

Y 4
.L 11/2
A 16/2
PT. 1

1043

KANSAS STATE UNIVERSITY LIBRARY

9/14/4
L 11/2
N 16/2/pt. 1

COMPREHENSIVE NARCOTIC ADDICTION AND DRUG ABUSE CARE AND CONTROL ACT OF 1969

GOVERNMENT
Storage



HEARINGS BEFORE THE SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE NINETY-FIRST CONGRESS

FIRST SESSION

ON

S. 2608

TO PROVIDE FOR THE COMPREHENSIVE CONTROL OF
NARCOTIC ADDICTION AND DRUG ABUSE, AND FOR
OTHER PURPOSES

S. 1816

TO AUTHORIZE THE SECRETARY OF HEALTH, EDUCA-
TION, AND WELFARE TO MAKE GRANTS FOR TREATMENT
AND REHABILITATION CENTERS FOR DRUG ADDICTS
AND DRUG ABUSERS, AND TO CARRY OUT DRUG ABUSE
EDUCATION CURRICULUM PROGRAMS, AND TO
STRENGTHEN THE COORDINATION OF DRUG ABUSE CON-
TROL PROGRAMS BY ESTABLISHING THE NATIONAL
COUNCIL ON DRUG ABUSE CONTROL

AND RELATED BILLS

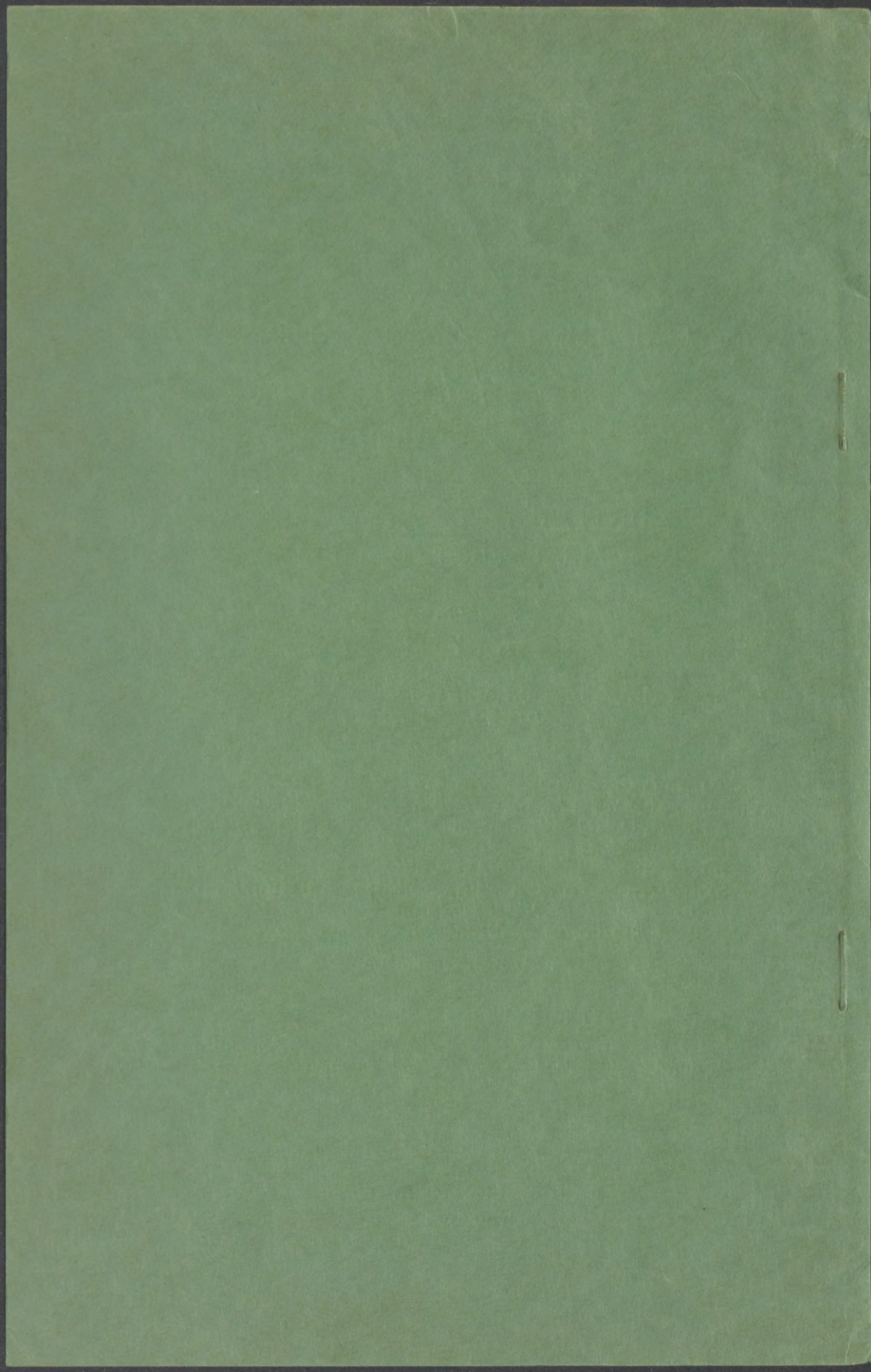
SEPTEMBER 18 AND 19, 1969

Printed for the use of the Committee on Labor and Public Welfare



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1969

34-788



COMPREHENSIVE NARCOTIC ADDICTION AND DRUG ABUSE CARE AND CONTROL ACT OF 1969

HEARINGS BEFORE THE SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE NINETY-FIRST CONGRESS

FIRST SESSION

ON

S. 2608

TO PROVIDE FOR THE COMPREHENSIVE CONTROL OF
NARCOTIC ADDICTION AND DRUG ABUSE, AND FOR
OTHER PURPOSES

S. 1816

TO AUTHORIZE THE SECRETARY OF HEALTH, EDUCA-
TION, AND WELFARE TO MAKE GRANTS FOR TREATMENT
AND REHABILITATION CENTERS FOR DRUG ADDICTS
AND DRUG ABUSERS, AND TO CARRY OUT DRUG ABUSE
EDUCATION CURRICULUM PROGRAMS, AND TO
STRENGTHEN THE COORDINATION OF DRUG ABUSE CON-
TROL PROGRAMS BY ESTABLISHING THE NATIONAL
COUNCIL ON DRUG ABUSE CONTROL

AND RELATED BILLS

SEPTEMBER 18 AND 19, 1969

Printed for the use of the Committee on Labor and Public Welfare



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1969

COMMITTEE ON LABOR AND PUBLIC WELFARE

RALPH YARBOROUGH, Texas, *Chairman*

JENNINGS RANDOLPH, West Virginia	JACOB K. JAVITS, New York
HARRISON A. WILLIAMS, Jr., New Jersey	WINSTON L. PROUTY, Vermont
CLAIBORNE PELL, Rhode Island	PETER H. DOMINICK, Colorado
EDWARD M. KENNEDY, Massachusetts	GEORGE MURPHY, California
GAYLORD NELSON, Wisconsin	RICHARD S. SCHWEIKER, Pennsylvania
WALTER F. MONDALE, Minnesota	WILLIAM B. SAXBE, Ohio
THOMAS F. EAGLETON, Missouri	RALPH T. SMITH, Illinois
ALAN CRANSTON, California	
HAROLD E. HUGHES, Iowa	

ROBERT O. HARRIS, *Staff Director*

JOHN S. FORSYTHE, *General Counsel*

ROY H. MILLENSON, *Minority Staff Director*

EUGENE MITTELMAN, *Minority Counsel*

SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS

HAROLD E. HUGHES, Iowa, *Chairman*

RALPH YARBOROUGH, Texas	JACOB K. JAVITS, New York
JENNINGS RANDOLPH, West Virginia	PETER H. DOMINICK, Colorado
HARRISON A. WILLIAMS, Jr., New Jersey	WILLIAM B. SAXBE, Ohio
EDWARD M. KENNEDY, Massachusetts	RICHARD S. SCHWEIKER, Pennsylvania
WALTER F. MONDALE, Minnesota	

(II)

CONTENTS

Text of—	Page
S. 2608.....	5
Section-by-section analysis.....	32
S. 1816.....	38

CHRONOLOGICAL LIST OF WITNESSES

THURSDAY, SEPTEMBER 18, 1969

Williams, Hon. Harrison A., Jr., a U.S. Senator from the State of New Jersey.....	35
Javits, Hon. Jacob K., a U.S. Senator from the State of New York.....	67
Ingersoll, John E., Director, Bureau of Narcotics and Dangerous Drugs, Department of Justice; accompanied by Michael R. Sonnenreich, Deputy Chief Counsel; and Edward Lewis, M.D., Chief Medical Officer, Bureau of Narcotics and Dangerous Drugs, Department of Justice.....	68
Nowlis, Dr. Helen, professor of psychology, research consultant on student affairs, University of Rochester, Rochester, N.Y.....	92
Halleck, Hon. Charles, judge, District of Columbia Court of General Sessions, Washington, D.C.....	100
Brill, Henry, chairman, American Medical Association, Committee on Alcoholism and Drug Dependence; and director, Pilgrim State Hospital, West Brentwood, N.Y.; accompanied by Harvey Peterson and Paul Donelan, attorneys, Legislative Department, American Medical Association.....	107
Goddard, James, M.D., vice president, Electronic Data Processing Technology, Inc., Atlanta, Ga.; accompanied by Paul D. Stolley, M.D., assistant professor, The Johns Hopkins School of Public Health, Department of Medical Care; and Theodore O. Cron, president, American Patients Association, Washington, D.C.....	114

FRIDAY, SEPTEMBER 19, 1969

Black, Creed C., Assistant Secretary for Legislation, Department of Health, Education, and Welfare; accompanied by Theodore Ellenbogen, Assistant General Counsel for Legislation; and Dr. Morton G. Miller, Associate Director for Special and Collaborative Programs.....	138
Freedman, Daniel, chairman, Department of Psychology, University of Chicago School of Medicine, Chicago, Ill.....	381
Brotman, Dr. Richard, professor, Department of Psychiatry, New York Medical College.....	389
Farnsworth, Dr. Dana, director, University Health Services, Harvard University.....	397
Chayet, Neil L., assistant professor of legal medicine, Law-Medicine Institute, Boston University.....	403

STATEMENTS OF WITNESSES

Black, Creed C., Assistant Secretary for Legislation, Department of Health, Education, and Welfare; accompanied by Theodore Ellenbogen, Assistant General Counsel for Legislation; and Dr. Morton G. Miller, Associate Director for Special and Collaborative Programs.....	138
---	-----

(III)

	Page
Brill, Henry, chairman, American Medical Association, Committee on Alcoholism and Drug Dependence; and director, Pilgrim State Hospital, West Brentwood, N.Y.; accompanied by Harvey Peterson and Paul Donelan, attorneys, Legislative Department, American Medical Association-----	107
Brotman, Dr. Richard, professor, Department of Psychiatry, New York Medical College-----	389
Chayet, Neil L., assistant professor of legal medicine, Law-Medicine Institute, Boston University-----	403
Farnsworth, Dr. Dana, director, University Health Services, Harvard University-----	397
Freedman, Daniel, chairman, Department of Psychology, University of Chicago School of Medicine, Chicago, Ill-----	381
Goddard, James, M.D., vice president, Electronic Data Processing Technology, Inc., Atlanta, Ga.; accompanied by Paul D. Stolley, M.D., assistant professor, The Johns Hopkins School of Public Health, Department of Medical Care; and Theodore O. Cron, president, American Patients Association, Washington, D.C-----	114
Halleck, Hon. Charles, judge, District of Columbia court of general sessions, Washington, D.C-----	100
Ingersoll, John E., director, Bureau of Narcotics and Dangerous Drugs, Department of Justice; accompanied by Michael R. Sonnenreich, Deputy Chief Counsel, and Edward Lewis, M.D., Chief Medical Officer, Bureau of Narcotics and Dangerous Drugs, Department of Justice-----	68
Javits, Hon. Jacob K., a U.S. Senator from the State of New York-----	67
Nowlis, Dr. Helen, professor of psychology, research consultant on student affairs, University of Rochester, Rochester, N.Y-----	92
Williams, Hon. Harrison A., Jr., a U.S. Senator from the State of New Jersey-----	35

ADDITIONAL INFORMATION

Articles, publications, etc.:

"Control of Narcotics and Dangerous Drugs," the President's Message to the Congress Outlining Actions Taken and Proposing Additional Measures, July 14, 1969-----	147
"Drug Abuse Education," Guidelines and Selected References-----	191
"Hashish Fad in U.S. Worries Officials," by Lesley Oelsner, from the New York Times, September 17, 1969-----	88
"It's About Time Someone Did a Public Service Campaign on Drug Abuse," publication of National Institute of Mental Health, Department of Health, Education, and Welfare-----	153
"Marijuana Bill Neither Cure nor Bridge," by Neil L. Chayet, from Today's Boston Globe, September 15, 1969-----	408
"Pot—A Rational Approach," opinion by Joel Fort, M.D., from Playboy magazine, October 1969-----	56

Communications to:

Yarborough, Hon. Ralph, a U.S. Senator from the State of Texas, from: Farnsworth, Dana L., M.D., chairman, Council on Mental Health, American Medical Association, Cambridge, Mass., October 8, 1969-----	403
--	-----

Memo from the Director, National Institute of Mental Health, Department of Health, Education, and Welfare, re statements on "Drug Abuse" and "Drug Abuse: Educational Efforts" at hearing before the House Committee on Interstate and Foreign Commerce-----	167
--	-----

Selected tables:

Table I—Deaths from Narcotism-----	379
Table II—New York City Narcotics Register Data-----	379
Table III—Deaths by Poisoning and Suicides, New York State-----	379
Comparison of Recent Drug Abuse Treatment and Control Bills-----	118

COMPREHENSIVE NARCOTIC ADDICTION AND DRUG ABUSE CARE AND CONTROL ACT OF 1969

THURSDAY, SEPTEMBER 18, 1969

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10:10 a.m., pursuant to notice, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes (presiding), Yarborough, Saxbe, and Dominick.

Committee staff members present: Robert O. Harris, staff director; John S. Forsythe, general counsel; James Babin, professional staff member to the subcommittee; Roy H. Millenson, minority staff director; and Jay Cutler, minority counsel to the subcommittee.

Senator HUGHES. The Subcommittee on Alcoholism and Narcotics will come to order.

We will begin with an opening statement and testimony of Senator Ralph Yarborough of Texas, chairman of the full Committee on Labor and Public Welfare, of which this subcommittee is a part.

Senator YARBOROUGH. Mr. Chairman, I want to take this opportunity to congratulate Chairman Hughes on his initial hearings on drug abuse held last month. They were a model of deep exploration of a complex subject. I am certain that the Special Subcommittee on Alcoholism and Narcotics, under his able, dedicated and highly intelligent leadership, will make great strides in combating alcoholism, dangerous drug abuse and narcotics.

Unfortunately, the administration has not taken such an enlightened approach to the drug abuse problem. On September 15, Attorney General John Mitchell testified before the Senate Judiciary Committee that he was for "flexible penalties."

The administration bill has what I consider to be repressive penalties in the drug abuse area. I concur with Senator Hughes' statement of August 6 when he said:

You cannot fail to understand that if you make the sale of marihuana or LSD not less than 5 years and not more than 20 years in prison for a first offense and not less than 10 years nor more than 40 for a second, you are only compounding our problem. The ones who will get caught are not the big-time pushers but the college kid with "grass" and the wretched addicts in the ghettos who are pushing only to sustain their habit.

The hearings that I held for 4 days before we ascertained this problem was so great we had to have a full-time subcommittee on it—and you generously offered, when we requested you, to take the chairman-

ship and devote your time to this subject—in the 4 days of hearings I held here, in San Antonio and Fort Worth, with witnesses from as far away as New York and Los Angeles, showed that the use of marihuana had spread not only in the high schools, but into the junior high schools, and even to the grade schools in some places.

Yesterday, Dr. Sidney Cohen, Director of the Division of Narcotic Addiction and Drug Abuse of the National Institute of Mental Health, stated in regard to penalties for marihuana: "Existing legislation in this regard is not only excessively harsh, but has not worked in the past and is most unlikely to work in the future." Dr. Yolles, who will be with us tomorrow, has stated that he agrees with Dr. Cohen's views.

We must try something new. I believe that my bill, S. 2608, the Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act of 1969, offers a sensible beginning to the solution of our problems in the drug abuse area.

I might say parenthetically that I didn't originate this bill, of course. It has been prepared, and we have been working on it, Senator, long before your subcommittee was created.

We had much expert advice. We had consultations with people in different branches of the Government and people outside from groups who have tried to do something about the problem.

So, the bill introduced was after great staff work. I want to congratulate the staff of the full committee and of the Health Subcommittee. This is a great staff and has coordinated much thought in this country into this bill. I was merely the instrumentality which, with this staff, brought together the recommendations and items offered in the comprehensive bill, and you, as chairman, cosponsored it with the others.

During recent months, the Health Subcommittee, of which I am chairman, heard testimony from many of our Nation's outstanding experts on drug dependence and abuse, and we gave intensive study to the factors to be considered in developing an effective pattern for a national program of drug abuse control.

It is imperative that we accelerate our efforts simultaneously in development of treatment and rehabilitation facilities, research, education and information programs, and the training of specialized personnel.

We are well aware of the need for coordinated activities among the several governmental agencies with responsibilities in the drug area. At the same time, we must recognize that there must be a clear indication by the Congress that those agencies most expert in any particular aspect of the problem be strengthened, rather than have wasteful duplication and squandering of scarce resources.

It is important that the major responsibility for health and scientific aspects of a drug prevention and control program be placed within the agency whose jurisdiction most properly embraces them. Research, education, training, prevention and treatment efforts properly should be assigned to the agency charged with administration of matters of health, education, and social welfare.

The Department of Health, Education, and Welfare is thus clearly the appropriate agency to be charged with responsibilities for the conduct of research, education, and treatment activities. The Department of Justice, on the other hand, should properly be charged with responsibilities for law enforcement and control.

Health concerns are clearly not within the jurisdiction of the Attorney General, and every care should be taken to assure that they remain within the jurisdiction of the Department long since designated by the Congress as responsible for these activities.

This bill, S. 2608, for the first time provides for a comprehensive and coordinated attack on the narcotic addiction and drug abuse problem. Its scope is necessarily broad.

The bill includes authorities for (1) a great expansion in research to improve our knowledge about the causes and cures of the problem, (2) increased training to relieve the serious shortage of manpower to work in this critical area, (3) a program of incentive grants to enable communities to launch critically needed and long delayed treatment and rehabilitation programs for drug dependent persons, (4) a major prevention and education effort designed to reach a wide audience, particularly those youngsters who are most prone to use drugs, (5) a new approach to the problem of control of substances liable to abuse which clearly places responsibility for the health and scientific aspects on the Secretary of Health, Education, and Welfare, and (6) the establishment of an advisory committee on narcotics and dangerous drugs to advise the Secretary regarding the designation of drugs considered to be liable to abuse.

Mr. Chairman, jurisdiction in the past has been under Health, Education and Welfare. It started in 1935 with the Lexington, Ky., facility, and in 1938 with the Fort Worth, Tex., facility.

It has been there for over 30 years, and this is a continuation of this jurisdiction, but it has been limited in scope and limited in funds to carry it out. We learned in those 4 days of hearings that there are only three places having research and treatment facilities comparable to the two Federal facilities the one at Lexington, Ky., serving all States east of the Mississippi, and the one at Fort Worth, Tex., serving all States west of the Mississippi; they are: California, which has a comprehensive plan, New York and Chicago.

So there are 47 States that have absolutely no facilities for research and treatment, and in the limited number of such facilities for narcotic addiction, the two Federal research centers have served as training grounds.

Most of the people who go into this work come out of those two Federal centers.

The cutback in those has discouraged scientific personnel from going into this type of work.

This bill includes authority for great expansion and research to improve our knowledge about the causes and cures of the problem, increased training to relieve the serious shortages that we have in those categories, and the other programs that we have mentioned.

For the above purposes, this bill would authorize a total of \$380 million over a 5-year period. It was testified, for example, in San Antonio, the day we had hearings there, it was testified by people there who had worked with this problem for years that they considered the drug addiction problem was costing San Antonio alone \$87 million a year, or \$435 million over 5 years.

Nationwide, it is costing billions of dollars. They gave a breakdown. In San Antonio alone, this drug problem would cost them more money than this bill would spend over 5 years for the entire Nation. While

that is a lot of money, it is small in comparison to the cost of addiction.

There is also a very important provision which removes marihuana from the Internal Revenue Code and adds it to the definitions of depressant or stimulant drugs in the Food, Drug, and Cosmetic Act, making it subject to the penalties and controls imposed on such substances rather than those provided for narcotic drugs in the Internal Revenue Code.

The possession of marihuana is illegal under the provisions of my bill, S. 2608. Because of the so-called *Leary* decision by the Supreme Court, there presently are no effective Federal penalties for the possession of marihuana.

Thus, my bill reinstates Federal penalties for the possession of marihuana. It would reinstate Federal prosecution, but not under the Narcotic Code. Your bill and my bill would put it under the Food, Drug, and Cosmetic Act, and make it subject to penalties there, rather than calling it a narcotic.

Mr. Chairman, I ask consent that a copy of this bill, S. 2608, and a section-by-section analysis of it be printed at this point in the record.

Senator HUGHES. It will be so ordered.

(The bill and a section-by-section analysis follow:)

91ST CONGRESS
1ST SESSION

S. 2608

IN THE SENATE OF THE UNITED STATES

JULY 14, 1969

Mr. YARBOROUGH (for himself, Mr. HUGHES, Mr. BURDICK, Mr. CRANSTON, Mr. EAGLETON, Mr. HART, Mr. KENNEDY, Mr. MONDALE, Mr. MOSS, Mr. NELSON, Mr. PASTORE, Mr. PELL, Mr. RANDOLPH, and Mr. WILLIAMS of New Jersey) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To provide for the comprehensive control of narcotic addiction and drug abuse, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SHORT TITLE

4 SECTION 1. This Act may be cited as the "Comprehen-
5 sive Narcotic Addiction and Drug Abuse Care and Control
6 Act of 1969".

7 DECLARATION OF FINDINGS AND PURPOSES

8 SEC. 2. (a) The Congress finds that—

9 (1) Narcotic addiction and drug abuse are major health
10 and social problems afflicting a significant proportion of the

1 public, and much more needs to be done by public and
2 private agencies to develop effective prevention and control.

3 (2) Narcotic addiction and drug abuse treatment and
4 control programs should whenever possible: (A) be com-
5 munity based, (B) provide a comprehensive range of serv-
6 ices, including emergency treatment, under proper medical
7 auspices on a coordinated basis, and (C) be integrated with
8 and involve the active participation of a wide range of public
9 and non-governmental agencies.

10 (3) There is an urgent need to educate young people
11 and the public in general on the abuse of drugs and that
12 insufficient manpower currently are available to undertake
13 such educational programs.

14 (4) There is a serious shortage of professional and
15 other personnel trained to work more effectively in relation
16 to the prevention and treatment of narcotic addiction and
17 drug abuse.

18 (5) Current knowledge regarding the causes, preven-
19 tion, and treatment of narcotic addiction and drug abuse are
20 inadequate.

21 (b) In order to preserve and protect the health and
22 welfare of the American people in meeting these needs, it is
23 the purpose of this Act to authorize the Secretary of Health,
24 Education, and Welfare to establish a program of grants and
25 contracts for the construction, staffing, operation, and main-

1 tenance of facilities for the prevention and treatment of nar-
2 cotic addiction and drug abuse, for the development of nar-
3 cotic addiction and drug abuse education programs, for the
4 training of professional and other personnel, for the conduct
5 of appropriate study, research, and experimentation, and for
6 the creation of appropriate demonstration projects relating
7 to narcotic addiction and drug abuse.

8 TITLE I—CONSTRUCTION, STAFFING, AND
9 OPERATION OF TREATMENT FACILITIES

10 SEC. 101. (a) Section 251 (a) of the Community
11 Mental Health Centers Act is amended by striking out “of
12 compensation of professional and technical personnel for
13 the initial operation” and inserting in lieu thereof “of opera-
14 tion, staffing, and maintenance.”

15 (b) Section 251 (b) of the Community Mental Health
16 Centers Act is amended by striking out “in excess of 66 $\frac{2}{3}$
17 per centum” and inserting in lieu thereof “in excess of 90
18 per centum”.

19 (c) Section 251 (c) of the Community Mental Health
20 Centers Act is deleted and the following is inserted in lieu
21 thereof:

22 “(c) Grants under subsection (a) for the costs of op-
23 eration, staffing, and maintenance of a facility may be made
24 only for the first eight years that such facility is in operation
25 and the amount of any such grant shall not exceed 90 per

1 centum of such costs for the first two years of the grant
2 and 75 per centum of such costs for each of the next six
3 years.”

4 (d Section 261 (a) of the Community Mental Health
5 Centers Act is amended to read as follows:

6 “(a) There are authorized to be appropriated \$15,-
7 000,000 for the fiscal year ending June 30, 1970; \$20,-
8 000,000 for the fiscal year ending June 30, 1971; \$40,000,-
9 000 for the fiscal year ending June 3, 1972, \$50,000,000
10 for the fiscal year ending June 30, 1973; and \$75,000,000
11 for the fiscal year ending June 30, 1974; for construction,
12 operating, staffing, and maintenance grants under parts C or
13 D. Sums so appropriated for any fiscal year shall remain
14 available for obligation until the close of the next fiscal year.”

15 (e) Section 261 (b) of the Community Mental Health
16 Centers Act is amended to read as follows:

17 “(b) There are also authorized to be appropriated for
18 the fiscal year ending June 30, 1971, and each of the next
19 eleven fiscal years such sums as may be necessary to continue
20 to make grants for staffing with respect to any project under
21 part C or D for which a staffing, operation, and maintenance
22 grant was made from appropriations under subsection (a)
23 of this section for the fiscal years ending June 30, 1970,
24 through 1975.

25 “(c) For purposes of parts C and D, the term ‘staffing’

1 means salaries, fringe benefits, and travel allowances for
2 professional, technical, and support personnel needed to pro-
3 vide services to administer, evaluate, operate, and maintain
4 the facilities and program of a treatment center.

5 “(d) For purposes of parts C and D, the term ‘opera-
6 tion and maintenance’ means upkeep and repairs, supplies,
7 utilities, rent, equipment cleaning, food and drugs, and
8 similar items of cost incurred by a treatment facility.”

9 TITLE II—TRAINING AND EVALUATION, AND
10 DRUG ABUSE EDUCATION

11 SEC. 201. (a) Section 252 of the Community Mental
12 Health Centers Act is amended to read as follows:

13 “TRAINING AND EVALUATION

14 “SEC. 252. (a) For the purpose of assisting in overcom-
15 ing the critical shortage of scientific and professional per-
16 sonnel trained to deal with drug abuse and addiction, the
17 Secretary is authorized to make grants to States and political
18 subdivisions thereof and to public or nonprofit private agen-
19 cies and organizations, and to enter into contracts with other
20 private agencies and organizations, for—

21 “(1) the development of specialized training pro-
22 grams or materials relating to the provision of health
23 services for the prevention and treatment of drug abuse;

24 “(2) the development of inservice or short-term

1 refresher courses with respect to the provision of such
2 services;

3 “(3) training personnel to operate, supervise, and
4 administer such services;

5 “(4) the conduct of a program of research and
6 study relating to (A) personnel practices and current
7 and projected personnel needs in the field of drug abuse
8 (including prevention, control, treatment, and rehabili-
9 tation), (B) the availability and adequacy of the edu-
10 cational and training resources of individuals in, or pre-
11 paring to enter, such field, and (C) the availability and
12 adequacy of specialized training for persons such as
13 physicians and other health professionals who have
14 occasion to deal with drug addicts, including the extent
15 to which such persons make the best use of their pro-
16 fessional qualifications when dealing with such persons;
17 and

18 “(5) the conduct of surveys and field trials to
19 evaluate the adequacy of the programs for the preven-
20 tion and treatment of narcotic addiction within the
21 several States with a view to determining ways and
22 means of improving, extending, and expanding such
23 programs.

24 “(b) Training grants under this section may be made
25 only upon recommendation of the National Advisory Men-

1 tal Health Council. Such grants may be paid in advance or
2 by way of reimbursement as may be determined by the Sec-
3 retary, and shall be made on such conditions as the Secretary
4 finds necessary.

5 “(c) As used in this section, the term ‘professional per-
6 sons’ shall include, but not be limited to persons in the fields
7 of medicine, psychiatry, nursing, social work, psychology,
8 education, and vocational rehabilitation.

9 “(d) There are hereby authorized to be appropriated
10 for carrying out the provisions of this section \$2,000,000 for
11 the fiscal year ending June 30, 1970; \$3,000,000 for the
12 fiscal year ending June 30, 1971; \$5,000,000 for the fiscal
13 year ending June 30, 1972; \$6,000,000 for the fiscal year
14 ending June 30, 1973; and \$6,000,000 for the fiscal year
15 ending June 30, 1974.”

16 SEC. 202. The Community Mental Health Centers Act
17 is amended by redesignating sections 253 and 254 as sections
18 255 and 256 respectively, and by inserting after section 252
19 the following new sections:

20 “FELLOWSHIP GRANTS

21 “SEC. 253. (a) The Secretary is authorized to make
22 fellowship grants (including such stipends and allowances
23 (including travel and subsistence expenses) as the Secre-
24 tary may deem necessary) to professional personnel for train-

1 ing in relation to drug addiction and other drug-abuse-related
2 problems. Each applicant for a fellowship shall present a plan
3 for his training which includes appropriate information re-
4 garding the participation of the institutions or agencies who
5 will be providing the training.

6 “(b) Training grants under this section may be made
7 only upon recommendation of the National Advisory Mental
8 Health Council. Such grants may be paid in advance or by
9 way of reimbursement as may be determined by the Secre-
10 tary, and shall be made on such conditions as the Secretary
11 finds necessary.

12 “(c) As used in this section, the term ‘professional per-
13 sons’ shall include, but not be limited to persons in the fields
14 of medicine, psychiatry, nursing, social work, psychology,
15 education, and vocational rehabilitation.

16 “(d) The term ‘fellowship’ shall include such stipends
17 and allowances (including travel and subsistence expenses)
18 as the Secretary may deem necessary.

19 “(e) Training and fellowship awards under this title
20 shall be made at such levels as may be required to facilitate
21 the recruitment of the necessary professional manpower to
22 this high priority area.

23 “(f) There are hereby authorized to be appropriated for

1 carrying out the purpose of this section \$400,000 for the
2 fiscal year ending June 30, 1970; \$600,000 for the fiscal
3 year ending June 30, 1971; and \$1,000,000 for each of the
4 next three fiscal years.

5 "DRUG ABUSE EDUCATION

6 "SEC. 254. (a) The Secretary is authorized to make
7 grants to States and political subdivisions thereof and to
8 public or nonprofit private agencies and organizations, and
9 to enter into contracts with other private agencies and or-
10 ganizations, for—

11 "(1) the collection, preparation, and dissemina-
12 tion of educational materials dealing with the use and
13 abuse of drugs and the prevention of drug abuse, and

14 "(2) the development and evaluation of programs
15 of drug abuse educations directed at the general public,
16 school-age children, and special high-risk groups.

17 "(b) The Secretary, acting through the National In-
18 stitute of Mental Health, shall (1) serve as a focal point
19 for the collection and dissemination of information related
20 to drug abuse; (2) collect, prepare, and disseminate mate-
21 rials (including films and other educational devices) deal-
22 ing with the abuse of drugs and the prevention of drug

1 abuse; (3) provide for the preparation, production, and
2 conduct of programs of public education (including those
3 using films and other educational devices); (4) train pro-
4 fessional and other persons to organize and participate in
5 programs of public education in relation to drug abuse; (5)
6 coordinate activities carried on by such departments, agen-
7 cies, and instrumentalities of the Federal Government as
8 he shall designate with respect to health education aspects
9 of drug abuse; (6) provide technical assistance to State and
10 local health and educational agencies with respect to the
11 establishment and implementation of programs and proce-
12 dures for public education on drug abuse; and (7) undertake
13 other activities essential to a national program for drug
14 abuse education.

15 “(c) The Secretary, acting through the National In-
16 stitute of Mental Health, is authorized to develop and con-
17 duct workshops, institutes, and other activities for the train-
18 ing of professional and other personnel to work in the area
19 of drug abuse education.

20 “(d) All grants made under this section can be made
21 only upon recommendation of the National Advisory Mental
22 Health Council.

23 “(e) There are hereby authorized to be appropriated
24 for carrying out the purposes of this section \$2,000,000
25 for the fiscal year ending June 30, 1970; \$4,000,000 for

1 the fiscal year ending June 30, 1971; \$6,000,000 for the
2 fiscal year ending June 30, 1972; and \$8,000,000 for each
3 of the next two fiscal years."

4 TITLE III—AMENDMENTS TO THE PUBLIC
5 HEALTH SERVICE ACT FOR RESEARCH AND
6 STUDIES RELATING TO DRUG USE, ABUSE,
7 AND ADDICTION

8 SEC. 301. (a) Section 302 (a) of the Public Health
9 Service Act (42 U.S.C. 242 (a)) is amended—

10 (1) by inserting "depressant or stimulant drugs
11 and" before "narcotics" in the first sentence;

12 (2) by striking out "the use and misuse of narcotic
13 drugs," in the first sentence and inserting in lieu thereof
14 "(1) the use and misuse of depressant or stimulant
15 drugs and narcotic drugs, and (2)"; and

16 (3) by striking out "at his discretion" in the second
17 sentence.

18 (b) Section 302 of the Public Health Service Act is
19 further amended by adding a new subsection (c) at the end
20 thereof to read as follows:

21 "(c) The Secretary is authorized to establish a program
22 of grants to be administered by the National Institute of
23 Mental Health to—

24 "(1) support and conduct programs of research
25 into all phases of drug use and abuse, including the

1 origins, causes, incidence, and prevention of drug use
2 and abuse, the abuse potential of drugs, and the thera-
3 peutic and rehabilitation agents and techniques;

4 “(2) make grants to State or local agencies and
5 other public or nonprofit agencies and institutions, and to
6 enter into contracts with any other agencies or institu-
7 tions, for the conduct of investigations, experiments,
8 demonstrations, studies, and research projects with
9 respect to the development of improved methods of
10 diagnosing drug addiction and abuse and of care, treat-
11 ment, and rehabilitation of drug addicts and drug
12 abusers;

13 “(3) make grants to State agencies responsible for
14 administration of State institutions for care, or care and
15 treatment, of drug addicts or abusers for developing and
16 establishing improved methods of operation and admin-
17 istration of such institutions;

18 “(4) conduct surveys evaluating the adequacy of
19 programs for the prevention and treatment of drug abuse
20 and for necessary planning studies;

21 “(5) develop field trials and demonstration pro-
22 grams for the prevention and treatment of drug abuse;

23 “(6) establish a National Registry of Narcotic
24 Addicts to facilitate research in drug addiction; and

25 “(7) make project grants to State or local agencies

1 and other public or nonprofit agencies or institutions for
2 the establishment, construction, staffing, operation, and
3 maintenance of regional centers for research in drug
4 abuse and related problems, one of which centers shall
5 be established as a National Addiction and Drug Abuse
6 Research Center as part of the National Institute of
7 Mental Health, and shall be located in close proximity
8 to the central research facilities of such Institute so as
9 to avoid duplication of basic science laboratories and
10 to allow for exchange of scientific information in col-
11 laboration between researchers in these closely related
12 areas.

13 Any information contained in the National Registry of Nar-
14 cotic Addicts, established under paragraph (6), shall be
15 used only for statistical and research purposes and no name
16 or identifying characteristics of any person who is listed in
17 the Registry shall be divulged without the approval of the
18 Secretary and the consent of the person concerned except
19 to personnel who operate the Registry. The Secretary may
20 authorize persons engaged in research under this subsection
21 on the use and effect of drugs to protect the privacy of
22 individuals who are the subject of such research by with-
23 holding from all persons not connected with the conduct of
24 such research the names or other identifying characteristics

1 of such individuals. Persons so authorized to protect the
2 privacy of such individuals may not be compelled in any
3 Federal, State, civil, criminal, administrative, legislative, or
4 other proceeding to identify such individuals.

5 “(d) The following amounts are hereby authorized to
6 be appropriated:

7 “(1) For carrying out the purposes of section 302 (c)
8 (1) through (6), \$3,000,000 for the fiscal year ending
9 June 30, 1971; \$10,000,000 for the fiscal year ending
10 June 30, 1972; \$10,000,000 for the fiscal year ending
11 June 30, 1973; and \$10,000,000 for the fiscal year ending
12 June 30, 1974.

13 “(2) For carrying out the purposes of section 302 (c)
14 (7), \$3,000,000 for the fiscal year ending June 30, 1970;
15 \$10,000,000 for the fiscal year ending June 30, 1971;
16 \$25,000,000 for the fiscal year ending June 30, 1972;
17 \$20,000,000 for the fiscal year ending June 30, 1973;
18 \$20,000,000 for the fiscal year ending June 30, 1974;
19 and \$15,000,000 for the establishment of the National Addic-
20 tion and Drug Abuse Research Center, to remain available
21 until expended.”

1 TITLE IV—CONTROL OF DANGEROUS
2 SUBSTANCES

3 SEC. 401. (a) The Congress finds and declares that the
4 importation, manufacture, distribution, possession, and use
5 of narcotic drugs and depressant and stimulant drugs for non-
6 medical and nonscientific purposes have a substantial and
7 detrimental effect on the health and general welfare of the
8 American people, that the medical and scientific use of such
9 drugs are important elements of the practice of medicine and
10 of scientific research, and that adequate provision must be
11 made to insure the availability of controlled drugs for such
12 legitimate purposes.

13 (b) The Congress further finds that there is a need for a
14 single comprehensive code which makes the necessary dis-
15 tinctions among narcotic drugs and depressant and stimulant
16 drugs with respect to the degree of control required and be-
17 tween their medical and scientific use as against their abuse
18 for nonmedical and nonscientific purposes. It is therefore the
19 purpose of this title to provide for the establishment of such
20 a code, by utilizing the medical and scientific expertise of the
21 Secretary of Health, Education, and Welfare, and the partic-

1 ular competence and expertise of persons versed in the fields
2 of mental health and pharmacology.

3 SEC. 402. (a) In order to aid the States and communi-
4 ties, the medical and scientific professions, law enforcement
5 authorities and other concerned groups and individuals in
6 coping with the problems of drug abuse, while at the same
7 time encouraging ready access to certain substances for sci-
8 entific, therapeutic, industrial, or other legitimate purposes,
9 the Secretary shall—

10 (1) carry out the studies and investigations pertain-
11 ing to narcotics and depressant and stimulant drugs as
12 directed by section 302 (a) of the Public Health Service
13 Act;

14 (2) determine which substances should be subject
15 to control because of their ability to produce physical or
16 psychological dependence which could lead to abuse;

17 (3) place these substances in such classes and cate-
18 gories as he shall find necessary, ranked according to the
19 extent of their ability to produce physical or psychologi-
20 cal dependence and their relative capabilities for abuse;

21 (4) promulgate a list of all such substances classi-
22 fied or categorized as directed by paragraph (3) ; and

23 (5) amend such list from time to time by adding,
24 deleting, or changing the classification or categorization

1 of a substance as he shall find necessary in the light of
2 new scientific knowledge.

3 (b) No substance may be included on such list unless
4 it is a narcotic drug (as defined in section 4731 of the In-
5 ternal Revenue Code) or is a depressant or stimulant drug
6 determined under section 201 of the Federal Food, Drug, and
7 Cosmetic Act and not exempted under section 511 (f) of that
8 Act.

9 (c) The initial list promulgated by the Secretary shall
10 not take effect until after such list has been published in the
11 Federal Register, and not less than thirty days shall have
12 passed thereafter. If within such thirty-day period any person
13 adversely affected by such listing shall require opportunity
14 for a hearing, the Secretary shall provide for such hearing,
15 in conformity with the procedures prescribed in section 701
16 of the Federal Food, Drug, and Cosmetic Act, with judicial
17 review available in conformity with such section. After such
18 list shall have become final, any change in the category of
19 any substance may be carried out by the Secretary only after
20 similar notice, opportunity for a hearing, and opportunity for
21 judicial review in conformity with such section 701.

22 SEC. 403. Before making any of the determinations
23 required by section 402, the Secretary shall consider the ad-

1 vice of the Advisory Committee on Narcotics and Dangerous
2 Drugs, established by section 503 of this Act, and shall con-
3 sult with the Attorney General.

4 CONTROL OF ILLEGAL TRANSACTIONS IN MARIHUANA

5 SEC. 404. (a) Section 201 (v) (3) of the Federal Food,
6 Drug, and Cosmetic Act (21 U.S.C. 321 (v) (3)) is
7 amended (1) by striking out "and any other" and inserting
8 in lieu thereof, "marihuana, and any"; and (2) by striking
9 out " , and marihuana as defined in section 4761, of the In-
10 ternal Revenue Code of 1954 (26 U.S.C. 4731, 4761)" and
11 inserting in lieu thereof "of the Internal Revenue Code of
12 1954".

13 (b) Section 201 of such Act is amended by adding at
14 the end thereof the following new paragraph:

15 "(y) The term 'marihuana' means all parts of the plant
16 Cannabis sativa L., whether growing or not; the seeds
17 thereof; the resin extracted from any part of such plant; and
18 every compound, manufacture, salt, derivative, mixture, or
19 preparation of such plant; its seeds, or resin; but shall not
20 include the mature stalks of such plant, fiber produced from
21 such stalks, oil, or cake made from the seeds of such plant,
22 any other compound, manufacture, salt, derivative, mixture,
23 or preparation of such mature stalks (except the resin
24 extracted therefrom), fiber, oil, or cake, or the sterilized
25 seed of such plant which is incapable of germination."

1 REGISTRATION OF RESEARCH ESTABLISHMENTS

2 SEC. 405. Title V of the Public Health Service Act is
3 amended by adding at the end thereof the following new
4 section:

5 "REGISTRATION OF RESEARCH ESTABLISHMENTS

6 "SEC. 513. (a) No person may conduct any research
7 project with any narcotic drug (as defined in section 4731
8 of the Internal Revenue Code of 1954) or with marihuana
9 (as defined in section 201 (y) of the Federal Food, Drug,
10 and Cosmetic Act) unless such research is conducted by
11 an establishment currently registered by the Secretary under
12 this section. Registration under this section shall be for
13 one-year periods, and shall be renewable for like periods.

14 "(b) (1) No establishment may be registered under
15 this section except pursuant to application which shall set
16 forth—

17 "(A) the name of the applicant;

18 "(B) his principal place of business;

19 "(C) the number or other identification of any ap-
20 plicable Federal, State, or local license or registration,
21 relating to narcotic drugs or marihuana, currently held
22 by the applicant including the number or other identifi-
23 cation of any such Federal license or registration pre-
24 viously held by the applicant;

25 "(D) procedures for accountability for drugs used

1 in research projects of the applicant and the methods to
2 be used and the safeguards to be instituted against diver-
3 sion of the drugs used in such projects to nonmedical or
4 nonscientific uses; and

5 “(E) any other information required by the Secre-
6 tary by regulations.

7 The Secretary may not register an establishment under this
8 section unless he determines that the applicant has estab-
9 lished adequate procedures to provide for accountability
10 for drugs used in research projects of the applicant and
11 adequate methods to safeguard against diversion of such
12 drugs to nonmedical or nonscientific uses, in accordance
13 with regulations issued by the Secretary, with the concur-
14 rence of the Attorney General. Such regulations shall permit
15 the conduct of double-blind studies.

16 “(2) Each applicant registered under this section shall,
17 before any drugs are administered to human beings under a
18 research project of the applicant, submit to the Secretary,
19 in such form and containing such information as the Secre-
20 tary may require, a research protocol, describing the research
21 to be conducted, listing the investigators (each of whom must
22 be registered under section 4722 or 4753 of the Internal
23 Revenue Code, as applicable) and their qualifications to
24 engage in such research, and otherwise conforming to the

1 requirements of section 505 (i) of the Federal Food, Drug,
2 and Cosmetic Act. No such research protocol may provide
3 for the dispensing or administration of drugs to human beings
4 except by persons licensed to dispense or administer such
5 drugs under applicable State laws.

6 “(c) (1) The Secretary may revoke or suspend the
7 registration of any establishment granted under this section
8 if he finds (A) that the application for such registration con-
9 tains any untrue statement of material fact, (B) that research
10 projects in such establishment are not being conducted in
11 accordance with approved procedures or methods relating
12 to accountability for drugs or safeguards against diversion of
13 drugs used in such project to nonmedical or nonscientific
14 uses, or (C) research projects involving the dispensing or
15 administration of drugs to human beings are being conducted
16 by persons not licensed under applicable State law to dispense
17 or administer drugs.

18 “(2) Regulations of the Secretary shall provide for
19 notice and opportunity for a hearing before revocation or
20 suspension of registration under this section, except that, upon
21 a finding of imminent hazard to the public health, such reg-
22 istration may be suspended or revoked prior to such hearing,
23 but opportunity for a hearing shall be granted immediately
24 in such cases.”

1 AMENDMENTS RELATING TO DRUG RESEARCH IN REGU-
2 LATED ESTABLISHMENTS

3 SEC. 406. (a) Section 4704 (b) of the Internal Rev-
4 enue Code of 1954 is amended by striking out the period
5 at the end thereof and inserting in lieu thereof “; or”, and
6 by inserting immediately below paragraph (2) the follow-
7 ing new paragraph:

8 “(3) RESEARCH.—To the dispensing or adminis-
9 tration of narcotic drugs in the course of a research
10 project conducted by an establishment currently regis-
11 tered under section 513 of the Public Health Service
12 Act, if records of the drugs so dispensed or administered
13 are kept as required by this subpart.”

14 (b) Section 4705 (c) of the Internal Revenue Code of
15 1954 is amended by adding at the end thereof the following:

16 “(5) RESEARCH.—To the dispensing or adminis-
17 tration of narcotic drugs to any person in the course of
18 a research project conducted by an establishment cur-
19 rently registered issued under section 513 of the Public
20 Health Service Act. Such registrant shall keep a record
21 of all such drugs dispensed or administered, showing
22 the amount dispensed or administered, the date, and
23 the name and address of the person to whom such drugs
24 are dispensed or administered, except such as may be
25 dispensed or administered to a patient upon whom a

1 physician, dentist, veterinary surgeon, or other prac-
2 titioner shall personally attend; and such record shall be
3 kept for a period of two years from the date of dispensing
4 or administering such drugs, subject to inspection, as
5 provided in section 4773."

6 (c) Section 4721 (5) of the Internal Revenue Code of
7 1954 is amended by striking out "research, instruction, or
8 analysis" and inserting in lieu thereof "instruction or analysis,
9 or for the purpose of research by an establishment currently
10 registered under section 513 of the Public Health Service
11 Act,".

12 (d) Section 4742 (b) of the Internal Revenue Code of
13 1954 is amended by adding at the end thereof the following:

14 "(6) RESEARCH PROJECTS.—To a transfer of mari-
15 huana to or by a person in the conduct of a research proj-
16 ect conducted by an establishment currently registered
17 under section 513 of the Public Health Service Act.
18 Such registrant shall keep a record of all such marihuana
19 used in such project, showing the amount used and the
20 name and address of the person using such marihuana,
21 and such record shall be kept for a period of two years
22 from the date of such use, and be subject to inspection
23 as provided in section 4773."

