knew some day he would be old enough to exercise the rights that his father and schoolmaster were exercising.

Today by an accident of history we have a break and the drugs that the young people want to use, the stimulants, the energizers, the pacifiers or whatever you wish to call them, are ones that the adults don't want to use so there is now what appears to be a new form of tyranny by the adults over the young, and you have the adult standing with a cocktail in one hand and a cigarette in another saying "I would beat the- - - -out of any child of mine who ever smoked pot."

Now, this position is untenable, and it is leading to a degree of distrust, a breakdown of law and order, that, beside which the prohibition conditions of 1920's in which I grew up pale completely because we now have this vicious relationship between marihuana and hard drugs, which we invented, and which wasn't necessary at all.

This week it was reported in the press that owing to the various operations to stop the importation of marihuana in the country children are now being sold heroin instead, so that instead of a pleasant indulgence that is less noxious than that engaged in by their elders they may be turned into hard drug addicts for life.

I would like to mention at this point an editorial from WIIC in Hartford, Conn., praising the new Connecticut law which makes it possible now for children who have gotten involved in hard drugs or in dangerously manufactured drugs, to go for help without their parents' consent. (See p. 5477.)

Now, the reason we have to have such a law is because of the break between the adult forms of belief of what is legitimate practice and what the young people want as legitimate is so drastic and it is more drastic, I think, than the break that occurred at the time of prohibition.

Senator NELSON. Thank you, Dr. Mead.

I had one question I forgot to ask a little while back. Assume an individual who has prescribed for him one of the tranquilizer drugs for a necessary purpose. What about that individual continuing to rely upon the drug all of his life when he may very well have only needed it for a year. Perhaps he ought to be taken off the drug. I don't know how often this happens but I know of instances where a person who has relied very heavily upon it for awhile thinks he can't get along without it and finally is told by his doctor "You just can't use it any more." He is then taken off the drug, becomes adjusted very well without it.

What do we do about the person who goes on the drug for an appropriate purpose but there is no reevaluation by any physician of his status and he continues to take it for 10 or 15 or 20 years or the rest of his life? Is that harmful? Would he be better off if there was some reevaluation and he was removed from the drug? Do we know much about that problem?

Dr. MEAD. I think it would be very useful to have reevaluation of everyone, that everybody ought to have some kind of periodic checkup, and one of the very serious things in this country is that the average male from the time he leaves his pediatrician until he is so sick it is too late to do anything for him has no doctor of his own. He never goes to a doctor except when he is seriously ill. Women, from the cradle to the grave now, have specialists. They will go from the pediatrician to the obstetrician, to the gynecologist to gerontologist.

But we have no regular system for the whole population. We have no good examination of children. The examination for the draft is simply for purposes of rejection and if people are found to be ill all we do with them is to turn them away. The only defects that we remedy are ones that occur within those who are drafted or who enlist for the Armed Services. Of course, there are some industries that take this kind of responsibility.

Of course, we need to check up on the use of drugs. We need a periodic checkup; we need ways in which we could register, which again could be done now electronically. Somebody was put on this particular drug on May 9, 1969. Automatically, say May 9, 1970, these people will come up the way, you know, a well behaved dentist sends you a little note saying "6 months since I saw you."

But we can't expect this to be done with the existing medical facilities in this country without help, because the average practitioner is too busy and harassed and he has no way of getting at the informtaion and he doesn't know which drugs you ought to watch for a follow-up and which you ought not. That is one side, that is one answer to your question.

The other answer to your question is I would want to be convinced that it did him any harm to take this drug that he was taking for years. There are many people who have taken perfectly useless drugs all their lives, the drugs have kept them nice and well because they believed in them.

Now, if one could demonstrate that the drug itself was bad for one biochemically or inordinately expensive and therefore making a drain on one's budget, I think one can make a case. There are people who believe when they get up in the morning they need a cup of coffee. There are large numbers of people who believe they simply cannot function, they can't think, they can't act without that coffee. Now, there is no proof whatsoever that one cup of coffee supplies all that energy and considerable organization. Would you take that cup of coffee away from them? They also believe after they have drunk that cup of coffee they are alert, bright-eyed and bushy-tailed and ready to deal with the world? Now do you want to take these away from people? I don't see any reason for taking them away merely because there is what we call psychological dependence. If there is an addictive dependence which means you have to continually raise the dose and if you get biochemical addiction, this is a different problem but looking at the psychotropic drugs this potential addiction is true of some and not others.

