating communities.

5. Funding would be available when a community (Awareness) program is received and approved for implementation by the office of social problems and the drug abuse advisory board.

Community Activity Programming

Recognizing that drug abuse activity is heavily dependent on the socio-economic culture of each community, and that each community must be heavily involved in any program that may be effective in that community, the county should subsidize each community that develops appropriate plans to initiate drug abuse programs. The county shall subsidize:

1. Fifty per cent or one-half of the salary of a coordinator who will be assigned the activity of coordinating drug abuse activities for the community not to exceed $5,000.

2. Each community activity in facility, rental/use, or purchase not to exceed $1,000 each year of operation.

3. Each community activity in faculty operations in an amount not to exceed $500 per year of operation.[36]

Budget Needs and Planning

To assist in budget development, each activity concept would be individually "costed out" to enable broad

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[36]Oakland County Drug Abuse Committee Unpublished Report, 1970, p. 83.

funding opportunities and decision-making pertaining to the feasibility of program implementation. Funds would be sought from every area possible to enable the broadest possible program with the most possible funding ability. The funding can take the form of service, goods, and actual monetary support. Funds would be sought from:

1. Current Federal Acts.
2. National Institute of Mental Health
3. The Federal Bureau of Dangerous Drugs.
4. Federal and State agencies relating to education as Education Acts, i.e., National Defense Student Loans, Work-Study Programs, Economic Opportunity Grants, State Guaranteed Loans, etc.
5. Professional state and national agencies to support drug use related activities as a national demonstration project, and/or county operational project from professional groups as the American Association of Junior Colleges, the American Personnel and Guidance Association, the American Psychological Association, the American Medical Association, and other such related professional organizations and societies.
6. County-wide organizations to support activities as need dictates and groups or individuals volunteer.
7. Numerous other areas: a special effort would be made by the Drug Abuse Committee to seek funds necessary to operate a total comprehensive program.
8. All fund requests and proposals would be evaluated by the Drug Abuse Committee and be submitted to the Human Resources Committee and Board of Supervisors for support and action.

Advisory Committee

To assist the Executive Director of drug abuse activities in relevant community planning, it is recommended that the Drug Abuse Committee serve as an Advisory Committee. The Advisory Committee would assist:

1. The Executive Director in planning and implementing a county-wide drug activity.
2. The Executive Director in community development, and encourage the total drug caucus, composed of community coordinators and community advisory committees in relevant program planning.
3. Perform functions necessary to enable the efficient functioning of all drug related programs.

Executive Director Job Description

The Executive Director of the county drug abuse program would be responsible to the county Board of Supervisors through the established standing committee of the Human Resources. The primary responsibility of the Executive Director would be to coordinate a comprehensive drug use program for the county. The functions of the Executive Director would be as follows:

1. The establishment and supervision of the office of the drug abuse program for the county.
2. The preparation and management of the budget activities as prescribed by the established budget approved by the county Board of Supervisors and procedures established for the county.

3. The total administration and coordination of the county drug abuse program as it relates to liaison activities with established agencies and institutions in the county.

4. The coordination and development of the in-patient program treatment activities in the county facility adopted for the use of drug treatment activities.

5. The coordination and development of the physical health services with appropriate health service agencies in the county.

6. The coordination and administration of activities pertaining to the involvement of county mental health services in conjunction with the drug abuse programs.

7. The development and coordination of procedures with established agencies pertaining to the identification and referral of individuals into drug use control programs.

8. The development and coordination of the prescriptive services of the drug use control programs as it relates to education, physical activities, cultural activities, employment activities, supervisory life (probation) activities, supportive life experiences, and other such activities necessary for a meaningful drug use activity program.

9. The development, coordination and dissemination of repository materials for use in drug use activity programs.

10. The development and coordination of in-service training programs and facilities for such events as established by community needs and/or various institutions or agencies requesting in-service programs.

11. The development and coordination of all research activities necessary to evaluate an ongoing drug use control program.

12. The coordination and development of necessary field work activity as it relates to establishing task forces to resolve individual problems as it relates to judicial needs, state-wide legislation, and county and/or community action.

13. The development and coordination of program adjustments that will be necessary to make the drug abuse control program operational and responsive to human needs.

14. The recommendation of staff personnel (including professional, para-professional and classified) necessary to operate a county-wide drug use control program.

15. The development and coordination of liaison activities within various communities that wish to embark on community-oriented drug abuse activity programs.

16. The preparation of budget needs for the drug abuse activity programs including the preparation of federal, state and local grants as well as seeking private funds to implement the county-wide program on drug use control.

17. The coordination and implementation of drug abuse activities as recommended by the advisory committee designed for drug use control for the county.

18. Perform other such activities necessary to implement a county-wide program on drug use control and as requested by the Human Resources Committee and the Board of Supervisors. This includes the preparation of necessary state and federal reports as well as internal reports necessary for an ongoing evaluation of the drug abuse activity programs.

Director of Community Programs
Job Description

The Director of Community Programs would be responsible to the Executive Director of the county drug abuse program. The primary responsibility of the Director

would be to assist the program development within communities that will be responsive to the community needs pertaining to drug use control. The following would be the responsibilities of the Director:

1. Meet with the various community groups to assist in the development of a comprehensive community-based program pertaining to drug use control.

2. Assist in the establishment and coordination of the activities designed by the community to implement drug use control programs.

3. Assist in the articulation of referrals and/or determining of needs established by community operational programs to be coordinated in the total county drug abuse program.

4. Assist in the development and coordination of systematic programs involving broad participation of professionals and individuals within the community so that consistent procedures might be evoked that are responsive to community needs, and that these programs be exemplary of the most representative of professional judgment.

5. Assist in the development and coordination of evaluation of the community operational programs as it relates to community needs in county-wide program actions.

6. Perform other activities as prescribed by the Executive Director of the county drug abuse program as requested.

Director of Program Planning
Job Description

The Director of Program Planning would be responsible to the Executive Director of the county drug abuse program and would be primarily responsible for

assisting in the design of meaningful programs pertaining to drug use control. In implementing his activities he would perform the following tasks:

1. Arrange in-service training programs to assist community coordinators in planning responsive community recommended programs for action pertaining to drug use control.

2. Arrange for in-service training programs pertaining to the various disciplines of drug use control as, for example, educators, clergy, doctors, counselors, and other such personnel including lay people interested in working in drug use control activities.

3. Assist in the development and coordination of program development for articulating drug use activity programs with various established institutions and agencies within the county.

THE LOCAL COMMUNITY PROGRAM FOR CONTROL OF DRUG MISUSE

Drug use is a symptom of a troubled society. Similar to the issues of housing, employment, education and health care, if we are to deal with these problems, we must help the individual who in turn must help others. The concept proposed is that each community develop a comprehensive program of activities central to drug abuse and unite in a concerted effort to deal with community adjustment. The following procedures will enable the development of a local community program for control of drug misuse.

Community Drug Caucus

It would appear that the most logical sequence to develop any community-wide action is to have a community drug caucus. Hopefully, at such a caucus there will be broad representation of educational leaders, community leaders, various organizational presidents as well as church representation and broad student representation. The entire scope and purpose of the caucus will be to develop a community leadership corps that will assume the function of supporting a broad community commitment. If the end product of the community caucus results in a coordinating council or an advisory board for community-coordinated action, it would be a satisfactory conclusion of the caucus.

A Community Drug Activity Coordinator

It would then be the responsibility of the community-selected advisory board to identify a full-time position of a community coordinator for Awareness Programs. The person should be adequately rewarded financially so that he can devote full time to program establishment by working with young people, organizations and interested parents in determining the community needs and the specific model of a program that will be identified for operation.

Proliferate Programs

This simply reiterates that there is no one workable program to deal with community problems. The kind of program that may be most successful in one case will be easily judged the most inefficient in another. Creative programs have been begun nationally under a therapeutic community concept wherein rap sessions and encounter groups are carried out. In other communities the Free Clinic approach is imperative whereas in other groups the formal program takes the concept of a family.[37] As the program begins its initial operation it should be quite flexible and the kind of thing that works best in the community needs to be expanded. When this occurs, it should have full community understanding so that it is assisting in dealing with the communities' problems.

Facility Location

This will be a unique problem to each community. In some communities the school might well provide the facility in a distinct area of a school building. In other communities it may well be a church or even a store-front operation. In every regard the facility seems to become a nerve center for planning and to assist the program development. In reality the presence of the building and/or facility becomes a symbol of awareness

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[37]Appendix II of this report, p. 138.

for the community that desires to deal with its social problems.

Program Evaluation

It is quite important to consider the criteria for evaluating the effectiveness of a community program. Unless people are prepared to deal with this concept prior to the beginning of the facility activities, concepts such as the increase or decrease of drug use in a community may become the sole criteria for judgment of a program's success. Unfortunately, if the program is effective, people will be more aware of the drug use and, indeed, it might conversely be a criterion of the program's success. Factors such as increase of referrals to medical centers, increase of youth employment, the creation of teen centers, and other not normally expected activities may in fact be the true criteria in judging the success of the community program. In this regard it is most apparent that we must clearly establish the kinds of criteria we will use for judging program effectiveness.

In-Service Training (Participation)

One of the major activities that a program in a community will provide is in-service training for all community members. Hopefully the in-service training will take the form of human participation in the activity as opposed to outright lecture series. Naturally, classroom

kind of experiences and media and materials are also part of in-service training but hopefully broad community participation by professional as well as lay people, will be the most significant part of in-service training. If appropriately planned, this kind of experience will extend itself into such existing community institutions as, for example, the church, the school, the law enforcement agencies and civic and fraternal organizations.

Publications and News Flow

It is most important that as soon as the program begins, appropriate procedures need to be established for the news flow of its activities and the publications of its progress. Naturally, the close involvement of the media agencies within the community is important, as is the need for the activity to generate its own media. Hopefully by preparing brochures, flyers, and having a continual contact with the established agencies and institutions within the community, a true representation of the total activity will be made available to the public. Once again, accuracy of data is most important so that trusted integrity is a part of the entire operation.

