

Spring 1974

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Recommended Citation

William F. Griglak, *IV. Drug Abuse: Indiana's Response*, 8 Val. U. L. Rev. 641 (1974).
Available at: <https://scholar.valpo.edu/vulr/vol8/iss3/5>

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IV. DRUG ABUSE: INDIANA'S RESPONSE

WILLIAM F. GRIGLAK*

The 1971 Indiana General Assembly enacted the Indiana Drug Act¹ which created a new division within the Department of Mental Health, the Drug Abuse Division,² to coordinate a statewide effort aimed at reducing the incidence of drug misuse and providing effective treatment for those addicted.³ As part of this farsighted legislation, the division was given many responsibilities and powers. Procedures for persons electing treatment in lieu of incarceration were developed;⁴ treatment of minors was accepted;⁵ an Advisory Committee was appointed.⁶ Primary mandates were clearly issued to develop: (1) a coordinated state plan in the areas of prevention, intervention and postvention;⁷ (2) rules and regulations governing synthetic narcotic treatment programs;⁸ (3) regulations concerning

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1. Act of April 8, 1971, Pub. L. No. 222, § 1, [1971] Ind. Acts 882 (codified at IND. ANN. STAT. §§ 9-3901 *et seq.* (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-1 *et seq.* (1971)).

2. IND. ANN. STAT. § 9-3903 (Cum. Supp. 1971), IND. CODE § 16-13-7.5-3 (1971).

3. The General Assembly stated the purpose of the Act as follows:

It is the judgment of the General Assembly of the State of Indiana that a concentrated effort must be exerted to curtail or greatly reduce the incidence of drug misuse and to effectively treat and rehabilitate those who are physically or mentally dependent upon drugs.

It is also the judgment of the General Assembly that in order to efficiently and successfully direct preventive, educational, treatment, and rehabilitative drug programs, it is necessary to establish an administrative unit concerned solely with the creation and administration of such programs.

It is the further belief that such an administrative entity should have the primary responsibility for directing all drug, narcotic drug, dangerous drug, and harmful substances programs as they concern treatment within the state of Indiana, either through its own direct implementation or by compliance of other agencies of state government with its stated wishes. The only hope for an effective attack against drugs is the complete coordination of activities among all state, local governmental agencies and private agencies which have some responsibility for dealing with some aspect of the drug problem.

IND. ANN. STAT. § 9-3901 (Cum. Supp. 1971), IND. CODE § 16-13-7.5-1 (1971).

4. IND. ANN. STAT. § 9-3916 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-16 (1971).

5. IND. ANN. STAT. §§ 9-3920, 3921 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-20, 21 (1971).

6. IND. ANN. STAT. §§ 9-3909 to -3913 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-9 to -13 (1971).

7. IND. ANN. STAT. §§ 9-3901, 3904(a) (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-1, 4(a) (1971).

8. IND. ANN. STAT. §§ 9-3904, 3923 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-4, 23 (1971).

accreditation or certification of all treatment programs in the State of Indiana.⁹

The newly formed Advisory Committee met in June 1971 to begin the task of laying long- and short-range plans to implement this new law. Franklin G. Osberg, M.D., became the first Director. Doctor Osberg, along with the Advisory Committee and assistant director, began drafting the three major documents noted above. March 1972 saw the promulgation of the *Methadone Rules and Regulations*;¹⁰ Indiana's first *State Plan on Drug Abuse* was published in July 1972;¹¹ and, public hearings were held in 1973 on the *Treatment Program Accreditation Regulations*.¹²

It soon became quite clear that the law had preceded available treatment facilities within the Department of Mental Health system.¹³ It was not until November 1971 that courts and clients were able to utilize the provisions of the law concerning election of treatment in lieu of incarceration. By July 1, 1973, however, over 400 clients had taken advantage of the Indiana Drug Act.¹⁴ Aided by expert legal counsel, the Drug Abuse Division has devised a clear process by which a person may invoke the law.¹⁵

To complete the law further, the 1973 General Assembly passed the following amendments:

(1) *Treatment by the department.* The Assembly expanded

9. IND. ANN. STAT. 9-3902(l), 3904(i), 3904(k), 3925 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-2(l), 4(i), 4(k), 25 (1971).

10. On file, Indiana Dep't of Mental Health, Drug Abuse Division, Indianapolis, Indiana and in the 14 Mental Health and Mental Retardation Planning Region offices. The regulations were further amended in May 1973.