24 (e) Section 4751 (4) of the Internal Revenue Code of
25 1954 is amended by striking out "research, instruction, or

1 analysis” and inserting in lieu thereof “instruction or analysis,
2 or for the purpose of research by an establishment currently
3 registered under section 513 of the Public Health Service
4 Act,”.

5 TITLE V—MISCELLANEOUS

6 TRANSFERS OF AUTHORITY

7 SEC. 501. The functions, powers and duties of the
8 Attorney General under Reorganization Plan Number 1 of
9 1968 to designate a drug as a depressant or stimulant drug
10 under section 201 (V) of the Federal Food, Drug, and
11 Cosmetic Act, and to make a finding that a drug or other
12 substance is an opiate under section 4731 of the Internal
13 Revenue Code of 1954, to determine the medical, scientific,
14 and other legitimate needs of the United States for the
15 purpose of establishing manufacturing quotas for narcotic
16 drugs under section 509 of the Narcotics Manufacturing Act
17 of 1960, and the amounts of narcotic drugs that should be
18 imported or exported under sections 173 and 182 of title 21
19 of the United States Code, are transferred to the Secretary.

20 AMENDMENTS RELATING TO TRANSFERS OF AUTHORITY

21 SEC. 502. (a) The Internal Revenue Code of 1954 is
22 amended as follows:

23 (1) Section 4702 (a) (1) is amended by striking out
24 “The Secretary or his delegate” where it appears after sub-
25 paragraph (B) and inserting in lieu thereof “The Secretary

1 of Health, Education, and Welfare, after consultation with
2 the Attorney General”.

3 (2) Sections 4702 (a) (3) and 4702 (a) (5) are each
4 amended by striking out “The Secretary or his delegate”
5 where it appears in those sections and inserting in lieu thereof
6 “The Secretary of Health, Education, and Welfare, after
7 consultation with the Attorney General”.

8 (3) Section 4705 (c) (2) (C) is amended by striking
9 out “The Secretary or his delegate” and inserting in lieu
10 thereof “The Secretary of Health, Education, and Welfare,
11 after consultation with the Attorney General”.

12 (4) Sections 4731 (g) (1) and 4731 (g) (2) are each
13 amended by striking out “The Secretary or his delegate
14 (after considering the technical advice of the Secretary of
15 Health, Education, and Welfare or his delegate, on the sub-
16 ject)” and inserting in lieu thereof in each such section “The
17 Secretary of Health, Education, and Welfare, after consulta-
18 tion with the Attorney General”.

19 (b) Section 2 (b) of the Narcotic Drugs Import and
20 Export Act is amended by striking out “the board” and in-
21 serting in lieu thereof “the Secretary of Health, Education,
22 and Welfare, after consultation with the Attorney General”.

23 (c) Section 10 (a) of the Opium Poppy Control Act of
24 1942 (21 U.S.C. 188) is amended by striking out “The
25 Secretary of the Treasury” and inserting in lieu thereof “The

1 Secretary of Health, Education, and Welfare, after consulta-
2 tion with the Attorney General”.

3 (d) The Narcotics Manufacturing Act of 1960 is
4 amended as follows:

5 (1) The second sentence of section 5 (b) (21 U.S.C.
6 503) is amended by striking out “The Secretary or his dele-
7 gate” and inserting in lieu thereof “The Secretary of Health,
8 Education, and Welfare, after consultation with the Attorney
9 General”.

10 (2) The second sentence of section 5 (d) is amended by
11 striking out “The Secretary or his delegate” and inserting in
12 lieu thereof “The Secretary of Health, Education, and Wel-
13 fare, after consultation with the Attorney General”.

14 (3) Section 6 (21 U.S.C. 504) is amended by striking
15 out “The Secretary or his delegate” the first and third
16 time it appears and inserting in lieu thereof “The Secre-
17 tary of Health, Education, and Welfare, after consultation
18 with the Attorney General”.

19 (4) Section 7 (b) (21 U.S.C. 505 (b)) is amended
20 by striking out “if the Secretary or his delegate” and in-
21 serting in lieu thereof “if the Secretary of Health, Educa-
22 tion, and Welfare, after consultation with the Attorney
23 General”.

24 (5) Paragraph (1) of Section 8 (a) (21 U.S.C. 506
25 (a)) is amended by striking out “which will produce” and

1 inserting in lieu thereof "which the Secretary of Health,
2 Education, and Welfare, after consultation with the At-
3 torney General, determines will produce".

4 (6) Section 11 (a) (21 U.S.C. 509) is amended by
5 striking out "the Secretary or his delegate" and inserting
6 in lieu thereof "The Secretary of Health, Education, and
7 Welfare, after consultation with the Attorney General".

8 (7) Section 11 (b) is amended by striking out "the
9 Secretary or his delegate" the first time it appears in that
10 section and inserting in lieu thereof "The Secretary of
11 Health, Education, and Welfare, after consultation with the
12 Attorney General".

13 ADVISORY COMMITTEE

14 SEC. 503. The Secretary of Health, Education, and Wel-
15 fare shall appoint a committee of experts to advise him with
16 respect to any of the determinations pertaining to drugs
17 which he is required to make under amendments made by
18 this Act. This committee shall be known as the Advisory
19 Committee on Narcotics and Dangerous Drugs. It shall be
20 composed of not less than twelve persons of diverse pro-
21 fessional backgrounds, including the fields of pharmacology,
22 psychiatry, psychology and other behavioral sciences, man-
23 ufacturing, and distribution, who, in the opinion of the Sec-
24 retary, qualify as experts on the subject of narcotic drugs
25 or depressant or stimulant drugs.

COMPREHENSIVE NARCOTIC ADDICTION AND DRUG ABUSE CARE AND CONTROL ACT
OF 1969

(Section-by-Section Analysis)

SECTION II—FINDINGS AND PURPOSES

The Congress finds that narcotic addiction and drug abuse are major health and social problems afflicting large numbers of persons and that much more needs to be done in relation to prevention and control; that programs should be community-based, comprehensive and coordinated with other services under medical auspices; that current knowledge about causes, prevention and treatment of narcotic addiction and drug abuse is inadequate and that public education is urgently needed on this subject; and finally, that there is a serious shortage of trained personnel to work in this area. The purpose of the Act is to help prevent and control narcotic addiction and drug abuse through authorization of Federal aid in the construction, staffing, operation and maintenance of facilities for the prevention and treatment of narcotic addiction and drug abuse, in the development of drug abuse education programs, in the training of professional and other personnel, in the support of appropriate demonstration projects relating to narcotic addiction and drug abuse and in the conduct of needed research, study and experimentation.

Title I—Construction, staffing and operation of treatment facilities

The Community Mental Health Centers Act would be amended to:

1. Make operation and maintenance costs, as well as all staffing costs, eligible for Federal funding. "Staffing costs" would be further defined to include fringe benefits and travel allowances for all personnel, including support personnel, as well as salaries. Operation and maintenance would include costs of upkeep and repairs, supplies, utilities, rent, equipment cleaning, food and drugs, and similar items of cost. At present, only construction and staffing costs are eligible, and the latter are limited to salaries of professional and technical personnel only.
2. Increase the maximum Federal participation in the costs of construction of treatment and rehabilitation facilities from 66⅔% to 90%.
3. Increase the maximum percentage and duration of Federal participation in operation, staffing and maintenance costs to 90% for the first two years and 75% of such costs for the next six years. At present, such support is limited to 75% of the costs of salaries for professional and technical personnel for the first 15 months of the grant, 60% for the next year, 45% for the next year, and 30% for the final year of the grant.

Authorized appropriations for construction, staffing, operation and maintenance grants under the alcoholism and the narcotic addiction sections of the Act are as follows: \$15 million for the fiscal year ending June 30, 1970; \$20,000,000 for the fiscal year ending June 30, 1971; \$40,000,000 for the fiscal year ending June 30, 1972; \$50,000,000 for the fiscal year ending June 30, 1973; and \$75,000,000 for the fiscal year ending June 30, 1974. "Such sums as may be necessary" are authorized for continuation grants covering fiscal year 1971 and each of the next 11 fiscal years.

Title II—Training and evaluation, and drug abuse education

Sec. 201—The Secretary is authorized to make grants to States and political subdivisions and to public or nonprofit private agencies or to contract with other private agencies or organizations for a number of special purposes:

- (1) for the development of specialized training programs or materials for the prevention and treatment of drug abuse and for the training of personnel to administer such programs and services,
- (2) for research and study relating to current and projected personnel needs in the field of drug abuse (such a study to include research on the adequacy of educational and training resources in the drug abuse field, and to examine the availability of specialized training for persons such as physicians and other health professionals who have occasion to deal with narcotic addicts and drug abusers), and
- (3) for the planning and conduct of surveys and field trials to evaluate the adequacy of State programs for the prevention and treatment of narcotic addiction and drug abuse. The training grants can be made only upon recommendation of the National Advisory Mental Health Council.

The following appropriations would be authorized: \$2,000,000 for the fiscal year ending June 30, 1970; \$3,000,000 for the fiscal year ending June 30, 1971; \$5,000,000 for the fiscal year ending June 30, 1972; \$6,000,000 for the fiscal year ending June 30, 1973; and \$6,000,000 for the fiscal year ending June 30, 1974.

Sec. 202—The Secretary would also be authorized to make fellowship grants to professional personnel for training in relation to drug addiction and other drug abuse related problems. These grants again would require the approval of the National Advisory Mental Health Council. In both these sections, "professional personnel" is defined to include, but not be limited to, persons in the fields of medicine, psychiatry, nursing, social work, psychology, education and vocational rehabilitation.

The following appropriations are authorized for carrying out this fellowship program: \$400,000 for the fiscal year ending June 30, 1970; \$600,000 for the fiscal year ending June 30, 1971; and \$1,000,000 for each of the next three fiscal years.

DRUG ABUSE EDUCATION

A new section would be added to the Centers Act to authorize the Secretary to make grants to States and political subdivisions and to public or nonprofit private agencies, or to contract with other private agencies or organizations for the collection, preparation and dissemination of educational materials, and for the development and evaluation of programs of drug abuse education directed to the general public, school age children and other high risk groups.

The Secretary, acting through the National Institute of Mental Health, is designated as the focal point for 1) the collection and dissemination of information and materials, including films and other educational devices, dealing with drug abuse and its prevention; 2) the conduct of drug abuse public education programs and the training of persons to organize and carry out such programs; 3) the coordination of Federal activities, with respect to the health education aspects of drug abuse; 4) the provision of technical assistance to State and local health and educational agencies; and 5) the development and conduct of workshops and other institutes or activities for the training of personnel to work in the area of drug abuse education. All such grants are to be awarded only after approval by the National Advisory Mental Health Council.

The following appropriations would be authorized: \$2 million for the fiscal year ending June 30, 1970; \$4 million for the fiscal year ending June 30, 1971; \$6 million for the fiscal year ending June 30, 1972; and \$8 million for each of the next two fiscal years.

Title III—Amendments to the PHS Act for research and studies relating to drug use, abuse, and addiction

Section 302(a) of the Public Health Service Act would be amended by authorizing studies of depressant or stimulant drugs as well as studies of narcotics and by requiring the Secretary of the Treasury to use the results of the Surgeon General's studies of the country's medical and scientific requirements for crude opium and other narcotics in determining the amounts of crude opium and coca leaves to be imported. (The Secretary of the Treasury's authority under this section is presently vested in the Attorney General by virtue of Reorganization Plan No. 1 of 1968. The Surgeon General's authority under this section is presently vested in the Secretary pursuant to Reorganization Plan No. 3 of 1966).

A new subsection (c) would be added to Section 302 to authorize the Secretary to establish a program of grants, to be administered by the National Institute of Mental Health, to State or local agencies and to public or nonprofit private agencies, and to contract with other agencies or institutions for:

1. the conduct of a broad program of research into all phases of drug use and abuse, including origins, causes, incidence and prevention, the abuse potential of drugs, and therapeutic and rehabilitation agents and techniques;
2. the investigation and study of improved diagnostic and treatment techniques;
3. the development of improved methods of operation and administration of State institutions caring for and treating drug addicts or abusers;
4. the conduct of surveys to evaluate the adequacy of treatment and prevention programs;
5. the development of field trials and demonstration programs for prevention and treatment of drug abuse;

6. the establishment of a National Registry of Narcotic Addicts; and

7. support of the construction, staffing, operation and maintenance of regional centers for research in drug abuse and related problems. The bill specifies that one of the regional research centers is to be established as a National Addiction and Drug Abuse Research Center and made a part of the NIMH, to be located in close proximity to the NIMH's central research facilities.

There is also a provision forbidding the divulgence of names of persons listed on the National Registry of Narcotic Addicts, except for statistical and research purposes and then only with approval of the Secretary and the consent of persons involved. The Secretary may also authorize researchers to protect the privacy of their subjects by refusing to give identifying characteristics to anyone not connected with the research.

The following appropriations are authorized for the establishment of the regional research centers: \$3 million for FY 1970; \$10 million for FY 1971; \$25 million for FY 1972; \$20 million for FY 1973; and \$20 million for FY 1974. An additional \$15 million is earmarked for the establishment of the NIMH National Addiction and Drug Abuse Research Center.

For all the other grants authorized by this section, the appropriations authorized are: \$3 million for FY 1971; and \$10 million each year for Fiscal Years 1972, 1973 and 1974.

Title IV—Control of dangerous substances

Section 401—Findings and Declaration. The Congress finds and declares that the importation, manufacture, distribution, possession or use of narcotic or depressant and stimulant drugs for non-medical and non-scientific purposes is seriously detrimental to the health and welfare of the American people, but that it is vitally important that such drugs be readily available and in adequate supply for use in the practice of medicine and for scientific research. The purpose of the title is stated to be the provision of a single comprehensive code which will establish a method for identifying substances which should be Federally controlled, distinguish among them with respect to the degree of control required and between their medical and scientific use as against their abuse for non-medical or non-scientific purposes. The Congress expresses its intent to rely on the medical and scientific expertise of the Secretary of the Department of Health, Education, and Welfare, particularly that of his staff versed in the fields of mental health and pharmacology, in making all these determinations.

Section 402—This section authorizes the Secretary to establish and promulgate by regulation classes of narcotics and depressant or stimulant drugs which in his opinion require Federal control because of their ability to produce physical or psychological dependence. Such substances are to be ranked according to their ability to produce physical or psychological dependence and their relative capabilities for abuse.

The Secretary would also be authorized to add, delete, or change a substance from one classification to another, or to reorganize the classification system entirely at any time, and to promulgate the changes through amended regulations.

Only substances fitting the definition of "narcotic drug" as set forth in the Internal Revenue Code or of "depressant or stimulant drugs" as set forth in the Federal Food, Drug, and Cosmetic Act, and which are not exempted under provisions of that Act, may be included.

Section 403—All designations under this section are to be made by the Secretary only after consulting with and upon the advice of an Advisory Committee established by Section 503 of the Act, and after consultation with the Attorney General.

Section 404—Control of illegal transactions in marihuana. This section would remove marihuana from the Internal Revenue Code and add it to the definitions of depressant or stimulant drugs in the Food, Drug, and Cosmetic Act, making it subject to the controls imposed on such substances rather than those provided for narcotic drugs in the Internal Revenue Code.

Section 405—Registration of Research Establishments. A new section 513 would be added to the Public Health Service Act to require all persons wishing to conduct research with any narcotic drug or with marihuana to register with the Secretary. Registration is pursuant to an application to the Secretary containing such information as the Secretary may require, and which satisfies him that adequate safeguards against diversion of the drugs to be used to non-medical or non-scientific uses will be provided. Before any drugs are administered to human beings, a research protocol describing the research, the investigators and their qualifications must be submitted to the Secretary. Provisions for

revocation or suspension of the registration under certain circumstances are also included.

Section 406—Drug Research Amendments. This section exempts research in establishments registered under the new section 513, above, from various provisions of the Internal Revenue Code concerning narcotics and marihuana, and makes certain other conforming amendments.

Title V—Miscellaneous

Section 501—Transfer of Authorities. The authorities of the Attorney General which were transferred to him from the Secretary of HEW or the Secretary of the Treasury, by virtue of Reorganization Plan No. I of 1968, to designate a substance as a depressant or stimulant drug, or to make a finding that a substance is an opiate, or to determine the medical, scientific and other legitimate needs of the United States for the purpose of setting manufacture or export or import quotas, would be transferred to the Secretary of HEW by this section.

Section 502—Amendments relating to transfers of authorities. Various provisions of the Internal Revenue Code of 1954, the Narcotic Drugs Import and Export Act, the Opium Poppy Control Act of 1942 and the Narcotic Manufacturing Act of 1960 are amended to transfer decision making authority with respect to the abuse potential of or scientific requirements for narcotics or dangerous drugs in conformance with the transfer authorized by Section 501. In each instance, prior consultation with the Attorney General is required.

Section 503—Advisory Committee. This section establishes an Advisory Committee on Narcotics and Dangerous Drugs which is to assist the Secretary in making any of the determinations for which he is responsible under the Act. The Committee is to be comprised of 12 members of diverse professional backgrounds, including the fields of pharmacology, psychiatry, psychology and other behavioral sciences, and those engaged in the manufacturing and distribution of drugs, to be selected by the Secretary for their expertise in the area of narcotic or depressant or stimulant drugs.

Senator YARBOROUGH. I appreciate the chairman's courtesies. I would like to stay and hear the witnesses, particularly those from the Government, but unfortunately, there is an executive session of the Appropriations Committee meeting at 10:30, Mr. Chairman, and there are many projects in there that are of interest to many States, including mine.

I am forced to leave. It is only the fact that it is an executive session to mark up an appropriations bill that I have to leave.

Thank you, Mr. Chairman.

Senator HUGHES. Thank you very much for your presentation. I think as we move along at this hearing we will begin to realize the great amount of research that has gone into this piece of legislation.

Thank you very much.

Senator YARBOROUGH. Thank you, Mr. Chairman.

Senator HUGHES. Thank you very much.

I would like to enter into the record at this time a statement by Senator Harrison A. Williams, Jr., before the Subcommittee on Alcoholism and Narcotics.

(The statement referred to follows:)

**STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR
FROM THE STATE OF NEW JERSEY**

Mr. Chairman, I am most appreciative of this opportunity to work with you, and to acknowledge your creative leadership, in an area that has been too long overlooked and too little understood.

When the hearings on drug abuse began—more than a month ago—you accurately summarized our responsibility when you said:

The need to take action against the growth of drug abuse in the United States ranks with Vietnam, poverty and civil rights among our most urgent national priorities.

It is significant—and most reassuring—that the work of this subcommittee has resumed today. I am pleased to note that today's hearings will consider some specific proposals which are before this subcommittee, including the Drug Abuse Prevention and Rehabilitation Act which I introduced on April 15 of this year.

This bill was the first Senate bill of the current Congress to touch on the problem which concerns us today. We have come a long way since April, and I am glad that additional legislation is now pending before this subcommittee; legislation which fills in the details and supplies the substance for our overall consideration.

When I offered my Drug Abuse Prevention and Rehabilitation Act, it was my intention to use my proposals as part of the total picture. It is appropriate for this subcommittee to examine all aspects, explore all dimensions, of the crisis in drug abuse. In this spirit of exploration, then, Mr. Chairman, I would like to make a few brief remarks about my own proposed legislation.

Mr. Chairman, I ask unanimous consent that the text of S. 1816, the Drug Abuse Prevention and Rehabilitation Act of 1969, be reprinted in the hearing record at this time together with a list of those Senators who joined me in offering the bill.

Drug abuse is a relatively new phrase in our vocabulary. It is also much more complex than most people realize. Dr. Stanley Yolles, Director of the National Institute of Mental Health, in testimony before this subcommittee on August 6, 1969, stated that drug abuse "means excessive or persistent use of a drug beyond its medical need and where physical or emotional dependence on the drug is developed." This definition clearly covers more than mere addiction to morphine or heroin; in fact, it includes the misuse and overuse of many of those 30 or more drugs—pills, cough syrups, and so forth—found in the average American medicine chest.

Drug abuse, in short, is another way of describing the harm we are doing to ourselves with chemical and synthetic substances. It is another way of admitting that we are becoming a drugged society.

Dr. Yolles has summarized society's dilemma by pointing out that "drug abuse represents the end product of a complex of social, psychological, and cultural forces rather than a purely criminal one."

These deeper, less obvious issues are the focus of my legislation. My bill deals with them in two specific ways: first, it provides Federal help in establishing centers for the treatment of, and the prevention of, drug abuse; and, second, it provides Federal help in training professionals to deal with the problem, intelligently and effectively.

First, the bill provides for the establishment, development, and maintenance of prevention, treatment, and rehabilitation centers for drug addicts and drug abusers. We are already familiar with rehabilitation centers for narcotics addicts; I strongly support an increase in the number of these centers, and an expansion of the basic concept to include preventive and restorative functions as well.

Unfortunately, there has been the shadow of bureaucratic haggling and redtape confusion hanging over drug rehabilitation programs. The tradition of depending solely on the National Institute of Mental Health, and on the procedures and policies fostered by NIMH centers,

had led us astray. People, not programs, must become the focus of our drug rehabilitation effort.

To help in this task, we must include the private nonprofit organizations and agencies in the mix. The Federal supersystem doesn't have all the answers, and the "privates" may shake up the whole process with their creativity and energy, so let's waste no time in involving them in the work.

Title II of my bill provides that up to 30 percent of the available funds will be used for grants to nonprofit organizations to develop a comprehensive program for the prevention and treatment of drug addiction. It would also help these private organizations in their experimentation with new techniques and new methods of care for the drug abuser.

Second, my bill deals with the deeper, causal factors by encouraging drug abuse education curriculum programs for students of medicine, psychology, psychiatry, sociology, social work, and related fields. There are no medical schools in the country which offer an interdisciplinary course on drug abuse, yet we continue to advise those in trouble to "turn to your local doctor for information."

The time is well past for any more lengthy debate or rambling speculation. It is time to match platitudes with cold cash, and it is time to match concern with concrete action. If the State of California can spend \$75 million to apprehend marihuana "offenders," we can at least double the figure for a national program of rehabilitation and human rescue.

The time is also well past for hypocrisy and half-truth, meaningless codes, and empty challenges. As a cosponsor of Senator Yarborough's Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act of 1969, I endorse specifically section 404 of that bill. This provision would remove marihuana from the Internal Revenue Code and add it to the list of depressant and stimulant drugs in the Food, Drug, and Cosmetic Act. Marihuana would thus be subject to the controls imposed on other, similar substances, rather than to the inconsistent and often dangerously punitive controls provided for narcotics under the Internal Revenue Code.

Playboy magazine recently carried an excellent analysis of the marihuana problem by Dr. Joel Fort, and I would ask that this article be made a part of the hearing record at this time ("Pot: A Rational Approach," Playboy, October 1969). Perhaps the logic outlined in this article will guide us in our deliberations.

I am grateful for this opportunity to share some thoughts with you on the critical problems of drug abuse in a drugged society. I look forward to working with you, Mr. Chairman, and I await with interest the dialog which will accompany consideration of Senator Yarborough's bill.

(The text of the bill and the article referred to follow:)

91ST CONGRESS
1ST SESSION

S. 1816

IN THE SENATE OF THE UNITED STATES

APRIL 15, 1969

Mr. WILLIAMS of New Jersey (for himself, Mr. NELSON, Mr. BAYH, Mr. COOPER, Mr. GRAVEL, Mr. HART, Mr. HATFIELD, Mr. INOUE, Mr. KENNEDY, Mr. MCGEE, Mr. MONDALE, Mr. MOSS, Mr. PELL, Mr. RANDOLPH, and Mr. YOUNG of Ohio)

A BILL

To authorize the Secretary of Health, Education, and Welfare to make grants for treatment and rehabilitation centers for drug addicts and drug abusers, and to carry out drug abuse education curriculum programs, and to strengthen the coordination of drug abuse control programs by establishing the National Council on Drug Abuse Control.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That this Act may be cited as the "Drug Abuse Prevention
- 4 and Rehabilitation Act of 1969".

1 TITLE I—FINDINGS AND STATEMENT OF
2 PURPOSE

3 SEC. 101. (a) The Congress hereby finds and declares
4 that drug abuse and addiction diminishes the strength and
5 vitality of the people of our Nation; that such abuse and
6 addiction of dangerous drugs is increasing in urban and
7 suburban areas; that there is a lack of adequate facilities to
8 prevent drug abuse and addiction, and to rehabilitate those
9 who seek and need treatment and rehabilitation; that there
10 is a lack of authoritative information and creative projects
11 designed to educate students of medicine, psychology, psy-
12 chiatry, sociology, social work, and other related fields; and
13 that prevention and control of such drug abuse requires
14 intensive and coordinated efforts on the part of both govern-
15 mental and private groups.

16 (b) It is the purpose of this Act to provide for the
17 establishment, development, and maintenance of prevention,
18 treatment, and rehabilitation programs for drug abusers, and
19 to encourage the development of new and improved cur-
20 riculums on the problems of drug abuse in medical schools
21 and other institutions of higher education, and to strengthen
22 the coordination of drug abuse control programs by establish-
23 ing the National Council on Drug Abuse Control.

1 TITLE II—GRANTS FOR TREATMENT AND REHA-
2 BILITATION CENTERS FOR DRUG ADDICTS
3 AND DRUG ABUSERS

4 AUTHORIZATION OF APPROPRIATIONS

5 SEC. 201. There are hereby authorized to be appro-
6 priated \$50,000,000 for the fiscal year beginning July 1,
7 1969; \$60,000,000 for the fiscal year beginning July 1,
8 1970; \$70,000,000 for the fiscal year beginning July 1,
9 1971; \$80,000,000 for the fiscal year beginning July 1,
10 1972; and \$90,000,000 for the fiscal year beginning July 1,
11 1973, for the purpose of carrying out this title. Sums appro-
12 priated pursuant to this section shall remain available until
13 expended.

14 DRUG ADDICT TREATMENT AND REHABILITATION CENTERS

15 SEC. 202. (a) From the sums appropriated pursuant
16 to section 201, the Secretary shall make grants designed to
17 assist States and nonprofit private organizations in defray-
18 ing expenses and other costs incurred by any such State or
19 organization in establishing, developing, equipping, and oper-
20 ating drug addict prevention, treatment, and rehabilitation
21 centers, including the training of personnel necessary to
22 operate such centers, and the payment of salaries of such
23 personnel.

1 (b) Within three months after the enactment of this
2 title, the Secretary shall, by regulations, establish and pre-
3 scribe general standards for obtaining grants under this title.

4 (c) The regulations issued under subsection (b) shall
5 provide for regular reports to the Secretary by any State
6 or nonprofit organization receiving a grant under this title.
7 The Secretary shall, from time to time, on the basis of the
8 reports and other information available to him, review and,
9 if necessary, revise the general standards prescribed by him
10 pursuant to subsection (b) of this section.

11 APPLICATIONS

12 SEC. 203. After the regulations referred to in subsec-
13 tion (b) of section 202 of this title have been issued, any
14 State or nonprofit private organization desiring to secure
15 financial assistance under this title for any project for the
16 establishment of a drug addict prevention, treatment, and
17 rehabilitation center may submit an application to the Sec-
18 retary for a grant under this title to assist it in carrying out
19 such project. The application shall set forth—

20 (1) the kinds of prevention, treatment, and re-
21 habilitation services which will be provided under the
22 project with respect to which such application is filed;

23 (2) reasonable assurances that the applicant is
24 legally qualified and is competent to provide such serv-
25 ices; and

1 (3) a policy and procedure designed to assure that
2 Federal funds made available under this title will be so
3 used as not to supplant State, local, or private funds.

4 APPROVAL OF APPLICATION

5 SEC. 204. (a) The Secretary may approve any appli-
6 cation which complies with the provisions of this title and
7 regulations issued pursuant thereto. Upon the request of
8 any applicant, the Secretary may, on the basis of a high per-
9 centage of urban residents in the State in which the appli-
10 cant is located, modify the standards and requirements to be
11 met by the project of that applicant.

12 (b) The Secretary shall pay to any State or nonprofit
13 organization under this title upon approval by the Secre-
14 tary of the application of such State or organization the
15 cost of the project set forth therein. Payment of any grant
16 under this title shall be made on such conditions as the Sec-
17 retary finds necessary to carry out the purposes of this title
18 consistent with the provisions of this title.

19 DRUG PREVENTION, TREATMENT, AND REHABILITATION
20 PROGRAM

21 SEC. 205. (a) Of the amount appropriated pursuant to
22 subsection (a) of section 202 of this title for each fiscal
23 year, not less than 50 per centum thereof shall be used by
24 the Secretary in making grants under this title to States
25 or nonprofit private organizations which submit an applica-

tion pursuant to section 202 of this title which provides for a comprehensive program for the prevention, treatment, and rehabilitation of drug addicts, and for research, investigation, and experimentation in connection with new techniques and methods for providing such prevention, treatment, and rehabilitation.

(b) From sums available for the purposes of this section, the Secretary shall reserve an amount not less than 20 per centum thereof nor more than 30 per centum thereof to make grants to nonprofit private organizations to pay the cost of projects for the prevention and treatment of drug addiction, and the rehabilitation of drug addicts which the Secretary determines—

(1) involves the use of innovative methods or approaches to such prevention, treatment, or rehabilitation without the use of narcotic drugs or nonaddictive substitutes for drugs; and

(2) may have national significance or gives promise of more effectively promoting the objectives of the Act.

TITLE III—DRUG ABUSE EDUCATION

CURRICULUM PROGRAMS

AUTHORIZATION OF APPROPRIATIONS

SEC. 301. There are hereby authorized to be appropriated \$10,000,000 for the fiscal year beginning July 1, 1969; \$15,000,000 for the fiscal year beginning July 1, 1970; \$20,000,000 for the fiscal year beginning July 1, 1971;

1 \$25,000,000 for the fiscal year beginning July 1, 1972; and
2 \$30,000,000 for the fiscal year beginning July 1, 1973, for
3 the purpose of carrying out this title. Sums appropriated pur-
4 suant to this section shall remain available until expended.

5 USE OF FUNDS

6 SEC. 302. (a) From the sums pursuant to section 301,
7 the Secretary shall make grants under this title to assist medi-
8 cal schools and institutions of higher learning in defraying
9 expenses and other costs incurred by any such medical school
10 or institution of higher learning in developing and carrying
11 out such curriculum programs on drug abuse education. Such
12 sums shall remain available until expended for payments with
13 respect to applications filed under this title on or before
14 June 30, 1974, and approved by the Secretary on or before
15 June 30, 1975.

16 (b) Within three months after the enactment of this
17 title, the Secretary shall, by regulations, establish and pre-
18 scribe general standards for obtaining grants under this title,
19 including provisions for joint applications by any medical
20 school and one or more institutions of higher education.

21 (c) The regulations issued under subsection (b) shall
22 provide for regular reports to the Secretary by any medical
23 school or institution of higher education, or both, receiving a
24 grant under this title. The Secretary shall, from time to time,
25 on the basis of the reports and other information available to

1 him, review and, if necessary, revise the general standards
2 prescribed by him pursuant to subsection (b) of this section.

3 APPLICATIONS—

4 SEC. 303. After the regulations referred to in subsection
5 (b) of section 302 of this title have been issued, any medical
6 school, institution of higher education, or both jointly, desir-
7 ing to secure financial assistance under this title for the pur-
8 poses set forth in section 302 of this title may submit an
9 application to the Secretary for a grant under this title. The
10 application shall be in such form and contain such informa-
11 tion or other matters as the Secretary may by regulation
12 prescribe.

13 APPROVAL OF APPLICATIONS

14 SEC. 304. The Secretary may approve any application
15 which complies with the provisions of this title and regula-
16 tions issued pursuant thereto. The Secretary shall pay to any
17 medical school or institution of higher education, or both
18 jointly, the cost of the project or projects set forth in such
19 application, upon approval by the Secretary of such applica-
20 tion. Payment of any grant under this title may be made on
21 such conditions as the Secretary finds necessary to carry out
22 the purposes of this title consistent with the provisions
23 thereof.

9

1 TITLE IV—COORDINATION OF DRUG ABUSE
2 CONTROL PROGRAMS

3 COUNCIL ESTABLISHED

4 SEC. 401. (a) There is hereby established in the
5 Executive Office of the President the National Council on
6 Drug Abuse Control (hereinafter referred to as the "Coun-
7 cil") which shall be composed of—

- 8 (1) the Vice President;
9 (2) the Secretary of the Treasury;
10 (3) the Secretary of Defense;
11 (4) the Attorney General;
12 (5) the Secretary of Labor;
13 (6) the Secretary of Health, Education, and Wel-
14 fare, who shall be Chairman of the Council;
15 (7) the Administrator of Veterans' Affairs; and
16 (8) the Director of the Office of Economic Op-
17 portunity.

18 (b) Each member of the Council may designate an-
19 other officer of his department or agency to serve on the
20 Council as his alternate in his unavoidable absence.

21 (c) The President shall from time to time designate
22 one of the members of the Council to preside over meetings

1 of the Council during the absence, disability, or unavaila-
2 bility of the Chairman.

3 (d) Whenever any matter is considered by the Council
4 relating to the interests of a Federal department or agency
5 not represented on the Council, the Chairman may invite
6 the head of any such department or agency to participate
7 in the business of the Council.

8

FUNCTIONS

9 SEC. 402. It shall be the function of the Council to—

10 (1) advise and assist the President, as he may
11 request, on drug abuse control education programs con-
12 ducted by Federal, State, and local public agencies or
13 private organizations and on drug abuse law enforcement
14 activities of Federal agencies;

15 (2) provide effective procedures for coordinating
16 all drug abuse control education programs and activities
17 conducted or assisted by any department or agency of
18 the Federal Government with particular emphasis upon
19 the exchange and dissemination of information concern-
20 ing the dangers of drug abuse;

21 (3) provide effective procedures for coordination of
22 programs that would contribute to strengthening the
23 effectiveness of the law enforcement activities of the
24 Bureau of Narcotics and Dangerous Drugs of the Depart-
25 ment of Justice;

1 (4) review all Federal and State laws with respect
2 to narcotics and other dangerous drugs in order to deter-
3 mine the effectiveness of such laws in controlling drug
4 abuse, and make appropriate recommendations to the
5 President and the Congress;

6 (5) provide, where appropriate, for a national pro-
7 gram on the dissemination of significant information on
8 drug abuse control;

9 (6) encourage State and local public agencies and
10 private organizations to participate fully in efforts to
11 combat the abuse of narcotic and dangerous drugs; and

12 (7) report to the Congress at least once in each
13 year on the activities of the Council during the preced-
14 ing year together with such recommendations, including
15 legislative recommendations, as the Council deems
16 appropriate.

17 ADMINISTRATIVE PROVISIONS

18 SEC. 403. (a) The Council may employ a staff to be
19 headed by an Executive Secretary. The Executive Secretary,
20 subject to the direction of the Chairman, is authorized to—

21 (1) appoint and fix the compensation of such staff
22 personnel as he deems necessary without regard to the
23 provisions of title 5, United States Code, governing
24 appointments in the competitive service, and without

1 regard to the provisions of chapter 51 and subchapter
2 III of chapter 53 of such title relating to classification
3 and General Schedule pay rates, at rates not in excess
4 of the maximum rate for GS-18 of the General Schedule
5 under section 5332 of such title; and

6 (2) procure temporary and intermittent services
7 to the same extent as is authorized by section 3109 of
8 title 5, United States Code.

9 (b) The Council shall, to the fullest extent possible, use
10 the services, facilities, and information, including statistical
11 information, of other governmental agencies as well as
12 private research agencies. Each department, agency, and
13 instrumentality of the executive branch of the Government,
14 including any independent agency, is authorized and directed
15 to furnish to the Council, upon request made by the Chair-
16 man, such information as the Council deems necessary to
17 carry out its functions under this title.

18 (c) The Council is authorized to establish an advisory
19 committee and may consult with such representatives of State
20 and local governments and other groups, organizations, and
21 individuals as the Council deems advisable.

22 COMPENSATION OF THE EXECUTIVE SECRETARY

23 SEC. 404. Section 5315 of title V, United States Code, is
24 amended by adding at the end thereof the following new
25 paragraph:

1 “(92) Executive Secretary, National Council on
2 Drug Abuse Control.”

3 TITLE V—GENERAL PROVISIONS

4 DEFINITIONS

5 SEC. 501. As used in this Act—

6 (1) “Secretary” means the Secretary of Health,
7 Education, and Welfare;

8 (2) “State” includes, in addition to the several
9 States of the Union the Commonwealth of Puerto Rico,
10 the District of Columbia, Guam, American Samoa, the
11 Virgin Islands, and the Trust Territory of the Pacific
12 Islands and includes any political subdivision or other
13 general purpose governmental entity thereof;

14 (3) “institution of higher education” means an edu-
15 cational institution in any State which—

16 (A) admits as regular students only persons
17 having a certificate of graduation from a school pro-
18 viding secondary education, or the recognized equiv-
19 alent of such a certificate;

20 (B) is legally authorized within such State to
21 provide a program of education beyond secondary
22 education;

23 (C) provides an educational program for which
24 it awards a bachelor’s degree or provides not less

1 than a two-year program which is acceptable for full
2 credit toward such a degree;

3 (D) is a public or other nonprofit institution;
4 and

5 (E) is accredited by a nationally recognized
6 accrediting agency or association or, if not so ac-
7 credited, (i) is an institution with respect to which
8 the Commissioner has determined that there is satis-
9 factory assurance, considering the resources avail-
10 able to the institution, the period of time, if any,
11 during which it has operated, the effort it is making
12 to meet accreditation standards, and the purpose for
13 which this determination is being made, that the
14 institution will meet the accreditation standards of
15 such an agency or association within a reasonable
16 time, or (ii) is an institution whose credits are ac-
17 cepted, on transfer, by not less than three institu-
18 tions which are so accredited, for credit on the same
19 basis as if transferred from an institution so
20 accredited.

21 Such term also includes any school which operates not
22 less than a one-year program of training to prepare
23 students for gainful employment in a recognized occupa-
24 tion and which meets the provisions of paragraphs (A),
25 (B), (D), and (E). For purposes of this subsection,

1 the Commissioner shall publish a list of nationally rec-
2 ognized accrediting agencies or associations which he
3 determines to be reliable authority as to the quality of
4 training offered.

5 (4) "medical school" means a medical institution
6 offering medical training leading to a degree of doctor
7 of medicine, which is accredited by a nationally recog-
8 nized accrediting association.

9 CONSULTATION WITH OTHER FEDERAL AGENCIES

10 SEC. 502. (a) The Secretary may not approve an appli-
11 cation for assistance under title II or title III unless he has
12 given the Director of the National Institute of Mental Health
13 and the head of the Bureau of Narcotics and Dangerous
14 Drugs in the Department of Justice an opportunity to re-
15 view the application and make recommendations thereon
16 within a period of not to exceed thirty days.

17 (b) The Secretary shall promulgate regulations estab-
18 lishing the procedures for consultation with other Federal
19 agencies (including the consultation required by subsection
20 (a)) and with other appropriate public and private
21 agencies.

22 ADVISORY COMMITTEE ON DRUG ABUSE EDUCATION

23 SEC. 503. (a) The Secretary shall appoint an Advisory
24 Committee on Drug Abuse Education, which shall—

25 (1) advise the Secretary concerning the adminis-

1 tration of, preparation of general regulations for, and
2 operation of, programs supported with assistance under
3 this title;

4 (2) make recommendations regarding the alloca-
5 tion of the funds under this title among the various pur-
6 poses set forth in section 202 and the criteria for estab-
7 lishing priorities in deciding which applications to
8 approve, including criteria designed to achieve an ap-
9 propriate geographical distribution of approved projects
10 throughout all regions of the Nation;

11 (3) review the administration and operation of pro-
12 grams under this title, including the effectiveness of such
13 programs in meeting the purposes for which they are
14 established and operated, making recommendations with
15 respect thereto, and make annual reports of its findings
16 and recommendations (including recommendations for
17 improvements in this title) to the Secretary for trans-
18 mittal to the Congress; and

19 (4) evaluate programs and projects carried out
20 under this title and disseminate the results of such
21 evaluations.

22 (b) The Advisory Committee on Drug Abuse Educa-
23 tion shall be appointed by the Secretary without regard to the
24 provisions of title 5, United States Code, relating to appoint-
25 ment in the competitive service and shall consist of twenty-

1 one members, seven of whom shall be from among persons
2 nominated by the Attorney General. At least three members
3 shall be ex-addicts. The Secretary shall appoint one member
4 as Chairman. The Committee shall consist of persons familiar
5 with educational (including elementary, secondary, and adult
6 education, and higher education), mental health, social, and
7 legal problems associated with drug abuse. The Committee
8 shall meet at the call of the Chairman.

9 (c) Members of the Advisory Committee shall, while
10 serving on the business of the Advisory Committee, be en-
11 titled to receive compensation at rates fixed by the Secre-
12 tary, but not exceeding \$100 per day, including traveltime;
13 and while so serving away from their homes or regular places
14 of business, they may be allowed travel expenses, including
15 per diem in lieu of subsistence, as authorized by section 5703
16 of title 5 of the United States Code for persons in the Gov-
17 ernment service employed intermittently.

18 PAYMENTS

19 SEC. 504. Payments under this Act may be made in
20 installments and in advance or by way of reimbursement,
21 with necessary adjustments on account of overpayments or
22 underpayments.

23 ADMINISTRATION

24 SEC. 505. In administering the provisions of this title,
25 the Secretary is authorized to utilize the services and facili-

1 ties of any agency of the Federal Government and of any
2 other public or private agency or institution in accordance
3 with appropriate agreements, and to pay for such services
4 either in advance or by way of reimbursement, as may be
5 agreed upon.

6 CERTIFICATION OF ADEQUATE FACILITIES FOR THE COM-
7 MITMENT AND TREATMENT OF DRUG ADDICTS

8 SEC. 506. (a) Subsection (b) of section 2902 of title
9 28, United States Code, is amended by deleting the follow-
10 ing: “, except that no individual shall be committed under
11 this chapter if the Surgeon General certifies that adequate
12 facilities or personnel for treatment are unavailable”.

13 (b) Subsection (a) of section 4253 of title 18, United
14 States Code, is amended by deleting the following: “, except
15 that no offender shall be committed under this chapter if
16 the Attorney General certifies that adequate facilities or
17 personnel for treatment are unavailable”.

[From Playboy magazine, October 1969]

POT: A RATIONAL APPROACH

A LEADING AUTHORITY ON PSYCHOPHARMACOLOGY CALLS FOR A LIFTING OF LEGAL PROHIBITIONS AND PUNISHMENTS RELATING TO MARIHUANA—AND EXPLAINS WHY

(Opinion by Joel Fort, M.D.)

There are an estimated 10,000,000 Americans who smoke marihuana either regularly or occasionally, and they have very obvious reasons for wishing that pot were treated more sensibly by the law. As one of the 190,000,000 who have never smoked marihuana, I also favor the removal of grass from the criminal laws, but for less personal reasons. It is my considered opinion, after studying drug use and drug laws in 30 nations and dealing with drug-abuse problems professionally for 15 years, that the present marihuana statutes in America not only are bad laws for the offending minority but are bad for the vast majority of us who never have lit a marihuana cigarette and never will.

That some changes in these laws are coming in the near future is virtually certain, but it is not at all sure that the changes will be improvements.

On May 19, 1969, the U.S. Supreme Court, in an 8-0 vote, declared that the Marihuana Tax Act of 1937 was unconstitutional. This decision delighted the defendant, Timothy Leary, and was no surprise at all to lawyers who specialize in the fine points of constitutional law. It had long been recognized that the Marihuana Tax Act was "vulnerable"—a polite term meaning that the law had been hastily drawn, rashly considered and railroaded through Congress in a mood of old-maidish terror that spent no time on the niceties of the Bill of Rights, scientific fact or common sense.

Celebrations by marihuanaphiles and lamentations by marihuanaphobes, however, are both premature. The Court, while throwing out this one inept piece of legislation, specifically declared that Congress has the right to pass laws governing the use, sale and possession of this drug (provided these laws stay within the perimeter of the Constitution).

And, of course, state laws against pot, which are often far harsher than the Federal law, still remain in effect.

There were two defects found by the Supreme Court in the Federal anti-marihuana law—a section that requires the suspect to pay a tax on the drug, thus incriminating himself, in violation of the Fifth Amendment; and a section that assumes (rather than requiring proof) that a person with foreign-grown marihuana in his possession knows it is smuggled. These provisions were perversions of traditional American jurisprudence, no less than the remaining parts of the law that are bound to fall when challenged before the Supreme Court. These forthcoming decisions will, inevitably, affect the anti-marihuana laws of the individual states as well. However, the striking down of the old laws does not guarantee that the new ones will be more enlightened; it merely invites more carefully drawn statutes that are less vulnerable to judicial review. In fact, in a message to Congress, President Nixon specifically demanded harsher penalties for marihuana convictions. But every sane and fair-minded person must be seriously concerned that the new laws are more just and more in harmony with known fact than the old ones. In my opinion, such new laws must treat marihuana no more harshly than alcohol is presently treated.

It is ironic that our present pot laws are upheld chiefly by the older generation, and flouted and condemned by the young; for it is the senior generation that should understand the issue most clearly, having lived through the era of alcohol prohibition. They saw with their own eyes that the entire nation—not just the drinkers and the sellers of liquor—suffered violent moral and mental harm from that particular outbreak of armed and rampant puritanism. They should certainly remember that attempts to legislate morality result only in widespread disrespect for law, new markets and new profits for gangsters, increased violence and such wholesale bribery and corruption that the Government itself becomes a greater object of contempt than the criminal class. Above all, they should be able to see the parallel between the lawless Twenties and the anarchic Sixties and realize that both were produced by bad laws—laws that had no right to exist in the first place.

"Bad law," it has been said, "is the worst form of tyranny." An open tyranny breeds open rebellion, and the issues are clear-cut; bad law, in an otherwise democratic nation, provokes a kind of cultural nihilism in which good and evil become hopelessly confused and the rebel, instead of formulating a single precise

program, takes a perverse delight in anything and everything that will shock, startle, perplex, anger, baffle and offend the establishment. Thus it was during alcohol prohibition and thus it is under marihuana prohibition. The parallel is not obvious only because there were already millions of whiskey drinkers when the Volstead Act became law in 1919, leading to immediate flouting of "law and order" by vast hordes—whereas the use of marihuana did not become extensive until the early 1950s, more than 13 years after the Government banned pot in 1937. But the results, despite the delay, are the same: We have bred a generation of psychological rebels.

Banning marihuana not only perpetuates the rebelliousness of the young but it also establishes a frightening precedent, under which puritanical bias is more important to our legislators than experimentally determined fact—something every scientist must dread. Dr. Philip Handler, board chairman of the National Science Foundation, bluntly told a House subcommittee investigating drug laws, "It is our pruitan ethics . . . rather than science" that say we should not smoke marihuana.

Consider the most recent study of the effects of marihuana, conducted under careful laboratory conditions and reported in *Science*. This is the research performed by Drs. Norman E. Zinberg and Andrew T. Weil at Boston University in 1968. This study was "double-blind": that is, neither the subjects nor the researchers knew, during a given session, whether the product being smoked was real marihuana (from the female Cannabis plant) or an inactive placebo (from the male Cannabis plant). Thus, both suggestibility by the subjects and bias by the experimenters were kept to the scientific minimum. The results were:

1. Marihuana causes moderate increase in heartbeat rate, some redness of the eyes and virtually no other physical effects. Contrary to the belief of both users and policemen, pot does not dilate the pupils—this myth apparently derives from the tradition of smoking Cannabis in a darkened room; it is the darkness that dilates the pupils.