Personnel Support and Funding

Under the proposed plan for the county, funds would be made available to each community that develops an operational plan. The support would include assistance

in the coordinator's salary, facility rental, and general operations. Naturally, the funding would only be seed money and the community would additionally need to support the activity. One of the concepts recognized nationally in these kinds of activities is that of a successful program has little difficulty in securing funds. True commitment comes in the form of human participation both by talents and by money. A systematic program, then, should be established to enable appropriate funding so that the activity can expand and become manifest in all aspects of the community activity.

Budget Proposal for Community Awareness Activity

Since each community program will vary in nature and the scope of activities undertaken by each program will differ, it becomes most difficult to determine the exact nature of the budget for this program. Hopefully, any community that embarks upon this activity would recognize the need to be flexible and that the kinds of programs that work may need to be expanded while others would be curtailed. It still is necessary, however, to establish what appears to be a minimal operational fund. In this regard, other communities throughout the United States have established action centers and have been able to operate within a budget of ten to twelve thousand dollars per

year.[38] As the need arises, however, the community can be expected to assist further, and at that point the program may well expand. It is proposed in the county plan that each community would be subsidized for a coordinator's salary at a rate of fifty per cent or five thousand dollars, whichever is more. Further, the county would be requested to provide one thousand dollars annually for facility use. An additional five hundred dollars would be expected to be awarded to a community to support its operational costs. This theoretically would provide half of the funding necessary to initiate a community activity center.[39]

These are general concepts for implementing a community awareness activity. One continually is urged to underscore that there is a great need for any effective program to have involvement and commitment from humans that are concerned for others. Most areas would find that there are young people today in our society, particularly in each high school and junior high, who would be willing to talk about life with others, and this becomes the nucleus for a strong action center. The involvement of parents, particularly those who have been identified as drug users, needs to be accomplished quite rapidly. These parents need assistance and they, in turn, will be able to assist each other. This is a grass roots approach to dealing with a social problem. Its success, however, is

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[38] Appendix III of this report, p. 168.

[39] Oakland County Drug Abuse Committee unpublished report, 1970, p. 87.

dependent on the humans involved in the interaction process.

OTHER PROGRAMS--SOME COMMENTS

While conducting this research and delving into the problem of drug misuse, the writer along with other members of the Oakland County Drug Abuse Committee visited several programs that are in present operation throughout the country. These visitations are discussed at length in the appendix, pages 138-167.

A brief resume of these program visitations is presented here by the writer.

The visitation to the San Francisco Medical Center in February of 1970 was to participate in a symposium on free clinics and neighborhood medical facilities with discussion on community approaches to drug abuse problems. The atmosphere at this symposium was one of strong commitment of the people attending. The scope of the Free Clinic Symposium in summary is as follows. There is a comprehensive commitment on the part of professional people such as doctors, lawyers, educators and social workers, to name a few, who give voluntary assistance to operate free clinics throughout the community. These free clinics focus on the total care of the individual and his family. There is a need to create parallel institutions to care for these people, such as free clinics for medical care,

employment centers, housing facilities and counseling services. There is a need for less rhetoric and more action towards solving the drug abuse problem. As such, the drug abuse problem is academic, the people problem is the main area of concern.

The visitation to the Clinical Research Center at Lexington, Kentucky revealed in capsule form the following. The staff personnel interviewed expressed the need for treating the drug dependent person within his own community and were concerned with the lack of adequate facilities within the State of Michigan. Michigan ranked first in sending persons to Lexington with 656 patients between July 21, 1967 and December 31, 1969. Pennsylvania was second with 305 patients. During 1969, 527 patients were sent from Michigan and 443 of these were discharged as not suitable for treatment. The staff interviewed expressed the opinion that new programs must be designed to deal with the drug dependent person in his own environment, rather than the traditional incarceration--supervisory deterrent system.

While visiting the City of New York Drug Program Operations in January of 1970 the following information was garnered. The essence of the New York Operation involves a central planning staff which operates facilities on an island, storefront operations in various communities and a total activity based on the needs and support of each

community. A heavy use of ex-drug addicts as supportive personnel is made. Drug abuse in New York is a massive problem. The entire program, according to those interviewed, has limited effect on the ever-increasing problem. The program structure is very centralized, with day-to-day problems and work handled by the ex-drug addicts, structured on a decentralized basis. From the discussions, there was little factual data to indicate success or failure of the programs and a difficulty was noted in actually determining when an addict was actually rehabilitated. There is a concerted and good working relationship between the drug abuse activities and the schools, courts and other agencies. Much stress is placed at the community level of program activity as it relates to their specific problems.

At the Illinois Drug Abuse Programs visitation in Chicago, it was found once again that heavy use was made of ex-drug addicts as supportive personnel. The most commonly used therapeutic method is group therapy. The waiting period for applicants to the program is several months. The staff personnel interviewed indicated that barbiturate addicts required close medical supervision due to withdrawal convulsions. They are in the process of starting a losers clinic for those who have previously dropped out of the program. They made no claims to curing anyone, and hope mainly to provide some guidance, understanding and support relationships to help the addict to

better cope with his problem. At present, the program is totally supported by the Illinois Mental Health Department and is entirely voluntary, with the exception of court referral patients.

The Lafayette Clinic-Heroin Project, Detroit, is a research and treatment program aimed at finding more information in regards to addiction, addicts, their personality structure, family situation and response to treatment. The treatment concept is a total push type program where aftercare is integrated with the initial evaluation and hospitalization. Group therapy is once again the major treatment method. Certain drugs will be used to aid in withdrawal from heroin. The program began only one month prior to the visitation and is authorized by the Michigan State Senate and is the first State center for treating drug addicts, training doctors and carrying on research and education programs in narcotics.

Visitations to these areas and the study of their programs gave a more sound basis for ideas and innovations to be used in the implementing of the Oakland County Drug Abuse Program. Though, as has been stated many times throughout this study, what may well work in one area or community, may not in another. Much valuable information was acquired as to present methods of program development in various parts of the country.

CHAPTER IV

CONCLUSIONS AND A FORWARD LOOK

It has been shown that drug misuse contacts are definitely increasing at the community level of society. Some possible reasons why young people are abusing drugs have been garnered. The relationship of socio-economic factors to the phenomenon has been explored. The preponderance of males to females in misuse of drugs has clearly been established. Some drugs are misused more than others by various ages. The youth of the community seem to be the most involved and caught up in this attempted escape from reality.

Law enforcement and educational practices in the past have not experienced a great deal of success as to the illegal traffic of drugs, or in deterring a certain percentage of our society from drug misuse. It is obvious then that changes in these phases of drug misuse prevention are in order.

Judicial officials throughout the country insist that positive aspects of the law must be changed to give them more leeway in their decisions. Law enforcement must continue to apprehend those who insist on illegal drug

traffic for personal gains, but must also broaden their activities to a large degree in the field of prevention.

Education must accept its responsibility within the academic structure to present a more knowledgeable and factual program to all ages, especially from the fifth to tenth grades. The writer augmented a program of education regarding drug misuse at the eighth grade level in several public schools to be explored in a sociology type setting. After many months of study, and observations of the results of these classes, a new recommendation is forthcoming. Simply stated, the misuse of drugs should not be dealt with in special courses, but a program of health education at the junior high level should be offered. The structure of the anatomy would be explored as to various systems and after a thorough understanding was achieved of these systems and their functions, the study would be interwoven with all healthful and non-healthful materials that relate to a person being of sound mind and body. This health program would come under the auspices of the Science Departments, in a laboratory setting for scientific and exploratory purposes. Thus, the intake of materials into the body that are harmful for the systems would be categorized as such by the student, without the "you shouldn't" or "don't do it" concept which is the much too often approach of the educator. Through the above approach, topical and critical thinking on the part of the learner

can be fostered. While recommended at the junior high level, this type of educational program can be adapted to various ages, including the "drop-out" and adult in present adult education structures.

Whether one will experiment with dangerous drugs or not, is a personal decision that a great many members of society are facing and will face in the future. The penalties for experimentation are also very personal, whether legal, moral, mental or physical.

It is imperative then that one have the ability prior to this decision-making time of what will, in the end, be the proper decision for him. To this end, he must have the knowledge that will assist him in making a decision based on fact, logic and good judgement.

If in our society today we have a major problem of drug misuse as this research portends, then that society must consider the consequences of the problem and seek corrective measures. Criminal activities involved in the drug problem are a menace to our society. Drug misusers, especially of the frequent type, are in little or no position to solve their problems or the ones they foster. Thus it becomes one for the rest of society to assume. The drain on our human resources from the mental, physical and occupational aspects is and will be too great for society to condone or accept. It must be dealt with as any large scale community health problem, with all of the resources

available to deter it, and eventually eliminate it as a source of threat to our nation's health.

Drug misuse as a means of escape from reality is not acceptable to a healthful society. Generally all members of a given social system have problems at one time or another. Substances that offer escape from the reality of these problems oft times are appealing. However, unlike the taking of medicine to ward off a cold, when one recovers from the indiscriminate use of drugs, the symptoms are still present, only sometimes more pronounced and new problems have been added, those which we have discussed in detail throughout the thesis.

Programs for the alleviation of the problem have not kept up with the problem itself. In the future, all of the knowledge that has been used by professionals and para-professionals in the past to cope with other community health problems such as health, science, sociology and similar agencies must be systematically oriented and cohesed towards a common goal of eradication of the drug abuse problem.

The control of the problem by the local community requires that the members of that community understand what the problem of drug misuse is, what are the consequences of the misuse of drugs, and become knowledgeable of the nature of drug misuse in the human. Programs must be based on knowledge about the problem, why it exists,

and what is being done about it elsewhere. The aforementioned principles of organization in their search and development of programs such as assessment of resources, development of facilities, planning programs, goals and objectives, of services to be formed and constant analytical assessment and evaluations must take place.

To this end, all existing resources such as hospitals, education, etc., within the community must be tapped for assistance, both public and private. Few communities throughout the country have the same organizational structure, and what may well be workable in one area will not function in the same way elsewhere.

Regardless of how the programs are established and implemented, it seems that bringing the focal point of the programs to center at an early age will help to alleviate many of the resulting losses if intervention were to come at a later period.

Education towards the changing of present attitudes towards drug misuse for the general public is needed. Informational programs informing the members of the community how to recognize drug misuse and who to seek for assistance when it is noted are invaluable. The last portion of this study was dedicated to that end. The responsibilities of various agencies were ennumerated and discussions of implementation considered. It is suggested that through this model, other communities can incorporate similar programs.