11. *Id.* The State Plan was completely rewritten July 1973, for submission to the Dep't of Health, Education and Welfare.

12. *Id.*

13. There are six general state hospitals: Madison, Beatty, Central, Logansport, Evansville and Richmond. Of these, only two, Logansport and Richmond, have developed bona fide drug treatment units. Logansport began its unit in October 1972, and Richmond commenced operations in March 1973. From April 1971 (the effective date of the Indiana Drug Act), until October 1972, drug treatment was done on general wards without any definable treatment regimen.

14. Dep't of Mental Health, Drug Abuse Division, case files. The Drug Abuse Division maintains a file on each person who has elected treatment under the Indiana Drug Abuse Act.

15. Although the title may belie its contents, the DICK AND MARJANE READER, published by the Division, is an excellent handbook defining each step of the commitment and treatment process under the Indiana Drug Abuse Act.

the term "treatment by the department" to include treatment in any drug abuse program within the State of Indiana which meets the certification requirements of the Department of Mental Health and is currently certified.¹⁶ This amendment now enables the Department to designate many more facilities as acceptable for treatment in addition to the state hospitals.

(2) *Establishment of penalties for nonconformance to the law.* The Division was given the authority to compel compliance with the Act by appropriate legal or equitable actions against any individual or treatment program which deviated from the provisions of the Act.¹⁷ For example, the Division may now enjoin the operation of any treatment center which fails to satisfy the certification requirements of the Division or endangers public health. For some reason this was not included in the original Act thus leaving the Division powerless if mandates were not followed.

(3) *Expansion of the Drug Abuse Advisory Committee.* The federal Drug Abuse Office and Treatment Act of 1972¹⁸ demands that the single state agency in charge of drugs be represented by an advisory body whose membership includes minorities and representatives from various geographic portions of the state. The amendment was designed to insure conformity to the federal mandate.¹⁹

(4) *Examinations for treatment "within a reasonable time."* Specification of time limits within which the initial examination to determine eligibility must be completed is now to be determined by the Commissioner of the Department of Mental Health.²⁰ The Commissioner, in turn, has defined "reasonable time" as a period not to exceed thirty days.²¹

16. Act of April 12, 1973, Pub. L. No. 157, § 1, [1973] Ind. Acts 817 (codified at IND. ANN. STAT. § 9-3902(l) (Cum. Supp. 1973), IND. CODE § 16-13-7.5-2(l) (1973)).

17. *Id.* §§ 2, 9 to 11 (codified at IND. ANN. STAT. § 9-3904(l), 3925 to 3927 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-4(l), 25 to 27 (1973)).

18. 21 U.S.C.A. §§ 1101 *et seq.* (1972).

19. Act of April 12, 1973, Pub. L. No. 157, § 3, [1973] Ind. Acts 817 (codified at IND. ANN. STAT. § 9-3910 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-10 (1973)).

20. *Id.* §§ 4, 7, 8 (codified at IND. ANN. STAT. §§ 9-3914, 3917, 3918 (Cum. Supp. 1973), IND. CODE §§ 16-13-7.5-14, 17, 18 (1973)).

21. On file, Indiana Dep't of Mental Health, Drug Abuse Division, Indianapolis, Indiana and in the 14 Mental Health and Mental Retardation Planning Region offices.

(5) *Information required for accreditation.* Programs of treatment operating in Indiana are now required to provide specific information to the Division as part of the accreditation process.²² Each program must declare its purpose; methods of treatment; adherence to fire, health and zoning regulations; fiscal support; administrative hierarchy; board of directors; static and dynamic capacity of the program; types of clients to be served; qualifications of personnel; and, in addition, must submit articles of incorporation and bylaws.²³

(6) *Other clarifications.* Although clear to members of the Advisory Committee, dispute had arisen in the first year of operation over section 16 of the original law concerning "crimes of violence."²⁴ Section 16 originally provided, among other disqualifications, that a drug abuser charged with or convicted of a "crime of violence" would be ineligible for treatment.²⁵ The law was amended in 1973 to include "against the person"²⁶ to clarify the types of crime envisioned by the legislature. In addition, during 1971-72, the issue of multiple charges arose in courts and among attorneys. The original Act disqualified individuals who had "other criminal proceedings"²⁷ pending from electing treatment under the Act. This confusion led the committee and the Assembly to clarify this section by amending the Act to read "other criminal proceedings, not arising out of the same incident."²⁸ Thus where only one charge is at stake with possible multiple counts, the person will still be eligible to elect treatment.