2. Pot does not affect the blood-sugar level, as alcohol does, nor cause abnormal reactions of the involuntary muscles, as LSD often does, nor produce any effects likely to be somatically damaging. In the words of Zinberg and Weil, "The significance of this near absence of physical effects is twofold. First, it demonstrates once again the uniqueness of hemp among psychoactive drugs, most of which strongly affect the body as well as the mind. . . . Second, it makes it unlikely that marihuana has any seriously detrimental physical effects in either short-term or long-term usage."

3. As sociologist Howard Becker pointed out long ago, on the basis of interviews with users, the marihuana "high" is a learned experience. Subjects who had never had Cannabis before simply did not get a "buzz" and reported very minimal subjective reactions, even while physically "loaded" with very high doses, while experienced users were easily turned on.

4. The hypothesis about "set and setting" strongly influencing drug reactions was confirmed. The pharmacological properties of a psychoactive drug are only one factor in a subject's response: equally important—perhaps more important—are the set (his expectations and personality type) and the setting (the total emotional mood of the environment and person in it).

5. Both inexperienced subjects and longtime users did equally well on some tests for concentration and mental stability, even while they were on very high doses. On tests requiring a higher ability to focus attention, the inexperienced users did show some temporary mental impairment, but the veterans sailed right on, as if they were not too high at all. In short, experienced potheads do not have even a temporary lowering of the intelligence while they are high, much less a permanent mental impairment.

6. On some tests, the experienced users scored even higher while stoned than they did when tested without any drug.

7. Not only alcohol but even tobacco has more adverse effects on the body than marijuana does.

As Zinberg and Weil noted sardonically in a later article in *The New York Times Magazine*, there is a vicious circle operating in relation to marijuana: "Administrators of scientific and Government institutions feel that marijuana is dangerous. Because it is dangerous, they are reluctant to allow [research] to be done on it. Because no work is done, people continue to think of it as dangerous. We hope that our own study has significantly weakened this trend."

One slight sign that the trend may have been weakened was the appearance last June of a study by the Bureau of Motor Vehicles in the state of Washington concerning the effects of Cannabis on driving ability. Using driving-traffic simula-

tors, not only did the study find that marijuana has less adverse effect on driving ability than alcohol—which many investigators have long suspected—but also, as in the Boston study, the evidence indicated that the only detrimental effect is on inexperienced users. Veteran potheads behave behind the wheel as if they were not drugged at all.

In short, we seem to have a drug here that makes many users very euphoric and happy—high—without doing any of the damage done by alcohol, narcotics, barbiturates, amphetamines or even tobacco.

But we didn't have to wait until 1968 to learn that pot is relatively harmless. Some research has been done in the past, in spite of the vicious circle mentioned by Zinberg and Weil. As far back as 1942, the mayor of New York City, Fiorello La Guardia, alarmed by sensational press stories about "the killer drug, marijuana" that was allegedly driving people to rape and murder, appointed a commission to investigate the pot problem in his city. The commission was made up of 31 eminent physicians, psychiatrists, psychologists, etc., and six officers from the city's narcotics bureau. If there was any bias in that study, it must have been directed against marijuana, considering the presence of the narcotics officers, not to mention psychiatrists and M.D.'s, who were then, as now, rather conservative groups. Nevertheless, after two years of hard study, including psychological and medical examinations of users, electroencephalograms to examine for brain damage, sociological digging into the behavior patterns associated with marijuana use and intelligence tests on confirmed potheads, the commission concluded:

Those who have been smoking marijuana for a period of years showed no mental or physical deterioration which may be attributed to the drug. . . . Marijuana is not a drug of addiction, comparable to morphine. . . . Marijuana does not lead to morphine or heroin or cocaine addiction. . . . Marijuana is not the determining factor in the commission of major crimes. . . . The publicity concerning the catastrophic effects of marijuana smoking in New York City is unfounded.

Even earlier, a study of marijuana use in the Panama Canal Zone was undertaken by a notably conservative body, the United States Army. Published in 1925, the study concluded, "There is no evidence that marijuana as grown here is a habit-forming drug" and that "Delinquencies due to marijuana smoking which result in trial by military court are negligible in number when compared with delinquencies resulting from the use of alcoholic drinks which also may be classed as stimulants or intoxicants."

What may be the classic study in the whole field goes back further: to the 1893-1894 report of the seven-member Indian Hemp Drug Commission that received evidence from 1193 witnesses from all regions of the country (then including Burma and Pakistan), professionals and laymen, Indians and British, most of whom were required to answer in writing seven comprehensive questions covering most aspects of the subject. The commission found that there was no connection between the use of marijuana and "social and moral evils" such as crime, violence or bad character. It also concluded that occasional and moderate use may be beneficial; that moderate use is attended by no injurious physical, mental or other effects; and that moderate use is the rule: "It has been the most striking feature of this inquiry to find how little the effects of hemp drugs have intruded themselves on observation. The large numbers of witnesses of all classes who profess never to have seen them, the very few witnesses who could so recall a case to give any definite account of it and the manner in which a large proportion of these cases broke down on the first attempt to examine them are facts which combine to show most clearly how little injury society has hitherto sustained from hemp drugs." This conclusion is all the more remarkable when one realizes that the pattern of use in India included far more potent forms and doses of Cannabis than are presently used in the United States. The commission, in its conclusion, stated:

Total prohibition of the hemp drugs is neither necessary nor expedient in consideration of their ascertained effects, of the prevalence of the habit of using them, of the social or religious feelings on the subject and of the possibility of its driving the consumers to have recourse to other stimulants [alcohol] or narcotics which may be more deleterious.

Ever since there have been attempts to study marijuana scientifically, every major investigation has arrived at, substantially, the same conclusions; and these directly contradict the mythology of the Federal Bureau of Narcotics. In contrast with the above facts, consider the following advertisement, circulated before the passage of the 1937 Federal anti-marijuana law:

Beware! Young and Old—People in All Walks of Life! This [picture of a marijuana cigarette] may be handed you by the friendly stranger. It contains the Killer Drug "Marijuana"—a powerful narcotic in which lurks Murder! Insanity! Death!

Such propaganda was widely disseminated in the mid-1930s, and it was responsible for stampeding Congress into the passage of a law unique in all American history in the extent to which it is based on sheer ignorance and misinformation.

Few people realize how recent anti-marijuana legislation is. Pot was widely used as a folk medicine in the 19th Century. Its recreational use in this country began in the early 1900s with Mexican laborers in the Southwest, spread to Mexican Americans and Negroes in the South and then the North, and then moved from rural to urban areas. In terms of public reaction and social policy, little attention was paid to pot until the mid-1930s (although some generally unenforced state laws existed before then). At that time, a group of former alcohol-prohibition agents headed by Harry J. Anslinger, who became head of the Federal Bureau of Narcotics, began issuing statements to the public (via a cooperative press) claiming that marijuana caused crime, violence, assassination, insanity, release of anti-social inhibitions, mental deterioration and numerous other onerous activities.

In what became a model for future Federal and state legislative action on marijuana, Congressional hearings were held in 1937 on the Marijuana Tax Act. No medical, scientific or sociological evidence was sought or heard; no alternatives to criminalizing users and sellers were considered; and the major attention was given to the oilseed, birdseed and paint industries' need for unrestrained access to the hemp plant from which marijuana comes. A U.S. Treasury Department witness began his testimony by stating flatly that "Marijuana is being used extensively by high school children in cigarettes with deadly effect," and went on to introduce as further "evidence" an editorial from a Washington newspaper supposedly quoting the American Medical Association as having stated in its journal that marijuana use was one of the problems of greatest menace in the United States. Fortunately for historical analysis, a Dr. Woodward, serving as legislative counsel for the American Medical Association, was present to point out that the statement in question was by Anslinger and had only been reported in the A.M.A. journal.

Dr. Woodward deserves a posthumous accolade for his singlehanded heroic effort to introduce reason and sanity to the hearing. Most importantly, the doctor (who was also a lawyer) criticized the Congressmen for proposing a law that would interfere with future medical uses of Cannabis and pointed out that no one from the Bureau of Prisons had been produced to show the number of prisoners "addicted" to marijuana, no one from the Children's Bureau or Office of Education to show the nature and extent of the "habit" among children and no one from the Division of Mental Hygiene or the Division of Pharmacology of the Public Health Service to give "direct and primary evidence rather than indirect and hearsay evidence." Saying that he assumed it was true that a certain amount of "narcotic addiction" existed, since "the newspapers have called attention to it so prominently that there must be some grounds for their statements," he concluded that the particular type of statute under consideration was neither necessary nor desirable. The Congressmen totally ignored the content of Dr. Woodward's testimony and attacked his character, qualifications, experience and relationship to the American Medical Association, all of which were impeccable. He was then forced to admit that he could not say with certainty that no problem existed. Finally, his testimony was brought to a halt with the warning, "You are not cooperative in this. If you want to advise us on legislation, you ought to come here with some constructive proposals rather than criticism, rather than trying to throw obstacles in the way of something that the Federal Government is trying to do."

A similar but shorter hearing was held in the Senate, where Anslinger presented anecdotal "evidence" that marijuana caused murder, rape and insanity.

Thus, the Marijuana Tax Act of 1937 was passed—and out of it grew a welter of state laws that were, in many cases, even more hastily ill conceived.

The present Federal laws impose a two-to-ten-year sentence for a first conviction for possessing even a small amount of marijuana, five to twenty years for a second conviction and ten to forty for a third. If Congress is not forced to recognize scientific fact and basic civil liberties, these penalties will be retained when the new Federal law is written without the sections declared invalid in the Leary case. The usual discretion that judges are given to grant probation or

suspended sentences for real crimes is taken from them by this (and state) law as is the opportunity for parole. For sale or "dissemination," no matter how small the quantity of marijuana involved, and even if the dissemination is a gift between friends, the Federal penalty for first-offense conviction is five to twenty years; for a second offense, it's ten to forty.

The state laws, as I stated, are even hairier. Here are two real, and recent, cases: In Texas, Richard Dorsey, a shoeshine-stand operator in a bowling alley, sold a matchbox full of marijuana (considerably less than an ounce) to a Dallas undercover policeman, for five dollars. His sentence: 50 years.

In Michigan, for selling five dollars' worth of grass to another police agent, Larry Belcher was sentenced to 20 or 30 years in prison. This case is worth nothing as an example of how the marijuana laws actually function in many instances. Belcher is the only individual in Grand Traverse County to receive this sentence in the past two years; 25 other marijuana arrestees were all placed on probation within that time. Belcher, it appears, was the author of a column called "Dope-O-Scope" in a local underground newspaper and had presented there some of the same scientific facts incorporated into this article. People who publicly oppose the marijuana laws and marijuana mythology of our narcotics police have an unusually high arrest record.

There is no consistency in these laws from state to state. Until 1968, South Dakota had the nation's lowest penalty for first-offense possession—90 days (it has since been raised to two to five years); however, if you crossed the state line to North Dakota, the picture changed abruptly. North Dakota had (and still has) the nation's highest penalty for first-offense possession—99 years at hard labor. In New York State, in spite of the revelatory work of the La Guardia commission, the penalties have increased since the Forties. Today, in that state, selling or transferring marijuana to anyone under 21 carries a penalty of one to 25 years, even if the transfer is by somebody who is also under 21 and is a gift to a friend. (The state legislature recently tried to raise this penalty to 15 years to life, but Governor Rockefeller vetoed the bill.) In Louisiana, a minor selling to a minor is subject to five to fifteen years' imprisonment, while an adult selling to a minor may receive the death penalty. Finally, in Georgia, the penalty for a first conviction for selling to a minor is life imprisonment. If the offender is paroled or his sentence suspended, and he is convicted again, he can be sentenced to death.

The barbarity of such penalties in relation to pot's relative harmlessness is even beginning to be recognized in Washington, despite incessant and quite unscientific efforts to maintain the old mythology, emanating from the Federal Bureau of Narcotics. In 1963, President Kennedy's Advisory Commission on Narcotic and Drug Abuse called into question some of the prevailing beliefs about marijuana and recommended lighter sentences for possession. In 1967, President Johnson's Commission on Law Enforcement and the Administration of Justice took a similar view, recommending more flexible penalties; more significantly, it stated that marijuana has virtually nothing in common with true narcotics or opiates—the first time that fact was publicly admitted by a U.S. Government agency. And in 1967, Dr. James Goddard, while commissioner of the U.S. Food and Drug Administration, was quoted as saying that it would disturb him less if his teenage daughter smoked one marijuana cigarette than if she drank an alcoholic beverage. (Faced with a predictable outcry from conservatives in Congress, Goddard said he had been misquoted—but quite honestly added that the known facts did not support the opinion that marijuana is more dangerous than alcohol.)

Not only is marijuana comparatively harmless on the face of all the evidence but there are even reasons to believe it may be beneficial in some cases. In many countries, Cannabis has been used medicinally for as long as 5000 years and is regarded as a sovereign remedy for a variety of ills. There are references to medicinal uses of marijuana in American medical journals (mostly of the 19th Century) where doctors reported it as useful as an analgesic, appetite stimulant, anti-spasmodic, anti-depressant, tranquilizer, anti-asthmatic, topical anesthetic, childbirth analgesic and antibiotic. My own investigations in areas of the world where this folk medicine still flourishes and my study of 20th Century scientific literature lead me to believe that marijuana would be useful for treating depression, loss of appetite, high blood pressure, anxiety and migraine.

An English psychiatrist who employed marijuana in the therapy of depressive patients, Dr. George T. Stockings, concluded that it "might be more effective than any tranquilizer now in use." Dr. Robert Walton of the University of Mississippi has also suggested its use for certain gynecological and menstrual problems and in easing childbirth. We should not let lingering puritanical prejudices prevent us

from investigating these areas further. As Dr. Tod Mikuriya, a psychiatrist formerly associated with the National Institute of Mental Health, notes, "The fact that a drug has a recreational history should not blind us to its possible other uses. Morton was the first to use ether publicly for anesthesia after observing medical students at 'ether frolics' in 1846." While such speculations about the benefits of pot must await further research before a final answer is given, there can be no doubt that a grave injustice has been suffered by those currently in prison because of laws passed when the drug was believed to incite crime and madness.

Even the Federal Bureau of Narcotics and its propagandists have largely given up the "steppingstone theory" (that marijuana smoking leads to use of addictive drugs) and the "degeneracy theory" (that it leads to crime or "bad character"). They have recently rallied around the oldest, and most discredited, canard of all—the legend that marijuana causes insanity. To shore up this crumbling myth, they cite recent research at the Addiction Research Center in Lexington, Kentucky, where 30 former opiate addicts were given high doses of synthetic THC (the active ingredient in marijuana) or concentrated Cannabis extract. Most of the subjects showed marked perceptual changes, which the experimenter chose to describe as "hallucinations" and "psychotic reactions." This, of course, merely confirms a basic axiom of pharmacology; i.e., with increasing doses of any drug, different and more dangerous responses will occur; you could obtain some spectacularly adverse reactions with horse doctors' doses of aspirin, coffee or even orange juice. (With ordinary doses of THC or marijuana, the subjects experienced the same "high" found in normal, social marijuana smoking.)

A more serious defect in this research lies in the loaded terminology with which the experimenter, Dr. Harris Isbell, reported his results. Psychiatrist Thomas Szasz, a crusader for reform in the mental-health field, points out that a "psychotic reaction" is not something *in* an individual, Mr. A, like cancer; rather, it is a label that a second individual, Mr. B (more often, Dr. B), pins on Mr. A. The *fact* is that the subjects experienced perceptual changes; it is not a fact but merely an *opinion* whether one wants to call these changes "consciousness expansion" and "transcendence of the ego" (with Timothy Leary or "hallucinations" and "psychotic reactions" (with Dr. Isbell).

Sociologist Howard Becker—the observer who first noted the effect of "learning" on the marijuana experience—has researched medical literature from the early 1930s to the present in search of reported cases of "marijuana psychosis." He found none after 1940, a remarkable fact, considering the pyramiding acceleration of marijuana use during the Forties, Fifties and Sixties. Becker concluded that persons who were diagnosed as "marijuana psychotics" in the Thirties were simply anxious and disoriented because they hadn't learned yet how to use the drug. Dr. Isbell's subjects, almost certainly, were not advised about the effects of the drug; and his experiment is really just another proof of the effect of "set and setting" as well as high doses on drug experience.

A 1946 study examined 310 persons who had been using marijuana for an average of seven years each. There was no record of mental-hospital commitment among any of them.

The marijuanaphobes also cite studies from the Near East to prove that marijuana is associated with psychosis. In the first place, many of the people in these studies smoked hashish, not marijuana; and while hashish is derived from the same plant, Cannabis sativa, it is otherwise a considerably stronger form of the drug. One might compare the two Cannabis drugs with two alcohol drugs as follows: Smoking a pipe of hashish is equivalent to drinking a fifth of vodka; smoking the same pipe of marijuana is about like drinking a bottle of beer. However, the studies themselves do not deserve such careful rebuttal; they are scientifically worthless. They prove only that, in countries where most of the population regularly use Cannabis, many of the patients in mental hospitals also have a history of Cannabis use. Usually the proportion of users in the institution is less than that in the general population, leading to a possible conclusion that it is psychologically beneficial. In fact, however, there are no scientifically valid statistics or records kept at these facilities. The testimony turns out, on examination, to be impressionistic and anecdotal rather than scientific and precise. The diagnosis of psychosis and its attribution to Cannabis is often made by a ward attendant. In short, we are faced with the kind of "evidence" that the Indian Hemp Drug Commission discarded in 1893. I have visited the mental hospitals of several of the countries involved in the "Cannabis psychosis" and

none of the record keeping involved meets the minimum requirements demanded of freshman scientific reports in American colleges.

Perhaps the last bastion of marijuanaphobia is the argument by uncertainty. "Who knows?" this line goes. "Maybe, in the future, marijuana might be discovered, by further research, to have dangerous side effects that haven't been noted yet." This argument, of course, is unanswerable; but it applies equally well to such diverse objects as diet pills and bubble gum. One cannot prove that the future will not discover new things; but does such a fact—science's lack of clairvoyance—justify out present marijuana laws? It clearly does not. No drug, including marijuana, will ever be found to be totally harmless; and no drug, particularly marijuana, will ever be found to be as dangerous as the hydrogen bomb (once claimed by Anslinger). Social policy should not be determined by this anyway. The possible risks should be dealt with by education. What is unacceptable is locking a man up for 99 years for possessing something of far less proven danger than tobacco, alcohol, automobiles and guns.

Instead of decreasing marijuana usage, our present laws have created the contempt for Government about which I spoke earlier. In addition to continuing to disobey the law, hordes of young people have begun to flout it publicly. There have been smoke-ins—masses who gather in a public park, where those in the inner core of the group light up, while the outer perimeter obstruct and slow down the police until the evidence is consumed—at Berkeley, in Boston and elsewhere. Planting marijuana in conspicuous places has become a fad; among the notable seedlings have been the center strip of Park Avenue in New York City, the lawn in front of a police station in ultrarespectable Westchester County, the UN Building and (twice recently) in front of the state capitol in Austin, Texas.

But the American marijuana tragedy is even worse than I have indicated. Like other crimes-without-victims, pot smoking is a private activity and involves no harm to anyone else. Remember: The police do not have to engage in cloak-and-dagger activities to find out if there have been any banks or grocery stores robbed lately—the bankers and store owners (the victims) call them immediately. But since there is no victim in the "crime" of smoking marijuana, nobody is going to call the police to report it—except, very rarely, a neighbor who finds the evidence. Hence, the entire apparatus of the police state comes into existence as soon as we attempt to enforce anti-grass legislation; and by the nature of such legislation, totalitarian results must ensue. We cannot police the private lives of the citizenry without invading their privacy; this is an axiom.

That a man's home is his castle has long been a basic principle of Anglo-American jurisprudence, and some of us can still recall the near poetry of the great oration by William Pitt in which he says, "The poorest man may in his cottage bid defiance to the force of the Crown. It may be frail, its roof may shake; the wind may blow through it; the storms may enter; the rain may enter; but the King of England cannot enter—all his forces dare not cross the threshold of the ruined tenement!" This principle goes back to the Magna Charta and is firmly entrenched in the Fourth Amendment to our own Constitution, guaranteeing the people "the right . . . to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures."

This libertarian tradition is a great hindrance to the police when they attempt to enforce sumptuary laws—laws concerning the private morals of the citizens. And, in fact, the enforcement of the marijuana law requires pernicious police behavior.

For instance, the *Chicago Sun-Times* told, in 1967, how the police of that city obtain search warrants for use in legalizing raids that otherwise would be mere "fishing expeditions"—intolerable to any American court. In dealing with the organized-crime cartel usually called "the Syndicate," the police have obtained from the courts the right to use what are called "bank warrants"—warrants in which the witness who alleges he has seen the crime is permitted to sign a false name. This is supposedly necessary to protect informers against the wrath of the reputedly all-seeing and all-powerful Syndicate. Once this dangerous precedent was set, the police began applying it to marijuana users as well. As the *Sun-Times* noted:

Those methods are dubious. . . . We refer to the method of obtaining search warrants. The informer signs a search-warrant complaint, with an assumed name, alleging perhaps that he bought illicit drugs from a certain person, at a certain place. The police do not have to disclose the name of the informer or the time when the drugs were bought. There is also a device known as constructive possession: The police can arrest anybody found in the vicinity of prohibited drugs, whether he's an innocent visitor or the real culprit. The frameup is easy.

Plant the drugs, get the search warrant, grab everybody in sight. It could happen to you and you'd never have the right to face your accuser.

William Braden, a *Sun-Times* reporter, also uncovered one informer, a heroin addict, who admitted signing dozens of such warrants without the names of the accused on them. The narcotics squad could then type in the name of any individual whose apartment they wanted to raid and it would be perfectly "legal" in form—but a terrifying distance in spirit from the actual meaning of the Constitution. Such raids, of course, violate the Sixth Amendment—guaranteeing the right "to be confronted with the witnesses" against you—as well as the Fourth (no "unreasonable searches"); and they occur everywhere in the nation.

Most of us never hear of such things, because reporters routinely print the police version of the raid, without interviewing the arrested "dope fiends." It is also standard practice for the police to multiply the quantity of drugs seized in such a raid by a factor of two (and the price by a factor of ten) when giving the news to the press. This makes for impressive headlines; it also contributes to the growing tendency toward "trial by newspaper," which worries civil libertarians.

Some types of entrapment are regarded as legal in America today—although some still are not. In my own opinion, *all* forms of entrapment are profoundly immoral, whether technically legal or illegal; but my opinion is, perhaps, immaterial. The results of this practice, however, are truly deplorable from the point of view of anyone who has any lingering affection for the spirit of the Bill of Rights.

Here is a specific case: John Sinclair, a poet, leader of the Ann Arbor hippie community and manager of a rock group called MC-5, became friendly, around October 1966, with Vahan Kapagian and June Mumford, who presented themselves to him as members of the hippie-artist-mystic subculture that exists in all of our large cities. Over a period of two months, they worked to secure his confidence and friendship and several times asked him to get them some marijuana. Finally, on December 22, Sinclair, apparently feeling that he could now trust them, gave two marijuana cigarettes to Miss Mumford—one for her and one for Kapagian. He was immediately arrested; his "friends" were police undercover agents.

Sinclair has been convicted of both "possessing" and "dispensing" marijuana and faces a minimum of 20 years under each statute, and a maximum of life for the sale. If his appeal is not upheld, the very smallest sentence he could receive is 40 years. As his lawyers pointed out in his appeal, "The minimum sentence to which [Sinclair] is subject to imprisonment is 20 times greater than the minimum to which a person may be imprisoned [in Michigan] for such crimes as rape, robbery, arson, kidnaping or second-degree murder. It is more than 20 times greater than the minimum sentence of imprisonment for any other offense in Michigan law, except first-degree murder."

That illegal wire tapping has also been widely used by the narcotics police was an open secret for years; now it is no secret at all—and not illegal, either. The 1968 Omnibus Crime Bill authorizes such wire tapping for suspected marijuana users. Since this usage has spread to all classes and all educational levels, such suspicion can be directed at virtually anyone (after all, the nephew and the brother of one of President Nixon's closest friends were recently busted on pot charges); thus, almost any American can now have his phone tapped legally. Considering the elastic interpretation police usually give to such Congressional authorization, an anonymous tip by any crank in your neighborhood would probably be enough to get a tap on your phone by tomorrow morning. Why not? As *Chicago Daily News* columnist Mike Royko recently wrote, "There is a democratic principle in injustice. If enough people support it, they'll all get it."

With the doctrine of "constructive possession," anyone who has a pot-smoking friend is subject to marijuana laws if he walks into the friend's house at the wrong time. In California two years ago, a woman was sentenced to sterilization for being in the same room with a man who was smoking grass. The fact that a higher court overturned this sentence does not lessen its frightening implications.

And a new wrinkle has been added. According to a story in the *San Francisco Chronicle* last June 20, the Government is planning "an unpleasant surprise for marijuana smokers—'sick pot.'" The article goes on to explain how an unspecified chemical can be sprayed on Mexican marijuana fields from a helicopter, whereupon "just a puff or two produces uncontrollable vomiting that not even the most dedicated smoker could ignore."

This, I submit, could have come from the morbid fantasy of Kafka, Burroughs or Orwell. The Government, in its holy war against a relatively harmless drug, is

deliberately creating a very harmful drug. Nor is the *Chronicle* story something dreamed up by a sensation-mongering reporter. A call to the Justice Department in Washington has confirmed that this plan has been discussed and may go into operation in the near future.

Consider, now, the actual social background in which this crusade against Cannabis is being waged. America is not the Victorian garden it pretends to be; we are, in fact, a drug-prone nation. Parents and other adults after whom children model their own behavior teach them that every time one relates to other human beings, whether at a wedding or at a funeral, and every time one has a pain, problem or trouble, it is necessary or desirable to pop a pill, drink a cocktail or smoke a cigarette. The alcohol, tobacco and over-the-counter pseudo-"sedative" industries jointly spend more than \$2,000,000 a day in the United States alone to promote as much drug use as possible.

The average "straight" adult consumes three to five mind-altering drugs a day, beginning with the stimulant caffeine in coffee, tea or Coca-Cola, going on to include alcohol and nicotine, often a tranquilizer, not uncommonly a sleeping pill at night and sometimes an amphetamine the next morning to overcome the effects of the sedative taken the evening before.

We have 80,000,000 users of alcohol in this country, including 6,000,000 alcoholics; 50,000,000 users of tobacco cigarettes; 25,000,000 to 30,000,000 users of sedatives, stimulants and tranquilizers; and hundreds of thousands of users of consciousness alterers that range from heroin and LSD to cough syrup, glue, nutmeg and catnip—all in addition to marijuana use.

Drs. Manheimer and Mellinger, surveying California adults over 21, found that 51 percent had at some time used sedatives, stimulants or tranquilizers (17 percent had taken these drugs frequently) and 13 percent had at some time used marijuana.

Further underlining the extent of use of the prescription drugs is the estimate from the National Prescription Audit that 175,000,000 prescriptions for sedatives, stimulants and tranquilizers were filled in 1968. Also enough barbiturates (Nembutal, Seconal, phenobarbital) alone are manufactured to provide 25 to 30 average doses per year for every man, woman and child in this country.

In the light of this total drug picture, the persecution of potheads seems to be a species of what anthropologists call "scapegoatism"—the selection of one minority group to be punished for the sins of the whole population, whose guilt is vicariously extirpated in the punishment of the symbolic sacrificial victims.

Meanwhile, my criticisms—and those of increasing numbers of writers, scientific and popular—continue to bounce off the iron walls of prejudice that seem to surround Congress and state legislatures. It is quite possible that our new, post-Leary pot laws will be as bad as the old ones. If there is any improvement, it is likely to come, once again, from the courts.

Several legal challenges to our anti-pot mania are, in fact, working their way upward toward the Supreme Court, and the issues they raise are potentially even more significant than those involved in the Leary case.

First is the challenge raised by attorney Joseph Oteri in his defense of two Boston University students. Oteri's case cites the equal-protection clause of the Constitution—grass is less harmful than booze, so you can't outlaw one without the other. He also argues that the marijuana statute is irrational and arbitrary and an invalid exercise of police power because pot is harmless and wrongly defined as a narcotic, when it is, technically, not a narcotic. This is not mere hairsplitting. It is impossible, under law, to hang a man for murder if his actual crime was stealing hubcaps; it should be equally impossible to convict him of "possession of a narcotic" if he was not in possession of a narcotic but of a drug belonging to an entirely different chemical family.

And marijuana, decidedly, is not a narcotic—although just what it should be called is something of a mystery. The tendency these days is to call it a "mild psychedelic," with the emphasis on mild; this is encouraged both by the Tim Leary crowd—to whom psychedelic is a good word, denoting peace, ecstasy, non-violent revolution, union with God and the end of all neurotic hang-ups of Western man—and by those to whom psychedelic is a monster word denoting hallucinations, insanity, suicide and chaos. I doubt the psychedelic label very much and think it is as off base as narcotic. Since marijuana has very little in common with LSD and the true psychedelics, but much in common with alcohol and other sedatives, and a certain similarity also to amphetamine and other stimulants, I prefer to call it a sedative-stimulant as it is classified by Dr. Frederick Meyers, who also notes its resemblance to laughing gas (nitrous oxide). Dr. Leo Hollister finds enough resemblance to LSD to call it a sedative-hypnotic-

psychedelic. *Goodman and Gilman*, the orthodox pharmacological reference, dodges the issue entirely by listing marijuana as a "miscellaneous" drug. In any case, it is not a narcotic, and anyone arrested for having a narcotic in his possession when he actually has marijuana definitely is being charged with a crime he hasn't committed.

A second challenge, raised by Oteri and also being pressed by two Michigan attorneys, is based on the prohibition of "cruel and unusual punishments" in the Eighth Amendment. The courts have held, in the past, that a law can be struck down if the punishments it requires are cruel and unusual in comparison with the penalties in the same state for similar or related crimes. For instance, the statute against chicken stealing was made quite harsh in the early days of Oklahoma, apparently because the offense was common and provoked great public indignation. As a result, a man named Skinner was threatened with the punishment of sterilization under one section of this law. He appealed to the Supreme Court, which struck down the Oklahoma statute because similarly harsh penalties were not provided for other forms of theft. Obviously, in the states where the penalty for possession of marijuana is higher than the penalty for armed robbery, rape, second-degree murder, etc., the law is vulnerable to legal attack as cruel and unusual.

There is also the "zone of privacy argument, originally stated in the Connecticut birth-control decision and more recently invoked by the Kentucky supreme court, in striking down a local (Barbourville, Kentucky) ordinance making it a crime to smoke *tobacco* cigarettes. The court ruled that "The city . . . may not unreasonably interfere with the right of the citizen to determine for himself such personal matters." The zone of privacy was also cited by the U.S. Supreme Court in invalidating the Georgia law against possession (not sale) of pornography.

The drug police and their legislative allies have been experimenting with our liberties for a long time now. The Leary decision, however, shows that it is not too late to reverse the trend, and the issues raised by the constitutional questions discussed above show how the erosion of our liberties can, indeed, be reversed.

A compelling medical, sociological and philosophical case exists for the full legalization of marijuana, particularly if legalization is the only alternative to the present criminalization of users. But an even more substantial case exists for ending all criminal penalties for possession or use of the drug, while still exercising some caution. I would recommend, for example, that to prevent the sale of dangerously adulterated forms of the drug, marijuana be produced under Federal supervision, as alcohol is. Furthermore, sellers of the drug should be licensed, and they should be prohibited from selling to minors. If there are infractions of these laws, penalties should be directed at the seller, not the user. I would also strongly recommend that all advertising and promotion of marijuana be prohibited, and that packages of the drug carry the warning: **Caution: Marijuana may be harmful to your health.**

If marijuana were to be legalized, what would happen? According to the marijuanaphobes, the weed will spread into every American home; people will become lazy and sluggish, sit around all day in a drugged stupor and talk philosophy when they talk at all; we will sink into the "backward" state of the Near Eastern and Asian nations.

There are good, hard scientific reasons for doubting this gloomy prognostication.

1. Most Americans have already found their drug of choice—alcohol—and there is more conditioning involved in such preferences than most people realize. The average American heads straight for the bar when he feels the impulse to relax; a change in the laws will not change this conditioned reflex. When the Catholic Church allowed its members to eat meat on Friday, the majority went right on following the conditioned channel that told them, "Friday is fish day."

2. Of the small minority that will try pot (after it is legalized) in search of a new kick, most will be vastly disappointed, since (a) it doesn't live up to its sensational publicity, largely given to it by the Federal Narcotics Bureau; and (b) the "high" depends, as we have indicated, not only on set and setting but, unlike alcohol, on learning.

This involves conditioning and the relationship of the actual chemistry of the two drugs to the total *Gestalt* of our culture. What pot actually does—outside mythology—is produce a state midway between euphoria and drowsiness, like a mild alcohol high; accelerate and sharpen the thoughts (at least in the subjective impression of the user), like an amphetamine; and intensify sound and color perception, although not nearly as much as a true psychedelic. It can

also enhance sexual experience, but not create it—contrary to Mr. Anslinger, pot is not an aphrodisiac. It is, in short, the drug of preference for creative and contemplative types—or, at least, people with a certain streak of that tendency in their personality. Alcohol, on the other hand, depresses the forebrain, relaxes inhibitions, produces euphoria and drowsiness and, while depleting some functions, such as speech and walking, does not draw one into the mixture of sensuality and introspection created by pot. It is the drug of preference for aggressive and extroverted types. Therefore, the picture of pot spreading everywhere and changing our culture is sociologically putting the cart before the horse; our society would first have to change basically before pot could spread everywhere.

3. Even if, against all likelihood, marijuana were to sweep the country, this would not have dire consequences. Marijuana has no specifically anti-machine property in it; it would not make our technology go away, like a wave of an evil sorcerer's wand. Nor does it dull the mental faculties, as we have seen in reviewing the scientific evidence. (I might add, here, that the highest honor students at certain Ivy League colleges are frequently pot users, and one study at Yale found more marijuana smokers at the top of the class than at the bottom.)

4. Finally, the whole specter of America sinking into backwardness due to pot is based upon totally false anthropological concepts. The Near East is not tribal, preindustrial, superstitious, and so forth, merely because Mohammed banned alcohol in the Koran but forgot to exclude Cannabis drugs also; a whole complex of historical and cultural factors is involved, not the least of which is the continuous intervention of Western imperialism from the Crusades onward. Other factors are the rigid structure of the Islamic religion and the lack of a scientific minority that can effectively challenge these dogmas; the Western world was equally backward—please note—when the Christian religion was not open to scientific dissent and criticism. Backwardness is a relative concept, and, although pot has been used in the Arabic countries for millenniums, they have several times been ahead of the West in basic science (the most famous example being their invention of algebra). The populations of these nations are not "lazy" due to marijuana nor to any other cause; they are merely underemployed by a feudalistic economic system. The ones lucky enough to find work usually toil for longer hours, in a hotter sun, than most Americans would find bearable.

Thus, treating marijuana in a sane and rational way presents no threat to our society, whereas continuing the present hysteria will alienate increasing numbers of the young while accelerating the drift toward a police state. I take no pleasure in the spread of even so mild a drug as marijuana, and I am sure (personally, not scientifically) that in a truly open, libertarian and decent society, nobody would be inclined to any kind of drug use. While I agree with the psychedelic generation about the absurdity and injustice of our criminal laws relating to drugs, I am not an apostle of the "turn on, tune in, drop out" mystique. I recognize that drugs can be an evasion of responsibility, and that there is no simple chemical solution to all the psychic, social and political problems of our time. My own program would be: Turn on to the life around you, tune in to knowledge and feeling, and drop *in* to changing the world for the better. If that course could prevail, the adventurous young, no longer haunted by the anxiety and *anomie* of the present system, would probably discover that love, comradeship, music, the arts, sex, meaningful work, alertness, self-discipline, real education (which is a lifelong task) and plain hard thought are bigger, better and more permanent highs than any chemical can produce.

But, meanwhile, I must protest—I will continue to protest—against the bureaucrat who stands with cocktail in one hand and cigarette in the other and cries out that the innocent recreation of pot smoking is the major problem facing our society, one that can be solved only by raising the penalty to castration for the first offense and death for the second. He would be doing the young people—and all the rest of us—a true favor if he forgot about marijuana for a while and thought, a few minutes a day, about such real problems as racism, poverty, starvation, air pollution and our stumbling progress toward World War Three and the end of life on earth.

It is an irony of our time that our beloved George Washington would be a criminal today, for he grew hemp at Mount Vernon, and his diary entries, dealing specifically with separating the female plants from the male before pollination, show that he was not harvesting it for rope. The segregation of the plants by sex is only necessary if you intend to extract "the killer drug, marijuana" from the female plant.

Of course, we have no absolute evidence that George turned on. More likely, he was using marijuana as many Americans in that age used it: as a medicine for bronchitis, chest colds and other respiratory ailments. (Pot's euphoric qualities were not well known outside the East in those days.) But can you imagine General Washington trying to explain to an agent of the Federal Narcotics Bureau, "I was only smoking it to clear up my lumbago"? It would never work; he would land in prison, perhaps for as long as 40 years. He would be sharing the same cruel fate as several thousand other harmless Americans today. As it says in the book of *Job*, "From the dust the dying groan, and the souls of the wounded cry out."

Senator HUGHES. I would like to enter into the record a copy of a statement by Senator Javits, of New York, at this time.

(The statement referred to follows:)

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

The special subcommittee today begins urgently desirable hearings on S. 2608, the "Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act of 1969," and of which I am a cosponsor, and other legislative proposals to combat narcotics addiction and drug abuse.

The President's message to Congress on the drug problem called it "a serious national threat" and the Presidential Task Force on Narcotics, Marijuana, and Dangerous Drugs said:

One of the most serious problems facing the United States today is the marked increase in the use of narcotics, marijuana, and other hallucinogenic or "mind-changing" drugs. This problem is especially prevalent among the youth of our nation, who have experimented with these drugs.

The National Institute of Mental Health estimates there are 100,000-125,000 active narcotics abusers in the United States, and New York City alone has records of some 40,000 heroin addicts and the number rises between 7,000 and 9,000 a year. The total number of non-narcotic drug abusers, including those addicted or habituated to sedatives, stimulants, marihuana, LSD, and related drugs, and certain tranquilizers is estimated at between 250,000 and 500,000 persons. The number of juveniles and adults who have used marihuana at least once is conservatively estimated between 8 and 12 million.

We have become increasingly aware that narcotics addiction and drug abuse touches every facet of our society, from the depths of poverty in our urban ghetto to the affluent suburban college campus. We can define the social and economic cost—maintenance of an elaborate penal system, courts, and jails through which all too often pass the habitual narcotics addict and drug abuser, crimes of violence against persons and property, lives destroyed and death brought on by drug experimentation and addiction—and the Director of the National Institute of Mental Health has set the range of loss at \$2 to \$3 billion a year.

Prosecution for narcotics addiction and drug abuse takes place under a multitude of statutes—generally inflexible in terms of minimum mandatory penalties—yet it is apparent that strong penalties have not reduced narcotic addiction and drug abuse. In fact, the evidence is to the contrary, for in the face of harsh marihuana penalties—raised in 1956—juvenile drug arrests have risen more than 800 percent. In one State alone (California) juvenile arrests for drug offenses in-

creased from 1,271 in 1961 to 14,112 in 1967 and of the 14,112—10,987 were arrested for marihuana violations. The President rightly called the drug problem a "rising sickness in our land."

It is essential to distinguish between those who use the drug, potentially harming themselves, and those who reap enormous profits from its illegal sale. I believe if we are to make progress against narcotics addiction and drug abuse, we must change society's attitude toward drug dependency. We must realistically characterize and treat the physically or psychologically dependent person for what he is—sick, not evil, *per se*. We must as a nation acknowledge the complexity of drug problems, understanding that some are linked to mental and physical ill health, others to lack of information, some to overexposure or undercontrol of drug-using situations.

We must properly shape the dimension of Federal support to State, local government, and private programs in order to, first, permit expanded research to further our knowledge of the causes and effects of narcotics addiction and drug abuse, and to seek better to understand why our young people turn to mind-altering substances as a means of "acting-out" their particular psychological and character disorders; second, to provide resources for innovative treatment, rehabilitation, and aftercare services for narcotics addicts and drug abusers, desperately in need of mental health care; and third, to develop educational and information programs designed effectively to communicate the facts about narcotics addiction and drug abuse to the people, particularly our student population. At the same time we need aggressive law enforcement directed at damming up the flow of dangerous drugs into and within the country and at destroying organized crime which feeds upon and profits from the drug traffic. We also must revise our Federal statutes relating to narcotics addiction and drug abuse to permit flexibility in prosecution, deal more wisely with the question of penalties for users (as for example, of marihuana), and to make available to the courts a full range of services for diagnosis, counseling, and treatment for narcotics addiction and drug abuse.

Unless we establish a Federal commitment for adequate funding of research, the development of treatment and rehabilitation facilities, innovative after-care services and educational programs, we will have failed to meet the challenge set forth by President Nixon, who said:

Society has an obligation both to itself and to these people (the psychologically dependent regular users and the physically addicted) to help them break the chains of their dependency.

Senator HUGHES. Mr. Ingersoll, I believe we can proceed as you desire. If you would like to proceed with your statement, do so as you wish.

STATEMENT OF JOHN E. INGERSOLL, DIRECTOR, BUREAU OF NARCOTICS AND DANGEROUS DRUGS, DEPARTMENT OF JUSTICE; ACCOMPANIED BY MICHAEL R. SONNENREICH, DEPUTY CHIEF COUNSEL; AND EDWARD LEWIS, M.D., CHIEF MEDICAL OFFICER, BUREAU OF NARCOTICS AND DANGEROUS DRUGS, DEPARTMENT OF JUSTICE

Mr. INGERSOLL. On my right is Michael Sonnenreich, the Deputy Chief Counsel at the Bureau, and on my left is Dr. Edward Lewis,

the Chief Medical Officer of the Bureau of Narcotics and Dangerous Drugs.

Mr. Chairman, it is a pleasure to appear before you today to discuss S. 2608, a bill dealing with several aspects of the problem of narcotic addiction and drug abuse. The issue of drug abuse and misuse in the United States is one of increasing concern in the minds of so many Americans. It is a critical problem and one which requires congressional attention if we are to effectively meet the challenge it presents.

As the Attorney General stated on September 15, 1969, in his testimony before the Senate Subcommittee on Juvenile Delinquency which is considering S. 2637, the administration's proposed Controlled Dangerous Substances Act of 1969, "It has long been realized that the problems of drug abuse cannot be overcome by good law enforcement alone."

The legislation which we are considering today would amend the Community Mental Health Centers Act and the Public Health Service Act. In addition, this legislation would substantially amend the Drug Abuse Control Amendments of 1965, the Harrison Narcotic Act, and the Marihuana Tax Act. To a lesser extent, it would also amend the Narcotic Drugs Import and Export Act, the Opium Poppy Control Act of 1942, and the Narcotics Manufacturing Act of 1960.

Additionally, Reorganization Plan No. 1 of 1968 would be substantially modified since numerous functions, powers, and duties of the Attorney General under that plan would be transferred to the Secretary of Health, Education, and Welfare.

Included in the proposed legislation are provisions which would:

- (1) Allocate funds for the construction, staffing, and operation of facilities for the prevention and treatment of narcotic addiction and drug abuse.

- (2) Allocate funds to permit the Secretary of Health, Education, and Welfare to make grants to assist State and local governments and private agencies in training scientific and professional personnel in the areas of prevention, treatment, and education of drug abuse and drug addiction.

- (3) Authorize the Secretary of Health, Education, and Welfare to make grants to professional personnel for training in the field of drug abuse and drug addiction.

- (4) Authorize the Secretary of Health, Education, and Welfare to make grants to State and local governments for the collection of educational material dealing with drug abuse and to develop special drug abuse educational programs.

- (5) Make the National Institute of Mental Health the focal point for the collection and dissemination of information relating to drug abuse.

- (6) Amend the Public Health Service Act to include depressant and stimulant drugs within the authorized scope of studies and investigations conducted under the act.

- (7) Authorize the Secretary of Health, Education, and Welfare to establish a program of grants to be administered by the National Institute of Mental Health for research into all phases of drug use and abuse, including treatment of drug addicts and drug abusers.

The Department of Justice supports programs for prevention, treatment and education in the fields of narcotic addiction and drug abuse. To this end, we believe the Federal Government should provide guid-

ance and assistance to State and local governments and private agencies.

Public education on drug addiction and abuse should not be the exclusive function of any one agency of government. The Bureau of Narcotics and Dangerous Drugs, as the Federal law enforcement agency charged with the primary responsibility for enforcing the narcotic and dangerous drug laws, by necessity and public demand, shares an obligation to engage in public education in this area.

The primary responsibility and objective of the Bureau of Narcotics and Dangerous Drugs is the identification and prosecution of the major illicit drug conspiracies in the United States. Public officials and the public at large, however, seek information from the Bureau on drug related problems not directly connected with law enforcement, such as the dangers of drug abuse and narcotic addiction.

Accordingly, while recognizing the paramount positions which the Department of Health, Education, and Welfare occupies in the field of drug education—particularly the National Institute of Mental Health—we oppose that provision of the legislation which would tend to establish public education in the areas of drug addiction and drug abuse as the exclusive responsibility of that Department.

Senator HUGHES. Could I interrupt you, Mr. Ingersoll? What would you recommend? You say you oppose it as the exclusive right of the Department of Health, Education, and Welfare.

I understand you feel you have a responsibility in education itself. How would you propose that be carried out? What would you propose as an alteration in the bill to carry that function out, or what part of education do you feel yourself that can be segregated from any other part?

Mr. INGERSOLL. I think I will cover that in my statement, Mr. Chairman, and if I may, I will continue.

Senator HUGHES. All right.

Mr. INGERSOLL. With respect to more formalized training, we would point out for this committee's attention possible areas of duplication of effort since the Bureau of Narcotics and Dangerous Drugs currently has a comprehensive program of training for State and local law enforcement and other personnel. President Nixon in his message to the Congress on July 14, 1969, stated:

The enforcement of narcotics laws requires considerable expertise, and hence considerable training. The Bureau of Narcotics and Dangerous Drugs provides the bulk of this training in the Federal Government. Its programs are extended to include not only its own personnel, but State and local police officers, forensic chemists, foreign nationals, college deans, campus security officers, and members of industry engaged in the legal distribution of drugs.

Last year special training in the field of narcotics and dangerous drug enforcement was provided for 2700 State and local law enforcement officials. In fiscal year 1969 we expanded the program an estimated 300 percent in order to train some 11,000 persons. During the current fiscal year we plan to redouble again that effort to provide training to 22,000 state and local officers. The training of these experts must keep pace with the rise in the abuse of drugs, if we are ever to control it.

In making the National Institute of Mental Health a focal point for the collection and dissemination of information relating to drug abuse, it should be noted that the Bureau of Narcotics and Dangerous Drugs also collects drug abuse data from the State and local police, health departments, and poison control centers. S. 2637, the proposed

Controlled Dangerous Substances Act of 1969, there is a provision which would formalize this collection and dissemination, or exchange, of information.