(The complete prepared statement of Dr. Mead follows:)

EXCERPTS FROM THE TESTIMONY OF MARGARET MEAD, CURATOR EMERITUS OF ETHNOLOGY AT THE AMERICAN MUSEUM OF NATURAL HISTORY AND ADJUNCT PROFESSOR OF ANTHROPOLOGY AT COLUMBIA UNIVERSITY

My credentials for discussing this subject are: I am an anthropologist who has concerned herself with the relationship between culture and practice, in the fields of technological change, nutrition, medicine, specifically, nursing, psychiatry and community mental health. Institutionally, I am Curator Emeritus of Ethnology, in The American Museum of Natural History, Adjunct Professor of Anthropology at Columbia University, and Chairman of the Department of Social Science in Fordham University new liberal arts college at Lincoln Center. I have been for several years, Visiting Professor Anthropology in the

School of Psychiatry at the Menninger Foundation, and I have been for the last ten years, Visiting Professor of Anthropology in the Department of Psychiatry, in the University of Cincinnati College of Medicine.

I was president of the World Federation for Mental Health in 1956, and I was a member for seven years of the group who evaluated research for the National Institute of Mental Health. During World War II, as secretary of the Committee on Food Habits of the National Research Council, I developed the relationship between the human sciences and the field of nutrition. I have also had some experience with the field of the specific training given to detail men, by pharmaceutical companies, and with the relationship between government and industrial practice as chairman, 1965–1969 of the Committee on Science in the Promotion of Human Welfare of the American Association for the Advancement of Science, and as a member of the Board of Directors of the Scientists Institute for Public Information.

Specifically, I have combined intensive anthropological research in eight different primitive cultures, over the last forty-three years, with studies of our own American culture, of sub-groups within American culture and made comparative studies at a distance of other high cultures. I have been specifically concerned with the way in which American values were conveyed, inexplicitly as well as explicitly, by advertising, education, and the particular ethics and style of different professional groups, nutritionists, health educators, nurses, physicians, public relations practitioners, advertisers, architects, etc. both within the United States and in our relationships with the developing countries. I have been and am deeply concerned with the way in which we develop institutional changes by administrative or legislative action, and how styles of commercial behavior, and medical and health education, reverberate—together with United Kingdom, France, Germany, Switzerland, Japan and all industrialized countries—throughout the technologically underdeveloped world. Several years ago I was stranded for a couple of days in Kaboul, Afghanistan, where I met two detail men, one an Indian and the other a Pakistani who were representing exactly the same style of drug salesmanship that has been developed among detail men in the United States. In my testimony I will address myself to the problems of the psychotropic drugs, as they have been defined in previous hearings of this Committee on July 16, 1969 as major tranquilizers, minor tranquilizers, anti-depressants, stimulants and hypnotics.

But while doing so, I count it as my most useful contribution to place the question regarding this particular group of drugs within the wider context of American attitudes towards such problems as whether it is better to make an innovation which improves the chances that an individual will be healthy, happy and wise—to quote a traditional wish for a child—or to continue to cope with unimproved conditions, with our American attitude towards all substances which alter mood, and with our current attitudes towards drugs, which include our panicky response to the present—and inevitably passing as the first generation of Post World War II children move out of adolescence into adulthood—generation gap. It is also necessary to take into account our traditional attitudes which separate the pursuit of profit, appropriate to private enterprise, the pursuit of power, appropriate to politicians, the pursuit of good behavior, appropriate to educational and religious institutions, and the attempt to make a changing society more human and productive of great human well being, appropriate to those public and private agencies explicitly devoted to altering the relationship between current practice and potential for well being, such as public health, social case work, urban planning, etc. The traditional separation of the goals and appropriate practices of these different agencies, has fragmented contemporary life, and made it exceedingly difficult except in wartime. I will, however, relate to a wider cultural context of beliefs about the use of any stimulant or tranquilizer, and more widely still to cultural attitudes towards pain and pleasure, on the one hand, and to the general health network of research-development-distribution-prevention-care and cure on the other.

Psychotropic drugs are only appropriate for this particular inquiry because they have happened to represent a point where our moral attitudes towards stimulants and tranquilizers and other chemically effective agents cross our legitimate concern for the consequences of a health network which is developing at such galloping speed that many aspects of it are out of control. There is a frightening lack of integration of the roles played by medical schools, physicians,

and pharmaceutical companies, research, education, the paramedical occupations, the mass media, governmental legislative, regulative and adminstratve agencies and the public provision for health and welfare. The British experience highlights the problems of a welfare society; our American experience highlights the problems of a mixed economy, where the different roles played by government, medicine, industry and the mass media are seen as competitive and antagonistic, rather than supplementary or complimentary.