Another issue has arisen over the past year concerning the interpretation of section 17.²⁹ The treatment unit may or may not be the examination unit. Whether it is or is not, the law asks the examination unit to determine two things: (1) is the client a drug abuser and (2) is he amenable to treatment? The unit is then to

22. Act of April 12, 1973, Pub. L. No. 157, § 9, [1973] Ind. Acts 817 (codified at IND. ANN. STAT. § 9-3925 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-25 (1973)).

23. See IND. DRUG ABUSE DIV., OFFICIAL RULES FOR CERTIFICATION OF DRUG ABUSE TREATMENT PROGRAMS (1973).

24. IND. ANN. STAT. § 9-3916 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-16 (1971).

25. *Id.*

26. Act of April 12, 1973, Pub. L. No. 157, § 1, [1973] Ind. Acts 817 (codified at IND. ANN. STAT. § 9-3902(m) (Cum. Supp. 1973), IND. CODE § 16-13-7.5-2(m) (1973)).

27. IND. ANN. STAT. § 9-3916 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-16 (1971).

28. Act of April 12, 1973, Pub. L. No. 157, § 6, [1973] Ind. Acts 817 amending IND. ANN. STAT. § 9-3916 (Cum. Supp. 1971), IND. CODE § 16-13-7.5-16 (1971).

29. IND. ANN. STAT. § 9-3917 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-17 (1971).

submit its findings to the Department of Mental Health which, in turn, submits its report to the court. The court makes the final decision whether to accept the recommendations of the Department.³⁰ If it does, the option of accepting the client lies with the Department of Mental Health. If the Department does not accept the court's request, no appeal can be made.³¹ What is important to note is that the examination unit, if it is the same as the treatment unit, is not to engage in treatment during the examination period, but simply determine *eligibility* for treatment. Only after the report is accepted by the court and appropriate orders given can treatment be started.³²

Finally, in the waning months of 1973, legislation has been prepared for the 1974 General Assembly to combine the Division on Alcoholism and the Drug Abuse Division into a single Addiction Services Division.³³ Such an administrative move is felt by many to be another forward step since alcohol is a major drug of abuse, the clientele to be served are often multi-drug users (most often including alcohol as one of the drugs), and both divisions share many of the same state and federal mandates.

The responsive legislation passed in 1971 by the General Assembly and its expansion and clarification by subsequent Assemblies provides that Indiana shall have a coordinating, monitoring and catalytic agency to act as a clearinghouse for drug related programs in the areas of prevention and treatment. In addition, and by no means unrelated to the first task, Indiana officially recognized in 1971 that drug abuse, in many instances, is but the tip of the iceberg. Despite the illegal and antisocial activities involved, the person so addicted or habituated to drugs may still find a better avenue to rehabilitation than through incarceration. A distinct opportunity was provided in the Indiana Drug Act to see if, in certain cases, drug addiction or dependence might best be handled outside prison walls and within the framework of a treatment setting. One historical fact is known: the recidivism rate for drug abusers re-

30. *Id.*

31. IND. ANN. STAT. § 9-3918 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-18 (1971).

32. *Id.*

33. The proposal was authored by Mr. Sam Stoehr, legal consultant to the Division, and prefiled as S.B. 27 by Senators Robert L. Sheaffer and Wilfrid W. Ullrich into the 1974 Indiana General Assembly.

leased from a prison setting is very high.³⁴ It is only fair to admit that there is no agreement in Indiana's judicial, law enforcement or legal system on the effectiveness of the Act.³⁵ Only time will provide an answer. What is important to note is that Indiana was willing to lay the legislative groundwork for an additional system to cope with the drug abusing person.