With respect to the research proposals of this bill other than those dealing with enforcement, which are clearly the responsibility of the Bureau of Narcotics and Dangerous Drugs, we note that S. 2637 would provide that the Attorney General may grant the necessary immunity for legitimate research involving controlled dangerous substances. Close coordination between NIMH and the Bureau will enable this portion of the legislation to be implemented smoothly and effectively.

S. 2608 also calls for the establishment of a National Registry of Narcotic Addicts. Again we must refer to the drug bill proposed by the administration, S. 2637. In that bill there is a provision which would establish in the Bureau of Narcotics and Dangerous Drugs a unit to accept, catalog, file, and otherwise utilize all information and statistics, including records of dangerous substance addicts and other dangerous substance law offenders, which may be received from Federal, State, and local agencies, and make such information available for Federal, State, and local law enforcement purposes.

I would like to add, also, that there is a provision in title III which would, in effect, bind the Attorney General to the recommendations made by the Secretary of Health, Education, and Welfare as to the quantities of crude opium and cocoa leaves which could be imported in any given year. The Department of Justice recommends against enactment of this provision because of its direct effects on the Attorney General's discretionary powers, as provided in title 42, United States Code, section 242.

Other provisions of S. 2608 with which we are also concerned, are those which would: (1) transfer from the Attorney General to the Secretary of Health, Education, and Welfare, the authority to designate drugs as stimulants, depressants, or opiates; (2) transfer from the Attorney General to the Secretary of Health, Education, and Welfare, the authority to register persons conducting research with narcotics, marihuana, and other dangerous drugs; (3) establish an Advisory Committee on Narcotic and Dangerous Drugs whose members would be appointed by the Secretary of Health, Education, and Welfare and whose functions would be to advise the Secretary with respect to the various determinations, including classification of drugs, which he would be required to make under the proposed legislation; and (4) place marihuana control under the Drug Abuse Control Amendments of 1965. The Department of Justice strongly recommends against enactment of these provisions.

Under present law, the Attorney General has the authority to designate a drug as a stimulant or depressant upon the recommendation and advice of a scientific advisory committee that the drug has a potential for abuse. The scientific advisory committee, which is made up of a group of qualified scientists drawn from a list prepared by the National Academy of Sciences, derives its information on a drug's potential for abuse from a variety of sources, including the academic community and Federal, State, and local governmental agencies.

In addition, a substantial amount of information on the actual street abuse of the drugs in question is obtained from agent investigations carried on by the Bureau of Narcotics and Dangerous Drugs.

The Attorney General designates a drug as an opiate under either of two methods. First, he may do so by publication in the Federal Register of a notification from the Secretary General of the United Nations that the drug has been placed under the Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, 1931. Second, he may designate a drug as an opiate after "considering the technical advice of the Secretary of Health, Education, and Welfare."

However, once the Attorney General receives a recommendation that a drug should be controlled, he must make a policy determination as to whether or not the drug actually will be controlled. This policy determination is based in great part on the very practical problems of enforcement and compliance, since control would necessitate investigation and regulation to insure against illicit diversion and illicit trafficking.

Accordingly, since a critical factor in determining whether or not a drug will be controlled is the enforcement problem, the Attorney General, as the Nation's chief law enforcement officer, is best qualified to make the determination.

He has available to him the advice and counsel of the Department of Justice's Bureau of Narcotics and Dangerous Drugs, the agency charged with the responsibility of enforcing the Federal laws with respect to dangerous drugs and narcotics.

The Secretary of Health, Education, and Welfare has, of course, a present role in the determination. Two consultants of the Scientific Advisory Committee are appointed by the Secretary of Health, Education, and Welfare, and under the proposed Controlled Dangerous Substances Act of 1969, the advice of the Secretary is required before the Attorney General makes a decision to control a particular substance.

Other Government agencies also play a role in the determination as to whether or not the drug should be controlled. The Secretary of State, for example, will advise the Attorney General of the effect that control of a given drug may have on international obligations and relations. Other departments, such as the Departments of Treasury and Defense, on occasion, also provide information for the Attorney General. However, since the ultimate effectiveness of drug control is dependent upon enforcement, the final policy decision should be with the Attorney General. The need for the Advisory Committee on Narcotics and Dangerous Drugs to be established by the legislation will, of course, be obviated if the authority to designate a drug as a stimulant, depressant, or opiate remains with the Attorney General.

The Department of Justice also strongly recommends against enactment of those provisions which would transfer from the Attorney General to the Secretary of Health, Education, and Welfare the authority to regulate establishments conducting research with marihuana and narcotics.

The reasons for this recommendation are much the same as those outlined earlier. When institutions of any type, no matter how well qualified or competent to conduct scientific research, are given permission to engage in research with narcotics, marihuana, and other dangerous drugs, serious problems are created in the area of enforcement of the drug and narcotic laws. This stems from the fact that un-

less proper controls are initiated at the time the studies begin and are continually imposed on the research establishments during the life of the research projects, serious and substantial diversion of narcotics and dangerous drugs may occur. It is well recognized that the sources of substantial quantities of narcotics and dangerous drugs, particularly in the illicit drug market, may be traced back to legitimate establishments, including those engaged in legitimate scientific research. Therefore, the authority to regulate these institutions should remain with the Department of Justice.

Section 404 of the bill would place marihuana under the Drug Abuse Control Amendments of 1965. Apparently, this is an attempt to plug the holes left in the Marihuana Tax Act as a result of the decision in *Leary v. United States*.

However, we recommend against enactment of this provision since S. 2637, the legislation sponsored by the administration, will solve the problem created by the *Leary* decision by taking narcotics and marihuana out from under the taxing power and placing those drugs jurisdictionally under the Commerce clause.

In conclusion, I would like to repeat that the Department of Justice recognizes the need for legislation in this area. However, I would respectfully point out to this committee that the administration's bill, S. 2637, is a comprehensive piece of legislation which covers much of the same ground as does S. 2608.

Those provisions of S. 2608 which do not conflict with S. 2637 or interfere with our narcotics and drug enforcement responsibilities, we endorse. The authority of the Attorney General to designate drugs for control and to regulate research establishments is a necessary concomitant to effective overall law enforcement, and should not be separated and placed in another department.

Mr. Chairman, that concludes my statement, and if it suits your purpose, along with my colleagues, I will try to answer your questions. Thank you.

Senator HUGHES. Do they have any statement they would like to make in addition?

Mr. INGERSOLL. No, sir.

Senator HUGHES. Did you three men write S. 2637?

Mr. INGERSOLL. We had a share in the initial drafting of it; yes, sir. We participated with the Department of Justice and other agencies, in and out of Government.

Senator HUGHES. I would like to go back to the questions I originally asked you. I don't think you answered them in your testimony.

I would like to know, and perhaps Mr. Sonnenreich—do you direct the educational facilities of the Department?

Mr. SONNENREICH. No, sir, I don't. The educational facilities are directed by Mr. Frederick Garfield, who is an Assistant Director.

Mr. INGERSOLL. Mr. Chairman, I can respond in more detail to your question, if you would like.

Senator HUGHES. All right.

Mr. INGERSOLL. I think if you look at the problem of drug abuse in the country along a line, at one end you can see the control problems and the enforcement problems, and I think everyone agrees these are obviously problems for the enforcement agency, and its responsibility.

At the other extreme, we see the health problem, which is directed to the rehabilitation and cure of addiction, and removal of depend-

ency on drugs, and these are very clearly health problems, and a rehabilitation problem.

The enforcement organization of the Government has only the responsibility to be informed and to encourage and improve rehabilitation programs.

But in the middle, between these two extremes, there is a need to improve our knowledge about the nature of drug abuse and about the natures of the substances that are abused. There is a need to inform the public and special interest groups within the public arena of these findings.

In this area, I believe enforcement agencies, as well as a health or rehabilitation or research agency, has an important and very responsible role to play.

We are doing it in this manner: We have a relatively small staff which is devoting its attention, working in close coordination with other governmental agencies, such as the NIMH, Office of Education, Department of Defense, and others interested in the problem—

Senator HUGHES. Why is the Department of Defense interested in the problem?

Mr. INGERSOLL. Because of the problems among its own personnel on drug abuse.

Senator HUGHES. That conflicts with the statement they sent me. They said they have no problems.

Mr. INGERSOLL. Well, I can't comment on the statement they sent you, sir.

Senator HUGHES. Do you think they do have problems?

Mr. INGERSOLL. Yes, sir.

Senator HUGHES. Thank you. I will pursue it a little later.

Mr. INGERSOLL. Our program is one that is intended and designed mainly to stimulate and motivate groups from the grassroots area through professional groups to educate and train the general public and particularly those people who are most susceptible to drug abuse problems.

As examples of this, we recently were requested by the Fairfax County Medical Society to run some seminars for doctors and physicians in Fairfax County, which we did.

We have run programs for secondary school administrators, who in turn carry the information we present to them back to their schools in an effort to eliminate or reduce the amount of drug abuse in school.

Senator HUGHES. May I interrupt you? When you say "we," and perhaps Dr. Lewis can answer the question, who conducts those seminars? What is the composition of your staff that actually conducts those seminars for these officials?

Dr. LEWIS. Sir, we were requested by the Fairfax County Medical Society to put on this seminar so that the doctors on their drug abuse committee could more effectively speak when they speak with community groups, parents, and school children.

The people that we had participating in the seminar were physicians, pharmacologists, some of our law enforcement people, and our legal staff on aspects of the various laws. It is sort of a broad sweep in giving the doctors some information which they did not have. They came to us for this purpose.

Senator HUGHES. Doctor, could I ask you a question, then: When the Medical Society of Fairfax County asks you for an institute

of drug abuse, what kind of a conflict do they find themselves in? When a student comes who is obviously using drugs and wants treatment, as far as your law enforcement facilities are concerned, what position are they in? Do they have the patient-doctor relationship that they do not report this to the law?

Dr. LEWIS. I think Mr. Sonnenreich could answer that better than I.

Mr. SONNENREICH. They do have a physician-patient relationship where they have these people coming and talking to them. This is a problem for them. They don't know what the laws are in the area, and part of our function in conducting the segment of the seminar was to give them the laws, not just the broad view, but the actual laws as it affects them, both in their hospitals and in their clinics.

Senator HUGHES. What is the law?

Mr. SONNENREICH. The law is that as long as the person comes to them, and they take no overt action to actively conceal the drug or facilitate the persons continued use of the drug, there is no violation of Federal law.

The only way there would be a violation of Federal law would be section 4 of title 18. That requires some active, overt act on their part to conceal the man's drug use. It is something more than hearing about the fact that he is taking drugs. It goes beyond the fact of giving them medical treatment.

The only other Federal law that would apply would be the aiding and abetting statute, if they were to hide him when told the police were after him. These are the only two statutes that would affect the people when they are in a patient-physician relationship.

Senator HUGHES. You are saying that anyone who is a user of drugs and seeks medical help and goes to his own private physician need not fear the law?

Mr. SONNENREICH. That is true. It is a privileged communication.

Senator HUGHES. I think there are thousands of people in America who have not sought medical attention because they feared the penalties of the law. We had testimony before this subcommittee that parents in Washington, D.C., and in suburban areas are supporting the narcotics habits of their own children and supplying the money to make purchases for the very simple reason that they are afraid of the penalties of the law.

I think it is necessary that public information in this area be out and that they be advised to seek help if there is no penalty under the law.

Mr. SONNENREICH. We agree with you, Senator, and that was part of the function of the legal segment of these seminars. This doesn't apply to the doctors only, but to the college deans, and Mr. Ingersoll explained that we have several programs during the course of the year where we have courses for college deans, deans of men, so that we can explain to them just what the legal ramifications are in addition to the medical aspects of the problem. There is a lot of information in this area, as to what constitutes a Federal offense.

Senator HUGHES. Thank you, Mr. Sonnenreich. I wanted to pursue that while we were on the subject.

May I then make an assumption from your statement, and you selected this area, I didn't. It is no different from any other area, in my opinion. Apparently narcotics is a problem in high schools, and

junior high schools, and a problem in Fairfax County, or they wouldn't have sought your assistance. Is that right?

Mr. INGERSOLL. I think that is correct, sir.

Senator HUGHES. Go ahead. I interrupted you.

Mr. INGERSOLL. Moving a little bit further in our educational programs, I should say that these are relatively new, that they are programs that have been in the development stage only since the establishment in the Bureau of Narcotics and Dangerous Drugs last year. Among others things, we also work very closely with an organization known as the National Coordinating Council for Drug Abuse Education.

Senator HUGHES. What is that organization?

Mr. INGERSOLL. This is an organization composed of some 60 national associations. It includes organizations such as the National Students Association, the American Legion, and I think that will give you the spectrum that it covers.

Its purpose is to provide coordination on a national basis for the numerous drug abuse prevention programs that are conducted throughout the country to provide a central point of information exchange, to consider program procedures and evaluate existing programs, and to encourage the implementation of drug abuse prevention programs throughout the United States.

I might point out that we assisted the founding of this organization and sat in an ex officio capacity on its executive board.

It is a private sector organization which is also fairly new, and has great potential. This is another example of the kinds of activities that we encourage.

In addition, we make available our own personnel on invitation to address groups throughout the nation, and, indeed, overseas, where we have personnel stationed. We address American personnel who are assigned overseas in the same field.

We just completed the second—we sponsored two symposia at Rutgers University. The second was just completed. It brought together a number of people from the scientific research world as well as the educational world in order to bring the thoughts and expertise of these groups together, and to lay out some national programs.

In addition, this month we sponsored a seminar composed of, in the main, researchers, of a variety of scientific disciplines, which addressed the subject of developing better methodology for predicting drug abuse. Both of these conferences occurred this month.

I think that unless you care to explore it further—

Senator HUGHES. I would like to intervene and compliment you on the expansion of your training program of law enforcement people. From 2,700 to 22,000 in a year and a half is a tremendous expansion.

Certainly one of the problems that we have become aware of is the inefficiency of local law enforcement people in the country. They don't know how to get proper testimony, if they go to court for trial, so that it will stand up before the court. That is extremely important when we are dealing with hard narcotics, as you are far more aware than I am.

How wide can this program be extended? Do you have regional conferences on this, or is it all done locally here? How do you carry it out? I think this type of training is absolutely essential.

Mr. INGERSOLL. May I illustrate some of the programs for you, Mr. Chairman, and I think that will answer your question.

Senator HUGHES. Yes.

Mr. INGERSOLL. We have a training staff, of course, at headquarters, which is responsible for our own Bureau training as well as the kind of training which you have just mentioned.

Also, in each of the 14 regional offices we have in the United States, there is one or more training and education officers who are responsible for putting on these programs in the regions.

Now, in Washington, our bread and butter course, or our main course, is a two week program of some 80 hours which is intended to train people who will specialize in narcotics enforcement.

This program has been given to about 1,300 people in the last year. We run them both in Washington, and we also take them out through the United States to various sections of the country.

We just completed one of these, I believe, in Detroit, for example, and one in Los Angeles not too long ago.

In addition to this, we run a number of seminars ranging in time from 1 day a week, which capture or corral a large number of police officers.

In Baltimore and Washington, and in Baltimore County, we are experimenting at this time with a new approach to training police officers, particularly municipal police officers, and we are undertaking to train all the uniformed police officers in the Baltimore and Washington Metropolitan Police Departments in a 3-day, 24-25 hour session, which will give them the rudiments of the law, and the rudiments of how to recognize the substances involved, the people, and so on, and how to develop the elements of a criminal case at the lowest echelon of the traffic.

These departments have asked us to do this so that all of their police officers, all of the uniformed officers, as well as their specialists, will be familiar with the investigation of narcotic and drug violations, so that then their specialists can concentrate on the higher levels of the trafficking, and the spectre of open drug dealing on the street will be eliminated.

In some cities, the uniformed officer doesn't know what to do in a drug case, and we are testing this program to see if it is viable and can be carried on the rest of the United States.

In Baltimore, we have seen dramatic results in police effort as a result of the early stages of training in this program.

We also provide training for forensic chemists, in addition to our own chemists who are involved. This is also a very highly specialized area of criminalistics, and provides training which is available, apparently, only through our organization.

Senator HUGHES. Do you know how many States have forensic chemists who are available to the law enforcement agencies?

Mr. INGERSOLL. I can't give you an exact figure.

Senator HUGHES. There are many of them that do not have.

Mr. INGERSOLL. That is right.

Senator HUGHES. Most cities do not have.

Mr. INGERSOLL. That is correct, sir. We are making an effort through the law enforcement program for States that do not have their own forensic laboratories to create them. I would hope that more States would develop their own laboratory facilities.

Senator HUGHES. Is it easier to detect marijuana than any other narcotic?

Mr. INGERSOLL. Marijuana, first of all, is not a narcotic.

Senator HUGHES. What is it?

Mr. INGERSOLL. It is classified scientifically as an hallucinogen. In the Federal law, it is classified as a substance unto itself. In some State laws, it is classified a narcotic.

Senator HUGHES. You do not consider marijuana a narcotic?

Mr. INGERSOLL. No, sir.

Senator HUGHES. Do you consider it addictive?

Mr. INGERSOLL. No, sir.

Senator HUGHES. Do you have any reliable figures on the percentage of hard narcotics addicts in the country?

Mr. INGERSOLL. I think that the figures we have are a minimum estimate. These are hard narcotics addicts on whom we have identifying information, information such as names, age, physical description, and so on.

Our files contain information of this kind on about 64,000 addicts at the present time. I believe, however, that this is a very minimal number, that the actual number is probably higher. I don't know that anybody can state with any degree of precision the actual number.

Senator HUGHES. I would like to ask a couple of questions. I know that they are not related to your testimony, but it came up in other testimony before this subcommittee.

We had a number of recovered addicts testify before the subcommittee, that they could more readily obtain heroin in prisons than they could on the street, including the Federal prisons.

We had one man testify that he had been in nine prisons, and that he was easily able to support his habit in all those prisons, including two Federal prisons.

Another man was in seven, including the city jail here in the District.

He said he had never been in an institution in which he couldn't easily sustain his narcotics habit, as easily on the inside as he could on the outside.

Is the Bureau of Prisons under your direction, also?

Mr. INGERSOLL. No, sir, it falls under the jurisdiction of the Department of Justice.

Senator HUGHES. Are you doing anything to stop addiction in the prisons?

Mr. INGERSOLL. I think the Director of the Bureau of Prisons could answer that question better than I. We are working with them in an effort to—along the same lines that I think I mentioned in terms of law enforcement officers.

We have offered to train prison personnel, Federal prison personnel in much the same manner of recognition.

Senator HUGHES. Have they accepted that offer?

Mr. INGERSOLL. I don't think that program is underway yet, sir.

Senator HUGHES. Would it be your policy that a little narcotics in prison is not bad as long as it keeps the prisoners quiet and calm?

Mr. INGERSOLL. No; I would not subscribe to that policy.

Senator HUGHES. The Department would not subscribe to that?

Mr. INGERSOLL. No, sir.

Senator HUGHES. I asked those things for the record primarily because those rumors have been floating around, that they don't want

to put the heat on too hard, or they have a real problem in prison. I am sure those are not the policies, but I wanted to get it on the record.

If we are going to pursue enforcement outside, we should pursue it inside as well.

In view of public education, you did not mean to say that your department wanted to engage in the education in schools relating to narcotics when the children start through the school processes, or educating teachers to teach about narcotics?

Mr. INGERSOLL. I think we do have some expertise that should be put into these programs, yes, sir.

Senator HUGHES. You mean you think that you should be the Department that goes into all of the high schools and elementary schools in America?

Mr. INGERSOLL. No, I don't believe that. I think we are out to participate in programs which are developing curriculums in these areas.

Senator HUGHES. With the development of the curriculums, and assisting in that development?

Mr. INGERSOLL. Yes, and as a matter of fact, we are doing that. In some cases we do, though I discourage the practice, in some cases we do participate in school assemblies and things of this nature. More particularly, we prefer to relate to PTA groups and parent groups and teacher groups. We are also working with the National Education Association in their curriculum development operation.

Senator HUGHES. Do you know of any teachers training colleges in America that actually conduct courses during the training of a teacher in the field of narcotics, along with other things?

Mr. INGERSOLL. No, I don't know of any, Senator.

Senator HUGHES. Do you think it would be advisable if we did this?

Mr. INGERSOLL. I think it would be advisable if this was done, but in the past as a police officer I participated in programs for student teachers who were going through the last phases of certification, in acquainting them with all aspects of law enforcement. I think that teachers certainly have to be better informed on the function of law enforcement in our Government, in our society today, across the board, and I would guess that there imparting information on drug control would also be worthwhile.

Senator HUGHES. If this were provided by law, as you suggest, do you have a responsibility in the area? I am not prepared to deny that you do not at this point; I am asking with an open mind. What would be the controlling factor in the education process, where we now have divided authority?

Mr. INGERSOLL. At the present time, Mr. Chairman, the executive branch is bringing together all of the agencies which have an interest and a role to play in public education programs in this area, and under the chair of the White House, a committee has been established, an ad hoc committee has been established to consider the coordination, or to provide coordination, throughout the executive departments in drug abuse education programs.

Senator HUGHES. I believe, if I understand your testimony correctly, you do not pursue the thought that you have any control or desire to

control anything in the field of recovery, rehabilitation, and regeneration of users. Is that correct?

Mr. INGERSOLL. With the exception that in the drug maintenance programs, where this is used as therapy, we do have a responsibility to prevent diversion of those substances.

Senator HUGHES. Are you talking about Lexington, or about using methadone?

Mr. INGERSOLL. I am talking about using methadone. Our official interest stops there. However, I am as anxious as anybody else to find the proper rehabilitative technique to eliminate this problem in the country.

Senator HUGHES. You don't intend to discuss the social reasons for the heavy experimentation in narcotics right now in America, do you?

Mr. INGERSOLL. I am sorry. I don't understand.

Senator HUGHES. You are not wanting to even offer social solutions, are you, at this point?

Mr. INGERSOLL. I don't have a solution.

Senator HUGHES. I have been taking up a lot of time.

Mr. INGERSOLL. Mr. Chairman, may I just qualify the last answer to this point: The Department does have an interest in rehabilitation, the Department of Justice does, because it does have to administer part of the Narcotic Addict Rehabilitation Act, and the Bureau of Prisons does run special programs for addicts in California and West Virginia under title II of the Narcotics Rehabilitation Act of 1966.

So, my answers to those questions were personal answers and as Director of the Bureau of Narcotics and Dangerous Drugs, not as a representative of the Department of Justice.

Senator HUGHES. Does imprisonment of an addict do anything to get him off the drug?

Mr. INGERSOLL. Well, if it removes him from drugs, it will play that role. I think that while a person is institutionalized, it is relatively easy to keep him off of drugs for that time. The problem is that the rehabilitation breaks down when he returns to his environment.

Senator HUGHES. Our testimony indicates that it is just as easy for them to get the drugs in prison as out.

Mr. INGERSOLL. As I say, I can't respond to that from any position of expert knowledge. I think that this is a question for the Bureau of Prisons.

Senator HUGHES. The Director is Dr. Alexander?

Mr. INGERSOLL. Mr. Alexander. Yes.

Senator HUGHES. I think we will have to get him later for some testimony in this area to see if we can't clarify that just a little bit.

At this time, I will defer to Senator Dominick for questions, if he has some.

Senator DOMINICK. Thank you very much.

Mr. Ingersoll, I unfortunately couldn't be here to hear all of your testimony, but I have scanned it and I listened with interest to the questions of the Senator from Iowa.

In your prepared statement, you refer to the designation of a drug, and how it comes about.

You refer, among other things, to a notification from the Secretary General of the United Nations that the drug has been placed under the convention relating to narcotic drugs.

How many different types are now involved in that type of notification or limitation?

We are now talking about, I am sure, the transport of drugs.

Mr. INGERSOLL. May I ask Mr. Sonnenreich, my counsel, to respond to that? I think he can give you a more definitive answer.

Mr. SONNENREICH. Senator, as I understand your question, you are asking the scope of drugs that would be controlled by this procedure?

Senator DOMINICK. That is right. How extensive is the role of the United Nations in trying to limit the transportation and use of drugs?

Mr. SONNENREICH. The convention which is mentioned here, which is a 1931 convention, Senator, is only partly in force. Our basic treaty obligation is called the Convention on Narcotic Drugs which was formed in 1961, passed and agreed to by the United States in 1967. It covers all the narcotic drugs that we would be familiar with, and marihuana, and the control is through the World Health Organization of the United Nations.

There are meetings through the Economic Social Council and the World Health Organization determines various drugs on the basis of scientific expertise, scope of abuse, scope of international commercial problems with them, and then makes a determination.

An example of this is the drug benzitramide, which we were informed was designated as a drug to be controlled under the convention. We did so place it under control approximately 8 months ago.

Senator DOMINICK. What is that drug?

Dr. SONNENREICH. It is a narcotic, sir, called benzitramide.

Senator DOMINICK. You had better spell it for the reporter.

Mr. SONNENREICH. We will supply it.

Senator DOMINICK. Then, in fact, what you are saying in this paragraph on page 11 is the fact that the World Health Organization has designated, as a drug subject to limitation and subject to penalties, all the drugs that we are talking about in these hearings?

Mr. SONNENREICH. No, sir.

Mr. INGERSOLL. Excuse me. The United Nations controls, or these notifications would apply only to what are classified as narcotic drugs under the Single Convention. It would not apply to the hallucinogens, the depressants or the stimulant drugs.

There is presently under consideration in the United Nations Commission on Narcotic Drugs a protocol which will cover these other drugs, what they call the psychotropic drugs.

This protocol is in about the third draft stage. The session last January in Geneva concerning it took place, and I think there will be another session this January in Geneva to consider that protocol, and we think it will come out very quickly after that.

Senator DOMINICK. At the present time, then, in order to get the record straight and for my own information, the World Health Organization and the United Nations have been dealing largely with narcotic drugs. The other drugs which we have classified in one way or another as being injurious to health would include the hallucinogens and psychotropic drugs, which you have been referring to here, and that is an independent evaluation by our country. Is that correct?

Mr. INGERSOLL. At the present time, the controls over these drugs, with the exception of marihuana, the control over the other drugs is

at the discretion of the individual members of the United Nations, and that would be true in our case.

Our controls, or lack of controls, are a matter of national policy, irrespective of U.N., influences at this time.

Senator DOMINICK. Do we have subsidiary or bilateral agreements, for example, with Mexico, on the transportation of the various classes of drugs?

Mr. INGERSOLL. Not at this time.

Senator DOMINICK. We have no agreement with them at all?

Mr. INGERSOLL. Not as to drugs, sir.

Senator DOMINICK. Do you have any information, or could you furnish any information, on the type of controls that the country of Mexico has over production and distribution of drugs there?

Mr. INGERSOLL. Yes, can I give you some general information, and provide specific information at a later time, if you wish?

I think generally Mexico is a member of the single convention, and therefore their controls over narcotic drugs and marihuana are similar to ours.

They have to—

Senator DOMINICK. If they are similar to ours, they are not very effective, I might add.

Mr. INGERSOLL. Well, I think there is a difference between legislating an enforcing the legislation.

In the case of what I referred to before as psychotropic drugs, there is no Federal law concerning the control of them. It is my understanding that they have one under consideration, a proposal under consideration at this time.

Senator DOMINICK. What about the hallucinogens?

Mr. INGERSOLL. I mean those and stimulants and depressants in that statement.

Senator DOMINICK. What you are saying, Mr. Ingersoll, is that the problem is serious enough in the country as a whole so that it needs a rather strong, massive effort by a number of departments to try to provide a solution. Is that correct?

Mr. INGERSOLL. Yes, sir. I think that is a very fair summary of it.

Senator DOMINICK. You feel it would be a mistake to transfer the total responsibility to HEW?

Mr. INGERSOLL. Yes, sir.

Senator DOMINICK. On the other hand, you feel there is a role for HEW, in the instruction and educational field in particular?

Mr. INGERSOLL. As a matter of fact, I think their role there should be dominant, and ours should be secondary, intended to bring forth the expertise our organization possesses.

Senator DOMINICK. I won't take much longer, Mr. Chairman, but I am interested in this point.

You refer to the training you have done with State and local enforcement officers. Are they policemen?

Mr. INGERSOLL. In addition to police officers, we will provide training programs for people from other activities who have an interest in this.

Senator DOMINICK. Such as what?

Mr. INGERSOLL. Chemists, college deans, and security officers. We have provided programs for secondary school administrators in the Washington, D.C., area. We have—

Senator DOMINICK. When you say you provide training for college educators, are you talking about training in order to be able to detect the presence of one of these stimulants or drugs in an individual, or what?

Mr. INGERSOLL. No, I think basically, Senator, we are trying to get across the message, particularly to college administrators, that—we are trying to make them aware of the extent of the problem, nationally as well as in colleges and universities.

We are trying to acquaint them with the law, which controls the transactions, various transactions in narcotics and drugs in this country.

I think we are also trying to get them to introduce within their own institutions drug prevention programs.

So, we are acting as a catalyst.

This is in the training session in the sense that it is a lecturer-student relationship. I think there is a good deal of interaction between our personnel who participate and the people who come in for it.

It is in the nature of a seminar.

Senator DOMINICK. Is this done by volunteer requests of the educators, or is it done by sending people out to the colleges, or is it done by some other means?

Mr. INGERSOLL. In the college programs, almost all of them are run in Washington, and therefore the administrators come to Washington to participate.

Senator DOMINICK. You notify them that you are having it and they can come if they are interested?

Mr. INGERSOLL. Yes.

Senator DOMINICK. Have you had a large attendance out of this?

Mr. INGERSOLL. Yes. We usually have about 40 to 50 people in each class, and I am sure we have a waiting list, as we do for most of our training and educational programs.

Senator DOMINICK. I ask these serious questions, because in our own State of Colorado, and particularly in the Denver metropolitan area, we have had an absolutely phenomenal increase in drug use and drug abuse both, and it isn't restricted to the college students.

They are in the high school, they are in the elementary schools. A lot of people apparently just don't recognize that this is going on. What do we do about this? What educational programs and material is your organization putting out trying to combat this?

Mr. INGERSOLL. I think initially, Senator, we have to bring to the attention of the general public facts and not myths concerning drugs and the hazards of drug abuse.

Our organization does this primarily through other organizations. We try to inform key members of various and sundry associations throughout the United States, and in turn encourage them to bring this information to the attention of their constituents.

Well as an example, my deputy director and I are attending every meeting of State broadcaster associations that we can in an effort to acquaint them with our experiences and our recommendations, and in turn soliciting their assistance in using the broadcast media to inform the public, their listening public.

Senator DOMINICK. Mr. Ingersoll, without trying to be in any way personal, you are not medically trained, are you?

Mr. INGERSOLL. No, sir.

Senator DOMINICK. Dr. Lewis is your medical officer?

Mr. INGERSOLL. Yes, sir.

Senator DOMINICK. Recently, we have had some very conflicting reports on the question of the problems of marihuana, whether making this a crime is really helpful in trying to stop the abuse, or whether we ought to try to stop it at all. Some people have said the side effects are perfectly terrible, but recently we have had a statement saying it is like eating salt on meat.

What is your reaction to this?

Mr. INGERSOLL. Are you addressing the question to Dr. Lewis?

Senator DOMINICK. Yes.

Dr. LEWIS. My personal and immediate reaction is similar to those expressed by other members of the profession, that marihuana is a mild hallucinogen. We know little about the long-term effects. There have been some studies that have shown numbers of psychotic episodes following the use of marihuana. I think we are in the position where we have to collate what data we have, which is small, and add to the more realistic data based upon experimentation with controlled amounts of pure substances, which would be the active ingredient of marihuana. This has not previously been done, and I think this is what leaves the various loopholes in anybody's testimony about marihuana.

The Government's present position, I think, is fairly concise, as stated in this Task Force Report on Narcotics and Dangerous Drugs which we can make available.

Senator HUGHES. We already have copies of it, Dr. Lewis.

Senator DOMINICK. In short, what you are saying is that before any real determination is made legislatively, more research must be done on this to determine what the ingredients are, what their effects are and so forth. Is that correct?

Dr. LEWIS. Yes. I think that before any scientifically sound conclusions can be drawn that we are going to need more data. I think the question as to how severely marihuana offenders should be punished in comparison with those who use other types of dangerous substances is the big question, and I professionally can only say that marihuana is a mild hallucinogen, and it has some dangers.

I think that little more can be said with regard to marihuana. We do think that it is not physiologically addicting. We think also that it may produce psychic dependence, habit forming, if you want to call it that, like cigarette smoking, and we know little about the long-term effect at this time.

Senator HUGHES. I would like to ask you this: I refrained from it the first time around because I didn't know we were going to get into this section, but I think it is important that we get your testimony on it.

Since this is a committee on alcoholism as well as narcotics, is alcohol a drug?

Dr. LEWIS. Yes, sir; it is.

Senator HUGHES. As marihuana is a drug?

Dr. LEWIS. Marihuana technically is a drug, because it has a pharmacological effect on the structure or function of the body. In this case, function.

Senator HUGHES. Does alcohol also create a psychological dependency and erratic conduct?

Dr. LEWIS. Yes, sir. There is an alcoholic psychosis. It is called a syndrome, and it is an alcoholic psychosis.

Senator HUGHES. How do you compare the consumption of alcohol in this country with the use of marihuana? Give me a wild guess, if you can't—

Dr. LEWIS. You mean the use or the dangers?

Senator HUGHES. The use and the dangers.

Dr. LEWIS. I don't know about the use. I would estimate that alcohol is used quite extensively throughout this country, and perhaps more than marihuana. I don't know. On the dangers, with regard to alcohol, we have the immediate dangers and longterm dangers, and the immediate dangers of alcohol, I would say, in the usual social use, are not, perhaps, as bad as smoking a number of potent marihuana cigarettes. But we are striking a comparison between two unknown entities, really.

Senator HUGHES. If you took a number of potent drinks, what effect would that have on you in comparison with a number of potent cigarettes?

Dr. LEWIS. I would say with marihuana you would be behaving in an erratic fashion, possibly hallucinating.

With alcohol, if you had a lot of drinks, you would get drunk, and then become horizontal, and that would probably be the end of the dosage.

Senator HUGHES. How do you account for the 25,000 automobile deaths on our highways every year for intoxication if they are horizontal?

Dr. LEWIS. This is very true, and I must say this, that I anticipate some day that we will be able to determine the blood serum, or urine levels at which one may say someone is actually under the influence of marihuana. We don't have this at this time.

Senator HUGHES. Isn't marihuana usage detectable by urine analysis within a 24-hour period?

Dr. LEWIS. Not to my knowledge.

Senator HUGHES. Not to your knowledge. Maybe I am talking about another hallucinogen.

Dr. LEWIS. Heroin and morphine and methadone and barbiturates and cocaine are relatively easy to detect in the urine. We don't have the methodology at this time for these determinations with regard to marihuana nor with regard to methadone, I might say, and this is one area where this Bureau has an interest in research, which is very pertinent to law enforcement.

I think if anyone is going to investigate how much marihuana or methadone one must take to get psychotic from it, we had better know what the blood levels and urine levels are, and how they relate to the dosage taken.

Senator HUGHES. This is the kind of research you referred to as necessary to be done?

Dr. LEWIS. I would consider this very necessary; yes, sir.

Senator HUGHES. You brought out what I think is an important point, and this is research. All I am trying to do is get the facts and tell them in perspective.

I have heard a lot of people say that marihuana leads to usage of harder narcotics, and that in almost every instance anyone who uses

amphetamines or barbiturates or heroin has preceded that with the use of marihuana. Is that correct in your opinion?

Dr. LEWIS. No, sir, it is not in my opinion.

Senator HUGHES. It is not correct in your opinion?

Dr. LEWIS. No, sir. Many of the hard narcotic addicts with whom I have spoken have never smoked a marihuana cigarette.

Senator HUGHES. We have had testimony of this nature, too, before this committee.

Do you find that most narcotics users have preceded the usage of their narcotics with alcohol?

Dr. LEWIS. I have no statistics, but many of them do, and many of them continue to use alcohol along with hard narcotics.

Interestingly enough, many heroin addicts will gain an additional sense of euphoria by the use of central nervous system stimulants such as cocaine so there are such things as multiple drug users, and many of them continue to use alcohol and other drugs.

Senator HUGHES. Because of your profession, do you find many physicians in this country who realize that in the treatment of alcoholics and narcotics abusers the danger of other drugs written by prescriptions in the hope of helping the person may, in fact, have the adverse effect.

Dr. LEWIS. Yes. I would like to address myself to that. I think that many professional people are—it is not that they are unaware, but they are sometimes inclined to be liberal in their use of certain types of tranquilizers to help the individual get over his anxieties that drive him to abuse of alcohol or other drugs, and if the individual sails along smoothly on a particular group of tranquilizers for a while and then is triggered off into an emotional episode and goes back to drinking alcohol and certain of the tranquilizers, they are what we call synergistics and it is like taking two doses plus two doses equals 9 doses, instead of just four, and I think this presents problems.

It is difficult for any practitioner to be with his patient at all times and supervise the use of the drugs. I think he could be quite discreet in the patients he gives the drugs to, and the amounts of drugs that he prescribes.

Senator HUGHES. Thank you.

I believe the physicians in the country are becoming increasingly more aware in recent years of the danger of just prescribing without really knowing the patient.

Thank you, Senator Dominick. I am sorry to continue so long.

Senator DOMINICK. That is all right. I was just following up.

I have here a report from the National District Attorneys Association, Committee on Drug Abuse, and they refer on page 36 of this to the 1965 report on drug dependence by the World Health Organization.

It lists the following psychological and physiological effects from the intake of marihuana: Among the more prominent subjective effects of marihuana are hilarity, carelessness, loquacious euphoria, distortion of sensation and perception, impairment of judgment and memory, destruction of emotional responsiveness, irritability, and confusion.

Other effects that appear after repeated administration include lowering the threshold for optical stimuli, antisocial behavior, various sensory and intellectual derangements.

The effect of marihuana on the nervous system is most profound and, unfortunately, least explored.

Just looking at the objective results, I have trouble distinguishing this from anybody who is intoxicated from alcohol. I was trying to see if there is any relationship here between this and the use of harder drugs, or whether it was like having too much to drink.

Mr. INGERSOLL. Senator, the 1968 annual report of the World Health Organization repeats much of what you have just referred to, and also calls for additional research, but concludes that the evidence now at hand does indicate that marihuana is a dangerous drug and ought to remain under control.

But I think your questions and those of the chairman point out the great confusion that exists among the scientific community as to what marihuana is and what its effects are.

The latest figures that I heard concerning the number of marihuana users in this country was given in testimony yesterday before Senator Dodd's committee, by Dr. Stanley Yolles, who is Director of the National Institute of Mental Health. I am informed that he estimated there are between 8 and 12 million users of marihuana in this country today, of whom 10 percent are confirmed "potheads," as he put it, I understand, and of these, 5 percent go on to heroin use.

Now, I am capsulizing what I think he said. This would mean, in effect, that 40,000 to 60,000 heroin users in this country today can definitely be linked to the beginning with marihuana.

I have been in law enforcement since 1951 and I have met a lot of narcotic addicts in that time and other drug users, and I have yet to meet the narcotic addict that does not tell me that marihuana was not the first drug that he used.

I am not trying to say there is a progressive relationship between them, but I think there is definitely an association between the use of one drug and the use of other drugs, even if it is only an environmental association.

Further confusion that exists in the scientific community, and which is why I think law enforcement must have a strong hand in deciding what drugs should be controlled, and here is an article that appeared in the New York Times yesterday concerning hashish.

I would like to quote one part of this article.

The reporter says:

And ask whether hash causes paranoia, as some of its users have said, and you will get answers such as these:

"True psychotic experiences are very rare with marijuana or hashish. What does happen is that people have panic reactions. They interpret it as a psychosis; they say they're losing their minds * * * but if you just reassure them, in a few hours they'll be OK."

That is a quote of Dr. Andrew Weil of the National Institute of Mental Health.

If there's a psychological disability, the drug tends to aggravate it * * * large doses cause acutely the same kind of psychotic break as with LSD * * * marihuana can cause what psychologists call an acute attack of hallucinations and delusions.

Another quote:

It depends whether you eat it or smoke it. Smoking is self-limiting * * * if you are to eat hash brownies, for instance, you have more likelihood of having a bad trip.

That is attributed to a Dr. Robert Petersen, and one doctor said :

We just don't know : "hash" is about eight or 10 times stronger than marijuana, but we don't even really know the exact effects of marijuana.

Senator HUGHES. Does that also comment on the policy of the administration on the Mexican border?

Mr. INGERSOLL. No. This particular article is an effort to analyze the increase, or discusses the increase in the use of hashish in the United States, and the great bulk if not all of the hashish that comes into the United States comes from the Middle East.

Senator HUGHES. I would like to enter that entire article in the record at this point.

(The article submitted follows:)

[From the New York Times, Sept. 17, 1969]

HASHISH FAD IN U.S. WORRIES OFFICIALS

(By Lesley Oelsner)

In suburban homes, city apartments and hippie pads, in communities from the Atlantic to the Pacific, thousands of American youths are turning on with a drug that for centuries has been associated by legend with hallucination, lassitude and ecstatic visions—hashish.

"Hash is everywhere," a 16-year-old user said as he puffed on a homemade water pipe. Around the country the police and parents and doctors agree. For the first time, they say, hashish has become a major element of America's drug subculture.

And because the authorities have no reliable data on the effects of hashish usage, they are becoming increasingly concerned about the seemingly vast, and growing, popularity of the drug, which is stronger than marijuana. It is a concern felt by families, health experts, local police, the Federal Government—and it is felt, too, even by some of the new young hash users.

"The danger of these drugs is that they're an easy way out from reality," said Dr. Bruno Bettelheim, director of the Orthogenic School of the University of Chicago. The user, he adds, "gets used to looking for this escape"—and "the younger the individual, the more dangerous" the usage.

Child psychiatrists, faced with increasing drug use by 14-and-15-year-olds, are especially concerned. For they fear the use by adolescents of any drug—from marijuana to hashish to LSD—hinders or even endangers the maturation process.

"I don't think a teen-ager can handle it—I think it's confusing, it's bewildering ; he's not ready for responsibility," said Dr. Nathan Stockhammer, director of the Early Adolescence and Young Adult Treatment Center of the William Alanson White Institute in Manhattan.

Hashish usage, he said, is—like sex and alcohol—a "very complicated experience" that an adolescent can't handle. "Psychologically, at 14, the person isn't fully organized. He hasn't had all the experiences that a 19-year-old has had."

No one really knows how many people are turning to hashish. But for months, customs officials say, half-pound bricks of hashish have been arriving through the mails and passing border checkpoints, concealed in two-foot-high wooden crucifixes, in plaster wall plaques and in the dufflebags of students returning home from European tours.

The United States Bureau of Customs has announced that it seized more hashish in the 1969 fiscal year than it did the previous year. The New York City office of the Bureau of Customs has estimated that every week at least 10 packages of hashish arrive here through the mails. And the Federal Bureau of Narcotics, in the space of six months, has seized more than 100 kilos of the drug in raids in five cities.

The young are turning to hash because this year the supply of marijuana has shrunk ; because hash gives, they say, a quick and pleasant high, and because, in the words of a high school dropout who works now as a clerk in a New York shop, "it's there."

"It's better than alcohol," said a 23-year-old welfare caseworker in New York. She paused for a moment, brushing her bangs from her forehead and then rubbing her eyes to put out the sting of the smoke coming out of her hashish-filled corn-cob pipe.

Then she continued, giving reasons that in past years other young people have used to explain their attraction to the milder drug of marijuana. "If I drink alcohol and get high, it last for five minutes and then I get nauseous. This way it lasts longer, and I don't feel sick."

Both hashish and marijuana, in fact, come from the same plant—the Indian hemp, or "*cannabis indica*," plants. Hashish is the dried resin of the plant, while marijuana is made from the stalk and sometimes the branches.

EFFECTS MAY VARY

A chunk of hashish about one inch square and a quarter of an inch thick costs \$35. It doesn't look like much—a clod of dirt found in the base of a tree, perhaps, or a piece of sod gouged from a parched lawn.

It doesn't taste like much, either—nothing more, really, than a hint of the household spice thyme.

But put tiny pebble of it in a pipe, or sprinkle a few crumbs of it onto a cookie. Maybe, like some who have tried it, the user won't feel anything but a slight drowsiness. And maybe, if it's "good" hash, if it is puffed or chewed for long and if the user is worried or unstable, he may panic and scream and say he's losing his mind.

Take it for a long time, day after day, year after year, and what will happen to the user is even more of a guess. Will his body and mind remain unchanged, as many of America's new young drug users insist? Or will the user become lethargic, apathetic, as doctors in countries with long histories of hashish suggest? No one really knows.

DETAILED STUDIES URGED

Faced with this lack of knowledge, the Federal Government is now reviewing two proposals for the nation's first scientific studies of the drug. The proposals, submitted to the Public Health Service by professors at New York Medical College, call for analysis of the short terms, as well as long-term effects of hashish usage.

"The big problem [in the United States] is the young acute hashish user—what will happen if he uses it for 30 years?" asked Dr. Max Fink, one of the professors who worked on the proposals. "As far as facts are concerned, I regret to say we don't have them."

Because the heavy use of hashish is so new to America, experts as Dr. Fink say, this nation's studies must be conducted in countries where large numbers of people have used the drug for decades. Studies previously made by inhabitants of some of these areas, such as India and Greece, indicate that prolonged use destroys the ability or will to work, but few experts here accept the studies as totally reliable.

One of the projected studies would involve investigation of marijuana as well as hashish. The other, would involve only hashish, and only the effects of long and heavy use. If conducted according to the present proposal, it would be an analysis of a group of about 200 people in Greece who have used hashish daily for several years.

"In most, and maybe all, countries where hash is used heavily, they do have a hashish equivalent of our alcoholic skid row," said Dr. Robert Petersen, chief of the Center for Study of Narcotics and Drug Abuse of the National Institute of Mental Health, a Public Health Service research facility in Bethesda, Md. "But whether this is strictly related to hashish is debatable."

VALID STUDIES SOUGHT

The foreign studies, he said, were largely uncontrolled and were not subject to the "strict standards of validity" used in this country.

Dr. Norton Miller, the institute's associate director for special and collaborative projects, declined to pinpoint the nation that might be studied or to predict whether the proposals would be approved. He did say, however, that the Government was "considering contracting for foreign studies."

For until these proposed studies, or others, are completed, the use of hashish will remain clouded by confusion far thicker than the spicy smoke that drifts languidly from burning cubes of hash. It is a confusion about not only the effects but also the making and even the definition of the drug, and it is a confusion felt by some of the city's and the nation's top law-enforcement figures.

Ask how hashish is prepared, for example, and a reporter gets answers such as these:

"Hashish is boiled marijuana . . . it takes 625 pounds of marijuana to boil up a pound of hashish."—John McCahey, deputy chief of the New York City Police Department's narcotics squad.

"They get the marijuana all dried, put it in burlap sacks and beat [the sacks] against the wall . . . [dust comes out of the sacks] and they pick up the dust and solidify it."—Carl Esposito, assistant customs agent in charge of enforcement at the New York office of the Bureau of Customs.