Where earlier witnesses were particular to confine their discussion to the use of prescription drugs, excluding the relationship of illegal uses of drugs in drug using contexts of the "youth culture," in the type of discussion which I present, a wider context is necessary.

Throughout the entire western tradition there has been a marked ambivalence toward the body, towards bodily pleasures, and towards pleasure and pain. From the days of Diogenes, when Cynic converts lived a life of the most severe abstinence, dependent upon the bounty which other members of their society gave them, through the traditions of early Christian hermits, to the development of monasticism, there have been some individuals who sought the spiritual life in ways which depended upon bonuses to them as beggars from others who lived in the world. Within this tradition which still survived in some Catholic and Islamic communities, abstinence by the few was matched by cheerful indulgence by the many. However there has been a parallel tradition in which the requirement of abstinence appropriate for the few whose fasts, prayers and medications was believed to benefit the many, has been extended to the entire population. Instead of few religious dependent upon the world, the entire population has been enjoined to live a life of rigid self discipline, to eschew all stimulating intoxicating and relaxing drugs and practices, to meet pain and physical deprivation gladly, and to conduct their lives by excluding related pleasures. Where the countries that permitted gaiety, relaxation and pleasure to the bulk of a population who led seriously constricted lives in terms of actual economic well being, assigned abstinence and monastic lives only to a selected portion of the community, the countries with a puritanical and protestant tradition prospered economically, demonstrating the virtues of a thrifty, sense denying, pleasure avoiding, gratification postponing way of life.

The extreme Protestant sects, Hudderites, Mennonites, and the many other self-denying sects originating in Germany demonstrate this most completely. Plain clothes, no alcohol or tobacco, no card playing, dancing or reading secular literature—the basic tenets of this group-wide self-denial—is occasionally elaborated to forbid even tea and coffee. Also, under the extreme emphasis on self-discipline and self control, any substance not necessary to life, which involves addiction—loss of complete control over the self, is disapproved. So, in an American traditional Protestant setting, drugs which alter moods represent the most reprehensible extreme of a series of indulgences which are seen as ways of escaping the requirements of a sternly moral life. Such groups characteristically seek to legislate the behavior of the entire community, legislating sabbath observances, prohibition of alcoholic beverages and the expression of sex behavior, even going to the extremes of forbidding a married man to kiss his wife on Sunday, or members of a community to take a bath in bathtubs during the winter months. Where the advocates of such rigorous self denial live close by others who believe that life should be enjoyed or its deprivations ameliorated, they attempt to invoke the shared desire to protect the young, so that where prohibition on alcohol, or cigarettes or extramarital sex activities for adults fails, they concentrate on forbidding them to minors.

These attitudes apply also to food necessary for survival, food that is good for you (to eat), and food that is good (to eat) is not good for you. Furthermore weight, even moderate amounts of plumpness are morally derogated as showing a lack of self-control. Medicine, necessary for health should be nasty to take, and medicines that relieve pain, probably richly deserved by our human state if not from recent indulgence in vice, are disapproved of. In my childhood the kind of woman who took headache powders was disapproved of as much as someone who today lives on tranquilizers. The distinction between virtue and vice was clear, virtue was distinguished by pain followed by pleasure, vice was pleasure (indulgence), followed by pain.

Although we are a people whose culture has been shaped by many traditions, our cultural attitudes, and particularly our laws strongly reflect the moralistic position known as the Puritan Ethic, while many of our large cities have been

conspicuously influenced by the complimentary European Catholic tradition based on a distribution between a pleasure seeking majority and a spiritually ascetic minority.

Meanwhile, as our American economy was shaped by the presence of the open frontier and what looked like unlimited resources, a third ethic has grown, the peculiarly American belief that it is better to alter the environment than to continue to cope with unsatisfactory circumstances, that it is moral to take advantage of every possible external aid to the good life, that unnecessary and avoidable pain should be prevented, and that any continued attempt to cope—by altering or exercising one's character with things that could be fixed instead, is at best unenterprising rather than virtuous. Our definition of coping is altering the environment, or our social situation, using something external to the self, a new technique, money, medicine, budgetary arrangements, to attain a better, more human, way of living. Several of these who testified at previous hearings have emphasized that the psychotropic drugs are taken not as a form of escape, but as a new way of coping with life situations. Within this frame of reference Americans approve any dietary supplement, medicine, drug or stimulant, which increases their efficiency.