INDIANA DRUG ABUSE PROGRAMS: PREVENTION, INTERVENTION, POST-VENTION

In every new field a lexicon is devised. The drug arena is no exception. Old and new concepts merge; old therapies are combined with new therapies; felt need and real need are brought together. It is not at all surprising, when looking at the drug abuse battlefield, that most of the early work concentrated on heroin addiction and subsequent treatment for the persons so addicted.³⁶ Social casualties are the easiest to see. Treatment (or intervention) becomes a concrete issue. To that end, across the nation (and in Indiana) a number of "field hospitals" were established. From small hotlines to storefront operations, from massive methadone support clinics to therapeutic communities—all began in an attempt to offer the social casualty an opportunity to "kick the habit." As other drugs came into prominence (from "speed" to "sopors," from "barbs" to "pot") the programs tried to meet such needs. Most programs began on a shoestring, and those still in existence live, for the most part, from hand to mouth financially.³⁷ Indiana, at the present time, can

34. The now famous Lexington, Kentucky data shows a recidivism rate as high as 98 percent from an incarcerated drug treatment setting. E. BRECHER, *LICIT AND ILLICIT DRUGS* 69 (1972).

35. This opinion is derived from discussions and seminars with judicial, legal and enforcement participants. The philosophical chasm concerning the best way to deal with the drug abuser reveals that a number of officials believe that the Indiana Drug Act "coddles" the drug abuser and that drug treatment will not be helpful. Since the majority of commitments under this Act have come since November, 1972, it is as yet too early to claim either success or failure.

36. In fact, over 95 percent of our federal resources utilized to combat drug misuse have been spent in this area which accounts for less than five percent of the drug misuse problem. Statistics presented by the Special Action Office of Drug Abuse Prevention at the National Training Center, Washington, D.C. December 4-8, 1972.

37. This fact is not peculiar to Indiana. Street programs are usually financed in a skeletal way through private donations, church affiliated backing or, at best, minimal United Way or other foundation money. Most programs, emerging in the last half of the 1960's, have been started by either street people or cause-oriented professionals. They usually came into

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tally the following programs: 9 methadone support clinics, 15 therapeutic communities, 17 hotlines, 2 state hospital programs, 2 prison programs, 38 crisis counseling operations and 4 multimodality programs.³⁸

The nine Indiana Methadone Support Clinics are located in Gary, South Bend, Fort Wayne and Indianapolis.³⁹ These clinics are, by federal law, to be more than dispensaries.⁴⁰ Each must provide a range of ancillary or support services in the areas of counseling, group therapy, job training, placement and family counseling. At this time there seems to be no need for additional methadone clinics in Indiana. The data available from the recent epidemiological study⁴¹ reveals that, while the heroin usage is understated, a proliferation of methadone support clinics would be ill-advised both from a financial viewpoint as well as a priority perspective. Poly-drug usage is, by far, a more serious problem area in Indiana and must be addressed in terms of money and priority of treatment. Data available in the Division office shows that the nine methadone support clinics⁴² serve over 1,100 clients with almost 100 treatment slots still available. The need, therefore, can be met with existing clinics.

Therapeutic communities are located in South Bend, Fort Wayne, Logansport, Richmond, Lafayette, Indianapolis, Bloomington and Evansville.⁴³ Each of these ventures offers a particular

existence as the result of some crisis in a community, such as overdose deaths, poor quality drugs or middle class involvement.

38. See IND. DRUG ABUSE DIV., 1973-74 INDIANA DRUG ABUSE PREVENTION PLAN 28-40 (1973).

39. Methadone is an addicting narcotic which has a blockading effect and has been shown to diminish the need for heroin or other opiates. Opiate addicts, under strict federal regulations, are permitted to take this drug in prescribed dosages each day accompanied by ancillary or support services such as counseling, vocational training and family counseling. See note 40 *infra*. The names and location of the Indiana Methadone Support Clinics are as follows: Miracle Products (Gary, Indiana); Aurora House (South Bend); Summit House (Ft. Wayne); Martindale Clinic, Westside Methadone Clinic, Methodist Hospital Methadone Clinic, Barrington Clinic, Renata House, Veteran's Hospital (all in Indianapolis).