Since the community, through all of the sources previously discussed in this writing, has become aroused to the problem of the misuse of drugs, especially by the youthful offender and is making strides as elsewhere in this nation to formulate programs dealing with the problems, the future looks much brighter. Progress of any kind in the presence of public apathy, has been doomed to failure. However, no longer is this the case, either locally or at the state and national levels. Legislatures, both state and federal, are grappling with the problem of drug misuse and some sound legislation should be forthcoming. Much research must be continued, and new research augmented.

The goal of our local communities, as well as the state and nation, and all members of our society with the abilities needed in pooling efforts toward a common end, must be a concerted fight against the misuse of drugs that that society will be a healthful and enduring one, holding its place throughout the world.

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APPENDICES

APPENDIX I

APPENDIX I

OAKLAND COUNTY--COMMUNITY PROGRAM FOR CONTROL OF DRUG MISUSE

Having established the existence of the problem and its apparent rate of growth, the question now becomes, where do we go from here?

RECOMMENDATION

It is recommended that the County of Oakland establish a central treatment facility. This should be a resident facility equipped to handle court referrals, self-referrals, and community referred individuals who have been identified as requiring in-patient care. In addition, the county will encourage coordinated community programs to deal with community problems. Communities will be encouraged to develop the awareness house concept, thereby offering that supportive arm to the individual being released from the resident facility. The county, it is recommended, will subsidize community programs that are developed to meet community needs.

EDUCATION

About The Student

With few exceptions, drug education in the County of Oakland is at best, uninformed and sporadic, and generally nonexistent. That drug education is necessary, and indeed required, is evidenced by the law as it appears in the School Code of 1955:

> (15.3364 Physiology and hygiene; instruction) Sec. 364. In addition to the branches in which instruction is now required by law to be given in the public schools of the state, instruction shall be given in physiology and hygiene, with a special reference to the nature of (tobacco), alcohol and narcotics and their effect upon the human system. Such instruction shall be given by the aid of textbooks in the case of pupils who are able to read, and as thoroughly as in other studies pursued in the same school. (CL '48, § 340.364.)

Whether the current attempts at drug education being offered in our school districts satisfy the requirements of that provision, is debatable. In light of today's problem, however, even strict adherence to the requirements of this provision would fall far short of what is necessary. We must be cognizant of the fact that traditional methods of deterrence involving reliance on scare techniques or moral persuasion have not proven effective.

High school student assemblies are not the answer to drug education. Drug education must be conducted in a classroom setting where the potential for individual student involvement in the work study unit is at its highest. It must occur with greatest intensity during

the elementary years where concepts, attitudes, and behavior are developing. Taking advantage of this learning opportunity, a well planned, structured curriculum can most effectively deal with preventive education.

About the Teacher

It is not surprising that most teachers forced to deal with drug abuse education, feel frustrated and troubled concerning how to go about it. Of all the professionals involved in this field, the teacher is probably the least prepared.

The task we propose demands careful preparation and implementation; yet what resources are available to our educators? If all available resource materials were to be placed in the hands of our teachers today, they would still lack the personal preparation that would enable them to evaluate the material and determine which is relevant or which is irrelevant; which is meaningful and will be effective or which merely perpetuates the unrealistic myths. It is not surprising that one would demonstrate a hesitancy to become involved in a project that he personally feels inadequately prepared for. This situation must be changed.

RECOMMENDATION

The County of Oakland, through the Department of Drug Abuse Control and in cooperation with the Oakland Schools, will plan, develop, and conduct in depth educator workshops for the school districts of the County of Oakland. Refresher and continuing educational courses will be an on-going part of the total project and will be accomplished through the utilization of teacher in-service workshops.

School districts will then be encouraged to design and implement work study units which will become a part of their total curriculum. These work study units must be designed by the individual school districts in order that they may realistically fill the needs of the students serviced by that district.

The work study units and the teacher training programs which are developed, along with all new materials relative to the educational field, will become a part of the Drug Abuse Repository maintained by the Department of Drug Abuse Control, and made readily available to all educators within the Oakland Schools.

THE CHALLENGE OF THE NARCOTIC ADDICT

The Problem Does Exist

Debate continues as to whether or not a narcotic addict, i.e., a heroin user, actually exists in the County

of Oakland in numbers of any consequence. It is no longer a moot question, and to continue the debate would be an exercise in futility. We must begin to effectively deal with the problem.

A conservative estimate from the Narcotics Bureau of the Pontiac Police Department indicates the existence of 500 heroin addicts in that city alone. One agency, already active in Pontiac, claims the registration of 163 heroin addicts. In addition, reliable resources of intelligence and the Drug Abuse Committee survey, indicates the likely existence of at least as many and potentially more in the suburban areas of the county. Health and law enforcement officials say there are three to four thousand known narcotic addicts in the City of Detroit, and the Governor's special committee on drug dependence and abuse estimated the cost of the criminal activity necessary to provide these addicts with money for their drug purchases may easily amount to more than $40,000,000 per year. It would be unwise to assume that Eight Mile Road is a line of demarcation beyond which heroin traffic fails to flow. It is apparent that heroin addiction is a problem Oakland County is forced to deal with.

Methadone--A Drug to Fight a Drug

Methadone therapy now offers substantial hope of rehabilitation for heroin and other opiate addicts. Legally, methadone therapy is still experimental in the United States; practically, its effectiveness has been adequately established and its benefits clearly outweigh its hazards.

According to Dr. Jerome Jaffe, Director of the Drug Abuse Division of the Illinois Department of Mental Health, they can find no long-term toxic effects of orally administered methadone as it is used in well regulated clinics. He goes on to say that we must recognize that we're dealing with a potentially lethal disease called addiction; the death rate is high; the complication rate is high. Compared to that, methadone has few complications.

Dr. Vincent Dole, a specialist in metabolic research, and Dr. Marie Nyswander, a psychiatrist from the Lexington Hospital, joined forces in 1963 and took a long look at the drug problem. Having witnessed the failure of many varieties of psychotherapy, both were convinced that it would never be a sufficient treatment by itself. According to Drs. Dole and Nyswander, heroin or opiate type addiction produces a metabolic change within the individual and psychological treatment can only be effective if those changes are taken care of. Methadone

appears to deal with those changes. It is not an answer in itself, but certainly is part of the answer.

The experience of the Drug Abuse Committee in looking at programs around the country, indicated that without question, for the overwhelming majority of long-term chronic heroin users in urban areas, methadone maintenance was the most acceptable form of treatment. And for those people who stay in the programs, and most of them do, the rate of gainful employment more than doubled and the arrest rate dropped from anywhere from one-fifth to one-tenth of what it was prior to their entering treatment. It is safe to say that the methadone maintenance program is quite successful as compared to other treatment programs.

Detoxification

The weight of emphasis to be placed on in-patient care versus out-patient care, is a crucial question. If we accept the theory that all drug abusers do not have a mental and/or physical health problem, available resources should be martialed to emphasize the development of out-patient care. This direction will undoubtedly attract the greatest number of individuals into programs.

We cannot ignore, however, that percentage of people who become acutely ill and require hospitalization for the purpose of detoxification. In-patient service at

the present, is terribly inadequate. Although many institutions claim to accept addicts into regular service, the existing in-patient facilities now turn away 95 per cent of all drug abusers referred to them, and thousands of youths do not seek referral because they don't know who to contact. In many instances, physicians are at a loss for direction when faced with an acutely ill drug user who requires immediate hospitalization.

Laboratory services for blood analysis and urinalysis on a twenty-four hour basis are presently not available in the County of Oakland. This service also is desperately needed to enable the physician to most effectively treat the acutely ill patient.

Recommendation

Methadone maintenance programs should be available in the County of Oakland. In addition, all hospitals in the county should be contacted in order that their capability and willingness to handle acutely ill drug patients may be established. A list of these services should then be prepared and published. Twenty-four hour laboratory service must also be made available.

INTRODUCTION TO PROGRAMS

This section of the plan contains programs endorsed in concept by the Oakland County Board of Commissioners. Their design is such that they can most

effectively deal with the needs and priorities as defined in the first part of this program. As the nature of the problem changes, so will the needs. This plan then, and the programs included, are subject to revision as necessity dictates.

The basic programs described herein are reliant upon one another to accomplish a common goal. Each program concept, in and of itself, is not a solution; but together they form the comprehensive plan for dealing with the drug abuse problem in Oakland County.

THE CENTRAL TREATMENT FACILITY

The Physical Plant

Oakland County will purchase, develop, lease, rent, or coordinate the use of a comprehensive facility suitable to implement the total drug abuse abatement program. The facility will be so designed as to accommodate those individuals in the program who have been diagnosed as in-patients.

It will provide resident accommodations suitable for short or long term occupancy, and a dining facility for meal preparation and food service for those in residence. Indoor and outdoor recreational facilities; areas for medical examinations and related non-surgical medical activities; and rooms suitable for use as educational classrooms will also be provided.

The central facility will house the Drug Abuse Repository, as well as provide necessary office space for professional, para-professional, and classified staff.

Objectives

To provide, in conjunction with the Oakland County Department of Public Health, complete health supervisory services necessary for the facility activities.

To provide, in conjunction with the Oakland County Mental Health Division, a total mental health service program which will:

1. Provide complete mental health diagnostic service.
2. Provide complete mental health prescriptive service, including medication, therapy, and prescribed guidance services.
3. Provide complete supervisory service of the related mental health programs designed for individuals in the drug use abatement program.
4. Provide necessary emergency service facilities.

CLIENT INDUCTION

Individuals being accepted into the central treatment facility will be referred through numerous resources.

1. When appropriate, the various courts in Oakland County may assign individuals to the central treatment facility for evaluation, treatment and programming.

2. Guardians may refer individuals to the central treatment facility.

3. Individuals may refer themselves to the central treatment facility.

4. Individuals may be referred to the central treatment facility from a satellite house.

THE PRESCRIPTIVE SERVICE ACTIVITY

The Central Facility will provide a total prescriptive activity consistent with the recommendations of the Oakland County Public Health and Mental Health Departments and other staff consultants.

Wherever possible this service will be coordinated through the central treatment facility activities, in conjunction with the existing staff providing this service in Oakland County.