Physicians in responding to advertising or salesmanship carry these three attitudes in different proportions just as their patients do. Copy writers—also Americans—vary also in which they invoke.

The situation has become further complicated today because the young—instead of surreptitiously tasting the wicked joys reserved for adults—coffee, tobacco and alcohol, which they will later be permitted to use—or righteously forswear—have chosen a different drug—marijuana, which the elders have not used and do not crave. The attempt to restrict the use of this youth choice has resulted in graver social consequences than those associated with prohibition in the 1920's, and with our moralistic attempts to treat the use of hard drugs by adults punitively, instead of medically and socially. By associating marijuana with hard addictive drugs, with youthful premature experimentation, and with the presence of new mood regulating phychotropic drugs—like the amphetamines—we have produced an exceedingly dangerous situation, dangerous to the relationships between youth and age, to the moral fibre of society which permits indulgence to the old and denies indulgence to the young, and which by the handling of all aspects of the drug traffic, steadily involves a larger portion of the population in crime, as criminals and the victims of criminal activities. Speedy legalization of marihuana would break part of this chain, but only the substitution of medical measures for punitive measures can hope to cope with it.

The special emphasis that has been given in these hearings on psychotropic drugs can only be fully explained in the light of these contemporary cultural attitudes. Psychotropic drugs, because they alter mood, because they stimulate or tranquilize, get into the moral category of "drugs," which are considered to be reprehensible basically escapist and liable to undermine our civilization based upon the acceptance of deferred gratification and pain. European comment, coming as it does out of a continuing economics of scarcity, has reinforced the criticism of American use of psychotropic drugs. The over prescription and over use of psychotropic drugs, presenting as it does, dangers of side effects, of conflicts with other medication or sometimes with foods, and involving disproportionately high expenditures, by individuals, in some cases by industries, and where there is governmental underwriting of medical expenses, by taxpayers, *are the same as the problems that arise from other drugs.* They seem different because they have come to symbolize these conflicts between good and evil, between emphasis on production and emphasis upon consumption, between deferring gratification, and enjoying the present moment.

I will now turn to the way in which these drugs, like other drugs less surrounded with moralistic implications, are related to our present confused health network. We are dependent upon the pharmaceutical companies for the initial research which developed the thousands of possible chemical substances, from which new drugs are eventually developed. Because of the nature of competition within these industries, there is an emphasis on rapid high returns. As presently constituted, society is deeply dependent upon this initial experimentation. But for traditional separation of appropriate motives for industry, politics and government create a series of oppositions, in which the pharmaceutical industries are cast in the role of conscienceless profit seekers, their advertisers and salesmen as ruthless exploiters of popular—as opposed to scientific motives—

politicians are cast as seeking causes which will advance their political careers, and physicians as burdened by responsibilities that they can not possibly carry out under today's information and drug explosion, regulative agencies vested with inappropriate and often unenforceable mandates, medical schools, reeling under cuts in Governmental support are enjoined to do a better job of pharmaceutical education, and the general public which cheerfully pays exorbitant amounts for cosmetics, and cars, is pictured as somehow much more victimized when the mass selling is applied to drugs.

What is needed in this situation of incredible productivity in pharmaceutical invention is a modification of these respective limited demands on each sector of the health networks, so that industry can accept more responsibility, politicians will be recognized as seeking the general good as well as continuance in office, government agencies will not be driven frantic by exorbitant work loads, medical schools and schools in general can prepare the public better for choices, and the population of the United States, and of the world be protected against premature or inappropriate or dangerous use of untried drugs.

But in addition to a change towards more cooperation among the different parts of this very complex network, what is most urgently needed are the full use of the modern devices with which the same information explosion that has given us our problems, has provided us.

Some of these are:

(1) Use of retrieval and presentation devices to permit information about new drugs to be processed rapidly so that the practicing physician, be he general practitioner or psychiatrist, can have access to the necessary information.

(2) Legislation to permit formal, computer based and monitored, connections between testing laboratories.

(3) Adequate funding of international drug information through WHO.

(4) An *individual cumulative health card* on which would be registered past health history, blood type, allergies, AND present medication from all sources, other physicians and self medication by prescription drugs and drugs sold over the counter. Such a card should be in form that a medically trained secretary could elicit the information—process it—and present it in an immediately relevant way to the physician.