PSYCHOLOGICAL VIEWS DIFFER

"The whole plant, including the stalk and branches and twigs, is dried . . . it's carried into these small rooms. And in these rooms, which are lined with burlap, walls and floor and ceiling, they beat the plants into dust. The resinous content rises in the form of dust [and sticks to the walls] . . . It's scraped off, and compressed into cakes. The best grade is that which adheres to the ceiling, the next best is that which adheres to walls and that on the floor is the thinnest and cheapest."—Lawrence Fleishman, assistant commissioner of the United States Bureau of Customs.

Yet doctors who study drugs, though they concede that there are many ways of preparing hashish, say that the usual method is merely to scrape the resin from the top of the hemp plant and then compress it.

And ask whether hash causes paranoia, as some of its users have said, and you will get answers such as these:

"True psychotic experiences are very rare with marijuana or hashish. What does happen is that people have panic reactions. They interpret it as a psychosis; they say they're losing their minds . . . But if you just reassure them, in a few hours they'll be O.K."—Dr. Andrew Weil of the National Institute of Mental Health.

"If there's a psychological disability, the drug tends to aggravate it . . . large doses can cause acutely the same kind of psychotic break as with LSD . . . several milligrams of THC [tetrahydrocannabinol, the toxic ingredient of both hashish and marijuana] can cause . . . what psychologists call an acute attack of hallucinations and delusions."—Dr. Henry Brill, director of the Pilgrim State Hospital on Long Island.

"It depends whether you eat it or smoke it. Smoking is self-limiting. . . . If you were to eat hash brownies, for instance, you have more likelihood of having a bad trip."—Dr. Robert Petersen.

STRONGER THAN MARIJUANA

The fact is, one doctor said, "we just don't know; hash is about eight or ten times stronger than marijuana, but we don't even really know the exact effects of marijuana."

One reason for the uncertainty is the variety of hashish that is available. "It depends where it grows," explained Irving Lang of the State Narcotic Addiction Control Commission. "It depends how it's grown; it depends on the climate, the method of harvesting, the closeness of the plants—even whether it's a male or female plant."

Warm, humid climates, he said, generally produce the more potent brands of hash.

Still another reason for the confusion, is that some users mix hashish with opium, which is addictive. "We call the mix 'primordial goo,'" a youth said, "because it's wetter and stickier than straight hash."

What of the young American hashish users—the honor roll students and the high school dropouts, the Madison Avenue copywriters and the East Village teenyboppers, the Wall Street lawyers with pin-striped suits—what do they think of the controversy stirred by their latest choice of drugs?

For the most part, they simply don't care.

"Parents get all uptight about hash, but actually they probably really want to try it themselves," said a young serviceman home on leave. "It doesn't knock you out or make you insane. And you're not likely to get caught with it, because it's so small you can hide it anywhere—in a light socket, even in the top of a toothpaste tube."

DRUGS USED INTERCHANGEABLY

Many of the new young smokers and nibblers of hashish consider the drug no more dangerous than marijuana—just a bit stronger. They use the two inter-

changeably, taking whichever they can get. Taking what they can get, in fact, is one reason why so many people have turned to hash.

"There's been a drought on the Eastern Seaboard—no one has had any grass [marijuana] for months," said a June graduate of Barnard College, echoing reports of the Customs Bureau and the New York City Police Dept. One reason for the scarcity is a joint effort by United States and Mexican authorities to crack down on the smuggling of Marijuana into this country. Another reason, said Assistant Customs Commissioner Fleishman, is that Mexico had a bad crop of hemp this year.

But hash, according to Mr. Esposito of the New York Customs office, has been coming here from India via Israel, from Colombia via Miami, and from Vietnam via San Francisco. Although a variety of reasons are suggested for the increased influx—including Mr. Fleishman's "it's sort of the thing to do with this hippie element"—the most widely accepted reason is the ease of smuggling hashish.

A dosage takes up far less space than an equally potent dosage of marijuana. And though there are no official figures, a half-pound brick of hashish is also far more profitable to a seller than an equal amount of marijuana.

Experts agree that organized crime is not involved in the sale of hashish, according to John Enright, chief of criminal investigation for the Federal Bureau of Narcotics and Dangerous Drugs. "It's just a bunch of college kids going over to the Middle East and bringing it back," he said.

"FRIENDLY" TRANSACTIONS

The users insist they buy only from their friends or from friends of friends. They say, too, that all they have to do to get some is to make a few phone calls and then hand over the money. They admit hash is expensive—"5 for a 5-minute rare exception, they do not begrudge their seller his profit, since he is taking the major risk.

The penalties for selling hash are the same as those for selling marijuana. "The legal risks are pretty high," explained an employee of an advertising firm. "We had a guy at school, one of the students, who bought two cars and a house with the money he made from us. But I never heard anyone complain—we were all glad that someone was getting the stuff for us."

Rare is the hashish user who thinks he may suffer any long-term effects. But one young man, who started using hash two years ago, and who says everyone he knows uses hash, had this comment:

"I've seen a lot of people lose the achievement complex. It's not because of the drug itself—it's because the drug leads to an over-amount of thinking . . . there's an overdose of root thinking, which can kill anything, because everything has bad roots.

"It's bad, it's terrible. People are removing themselves from the rat race, and, like it or not, the rat race is what keeps the wheels moving."

Will he give up hash? "No," he said, "because I've got a lock on what I want to do. It's the people who don't know what they're doing who should give it up."

Senator DOMINICK. Just one more comment.

Some of my younger friends report to me that in the "village" in New York, you go to a party, and as you go in they have hash or pot on one side and drinks on the other and you just take your choice.

They are treating it that way, just as though it were nothing different.

So, the educational process, if there is anything wrong with pot and hashish, and it seems to me there is, as well as with alcohol, education hasn't gotten through.

Senator HUGHES. I notice you inadvertently referred to marihuana as a drug. You testified that it was not a drug earlier, did you not?

Mr. INGERSOLL. No, sir, I testified that it was not a narcotic. A narcotic has special characteristics which set it aside as a particular kind of drug. Marihuana is a drug, but it is not a narcotic drug, medically speaking. Is that correct, Dr. Lewis?

Dr. LEWIS. Yes.

Senator DOMINICK. That is all, Mr. Chairman.

Senator HUGHES. Senator Saxbe?

Senator SAXBE. No questions.

Senator HUGHES. I want to thank you, gentlemen, very much, for your testimony here this morning. I think it will be very helpful in considering this legislation before us.

Primarily, in my pursuit of the question, I want to make myself clear. I have no disagreement with controls. My pursuit of it is to try to place the total object in perspective in what we are doing.

I think we have created in this country an image that we can utilize widely one drug, alcohol, to almost an insensible reason we want to, and that is totally acceptable.

Yet, we have a younger generation on our hands who have said, "You have your drug, why can't we have ours?"

Unless we look at both of them in perspective, I think we are not doing a fair job of consideration and control in all of these areas of rehabilitation and education.

In my opinion, alcoholism needs more of this, probably, than the rest in the country, if we were to approach it properly.

Thank you very much for your testimony.

Mr. INGERSOLL. Thank you very much, Mr. Chairman.

Senator HUGHES. The Chair calls Dr. Helen Nowlis.

**STATEMENT OF DR. HELEN NOWLIS, PROFESSOR OF PSYCHOLOGY,
RESEARCH CONSULTANT ON STUDENT AFFAIRS, UNIVERSITY
OF ROCHESTER, ROCHESTER, N.Y.**

Dr. Nowlis, you may proceed with your testimony as you wish.

Dr. NOWLIS. Thank you, Mr. Chairman.

It is a privilege to be here and I think because of the peculiar experiences that I have had, that I may be able to help with some of the justifiable confusion.

I would like to start out by telling you a little bit about myself so that you understand the point of view from which I am speaking and I will tell you why in a minute.

I am basically a departmental psychologist, and for some 35 years have been involved in research on the growth and development throughout childhood, youth, and adolescence.

When I reached a certain stage, I become a college administrator, and served as a college dean. I was persuaded 3 years ago to take a year's leave of absence to respond to the felt need of the professional organization of college deans and vice presidents for student affairs, to learn more about what they perceived as a growing problem.

I thought that it was going to be like all other years' leaves of absence, that I would do a program, write a report, and go back to life as usual.

But events have dictated otherwise.

Within the past 3 years, I have spent a great majority of my time traveling the length and breadth of this country—I average about 80,000 miles a year—visiting institutions, school systems, conferring with all of the many disciplines that have something to say about this problem—with biochemists, pharmacologists, internists, anthropologists, psychologists, law enforcement officers, and so forth.

So I think I have an overall perspective on this, which, by sharing it with you, might help you a little bit as you continue your hearings.

This is a very complex problem. For too many years we have made the assumption that the problem was drugs.

Now, many of the things that I am going to say will be quite contrary to many of the things which Mr. Ingersoll, who is a friend of mine and with whom I have worked, has said.

I think you need to recognize that everyone who looks at this problem looks at it in terms of his own training, background, interests—indeed, his own philosophy.

When you do this, you get into a great deal of conflict, because of the complexity of the problem with which we are dealing.

Now, if I could assume, which I do not, that drugs as pharmacological agents were the problem, and if I could assume, as I do not, that the way to deal with the problem was to control those agents, I could agree with most everything that Mr. Ingersoll has said.

Now, one of the big problems here is the complete lack of understanding of what drugs are and how they act.

Actually, there is no such thing as a safe drug or a dangerous drug. And the factors that go into the response to a drug are very complex, and most of them, many of them, are nondrug factors.

As I try to explain this, you can think of alcohol as a prototype, because alcohol is a drug, and it obeys the same principle as all other drugs. I think you may understand a little bit the reason why we are in the difficulty we are, and why there is so much confusion in the scientific world, in the general public, and in almost every other area.

A drug, pharmacologically, is a chemical which interacts with a very complex biochemical system which is the human organism.

Now, we know a good deal about this biochemical system. We don't know nearly enough, and one of the most exciting frontiers of research is in the organism as a biochemical system.

Now, we know a great deal about this system. We know, for instance, that it varies from individual to individual. That is, varies from time to time in the same individual, that it varies with sex, that it varies with age, that it varies in sickness and in health.

So it doesn't make any difference to try to say that there is a given effect of a given drug, because this depends on many nondrug factors.

For instance, I am sure you are all aware that before a drug goes on the market a number of determinations must be made: The effective dose, the toxic dose, and the lethal dose, and all of these actually are statistics.

The effective dose is LD-50, that dose by which—not at which—a given effect is produced in approximately 50 percent of the people.

The same thing with the toxic dose, and the same even for the lethal dose.

The lethal dose of a drug is that dosage by which 50 percent of a group of animals die.

This means many died much sooner, and many survived much later.

So, until we put the person, biochemically defined, psychologically defined, and socially defined, into the equation of drug to behavior, we are just barking up the wrong tree.

Now, again, I remind you of alcohol. The response to alcohol depends first of all on the dose level.

Second, it depends on the physiological individual. There are some people who get high on a very small amount, and there are other people who cannot show the same substantive effects or behavioral effects until they have had a great deal more than the drug.

It depends on the meaning of the drug use for the individual.

So, what I am suggesting is that as you go around the country and talk to people, as I understand you intend to do, that you not search for answers to "What is the effect of this or that drug?" because there is no predictable, reliable effect.

The really important thing is to look at the use of drug, the meaning and significance of the use of the drug, and the effect of the use of the drug.

Now, the whole controversy about marihuana versus alcohol first of all depends a great deal on dosage, and, as has been already pointed out, when we try to determine strength of dosage, about all we have is the subjective report of people who have used it.

"This is good stuff; this is not good stuff. This produces a high; this does not produce a high."

We also have to, as was mentioned in the testimony earlier, recognize that the route of administration of the drug is extremely important. It makes a difference whether you inhale it, ingest it, or inject it.

The effect of some drugs we ingested is higher than the lethal dose of the same drug we injected.

So we simply cannot look for answers to what is a real problem by arguing about the effects of drugs.

We have to talk about the meaning and the significance and the effect on the total functioning of the individual of his decision to use the drug, how much he uses, the pattern of his use, and the period over which he uses it, whether he uses it in the privacy of his own world, or whether it is a social drug.

So, I would just urge you not to get too confused by reports, because you can pull out from the literature so-called effects of drugs on small samples, on specific types of people, at certain dosage levels, under some circumstances, and you can support any position you want for other reasons to support.

I think this is extremely important.

I said that I didn't agree with Mr. Ingersoll's definition of "drug," and I doubt very much if I agree with his definition of education.

It sounded to me a little bit as if he knew the answer on education, and from someone who has struggled for 3 years and who has been in contact with most of the other people who have been faced with this problem, we do not know the answer as to what is an effective education program.

One of the points in Senator Yarborough's bill that I would like to commend is the strong emphasis on creative approaches, and on evaluation.

For too long, we have been casting our bread upon the waters without knowing what the result has been, and some of us feel quite strongly that many of our efforts, instead of deterring, may even have stimulated some drug abuse.

We don't have the answers. I think we can find the answers, but it will take creative approaches, pilot studies which are carefully evaluated, and people who understand young people, who understand the education process, and who will tackle this problem.

There are a number of other things that I would like to speak favorably about in the bill. One is quite in contrast to Mr. Ingersoll. I feel very strongly that the major responsibility for this whole problem should rest in the Department of Health, Education, and Welfare. It should rest with the people who have the expertise and the experience in dealing with people in all of their aspects, not only medical, but psychological, psychiatric, social, sociological.

I feel very strongly that we are not going to get any simple solution from this.

I think it is extremely important that in the bill there is provision for the interdisciplinary development of materials and training personnel. I think that the provision for fellowship grants, for training of additional personnel is extremely important, and I would hope that this would be defined fairly broadly.

From where I sit at my desk, I have many requests for, well, for instance, a college dean of students who says, "I have a year's leave of absence coming up, and I would really like to become better trained and more effective in dealing in this area. Do you know where I can go?"

And my answer has to be, "No."

I see this as not only very important for dealing with addicts, but also at the educational level, and here, again, I think that the resources of Health, Education, and Welfare should be at the disposal of such a program, and that it should, indeed, be interdisciplinary.

I think that the sections dealing with the amendments to the Public Health Act, the Public Health Service Act, for research are extremely important. I feel strongly that a physician should be the one to determine the narcotic needs for the country.

I am particularly interested in the establishment of a national center for a broad approach to the whole drug problem, which will take its place alongside of the center for alcohol and alcohol studies, the center for suicidology and many other aspects.

Because I have become increasingly convinced that unless we put the problem of drug abuse in the perspective of a variety of other deviant, if you wish to use that term, behaviors, that we are missing the boat.

All of these are symptoms of basic problems and we must finally face some of those basic problems.

As long as we think that all we have to do is control drugs, we have a very easy way out from facing some very difficult problems.

In title IV, the control of the dangerous substances, I think the recognition that there must be discrimination among substances based on what we know, and not what we formerly believed, is extremely important.

I think the provision for flexibility in determining how these substances shall be classified is extremely important.

The modern era, the modern scientific era of understanding drugs and drug use is relatively recent.

For instance, the standard Goodman and Gillman textbook, "The Pharmacological Basis of Therapeutics" which was written by two men in 1954, they revised it 5 years later and in the third revision, it took 40 men to write it, because so much has been added to our knowledge of drugs and I used the term very broadly, to include prescription drugs, over-the-counter drugs, so-called drugs of abuse.

So much has been learned, not only about the drugs, but about this complex biochemical system with which they interact, that the book now really needs to be revised every 3 or 4 years, and an increasing number of experts need to be involved in it.

It is a very fast-growing field, and I think we can no longer afford to base our thinking, our education, our action, our laws, on what we used to think we knew, rather than what we now know.

This, again, is a very exciting area of research.

I would also like to speak to the Advisory Council, particularly in view of some of the remarks that Mr. Ingersoll made. I think a scientific advisory council for the Secretary of Health, Education, and Welfare is extremely important, but I think we need another kind of council which would be in close touch with the advisory council, and that would perhaps correspond to the council which Senator Williams has proposed in his bill, where all agencies in the Government are forced to come together and to face and to think through their efforts, their decisions, the law enforcement practices in a total context.

Here, perhaps, would be a good place for me to point out that among many other things I am president of the National Coordinating Council on Drug Abuse Education and Information, to which Mr. Ingersoll referred, and if I may, I would like to put into the record a description of that council.

It is not quite as simple as it was reported.

It is a young organization, a new organization, which represents not only everything from the American Legion on to the Boy Scouts, but includes the American Medical Association, the American Psychiatric Association, the American Sociological Association—all of the professions which have an interest in this area.

I would like to end the formal part of my presentation with a plea: As I read the bill, except for the shifting of marihuana from the class and control as a narcotic to control as a dangerous drug, I see no basic change in the basic assumption that law enforcement and criminal penalties are the way to deal with this problem.

I feel very strongly that as long as we maintain criminal penalties for possession, that all of our efforts at research, at education, at rehabilitation, and at treatment will be hampered.

I can expand this later if you would like me to.

I am very naive about legislative processes in government, although I am learning, and it is conceivable to me that one bill would be introduced and referred to one committee, and another bill, which is so important in terms of the implementation of the other bill, would be considered separately by another committee.

Now, I have been told that this is necessary; this is the way it is done. So my plea to you would be, as Senators who will eventually be voting on the other bill, and as Senators who can perhaps influence some of your colleagues, to be very much aware of the fact that what is done in the Judiciary Committee and with the bill that they report out will have a tremendous effect on the implementation and the effectiveness of the bill which you are reporting out.

I could say lots more, but I think perhaps responding to questions, if there is still time, would be more helpful.

Senator HUGHES. Does that conclude your statement, Dr. Nowlis?

Dr. NOWLIS. Yes.

Senator HUGHES. I might just as a matter of information say that this particular bill was researched and brought up this way to make sure that it would not go to the Judiciary Committee.

Dr. NOWLIS. I understand, but what I am pointing out is that what the Judiciary Committee does is terribly important.

Senator HUGHES. We understand that. Of course, the one bill that gets to the floor of the Senate would be the vehicle on which probably the rest of the matters that are included in the other will have to be attached and then debated as a total.

Dr. NOWLIS. But could it work the other way around, since the other bill is the administration bill?

Senator HUGHES. That is why I am here today.

Dr. NOWLIS. That is what troubles me.

Senator HUGHES. That is why I am here holding these hearings that I had not scheduled until later in the fall.

For the research that we need to do as a committee, we need a vehicle of legislation, and this is the best proposed vehicle of legislation in my opinion. So, as chairman of this committee I am holding hearings on this legislation in order to use it as a vehicle to continue our pursuit of more information.

Dr. NOWLIS. I feel the other bill, as it now stands, if it is passed, that you might just as well forget it.

Senator HUGHES. I will never forget it.

Dr. NOWLIS. I hope not.

Senator HUGHES. We appreciate a very enlightened statement and discussion of the area, and my administrative assistant just brought to my desk this morning your book on the subject matter. I have had a brief opportunity to glance over your background and your familiarity with this subject, and I deeply appreciate the things you have said, particularly as you understand the controversy so strongly—the jurisdictional battle that is going on concerning legislation of this type, between the Department of Justice, which would be deprived of areas they feel should be exclusively theirs, probably, and the bill which would substitute the Department of Health, Education, and Welfare in it.

I would like for you, if you will take the time, to expand on your statement that criminal penalties for the use of marihuana and drugs are certainly no solution to the matter, and what you would recommend? You say it hinders the research?

Dr. NOWLIS. Yes, and may I make an aside?

Senator HUGHES. Yes, please do.

Dr. NOWLIS. I think too many people assume that the research that is needed is laboratory research, and I would point out to you that we do research with a drug in the laboratory: if you want to say anything about the drug at all, you must control all of the nondrug factors.

So what we need is not research in the laboratory. We need research in the field. We need to be able to study the people who choose to use drugs, why they choose to use them, the pattern of use.

It is quite interesting that some of us are feeling more and more that many of the students, particularly at the college level, who get involved casually with marihuana or perhaps LSD, decide somewhere within a year or year and one-half that it really isn't what it's cracked up to be, and that it can be quite unpleasant, and that there are better ways to have fun.

So, that there definitely is—we see it quite regularly, although I don't have hard research data to report—that there is a maturing out, but we need to study people using drugs.

We don't need to study drugs in the laboratory, because I can take almost any drug, and if you will let me choose the dosage level—and I am not talking about lethal dosage—the subjects and the set and setting in which I administer it, I can produce almost any behavior you wish to specify.

In some cases, I can do it with a sugar pill, because the nondrug factors are so much more important than the moderate dose level of the drug as a pharmacological agent.

Now, if you want to study people who use drugs, if you accept my premise that this is the kind of research that we need to do, you are asking us to study people under conditions where they must admit that they have committed a felony.

As my husband and I both have counseled with, and done research with young people using drugs, we finally faced a very difficult decision, and that was that in order to get the information we needed to have, in order to be trusted, we had to guarantee confidentiality.

We had to guarantee it to the point where we, between us agreed, that we would face contempt rather than betray a confidence.

Now, let me give you another example: there is a survey of high school student drug use, which was done a year and one-half ago in California—it was a very careful survey; a very comprehensive questionnaire was used, and when they came to analyze the data, two questions were blank on one-third of the respondents, and the two questions were: "Have you used marihuana? Have you used LSD?"

These are the keystones.

This is the variable on which you look at all the other information you have.

Now, in research you always get some "no" answers, maybe 1 percent, and you make the cavalier assumption that if they had answered probably half would have said "Yes", or "No" and you divide the data and go on merrily, but you can't do this with a third of your population.

So, I think we cannot do the kind of research that needs to be done as long as we are dealing in an area which requires the person to label himself as a felon.

This applies in treatment. We simply do not get to young people who are truly abusing drugs early enough to be of real help, and I would comment on statements that were made this morning on this question.

They were talking only about the Federal law, and you must realize that almost all drug prosecutions are under the State law and the State laws are even more barbaric than the Federal laws, even going so far as the death penalties for selling, and I hope you realize that "selling" legally means "give" marihuana to a minor, and this then becomes defined as if you have passed your 21st birthday and the other person has not.

Under conditions like this, one must also realize that the laws and the enforcement of the laws are a form of communication with the general public, and right now the level of panic that is abroad in parents is preventing them from communicating with their sons and daughters, from dealing constructively with their sons and daughters.

I get anonymous phone calls saying, "You don't know me. I read in the paper a report of a talk you gave. You sound like a sensible person. I think my daughter, who is a student at a prominent college, is using marihuana. What can I do?"

Should I turn her over to the police?"

You say, "Have you talked to her about it?"

"Oh, no, I couldn't. It is too terrible," is the response you get.

This is not helping the so-called generation gap. It is putting up a barrier that is making it almost impossible.

I talked with one young man who sought me out. I had never seen him. It was in another State. He felt that his drug use was a problem, and he wasn't smoking marihuana or using LSD, he was using amphetamines, in excess, because he was convinced that it helped him get better marks.

But he was worried. Incidentally, he had lost 40 pounds.

I said to him, "Haven't you talked with your family?"

"My father banged the table the first time I mentioned drugs and said, 'Drugs will not be mentioned in this house'".

So, here I come from 2,000 miles away, and he said, "What am I going to do?"

We must communicate something different to the general public.

Senator HUGHES. It has also inhibited the investigations of this committee, I might add, and all governmental bodies that really hope to have an open mind on the subject.

Dr. NOWLIS. It is terribly important on the drug education issue, because if school systems try to begin to cope with this problem, members of the community—in one community, at least, there was a court injunction forbidding a program on drug abuse education.

So, we can't do honest education, we can't do effective education, we can't do research, we can't get to people who need treatment early enough, as long as we have these constraints and these constraints reinforce almost medieval contempts of drugs in the mind of the general public.

It is a very frustrating business.

Senator HUGHES. I share that frustration with you. If I compared my mail with yours, it would probably be the same already. Hundreds of thousands of people have poured in emotional inquiries. I can almost tell at this point, when people come to me for information about marihuana, whether they are using it, or their sons or daughters are using it.

I spoke recently to a group of about 200 adults, who are mostly friends, and a half a dozen of those people approached me afterward with concerns. They knew that their children were experimenting with marihuana, particularly, and were scared to death.

They didn't know what to do about it.

Dr. NOWLIS. I have this experience on the average of once or twice a week.

Senator HUGHES. It is a shattering thing to realize that in a great and supposedly free democracy like ours that we can't intelligently discuss this matter openly.

Until recently, as I am sure you know, a politician dare not enter this subject with an open mind.

Dr. NOWLIS. It is still a hazard.

Senator HUGHES. I want to thank you for being here, if that concludes your testimony, for sharing your knowledge.

Particularly, I appreciate your testimony in this field, and I feel it will be valuable to the subcommittee.

Though the other members are not here, for one reason or another, they will have available to them your testimony, and it will be considered.

Dr. NOWLIS. As you make plans to move around the country, I would be very happy to make available the names of people who had long experience and deep concern in this area, if it would be of any help.

Senator HUGHES. My staff will undoubtedly be calling you.

Thank you very much.

Senator HUGHES. The Chair will recess for about 5 minutes. The last witness isn't here yet.

(A brief recess was held.)

Senator HUGHES. We will reconvene, and the Chair calls Judge Charles W. Halleck.

Judge Halleck, you may proceed with your statement as you desire.

STATEMENT OF HON. CHARLES W. HALLECK, JUDGE, DISTRICT OF COLUMBIA COURT OF GENERAL SESSIONS, WASHINGTON, D.C.

Judge HALLECK. If I may, Senator, advise you that I was just a few moments ago asked to come up here and share some of my thoughts with the committee, which I am only too happy to do.

I must apologize to the committee for not having had an opportunity to prepare a statement, or to really go into this matter so that I could come here and give you some sort of orderly presentation.

I do feel that I may be able to give you some statements which may be helpful to your investigation, and for that reason I left the court to come up here.

I think, Mr. Chairman, that perhaps the most valuable thing that I can share with you is some of my experience as a judge in the District of Columbia in the court of general sessions, as it relates to the problem of the narcotics offender, the use of narcotics, and what does or does not happen.

I believe that just recently there has been released by the Department of Corrections the results of a study which it undertook which indicates on an incomplete sampling that in excess of 50 percent of those persons coming into the District of Columbia jail who were willing to submit voluntarily to urinalysis were found to have used hard narcotic drugs in the 48 hours preceding their entry into the jail.

Senator HUGHES. Fifty percent?

Judge HALLECK. I believe it is in excess of 50 percent, Senator.

It is my understanding that the program was undertaken on a voluntary basis. Therefore, anyone who did not wish to provide the urine sample was not required to do so, and I think we can only assume that those persons who were involved with heroin and did not want that fact known would refuse.

Therefore, I think that the figures, based upon the sample that was used, are probably, as a practical matter, on the low side, extremely conservative.

It has been my own experience, Senator, that of those persons involved in criminal activity that come before me and through my

court probably 75 percent of them are involved with hard narcotic drugs.

It is, as I think we all recognize now, an epidemic problem, and one which can no longer be ignored or swept under the rug.

For myself, I am convinced that it requires immediate and extensive action, not talk—action.

We have come to a point where I don't believe we can any longer afford to discuss it, to appoint committees to study it, to thrash it out, to have reports written and come back. I think the cold, hard facts are before us, and particularly in the District of Columbia, that unless we move, and move now, the thing is going to get completely away from us.

I am on a subcommittee of the court of general sessions, made up of three judges, which is concerned with working with our Probation Department. Our Probation Department is beginning to think in terms now of attempting to set up some sort of a separate unit, or a separate program to deal with individuals referred to them who have narcotics problems.

The biggest problem that we face in attempting to do something is to find the money for it. It is going to take a lot of money, and it is going to take a big appropriation, and I suppose that we may get to the point where we have to look around to some outside funding to help.

Now, to my way of thinking, Senator, that comes under the heading of a real shame. Every program that I know of that has sought to do something in the District of Columbia with the narcotic addict, to face the problem of the addict and his criminal connection has run head on into funding problems.

The first and foremost concern of everybody is, "Can we get any money, and where can we get it?"

The programs that are available and the things that are being done in the District right now are in a completely fragmented state.

Because, Senator, each one of these little organizations, each one of these little drops in the bucket, as it were, is operating independently, on their own, with their own funding, their own little program, their own little idea, and there is to a certain extent some professional jealousy among them.

There is some overlap, and there just is no coordination.

Our entire Department of Corrections is understaffed, underfunded, antiquated, and is struggling against impossible odds simply to keep the lid on, so that the riots don't tear it all apart and burn it down.

There is no money available, and no funding available for meaningful programs for the addict within the Department of Corrections and within the prison system.

Where does that put us? Where does it put me as a judge? Where does it put me when 75 to 80 percent of the people who come before me are involved with narcotics? Deciding who is guilty and innocent is the least of my problems. That can be done, or the jury does it; but the real problem for the concerned, thinking jurist comes when he has to decide what to do with the individual who has been convicted of something.

At that point Senator, I don't have any meaningful options in the District of Columbia when it comes to dealing with an individual who has a narcotics problem.

Let me give you an example of one of the options I thought I had: It just came up today, and I brought the paper with me. You are familiar, I am sure, with Public Law 89-793 of the 89th Congress, passed in November of 1966, called the "Narcotic Addict Rehabilitation Act of 1966."

Under title II of that act, a judge may commit to the custody of the Attorney General a person that he believes is an eligible offender and an addict.

The idea is that the individual shall be sent to one of the facilities, in our case usually at Danbury, where he will be examined for a period of 30 days, and a report sent back indicating, No. 1, whether he is an addict, and, No. 2, whether he is likely to be rehabilitated through treatment.

On July 17, 1969, I ordered Melvin Alphonso Lucas, who was convicted of the crime of petit larceny, a crime for which he can only receive a maximum of 1 year; committed for study, evaluation and report under title II of the Narcotic Addict Rehabilitation Act.

Our clerk's office on that same day, July 17, issued an order of commitment to the Attorney General of the United States to receive into his custody Melvin Alphonso Lucas, committed for examination pursuant to title 18, section 4252, to determine whether he is a narcotic addict, and whether likely to be rehabilitated through treatment.

The matter was continued, not 1 month, but 2 months, to September 17, for a report.

September 17 came, Senator, yesterday. I looked for Melvin Alphonso Lucas, and the report back from Danbury.

Melvin Alphonso Lucas is still down at the Lorton Reformatory. He has never even been sent to Danbury; let alone examined, and the report back, Senator.

What good is an act, what good is it for the U.S. Senate and the Congress in their infinite wisdom to pass an act like the Narcotic Addict Rehabilitation Act that looks so good on paper if, when a judge sends some poor man who needs help to the Attorney General to have him sent up to Danbury and 2 months later he is still sitting in prison?

We as judges, Senator, are in the midst of bankruptcy. Once I commit an individual to the Attorney General pursuant to that act, I cannot make them take him up there. Now, what is going to happen in this case?

He has been down there in jail. Even if the report comes back that he is an addict, the report is going to say he cannot be rehabilitated because they must have at least 3 years to work with him.

Now, what this means, Senator, is that this act is effectively denied to the judges in the court of general sessions, because we deal presently with misdemeanors.

Narcotics addicts are notoriously arrested for misdemeanors, shoplifting, breaking into cars, and theft.

In many instances, they are arrested for robberies and pocketbook snatching, but because of the tremendous press of cases, those actions are prosecuted as misdemeanors.

Senator, it has been estimated that there are literally thousands of addicts, hardcore heroin addicts in the metropolitan area of the District of Columbia. A figure that is kicked around a lot runs near 10,000.

If each one of them has a \$50 a day habit, and that is a cheap habit, and that is 7 days a week, 52 weeks a year, we are talking about the need to obtain a half million dollars a day for those people to pay for those habits.

My experience indicates that the market for stolen property is glutted, so that now an addict probably has to steal, if he is going to steal merchandise, between six and eight times the value of his habit. That is between \$3 and \$4 million a day in stolen goods.

Now, when we look at it that way, it is incredible to me that the public, be it the taxpayer, or the Senate, or the Congress, or the D.C. government, or whoever else it is, is unwilling to put out the funds necessary to attempt to deal with this problem at its source, because to fail to deal with it effectively now simply means that the matter continues to grow and to snowball.

We had 707 armed robberies last January in the District of Columbia—armed robberies. That doesn't count pocketbook snatching and so forth.

In July, if I recall the figures, it showed 714.

When you are dealing with 700 armed robberies a month and a concomitant number of murders and rapes and burglaries, the police department has got to spend its time trying to solve these serious crimes, and when it gets down to these lesser things that are committed by addicts day in and day out, there simply isn't enough equipment, nor enough policemen, nor enough wherewithal to catch them.

It seems to me a mistake to put the emphasis on catching the addict committing these crimes. If you catch him, there is nothing you can do with him, except send him down for a few months or a year, to a jail, which is nothing short of a barbaric hell hole.

Senator, I have had reports from the Probation Department, from defendants who have been convicted of crimes before me, who have prior records and report they are addicts, that their first experience with heroin came at Lorton or at the District of Columbia jail.

It is easier to get drugs in many instances in the jail than it is on the street, and I cannot for the life of me understand why the Department of Corrections can't halt the influx of drugs in the jail, unless, Senator, unless the influx of those drugs is being aided, abetted, or committed by jail personnel—guards, institutional people.

The jail is no place to send people who are addicts. We must make a distinction between the pusher or those individuals who were involved in the importation, distribution, and sale of narcotic drugs primarily for profit. We must distinguish between them and the addict who buys it, who has it for his own use, or who is forced into the penny ante first level buying and selling in order to support his own habit.

The former category should be searched out, should be discovered, and should be prosecuted with a vigor second to no other crime in the United States. The latter should be treated.

Senator, our probation department doesn't have the funds, doesn't have the facilities, doesn't have anything to do for a narcotic addict except for asking him to go to DATRC, or asking him to go to some voluntary program. That doesn't solve anything.

Putting an addict in jail doesn't solve anything, because until they get sufficient funds and sufficient programs within the Department of Corrections to do something for the addict, all we are doing is putting

him in cold storage and putting him into an environment which is brutal at its best, and barbaric at its worst, in which drugs are readily available, in which those not accustomed to drugs are introduced to it for the first time, and in which, while he is down there, he takes part, if you will, in a finishing school for crime.

If he doesn't know where the connections are and where to get the drugs when he goes in, he sure knows when he comes out.

We have got to find some better way of dealing with addicts, and we have got to find some better way of enforcing our laws against the serious peddlers and the serious profiteers who are poisoning the mainstream of our American life for profit and gain.

It is the hustlers, the pushers, and the criminal element who ride up and down the streets in the cities' ghettos with an aura of success.

Why is it that the black child measures that as success? Because all he sees out of television is constant emphasis upon what he has got to have.

He sees all these beautiful people whose apparent measure of success is how much they have in terms of material goods, because the makers of the material goods are sponsoring the programs, and they are trying to sell merchandise; and in selling merchandise they are trying to convince everybody that the only way to be somebody is to own "my" product, and it all makes sense.

After all, they are trying to sell something. The way to sell it is to make somebody want it.

But what happens to the young fellow who is motivated to want it? He either gives up completely and turns to crime or drugs as a method of retreat, as a method of finding another out, of opting out, or he turns to crime in order to have those things.

He steals color television sets because he can't buy them. Nobody's family is worth anything if they don't have a color TV.

Look at television the month before Christmas during the day when kids are usually watching. There is nothing on there except the hucksterism directed to kids to have every kind of expensive toy in the world, and you are nobody if you don't have it.

It is no wonder we drive our ghetto dwellers, or hopeless people, to drugs and crime.

But we have got somehow to teach the people who live in our urban areas, in our cities, that there is a better way, and show it to them and prove it to them if we are going to stop the epidemic plague that we call drugs that preys upon them.

The other side of the coin is the Georgetown type, our suburban areas, where drugs have become the "in" thing. It is experimented with and used.

I suppose that honest medical people who have made some investigation will say frankly, if they will be honest, that the father who sits in the house lecturing his 17-year-old son about smoking a couple of marihuana cigarettes while he is finishing his third martini is probably poisoning himself medically and physically worse than his son is by smoking a couple of marihuana cigarettes.

The parent who has a pocketfull of tranquilizers to go to sleep, and pep pills to wake up, and diet pills to lose weight, and all the other pills that they pop into their mouths day in and day out, and then

his children, "Don't get involved with drugs, they are bad for you," demonstrates hypocrisy at its worst.

Marihuana, in my view, should not be legalized, but it should be dealt with in about the same category in most instances as some form of disorderly conduct.

It should be treated as an extremely minor offense when all it involves is a college kid or a high school kid smoking a couple of marihuana cigarettes, or passing a couple to somebody else.

You should not ruin a young man for the rest of his life when he gets involved with a couple of marihuana cigarettes, particularly when we know their use isn't as bad as drinking a couple of martinis or a bourbon.

You spoke several days ago, Senator, and I believe you referred to the present laws relating to marihuana and the penalties that accrued to what is really a minor offense as being barbaric. I think that is the word you used.

I couldn't agree with you more.

Let me tell you what happens to me, the situation I find myself in in my court as a practical matter, relating to this marihuana problem.

Now, I get some 19- to 20-year-old white, long-haired, gentle, soft-skinned, nonviolent young boy in my court convicted of a misdemeanor for possession of marihuana.

In the first place, when he comes in the first time, if I set a bond he can't make, I know that before he even gets down to the jail on the bus, he probably will be raped homosexually at least twice, and forced to submit to acts of sodomy, on the bus that the marshal is driving.

If I send anybody like that to the jail even for 30 days, Senator, he is going to be the victim of the most brutal type of homosexual, unnatural, perverted assaults and attacks that you can imagine, and anybody who tells you it doesn't happen in that jail day in and day out, is simply not telling you the truth.

I recall a recent case, and I shan't mention the name, and I won't be too specific, because I wouldn't want to identify anybody.

Growing out of a demonstration, a demonstration that evidenced certain political views that were not perhaps popular with the vast majority of people, a young, very gentle, noncombative white man was sentenced to jail for 60 days.

About 90 percent of the jail population, Senator, is black, and they are young, and they are angry, and they are mad, and they are mad at the white establishment. They are mad at all white men, because they see them as responsible for their being in the jail, for their frustrations and their anger.

Most of the guards, most of the people who work in that jail, Senator, guarding the prison population of about 90-percent urban ghetto blacks, are recruited from southern Virginia, and they are white.

There could not be a more conflicting situation.

This young man went down there. When he came out, I understand he went into the hands of a psychiatrist. I saw him several months ago walking on 17th Street and, Senator, I didn't recognize him.

I heard through reliable sources that the guards in that prison, in that District of Columbia jail, so disapproved of this young man because of his political views, they were so at odds with him because of their background and their character, and from whence they come,

they so totally disapproved of him, that they were not willing to lift a hand to save him.

He was in a dormitory, and one night 25 or 26 blacks set upon him and for the entire night they raped him, homosexually assaulted him, forced him to commit sodomy, over and over and over again, and he screamed for help until you could hear it out on the street, and nobody lifted a hand to help him.

How in God's name, Senator, can I send anybody to that jail knowing that? How can I send some poor young kid who gets caught by some zealous policeman who wants to make his record on a narcotics arrest? How can I send that kid to that jail?

I can't do it. So I put him on probation or I suspend the sentence and everybody says the judge doesn't care. The judge doesn't care about drugs, let's them all go. You just simply can't treat these kinds of people like that.

If you are going to, then you have got to do something about that prison system. I have no place to send a narcotics offender, a narcotics addict for help. There are no programs, there is nothing available for me as I sit there as a judge. The prison system is hopeless. I can't get any help for anybody and all I can do is sit there and see archaic unrealistic laws resulting in the conviction of people, some of whom should not be convicted, some of whom are convicted for serious crimes when they shouldn't be and then sit there and torture myself when it is over about what I am going to do.

Senator, one of the things we need in this country in relation to this drug problem is some straight honest talk about what these various drugs are, what they do, what the evils of them are or the lack of evils of them are, so that the kids that we talk to, be they out in suburbia or in the ghetto, can get level information and can assess and evaluate what it is that will happen.

When we do that, and when those people in a position to explain what is going on tell it like it is, then the young people are going to believe us when we tell them about the dangers of speed and about what heroin will do to them and when we show them examples of heroin addiction and what it means to them.

I am afraid, Senator, I have probably talked much too long and covered subjects you are not interested in, or maybe you are. I am not sure what the extent of your inquiry is.

The only thing I can say to you, sir, is that as one jurist at the bottom of the ladder in the District of Columbia, I am concerned. I think I have got a bigger conscience about this problem and a greater feeling of helplessness and frustration than most of the people in the District of Columbia. Senator, I have to sit down there with this bankruptcy around me, with these unsolved problems and with the future of this city, this country at stake.

If you will, I have to "play God" with people's lives day in and day out. I don't have anything to offer the addict.

Now I will be glad to answer any questions that you might have or to try and make any suggestions I could; or if you would like, I will get any further information and submit it later.

Senator HUGHES. Judge Halleck, I appreciate very much your taking the time to come over and to inform the committee of your experiences in the courts here in the District of Columbia, and particularly

to, I think, somewhat dramatize for us the seriousness of the problem in your court in this great Capital City of ours.

I can understand your very deep personal concerns in the capacity you hold and your hope that certainly the Congress of the United States as well as the various States in this country will begin to recognize this problem and the semblance of truth of what it is.

I think you have covered about every section or area I could want covered here today in your statement. I simply want to express on behalf of myself and the committee my appreciation for the fact that you are willing to come and testify before us.

Thank you very much.

Judge HALLECK. Thank you, Senator.

Senator HUGHES. The committee is going to recess for a period of 30 minutes and reconvene at 2:30.

(Whereupon, at 2 p.m. the subcommittee recessed, to reconvene at 2:30 p.m. on the same day.)

AFTER RECESS

(The subcommittee reconvened at 2:30 p.m., Senator Harold E. Hughes, chairman of the subcommittee, presiding.)

Senator HUGHES. The committee will come to order and the Chair calls Dr. Henry Brill.

Dr. Brill, if you will, be seated with your colleagues and introduce them properly for the record, please.

STATEMENT OF HENRY BRILL, CHAIRMAN, AMERICAN MEDICAL ASSOCIATION COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE; AND DIRECTOR, PILGRIM STATE HOSPITAL, WEST BRENTWOOD, N.Y.; ACCOMPANIED BY HARVEY PETERSON AND PAUL DONELAN, ATTORNEYS, LEGISLATIVE DEPARTMENT, AMERICAN MEDICAL ASSOCIATION

Dr. BRILL. Mr. Chairman, I am Dr. Henry Brill of West Brentwood, Long Island, and I am chairman on the Committee of Alcoholism and Drug Dependence of the American Medical Association's Council on Mental Health. With me are Mr. Paul Donelan, on my right, and Mr. Harry Peterson, attorneys in the legislative department of the American Medical Association.

We are pleased to respond to the committee's invitation to present views of the American Medical Association on the subject matter before you and we regret that in the short period that was available to us we were not able to prepare a formal statement for your consideration. However, on a preliminary examination of S. 2608, we would like to offer the following comments:

We are in full agreement with the flexibility of the program of this bill and with the findings in the bill that narcotic addiction and drug abuse are a major health and social problem affecting a significant proportion of the public and that much more needs to be done by public and private agencies to develop effective research and control.

We supported the enactment of the narcotic addict rehabilitation provisions of the Community Mental Health Centers Act when it was considered by Congress. We note that the bill now proposes what appears to be a significant modification of the operating, staffing, and

maintenance grants. But we shall not comment on this aspect, because it is now under review by the association.

We support the provisions for training programs and educational programs fully. We are particularly pleased with the provisions relating to the development and evaluation of programs of drug abuse education directed to the general public, school age children and special high-risk groups.

We are in favor of broadening the forces of research within Health, Education, and Welfare to include the entire range of drugs of dependence and the establishment of a grant program to implement this policy with respect to all aspects of drug dependence.

As to the provisions establishing a national registry of narcotic addicts and creating regional research centers, the association is presently reviewing these parts of the bill and again we will not make a comment on that because they are under consideration.

We are strongly in favor of the philosophy of the bill which calls for a comprehensive code which makes the necessary distinction among all drugs of dependence with respect to the degree of control which they require and which distinguishes between medical and scientific use, on the one hand, and abuse, on the other.

We further believe that the Secretary of Health, Education, and Welfare is in a favorable situation to provide for the necessary basic studies to evaluate recommendations for classification of the drugs.

A minor and almost editorial point is the terminology proposed for describing marihuana. The bill would declare marihuana a depressant or stimulant drug. This would serve legal and administrative purposes, but if possible it would be better to use the medical classification and to classify marihuana with the hallucinogens since it is a diluted hallucinogen.

If I may say something extemporaneously, it is unfortunate when the medical and legal meanings of words diverge. We have seen this with respect to the word "narcotics." It has created testimony confusion, and if possible, we would favor not having a medical and legal meaning diverged.

An area of serious concern is that of research establishments dealing with narcotics or marihuana and apparently limiting registration to establishments, per se. We question the advisability and the necessity of this additional limitation on research.

From our reading of the bill, and it is a preliminary reading, it appears that a physician who may now order a narcotic for a clinical use will no longer be able to use such a drug for animal studies. In other words, even under the new bill a physician could order a drug for a clinical use, but he would no longer be able to use it in research for animal studies or even chemical studies.

We would favor continuation of the present practice of allowing either an individual or an institution to be registered and would point out that this area of concern includes a number of drugs other than marihuana and narcotics, for example, LSD would somehow have to be provided for in this new system.

We believe the present legal and administrative practices provide adequate controls in this area.

The bill provides for the transfer of certain authority from the Attorney General to the Secretary of Health, Education, and Wel-

fare, and we believe that the designation of the depressant or stimulant drugs and other medical determinations should properly be within the Department of Health, Education, and Welfare, and we support the provisions to accomplish these purposes.

Mr. Chairman, we would be happy to respond to any questions which you may have.

Senator HUGHES. Dr. Brill, we had some testimony from the Attorney General's office this morning in which they indicated at least one problem they had was control of research facilities. You mentioned in your testimony the restriction of these research facilities which you felt was a handicap in doing adequate research.

Could you expand on that, perhaps, and the administration's bill also, regarding research problems in the Attorney General's office?

Dr. BRILL. I think the justification for control is the possibility that such drugs may be diverted to nonscientific purposes or that in humans work standards might not be met.

Those are the two basic reasons for control. I am not aware that bona fide research has given rise to any diversion. I think it is important that there should be knowledge of the research that is going on with respect to this particular group of drugs, but when one begins to pile up a series of cumulative restrictions on the ability to do research with specific chemical agents, it can eventually stop all action.

Because there is a series of requirements which have to be met and if anyone of them is not met, the research can't be done.

It is in the field of marihuana research that this has been most obvious. I think that as a matter of principle the channels for research should be simplified as much as possible consistent with control of diversion and with good standards, because a great deal of research is chemical research in a laboratory. It does not even involve animals. A lot of it involves botanical work, biological work on unicellular animals; and then, of course, there is animal research all of which does not involve anything more than small amounts of drug and reasonable protection against diversion.

I am reminded that you also probably had in mind the recommendations that HEW carry out research in this field. I feel that this is a very important part of their task; the research that they carry out directly and the research that they support by grants in research institutions throughout the country.

This, incidentally, is the official position of the American Medical Association.

Senator HUGHES. Without wanting to penetrate the areas that you have still not formulated an official position on, it is rather difficult for me in a couple of these areas, but I still want to ask some questions around that subject matter.

Have you reached any conclusions in the field of human research or do you recommend conducting human research in the field of marihuana and if so, under what type of controlled conditions? I am getting the terms mixed up myself, Doctor; that is the problem we have with this subject matter.