The prescriptive service activity will provide:

1. Individual and group therapy treatment to all individuals identified for treatment at the facility.

2. Group and individual guidance and counseling to all individuals identified for treatment at the facility.

3. Educational programming and planning to all individuals identified for treatment at the facility.

4. Physical activities to all individuals identified for treatment at the facility.

5. Cultural activities to all individuals identified for treatment at the facility.

6. Vocational and educational planning to all individuals identified for treatment at the facility.

7. Work-experience programming to all individuals identified for treatment at the facility.

8. Supportive life experience (family counseling) to all individuals identified for treatment at the facility.

9. Related supportive-explanatory experiences necessary for a meaningful life to all individuals identified for treatment at the facility.

COMMUNITY INVOLVEMENT

The Concept

Communities will be encouraged to develop comprehensive programs of activities, central to drug abuse, and unite under the drug umbrella to deal with community adjustment.

Recognizing that drug abuse activity is heavily dependent on the socio-economic culture of each community, the community must be heavily involved in diagnosing the problem and suggesting an effective program to deal with it.

The Satellite House

The development of community satellite houses is an integral part of the total Oakland County comprehensive plan to combat drug abuse. Oakland County through the Department of Drug Abuse Control, will subsidize community

satellite centers in accordance with the section on Education of this comprehensive plan.

EDUCATION

Informing The Educator

In conjunction with the Oakland Schools, teacher workshops will be planned, aimed at supplying the educator with the information necessary to become effectively involved in drug education. These workshops will be made available to school districts and should have in attendance, educators representing each school within that district.

1. The process will begin by offering half-day seminars involving the total staff of each school within the district. These seminars will be conducted on a school-by-school basis.

2. At the conclusion of these seminars, a questionnaire will be completed by the staff, indicating their interest and their needs.

3. After evaluating these questionnaires, the total workshop for that school district will be planned and implemented.

4. The workshop will be a minimum of one week in duration. The first three days will involve lecture and discussion with acknowledged experts, and evaluation of material. The final two days will be spent in designing work study units to be used within that school district.

As new material and new ideas become available, they will be passed on to educators through the use of in-service training days.

Curriculum Development

There should be basic educational courses which deal with the total drug situation. They should be objective, honest, presentations. The content of this material could be incorporated into the traditional biology, sociology, psychology and other related courses. These programs should begin in the elementary schools and continue through the traditional K-12 program. The school should consider the creation of a position of Drug Curriculum Coordinator, whose responsibilities would include the implementation of the work study units designed for that school district.

The work study units used within each district should be developed as a result of the teacher education process defined in Informing The Educator on the preceding page.

A communication and authorization flow chart, which may be used as a model to explain the responsibility and authority to initiate, develop, and carry through a curriculum program, appears on page 80 of "A Teacher Resource Guide for Drug Use and Abuse for Michigan's Schools," prepared by the Michigan Department of Education. It is reproduced here, with their permission.

COMMUNICATION AND AUTHORIZATION FLOW CHART

Superintendent

Recommends to Board of Education that curriculum be developed through an advisory committee.

Board of Education

Approves plan to develop a curriculum in drug education. Authorizes advisory committee and specified its duties.

Drug Education Advisory Committee

1. Develop plans for:
    a. In-service education
    b. Work through professional staff to evolve drug education program.
    c. Pilot programs and judging their effectiveness.
2. Makes recommendations to administration and Board of Education regarding program plans.
3. Recommends program goals for the drug education program to the Board of Education.
4. Receives information from professional staff.
5. Communicates program plans to community when approved by Board of Education.

Professional Staff

Representatives serve on advisory committee
Engages in in-service education
Plan instructional program
Carries out pilot programs
Evaluates pilot projects
Carries out instructional program
Re-evaluates for all pupils.

It should be clear that the above model is not a flow chart showing legal authority. Since the Superintendent properly functions under control of the Board of Education and no advisory committee could assume authority between the board, the administration and the staff, this is simply a communication chart. Oakland County, through the Department of Drug Abuse Control, will subsidize curriculum programs and education workshops in accordance with the section on Curriculum Development (p. 122).

THE ACUTE PATIENT AND THE HEROIN ADDICT

Detoxification

There is an immediate need for emergency hospital facilities offering short-term care for the individual under the acute influence of drugs. Medical examinations, lab tests, and detoxification services are all needed.

The program should provide twenty-four hour emergency treatment for individuals in a toxic state due to substance abuse. Services should include emergency short-term hospitalization for holding, examining, detoxification, and diagnostic service for the purpose of referral to the appropriate aftercare treatment services, i.e., Central Treatment Facility, Satellite House, etc. The County of Oakland through the Department of Drug Abuse Control, will encourage existing hospitals to become an integral part of the community health system.

1. The use of existing facilities, where possible, will greatly expedite the creation of a total community health system and is likely to be a much less expensive approach than developing a public system with entirely separate facilities.

2. The County of Oakland, through the Department of Drug Abuse Control, will negotiate with the existing facilities in order to subsidize the short term care of those patients determined to be indigent.

Methadone

The County of Oakland, through the Department of Drug Abuse Control, will encourage the establishment of a methadone maintenance clinic, operated on an outpatient basis. Those individuals accepted for methadone maintenance will be required to participate in a total program including vocational rehabilitation, job placement, and psychological or psychiatric treatment as indicated. The County of Oakland will subsidize a methadone maintenance program in accordance with the provisions of the section on Detoxification on the preceding page of this comprehensive plan.

NEW PROGRAMS

Undoubtedly, as involvement in this area grows, new methods of programming will evolve. It can be assumed that there will be occasions when new concepts will be brought to the attention of the Department of Drug Abuse Control, and requests for funding will be made for a program not identified within the basic comprehensive plan.

When this situation occurs, the staff will evaluate the program. Then, after consultation with the Board of Auditors, it will be presented to the Human Resources Committee for consideration and recommendation to the Oakland County Board of Commissioners.

THE SATELLITE CENTER--WHO MAY APPLY

Governmental Units

Cities, townships, and villages, or combinations thereof, representing a combined population of not less than 30,000, based on the 1960 census figures would represent the governmental units.

Official Committees

Recongized committees representing cities, townships, and villages, or combinations thereof, representing a combined population of not less than 30,000, based on the 1960 census figures. These groups must have:

1. Official endorsement from the local governing body of the city, township, and village, or combination thereof, which they represent.
2. Filed articles of incorporation.
3. Submitted a total program plan to the Oakland County Department of Drug Abuse Control for approval.
4. Submitted a line item budget pertaining to that program.
5. Indicated through letters of intent from local government, and other supportive agencies, how the community intends to support the program.

Where according to the 1960 census figures, a city or township has in excess of 60,000 in population, more than one program may be considered for funding. If there exists within that area, a socio-economic division that creates an unbalance in the population area to be served by the program, the 30,000 minimum population requirement may be waived and special consideration may be given to the application. (All other specifications designed in sub paragraphs 1 through 5 of paragraph one, above, will apply.)

THE SATELLITE CENTER-- FUNDING GUIDELINES

The Program Cost

A basis of $1.00 per capita will be used to project program costs, i.e., a program servicing a population area of 30,000 will be, for the purpose of computing assist funding percentage, projected at a maximum cost of $30,000.

County Participation

The county contribution will not exceed 30 per cent of the proposed budget, or 30 per cent of the $1.00 per capita cost factor, whichever is less.

1. In cases where local government clearly indicates it is unable to assume its portion of the funding responsibility, the county contribution may, after review, be adjusted accordingly.

2. At no time will land or building purchase expense be computed in the project cost, or be considered as a basis for county funding.

3. Only one program per population area will be funded.

EDUCATIONAL PROGRAMS

Definition

The Oakland County plan defines educational programs as curriculum development programs or special education programs designed and implemented by the schools.

Who May Apply

Applications will be received from school districts within the County of Oakland, pertaining to curriculum development for the schools within that district.

1. Only one program per school district will be considered.

Applications will be received from the offices of the Oakland Schools pertaining to special educational programs for the Oakland School Districts.

Funding

Except in cases where need is clearly demonstrated, county funding will be restricted to 20 per cent of the program budget.

OTHER PROGRAMS

Methadone

The county will assist in the establishment of a Methadone Maintenance Program.

1. The program should be designed to service not less than 200 heroin addicts.

2. The program budget should not exceed $75,000 in yearly costs.

3. County participation will be restricted to 20 per cent of the total cost of the program.

APPLICANT RESPONSIBILITY

Satellite Centers

Each satellite center director, or an alternate, will attend bi-weekly meetings at the County Department of Drug Abuse Control. These meetings will be designed to share information, and further coordinate the ongoing efforts within the county.

Brief bi-monthly progress reports will be submitted to the County Department of Drug Abuse Control. These reports will be due no later than the fifteenth day of the second, fourth, sixth, eighth, tenth, and twelfth months of the calendar year.

A year-end evaluation of each satellite center operation shall be submitted to the Oakland County Department of Drug Abuse Control. The calendar year will be used for the basis of the evaluation, and they shall be due no later than the first day of March of each year.

Educational Curriculum Programs

Copies of all work study units developed by school districts shall be forwarded to the Oakland County

Department of Drug Abuse Control to become a portion of the Drug Abuse Repository, and will be made available to other school districts.

At the end of each school year, the school district shall submit to the Oakland County Department of Drug Abuse Control an evaluation of the curriculum program conducted during that year.

The Methadone Maintenance Program

The administration of the Methadone Maintenance Program shall submit to the Oakland County Department of Drug Abuse Control, bi-monthly status reports. These reports will be due no later than the fifteenth day of the second, fourth, sixth, eighth, tenth, and twelfth months of the calendar year. These reports shall reflect:

1. The total number of clients involved in the program at the present time.
2. The total number of clients serviced by the program to the present date.
3. The length of time each client has been involved with the program.
4. The number of clients lost from the program.
5. The percentage of drop-out, according to the total number serviced.

The administrators of the Methadone Program shall submit to the Oakland County Department of Drug Abuse Control, a year-end evaluation of the program. This evaluation will be based on a calendar year and shall be due no later than March first of the following year.

PREPARATION INSTRUCTIONS FOR APPLICATION FOR FUNDING

Applications for funding from the County of Oakland are to be submitted in duplicate to:

Oakland County Board of Auditors
Department of Drug Abuse Control
1200 North Telegraph Road
Pontiac, Michigan 48053
Telephone: 338-4751, Ext. 177

Applications must be accompanied by copies of the total program, copies of the line item budget, and all other necessary supportive documents.