Psychotropics are drugs of proved worth in giving access to psychotics, improving mental hospitals and helping millions of ordinary individuals to cope better with the anxieties of an exceedingly exacting society. It is ridiculous to worry about their over-use at a period when no physician, or clinic, has time to take a history that will guard against the much more dangerous cross effects of drugs, beside which "side effects" pale.

Our problems in medicine and health care—as in many other fields—are problems of sudden explosive abundance with which we have not been prepared to cope. The methods for coping are already available. I believe that the most useful thing this Committee can do is:

(1) push for more funds for research and medical school education.

(2) push for the installation of devices using modern electronic methods within which each individual receiving any kind of drug treatment will be safe.

(3) push for the substitution of social and medically sound programs for the handling of all presently illegal drug uses which are presently treated punitively.

Senator NELSON. Senator Dole.

Senator DOLE. On page 13 of your statement in the summary of what this committee might do, you indicate the second suggestion would be to push for the installation of advisers using electronic methods. I wonder if you might elaborate on that proposal. I am not certain I understand just what it might do.

Dr. MEAD. It would be possible now to have a card, an individual card, on which these varieties of past medical history, specific sensitivities, disease states that the patient had had, and present medication, could be punched in, if someone who was not a physician was able

to do it, and then the information could be very briefly summarized so when the patient went into the doctor, the doctor would have it in front of him. This could be done by a machine.

One of our great problems today is to put the information in brief and graphic enough form so that the physician can use it. The record of the drugs currently in use, could, of course, be destroyed each year, and the record could start over with new drugs.

One of the things that makes one enthusiastic about our present health system which leaves a great deal to be desired is at least when you are taken into a hospital they usually ask for your hospitalization card. If you can attach to it the fact you are hypersensitive to pencillin or you are a diabetic or all the things they may not find out when they are treating you in an emergency ward there is some chance that it be noticed. That is our present position. And I think a health identity card, with blood type on it also, of course, is one of the first requirements, or where we have these millions of people wandering around in this system going from one doctor to another, in different cities, and going to different clinics, and buying things at the drugstore and taking the advice of their friends and keeping a nice old prescription they were given in 1955, something of this sort is the only way we can lick this problem. It would have to be national and compulsory so that every single person had such a card. A baby would be given it at birth along with their birth registration and it is carried forward.

Senator DOLE. Would you summarize what you have stated very well with reference to psychotropic drugs, of which there are six or seven different categories ranging from stimulants to sedatives, to depressants, antidepressants, and minor and major tranquilizers.

Dr. MEAD. Well, I think there has been over-prescription as there have of most other drugs where physicians are poorly informed or subject to high pressure salesmen methods and have no time and no method to find out what they should find out about each drug, and with the way these drugs come on the market there is just no hope of their understanding it unless it is put in quite different forms from the form that it is in today.

But I also think we are unduly worried about psychotropic drugs, and that we should be thinking about these other things, about the tremendous health hazards of mixtures of drugs, of drugs that are administered in ignorance of the idiosyncracies of the patient, of drugs that administered in ignorance of the foods that are incompatible with it and things of this sort, and that are far more serious. The reason we worry more about psychotropic drugs is a moral reason.

It is connected with our notions of will power, self-control, postponement of gratification and our definitions of virtue and vice. Virtue is when the pain comes first and the pleasure later. Vice is when the pleasure comes first and the pain later, and we feel this very strongly. [Laughter.]

Senator DOLE. Do you have any fear for the person who takes a stimulant in the morning and a sedative at night, aside from the moral reasons?

Dr. MEAD. I think we live through very complicated days under enormous varieties of pressures and unfamiliar situations, and in the morning we may need a stimulant and at night we may need a sedative, and the fact we vary this, that we have at our disposal some kind of pharmacopeia that works seems to me a very important thing, and what we are trying to develop are ways in which people can avoid unnecessary irrelevant suffering, unnecessary and irrelevant inefficiency, and prevent the buildup of the kinds of tensions that may lead to much more severe breakdown.

Senator DOLE. Well, when things go bad in my office, for example, should I take the tranquilizer or give it to my staff?

Dr. MEAD. It depends but I imagine it would be more useful to give it to you.

Senator DOLE. Thank you.

Mr. DUFFY. Dr. Mead, I would just like to pursue briefly one question that was asked you earlier. You were asked for your evaluation of taking certain drugs to improve performance. I think we got into it from the point of view of discussing this as to racehorses. I wonder if you feel there is anything wrong with a tired executive taking a psychotropic drug so that he is better able to enjoy a show or his dinner or something like that?