40. FDA, Methadone Rules and Regulations, 21 C.F.R. § 130.44 (1972).

41. See note 50 *infra* and accompanying text.

42. See note 39 *supra*.

43. The names and locations of the therapeutic communities are as follows: Delos House (South Bend); IADAC (Ft. Wayne); Logansport State Hospital Rainbow Unit; Richmond State Hospital; Lafayette Crisis Center; Renata House (Indianapolis); Ashram (Bloomington); Evansville Therapeutic Community.

method of operation, ranging from loosely structured therapies to the classic Synanon⁴⁴ approach. Therapeutic communities are 24 hour live-in, confrontation modalities whereas methadone support clinics are walk-in oriented. In classical mental health terms, the methadone support clinic is an outpatient setting in which the client comes in once a day for methadone and therapy while living at home in the area of the clinic. The therapeutic community, on the other hand, is an inpatient facility where a client takes up actual residence outside of his home in another facility for a period of time, usually three to nine months. In this setting, contacts with his home environment are limited until such time as the drug user has shown an ability to cope with himself and others. Usually, therapeutic communities operate on a graduated responsibility basis. The new resident must perform minimal tasks and accept minimal responsibility at first, gradually accepting more responsibility within the community to the point where "graduation" occurs. At this point, the resident leaves the therapeutic community and returns to his family or previous environment.

Intervention services are scattered throughout the state in both large cities and small towns. Almost all are privately funded, either through local civic organizations or church groups.⁴⁵ The term "intervention services" was coined by the federal government to contrast with "treatment services." Intervention implies a notion of crisis or emergency situation. Oftentimes, this occurs in the form of a drug hotline or emergency rescue service. It may also imply, for want of a better word, "one-shot" counseling. Also, the client may remain anonymous to the service—simply seeking help without revealing untold data about himself. Treatment services, on the other hand, will become involved in ongoing assistance to the client, necessitating revelation of name, problem areas, residence. In short, a tracking system is established between the treatment unit and the client. Emergency services (or intervention) arose in the late sixties to cope with overdose problems, to provide a brief respite setting for a transient client and to serve as a haven for people who felt "hassled" by the established society. Help usually came in terms of "trip sitting" (helping a person high on drugs come down). Comforting a

44. Synanon is the classic encounter-confrontation therapeutic model. For a complete description see L. YABLONSKI, *THE TUNNEL BACK* (1966).

45. Cf. note 37 *supra*.

drug user; offering advice during bad drug trips; listening to someone contemplating taking drugs; giving information about the effects of certain drugs—all of these became associated with the daily activities of the intervention-type services. In most cases, unless minors were involved, no attempts were made to probe into the client's past life, background, place of residence or other factual details. In addition, the physical settings of intervention services were important. Usually, they came into being in a store-front or old house. Only the barest of health, fire and zoning ordinances were followed. In short, they are run by street people and symbolize disdain for the establishment's inability to comprehend the drug problem.

Through the United States Office of Education [USOE], Indiana has been the recipient over the past two years of mini-grants to communities.⁴⁶ A training center in Chicago offers two-week training programs to six-person teams from designated communities. Mini-grants are given by USOE directly to the communities. Six members of the community are chosen (usually a major political figure in the community, a teacher, a minister, a law enforcement official, a young person and a street person) to represent their community.⁴⁷ All lodging, subsistence and travel bills are paid by USOE on a cost-reimbursement basis. The USOE Region 5 Training Center located in Chicago conducts approximately fifteen to eighteen cycles each year in which representatives of communities in a ten-state area come for two-week training sessions. These teams are then to return to their respective communities with definite action plans or strategies directed toward alleviating the drug problem in their area. They are to return to their community as catalysts in planning programs, coordinating activities and providing the impetus for a more concentrated attack on chemical misuse.

46. As part of the federal strategy backed by the Special Action Office of Drug Abuse, the United States Office of Education [USOE] has been mandated to provide funds for a national project entitled "Helping Communities to Help Themselves." The plan basically provides that six regional training centers be established and staffed by professionals and paraprofessionals to provide community representative teams an opportunity for two weeks of intensive cognitive and attitudinal awareness training. Indiana has received 21 such mini-grants for 1973-74.

47. While USOE presents guidelines concerning the qualifications of participants and sends field representatives into the community to assist in the selection of teams, the community selects its own participants.

In addition, the Department of Public Instruction has offered, through Indiana University, a series of training courses to the general populace from various cities and towns throughout the state. The Department of Public Instruction, having a state mandate to train people in the area of drug abuse and knowing that many people are unable to leave their community posts for long periods of time, has constructed mini-training seminars around the state. Like the USOE sessions, these training seminars are both didactic (learning about drugs) and attitudinal (learning about people, communication, relationships, community planning and providing services). Speakers are brought to the seminar to address the participants on pharmacology, law enforcement and social aspects of drugs and to provide a general education on drugs. Intensive group sessions are held to maximize input from each of the participants. Site visits (or field experience) to drug treatment programs are provided as part of the training experience.