Applicant Agency

The applicant agency is the organizational unit which is to be responsible for the administration of the program in accordance with the project agreement. Include the name and the complete address of applicant.

Date Submitted

Enter date of delivery to the Oakland County Department of Drug Abuse Control.

Funding Area

Indicate which of the following functional areas best describes the scope and intent of the program:

Area	Maximum County Participation
Satellite Center Project	30%
Educational Program	20%
Methadone Program	20%

Political Subdivisions Represented

Indicate by name, each unit of local government represented by this application. If more space is needed, attach additional sheet.

Population

Indicate the total population according to the 1960 census figures of each of the political subdivisions represented in this application, and the total population of all involved. If more space is needed, attach additional sheet.

Program Fiscal Officer

Enter the name, address, title, and telephone number of the individual who will be responsible for the fiscal administration of the program.

Budget Information

On Line A, enter total budget figure. Under Item B, identify the amount of financial participation by each of the represented political subdivisions, and the amount of financial participation from other agencies or fund raising projects. As a final entry, identify the amount requested as assist funding from the County of Oakland. If more space is needed, attach additional sheet.

Approval and Acceptance Conditions

The funding application form also serves as a project agreement. This section certifies to the acceptance of the terms of the project agreement.

Project Director

Type full name of the project director. This is the individual responsible for the continuing administration of the project. Enter the title and business address of the director in the appropriate spaces. Include the Area Code when listing the business and telephone number.

Local Authorizing Official or Officials

Enter the name of the authorizing official or officials. In some cases this will be the chief executive officer of the political subdivision, or representative agency, i.e., Mayor, City Manager, chairman of the official committee, etc. If more space is needed, attach additional sheet.

OAKLAND COUNTY BOARD OF AUDITORS
Department of Drug Abuse Control

Application for Funding

1. Applicant Agency (Name & Address)	2. Date Submitted 3. Funding Area
4. Political Subdivisions Represented: A. _____ B. _____ C. _____ D. _____	5. Population A. _____ B. _____ C. _____ D. _____ TOTAL

6. Program Fiscal Officer

Name Address Title Telephone

7. Budget Information

A. Total Budget ..... $ _____

B. Source of Funds

(1) _____	$ _____
(2) _____	$ _____
(3) _____	$ _____
(4) _____	$ _____
(5) _____	$ _____
(6) _____	$ _____
TOTAL	$ _____

8. APPROVAL AND ACCEPTANCE CONDITIONS:

It is understood and agreed by the recipient, that funds received as a result of this application are subject to the regulations contained in the Oakland County Board of Auditors, Department of Drug Abuse Control Comprehensive Plan for the County of Oakland, and specifically to those stated in Part IV, Section V, as applicable.

9. PROJECT DIRECTOR

Name Address Title Telephone

_____
Signature

Local Authorizing Official (s)

PLAN I

BUDGET NEEDS (ESTIMATED PROPOSAL)

To establish a central county drug-abuse activity and a network of community action programs, the following budget is proposed.

Central Operations

1.	Executive Director	$18,000	$25,000	$25,000
2.	Assistant Directors	14,000	18,000	36,000
3.	Clerical Assistants	15,000	18,000	18,000
	Office Equipment (6 stations)	3,000	5,000	5,000
	Operational Expenses	10,000	15,000	15,000
	Patient Care (30 patients)	(constant)		
	Medication Maintenance	5,000	8,000	8,000
		$65,000	$89,000	$107,000

*Community Operations (10)

Coordinators Salary (1/2)	$ 5,000
Facility Rental/Purchase	1,000
Operation Support Salary	500
	$ 6,500

10 each . . . . . $ 65,000

TOTAL BUDGET $172,000

*Recommended centers attachment.

Funding will be available when a community AWARENESS program is received and approved for implementation by the Executive Director and Drug-Abuse Advisory Board.

PLAN II

BUDGET NEEDS (ESTIMATED PROPOSAL)

To establish a central county drug-abuse activity and a network of community action programs, the following budget is proposed.

Central Operations

1.	Executive Director	$18,000	$25,000	$25,000
2.	Assistant Directors	14,000	18,000	36,000
5.	Clerical Assistants	25,000	30,000	30,000
2.	Social Workers	24,000	30,000	30,000
	Office Equipment (9 stations)	6,000	8,000	8,000
	Operational Expenses	10,000	15,000	15,000
	Patient Care (30 patients)	(constant)		
	Medication Maintenance	5,000	8,000	8,000
		$102,000	$134,000	$152,000

*Community Operations (25)

Coordinators Salary (1/2)	$5,000
Facility Rental/Purchase	1,000
Operation Support Salary	500
	$6,500

25 each $162,500

TOTAL BUDGET $314,500

*Recommended centers attachment.
Funding will be available when a community AWARENESS program is received and approved for implementation by the Executive Director and Drug-Abuse Advisory Board.

APPENDIX II

APPENDIX II

VISITATIONS

SAN FRENCISCO MEDICAL CENTER
MEDICAL SCIENCE AUDITORIUM
JANUARY 31 THROUGH FEBRUARY 1, 1970

This visitation to the San Francisco Medical Center was undertaken to participate in a symposium on free clinics and neighborhood medical facilities with discussion of community approaches to drug use.

The immediate atmosphere of the symposium indicated the strong commitment of the people involved in the symposium activities to the extent that even the registration was conducted by volunteers and young people. Over four hundred people from all professions and activities attended, and most states and numerous foreign countries were in representation. The entire scope and purpose of this symposium was to discuss free clinics--a concept that has arisen because of the apparent inability of the structured institutionalized medical service facilities to reach all parts of each community. The phenomenal part of these free clinics is that they are almost completely structured by volunteer help. When expenditures are present, they relate directly to providing medical area; namely, drugs and antibiotics to patients and telephone

expenses. Various clinics illustrated their budget factors and the service provided to a community. The Haight-Ashbury Clinic, for example, has serviced six throusand with an eleven thousand dollar budget in one year. Nine thousand was spent on medication to the individuals and two thousand for telephone calls. Numerous referrals were made to the medical centers for greater medical needs. The various faculty members from the medical schools and private physicians are totally operating the clinic with supportive volunteer work of para-professionals, nurses and community personnel. Perhaps the outstanding dimension of these free-clinic operations as illustrated in the Seattle Free Medical Clinic was the use of para-professionals who are trained in in-service programs to assist in medical work. The laws pertaining to use of para-professionals were quite clearly defined, and these para-professionals do not process any medication but are strictly involved in client care.

One might summarize overriding concepts of the parallel institutions; namely, the medical clinic to a hospital as an attempt to provide a broader service without repressive procedures to all community participants. More broadly, the free clinic approach attempts to deal with need of food, clothing, jobs, housing and medical service to people and confronts drug related problems in the process. Numerous anecdotes and studies were present

to illustrate the changing nature of the Haight-Ashbury group as well as the Black Man's Clinic and other similar clinics. Presentations were made from the Watt's Area Clinic, Boston Free Clinics, Seattle Clinics, Chicago Clinic, and, collectively, it appears that there are fifty operating today in the United States.

In reviewing the funding for these clinics it is apparent that various clinics seek funds from the Office of Economic Opportunity, private business, and some federal agencies. Some of the clinics were able to secure funds quite readily while others are struggling from one day of operations to the next. It would appear that the broad commitment for institutional support for these clinics is not yet prevalent, but that they are voluntary agencies structured to meet the needs of a community. The free clinic in the opinion of numerous doctors participating on the program is an alternative to studying rhetoric and is an approach to making health care facilities available to the public.

Other creative kinds of programs operative in the west coast area include: a free dental clinic sponsored by the staff of the University of California Dental School which has had fifty-thousand doctor/patient visits since 1967; a heroin withdrawal clinic; an out-patient detoxification clinic operated by volunteer staff; a Huckleberry House sponsored by community agencies that provides

immediate care and finances for runaway youngsters; a psychiatric section of numerous houses dealing with brief psychological analysis and referrals of individual problems; and various structured and unstructured programs titled "involvement core" that seek to involve disc-jockeys, labor, professional staff and interested personnel in realistic procedures for care and assistance to the people in each community.

The following points might summarize the scope of the Free Clinic Symposium in California:

1. Broad comprehensive commitment of professional staff including doctors, lawyers, dentists, educators and social workers who give of their time voluntarily to operate clinics throughout each community.

2. The Free Clinic approach in dealing with drug problems focuses on the total care of the individual and family which achieves resolution to the drug problem by caring for people.

3. There is a need to create parallel institutions to care for people, for example, free clinics for hospitals, employment centers for employment security offices, housing and rental areas for persons that are unable to find houses, and counseling services for the lack of psychiatric care service centers.

4. A commitment to action as opposed to rhetoric about the problem.

5. The drug problem is an academic question--the people problem is the area of concern.

CLINICAL RESEARCH CENTER
LEXINGTON, KENTUCKY

History of the Clinical Research Center

In January 1929 the 70th Congress approved an Act to establish two United States Narcotic Farms for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs, who had been convicted of offenses against the United States and for other purposes. In May of 1935, in Lexington, Kentucky, the first United States Narcotic Farm was opened for the treatment of individuals addicted to narcotic drugs. The name "Narcotic Farm" represented the experimental nature of the institution; during the first year the name was changed to the U.S. Public Health Service Hospital. In 1967 the U.S. Public Health Service Hospital of Lexington joined the National Institute of Mental Health and was renamed the Clinical Research Center. Since then the Center has undergone changes in its treatment program, basic philosophy, methods of operation, and physical plant. The Center no longer admits voluntary or prisoner patients, since all patients now enter under the provisions of the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89-793). "The Act represents the view that narcotic addiction is symptomatic of an illness that should be treated and not a criminal circumstance in itself." The Program is

administered by the National Institute of Mental Health and the Department of Justice.

Provisions of the NARA Act

Provisions of the NARA Act include:

Title I. Authorizes Federal Courts to commit for treatment certain eligible narcotic addicts who are charged with a Federal offense and who desire to be treated for their addiction, instead of being prosecuted for the criminal charge (Treatment in lieu of prosecution). The period of commitment is thirty-six (36) months, and if successfully completed, the criminal charge is dismissed.