Dr. MEAD. Of course, I don't. I don't think there is anything wrong at all in this. Then I think this racehorse business, you know, is just a part of the vagaries which go toward our attitude on horseracing which we all know is a pretty suspect activity.

Mr. DUFFY. Thank you.

Dr. MEAD. I don't think there is anything wrong with a high executive taking a drink either if it doesn't befuddle his mind. If it does there is something wrong.

You know the next step, but I don't think it will be quite within the province of this subcommittee, will be a search for knowledge of the relationship between individual temperament, individual biochemical makeup and particular drugs. Now the prescriptions are being made very independently of any knowledge of the patient. It is only in good mental hospitals where very careful records are kept—and most of those are kept now under the impetus of the kind of investigations that are being carried on which have made FDA requirements for more careful records—it is only in such hospitals that you ever know which kind of patient responded to which kind of drugs. What we know at present is a drug is a drug that is good for depression. If that doesn't work you try another antidepressant. I would expect in 10 or 15 years we will have the means of diagnosing the biochemical composition of the body and the temperamental style, and the idiosyncrasies of individuals so that there will be something else for which you can press a console and find out whether a patient who responds in a specific way to a series of tests will do better on one drug than another.

But I am all in favor of anything that will make the high executive function better, that will keep our statesmen when they arrive for overseas conferences awake or put them to sleep for an appropriate amount of time, and any way in which we can control better our functioning in a highly dangerous world at a highly dangerous period in human history.

Senator NELSON. Thank you, Dr. Mead.

The subcommittee appreciates very much your most thoughtful comments and testimony, and we thank you for taking time from your busy schedule to appear here today.

(Subsequent information follows:)

SUPPLEMENTAL STATEMENT OF DR. MARGARET MEAD

I have received many communications and questions about the portion of my testimony of October 27th devoted to marijuana. In the light of these discussions which show that some Americans regard making something legal as a positive sanction for its use, I would now suggest that it would fit better the present mood of the country to substitute for the term *legalizing marijuana*, the phrase *repealing all laws making the use, possession or sale of marijuana illegal.* Appropriate age limits could be established as they are for other activities such as driving a car, drinking beer or purchasing cigarettes; and regulations assuring quality standards could be introduced, and cautions could be required in advertising on such questions as excess use.

BROADCAST-PLAZA, INC.,[1]
Hartford, Conn., Oct. 23, 1969.

It's difficult to do, but try, if you will, to put yourself in the place of a Connecticut teenager who has been using marijuana, LSD or some other drugs, and wants desperately to stop. You know you need help. You're trapped, but you don't know where to turn. Of course, the best person to turn to is your mother or father. But you don't want to face your parents with the awful news that you have been on drugs. You know how it will hurt your mother and your father.

You don't want to go to the police because you've been breaking the law and you know many other people who have been breaking the law with you. You don't want to tell on anyone.

What do you do? Where do you turn? Thanks to a new law that just went into effect in Connecticut, the teenager in this difficult position now has somewhere to go and someone ready to help him . . . and no questions asked.

Since the first of October, if you are a young drug user, you can go to any city health department, any hospital or clinic and get the best of medical attention and treatment without the consent or knowledge of your parents. This is also true—and has been true for some time—of any teenager suffering from a venereal disease.

If you want to free yourself from drugs, you can seek help by approaching your school guidance counselor, school nurse or school doctor. Or, you can walk into any hospital or clinic or city health department and tell the person at the desk that you want to talk to someone about a problem with drugs.

A good place to go is one of the six clinics operated by the state. There are clinics in all sections of Connecticut: in Hartford at 2 Holcomb Street; in New Haven, 412 Orange Street; in Waterbury, 167 Grove Street; in Bridgeport, 50 Ridgefield Avenue; in Stamford, 322 Main Street, and in Norwich, in the Mitchell Building at the Norwich State Hospital. These addresses will be repeated from time to time on WTIC Radio and Television. The clinics are open weekdays from 8:30 in the morning to 4:30 in the afternoon. And we do hope the state will consider keeping them open later in the day and on Saturdays.

If you are a teenage drug user who wants to stop, take advantage of this new protection offered by your state. If you know of a teenager who has been taking drugs, let him know help is available. Tell him all this is confidential and tell him that since treatment is based on ability to pay, he or she won't have to be concerned about finding the money.

Please . . . spread the word about this new program, this new means of escape from drug dependence. You might save a teenager's life.

LEONARD J. PATRICELLI,
President.

(Whereupon at 11:20 a.m., the hearing was adjourned, to reconvene, subject to the call of the Chair.)

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[1] See p. 5469.