Perhaps the most heralded and coordinated program of education in the state is that provided through the Indianapolis Public School System. The Indianapolis Public School drug education venture, under the leadership of Mr. David Garrett, Education Coordinator, chose to develop a training program for teachers stressing attitudinal approaches to the issue rather than training teachers to be experts on drugs. Again, a content-oriented approach has been found to be wanting⁴⁸ and, as a federal and state strategy, more emphasis has been placed on the "why" of drugs rather than on the "what" of drugs.

ROLE OF THE DRUG ABUSE DIVISION

The Drug Abuse Division provides expertise to communities and regions (Indiana has fourteen planning regions) in the areas of planning, program development, staff training and grant writing. Because of the nature of the Division, the staff is heavily involved in conferences, symposia and meetings on a federal, state and local level. By state and federal mandate, the "single state agency" (the Drug Abuse Division in Indiana) is to provide administrative services in the areas of community planning, program development, certification of programs, data management assistance, rules and

48. See note 50 *infra* and accompanying text.

regulations for methadone maintenance, grants management and legislative liaison.⁴⁹ Federally funded programs have a direct relationship to the Division. The Division, by law, must review and comment on all federal grant applications.⁵⁰ Privately funded programs are much more autonomous. Basically, through certification the Division has some "handle" on programs—in general, an auditing-monitoring relationship.⁵¹ In addition, each program must relate to the regional planning bodies. The Indiana Department of Mental Health works with the fourteen planning regions in the state. All program development must be scrutinized by the regional council or committee in question. The Division holds contracts with each planning region in the state and through this relationship deals most often with individual programs. Finally, through the mechanism of funding (in the future) the Division will maintain close ties with each program so funded. Through the *Certification Rules and Regulations* there is established, as a last resort, an adjudication process should any program be found to be harmful to the health and well-being of clients seeking help.

Since most of Indiana's fiscal resources are from the federal government,⁵² federal thrusts must be heeded. New developments in the areas of treatment and intervention are subject to massive doses of program management, data collection, systems designs and other administrative controls. Indiana, through its state plan, has designated the areas of program management and systems designs as a major priority in order to obtain concrete data on the "drug scene" in Indiana. A major epidemiological study, for example, is now nearing completion from which will be generated the first "hard" data in Indiana on drug usage, drug patterns, drugs of choice and areas of high risk.⁵³ From this, it is hoped that future resources and programs can be planned more rationally.

49. IND. ANN. STAT. § 9-3904 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-4 (1973).

50. IND. ANN. STAT. § 9-3907 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-7 (1973).

51. IND. ANN. STAT. § 9-3925 (Cum. Supp. 1973), IND. CODE § 16-13-7.5-25 (1973).

52. Indiana's General Fund appropriation to the Division for fiscal year 1974 is \$204,000. Federal government appropriation to the Division through grants and contracts total over \$1,500,000: \$1,200,000 through National Institute of Mental Health for Methadone Support Clinics and \$315,000 from the National Institute of Mental Health Special Action Office of Drug Abuse Prevention for the administration of the Indiana State Plan.

53. Resource Planning Corporation, under the direction of Dr. Carl Chambers, completed this study. Eleven volumes of material are in the offices of the Drug Abuse Division. Because of the voluminous nature of this study, no copies are available, but an Implication

Prevention, however, is another issue. Prevention activities usually center around content-oriented educational ventures as if teaching facts about drugs would affect behavior and effect change in persons. This, as we know, has not been an effective approach.⁵⁴ The reason is basically that the mischief is not in drugs, the mischief is in people.

Finally, postventive activities have been limited because of the stigma attached to drug usage. Business and industry only recently have determined that if a treatment program is to be effective there must be some alternative to drugs available to the former user. Vocational training and job placement needs are critical if the initial intervention is to be successful.

Programs in Indiana, in varying degrees, try to assist many people in finding some answers to drug-taking. One of the responsibilities of the Drug Abuse Division is to assist programs in developing ever sounder approaches. Through its certification system, the Division has the authority to monitor all programs. The monitoring process includes audits, technical assistance, site visits and the responsibility to provide resource capabilities to all programs.