Title II. Provides for a sentencing procedure to commit for treatment addicts who qualify under the Narcotic Rehabilitation Act of 1966, and who have already been convicted of a crime. After an individual committed under Title II has been treated in the institution for a minimum of six months, he may be paroled to after care. Upon release to the community, the individual is supervised by a U.S. Probation Officer. In addition all Title II releases are provided with an after care program whenever community resources are available.

Title III. Provides for Civil commitment of addicts not charged with an offense. Any addict, or any relative of an addict may petition the local United States Attorney for the addict's admission to a United States Public Health Service Hospital. The treatment will include

an initial period of hospital care not to exceed thirty-six months, followed by a thirty-six month period of supervised care with his own community.

Setting

The Clinical Research Center at Lexington plans and conducts a broad program on the management, treatment, rehabilitation, and after care of drug dependent individuals. The approximately five hundred residents are involved in a program that is similar to a community therapeutic setting. A goal of this setting is the eradication of the anti-social and criminal behaviors, a way of life of the drug abuser. Another goal is the development of personal growth through emotional support and continuous positive reinforcement from peers and the staff. The objective of this latter goal is to develop a more orderly life style for the ex-drug user. In addition the Addiction Research Center within the hospital conducts research with co-equal objectives. Federal prisoners are voluntarily assigned to the Addiction Research Center as participants in the research program.

Treatment Phases

Treatment begins as soon as the patient arrives at the hospital, however it can be generally separated into several phases:

1. Withdrawal
2. Convalescence
3. Rehabilitation
4. Post Hospital Treatment

Phase 1--Withdrawal. Initially the patient is admitted to the Medical Center where a complete history of the patient's use of drugs is taken and a complete medical evaluation rendered. If there are no contra-indications to detoxification the patient is sent to the withdrawal unit of the hospital. Detoxification is accomplished by the administration of 10 milligrams of methadone four times during the first day of his arrival in the Withdrawal Ward and decreasing the dosage amount by 10 milligrams each succeeding day until detoxification is completed. Methadone is not used to sustain the patient. Each patient is also given a "test dose" of phenobarbital to ascertain the additional presence of barbiturate dependence. These patients must be stabilized on barbiturates as well as on methadone and gradually withdrawn from both medications. The withdrawal from barbiturates is prolonged and requires close medical supervision. Abrupt withdrawal is extremely dangerous and may result in toxic psychosis or even death. For the heavily addicted person, the acute phase of the withdrawal period may last ten to twelve days, but for the usual

addict, who has taken a highly adulterated drug, it is completed in approximately four days.

Phase 2--Convalescence and Orientation. Following the complete detoxification, the patient is transferred to the Orientation Ward for convalescence. While in the Orientation Ward, the patient is interviewed by various staff members representing psychiatry, education, vocational training, social services, psychology, religious counseling and recreation. Following a "staffing" by members of the aforementioned disciplines and the nursing staff, a determination is made of the patient's suitability to the program. This is generally determined by (1) his interest in continuing in the program, and (2) his adaptability to the program. At this time a treatment program is formulated. The Withdrawal and Orientation Phases generally last from two to four weeks.

Phase 3--Rehabilitation. The Rehabilitation Phase has many aspects--psychotherapy, social service, occupational therapy, recreational therapy, vocational assignments, special training, academic and non-academic education, and general medical, surgical and dental care. Each individual's progress is evaluated on a continuing basis through periodic staff evaluations. The Center uses routine urine testing (thin layer chromatographic analysis) for the detection of illicitly obtained drugs in an effort to maintain a drug free environment.

Integration back into the community is encouraged. Shopping trips, employment, vocational and educational classes and special field trips are part of this integration to help broaden and adjust the individual to the world beyond himself. Residents are expected to participate in part-time work related to the functioning of the Center.

Modifications of the organizational structure into separate autonomous units are currently underway to facilitate resident/staff relationships, heighten esprit de corps, and encourage units to sponsor their own projects. The educational and training sections recently created are designing, coordinating and implementing curricula for personnel and patients. To motivate the residents, attention has been given to the development of positive incentives and rewards for mature behavior, productivity and progress in therapeutic and rehabilitative activities. This includes increased freedoms, special social and recreational functions, choice of rooms, and improved vocational opportunities. The hospital seeks to provide a social milier which maximizes the therapeutic role of all employees. Open and extensive communication between staff and patients is encouraged, informally at work, in the ward, and in recreational groups, and more formally in group counseling and ward meetings.

Phase 4--Post Hospital or After Care Treatment.

A description of the number of after care facilities throughout the United States which are directly related to the post hospital treatment phase is beyond the intended scope of this report. Within the state of Michigan, the Wayne County Public Health Narcotic-After Care Division founded through The National Institute of Mental Health under the NARA Act does provide after care treatment for Wayne County patients committed to Lexington. Currently there are sixty patients committed to the after care program which until recently was operated by one staff member. The staff has been increased to include a Director, three ex-addict supervisors, and two counselors. The goal of the Wayne County after care facility is "to restore the dignity and worth of the drug dependent individual and hopefully to return him to society as a consumer, producer and taxpayer."

General Comments

1. The Clinical Research Center staff personnel interviewed expressed the need for treating the drug dependent person within his own community and, in that regard, were deeply concerned about the lack of such facilities within the state of Michigan.

2. Total admissions under Titles I, II, and III of the NARA Act between July 21, 1967 and December 31,

1969 were 2828. Michigan ranked first in sending 656 patients, followed by Pennsylvania with 305.

3. During the calendar year 1969, 527 patients were admitted from Michigan. Four hundred forty-three of these patients were discharged as not suitable for treatment (397 were discharged within just 30 days, 49 were discharged to after care, and 35 patients are still active).

4. The Clinical Research Center's total yearly budget is $6,250,000.

5. New programs must be designed to deal with the drug dependent person in his own environment rather than the traditional incarceration-supervisory-deterrent system.

CITY OF NEW YORK, DRUG PROGRAM OPERATIONS JANUARY 21, 22, and 23, 1970

The visitation team was received in Commissioner Larry A. Bear's office on January 21. A brief orientation was held and tour hosts were assigned for the two day visitation. Ongoing discussions were held during the visitation with the staff members assigned to host the visitations, as well as briefing sessions held at various places during the visit.

Summary of New York Operations

The New York operations include a series of activities which totally expend approximately fifty-six million dollars annually. The essence of the operation involves a central planning staff which operates facilities on an island, storefront operations in various communities, and a total decentralized activity based on the needs of support of each community. The phenomenal aspect of this entire program is the heavy use of ex-drug addicts in supportive personnel. During the entire visitation there was no contact with physicians, psychiatrists, and/or established social workers who obviously are present in a planning stage, but do not implement the program activities within the communities.

Physical Plants

The physical plants for the entire operation that were viewed provide a normal administrative office with several floors which is responsible for the planning and implementation of the drug abuse programs in New York. The facilities for implementing this activity include at least one island operation at which one hundred addicts are housed. This program, too, is run by ex-addicts who have multiple assignments conducting group and culture sessions, work training sessions, and general island management. Another operation visited involved a store-front operation that has been renovated to have three

rooms in which group sessions are conducted. The basement of this facility is a run-down area which is most conducive to general rap sessions with the young and old people. Another operation is a courthouse that has been leased to the activity for one dollar a month. Again, this is a sequence of rooms that will be used for group sessions and some related training programs.

General Operations

The general operations of the drug abuse activity pertain to human factors activity. The core of the entire program is defined in encounter groups. According to this theory, drug use is a manifestation of human maladjustment and, therefore, a symptom of the person's problem. The entire activity confronts the problems manifest in growth of development and attempts to promote lasting relationships between people which will assist them in resolving their personal problems. It is phenomenal and almost astounding to realize that during the two day visit there, and after viewing numerous sessions both of addicts and professionals in the area, no mention was made as to the nomenclature of various drugs and/or their attempts and/or procedures pertaining to law enforcement. The program is constructed from a theory of resolving the need for drug use which will ultimately dissipate the need for selling drugs. The broad general use of ex-addicts to

work with addicts is also most profound. These people view their past experience of addiction as having been on the mountain top and are now, therefore, able to communicate with others in the valleys of despair. The emotional experience of this visitation is difficult to recap but, as one might report, it was a most educational and informative visit. There seems to be an almost religious zeal about drug use in the New York operations, and it appears to emanate from the ex-addicts working with enthusiasm and love with those now addicted as well as the relatives and friends of those involved in a drug problem.

General Comments

1. Drug use is a massive problem in New York. It appears to be everywhere, and the entire program has only limited effect on an ever-increasing problem.

2. The entire structure of the program in New York is very centralized in planning and operations. The work and day-to-day affairs are decentralized and operated by ex-addicts in most cases.

3. There is no hard data on actual success of their program, but the discussions apparently indicate the difficulty in determining when an addict is actually rehabilitated.

4. There appear to be find working relationships between the drug abuse activities and the courts, schools, and other agencies.

5. The program is definitely an activity of each community as it relates to their specific problem.

ILLINOIS DRUG ABUSE PROGRAMS
CHICAGO, ILLINOIS

Nature of Facility(s) and Programs

A. Administrative

B. Non-residental Outpatient (Day Care): Day Care hours from 9 to 5 with 2 evenings.

C. Residential (24-hour

1. Safari House (Aftercare)--program for persons who may or may not have been in other programs but who are somehow functioning in some capacity within the community.

2. Gateway House (Therapeutic Community)--program where the patient has to live there and during the first three months cannot go out without an escort from the staff. After this period patients can go to work for six months while living there and after that the patient can be discharged to the community and does not participate in this program. However, he could go to some of the other programs if indicated.

3. The Tinley Park Unit is a closed unit in a state hospital for the purpose of detoxification and withdrawals from methadone or opiates addiction. Length of stay was six to eight months on the average.

Procedure for "Case" Identification (Courts, Self-Referral, etc.)

Self-referral

Court Referral

Other Agency Referrals

Research or Evidence of Program Success

There is no formal evaluation of the program at this time.

Program and Facility Operations

Most of the staff is non-professional, ex-drug addicts. From the description they seem to have excellent relationships with other programs and agencies within the community. Professionals are used primarily for the purpose of inservice training for the non-professional ex-drug addicts. The most commonly used therapeutic method is that of group therapy and the non-professional ex-drug addicts who serve as staff members go through a training program in group therapy which is primarily conducted at Tinley Park State Hospital.