I use "narcotic" in connection with marihuana and I guess it is not a narcotic.

Dr. BRILL. Legally it is; medically it is not.

Senator HUGHES. Which again sows the confusion we are talking about in clarifications of terminology. But anyway, we had some testimony this morning that the conditions under which people use narcotics need research since the conditions and the reactions of a narcotic can be stimulated depending on the circumstances, the setting of the scene, the backgrounds of the individuals, and dozens of other things.

In fact, some research has induced reactions with a sugar pill almost identical to those of the real narcotic involved. Would you care to comment on that in the field of research? How can we do it unless we in some way alter the structure of law and control?

Dr. BRILL. I first would like to confirm the tremendous influence of expectation on the effects of drugs of all types, but particularly the hallucinogens. In my own experience, we worked with LSD in the early 1950's, and there was nothing then which would have led us to suspect that this drug could become attractive as a drug of dependence.

It was used to produce what we considered a model psychosis; an imitation psychosis for study and treatment. So the expectation is enormously important and the opportunities to control the situation are, of course, crucial in many kinds of study.

I think that the kinds of control that have been established with respect to human studies with all kinds of pharmacological agents are enough for these drugs. The Helsinki Declaration is one embodiment of this series of principles. I believe that we already have regulations and practices that are sufficiently well developed for other kinds of drugs to control these specific drugs.

I don't think they require additional special controls. That is my own personal opinion. I do not speak now for the association.

Senator HUGHES. I would like to ask you for a further personal opinion if I might. You talked about education. You did not speak to the points of rehabilitation, recovery, and the social structure problems that may create the need for dependence of drugs or narcotics.

But I would like to ask you about the penalties of the law and the fact that we incarcerate a man who may be a heroin user, or he may simply be picked up for the possession of marihuana. What, in fact, does this do for the prevention of health problems or in the rehabilitation of that person?

Dr. BRILL. Speaking now for the association, it is our opinion that drug-dependent persons, and that includes addicts and people who use other drugs in this entire series, hallucination-producing drugs, sedatives, stimulants, people who are enslaved by these various drugs are to be considered primarily as sick people and that every effort should be made to see their treatment needs and that every effort should be made at rehabilitation.

Only where this has been thoroughly explored should other methods of rehabilitation, the correctional methods, be considered. I speak now of people who are dependents. I would not speak of drug traffickers.

Senator HUGHES. You are drawing a line of difference between those who simply use narcotics and those who sell it for profit and supply?

Dr. BRILL. Even though there is a gray area and there are some users who technically sell or give the drug away.

Senator HUGHES. To supply their own habit probably.

Dr. BRILL. Well, yes, and there is such a practice as one man buying for a group to cut down the hazard of buying it on the street, and

technically he is a trafficker. I speak now of the bona fide trafficker.

Senator HUGHES. You mentioned the support, I guess, of the medical association for the educational provisions of this bill. Would you have anything specifically, Dr. Brill, that you could recommend? We are talking now about education in every quadrant we can think of, even conducting courses so that teachers can at least present the subject matter intelligently so children of all levels can understand it.

As you know, this is a problem now in elementary schools and the exposure is in elementary schools as well as the fact that most kids by the time they are 15 years old know far more about drugs than do their parents, other than what the parents have got in the medicine cabinet.

Do you have any specific suggestions of how we might get at this problem?

Dr. BRILL. It may be that I could read an excerpt from a previous statement which has some relevance to your question. This refers to a proposal in H.R. 9312, the Drug Abuse Education Act of 1969.

We said at that time:

The leadership of the Department of Education gives assurance of the application of sound educational principles and provides a very effective channel for reaching all parts of the country's education system while full participation by the Department of Health, Education, and Welfare as well as the Department of Justice promises to maintain and extend the activities which are going on in their agencies.

We are further strongly in favor of the arrangement which will bring educational material to local and state agencies through a local assistance program, which will be specifically funded for this purpose because it is through such local agencies that most of the actual work of education must be carried out.

Now in a more general way more education in this field is urgently needed in the professional schools, and I speak now of schools of medicine, social service and so on, and education for the general public. Because, of course, public policy follows public opinion and I think that public opinion needs to be fully informed on this very important subject.

Senator HUGHES. Doctor, what would you say to a mother or a father who called you, as many have called me, and said, "I suddenly found out my son or my daughter is smoking marihuana. What am I going to do about it?" What do you say to that mother and father?

Dr. BRILL. I customarily say, and this is a frequent occurrence, that it is necessary to avoid panic and hysteria. Most such episodes are harmless and individual experiences with marihuana may carry a hazard of one's becoming interested in the drug, but, as I say, most of them are harmless.

However, this does call for some evaluation by a third party, by a person who is not emotionally involved. I would refer such an individual to the family physician or to someone who is knowledgeable in the field to evaluate whether there may be other and more profound problems, either personality problems, emotional problems, or whatnot.

It frequently happens that there is multiple-drug use because many of these young people take not only marihuana but a whole series of other drugs.

Senator HUGHES. This frequently happens nowadays. Within the last 3 days I have had it reported to me by friends, I might add, who suddenly were in a state of shock. One mother went down to the auto-

mobile outside the store after buying some packages, raised the trunk car lid and opened it up and the back end was full of marihuana.

I am talking about the raw material, not condensed or dried or anything. She pushed the panic button, went into a state of shock, and frantically sought help. She imagined all of the taboos and evils of the world had befallen members of her family.

There is another instance of a father who said to me he had suddenly found two of his sons in their late teens smoking marihuana, talked to them about it, begged and plead with them to quit and they flatly told him to go to hell.

He was really wondering what on earth he was to do. Was he to approach the police, and frankly he was not about to do that. He was even ashamed to go to his doctor and talk about it.

This is the stigma we are carrying with marihuana. This is the point I am trying to bring out. Until we can eliminate that stigma, people can't even seek advice. Parents won't even seek advice for their children.

We even had testimony here from parents who are buying heroin or supplying money to their kids to buy heroin because they feel they cannot go to their doctor to get treatment for that youngster. To keep them from stealing, they are supplying the money for them to make the purchases and praying every hour when they are out trying to make a pickup that the stuff is not contaminated so badly that it may be the cause of death, or that they won't get picked up and sentenced to 10 years in a hell-hole where they get no treatment and where they can supply their habits better than on the street.

So how do we get at this stigma, Doctor? In education?

Dr. BRILL. Senator, I think we can diminish the stigma, we can provide channels for treatment for rehabilitation, for diagnosis. There are, however, some aspects to the question which are technical and professional. For example, when you speak of the mother who provides the son or the daughter with drugs, you also may be dealing with a specific problem in this area.

There are mothers who will buy drugs for the offspring even when that offspring is under treatment in a recognized treatment facility; some sort of a pathological relationship also is seen in alcoholism where wives may suffer from the husband's alcoholism and still seem to lead him into it.

So here there are specifics that need to be taken into consideration. Perhaps in getting help, some of the technical problems can be avoided.

Senator HUGHES. I will just ask you one question personally and you don't have to reply as a personal family physician, but what does a personal family physician do when his patient is a 16- or 17-year-old youngster and he suddenly finds out in the process of discussion that part of the problem is marihuana and it is not a hard narcotic? Is the patient relationship extending to the point that you don't discuss it with parents or what does happen?

Dr. BRILL. This type of problem is not infrequent and to maintain the relationship, the proper procedure is not immediately to rush to the parents, but to gain the confidence of the youngster to such a point that the youngster tells the parents or that the youngster gives permission for the matter to be discussed with the parents.

I think that to keep such information indefinitely confidential without making an effort to communicate is also a problem. But normally this is not an insuperable obstacle. Again, I speak now from personal experience in such cases and the usual finding is that the youngster would like to have some way of communicating this in a nontraumatic, nonexplosive fashion.

Senator HUGHES. Again on the point of education, what about education of the parents? Do you have any specific recommendations of how we can get to those of us by age or our age so we can better understand the reasons and understand the effects and understand what should be done in order for sanity to prevail?

Dr. BRILL. There is a great deal of material available for reading. I think from the point of view of a Federal agency, a broad program of public education is important. Among other things, there is no question that the relationship between parents and children cannot be broken down into specific categories, for example, cannot be broken down to drugs and drugs alone.

I think that there is a relationship that covers all the problem areas and proper parent-children relationships are necessary in order to be successful in raising children. It includes drugs, but it also includes problems of sex, money, work, authority, and I think that the program needs to be part of a general education and a general pattern of relationship between the parents and children.

Senator HUGHES. How widespread do you think the use of marijuana is in this country?

Dr. BRILL. I think that experimentation, probably millions of people have taken a marijuana cigarette here and there. The regular use of the drug, which is the only significant use, is probably far more restricted. But it still is enormously more widespread today than it was 10 years ago or even 5 years ago.

I think that it has spread significantly and probably involves an important percentage of the young population. Perhaps it is not as high a percentage as alcoholism involves in the total population, but it begins to approach that.

Senator HUGHES. When we look at the effects of supporting habits of hard addicts having to steal to do it, it affects just as many people in all probability from the stealing side of it as it does from the health side of it.

Dr. BRILL. You mean the heroin and so on?

Senator HUGHES. The heroin addict who has to supply a \$60 or \$75 a day habit.

Dr. BRILL. Directly and indirectly it must have an impact on millions of people.

Senator HUGHES. Is there anything you can think of or add to your statement that would be helpful to the subcommittee in considering this legislation?

Dr. BRILL. There is an enormous lot to be said in this field, so much that it is hard to know where to start. The kind of a flexible program that has been outlined which puts responsibility with health agencies where the responsibility belongs, a balanced program which includes all the aspects of control of drug dependence, I think, is the best that I would be able to formulate and certainly no one approach, and I would emphasize that, I believe there is general agreement that no one approach to this problem is enough.

It takes a balanced program of all different approaches: control, education, treatment, rehabilitation, research, and if I were to put emphasis right now, it would be on adequate support and facilitation of research that will give us the information that we need. There has been a great deal of discussion about the lack of information with respect to various drugs, including marihuana.

People forget that our standards of information with respect to drugs have gone up very sharply in the past decade or two. Most of the information that was collected in this field is old information, so we have a lot of catching up to do. For the amount of money invested, I don't know anything that will give us more results than support of research.

Senator HUGHES. Dr. Brill, I thank you very kindly, you and your associates, for appearing and testifying before the subcommittee on this particular legislation. We would appreciate it if you do formulate any conclusions in those other areas you were discussing soon enough to be of help to us, that you would submit them either to the subcommittee or the full committee, wherever we are in the process of considering this legislation.

Dr. BRILL. Thank you, sir.

Senator HUGHES. Thank you very much.

The Chair calls Dr. James Goddard.

Dr. Goddard, you are familiar with this type of testimony. If you will, properly introduce your associates for the record and proceed with your testimony as you desire.

STATEMENT OF JAMES GODDARD, M.D., VICE PRESIDENT, ELECTRONIC DATA PROCESSING TECHNOLOGY, INC., ATLANTA, GA.; ACCOMPANIED BY PAUL D. STOLLEY, M.D., ASSISTANT PROFESSOR, THE JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF MEDICAL CARE; AND THEODORE O. CRON, PRESIDENT, AMERICAN PATIENTS ASSOCIATION, WASHINGTON, D.C.

Dr. GODDARD. Thank you.

On my left is Dr. Paul Stolley of Johns Hopkins University, a fellow member of the American Public Health Association, Program Area Committee on Drugs. On my right is Mr. Theodore O. Cron, the head of the American Patients Association, who has assisted me in the preparation of this and many other statements for congressional hearings.

Mr. Chairman, I am James L. Goddard, a physician and former Commissioner of the Food and Drug Administration. It is my privilege to appear before you this afternoon on behalf of the American Public Health Association to speak to the issue of drug abuse control. My remarks reflect the thinking of the association's expert Program Area Committee on Drugs, a committee which has given careful consideration to proposed drug legislation presented to the Congress in this session.

If I may, Mr. Chairman, I would like to recall the fact that Congress has already taken responsible action in the area of drug abuse control. Eleven months ago Public Law 90-639 was enacted and signed by the President. Enactment was achieved only after a great deal of

thought and discussion. Hearings involving this country's most responsible and most concerned professionals—in public service and private practice—were conducted in the Senate and in the House as well.

In all candor, Mr. Chairman, I must say that Public Law 90-639 did not capture my enthusiasm. The law carried a penalty for personal possession of lysergic acid diethylamide (LSD), depressants and stimulants, a penalty that did not appear in the original Drug Abuse Control Act of 1965. I will not pursue this point. It has been eloquently pursued many times by others. However, Mr. Chairman, we would do well to review the sense of the Congress as it enacted 90-639 last October.

The Committee on Labor and Public Welfare submitted to the Senate its report on H.R. 14096. In conference the House managers receded on all points to the Senate; hence, the Senate report represents a significant benchmark in the legislative history of drug abuse control. The Senate report carries two themes which hold particular interest to the American Public Health Association. Even those of us who did not agree with the ultimate fashioning of the law did recognize that the Congress would not tolerate law enforcement as the Government's sole weapon against drug abuse.

First, Congress looked to the Department of HEW to maintain not only interest, but influence in the shaping and implementation of national policy:

It is the committee's hope that the Department of Health, Education, and Welfare will make such continuing evaluations, consulting with outside authorities when it deems advisable, and will from time to time present its conclusions and recommendations to the Department of Justice, to this committee and to the Congress. Since the committee recognizes the expertise, experience, and responsibility of the Department of Health, Education, and Welfare in the field of public health and drug evaluation, it directs the Department of Justice to consult with and act in conjunction with the Department of Health, Education, and Welfare before designating a drug as a depressant or stimulant drug * * *

Second, Congress was fully aware of the magnitude of the drug abuse problem and the possibility of a dangerous national adventure in law enforcement.

It should be made clear that based on the evidence before Congress the increased penalties proposed in this legislation are needed to prosecute the criminal traffickers in dangerous drugs, but they should not be applied to the potentially large number of law-abiding citizens who might occasionally pass on a small amount of drugs to a friend or an acquaintance. * * * Testimony before Congress reflects concern among educators and social scientists that the indiscriminate enforcement of excessively severe drug laws increases disrespect for the law on the part of young people and tends to alienate them from society. * * *

Mr. Chairman, less than a year has passed since those words were published here on Capitol Hill. Less than a year has passed in which Public Law 90-639 has been enforced. Considering the language of caution and equity used by the Congress in clarifying its desires, we feel that 11 months is hardly enough time to demonstrate that Congress was, indeed, all wrong last year. And yet, Mr. Chairman, we are confronted at this moment by proposals that seek to reverse the sense of the Congress barely a year after it had been stated.

I have not come today to plead congressional consistency, but I have come to ask that Congress display at the very least the same degree of respect for the role of science and for the rights of individuals that

was displayed 11 months ago. If we are to work at developing a more rational policy on drugs, let us do it as cautious, reasonable men.

We believe this was the atmosphere last fall, even though a less than perfect law was produced. If we wish to move further along the road of reason, let us recall, then, the atmosphere of the journey and not move in fear or haste.

Mr. Chairman, drug abuse remains a serious national health problem, despite nearly 3 years of intensified efforts by physicians, educators, and law enforcement officers at every level of government. Drug abuse did not burst upon us in 1965. It had been developing for some years.

Drug abuse is not going to be "stamped out" in quick time either. It is a complex problem which, as Congress has already recognized, demands the combined and balanced efforts of science, law, and public education. These efforts will be carried on for many years, reaching millions of American citizens. The American Public Health Association, therefore, views with deep concern the program put forth by the current administration.

As expressed in S. 2637, the administration has placed undue emphasis on law enforcement as the major weapon;

The proposed schedule of offenses and penalties is plainly regressive;

The provisions for enforcement raise grave questions of threats to civil liberties;

The sweeping authorities in science and education, as well as law enforcement, are all assigned to the Attorney General.

Whereas the Congress has already noted that the Attorney General and the Secretary of HEW must share responsibilities in the campaign against drug abuse, the administration would give the Attorney General alone such powers as determining what is or is not a habit-forming drug, whether or not a drug should be listed in one of the four proposed "schedules," which drugs can get through the Food and Drug Administration and into the marketplace or be screened by the Justice Department beforehand, plus the power to register—or license—everyone who wants to manufacture, distribute or "dispense" any controlled substance.

Among "dispensers" would be all medical practitioners and researchers.

Section 309(d) even goes so far as to direct the Attorney General to tell the Secretary of HEW that a nonprescription drug with an "abuse potential" ought to become a prescription drug. In other words, the Attorney General and the Department of Justice are placed squarely within the practice of medicine, as well as within and surrounding the field of medical research. If enacted as drawn, Mr. Chairman, this bill would be intolerable.

Our association believes that S. 2637 is also inconsistent with the rulings of the Supreme Court of the United States as well. Beginning in 1962, Mr. Chairman, in the case of *Robinson v. California*, the Supreme Court has sought to maintain the balance between law and medicine. Robinson, "afflicted" with narcotic addiction, could not be judged—on that basis alone—as being a criminal. "A State law, which imprisons a person thus afflicted as a criminal," said the Court, "inflicts a cruel and unusual punishment."

In 1966 the Court extended the same protection of the eighth amendment to the Constitution in the case of *Easter v. District of Columbia*. Easter was considered by the Court to be suffering from the illness of alcoholism. Imprisonment, rather than treatment, was judged to be cruel and unusual punishment.

Then in 1968, in *Powell v. Texas*, the Supreme Court drew a sharper line. The Justices did not believe the Court should become, "under the aegis of the Cruel and Unusual Punishment Clause, the ultimate arbiter of the standards of criminal responsibility, in diverse areas of criminal law, throughout the country. * * * Formulating a constitutional role would reduce, if not eliminate, that fruitful experimentation, and freeze the developing productive dialog between law and psychiatry into a rigid constitutional mold. It is simply not yet the time to write the constitutional formulas cast in terms whose meaning, let alone relevance, are not clear either to doctors or to lawyers."

Mr. Chairman, from this brief résumé of decisions by the Supreme Court—coupled with the report of the Senate and House last fall—we can only assume that the movement of Government in matters involving health and law enforcement is to maintain a balanced position for each, with a deemphasis on criminal sanctions whenever possible.

In the light of this wealth of evidence and experience, the introduction of S. 2637 is little short of astounding. The American Public Health Association has made a title-by-title analysis of S. 2637. If the chairman requests, we would be pleased to make it available to this subcommittee.

Senator HUGHES. I would be pleased to have it entered into the record, Dr. Goddard.

Dr. GODDARD. Thank you, Mr. Chairman.

(Document follows:)

COMPARISON OF RECENT DRUG ABUSE TREATMENT AND CONTROL BILLS

S. 1816 (Williams) and H.R. 10342 (Howard)	S. 1895 (Dodd)	H.R. 11701 (Staggers)	S. 2608 (Yarborough)	S. 2637 (Dirksen—administration)
Drug Abuse Prevention and Rehabilitation Act of 1969.	Omnibus Narcotic and Dangerous Drug Control and Addict Rehabilitation Act of 1969.	Comprehensive Drug Abuse Control Act of 1969.	Comprehensive Narcotic Addiction and Drug Abuse Control Act of 1969.	Controlled Dangerous Substances Act of 1969.
1. Definitions. Note: Only 3 terms are compared (differences in other terms, if any are insignificant).	No comparable provisions (definitions primarily concerned with eligible applicants for drug abuse education programs).	Depressant or stimulant drugs—No comparable definition but see section on transfers of authority—authority to designate a drug as a depressant or stimulant drug transferred from Attorney General to Secretary of HEW (sec. 6).	Depressant or Stimulant Drugs—No comparable definition but see section on transfer of authority—authorities as depressants or stimulants transferred from Attorney General to Secretary of HEW (sec. 501), but Secretary required to consult with Attorney General (sec. 403).	Depressant and Stimulant Drugs—Identical to Dodd bill definition [Sec. 102 (j)].
2. Control of dangerous substances: (a) Standards and schedules.	3 classes of drugs established: class I—Narcotics; class II—Dangerous drugs with high potential for abuse; includes almost all barbiturates.	No comparable provisions.	No specific categories established. The Secretary is to rank all narcotics, depressant or stimulant drugs which he feels should be controlled according	4 schedules established, each subject to 3 special criteria: Schedule I substances have a high potential for abuse, no accepted medical use,
		Opiate—No comparable definition—but see section on transfers of authority—authority to designate drug as an opiate left with Attorney General but he must have the concurrence of the Secretary of HEW.	Opiate—No comparable definition but see section on transfers of authority—authority to designate a substance as an opiate transferred from Attorney General to Secretary of HEW (sec. 501) but Secretary must consult with the Attorney General (sec. 403).	Opiate—Identical to Dodd bill definition [sec. 102(r)].
	Marihuana—retains present wording of definition in Internal Revenue Code unchanged [sec. 102(r)].	Marihuana—Present wording of definition unchanged but the term itself is removed from the Internal Revenue Code and added to the Federal Food, Drug, and Cosmetic Act (sec. 4).	Marihuana—Identical to Staggers bill (sec. 404).	Marihuana—Identical to Dodd bill [sec. 102 (n)].

and are unsafe for use even with medical supervision. Not limited to narcotics; includes heroin, LSD and marihuana. Schedule II substances have high abuse potential; abuse may lead to severe psychic or physical dependence, but have accepted medical use; mainly class A narcotics. Schedule III substances have accepted medical use, less abuse potential than I or II, and moderate dependence-producing liability; includes most amphetamines and barbiturates. Schedule IV substances have low abuse potential and low dependence-producing liability (sec. 202).

Same as Dodd bill except that (1) Attorney General must also request the written advice of the Secretary of HEW before adding, deleting, or changing the classification of a substance; (2) he must make findings with respect to these criteria; and (3) Attorney General may not delete a schedule I substance from the act completely or reschedule it as III or IV unless specifically authorized by Congress to do so (sec. 201). Same as Dodd bill (sec. 201).

to the extent of their ability to produce physical or psychological dependence and their relative capabilities for abuse (sec. 402).

Secretary of HEW given authority to add, delete, or reschedule a substance as he shall find necessary, based on his judgment as to their dependence or abuse-producing capabilities. No other criteria specified, but substance must fit statutory definition of narcotic or depressant or stimulant drug. Secretary must consider the advice of an advisory committee and consult with the Attorney General (sec. 402).

Must publish list in Federal Register at least 30 days before it can be effective and hold an administrative hearing if requested within this period, followed by judicial review if requested, in accordance with Federal Food, Drug, and Cosmetic Act procedures (sec. 402 (c)).

stimulants, or hallucinogens (including marihuana and LSD), whether or not they have an established medical use. Schedule III drugs have low abuse potential and accepted medical use. No specific criteria given for each category (sec. 402).

Attorney General given authority to add, delete, or reschedule a drug as a narcotic or dangerous drug in accordance with general criteria, after obtaining the advice of an advisory committee. No requirement to make findings with respect to any of these criteria (sec. 401).

Must give notice of intention to issue ruling and solicit comments, in accordance with Administrative Procedures Act. No hearing required prior to a ruling (sec. 201).

COMPARISON OF RECENT DRUG ABUSE TREATMENT AND CONTROL BILLS—Continued

S. 1816 (Williams) and H.R. 10342 (Howard)	S. 1895 (Dodd)	H.R. 11701 (Staggers)	S. 2608 (Yarborough)	S. 2637 (Dirksen—administration)
1. (b). Import and export of dangerous drugs.	-----do----- Permits Attorney General to control import of all controlled drugs, even nonnarcotic drugs listed in lowest abuse potential class and export of all narcotics or class of nonnarcotic drugs (secs. 501, 502, and 503).	No comparable provisions but see subsection d on quotas.	No comparable provisions but see subsection d on quotas.	Permits Attorney General to control import of all narcotic drugs and all schedule I, II, and III nonnarcotic substances and export of all narcotics and schedule I or nonnarcotic substances (secs. 402 and 403).
(c) Manufacture, distribution, or dispensing of dangerous drugs.	-----do----- Everyone wishing to manufacture, distribute, or dispense a narcotic or dangerous drug must obtain an annual license from the Attorney General (and includes medical practitioners and researchers). Practitioners have an absolute right to a license if they are so authorized under State law except with respect to drugs with no accepted medical use. In all cases, and in the case of all other distributors, dispensers (including researchers), and manufacturers, a license may be granted in the discretion of the Attorney General only if it appears to be in the public interest, in accordance with 6 specified factors. It can be refused if applicant materially falsified the application, was convicted of a drug-related offense (not necessarily a felony), or has had his State license revoked or suspended. A practitioner's application to conduct research with drugs which have no accepted medical use must be referred to the Secretary of HEW for advice as to the applicant's qualifications and the design of the research protocol (sec. 507).	Requires registration only for persons or establishments wishing to conduct research with a narcotic drug or with marihuana. The registration is to be issued by the Secretary of HEW, with the concurrence of the Attorney General. The only grounds for denying the application initially are inadequate procedures for accountability, inadequate safeguards against diversion, or if research with narcotics is not conducted under applicable State law (sec. 5).	Same as Staggers bill (sec. 405).	Same as Dodd bill, except: (1) the requirement is for registration rather than a license; (2) separate (but essentially similar) criteria for determining the public interest with respect to schedules II and IV drugs are provided; and (3) if the Secretary deems a practitioner qualified to conduct research with a schedule I drug, the Attorney General may not deny him registration unless he materially falsified his application, was convicted of a drug-related felony, or had his State license revoked or suspended, or there is reason to believe that he may possess the substance to be illegally diverted (secs. 301-304).

(d) Establishment of quotas.

-----do-----
 The Attorney General would determine the total quantity of class I or II substances (includes most amphetamines and barbiturates, as well as narcotic drugs) needed to fill U.S. medical, scientific, and industrial requirements for quota setting purposes. Under existing law, only the basic class of narcotics is included in the Attorney General's quota-setting authority. Does not change existing law which requires him to consider the technical advice of the Secretary of HEW with respect to the total requirements for narcotic drugs (sec. 510).

3. Control of marihuana.

-----do-----
 Marihuana initially classified as a class II drug. However, the NIMH, in cooperation with the Attorney General, is to carry out a program of intramural and extramural research, covering all phases of marihuana use, within a 2-year period. On the basis of the NIMH study results, the Attorney General is to retain, to change the classification, or to exclude marihuana from control altogether (secs. 301 and 302).

4. Offenses and penalties.
 Sets up a National Council on Drug Abuse Control (see section on advisory committee) for composition and other functions, to provide effective procedures to coordinate programs of law enforcement by the Justice Department's Bureau of Narcotics and Dangerous Drugs. (sec. 402 (3)).

The Attorney General would continue to make the determination as to the amount of narcotic drugs necessary to be manufactured or imported to fill the medical and scientific needs of the United States, for the purpose of setting quotas but he would need the concurrence of the Secretary of HEW. (Present law just requires him to consider the technical advice of the Secretary.) Nothing is said about determining the Nation's requirements for nonnarcotic substances (sec. 9).

Marihuana removed from the Internal Revenue Code and placed instead with other depressant, stimulant, or hallucinogenic drugs in the Federal Food, Drug, and Cosmetic Act. Thus, it would be subject to the controls and sanctions for misuse imposed on those drugs rather than the more severe provisions for narcotics in existing law (sec. 4).

Except for marihuana (see previous section), present law unchanged.

Transfers authority to make the determinations as to the medical and scientific needs of the country for narcotic drugs for quota-setting purposes from the Attorney General to the Secretary of HEW, after consultation with the Attorney General. Nothing is said about determining the Nation's requirements for other schedule I or II drugs (secs. 501 and 502).

Same as Staggers bill (sec. 4C4).

Marihuana classified as a schedule I drug, subject to the most severe restrictions and penalties for illegal use (see "Offense and Penalties" for increased sanctions for distribution and simple possession) (sec. 202).

-----do-----
 Illegal manufacture, distribution or possession with intent to distribute a schedule I or II substance (includes marihuana but not most depressants or stimulant drugs) penalized at 5 to 20 years' imprisonment and/or \$25,000 fine. "Simple" possession of these drugs: 2 to 10 years and/or \$20,000 for a 1st offense, and 5 to 20 years for subsequent offenses, with no probation permitted. Simple possession of a schedule II or IV drug

Same as Dodd bill but limited to schedule I or II drugs, which does not include most amphetamines or barbiturates. No requirement that Attorney General consult or obtain advice of anyone in estimating these needs. The section of law requiring him to consider the technical advice of the Secretary of HEW with respect to the quantities of narcotic drugs needed is repealed (sec. 306).

COMPARISON OF RECENT DRUG ABUSE TREATMENT AND CONTROL BILLS—Continued

S. 1816 (Williams) and H.R. 10342 (Howard)	S. 1895 (Dodd)	H.R. 11701 (Staggers)	S. 2608 (Varborough)	S. 2637 (Girksen—administration)
5. Drug abuse education	or possession. Probation available for 1st offense for possession. After that, it is discretionary with court (Title VII), but see previous section. Marijuana could eventually be removed from control depending on results of NIMH study (secs. 301 and 302).	A new section added to the Community Mental Health Centers Act (Pt. D—Narcotic Addiction programs) authorizing extensive programs of grants and contracts to collect, prepare and disseminate educational materials and mount educational programs directed at all segments of the public re: drug use and abuse and prevention of drug abuse. Workshops and other training activities for drug abuse education personnel also authorized. The program is to be administered by the Secretary acting through the National Institute of Mental Health. No appropriation ceiling specified [sec. 2(a)].	Same as Staggers bill except that (1) grants can only be made on recommendation of the National Advisory Mental Health Council, and (2) appropriation ceilings specified of \$2,000,000 for fiscal year 1970, \$4,000,000 for fiscal year 1971, and \$8,000,000 for each of the next 3 fiscal years [sec. 201(a)].	(i.e., "Speedy"): 1 year imprisonment and/or \$5,000 for a 1st offense; 3 years and/or \$15,000 for subsequent offenses. A first-time offender for "simple possession" may be offered a suspended sentence and probation. Not available even at court discretion for subsequent offenses. Double penalties and no probation for distribution to minors (Title V).
Establishes a 5-year program of grants (fiscal year 1969-73) to medical schools and other institutions of higher learning for development of curriculum and operation of drug abuse education programs. Administered by the Secretary of HEW, the grants are to cover 100 percent of the costs. A national council on drug abuse control (see section on advisory committees) is to coordinate all Federal drug abuse education programs to assure exchange and dissemination of information. The Secretary is also directed to appoint a Special Advisory Committee on Drug Abuse Education. Appropriation ceilings start at \$50,000,000 for fiscal year 1969 and increase \$10,000,000 each fiscal year of the program (Title III).	Attorney General directed to carry out extensive educational programs, particularly with juveniles to prevent and deter misuse and abuse of narcotics and dangerous drugs. May require assistance and technical advice from any other Federal agency. Form of such programs—i.e., grants or contracts to State or local organizations—not specified. No appropriation ceiling specified (sec. 201, 202).	Attorney General authorized to carry out "educational or research programs necessary for the effective enforcement of the act." May contract with any agency public or private, or any individual for this purpose. The scope of his educational activities not spelled out further and no appropriations authorized. He may require assistance or technical advice from any other Federal agency (sec. 602).		

6. Research-----
- The only research authorized is in connection with the development of new and innovative techniques for prevention, treatment, and rehabilitation of addicts. Funds would come from the overall appropriation for treatment and rehabilitation centers (see section on "Treatment") (sec. 205(a)).
- Attorney General authorized to "encourage" research on the use and abuse of narcotics and dangerous drugs. He may make studies and undertake programs himself or through contracts with public or private agencies or individuals on virtually every aspect of drug abuse, including effects of such drugs, potential for abuse, patterns of abuse, prevention and treatment, etc. May authorize researchers to withhold the names of subjects and to possess and distribute dangerous drugs without fear of Federal or State prosecution. No appropriation ceiling specified (sec. 201).
- Amends the PHS Act by adding a new paragraph to sec. 303(a) authorizing a comprehensive program of grants and contracts to conduct research on all phases of drug use and abuse. Supports the construction, staffing, operation, and maintenance of regional research centers, one of which is to be established as a national center and made a part of the NIMH. Also establishes a National Registry of Narcotic Addicts to facilitate research, but limits identifying information about persons on the registry to personnel of the registry unless the Secretary and the individual consent to disclosure. Finally, it amends sec. 507 of the PHS Act to permit any grants for research, training, or demonstration projects or for construction or staffing of mental health, alcoholism, or narcotic addiction facilities under the PHS or the Centers Act to be made to specified Federal institutions at 100-percent funding. No appropriation ceiling given (sec. 3).
- Attorney General authorized to assist in training of Federal, State, and local law-enforcement personnel. (Sec. 202(a)) (3) The Surgeon General may make grants to State, local, and specialized organizations for medical training programs and materials relating to narcotic addiction treatment services (as part of an authorized continuation of the old sec. 402 of the NARA Act now expired. (See discussion under
- Attorney General authorized to operate drug addiction prevention and treatment centers is included within the scope of the grant establishing such centers. (See section on "Treatment"). No evaluation program authorized [Sec. 202(a)].
- Training of personnel necessary to operate drug addiction prevention and treatment centers is included within the scope of the grant establishing such centers. (See section on "Treatment"). No evaluation program authorized [Sec. 202(a)].
- Attorney General authorized to assist in training of Federal, State, and local law-enforcement personnel. (Sec. 202(a)) (3) The Surgeon General may make grants to State, local, and specialized organizations for medical training programs and materials relating to narcotic addiction treatment services (as part of an authorized continuation of the old sec. 402 of the NARA Act now expired. (See discussion under
- Same as Stagers bill, except (1) it also amends the PHS Act to authorize the Surgeon General to study depressant and stimulant drugs as well as narcotics, (2) to require the Secretary of the Treasury (the Attorney General) to use the results of these studies in establishing quotas (now discretionary), (3) specified that the research programs are to be administered by the NIMH, and (4) specifies appropriation ceiling of \$3,000,000 for fiscal year 1971 and \$10,000,000 for each year through fiscal year 1974 for the research grant program; appropriations ranging from \$3,000,000 in fiscal year 1970 to \$20,000,000 in fiscal year 1974 for construction and operation of the regional research centers; and \$15,000,000 for the NIMH National Research Center (title II).
- General broad authority to carry out "any educational or research program necessary for the effective enforcement of the act." (See comment above.) May also establish a unit in the Bureau of Narcotics and Dangerous Drugs to collect statistics, and records of drug abusers which may be received on a voluntary basis. May also authorize researchers to withhold identifying information about their subjects and protect against Federal or local legal action to compel disclosure (secs. 692, 603 (a)).
- Authorizes Attorney General to conduct training programs on dangerous-substance law enforcement for local, State, and Federal personnel. No evaluation program authorized. (Sec. 603(e)(3)).
- Same as Stagers bill except (1) requires grants to be recommended by the National Advisory Mental Health Council, (2) training and fellowship awards may be made at whatever levels are necessary to facilitate recruitment, and (3) appropriation ceilings for regular grants specified as \$2,000,000 for fiscal year 1970; \$3,000,000 for fiscal year 1971; \$5,000,000 for fiscal year 1972; and \$6,000,000 each year for

COMPARISON OF RECENT DRUG ABUSE TREATMENT AND CONTROL BILLS—Continued

S. 1816 (Williams) and H.R. 10342 (Howard)	S. 1895 (Dodd)	H.R. 11701 (Staggers)	S. 2608 (Voorborough)	S. 2637 (Dirksen—administration)
8. Treatment facilities. Secretary authorized to make grants to States and public or nonprofit private organizations for "establishing, developing, equipping, and operating," drug addict prevention treatment and rehabilitation centers.	"Treatment" below.) The Surgeon General may also conduct surveys to evaluate the adequacy of State treatment programs. Such sums as may be necessary are authorized (sec. 826).	and prevention programs retained. Authorizes separate program of fellowship grants for professional personnel in wide variety of related fields. No appropriation ceiling specified, but eliminates durational limit on training and evaluation grants, which in existing legislation was the same as for construction and staffing grants [Sec. 2(a)].	fiscal years 1973 and 1974. Fellowship grants authorized at \$400,000 for fiscal year 1970; \$600,000 for fiscal year 1971; and \$1,000,000 each year for fiscal years 1972, 1973, and 1974 [Secs. 201(a), 202.]	
Up to 50 percent of the funds appropriated must go to organizations demonstrating an innovative approach to prevention, treatment, and rehabilitation of drug addiction. Between 20 and 30 percent of these funds are reserved for nonprofit private organizations which do not use narcotic drugs or substitutes (such as methadon) in their programs.	Resurrects old sec. 402 of the NARA Act of 1966, which expired June 30, 1968, to authorize jointly financed cooperative arrangements with State, local and private organizations for construction, staffing, operation, and maintenance of treatment centers for narcotic addicts within the States.	Extends present program of grants for construction and staffing of alcoholism and narcotic addiction facilities authorized under the Community Mental Health Centers Act for an additional 3 years, through fiscal year 1973.	Extends present program of grants for construction and staffing of alcoholism and narcotic addiction facilities authorized under the Community Mental Health Centers Act for an additional 4 years, through fiscal year 1974.	No comparable provisions.
No requirement that they be tied in any way to community mental health centers, general hospitals, or other community-based organizations.	No requirement that they be tied in any way to community mental health centers, general hospitals, or other community-based organizations.	Applicants must qualify under provisions of sec. 251 of the Community Mental Health Centers Act.	Same as Staggers bill.	Do.
Up to 50 percent of the funds appropriated must go to organizations demonstrating an innovative approach to prevention, treatment, and rehabilitation of drug addiction. Between 20 and 30 percent of these funds are reserved for nonprofit private organizations which do not use narcotic drugs or substitutes (such as methadon) in their programs.	May be funded for 100 percent of costs.	Present matching provisions unchanged [sec. 2(c)].	Increases Federal share of construction costs to 90 percent (now 66 2/3 percent); overall duration of individual staffing grants lengthened to 8 years (from 51 months) with a maximum Federal share of 90 percent for the 1st 2 years and 75 percent for each of the next 6 years. Operation and maintenance as well as staffing included as eligible costs. Definition of "staffing" broadened to include support personnel as well as professional and	Do.

technical employees (title I). (Note: Somewhat different provisions are included in S. 2523, amending the Centers Act, also introduced by Senator Vartanovich on July 1, 1969.)		Do.
For construction, staffing, operation, and maintenance, \$15,000,000 for fiscal year 1970; \$20,000,000 for fiscal year 1971; \$40,000,000 for fiscal year 1972; \$50,000,000 for fiscal year 1973; and \$75,000,000 for fiscal year 1974.	No appropriation ceilings mentioned.	Same as Staggers bill (sec. 503)...
Appropriations ceilings specified: For establishing, equipping, and operation, \$50,000,000 for fiscal year 1969; \$60,000,000 for fiscal year 1970; \$70,000,000 for fiscal year 1971; \$80,000,000 for fiscal year 1972; and \$90,000,000 for fiscal year 1973.	Appropriations ceilings specified: For development, construction, operation, staffing, and maintenance, such sums as may be necessary.	Same as Dadd bill except that the committee must consist of at least 5 experts (sec. 604).
9. Advisory committees: (a) Size and scope of responsibility.	The Attorney General is to appoint a committee of experts to advise him as to which drugs should be controlled and how drugs should be classified. No other scientific-medical decisions are mentioned as being within the scope of the Committee's concern. The size of the committee is not specified (sec. 203).	Same as Dadd bill except that the committee must consist of at least 5 experts (sec. 604).
(b) Composition of committee.	Not specified.	Attorney General is to select members from a list down by the National Academy of Sciences. Members must qualify as experts and have diversified professional backgrounds [Sec. 604(a)(1)].
Members must have diverse professional backgrounds, including fields of pharmacology, psychiatry, psychology and other behavioral sciences, manufacturing, and distribution. Must qualify as experts on narcotic, depressant or stimulant drugs (sec. 7).	Members must have diverse professional backgrounds, including fields of pharmacology, psychiatry, psychology and other behavioral sciences, manufacturing, and distribution. Must qualify as experts on narcotic, depressant or stimulant drugs (sec. 7).	Members must have diverse professional backgrounds, including fields of pharmacology, psychiatry, psychology and other behavioral sciences, manufacturing, and distribution. Must qualify as experts on narcotic, depressant or stimulant drugs (sec. 7).

COMPARISON OF RECENT DRUG ABUSE TREATMENT AND CONTROL BILLS—Continued

	S. 1816 (Williams) and H.R. 10342 (Howard)	S. 1895 (Dodd)	H.R. 11701 (Staggers)	S. 2608 (Yarborough)	S. 2637 (Dirksen—administration)
10. Transfers of authority.	No comparable provision.....	Broadens existing authority of Attorney General, which he received under Reorganization Plan No. 1 of 1968, to license researchers with dangerous drugs as well as narcotics, to determine medical and scientific needs of the country not only for narcotics but for dangerous drugs as well, for quota-setting purposes, and in general makes applicable to all drugs the controls now reserved in existing law for narcotics.	Transfers authority of Attorney General, which he received under Reorganization Plan No. 1 of 1968, to designate a drug as a depressant or stimulant and to make certain exemptions under the Federal Food, Drug, and Cosmetic Act, to the Secretary of HEW (sec. 6). Other medical-scientific determinations (e.g., the designation of a drug as an opiate, or the determination of the medical scientific needs of the United States) are still to be made by the Attorney General but with the concurrence of the Secretary (sec. 9).	Transfers authority of Attorney General, which he received under Reorganization Plan No. 1 of 1968, to the Secretary of HEW to designate drugs not only as depressants or stimulants, but also as opiates, and to determine the medical and scientific needs of the United States for purposes of manufacture or import and export quotas. The Secretary must, however, consult with the Attorney General (secs. 501 and 502).	Same as Dodd bill. In addition repeals provision of Narcotics Manufacturing Act of 1960 that required the Attorney General to consider the technical advice of the Secretary of HEW in establishing quotas (sec. 801).
11. Present status.....	S. 1816 referred to Committee on Labor and Public Welfare, Subcommittee on Health. H.R. 10342 referred to the Interstate and Foreign Commerce Committee. No hearings have been held on either bill but Senator Williams is also a member of the Subcommittee on Alcoholism and Narcotics, which held hearings on the general subject of drug abuse on July 9, 10, 11, and 14, 1969.	Referred to Committee on the Judiciary, Subcommittee on Juvenile Delinquency. Hearings scheduled for Sept. 18, 1969.	Referred to the Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Welfare. No hearings have been scheduled.	Referred to the Committee on Labor and Public Welfare, Subcommittee on Alcoholism and Narcotics. Hearings held on July 9, 10, 11, and 14, 1969, on the general subject of drug abuse and this bill was discussed briefly. Further hearings may be held in September.	Referred to the Committee on the Judiciary, Subcommittee on Juvenile Delinquency. May be considered at the Dodd hearings on Sept. 18, 1969. Was also discussed briefly at the Alcoholism and Narcotics Subcommittee hearings on drug abuse in general, held in July.

Dr. GODDARD. Our association does not advocate a do-nothing attitude regarding drug abuse. While we oppose the administration's bill, we find many favorable points in S. 2608, the "Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act of 1969," introduced on July 14 by Senator Yarborough, yourself, Mr. Chairman, and a number of your colleagues in the Senate.

The primary virtue of S. 2608 is that it seems to be a logical development from the events of the past year. Rather than supplant Public Law 90-639—and large pieces of other laws as well, which is a feature of the administration's proposal—Senator Yarborough's bill would leave the present law intact, allowing the Government to gain more experience with it, but at the same time building upon it along the lines set by the last Congress and, indeed, by the opinions of the Supreme Court as well.

As we understand it, Mr. Chairman, S. 2608 recognizes the health and social problems created by narcotic addiction and drug abuse and seeks remedies by way of the development, staffing and the programming of centers for prevention and treatment, by a strong public education effort, by stimulating the recruitment and training of professional personnel for work in this area, and by research. These efforts would be carried out by the Secretary of Health, Education, and Welfare, utilizing primarily the facilities and resident expertise in the National Institute of Mental Health.

The American Public Health Association supports S. 2608 and would urge that Congress give it favorable consideration. We would consider its passage, with minor revisions, a major step forward in the national campaign against narcotic addiction and drug abuse. I would draw your attention, in particular, to section 404.

Here marihuana is finally given a realistic evaluation in light of all the evidence we have thus far—which admittedly is not much, but is yet enough to invite some rational action in Congress at this time. Under section 404 marihuana is removed from the Internal Revenue Code and placed with other hallucinogens in the Federal Food, Drug, and Cosmetic Act. The result of such a transfer would be to impose upon marihuana the same kinds of controls that now exist for the hallucinogens, stimulants, and depressants of that act, rather than the laws governing narcotics.

Mr. Chairman, the Director of the National Institute of Mental Health estimates that between 8 and 12 million Americans have used marihuana at least once. Under present law there are between 8 and 12 million Americans who are subject to prosecution under harsh criminal sanctions.

We know that the American system of justice will not tolerate such a mass caseload of foolishness and we are beginning to see that, as the marihuana inconsistency remains, some of our citizens—particularly among our youth—will not tolerate the American system of justice.

If there is any danger to our society posed by this ragged little plant, it is this realization by our young people that the law may be unjust and that science may be wrong.

Mr. Chairman, our association is firmly convinced that enough discussion, enough research, and more than enough prosecution have taken place to indicate what course of action is actually written into Senator Yarborough's proposed law, regarding the section on marihuana.

For this reason—and because we believe S. 2608 generally satisfies the requirements of the next phase in a national policy against drug abuse—we urge the Congress to examine, possibly modify, but move forward to enact S. 2608.

Mr. Chairman, the members of the Program Area Committee on Drugs, as well as other members of the American Public Health Association, would be pleased to offer this subcommittee any assistance in the refinement of S. 2608. If the chairman wishes, we will submit an analysis of the measure for your use.

On behalf of the 22,000 members of the APHA, I wish to thank the chairman and the members of his subcommittee for providing me with this opportunity to testify today. I am prepared to respond to questions or otherwise enlarge upon my statement at this time.

Thank you.

Senator HUGHES. Dr. Goddard, I certainly want to take advantage of your offer to provide an analysis of S. 2608, if you can, as soon as you can possibly do it. It will be helpful because we are trying to move along with this particular piece of legislation as rapidly as we can at this point.

I notice you felt earlier in your testimony it may need some modest revisions and I am assuming those would be included in your analysis.

Dr. GODDARD. They would be, indeed, sir.

Senator HUGHES. Do the State chapters of your association offer advice to State legislative committees and advisory groups on drugs?

Dr. GODDARD. It works in several ways. We have regional offices of the American Public Health Association and technical expertise is provided upon request to State legislative committees who are considering such measures.

I think I can speak on behalf of the association and our program area committee as well as the membership and say that we would be more than pleased to provide whatever assistance we can to State committees, State agencies of government in helping get at this problem in a more rational fashion than we have to date.

We have a lot of laws that are really quite distressing with some young people being convicted for 50 years for simple possession of marihuana in one State and in other States it is 1 week, a misdemeanor. That is not a rational way for our society to handle a problem that is as broad scale and wide as this one.

So, we would work toward that end.

Senator HUGHES. In two States isn't there actually a death penalty for passing marihuana?

Dr. GODDARD. Georgia is one of those States and I happen to be from Georgia at this time. Georgia does impose the death penalty for conviction for second sale or distribution to a minor.