It is, of course, taken for granted by the Division that no one program has all the answers for all drug using persons. Indiana programs have been established to meet both the short-term and long-term issues confronting a person. While, for example, methadone support is one type of treatment modality, its potential is very limited; a therapeutic community setting demands highly motivated persons willing to bear the extreme confrontation involved in such a program; the crisis counseling or hotline provides emergency scaffolding without seeking out long-range alternatives.

There are also programs providing alternatives through a Judaic-Christian ethic. Others lean heavily on the eastern philosophies (transcendental meditation and kundalini yoga for example). Some programs are didactic in tenor while others are highly emo-

Report, giving a summary of the study, is available from the Division, 3000 West Washington Street, Indianapolis, Indiana 46222.

54. See, e.g., Glenn, Drug Abuse as Normative Behavior (on file with the Drug Abuse Division); Halleck, *The Great Drug Education Hoax*, CAPSULES, Vol. 3, No. 1, April 1971, at 1; Swanson, *Fallin' Back Grinnin'* (Region V, USOE Training Center publication, Vol. 1, No. 6, October, 1973).

tional "trips." Some programs are highly sophisticated in the therapy-arts (e.g., transactional analysis, gestalt, encounter and therapy-group), while other programs shun the establishment modalities in favor of a "helping hand" or a "shoulder to cry on approach." All programs, whether operated by "street people" or professional therapists, try to alter a person's behavior. Many people, however, expect immediate results, failing to realize that the manipulative behavior of the drug-using person (alcoholism is an excellent example familiar to many people) cannot be changed with a wave of the magic wand. Perhaps the best we can hope for is that any program helps more than it hurts. As harsh as that may sound, both program designers and practitioners must learn that their program may not be the answer—or but one part of an answer. Drug programs are especially prone to feel the weight of the world falling on their shoulders. Only lately have diverse programs felt the need to sit down at the common table.

If "the mischief is not in drugs, the mischief is in people" is an adage which holds true, we must continue to look for creative alternatives to drug misuse. We must be honest, for example, in considering *all* chemicals of potential misuse and help each other learn to use chemicals *responsibly*. We must not equate the mere illegality of certain drugs with badness; nor the legality of other drugs with goodness. In doing so we become schizophrenic in our deliberations and demands as a society. Drugs are not magic; nor are they alien to most members of society. We must ask ourselves how *we* use chemicals: cigarettes, alcohol, caffeine, tranquilizers, pep and diet pills and a multitude of commonly used drugs. We might also consider *our* need for instant gratification. Each of these pieces fits into the tapestry of man-and-his-chemical-usage.

Further, we might consider such areas as education, life styles, goals, demands. If, for some people, education is a "bummer," can anything be changed? If not, why not? Can creative brainstorming produce alternative forms for young people today? If, for example, we are a drug-using culture, can anything be done to create new images in our families, in medical practice, in television?

We might ask about our own "addictions." How many are workaholics, tv-addicts, golf-addicts, football-addicts—caught up in needs which can barely be handled? Is our recreation really a re-creating of energies for us and for children? And what about our own ethics—in business, at home, in pleasure?

To speak of drug-taking thus involves asking questions of society and requires honest answers. But society is reluctant to admit that it is a drug-taking culture. Only recently have schools, churches, fraternal groups begun to ask new questions about the "drug problem." Perhaps another turn in the corner might carry us to a new point: there is no *drug* problem; there is very much a *people* problem in which drug-taking is but one way in which some people try to get high.

CONCLUSION

Many questions can be asked. Very few answers can be given. A beginning has been made in Indiana as across the nation. We are no longer content to mythologize drugs. By the same token we are wont to believe in simplistic answers. History is bearing out that neither approach is workable. One of the interesting facets of the 1971 Indiana Drug Act is that the Drug Abuse Division was created to be a catalytic agent in the state. While the Division is mandated to audit, certify, monitor, coordinate and provide fiscal responsibility; perhaps its greatest contribution will be in encouraging a deeper look at the issue of chemical intake in our society. After all, whether it is marihuana or alcohol, LSD or tranquilizers, weight pills or speed—whether illegal or legal, whether done by a fourteen year old or a forty-four year old—if done *irresponsibly*, we have another instance of a people problem. This as an advertisement recently pointed out, becomes a "medical problem, a legal problem, a social problem, a community problem, your problem, my problem."⁵⁵

55. N.Y. Times, Oct. 15, 1971, § B, at 63.