Summary Comments

There is a multi-modality program that presents ideas that can be used in the forming of a program for Oakland County. However, since it depends primarily on ex-drug addicts for staff members, it appears that whatever

part of this program could be established in Oakland County will require major adjustments in order to make it functional in the community.

Admission of the patient to the program was briefly described as follows: the candidate fills out an application at the central office. After the application is filled out his name is put on the waiting list. The waiting period was several months. When the patient's name comes up he or she is approached by letter and then a questionnaire is filled out by the patient. At this time the different programs are explained to him, primarily in relation to what each program offers. At this point the patient decides in what program he would like to be. The real assessment comes when he is assigned to his unit of treatment.

At this point the patient is referred to the dispensary for two weeks for a medical evaluation and for those in the methadone program an adjustment of the medication is made under the physician's supervision. One point made very clear was that if the patient at any time does not keep his appointment he is considered out of the program and may reapply at a future date. They felt that this is one of the strict rules that they must enforce if the program is going to be successful.

Other General Information

They expressed concern about the bill pending in Congress by which the drug abuse programs may be placed under the jurisdiction of the United States Attorney General. They felt this should be under the jurisdiction of the Department of Health, Education and Welfare.

They felt that barbiturate addicts are very different from other addicts and require close medically supervised programs because in the withdrawal process these patients sometimes have convulsions. They believe that they should be treated in closed units.

They are in the process of starting a "losers clinic" for those who had been drop-outs of the programs.

They stated that they do not cure anyone and the hope is that this kind of programming would offer some guidance, understanding, and support relationships and that the addict will learn how to better deal with his problems. They feel that drug addiction is a manifestation of underlying problems.

They said they would like to have more family therapy since the addicts with families require this type of therapeutic intervention. The visitation team was left with the impression that many of the answers to questions were not given because the team was part of a visiting group which included representatives from many

other groups such as church organizations, civic groups and the public, who went to visit this program for many different reasons.

Professionals are used in the capacity of consultants, trainers, and rehabilitation counselors. At present the program is totally supported by the Department of Mental Health, State of Illinois. The program is entirely voluntary and consequently patients are expected to cooperate. The exception to this, of course, are the patients probated to the program from the court.

LAFAYETTE CLINIC--HEROIN PROJECT
DETROIT, MICHIGAN

Nature of Facility(s) and Programs

This program is a research and treatment program with the aim of finding out more about addiction, addicts, their personality structures, family situation and response to treatment. The treatment concept is a total push type program where after-care is integrated with the initial evaluation and hospitalization. Group therapy is the major treatment method planned. In addition, drugs will be used for withdrawal from heroin and some of the patients groups will be put on an experimental drug which blocks the effect of heroin. Hospitalization will require 4 to 6 weeks, and follow-up care is planned for a minimum of six months. The groups will meet daily upon discharge.

Families of group members will be meeting weekly starting at the time of hospitalization.

Patients will be selected from two communities by referrals from doctors, police officials, families, and schools. School records and police records will be obtained and both the family and the patient will be interviewed. A complete outline of the program will be given to the patient and his family prior to acceptance to the program so that full cooperation can be expected. Patients who are psychotic or who are presently abusing multiple drugs will be excluded. Also excluded are patients with active hepatitis or serious medical problems. Final selection will be done by a team from Lafayette Clinic and community workers.

The program began one month before this visitation. Their plans as to data collection are: screening material and forms, in-patient psychiatric and psychological evaluation, intake research form and follow-up research form, group therapy records, family, intake and treatment group data and intensive, regular follow-up.

There is no separate budget. The Michigan State Senate recently authorized the Lafayette Clinic to begin this work, the first State center for treating drug addicts, training doctors and carrying on research and education programs in narcotics.

This type of program in Oakland County would necessitate the involvement/contract with a hospital as well as the involvement of vocational rehabilitation and existing agencies in mental health. It is the belief of the staff at the Clinic that for the youngsters addicted to heroin, methadone is not the drug of choice because of being highly addictive. They believe that Naloxone Hydrochloride is a better one but it is not available to the Clinic at this time.

Nature of Treatment Programs

Two communities will be involved, which will provide the patients, the after-care workers, and the after-care facilities while Lafayette Clinic will provide hospitalization, a research drug, a variety of personnel, collection of research data, and overall coordination. It is planned that a total of forty patients will be involved. Four groups of ten patients will be admitted for a four to six week period. It is anticipated that Nalozone Hydrochloride, Narcon, a narcotic blocking agent, will be made available. After-care will be intensive, provided by the community within the community with Lafayette Clinic personnel integrated in the program.

During the time of hospitalization, patients are subject to all the rules and regulations of the Clinic and of the Ward they are admitted to. In the event there

is any serious difficulty in conforming to the Ward milieu, the patient will be dropped from the program and discharged from the hospital to his parents.

It is planned that the patient will have no privileges during his first week in the hospital, limited phone privileges in his second week, and visitors limited to his family in the third week. There will be no visitation except by family members. The time of visitation is dependent on Ward policy and no visitors during the first and second weeks.

Patients are subject to physicals, psychological and laboratory studies (EEG, blood and urine tests, x-ray) as indicated and ordered by physicians. Medication will be prescribed by a physician, as indicated. Some of this medication are drugs which are not available for use except for the purpose of research. The effect of these drugs is to withdraw the patient from narcotics and block the effect of narcotics.

Patients will receive psychotherapy by group discussion and at times these sessions will be recorded by the therapist. Patients are not to discuss the problem of drugs with other patients except at the time of group therapy.

Use of drugs of any kind while in the hospital without medical permission and supervision would cause serious setbacks in the treatment program and will not be

accepted. Leaving the hospital without permission would be considered as lack of interest and although it would be handled individually could cause exclusion from the program.

At the time of discharge the patient will be assigned for continuation of therapy in the community. This will include a daily meeting in the community (which may be changed after the program progresses). Some groups will receive a blocking agent daily at this meeting. Failure to participate could cause exclusion from the program. After discharge periodic lab tests are required and the patient will be notified as to the time for such a study. After discharge a periodic study of the patient's condition and adjustment is required. Patient and family will be notified in advance of the appointment.

Since the program's purpose is to return the patient to his/her family, the close cooperation of family members is necessary. For this reason at the time of the patient's acceptance at the Clinic, parents are assigned to the community for group guidance. Lack of cooperation on the part of parents could be a determining cause for exclusion from the program.

A total of four groups of ten are planned, with each group being assigned a member of the Community Team at the Lafayette Clinic as a program coordinator.

The group therapist from Lafayette Clinic will begin meeting with the group on a two or three times a

week basis. The after-care group worker will come into the hospital for as many of these group sessions as possible. Other after-care workers will also be expected to take part in the hospital program. A co-therapist within the hospital will be assigned to help coordinate vocational rehabilitation and other possibly useful agencies. The first year resident who is assigned a group of five patients will follow the group handling medical or milieu problems and working with the group therapist. He could function as a co-therapist.

Family group treatment by an independent community-based therapist will be initiated in the community on a weekly basis at the time of hospitalization aiming for some modification of the environment prior to the patient's return.

After the end of four to six weeks, the first group would be discharged to the community. This would be the first group of five which would be followed by a second group of five within the next few weeks that would make up one group from one community. It is anticipated that twenty patients will be hospitalized from the one community and then twenty from the other.

Daily meetings in the community will be maintained for up to six months. At the end of six months, the blocking agent for the drug group will be stopped. During that six months, it is possible that groups will be able

to meet less frequently but this will be determined as the program develops. Family members will be continued in group therapy on a weekly basis and it is planned that the family will assist in the administration of the blocking agent if more than a once a day administration is required.

In recent months, increasing numbers of young, recently addicted Heroin addicts have begun to seek help for their addiction. Present programs aimed at this problem are minimal and yield discouraging results. A major factor in the poor results appears to be problems in after-care. This opens several areas of investigation, including long-term treatment centers, community-based half-way houses, or increased utilization of existing facilities. The program outlined below is an attempt to utilize existing facilities with available personnel, using existing knowledge, with the highly successful Methadone Maintenance Program as a partial model.

The plan is to involve two communities; one, Model Cities and one, a suburban community, Grosse Pointe, with the Lafayette Clinic. The communities will provide the patients, the after-care workers, and the after-care facilities while Lafayette Clinic will provide hospitalization, a research drug, a variety of personnel, collection of research data, and overall coordination. It is planned that a total of 40 patients will be involved. Four groups

of ten patients will be admitted for a four to six week period. It is anticipated that Naloxone Hydrochloride, Narcon, a narcotic blocking agent, will be made available by Endo Laboratories, Inc. After-care will be intensive, provided by the community within the community with Lafayette Clinic personnel integrated in the program. The planned program is outlined as follows:

1. Patient Selection

    a. Patients will be selected from within two communities by referrals from doctors, police officials, families, and schools. School records and police records will be obtained and both the family and the patient will be interviewed.

    b. A complete outline of the program will be given the patient and his family prior to acceptance to the program so that full cooperation can be expected.

    c. A rating scale for screening will be used. We plan to accept only patients scoring an average of 3 or above on the answered questions. Patients who are psychotic or who are presently abusing multiple drugs will be excluded. Also excluded are patients with active hepatitis or serious medical problems.

    d. Final selection to the program will be done by a team within the community, consisting of Lafayette Clinic personnel and community workers.

2. Hospitalization

    a. Five beds on the two adult in-patient services of the Lafayette Clinic have been established for treatment for a total of ten beds.

    b. The patients will all be admitted to 4 South and at the end of three weeks transferred to 3 North.

c. Medications and limits.

1. The patients will have no privileges in the first week. During this time they will be withdrawn from Heroin, utilizing Methadone.

2. During the second week there will be no medication given. Phone privileges will be started.

3. During the third week two of the four groups will be started on Naloxon and two of the group will serve as controls with the total push program with no Naloxon. During this week visiting, limited to the family, will be started.

4. At the end of three weeks the patients will be transferred to 3 North. They will remain there until discharge. Privileges will depend on their progress.

