Italian, Irish, and Jewish groups to the suburbs. This neighborhood was recently selected for a Model Cities program. It was also, significantly, the neighborhood where the "riot" in New Haven broke out in August, 1967. Yale Medical School is making major community health commitments to this neighborhood and our mental health program is part of this commitment. I mention these social factors because our experience indicates that in neighborhoods like this, alcoholism and drug addiction are prevalent and are part of a destructive cycle. I shall return to this later.

In the year and a half since the Center has been in operation we have learned that the extent of alcoholism and narcotic addiction in this neighborhood and in all of New Haven is far greater than had either been expected or planned for. Moreover, facilities, staff, and skills are limited in these problem areas and we are not able to deal adequately with patients with these problems.

NARCOTIC ADDICTION AND DRUG DEPENDENCE

Before discussing the programmatic aspects of narcotic addiction, I would like to say a few words about the terminology. While it is true that narcotic addiction, particularly to heroin, is the most serious problem, there are other drug-related areas. We also recognize problems of 1) illicit experimentation such as glue sniffing and use of LSD and marihuana 2) misuse of medications in excess of recommended or prescribed dosage, and 3) abuse: the repeated excessive use of drugs short of dependence. We have also found it more useful to use the term "drug dependence" as recommended by the World Health Organization as having broader scope. Narcotic addiction thus is one form of drug dependence. I mention this because a community mental health program probably should best be designed to deal with all forms of drug abuse and drug dependence, not exclusively drug addiction.

In New Haven, as in other cities, the predominant, although not exclusive, involvement with narcotic addiction is through the use of heroin among young negro males. Members of my staff estimate that there are between four and six hundred active heroin users in the New Haven area, only a fraction of whom are known to medical or law enforcement agencies. At the Connecticut Mental Health Center we do not have specialized facilities for detoxification treatment or rehabilitation of narcotic addicts, nor do they exist anywhere else in the New Haven region. The nearest in patient facility is at the Connecticut Valley Hospital, a state mental hospital thirty miles away to which patients must be escorted by ambulance or the police. This geographical separation creates special hardships for the family and social agencies, and limits programs for after care and rehabilitation.

Connecticut has recently enacted a far sighted and pioneering Drug Dependence Law which allows for treatment and rehabilitation as alternatives to criminal sentencing. In the past two years, admissions to public mental hospitals for drug-related problems have more than doubled, even before this law became operative in October, 1966. Judges, court officials, and probation officers tell us that existing treatment facilities are grossly inadequate. As a result, the goal embodied in this new legislation may be undermined because of inadequate facilities to care for those patients who can now be referred for treatment rather than sent to correctional institutions. As a member of the recently established Connecticut Drug Advisory Board, I have become increasingly aware of the many difficulties encountered. My experience as a psychiatrist has been supported by contracts with jurists, lawyers, and correctional officers. In Connecticut, as elsewhere, each of our communities, and particularly the urban communities, need specialized facilities where detoxification, treatment, rehabilitation, and after care can be provided. We are especially interested in initiating treatment programs with methadone and cyclazocine, new drugs which, in early studies, offer hope for interrupting the cycle of illegal narcotic dependency and thereby facilitating the narcotic addict's rehabilitation to a useful and productive life.

As I have mentioned, narcotic addiction has highest rates among underprivileged minority groups, especially young negro and Puerto Rican males. Our contact with neighborhood groups, including the black militants, indicates to us that within the inner city neighborhoods drug addiction is regarded as a problem of very high priority. Residents of the neighborhood and city officials insist that the problem is not being dealt with adequately, innovative and imaginative programs for narcotic addicts offer critical opportunities to relate mental health to the racial crisis of our urban centers. I hope that the mental health professions will not avoid this opportunity.