The first penalty is life imprisonment, conviction of the first offense. I am not certain about the other States. I would like to look at the analysis of State laws, but it illustrates the ridiculousness of laws and the situation we are in today where as a Nation we are not approaching this problem with any degree of rationality.

That is why we are concerned about the administration bill. I personally think, and the association thinks, it is a bad measure. It is regressive, it is offering harsher penalties and it does nothing to get at the root causes of the problem.

Until we begin to approach the root causes, Senator, as you well know, we are not going to get out from under it.

Senator HUGHES. You challenge me to get into areas you have not testified to, but I will try and restrain myself.

Dr. GODDARD. I will be happy to go into any area. I am well known for that.

Senator HUGHES. We have also had testimony, I believe, here today regarding the very difficult ways of doing adequate research. Would you care to add any additional comment to this in your broad experience?

Dr. GODDARD. I would say having reviewed the world's literature on marihuana in preparation for four congressional hearings in 1 week, and having talked to experts in this field, I have grave concern about the administration bill's possible impact on research and so does the American Public Health Association.

I would have to submit that we might not be in the predicament we are in today if we had not had such restrictive controls upon research on marihuana beginning with the Marihuana Tax Act in 1937. That act made it almost impossible for good research to be carried out in marihuana.

Now there are those who were involved with its administration who will plead otherwise. But one only has to look at the body of scientific literature and the absence of good work, the absence of almost any work of meaning in that time period, to recognize what impact those controls had.

Here we are about to embark upon another system of controls which has just as much potential for dampening and suppressing our research in this field, in the whole field of drug abuse. We are just beginning to support good research. This is the dangerous part of it.

Marihuana is just a token, if you will, of the problem of drug abuse in our society, because it is extended to all social classes and all age groups. We are concerned as an association with the broader problem of abuse of tranquilizers, amphetamines, barbiturates, by people who are considered to be upright citizens, pillars of the community, who get their medications legally, not like the young people who have to get them illicitly.

The one is just as much a problem as the other and just as much a threat to our society and our institutions. So we have to have research on a broad front to begin to get at these problems.

Senator HUGHES. I recall your statement of this sudden realization by our young people that the law may be unjust and that science may be wrong. I have had a great deal of testimony before this subcommittee and also I suggest several hundred letters from young people on college campuses who, incidentally, signed their names and gave their addresses.

They are not hiding the facts about the scarcity of marihuana presently due to a shortage or inclement season in Mexico or whatever it is, and the fact that so many of their friends are now going on to the amphetamines and to harder narcotics and are experiencing some very bad results.

We have confused this whole scene of marihuana, amphetamines, and heroin all in one package to the extent that they now believe it is one method.

Dr. GODDARD. First, you will be glad to know the customs people say there is a good crop down in Mexico and the shortage is about to be alleviated. It does raise a question.

As a national policy do we really consider what the alternatives are, what the outcomes will be derived from stiffer enforcement along the border on getting the Mexican Government to destroy the fields as they are growing. If one of the alternatives is to drive more people to experiment with hard narcotics, which have more of a predilection for producing physical dependency, then I say we ought to carefully consider that policy before we adopt it.

Years ago, I am told, Chief Jenkins in Atlanta comments on the drug scene and said, "We don't have hard narcotics here. We have a little marihuana, but I think maybe we had better leave well enough alone."

There are those who will recoil from that kind of philosophy, but I submit it is a fairly realistic philosophy when we don't have the other kinds of answers that enable us to solve the problem. You see the absolute ban, the prohibition we know does not work.

The Department of Justice testified that since 1960, in 8 years, from 1960 to 1968, there was a 322-percent increase in arrests due to drug abuse; 43,200 were under the age of 18 and 6,243 were under the age of 13.

Now that was in the statement from the year 1968, they arrested 162,177 persons all told that year; 42,000 of them, or 25 percent, were under the age of 18.

Mr. Chairman, this is a serious problem. We are arresting people for felonies who are minors because of laws that are unenforceable, that aren't based on good science. I think we have got to begin to cope with this problem in a more realistic way.

Senator HUGHES. Dr. Goddard, I would like for you to just re-enforce your statement in this line on what you said about Senator Yarborough's bill, about reclassifying marihuana. Everything you have said is supporting that.

Dr. GODDARD. Yes; we feel as an association and I strongly feel as an individual citizen that the bill that Senator Yarborough has introduced and you and a number of your colleagues have endorsed is a realistic step. It is in the right direction, it is classifying marihuana as a hallucinogen. At best it is only a mild hallucinogen.

It puts it under the Food, Drug, and Cosmetic Act, and it makes it a misdemeanor with up to a year in prison and up to \$1,000, which is a maximum under that act. It is another kind of a problem, but there it is. This would be an intelligent step forward that Congress could take.

Senator Yarborough, I am sorry you were not here before. I understand your busy schedule. I am pleased that you are here, because we think you have introduced a good piece of legislation and we hope your colleagues will react to it appropriately and it will be passed in this session of Congress.

Senator HUGHES. I was going to defer to Senator Yarborough for questions at this point.

Senator YARBOROUGH. We are very pleased with your strong support of this measure as representative of the APHA and the other groups you represent and your generous offer. We appreciate very much your leadership of the American Public Health Association.

As you know, our staff has worked for months on this bill. In fact, I wanted to introduce it earlier, but they were working with many people in this field.

I am offering, with the able and very dedicated Chair of this subcommittee, bill 2608 because of what I have learned in days of hearings earlier this year as chairman of the Health Subcommittee on this problem.

Realizing that we didn't have time in the Health Subcommittee to go into it as deeply as necessary, we created this Special Subcommittee on Alcoholism and Narcotics, the first in the history of the Senate. The distinguished Senator from Iowa agreed to serve as chairman. He is a very able and dedicated man in that position. He has been doing great work.

But in those earlier hearings as chairman of the Health Subcommittee we learned that the use of other dangerous drugs has spread from the high schools to the junior high schools and now to the grade schools.

To me it is just intolerable to pick up these teenage kids in high school who have smoked a few marihuana cigarettes and send them to the penitentiary for years with hardened criminals and sex perverts.

We need to reclassify this law as you so strongly testify. I think marihuana is pretty dangerous, but it is not a narcotic.

We learned further that some pupils smoke one cigarette and say, "That is not for me, I am through with it." So we want research in learning why some become addicts, why some say, "One trip with that and I am through." To paraphrase a line or two from "Macbeth," if we put everybody in the penitentiary who uses marihuana, there might not be enough left outside to guard it.

We know we are dealing in a field where the legislation is antiquated, improper. We need new approaches; we need research. With your great expertise, it is a pleasure to see you back here again.

It must be a great source of personal satisfaction and pride to realize that you had such an active and accomplishing role in bringing health care in so many areas to the American people, to improve the research and treatment of the major killers of mankind in America—heart, cancer, and stroke and many other things.

I could not review it all here in one afternoon. We compliment you and I am glad to see that you have taken this position with the American Public Health Association and that you have offered us your help and the help of that association in this difficult field of legislation.

We invite your continuing advice and I am speaking now for the Health Subcommittee of which I am chairman. I will cooperate with the chairman of this subcommittee in whatever he asks you to do to help us here.

Thank you very much.

I have read this statement and it is based on great knowledge and great experience and it is going to be very helpful to this committee.

Dr. GODDARD. Senator Hughes, I would disclaim much of what Senator Yarborough said about me. He is most generous. But one point I would like to pick up from what Senator Yarborough stated. I would hope the Senator also meant to include the problem of alcoholism as one that needs further research and understanding as to why some people can imbibe and some others can't.

What we must keep in mind in this society is that we are threatened by our chemical environment, that we have many substances that can and are being abused and will be abused and the passing of a law against a specific substance is not an answer. It is really most ineffective.

What we need to get at is the understanding of people, what shapes their personalities, what remedies can we seek to prevent the abuse of chemicals, no matter what their nature.

You see, when we begin to look at that part of the problem, we then begin to undertake the educational efforts, and I should stress those should be started today. I would like to ask that at a later point in time that Mr. Cron be given an opportunity to describe what we did at the Food and Drug Administration in an attempt to help provide good material for the schools.

But when we begin to do those things, then we will begin to get at the problem of abuse of chemicals, cigarettes, tobacco. You see, if we were to substitute tobacco for marihuana, we would have some interesting similarities.

The New York Times editorial on Friday, 2 weeks ago, said that with respect to cigarettes and the evidence that has been accumulated to date, they should be banned. They are a health hazard to a serious enough degree, but keeping in mind what happened with the Volstead Act, we doubt that would be feasible.

We conclude therefore that if a person 21 years of age or over has been fully informed of the dangers of smoking and chooses to do so, then he must be given that right. Now I bring this up, Senator, because I first heard this 3 years ago in Haight-Ashbury, and I heard it on the campuses of colleges in the intervening period of time.

Simply insert the word "marihuana" and it is the same argument that the young people make with regard to the use of that substance, you see, or alcohol.

Alcohol in terms of inciting people to acts of violence is far worse than marihuana. Now don't misunderstand me. I am not pleading for legalization here. I am pleading for rational handling of the difficult national problem.

Senator YARBOROUGH. That is what our bill tries to do. If you see other things from your vast experience in your profession and your vast governmental experience with health, any recommendations you have, we would be glad to have them.

We realize this is a difficult problem for which we don't know the answers, because we have not had enough research. You go to the basic things, personalities. Why is it that one young person calls for more and more and the other young person says, "I have tried that. I won't take it."

There are many questions that are unanswered and we seek research in this bill and treatment. Basically we need to find out why. You say there are other drugs more dangerous. We have had cases before us of glue sniffing where death has resulted, and we have been told that in some cities merchants could not keep varnish thinner in furniture stores because the kids in high school were sniffing it.

Not only that, the kids would put plastic bags over their heads to get a kick from one or two sniffs and they would suffocate or they would have permanent brain damage from doing it.

Dr. GODDARD. Or liver damage.

Senator HUGHES. Dr. Goddard, now that you mentioned alcohol, I was not going to bring it up, but you did bring it up. It is a favorite subject of mine. I have been questioning most of the medical researchers in testimony here in precisely the area you have mentioned.

Alcohol does, in fact, affect more than the alcoholic. The insidiousness of the disease, minimally estimated, three or four people for every ailing alcoholic are affected by it.

Dr. GODDARD. That would mean 18 million people in our society as a minimum are affected.

Senator HUGHES. I would hazard a guess at 40 million.

Dr. GODDARD. I would agree with your guess.

Senator HUGHES. Because we hide it so completely and so well until it is completely deteriorated that we are not at a definitive line to say, "You are an alcoholic."

We leave it up to the person to make that decision. But as you pointed out on cigarettes and tobacco, this Government spends about \$500,000 a year in educational programs as to the harm of usage of tobacco. Is that correct? Do you recall?

Dr. GODDARD. I have not seen any figures on how much they spend on the harm and use of tobacco; but I know we spend at least that much or more in promoting the sales of tobacco overseas as a Government.

Senator HUGHES. And we spend millions in support of growing it?

Dr. GODDARD. Yes, indeed. It is an interesting situation which has been commented on by others who are far more capable of analysis than I, that we underwrite crop subsidies, on the one hand, and provide public moneys to the health service, on the other hand, to fight the use of the crop we support.

I suspect the answer is going to have to be arrived at here by Congress with your colleagues from North Carolina, South Carolina, Georgia, who have a very lively interest in preservation of the present system. Only through debate here in these halls will you get at that problem.

We are helpless as individual citizens.

Senator HUGHES. It has also been reported to me, there was an editorial somewhere in this immediate area, saying as long as we put the liquor salesman on the city council and the pot salesman in the city jail, we have an acute problem.

Dr. GODDARD. There is no question that we favor one form of abuse over another.

Senator HUGHES. We have had testimony by young people here to the very point you made in your statement. They say you and your generation have your drug—it is booze. Why do you want to deny us in our generation our drug, which is marihuana?

Dr. GODDARD. Well, now that is a sort of a difficult argument for me to accept. I understand—I have had them throw it at me. But I like to turn it around to them and say, "Why do you have to have anything? Can't you overcome the problems to the extent that you don't really require anything?"

Can't we as a society begin to get out of our structure of society, our institutions, our interpersonal relationships and improve all of these things in such a way that humans won't have to cop out with anything?

Maybe that is asking for too much.

Senator HUGHES. I think you are perfectly right. Do you think we might begin by abandoning the cocktail party as a reception vehicle?

Dr. GODDARD. I vote for that.

Senator HUGHES. And the "happy hour."

Dr. GODDARD. Fine.

Senator HUGHES. How popular do you think that would be in America?

Dr. GODDARD. I think the alcohol lobby would fight strongly against your reelection if you brought that up.

Senator HUGHES. I am told we collect more than \$8 billion a year from taxes on alcohol and spend a few million to recover the alcoholic.

Dr. GODDARD. I think that is the truth, even in those areas where they have begun to recognize the alcoholic is a sick person. The taxpayers, through their elected representatives, have been unwilling to provide the medical facilities to provide proper care, so out of desperation the alcoholics again are trundled off to the work farms and into the city jail on a revolving door policy.

It is a very difficult problem for any major urban area where these problems are always more visible and seem more acutely.

Senator HUGHES. We had one very able witness testify in our alcoholism hearings that the truth of the matter was we could stand each other when we were sober.

Dr. GODDARD. He may have a good point.

Senator HUGHES. I just bring that up as a physician remark really, Dr. Goddard, though I think the spectacle we present is one that has to be overcome. All of my life in going to the theater and, before we had television, the instantaneous solution to a problem was a big, husky jowl of booze whenever something came up that shocked us a little bit.

If we lost a loved one, we found a solution in a bottle. If anything else came up, we found it in a bottle. Today it is the same thing, only it is in every living room in America, and many times in the bedroom and the kitchen as well.

As long as we present this type of an image, we are not going to face realistically the problem that marihuana has grown to in recent years. I think the testimony you gave of the constant need to update information in this field of drugs is one that was developed 5 years ago. Nothing applies to what is going on today; yet if you go to the library you are getting antiquated material, are you not?

Dr. GODDARD. And very little material is available. You asked a previous witness, Dr. Henry Brill, whom I have known for many years and admire greatly, what was available for the general public.

That question and his response were of interest to me, because coming up on the plane today and preparing for this hearing and a speech I have to give tomorrow on drug abuse, the gentleman seated next to me was aware of the material I was looking at. He asked me, "You know, I have a 14-year-old son who just entered high school. What is there I could read?"

This stopped me short and I did have this package of material from the American Public Health Association in my briefcase. I went through it and selected one publication for him. I gave it to him, so I can't give it to you for the record, but I would like to submit it at a later date, if I may.

Senator HUGHES. We would be happy to have it.

Dr. GODDARD. But it illustrates the problem I run into in traveling around the United States. People are hungry for information about drug abuse in general, marihuana specifically, and there are very few good pieces of literature available for them, factual information.

I would answer one of your questions that you posed to Dr. Brill. What can we do? You could fund, in using the mechanism of S. 2608, community councils. We just formed one in Atlanta, an interagency council on alcohol and drug abuse.

I am chairing that council. It is obvious that through these media and through those channels that agencies, existing agencies, show we have mechanisms for distribution already established.

Some moneys to provide the printed material and the preparation is needed. I would hope that in your legislative deliberations you would encourage the Office of Education to be even more involved in the future than they have in the past. That is another very excellent channel for getting good information.

Senator HUGHES. We had testimony this morning by Mr. Ingersoll from the Justice Department of their great reluctance to relinquish any of the areas that the Yarborough bill recommends and they presented a pretty strong opposition to it.

We have seen a change by the administration and again I say this just as a matter as I observe it, a change of position day to day on this.

I thought the Attorney General testified day before yesterday that the penalties were far too stiff and we ought to examine areas of perhaps even a weak penalty of usage of marihuana, and yet they still want to hold onto the areas of research, control, medication, education, and many other things.

If I understand your testimony, you feel strongly this should be with HEW?

Dr. GODDARD. Yes; and may I make clear something, Mr. Chairman. I was one of those who advocated transfer of the functions from the Department of the Treasury and the Department of Health, Education, and Welfare, and specifically FDA to the Department of Justice, to bring together the Bureau of Narcotics and the Bureau of Drug Abuse Control in a single agency that could become more effective.

I am sorry to say I don't think that has happened. I am surprised that on such short possession the Department of Justice has become such a zealous guardian of some prerogatives that were granted to them by presidential reorganization and by Congress failing to act in a negative fashion on that issue.

The point I would like to make is this: They have continued to work in the enforcement area almost exclusively. They have not devoted enough resources to checking for illegal diversions of amphetamines, barbiturates, and tranquilizers. They have concentrated on the employment of agents rather than accountants who are necessary for this kind of activity. They have not got at the organized crime, the syndicate, the Mafia, in a fashion that would help dry up the sources of "hard narcotics," heroin, et cetera, to the extent that I would have hoped they would.

Now the time is early; yes, we must give them more time and encourage them to do that. But it is clear to me at least from the testimony offered and by the bill they have submitted, which is just

unbelievable—I can only characterize it that way—that they really are perceptive of where the problem is in the sense that they need to get involved more in educational efforts and they need scientific expertise to a greater degree.

That is why I now reverse my stand completely of some 18 months ago and recommended that these functions as described in the Yarborough bill be removed from the Department of Justice and brought back to HEW.

Senator HUGHES. I thank you very much for your testimony. You have been a great help to us today and it has been so good that I hope you might consider favorably testifying in the future on the bill on alcoholism, which we will also be considering and which has a very devastating effect in this country, touching so many lives that it is almost immeasurable at this point.

Thank you very much.

Dr. GODDARD. Thank you, Senator.

Senator HUGHES. The session is recessed.

(Whereupon, at 4 p.m. the subcommittee recessed, to reconvene at 9:30 a.m., the following day, Friday, September 19, 1969.)

COMPREHENSIVE NARCOTIC ADDICTION AND DRUG ABUSE CARE AND CONTROL ACT OF 1969

FRIDAY, SEPTEMBER 19, 1969

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:40 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes and Javits.

Committee staff members present: Robert O. Harris, staff director; John S. Forsythe, general counsel; James Babin, professional staff member to the subcommittee; Roy H. Millenson, minority staff director; and Eugene Mittelman, minority counsel to the subcommittee.

Senator HUGHES. The committee will come to order.

The first witness is Mr. Creed C. Black, Assistant Secretary for Legislation, Department of Health, Education, and Welfare.

I would like the record to show that the committee asked Secretary Finch to testify and asked Dr. Egeberg to testify. Mr. Black, are you speaking for them, or are you speaking for yourself?

Mr. BLACK. I am speaking, Mr. Chairman, for the Department, for the Secretary.

Senator HUGHES. I talked to Dr. Egeberg on the phone last night and asked him to appear again before this subcommittee and testify, and I am going to give him time to work out problems he has, and I hope he can return and testify here, because repeatedly I have been trying to get the Secretary to come and testify, and he has been unable to do it.

I think when we are dealing with this important piece of legislation, that we should have the people directly involved in the decision-making come—which is certainly no reflection on yourself—but I am still going to keep pressure and insist that we do have testimony from the Secretary and Dr. Egeberg on this subject.

If you will, introduce your colleagues and proceed with your statement.

STATEMENT OF CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY THEODORE ELLENBOGEN, ASSISTANT GENERAL COUNSEL FOR LEGISLATION; AND DR. MORTON G. MILLER, ASSOCIATE DIRECTOR FOR SPECIAL AND COLLABORATIVE PROGRAMS

Mr. BLACK. Let me say first, in response to your comments, that I want to thank the members of the staff of the committee for arranging a 1-day delay in our appearance. We did hope to have Dr. Egeberg present. We had some serious scheduling problems, deriving in part, as you know, from the fact that this hearing was scheduled less than a week ago.

Dr. Egeberg had hoped to be here today, which is why we requested a 1-day delay, but we were not able to arrange his appearance. I am sure he probably told you last night that he had a longstanding commitment today to a group of people he has invited from all over the country to discuss one of the two subjects he told you earlier was dearest to his heart, family planning, the other being alcoholism.

But Dr. Egeberg is certainly a knowledgeable professional on this question that you are discussing. I am sure that he would be glad to come back and appear before the committee subsequently, and I think the same is true of the Secretary.

Meanwhile, however, I can assure you that I have participated in the decisionmaking process within our Department on this question of drug-abuse legislation, and I speak here today for the Secretary and for the Department.

I have with me on my right Mr. Theodore Ellenbogen, Assistant General Counsel for Legislation; and on my left Dr. Morton Miller, Associate Director of the National Institute of Mental Health.

We are here to discuss the problem of drug abuse in the United States and the efforts of the Federal Government to deal with this problem.

I think that the foundation on which legislative decisions should be based was expressed by President Nixon, in his message to the Congress on this subject.

The President pointed out that—

It has been a common oversimplification to consider narcotic addiction or drug abuse to be a law enforcement problem alone.

Pointing out that the effective control of illicit drugs requires the cooperation of many agencies of the Federal, State, and local governments, the President said:

At the Federal level, the burden of the national effort must be carried by the Departments of Justice; Health, Education, and Welfare; and the Treasury.

The Department of Health, Education, and Welfare is strongly in favor of this joint approach, Mr. Chairman, since drug abuse stems from a variety of social and psychological roots and is a problem of complex proportions.

Any solution will require the participation of the health, scientific, and medical experts in the field, working with law-enforcement officials.

The Department of Health, Education, and Welfare has the primary responsibility to develop research in drug abuse; to train the skilled manpower necessary to operate effective treatment and rehabilitation programs; and to support educational efforts at all levels of our society on the specific risks and dangers of illicit drugs.

Through these activities, which are centered in the National Institute of Mental Health, the Department is seeking to help meet the nationwide demand for effective governmental action in the field of drug abuse.

In this regard, we must intensify present efforts and embark on new approaches toward solving our Nation's dilemma.

The proposal before this committee recognizes the key importance of research in efforts to learn more about the use and misuse of drugs.

As President Nixon has said:

In addition to gathering existing data, it is essential that we acquire new knowledge in the field. We must know more about both the short- and long-range effects of the use of drugs being taken in such quantities by so many of our people. We need more study as well to find the key to releasing men from the bonds of dependency forged by any continued drug use.

The National Institute of Mental Health has primary responsibility in this area, and I am directing the Secretary of Health, Education, and Welfare to expand existing efforts to acquire new knowledge and a broader understanding in this entire area.

While we generally favor the long-range goal of a new national center for narcotic and drug abuse research, we believe, Mr. Chairman, that further consideration of this proposal should be deferred until budgetary constraints are less stringent.

The Department also generally supports expansion of the training of personnel in the drug abuse field. There are far too few people who are trained to provide treatment, aid the drug abuser in rehabilitation, or operate drug control programs. It is imperative that this situation be remedied.

HEW, however, already has the authority to carry out much of what is included on these matters in the bill before you today.

The Department of Health, Education, and Welfare also favors extension of Federal support to States and communities, in the joint funding of community mental health centers, in which treatment and rehabilitation of drug abusers can be most effectively provided.

The proposal before this committee, Mr. Chairman, includes provisions which would enable us to expand and strengthen these efforts toward community support. This is especially important, since States and communities, alone, are finding it difficult to marshal the financial and personnel resources necessary, without Federal aid.

We have begun to innovate such community-based programs, as a result of the passage of the Community Mental Health Centers Act and the Narcotic Addict Rehabilitation Act. As I indicated in previous testimony before the Senate Health Subcommittee, Mr. Chairman, it is our intention to include our specific proposals for both narcotics and alcoholism centers in the legislation we will submit soon on community mental health centers.

We believe that Federal support of these special-purpose facilities should be provided as an integral part of the network of community mental health centers. As I also testified earlier, however, we believe

that services for alcoholics and narcotic addicts will require special incentives—including preferential matching and a longer period of support than 51 months.

Through its administration of the Narcotic Addict Rehabilitation Act and the narcotic addict rehabilitation amendments to the Community Mental Health Centers Act, the National Institute of Mental Health is actively carrying out the congressional mandate to treat and rehabilitate, rather than punish, the drug addict.

As of June 30, 1969, the six community treatment programs funded under the provisions of NARA had a total of 1,948 addicts in treatment. By next year, the 10 community programs funded in fiscal year 1969 expect to be treating an additional 5,000 addicts.

In terms of community mental health centers, Mr. Chairman, their acceptance by the people who can go to them for aid in solving mental health problems of many kinds has been most gratifying.

As I said to the committee in July, the community mental health program is a major element in HEW's effort to alter the Nation's traditional patterns of organization and delivery of health services. This administration is committed to its continuation.

However, experience indicates that some changes are needed to meet problems which have been encountered, including increased need to provide services within these community mental health centers for the drug addicts and those who need treatment as the result of abuse of the other dangerous drugs.

Across the Nation, many communities which have been aware of their needs have been unable to initiate plans for community mental health centers, for lack of local resources. Other communities which have developed center programs have done so under provisions which call for the gradual decrease and termination of Federal support of the costs of initial staffing.

This administration, therefore, is actively working on legislation for extension of the community mental health centers program, including narcotic treatment and rehabilitation centers. We are doing so, as I testified earlier, in the context not only of the needs of this program itself but of the larger administration legislative program. For while our department is most strongly in favor of providing more research and treatment facilities and more trained manpower to meet the drug abuse problem, we must not lose sight of Federal budgetary constraints.

I would like now to turn to a problem which has been a subject of general discussion in recent months: the means by which dangerous drugs are classified, in terms of their risk to the population.

The administration, Mr. Chairman, favors provisions of S. 2637—which is under consideration in another committee of the Senate—since that proposal allows for flexibility in the classification of dangerous drugs, based on the need to be able to change such classification on the basis of new scientific knowledge, as it is developed.

We would also favor provisions of the same proposed legislation in regard to the establishment of responsibility for making a determination of the properties of each dangerous drug in such classifications.

In that bill, the Secretary of Health, Education, and Welfare is required to submit recommendations on the determination of these drugs,

in writing, to the Attorney General, and a Scientific Advisory Committee is also proposed, whose members would provide medical and scientific competence in this regard.

The Department of HEW therefore believes that this proposal will provide a procedure through which the advice and recommendations of the scientific and health community will be adequately presented in the determinations affecting these drugs.

In regard to the proposal before this committee which would transfer to this Department the classification of drugs with respect to their abuse potential, we prefer the procedures as set forth in S. 2637.

The Attorney General has stated that his point of view is flexible in regard to penalties and that he will be happy at any time to consult with others who share concern over the proposed changes in the penalty structure now in force in present drug statutes.

This concludes my formal statement, which has been necessarily brief because of time pressures. However, it is obvious to those of us in this administration that major changes in our national approach to the use, abuse, and control of dangerous drugs are overdue.

The recognition of this fact was reflected in the Presidents message, and the details of the changes we favor can be seen from the administration legislation already introduced, from the community mental health centers bill we hope to have before you soon, and from our formal departmental report on the legislation before you today, which also is in preparation.

I feel sure that the President, the Congress, and the various relevant departments of the executive branch can now establish the foundation of a policy which will provide protection to our society, without undue and inappropriate repression of any individual.

I would be happy, Mr. Chairman, to try to answer any questions you have.

Senator HUGHES. Mr. Black, the last witness yesterday appearing before this subcommittee stated that the only word he could find to describe the administration's proposal was "unbelievable," that it was a regression, that it was a step backward, and that it did not primarily concern itself with the health of the people of this country.

Now obviously you disagree with that statement of Dr. Goddard, a former FDA Director. That may not be an exact repetition of what he said, but in substance I believe it is factual.

With his long experience in this field, and with his present position of representing the Public Health Association of America, it certainly is in disagreement with the testimony you have just given the committee.

Do you think there is any reconciliation of those two viewpoints?

Mr. BLACK. Well, obviously, Senator Hughes, I would disagree with what Dr. Goddard said, and I think our Department would disagree.

I want to make this point plain about the administration's legislation, if he was referring to S. 2637: This is an administration bill, not a Justice Department bill.

The Department of Health, Education, and Welfare was consulted thoroughly and frequently in the preparation of this bill.

Senator HUGHES. Were you heard?

Mr. BLACK. We were listened to.

Senator HUGHES. How many of the debates did you win when you argued on points of the bill?

Mr. BLACK. I think, Senator Hughes, I could say we won all the major debates, and I really wouldn't call them debates.

Draft bills were exchanged. There were numerous conferences at the staff level. Professional people in HEW were asked to analyze the bill, to come up with their recommendations, with their objections to it, with any suggestions they might have.

Those were summarized and points of differences were crystalized for the Secretary. The HEW position was staked out. We met with Justice Department representatives, made our recommendations on the changes we thought were necessary to protect the interests of the scientific and medical communities, and the Department, and numerous changes were made in the bill on all of our major points, to our satisfaction.

Senator HUGHES. It is certainly not to my satisfaction, and I am disappointed that this is your total viewpoint on the approach to narcotics at this time in America.

But I do want to get down to the details of the bill. I know how you feel about it, and you know how I feel about it.

Mr. BLACK. Let me make one point here, Senator: that it is not our total approach.

Senator HUGHES. It appears to me it is your total approach. That is what bothers me very much. You talk about delays twice in your testimony due to budgetary necessities in your department.

Your department should look at the public health field in America and present and argue for that regardless of other budgetary requirements.

Mr. BLACK. Well, we certainly view it that way, and I say it is not our total approach. In the references I made to budgetary constraints, we are talking about a different piece of legislation, the Community Mental Health Centers Act. You and I discussed this on a previous visit that I had here when we were talking about that act.

I repeat what I told you then: The Department of Health, Education, and Welfare presses its case in matters such as this as vigorously as possible. We consider that to be our role. We also have to take into account the economic realities.

Senator HUGHES. What are the economic realities?

Mr. BLACK. They are that the country is in a very severe inflationary situation, that both the Congress and the President have imposed strict expenditure ceilings, that there are only so many dollars to be spent, and there are choices that have to be made among priorities. They are hard, but they have to be made.

Senator HUGHES. How many people are using drugs in America, Mr. Black?

Mr. BLACK. The estimates on that, Senator Hughes, vary quite substantially.

Senator HUGHES. What is your estimate?

Mr. BLACK. Dr. Miller has had more reliable figures on that, I think, than anybody in our department.

Dr. MILLER. In the area of hard narcotics, we estimate 100,000 to 200,000 persons who are addicted to and using heroin and drugs of that nature.

Marihuana is probably the most widely abused drug, our current estimates being that between 8 and 12 million persons have at least experimented with marihuana.

Hundreds of thousands of persons are using stimulants and sedatives, as well as hallucinogens.

Senator HUGHES. Is alcohol a drug?

Dr. MILLER. Yes, and I think it should be included. That is another 4½ to 6 million persons.

Senator HUGHES. I suspect these figures don't include the people around the lives of the addicts, plus the full jails. We had a local judge testify here yesterday that he was afraid to send a first offender into the city jail in the District of Columbia.

We have nothing to offer a narcotic addict, or a youngster smoking marihuana who is picked up on a first offense. The programs we have are total failures, and yet I think every person, every parent in America is worried. Don't you agree, Dr. Miller?

Dr. MILLER. Yes, sir.

Senator HUGHES. 200 million persons are living in fear of narcotics abuse and alcoholism. Wouldn't you consider that true?

Dr. MILLER. It is a great problem.

Senator HUGHES. Wouldn't you consider that a priority in America today?

Dr. MILLER. Yes.

Senator HUGHES. A problem of internal security and defense?

Dr. MILLER. I don't know that I am well qualified to respond to that.

Senator HUGHES. I think you are.

Dr. MILLER. As Mr. Black stated, this is a significant national problem of great magnitude.

Senator HUGHES. It is a critical national problem, isn't it, of the first magnitude?

Dr. MILLER. Yes, sir.

Senator HUGHES. It ranks with cancer and cigarettes?

Dr. MILLER. Yes, sir.

Senator HUGHES. It is just as important as all that.

As I take your testimony, Mr. Black, you are supporting the administration bill wholeheartedly with no changes, no alterations, no nothing. Is that correct?

Mr. BLACK. As I said, Senator, this is an administration bill. I wouldn't say that we support it in its present form without any changes at all. The Attorney General himself, in testimony before another Senate committee this week, invited the Congress to take a very close look at a particularly sensitive, controversial, and complex area, which is this whole area of penalties.

Senator HUGHES. If you wouldn't support this in its entirety, tell me where you disagree with it.

Mr. BLACK. I think, Senator, within our Department on this one area I was talking about, you will find the body of medical and scientific and professional opinion would favor a position similar to that outlined by the Attorney General himself on this question of penalties, favoring a much more flexible approach than the language as drafted provides.

The Attorney General said that the penalties that were sent up are largely those picked up from existing legislation.

I would like to read those words of the Attorney General, because I think they reflect a strong feeling within our Department on this question.

Mr. Mitchell said:

I personally believe in sentences which are reasonably calculated to be deterrent to crime and which also will give judges sufficient flexibility to tailor the sentences to the requirements of the drug violator or narcotics addict.

Prison is not the only logical alternative. In some cases, it might be advisable to use Federal rehabilitation programs, halfway houses, and private medical treatment while on probation or parole. Perhaps the most promising alternative is to approach the narcotics violator in relation to his function; the professional trafficker who should be given as severe sentence as possible; the casual and intermittent user who is perhaps only experimenting out of curiosity. * * *

Senator HUGHES. You are not a doctor, Mr. Black; are you?

Mr. BLACK. No, sir; I am not.

Senator HUGHES. I would like to direct a question or two to Dr. Miller, if I might.

Dr. Miller, is there any program in any prison or reformatory in America that you know of that does anything for the narcotic addict?

Dr. MILLER. The Federal Government does have a program for treatment within prisons for addicts committed under title II, sir.

Senator HUGHES. Where?

Dr. MILLER. I could supply that. I do not have the information with me.

Senator HUGHES. Do you have any knowledge, any medical knowledge, that they actually have brought about recovery from addiction to narcotics?

Dr. MILLER. In all fairness, Senator Hughes, those programs have been set up recently, and in terms of the specific program under title II, I think it is too early to make any definitive statement as to how effective they are.

Senator HUGHES. Judge Halleck testified yesterday that he took the proper court procedures to certify a young man, and when he was supposed to have a clinical report back at the end of the period of time that had passed, he asked the court for the papers on the man and found out the man was still in Lorton; that he had never been transferred. There was no clinical report back on the young man and there wasn't time to treat him.

How long does it take, Doctor, to treat or hope to treat a man who is addicted to heroin?

Dr. MILLER. It is a long-term process, Senator Hughes, starting with an evaluation, withdrawal from narcotic drugs, and then intensive treatment and rehabilitation.

As you know, most addicts suffer from a variety of problems, both psychological and social; and for effective rehabilitation, significant job training and education needs to be done as well as psychiatric treatment.

Certainly the 3 years which are provided for under the provisions of the Narcotic Addict Rehabilitation Act is a reasonable period of time for the comprehensive treatment of narcotics addicts.

Senator HUGHES. In other words, Doctor, with a minimum of 3 years applied, any man who is convicted under a misdemeanor and sentenced to a year has no hope for treatment; does he?

Dr. MILLER. Treatment certainly could start within the correctional setting; but in terms of the—as I said earlier—the treatment and rehabilitation of the addict, this would certainly take longer than 1 year, I believe, in most instances.

Senator HUGHES. Believe me, I favor this program. I am not trying to say anything against the program. I am just trying to get into the record that actually, even though the program is there, most offenders, at least on a first offense, are rather short-term prisoners, are they not, or is your knowledge adequate enough on that?

Dr. MILLER. I would like to distinguish between titles I and III and title II of the act. Title II is administered by the Justice Department in toto, although we assist in various ways in that regard.

Titles I and III are civil commitment programs which allow us to have an addict put in an inpatient as well as an after-care phase for a period up to 42 months in some instances.

Senator HUGHES. Well, it is my opinion from what observations I have been able to draw before this subcommittee to this point in the hearings that we cannot possibly take the rapid revolving-door repeater and do very much with him. Though our intentions are right and the start is in the right direction, our approach to this is still inadequate, and I have very little hope that we can succeed with this type of institutional approach.

We have had a number of witnesses testify on rehabilitation, and I am sure you have read about them in the papers. One man said that he had been in nine prisons, including two Federal prisons, and another had been in seven, including two Federal. In every prison they were easily able to get heroin, in fact more easily than he was on the street, and maintain their addiction in the prison.

In the city jail here—and in most large city jails in the country—it is as readily available as it is on the street.

To keep an addict off drugs when they are so available inside the institutions is almost impossible. So the setting seems almost impossible, under those circumstances, unless it is completely isolated, which I am sure would then contradict your other formulas of recovery.

Dr. Miller, I would like to ask your professional opinion, while I am talking to you.

Bill S. 2608, as you know, recommends a reclassification of marihuana.

As a professional, as a psychiatrist who has labored long in these areas, what is your professional opinion of marihuana?

Dr. MILLER. Speaking in that context, as a professional, Senator Hughes, on the basis of knowledge available to us today, I think first of all it is quite clear that marihuana is not a narcotic drug, and I think this needs to be clearly stated because in some ways some of our difficulties in reaching, particularly the youths who have used these drugs, is a lack of credibility, frankly, on our side.

I think one of the first things we could do to reestablish the credibility, which is a critical first step toward an effective program of prevention and treatment of addiction, is to clearly establish that marihuana is not a narcotic drug.

Marihuana is a mild hallucinogen. It is a euphoriant, it can affect behavior in unpredictable ways. I believe that it is a dangerous drug and should be perceived as a dangerous drug and should be controlled.

I do think, as a professional, that I would seriously question the extent of penalties, particularly the mandatory structures, directed at the possessor and experimenter and user of marihuana. I think that, professionally speaking, the jail sentence, the felony conviction associated with a possession offense under current legal structure is in

many ways much more detrimental to the user than the casual use of marihuana cigarettes:

Senator HUGHES. This bill primarily recommends that marihuana be reclassified with hallucinogens. You said it is not a dangerous narcotic. Since becoming chairman of this subcommittee, I have had difficulty in keeping the terminology straight. I think it is confusing to most Americans, and is one of the difficulties we are dealing with, whether we are talking about a drug or a dangerous narcotic, a hallucinogen, or however we are classifying it.

Did I understand correctly that you feel it is in the category of hallucinogens, is a dangerous drug, and should not be distributed freely, but should be controlled? Is that right?

Dr. MILLER. Yes.

Senator HUGHES. Could you, then, tell me this: Part of the problem we have encountered is a total disbelief among the young people in the country. They feel we have not been factual in our approach to marihuana, and that there is probably no more danger in amphetamines and speed than there is in marijuana. What is your professional opinion about that?

Dr. MILLER. From a scientific standpoint, from what we know about the actions of the drugs, amphetamine, or speed, when used intravenously is probably a more dangerous drug than marijuana.

Senator HUGHES. Is it more dangerous than heroin?

Dr. MILLER. That is a difficult kind of association to make. I think in a rated list of dangerousness, I think heroin and particularly intravenous amphetamines are equally dangerous to life, as well as to the psychological health of the individual. They are quite dangerous.

Senator HUGHES. Are you familiar with the statistical evidence on deaths from the use of amphetamines?

Dr. MILLER. I don't have what I would consider accurate information on deaths associated with amphetamines, no.

Senator HUGHES. I am not sure that I have, either. That is one of the difficulties with which we are coping. I was hoping that perhaps you did have. I would appreciate it if you could supply whatever statistical evidence you have in these various categories to the subcommittee. It might be helpful to us. I think that we have to approach this problem in its different phases, and completely recognize that progression from marihuana to amphetamines is a very dangerous step, and is not similar to progression from alcohol to marihuana, for example, if we are talking about the two drugs in that particular phase.

I think this is part of the public education process we are dealing with.

(The information subsequently submitted follows:)

DEATHS FROM USE OF AMPHETAMINES

A review of the information available to us indicates that there is no data available on the deaths from use of amphetamines. We do know, however, that intravenous use of amphetamines is hazardous not only because of possible overdose, but also because of psychological damage and possible physical disability such as hepatitis from contaminated needles.

Senator HUGHES. Mr. Black, I would like to ask you what particular steps you feel should be taken in the country at this time in the field of education, because we have had repeated testimony that the prob-

lem of drug abuse in our society is epidemic at this particular time. Do you agree that it is epidemic, that it is growing and growing dangerously?

Mr. BLACK. Yes, sir. I want to make that plain, Senator. There is no disposition on our part to minimize the seriousness of the problem.

In the particular area of education, I think there has been some misunderstanding of the administration's policy. I want to point out to you that in the President's message on drugs, which I think bears reading again, and I assume is in the record of this committee—if not, I would like to have it inserted.

Senator HUGHES. If it isn't in the record, I will order it inserted at this point. I can't recall whether it is or not.

(The document subsequently submitted follows:)

CONTROL OF NARCOTICS AND DANGEROUS DRUGS

The President's Message to the Congress Outlining Actions Taken and Proposing Additional Measures. July 14, 1969

To the Congress of the United States:

Within the last decade, the abuse of drugs has grown from essentially a local police problem into a serious national threat to the personal health and safety of millions of Americans.

A national awareness of the gravity of the situation is needed; a new urgency and concerted national policy are needed at the Federal level to begin to cope with this growing menace to the general welfare of the United States.

Between the years 1960 and 1967, juvenile arrests involving the use of drugs rose by almost 800 percent; half of those now being arrested for the illicit use of narcotics are under 21 years of age. New York City alone has records of some 40,000 heroin addicts, and the number rises between 7,000 and 9,000 a year. These official statistics are only the tip of an iceberg whose dimensions we can only surmise.

The number of narcotics addicts across the United States is now estimated to be in the hundreds of thousands. Another estimate is that several million American college students have at least experimented with marihuana, hashish, LSD, amphetamines, or barbiturates. It is doubtful that an American parent can send a son or daughter to college today without exposing the young man or woman to drug abuse. Parents must also be concerned about the availability and use of such drugs in our high schools and junior high schools.

The habit of the narcotics addict is not only a danger to himself, but a threat to the community where he lives. Narcotics have been cited as a primary cause of the enormous increase in street crimes over the last decade.

As the addict's tolerance for drugs increases, his demand for drugs rises, and the cost of his habit grows. It can easily reach hundreds of dollars a day. Since an underworld "fence" will give him only a fraction of the value of goods he steals, an addict can be forced to commit two or three burglaries a day to maintain his habit. Street robberies, prostitution, even the enticing of others into addiction to drugs—an addict will reduce himself to any offense, any degradation in order to acquire the drugs he craves.

However far the addict himself may fall, his offenses against himself and society do not compare with the inhumanity of those who make a living exploiting the weakness and desperation of their fellow men. Society has few judgments too severe, few penalties too harsh for the men who make their livelihood in the narcotics traffic.

It has been a common oversimplification to consider narcotics addiction, or drug abuse, to be a law enforcement problem alone. Effective control of illicit drugs requires the cooperation of many agencies of the Federal and local and State governments; it is beyond the province of any one of them alone. At the Federal level, the burden of the national effort must be carried by the Departments of Justice, Health, Education, and Welfare, and the Treasury. I am proposing ten specific steps as this Administration's initial counter-moves against this growing national problem.

I. FEDERAL LEGISLATION

To more effectively meet the narcotic and dangerous drug problems at the Federal level, the Attorney General is forwarding to the Congress a comprehensive legislative proposal to control these drugs. This measure will place in a single statute, a revised and modern plan for control. Current laws in this field are inadequate and outdated.

I consider the legislative proposal a fair, rational and necessary approach to the total drug problem. It will tighten the regulatory controls and protect the public against illicit diversion of many of these drugs from legitimate channels. It will insure greater accountability and better recordkeeping. It will give law enforcement stronger and better tools that are sorely needed so that those charged with enforcing these laws can do so more effectively. Further, this proposal creates a more flexible mechanism which will allow quicker control of new dangerous drugs before their misuse and abuse reach epidemic proportions. I urge the Congress to take favorable action on this bill.

In mid-May the Supreme Court struck down segments of the marihuana laws and called into question some of the basic foundations for the other existing drug statutes. I have also asked the Attorney General to submit an interim measure to correct the constitutional deficiencies of the Marihuana Tax Act as pointed out in the Supreme Court's recent decision. I urge Congress to act swiftly and favorably on the proposal to close the gap now existing in the Federal law and thereby give the Congress time to carefully examine the comprehensive drug control proposal.

II. STATE LEGISLATION

The Department of Justice is developing a model State Narcotics and Dangerous Drugs Act. This model law will be made available to the fifty State governments. This legislation is designed to improve State laws in dealing with this serious problem and to complement the comprehensive drug legislation being proposed to Congress at the national level. Together these proposals will provide an interlocking trellis of laws which will enable government at all levels to more effectively control the problem.

III. INTERNATIONAL COOPERATION

Most of the illicit narcotics and high-potency marihuana consumed in the United States is produced abroad and clandestinely imported. I have directed the Secretary of State and the Attorney General to explore new avenues of cooperation with foreign governments to stop the production of this contraband at its source. The United States will cooperate with foreign governments working to eradicate the production of illicit drugs within their own frontiers. I have further authorized these Cabinet officers to formulate plans that will lead to meetings at the law enforcement level between the United States and foreign countries now involved in the drug traffic either as originators or avenues of transit.

IV. SUPPRESSION OF ILLEGAL IMPORTATION

Our efforts to eliminate these drugs at their point of origin will be coupled with new efforts to intercept them at their point of illegal entry into the United States. The Department of the Treasury, through the Bureau of Customs, is charged with enforcing the nation's smuggling laws. I have directed the Secretary of the Treasury to initiate a major new effort to guard the nation's borders and ports against the growing volume of narcotics from abroad. There is a recognized need for more men and facilities in the Bureau of Customs to carry out this directive. At my request, the Secretary of the Treasury has submitted a substantial program for increased manpower and facilities in the Bureau of Customs for this purpose which is under intensive review.

In the early days of this Administration, I requested that the Attorney General form an inter-departmental Task Force to conduct a comprehensive study of the problem of unlawful trafficking in narcotics and dangerous drugs. One purpose of the Task Force has been to examine the existing programs of law enforcement agencies concerned with the problem in an effort to improve their coordination and efficiency. I now want to report that this Task Force has completed its study and has a recommended plan of action, for immediate and long-term implementation, designed to substantially reduce the illicit trafficking in narcotics, marihuana

and dangerous drugs across United States borders. To implement the recommended plan, I have directed the Attorney General to organize and place into immediate operation an "action task force" to undertake a frontal attack on the problem. There are high profits in the illicit market for those who smuggle narcotics and drugs into the United States; we intend to raise the risks and cost of engaging in this wretched traffic.

V. SUPPRESSION OF NATIONAL TRAFFICKING

Successful prosecution of an increased national effort against illicit drug trafficking will require not only new resources and men, but also a redeployment of existing personnel within the Department of Justice.

I have directed the Attorney General to create, within the Bureau of Narcotics and Dangerous Drugs, a number of special investigative units. These special forces will have the capacity to move quickly into any area in which intelligence indicates major criminal enterprises are engaged in the narcotics traffic. To carry out this directive, there will be a need for additional manpower within the Bureau of Narcotics and Dangerous Drugs. The budgetary request for FY 1970 now pending before the Congress will initiate this program. Additional funds will be requested in FY 1971 to fully deploy the necessary special investigative units.

VI. EDUCATION

Proper evaluation and solution of the drug problem in this country has been severely handicapped by a dearth of scientific information on the subject—and the prevalence of ignorance and misinformation. Different "experts" deliver solemn judgments which are poles apart. As a result of these conflicting judgments, Americans seem to have divided themselves on the issue, along generational lines.