5. If during hospitalization a patient demonstrates an inability to take part in the program by not conforming to ward milieu, he will be dropped from the program.

d. Individual Work-ups

1. Each patient will be assigned to a resident who will evaluate him medically and psychiatrically for presentation to a Staff Conference. One first year resident will be assigned a group of five patients. It is anticipated that the Staff Conference would be attended by the group therapist from the hospital and the community, as well as the regular staff.

2. Complete psychological testing will be done in order to attempt to evaluate these young addicts in depth.

e. Laboratory

1. CBC, urine, alkaline phosphator, S.G.O.T., serology, on admission and prior to discharge.

2. Other lab work that is needed as a result of the experimental drug.

3. Routine chest x-ray.

3. Treatment

   a. The group therapist from Lafayette Clinic will begin meeting with group on a two or three times a week basis.

   b. The after-care group worker will come into the hospital for as many of these group sessions as possible.

   c. Other after-care workers will also be expected to take part in the hospital program.

   d. A co-therapist within the hospital will be assigned to help coordinate vocation rehabilitation and other possibly useful agencies.

   e. The first year resident who is assigned a group of five patients will follow the group, handling medical or milieu problems and working with the group therapist. He could function as a co-therapist.

   f. Family group treatment by an independent community-based therapist will be initiated in the community on a weekly basis at the time of hospitalization aiming for some modification of the environment prior to the patient's return.

4. Aftercare Program

   a. At the end of four to six weeks the first group would be discharged to the community. This would be the first group of five which would be followed by a second group of five within the next few weeks that would make up one group from one community. It is anticipated that twenty patients will be hospitalized from the suburban community and then twenty from the Model Cities area.

   b. Daily meetings in the community will be maintained for up to six months.

   c. At the end of six months, the blocking agent for the drug group will be stopped. During that six months, it is possible that groups will be able to meet less frequently but this will be determined as the program develops.

d. Family members will be continued in group therapy on a weekly basis and it is planned that the family will assist in the administration of the blocking agent if more than a once a day administration is required.

5. Data Collection

a. Screening material and forms.

b. The in-patient psychiatric and psychological evaluation.

c. Intake research form and follow-up research form.

d. Group therapy records.

e. Family, intake, and treatment group data.

f. Intensive, regular follow-up.

6. Coordination

a. A total of four groups of ten are planned, with each group being assigned a member of the Community Team at the Lafayette Clinic as a program coordinator.

APPENDIX III

APPENDIX III

AN ACTION PROGRAM ON DRUG ABUSE FROM D.A.R.E (DRUG ABUSE RESEARCH AND EDUCATION) LOS ANGELES, CALIFORNIA

To combat the drug crisis among youth in the United States today and in Los Angeles in particular:

1. We must educate young people as to the risks involved (i.e., the "risk factor") in taking each drug so that they will decide not to use them, thus preventing drug abuse. The risks of heroin and LSD have been researched (and their use has declined) but not so for marijuana and amphetamine ("speed").

   For example: (a) Research Study on the Risk Factor in Marijuana's Use: This study is designed to measure the effects of marijuana and THC (Tetrahydrocannobinol, the active ingredient in marijuana) on driving performance. Many young persons drive under the effects of "pot" and many have accidents. Using one of the two most sophisticated drivers training laboratories in the world, UCLA's Institute of Transportation and Traffic Education, the effects of marijuana on driving can be documented; and (b) Research Study on the Risk Factor in Using Methedrine: There is a growing clinical evidence that chronic methedrine use is associated with organic brain damage. This study is designed to document this impairment by psychological and psychiatric examination of 20 chronic methedrine users and a brain damage in existence (the Reitan Test Battery) will be employed. Dr. Reitan himself from the University of Indiana, has agreed to interpret the data.

2. We must also understand why so many young persons use drugs. It is generally agreed that there is no "drug dependent personality" to describe all youthful drug users. Social forces as well as individual ones are important. Little attention has been paid to the non-user of drugs. If 60-80% of some affluent high school students try drugs, who do some young people resist experimentation: Is it fear, intelligence, intact homes, religion, naivete, special kinds of family communication, etc.?

   (a) Research Study on the Non-users of Drugs: This will be a longitudinal study of a group of 25 youngsters between the ages of 14 and 20 who attend schools in Los Angeles County and who participate in many aspects of the current teen culture (i.e., wear "mod clothes" and enjoy or participate in rock music), but who have always been entirely free from drug abuse. Through the use of psychiatric interviews, psychological testing and ongoing observations of the teenagers and their families (over a several years period) can we find any constant factors which have enabled this group of youngsters to resist peer and social pressures to "turn on" to drugs? The youngsters for the sample are those who have volunteered and are active in Project DARE. A matched control group of drug users will also be studied.

3. We must offer meaningful alternatives. Project DARE offers a peer group where it is "in" not to take drugs, yet it is also "in" to be involved with "psychedelic" music and modern clothing and fads. The group does not directly attempt to dissuade other young people from using drugs (although this has been a marked side benefit), but rather tries to reach parents and adults to help them bridge the communication gap and understanding (which is not synonymous with permissiveness) of today's teenagers so that they can develop meaningful alternatives to drug experimentation--as the DARE teenagers say--we "Turn on to Life."

ON PLANNING COMMUNITY DRUG ABUSE PROGRAMS

The following are some recommendations from Project DARE Volunteers for your consideration in planning a community drug abuse program.

1. Our position is that prevention is the most efficient and indeed the only effective way to reach the problem of drug abuse among our youth. Our recommendations are designed to meet the need for preventive measures in communities.

2. We regard adolescent drug abuse as a symptom of a larger problem: The existence of a serious communication breakdown between adults and young people is reflected in many individual and social problems. Drug abuse among youth is one of them. We recommend that the problem of communication between the generations be considered in the planning of all drug abuse programs.

3. We feel that both generations must be willing to sit down together and work on communicating more openly.

4. We feel that a workshop in the community should be designed to provide accurate facts, free of hysteria or exaggeration to the teenagers, their parents, their educators and others involved in the community (law enforcement and physicians for example) in the form of films, literature, consultations with professionals, etc.

5. In community workshops planned by Project DARE we find it effective to give adults an opportunity to talk with our DARE student volunteers who themselves have not used drugs but are trying to bridge the communication gap between the two generations.

   We have also found it effective to use our non(drug) users Rock Bank (The Stayns) to both attract young people to our exhibits and to be an effective example of how one can enjoy current fads of mod clothes, psychedelic art,

rock dance, and the innovative art form such as rock music--and still not be involved with or have a need for drugs.

6. We recommend the designing of a community program that provides positive reinforcement to those young people who have resisted experimenting with drugs. This is as compared to the large amount of publicity that goes toward reporting the negative aspects about young people and their activities.

7. Our goals include helping the community to mobilize its efforts toward prevention of adolescent drug abuse by:

   a. admitting that drug problems exist, and

   b. then trying to communicate openly and without hysteria or "putting down" (demeaning) young people having such problems. (This does not imply adult permissiveness or failure to take a stand about drug use--quite the contrary.)

8. The ultimate goals we have are to decrease the amount of drug usage while satisfying young people's curiosity about drugs, a curiosity that our adult culture has engendered. (Witness the number of TV commercials, for example, that advertise some form of mind altering drug.)

BERKELEY COMMUNITY HEALTH PROJECT
BERKELEY, CALIFORNIA

In the south campus area of Berkeley a growing need for comprehensive and inexpensive health services has evolved since the free-speech movement began in 1964. Until just recently, the community has been unable and/or unwilling to cope with this need in a meaningful way. The Berkeley Free Clinic and Switchboard began operation during the Peoples Park Crises in May of 1969 through the

combined efforts of the Medical Committee for Human Rights First Aid Team and the Free Clinic Steering Committee, which had been organized five months prior to the crises by a number of concerned citizens, university students and people from the street.

During the first eight months of operation, the Community Health Project has evolved into a non-profit organization providing health education, training and treatment to anyone who, for any reason, is not obtaining such services from the established medical facilities. The project has never had a fee-for-service policy but does encourage people to help the project in any way they can to assist the project in improving the health of the community. Essential operating expenses for medicines, supplies and overhead are presently averaging approximately $800/month. Thus far, all support has come from local contributions and one part-time staff salary from the Berkeley Health Department. Adequate professional supervision and other staffing has been maintained by volunteer efforts of the Project membership.

The major functions of the Project at present include a 24 hour a day switchboard including emergency, first aid, ambulance transportation, physician on-call and hospital referral services. These services are maintained by adequately trained medics. The Project also provides a professionally supervised in-service training program

for medics. A general medical clinic is open five evenings a week providing physician services and treatment for better than 1,000 people/month, plus facilitating referrals of very specialized or serious problems. A Rap Center is open seven days a week providing a variety of one-to-one and small group supportive experiences for over 500 people/month. A professionally supervised in-service training program is also providing responsible staffing for hot-line counseling, one-to-one crisis intervention, contact rapping and primary group leadership. Sex and drug education and informational services in the form of a Speakers Bureau and in-service programs at the local schools are in operation. The success of the educational projects has been due primarily to the competent non-professional members of the team. Community Awareness, which is one of the basic objectives of the Project, has been to improve community health through communication and understanding. In addition to the Medical Committee for Human Rights official recognition and limited support has been obtained from: Berkeley City Council; the University of California; Berkeley Health Department; Berkeley High School; Community Council on Drugs and Society; and the ACCMA.

Project plans for the near future to cope with still unmet needs include a community-based drug rehabilitation family program, an awareness house program

to improve understanding between alienated groups and to provide non-chemical alternatives for potential drug abusers, developing more comprehensive in-service training experiences in all phases of the Project's activities and developing job opportunities for minority groups in the general area of community health.

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EDUCATION:
Hillman Rural Agricultural High School
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Michigan State Normal College
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POSITIONS HELD:
Education:
Principal, 1950-1956
Instructor, Public Schools, 1956-1965
Law Enforcement Instructor, Community College, 1970-71
Chairman, Science Department, 1965-1971

Law Enforcement:
Deputy Sheriff, 1952-56; 1970 to date
Investigator, Department of State, 1954-59
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Juvenile Officer, 1952-54
Owner, Detective Agency, 1959 to date

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International Narcotic Enforcement Officers Association
Oakland County Drug Abuse Committee
Michigan Sheriffs Association
Michigan Educational Association
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