There are reasons for this lack of knowledge. First, widespread drug use is a comparatively recent phenomenon in the United States. Second, it frequently involves chemical formulations which are novel or age-old drugs little used in this country until very recently. The volume of definitive medical data remains small—and what exists has not been broadly disseminated. This vacuum of knowledge—as was predictable—has been filled by rumors and rash judgments, often formed with a minimal experience with a particular drug, sometimes formed with no experience or knowledge at all.

The possible danger to the health or well-being of even a casual user of drugs is too serious to allow ignorance to prevail or for this information gap to remain open. The American people need to know what dangers and what risks are inherent in the use of the various kinds of drugs readily available in illegal markets today. I have therefore directed the Secretary of Health, Education, and Welfare, assisted by the Attorney General through the Bureau of Narcotics and Dangerous Drugs, to gather all authoritative information on the subject and to compile a balanced and objective educational program to bring the facts to every American—especially our young people.

With this information in hand, the overwhelming majority of students and young people can be trusted to make a prudent judgment as to their personal course of conduct.

VII. RESEARCH

In addition to gathering existing data, it is essential that we acquire new knowledge in the field. We must know more about both the short and long-range effects of the use of drugs being taken in such quantities by so many of our people. We need more study as well to find the key to releasing men from the bonds of dependency forged by any continued drug abuse.

The National Institute of Mental Health has primary responsibility in this area, and I am further directing the Secretary of Health, Education, and Welfare to expand existing efforts to acquire new knowledge and a broader understanding in this entire area.

VIII. REHABILITATION

Considering the risks involved, including those of arrest and prosecution, the casual experimenter with drugs of any kind, must be considered at the very least, rash and foolish. But the psychologically dependent regular users and the

physically addicted are genuinely sick people. While this sickness cannot excuse the crimes they commit, it does help to explain them. Society has an obligation both to itself and to these people to help them break the chains of their dependency.

Currently, a number of federal, state and private programs of rehabilitation are being operated. These programs utilize separately and together, psychiatry, psychology and "substitute drug" therapy. At this time, however, we are without adequate data to evaluate their full benefit. We need more experience with them and more knowledge. Therefore, I am directing the Secretary of Health, Education, and Welfare to provide every assistance to those pioneering in the field, and to sponsor and conduct research on the Federal level. This Department will act as a clearinghouse for the collection and dissemination of drug abuse data and experience in the area of rehabilitation.

I have further instructed the Attorney General to insure that all Federal prisoners, who have been identified as dependent upon drugs, be afforded the most up-to-date treatment available.

IX. TRAINING PROGRAM

The enforcement of narcotics laws requires considerable expertise, and hence considerable training. The Bureau of Narcotics and Dangerous Drugs provides the bulk of this training in the Federal government. Its programs are extended to include not only its own personnel, but State and local police officers, forensic chemists, foreign nationals, college deans, campus security officers, and members of industry engaged in the legal distribution of drugs.

Last year special training in the field of narcotics and dangerous drug enforcement was provided for 2700 State and local law enforcement officials. In fiscal year 1969 we expanded the program an estimated 300 percent in order to train some 11,000 persons. During the current fiscal year we plan to redouble again that effort—to provide training to 22,000 State and local officers. The training of these experts must keep pace with the rise in the abuse of drugs, if we are ever to control it.

X. LOCAL LAW ENFORCEMENT CONFERENCES

The Attorney General intends to begin a series of conferences with law enforcement executives from the various States and concerned Federal officials. The purposes of these conferences will be several: first to obtain firsthand information, more accurate data, on the scope of the drug problem at that level; second, to discuss the specific areas where Federal assistance and aid can best be most useful; third, to exchange ideas and evaluate mutual policies. The end result we hope will be a more coordinated effort that will bring us visible progress for the first time in an alarming decade.

These then are the first ten steps in the national effort against narcotic marijuana and other dangerous drug abuse. Many steps are already underway. Many will depend upon the support of the Congress. I am asking, with this message, that you act swiftly and favorably on the legislative proposals that will soon be forthcoming, along with the budgetary requests required if our efforts are to be successful. I am confident that Congress shares with me the grave concern over this critical problem, and that Congress will do all that is necessary to mount and continue a new and effective federal program aimed at eradicating this rising sickness in our land.

RICHARD NIXON.

The White House
July 14, 1969

Mr. BLACK. I think it stakes out the administration's position in a definitive way.

In the particular area of education, the President in that message directed "the Secretary of Health, Education, and Welfare, assisted by the Attorney General through the Bureau of Narcotics and Dangerous Drugs, to gather all authoritative information on the subject and to compile a balanced and objective educational program to bring the facts to every American, especially our young people."

This program within HEW is one of the responsibilities of the National Institute of Mental Health.

Dr. Miller has testified previously before another committee, on the House side, that next year we hope we can substantially expand our education program and increase the expenditures for it.

As for the specifics of what is being done now and what we hope to do, I would again like to have Dr. Miller comment, because it is his program.

Senator HUGHES. Dr. Miller.

Dr. MILLER. In our approach to the question of drug addiction and information, we have started with a basic assumption that any information that we distribute be clearly based on the scientific knowledge that we now have, and that we need to point out those areas where facts are not known, where questions remain open, particularly in terms of the dangerousness of drugs.

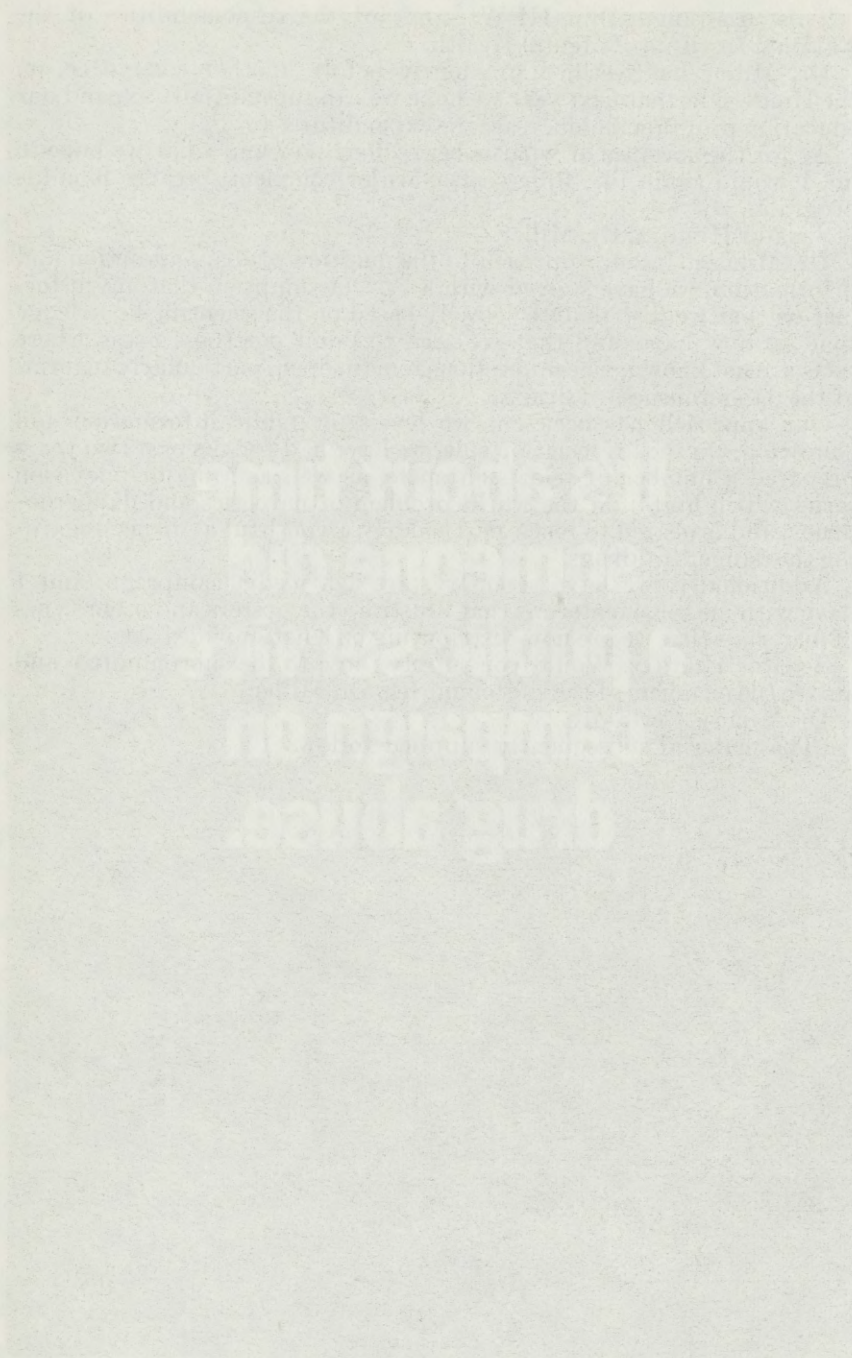
Our approach has been on two levels of public information and education. On the information side, we have had for the past two years prepared a number of television spots, as well as a major television series which highlight the world problem of narcotics and dangerous drugs, and is geared to reach particularly a youthful audience regarding the dangers of drugs.

Additionally, we have recently started a media campaign, and I have with me some materials that illustrate the posters and other types of materials that we are now distributing on a nationwide basis.

Senator HUGHES. Would you supply those to the subcommittee and also to the members of the subcommittee, Dr. Miller?

Dr. MILLER. Certainly.

(The material subsequently supplied follows:)



**It's about time
someone did
a public service
campaign on
drug abuse.**



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE OF MENTAL HEALTH
5454 WISCONSIN AVENUE
CHEVY CHASE, MARYLAND 20015
AREA CODE 301 TEL: 657-2944

August 10, 1969

ATTENTION: Editors

The abuse of dangerous drugs is a growing problem in communities across the Nation. The reasons for this serious situation are complex and demand action on many fronts. We are pleased to be able to offer, for the first time, a comprehensive national public service advertising campaign directed against this problem.

Factual information is one of the key elements in any drug abuse prevention program. The National Institute of Mental Health, which has a major responsibility for Federal research and education efforts relating to dangerous drugs, has initiated this campaign as part of a broad-based public education program to supply these facts. The enclosed magazine and newspaper ads are a vital part of this effort.

As you will note, the copy relates to the variety of drugs that are in today's headlines - marihuana, LSD, barbiturates and amphetamines, heroin. The ads have been specifically prepared for youthful, adult, black and Spanish groups and, thus, should be appropriately placed in magazines and newspapers directed to those readers. Each ad, prepared for us by Grey Advertising, Inc., has appropriate legal and medical clearance. The campaign has an Advertising Council listing.

A national grass-roots drug abuse educational program will be an important supplement to our national media campaign. Four flyers on drug abuse are already in circulation. We have scheduled press conferences and workshops for high school newspaper editors, exhibits at schools and at State fairs, mass distribution of films on drugs, a national poster contest, development of curricula and training workshops for teachers, and other activities.

I hope that you will join us in this important community service and that in the months to come, these ads will be prominently placed on your public service pages. Electros or glossy proofs may be ordered by filling out the blank on the last page. Thank you for your consideration and cooperation.

Gerald N. Kurtz
Director
Office of Communications



**Ever wonder
why your kid doesn't
take you seriously when
you lecture him
about drugs?**

GENERAL ADULT

Available sizes: 7 x 10/47 $\frac{5}{8}$ x 6 $\frac{1}{8}$
9 $\frac{3}{8}$ x 12 $\frac{1}{8}$ /4 $\frac{3}{4}$ x 6 $\frac{1}{2}$
Newspaper 1,000 lines (9 $\frac{1}{8}$ x 200)
600 lines (7 $\frac{1}{4}$ x 150)



Suppose he asked you how you got all those marvelous little "pep-me-up" pills?

And what about the ones that do wonders in lulling you off to sleep?

Or the ones that got you right back to a size 12 without feeling starved or knocked out?

If you can't honestly tell your kid you got them *all* from a qualified physician, and that you're taking them *exactly* as prescribed, maybe you need the lecture.

Before it's too late.

Amphetamines, the "up" pills, and barbiturates, the "down" pills, *are* drugs. Don't abuse them, and they won't abuse you.

For more facts about drugs, write for free drug booklets to:
National Institute of Mental Health
Box 1080, Washington, D.C. 20013

**Ever wonder
why your kid doesn't
take you seriously when
you lecture him
about drugs?**

GENERAL ADULT

Available sizes: 7 x 10/4 7/8 x 6 1/8
9 3/8 x 12 1/8/4 3/8 x 6 1/2

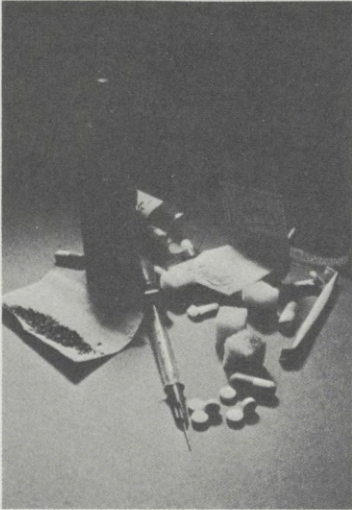
"Mom, how can you get so upset about drugs when you really don't know a thing about them?"

If you're having a little trouble these days getting through to your kids when you try to discuss illegal drug use, it may be because they know a lot more than you do about the subject.

We can't promise to make you an expert, but we can help you to catch up a little. Here are a few facts to talk from:

1. Marihuana:

Its use is a felony. Conviction, even with a suspended sentence, may cause interruption of education, difficulty in obtaining a driver's license in some states, entering a profession, getting a responsible job. While marihuana, which is *not* a narcotic, does not cause physical dependence, it may lead to "psychological dependence"



if taken regularly. There is no current conclusive evidence that marihuana is "medically safe." Research is currently being conducted to find out more about its physical and psychological effects.

2. LSD:

Its effects can differ at times in the same individual. There is no way of predicting whether a "trip" will be "good" or "bad." And days, weeks, even months after using LSD, the things the user experienced while on the drug may recur unexpectedly. The LSD experience can sometimes be disturbing enough to cause acute and even long-lasting mental illness.

3. "Ups and Downs":

Excessive use of amphetamines ("ups") can drive a person beyond his physical endurance and leave him totally depleted physically, since he feels like neither eating nor sleeping. The body develops a tolerance to these drugs, with larger and larger doses required to feel the effects. Long-term heavy users are usually irritable, unstable, and may suffer social, intellectual, and emotional breakdown. Abrupt withdrawal ("crashing") for the heavy user can result in a deep and suicidal depression.

Barbiturates ("downs") can, in regular and excessive doses, become physically addicting. Overdose, or abrupt withdrawal for a heavy user, can cause death. Barbiturates are a leading cause of accidental poison deaths in the U.S. Amphetamines are sometimes prescribed as "diet pills," and barbiturates are given as prescription sleeping pills, but neither should be taken except in strict accordance with a physician's prescription.

4. Narcotics:

Heroin is physically, as well as psychologically addicting. Large, or unexpectedly unadulterated doses can result in death. The addict's main object in life becomes getting the drug. He may turn to crime as the only way to get enough money to support his habit (which can run as high as \$100.00 per day).

For more detailed facts about these drugs, write for free drug booklets to:
National Institute of Mental Health,
Box 1080, Washington, D.C. 20013

GENERAL ADULT

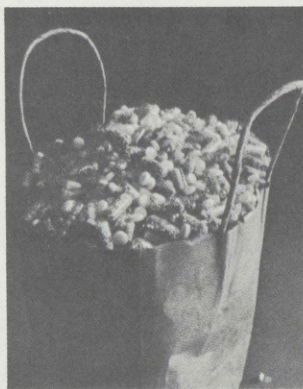
Available sizes: 7 x 10/4 7/8 x 6 1/4

9 3/8 x 12 1/8 / 4 3/4 x 6 1/2

Newspaper 1,000 lines (9 1/8 x 200)

600 lines (7 1/4 x 150)

If someone's selling you sacks of diet pills, he's not in business for your health.



Some men called "fat doctors" are getting rich selling diet pills.

The diet pills they sell are actually powerful drugs—amphetamines, barbiturates, hormones, diuretics, thyroid, digitalis.

Taken in excess, or in dangerous combinations, or without proper supervision and adequate checkups, these drugs can have severe effects. Even fatal.

Please, if you take diet pills, make sure you know exactly what you're getting. And from whom.

Make sure weight is all you lose.

For more facts about drugs, write for free booklets to:
National Institute of Mental Health,
Box 1080, Washington, D.C. 20013

ADULT WOMEN—DIET PILLS

Available sizes: 7 x 10/9 3/8 x 12 1/8
8 3/16 x 11 1/4

A Pot Primer for Parents.

Know enough basic facts about marihuana to talk to your son and daughter about it.

As a parent, you're concerned. You read that college, high school, even junior high students smoke marihuana. What about your own son or daughter? Have they tried it? Would they tell you? Do you just keep quiet and hope—do you talk?

Your youngsters may joke about grass, tea, joint, roach, head—words that mean something different to you. They seem to know more about drugs than you do—that's their side of the generation gap. But not all their "facts" may be facts.

Can you talk frankly to your child about pot?

As frankly as about other important matters, with tact and mutual respect. It may be easier to start by discussing marihuana experiences he's heard of from his friends. You won't want to come across as accusing or angry—it's as risky to assume he does "turn on" as to assume he doesn't. Keep it simple, direct. And make sure your concern for him, and what happens to him, shows.

Who uses pot, and why?

More boys than girls. Girls are likelier to try if their boyfriends smoke it. A majority of young people have not tried it, and have enough self-assurance to resist trying it. A number have tried it once or twice out of curiosity or boredom. A smaller number "turn on" just on weekends. A small percentage become "heads"—their lives centered around marihuana or other drugs, with very little interest in anything else.

What proven facts about marihuana can you tell him?

1. Individuals react very differently to this drug, which is why you hear stories of extreme reactions, and stories of no reactions.

2. Reactions vary according to setting, expectation, pattern of use, and the strength of the marihuana (which varies greatly).

3. Because of all these variables, little has been proven conclusively about specific effects of marihuana on the mind

and body. This does not mean there are no ill effects, but that they cannot be catalogued and predicted exactly.

4. Involvement with this drug during the years while the young personality is finding and shaping itself, and learning how to deal with life's problems, is an intangible danger to try to measure, but of deep importance. That's a hard fact for the young to understand.

5. The possession of marihuana is illegal under local laws. In many states, it is a felony, equivalent to the possession of heroin. The laws provide severe penalties. Even being in the company of someone who possesses marihuana may make your child liable for arrest.

Easy answers to hard questions.

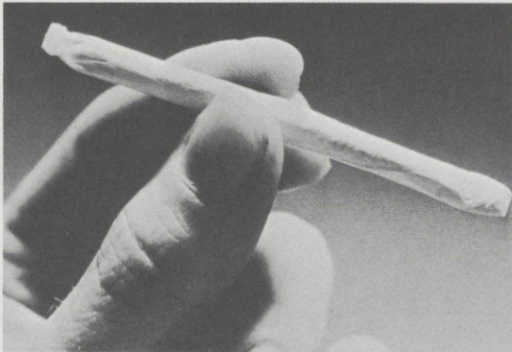
There aren't any. If your children ask, "What about parents' drinking and smoking?" a partial answer is that *your* body and personality have matured. Once anyone becomes dependent on any drug, including alcohol and cigarettes, it can be difficult to stop. Even if you're convinced they're harmful.

"Why do adults say marihuana leads to stronger drugs when that hasn't happened to my friends?" A teen-ager's experience is limited; it *has* happened. While marihuana itself does not lead to other drug use, association with "dealers" and drug users may be the first step to experimenting with LSD, speed and even heroin. And these drugs are far more than a stronger form of pot.

"What about the people who say pot is OK?" To be honest, scientists still don't know everything about the specific effects of marihuana. But certainly, the "authorities" your children quote, know even less. No expert is saying today that pot should be legal.

It boils down to this. Marihuana is a risk nobody *has* to take. Least of all somebody you care about.

For more detailed facts about marihuana and other drugs, write for free booklets to:
National Institute of Mental Health
Box 1080, Washington, D.C. 20013



GENERAL ADULT—MARIHUANA

Available sizes: 7 x 10/478 x 6 1/8
9 3/8 x 12 1/8 / 4 3/4 x 6 1/2
Newspaper 1,000 lines (9 1/8 x 200)
600 lines (7 1/4 x 150)

Gerald N. Kurtz

Director, Office of Communications, National Institute of Mental Health
5454 Wisconsin Avenue, Chevy Chase, Maryland 20015

Dear Mr. Kurtz:

Please send me the following electros or camera-ready glossy proofs in the sizes indicated:

- ☐ 1. Ever wonder why your kid doesn't take you seriously? (General Adult)

SIZE	ELECTRO	GLOSSY

- ☐ 2. Ever wonder why your kid doesn't take you seriously? (Body Copy Vers.) (Gen. Adult)

SIZE	ELECTRO	GLOSSY

- ☐ 3. Mom, how can you get so upset about drugs? (General Adult)

SIZE	ELECTRO	GLOSSY

- ☐ 4. If someone's selling you sacks of diet pills. (Adult Women—Diet Pills)

SIZE	ELECTRO	GLOSSY

- ☐ 5. A pet primer for parents. (Adult—Marihuana)

SIZE	ELECTRO	GLOSSY

- ☐ 6. When are they going to legalize pot? (Youth—Marihuana)

SIZE	ELECTRO	GLOSSY

- ☐ 7. The happy I am when I'm straight. (Youth—Speed)

SIZE	ELECTRO	GLOSSY

- ☐ 8. Happy 21st Birthday, Johnny. (Youth—Speed)

SIZE	ELECTRO	GLOSSY

- ☐ 9. Slavery '69. (Black—Heroin)

SIZE	ELECTRO	GLOSSY

- ☐ 10. Black is Beautiful. (Black—Heroin, Cocaine)

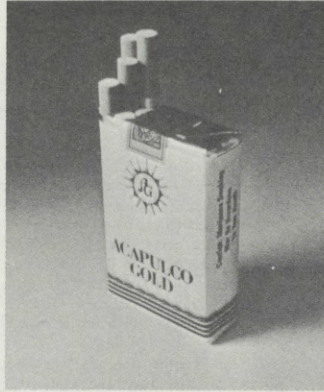
SIZE	ELECTRO	GLOSSY

- ☐ 11. Miseria '69. (Spanish—Heroin)

SIZE	ELECTRO	GLOSSY

Please send material to:

When are they going to legalize Pot?



A lot of people these days are going around saying it's only a matter of months until Acapulco Gold is available over the counter in menthol and king-size lengths.

Which is an indication of how little people know about marihuana. The real fact of the matter is that marihuana is a drug. Like all drugs, it affects the human body and the human brain. Like all drugs, it has side effects.

Today, research scientists are studying marihuana's effects on the brain, the nervous system, on chromosomes, and on various organs of the body. They're trying to find out why different people have different reactions to it.

They're studying its effects after one or two cigarettes, and they're trying to find out what happens with long term use.

Maybe it will turn out that there's no reason for it to be illegal. But nobody can be sure until all the facts are in. And until they all are, it's a pretty bum risk.

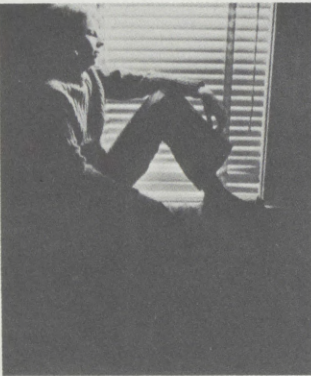
For more facts about drugs, write for free drug booklets to:
National Institute of Mental Health
Box 1080, Washington, D.C. 20013

YOUTH—MARIHUANA

Available sizes: 7 x 10/9³/₈ x 12¹/₈
Newspaper 1,000 lines (9¹/₈ x 200)
600 lines (7¹/₄ x 150)

"The happy I am when I'm straight is more beautiful than the happy I seemed to be when I was stoned."

The girl in the picture is named Chris. For over a year, she was on amphetamines, powerful drugs known as "speed." This is how she describes it:



"I think 'speed' is a lot worse than heroin. Kids have got to know about it, because they can fall so easily into taking it through the diet pill hassle, or needing something to help them study. You know, that's crazy. Because the combination of amphetamines and no sleep just blows your memory completely. There are whole sections of my life which I just can't remember. It got to be just 'do a little more, do a little more,' until that was all there was. And the 'crashing' . . . sometimes the 'crashing' is just really awful!

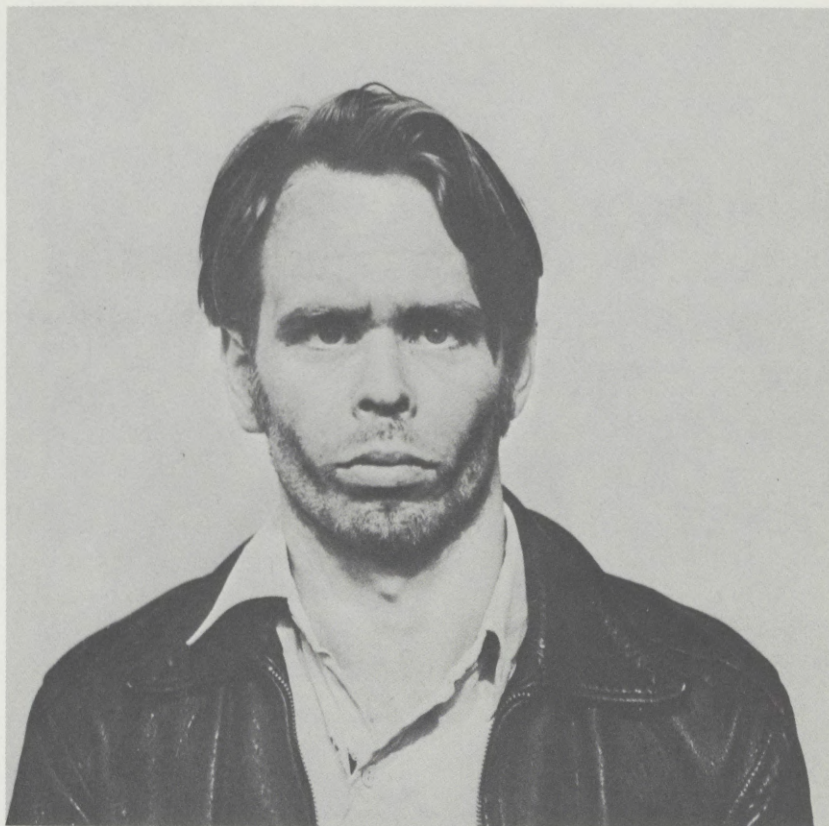
"For me to stop taking it, I had to feel that people were caring. And they were. I was really lucky. I was very close to two people that were really into amphetamines very deeply, and I loved them a lot. But as far as they were concerned, the only thing that they had was the 'meth,' and that was their life. And they're both dead now."

"Dexies," "bennies," "meth" are all called "speed" these days. And people who know "speed" know "speed" kills!

For more facts about drugs, write for free booklets to:
National Institute of Mental Health, Box 1080, Washington, D.C. 20013

YOUTH—AMPHETAMINES ("SPEED")

Available sizes: 7 x 10/9³/₈ x 12¹/₈
Newspaper 1,000 lines (9¹/₈ x 200)
600 lines (7¹/₄ x 150)



"Happy 21st Birthday, Johnny"

At least, we hope it's happy, Johnny's strung out on "speed," and most people take him for about 35. He's shooting "meth," now, but he started on pills: "dexies," "bennies." He has to use a little more each day to maintain the "high" and avoid "crashing." It's as though he were a car that's raced its motor continuously for a year. No wonder he looks like he's ready for a 50,000 mile overhaul.

You see, on "speed," you don't eat, you don't sleep,

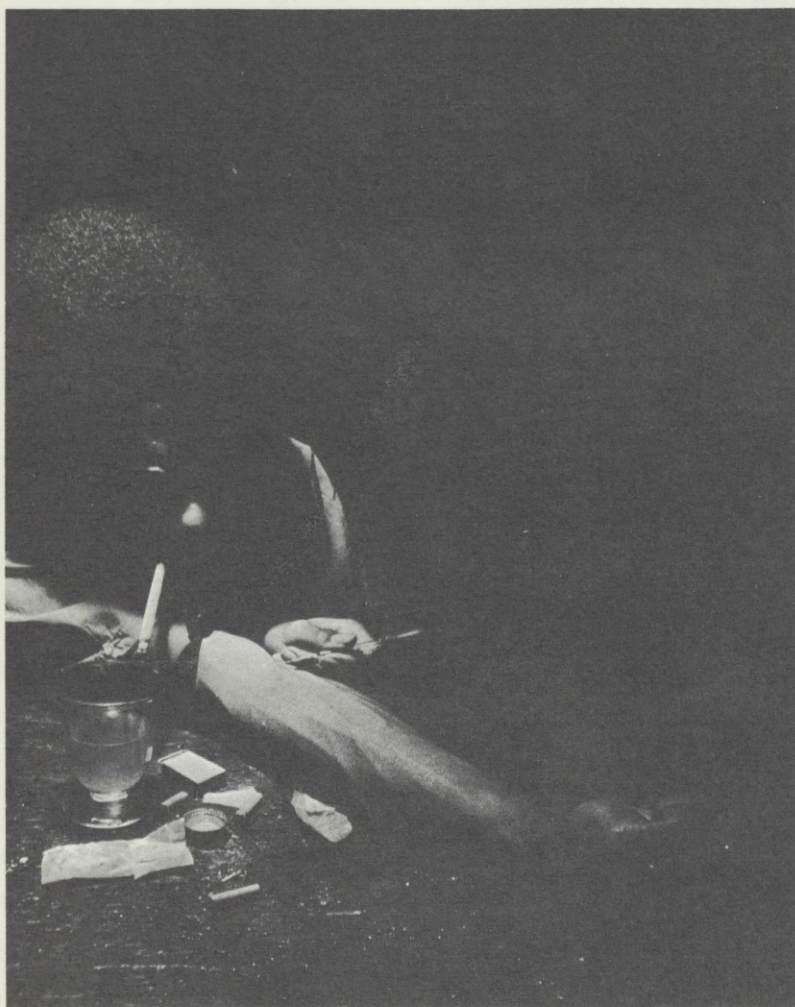
you don't feel you have to pay any attention to your health... because you feel so "up" all the time.

So while you're "up" on speed, your body runs down. Johnny raps all the time about how, since he's started "speeding," he's really living. At this rate, he may have lived his whole life before he reaches 22.

For more facts about drugs, write for free drug booklets to: National Institute of Mental Health, Box 1080, Washington, D.C. 20013

YOUTH—AMPHETAMINES ("SPEED")

Available sizes: 7 x 10/9³/₈ x 12¹/₈
Newspaper 1,000 lines (9¹/₈ x 200)
600 lines (7¹/₄ x 150)



Slavery '69

BLACK—HEROIN

Available sizes: $9\frac{3}{8} \times 12\frac{1}{8} / 3\frac{1}{2} \times 5$
 $9 \times 12 / 7 \times 10$
 Newspaper 1,000 lines ($9\frac{1}{8} \times 200$)
 600 lines ($7\frac{1}{4} \times 150$)

**Black
is beautiful.**

**Black
and on stuff
isn't.**

BLACK—HEROIN, COCAINE

Available sizes: $9\frac{3}{8} \times 12\frac{1}{8}$ / $3\frac{1}{2} \times 5$
 9×12 / 7×10

Newspaper 1,000 lines ($9\frac{1}{8} \times 200$)
600 lines ($7\frac{1}{4} \times 150$)



Miseria '69

SPANISH—HEROIN

Available sizes: 6¾ x 10

9 x 11¼ / 7 x 10

Newspaper 1,000 lines (9½ x 200)

600 lines (7¼ x 150)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH

**MEMO FROM
THE
DIRECTOR
NIMH**

May 1969

The National Institute of Mental Health this Spring began an intensive anti-drug abuse information campaign. On April 22, I appeared before the Subcommittee on Public Health and Welfare of the U.S. House of Representatives' Committee on Interstate and Foreign Commerce to discuss the scope of the National drug abuse problem and describe the efforts of NIMH to combat it. Dr. Sidney Cohen, Director of the Institute's Division of Narcotic Addiction and Drug Abuse, and Mr. Gerald Kurtz, Director of NIMH's Office of Communications, appeared with me to discuss the information campaign and other educational efforts of the Institute aimed at countering drug abuse.

I am anxious to share our remarks on that occasion with you through this Memo, to bring you up-to-date on the broad program the Institute has underway.



**PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
National Institute of Mental Health
5454 Wisconsin Ave., Chevy Chase, Maryland 20015**

April 23, 1969

NIMH PRESENTS AN EXCELLENT
PROGRAM ON DRUG ABUSE EDU-
CATION

(Mr. ROGERS of Florida asked and was given permission to address the House for 1 minute, to revise and extend his remarks and include extraneous matter.)

Mr. ROGERS of Florida. Mr. Speaker, yesterday afternoon an excellent presentation was made to the Members of the House on the drug abuse education activities of the National Institute of Mental Health.

Dr. Stanley F. Yolles, Director, National Institute of Mental Health; Dr. Sidney Cohen, Director, Division of Narcotic Addiction and Drug Abuse, National Institute of Mental Health; and Mr. Gerald N. Kurtz, Director, Office of Communications, National Institute of Mental Health, and their associates told the Members of some new approaches being taken by NIMH to inform the public, and particularly the young adult population, of the dangers of drug abuse.

I was particularly impressed with the audiovisual advertisements which, this week, are being distributed to radio and television stations across the Nation for local dissemination as a public service. These new advertisements are factual and to the point. And I believe that this will be the most effective way of stemming the shocking increase in drug abuse which we have witnessed in recent years.

I commend Dr. Yolles, Dr. Cohen, and Mr. Kurtz and those at NIMH for the work they are doing to meet this national problem, and at this point in the Record, I would like to insert the statements made by these gentlemen at yesterday's briefing session for the benefit of my colleagues:

DRUG ABUSE

Statement by

STANLEY F. YOLLES, M.D.

Director
National Institute of Mental HealthAssociate Administrator for Mental Health
Health Services and Mental Health Administration

Mr. Chairman:

I am happy to appear today to discuss the scope of the national drug abuse problem and the efforts of the National Institute of Mental Health in the area of drug abuse.

Drug abuse takes a multitude of shapes. It is the heroin user injecting his "H", the methedrine user high on "speed," or the fourteen-year-old sniffing airplane glue. But it is also the suburban housewife using her diet pills for a quick pick-me-up, the driving executive alternating between stimulants by day and sleep-inducing barbiturates at night, the urbanite needing those extra 1 or 2 lunch-hour martinis.

Yet, more than that, drug abuse and narcotic addiction are major and growing public health problems of major national concern. As of December 31, 1968, the number of active narcotic addicts reported by the U.S. Bureau of Narcotics was approximately 64,000 and estimates of the true number of addicts are appreciably higher and on the order of 100,000 to 110,000. Hallucinogenic substances such as marihuana have been at the least experimented with by millions of Americans.

The costs of narcotic abuse to society are both quantifiable and non-quantifiable. The latter include personal and social costs which result from the dysfunction of narcotic abusers as people.

The quantifiable factors associated with narcotic abuse include costs for: law enforcement, crime associated with abuse, lost productivity, and the cost of research and treatment programs. There are also welfare costs associated with broken families and with unemployed abusers.

The total of involuntary social costs of narcotic drug abuse amounts to \$541 million per year.

Narcotic addiction historically tended to be concentrated in ghetto neighborhoods with inadequate housing and a lack of physical and social cohesion. We are now witnessing the signs of increasing use of heroin in suburban areas.

The number of non-narcotic drug abusers, including those addicted or habituated to agents such as sedatives, stimulants, marihuana, LSD and related

drugs, and certain "tranquilizers," can only be grossly estimated. Inferences as to the size of the problem can be drawn, however, from data on production and illicit diversion of barbiturates and amphetamines.

About eight billion amphetamine tablets (40 tons) are produced in a year -- enough to provide each man, woman, and child in the United States with 35 doses. About half of these tablets, it is estimated, go into illicit channels of distribution at bars, gas stations, and restaurants.

Five hundred tons of barbiturates were produced 10 years ago. This is enough to provide 28 doses for each person in the population. Here, too, there is a large illegal market.

Several of the relatively new and popular non-barbiturate sedatives and tranquilizers have been found capable of causing states of intoxication and dependence if seriously overused. These drugs include meprobamate (Miltown, Equanil), glutethimide (Doriden), and chlordiazepoxide (Librium).

Of those abusing these drugs, the range of persons directly affected is between 200,000 and 400,000.

The use of LSD has declined during the past two years. In part it may be due to the information disseminated about its dangers and the fact that it does not provide instant insight or magical solutions to one's problems. It remains a drug of abuse essentially for young middle-class persons.

Marihuana use has been rapidly increasing in the past five years. Although originally restricted to certain jazz musicians, artists and ghetto dwellers, it has now appeared among the middle and upper class. A conservative estimate of persons, both juvenile and adult, who have used marihuana at least once is about 5 million.

The National Institute of Mental Health is expending considerable effort in the area of narcotic addiction research. Currently, the NIMH supports 59 research projects which have narcotics and/or narcotic abuse as their principal focus. These studies range from examination of the basic neurophysiology of drug action to the studies of the psychosocial characteristics of users. The NIMH expends approximately \$2,600,000 in the support of such research. In addition, fellowship, training and special facilities grants in this area raise total grant monies in fiscal 1969 to nearly \$11 million.

One major difficulty in the treatment of narcotic addicts has been their tendency to relapse. Current research is being conducted on the development of a method to verify an addict's abstinence from opiates. It is anticipated that early, reliable detection of relapses will prove helpful in the followup treatment of narcotic addicts.

An exciting and controversial advance has been the development of methadone maintenance programs and use of other narcotic antagonists, such as Cyclazocine and Naloxone. Since methadone maintenance involves the continued use of a narcotic on a long-term basis, it has been the object of criticism. The general idea consists of treating heroin addicts by first stabilizing them on a daily maintenance dosage of methadone and subsequently undertaking rehabilitation,

rather than the usual sequence in other programs of first withdrawing the narcotic drug and then attempting rehabilitation.

Research attempting to assess the efficacy of this treatment has indicated that for selected patients, social rehabilitation is a feasible goal. However, methadone does not appear to be a "universal treatment" for all addicts, nor does it result in an abstinence from drugs. Considering the impact of methadone maintenance programs, we need to gain a thorough understanding of its implications for all aspects of the individual's functioning, and a wide variety of studies toward this end are being supported. Studies are also being supported to develop new and long-acting antagonists.

To better understand the motivation of narcotics users, both those in city ghettos as well as middle-class suburbs, the Institute is supporting several studies.

Research is being conducted on drug users within the context of their local slum neighborhoods. The focus is on the specific individual with emphasis on his movement toward drug usage and his development of addict identity.

For any control program to be effective, knowledge is needed of the extent of the narcotics addiction problem.

In view of the estimate that over one-half of the narcotic addicts in the United States live in New York, principally in New York City, NIMH researchers are assisting the New York City Health Department with a register giving a reliable, up-to-date, unduplicated count of narcotic addiction there.

Results in the area of treatment have often been discouraging, particularly if the criterion of success is total abstinence from drugs. At least part of the difficulty with treatment has been that the addict was often treated in a hospital far from his home community and was not adequately followed up upon release.

Means for overcoming this deficiency, and others, were provided in the Narcotic Addict Rehabilitation Act of 1966 (P.L. 89-793). Through this Act, known as NARA, Congress established a new national policy. It calls for the treatment of narcotic addicts rather than prosecuting them under criminal statutes.

For the first time, Federal law provides that narcotic addicts may apply for treatment in lieu of prosecution for certain crimes and that addicts not charged with a criminal offense may also be committed to the Surgeon General for treatment and rehabilitation.

The Act set in motion a new nationwide program for the supervised treatment and rehabilitation of addicts in the community. The NIMH Division of Narcotic Addiction and Drug Abuse is responsible for the examination and treatment of patients committed under the Act.

Titles I, II, and III of NARA are designed to extend and improve treatment and rehabilitation programs already in existence. The basic principle of Title IV, the development of community programs for addicts, is now incorporated in a new law (P.L. 90-574) which permits the NIMH to make grants for construction and staffing of narcotic addict and alcoholism facilities in communities.

The first NARA patient was committed under the provisions of Title I on June 29, 1967. As of February 1, 1969, 1,287 addicts had been admitted to NIMH Clinical Research Centers in Fort Worth and Lexington. Of this number, 6 percent charged with a criminal offense chose commitment under the provisions of Title I in lieu of prosecution; and 66 percent were committed under Title III. Ninety-one percent of the Title III commitments were initiated by the addict himself.

When suitable State and local facilities have been developed, these services will be contracted for as close as possible to the addict's home community. As of March 1969, there were contracts for services with 70 agencies in 66 different cities and 39 different States caring for 306 patients. NIMH staff will be assigned to area offices in the 11 metropolitan areas having the largest population.

While searching for better means of treating narcotic addicts, the NIMH simultaneously conducts prevention and education programs. The basic philosophy underlying the NIMH information/education program is our intent to bridge the credibility gap by presenting the facts. Having long had the responsibility for drug abuse education and information, it is the NIMH's goal to develop effective educational programs for use in elementary, junior, and senior high schools and colleges, as well as parents' groups and other segments of the community. Other members of the NIMH staff who have accompanied me here today will tell you about these educational efforts aimed at the general population.

Other preventive and educational materials are made available to the scientific community and others who, by virtue of their frequent contact with users and potential users of drugs, can form a first line of defense against continued drug abuse.

As the national center for support of research in narcotic addiction and drug abuse, the NIMH has a primary responsibility in coordinating and disseminating research findings, technical information, and noteworthy scientific advances in the field. This is accomplished by ongoing consultation and liaison activities by the staff of the Division of Narcotic Addiction and Drug Abuse.

In addition, the Institute's National Clearinghouse for Mental Health Information, the world's largest computerized repository of mental health and related findings, is actively engaged in assisting the researcher and therapist keep abreast of technical information in drug abuse.

The goal is to develop a complete data bank of all important research and new methods relevant to the problems of drug abuse. This bank already is a valuable source of accurate and complete bibliographies and references tailored to the needs of individual researchers. Information gathered for the data bank will also be used to publish, on a regular basis, *Drug Dependence*, containing timely, original articles of major importance in drug abuse research and recent bibliographies of new research.

The potential audience of *Drug Dependence* is large. In addition to physicians, psychologists, sociologists, and other mental health professionals, educators, legislators, and lawyers will have use for these reports of research facts.

The Clearinghouse is also producing a complete directory of treatment and rehabilitation facilities in the United States. Although the number of such facilities is far from adequate, this directory giving essential information about the facilities will provide a much needed source of information to those who seek professional help. Another Clearinghouse publication, the Mental Health Digest, frequently carries scientific articles on drug abuse.

It is clear that one is not dealing here with a simple, unitary phenomenon. Drug abuse is a health, legal, social, economic, and moral problem. Drug abuse is a complex phenomenon in which the major interacting factors are the characteristics of the drug abused, the characteristics of the person abusing the drug, and the characteristics of the society within which the drug is abused.

It is evident that there will be no simple solution to the problem of drug abuse. Substantial effort must be devoted to prevention, discovery and dissemination of new knowledge, and development of more and better treatment resources.

It is the task of the National Institute of Mental Health to mount the programs needed to deal flexibly with the many problems of drug abuse. As the problem is complex and changing, so must be the strategies designed to understand and cope with it. This is the end toward which we at the NIMH have dedicated our resources.

###

DRUG ABUSE: EDUCATIONAL EFFORTS

Statement by

SIDNEY COHEN, M.D.

Director

Division of Narcotic Addiction and Drug Abuse
National Institute of Mental Health

It is evident that the prevention of drug taking behavior or the conversion of the drug abuser into an abstinent person is the ideal solution to the problem of drug dependence. These methods require a modification of attitudes and beliefs. Attitude and belief change can be best accomplished by skillfully presenting factual information and by correcting false ideas about the abused drugs. It is our position that the presentation of unbiased information is sufficiently impressive that it will deter most potential or actual users. Furthermore, attempts to sermonize or to scare with inaccurate statements is likely to fail or even encourage mass drug abuse. This is so because young people are likely to rebel against patently false information. In the drug area the generation gap often consists of ignorance about drugs on the part of the elders and illusions about drugs on the part of the youngsters. We are attempting to close the gap from both directions.

The National Institute of Mental Health is expending \$900,000 for Fiscal Year 1969 for drug education and information. A description of the more important educational projects follows.

I. For Teachers

Since the teacher is often the first person who is asked questions and must provide answers about dangerous substances, a number of projects are directed specifically at the educator.

1. A sixteen-page center insert dealing with the facts and techniques of teaching the facts about drug abuse was placed in the March 1969 issue of TODAY'S EDUCATION, the National Education Association journal which is circulated to 1,400,000 educators. The insert can be easily removed from the magazine for future use. Additional copies can be obtained on request. During Fiscal Year 1970 a second insert will be placed.

2. A two week teachers workshop in cooperation with the American Association for Health, Physical Education, and Recreation (AAHPER) was held for 20 teachers from all regions of the country in San Francisco and Mendicino State Hospital during October 1968. The entire workshop was videotaped and printed materials were developed. Each participant was to return to the school district and conduct two-day workshops for the local AAHPER members, 14 of which have already been held. From the experience gained at the workshops, a handbook of materials was selected for publication, entitled "Drug Abuse Education."

3. A film library is being selected by a group of scientific and communications experts. Mr. Kurtz will elaborate on this.

4. A contract to researchers in Dade County, Florida, is under serious consideration. They hope to develop a new model of drug abuse education. Teachers and parents will be involved, but the innovative aspect is the key role of the students themselves in doing the work of preparing materials, designing programs, and giving the instruction.

5. The Center for Studies of Substance Abuse in New York, N.Y. has been working under an NIMH grant to provide specific methods of dealing with the special problems that vary from school to school. Their team is invited into a school, where they obtain accurate information about the situation from students, faculty, and administration. Then they design a solution for the special situation.

II. For the Community

1. An up-to-date list of agencies and facilities concerned with drug abuse is badly needed. Resources where individuals and agencies can go for help and information will be collected by city. Numerous private, city, county, State, and Federal agencies are available, but a complete directory is not.

2. The NIMH has issued four flyers, called "Marihuana," "LSD," "The Up and Down Drugs" and "Narcotics." Over a million copies have been distributed, and another four million are in press.

3. A Spanish language edition of the four flyers mentioned above will be printed. In addition to direct translations, there will be other flyers for Puerto Ricans and Mexican-Americans tailored for the specific cultural requirements of those groups.

4. Reprints of other educational materials, such as a NEW YORK TIMES MAGAZINE article by Dr. Yolles, and a flyer on the NARA (Narcotic Addict Rehabilitation Act) program, are being distributed.

5. Personnel from the Division of Narcotic Addiction and Drug Abuse have given many talks to high schools, colleges, community groups, jurists, legislators, and professional groups. Although no assigned personnel are available for these lectures and discussion groups, the staff willingly attempts to meet as many requests for speakers as possible.

6. Consultations with many agencies, public and private, have been provided. Committees and groups which are forming to deal with some aspect of drug abuse have sought out the NIMH as a source of information.

7. Written into the grants of our six NARA Centers and of the additional ones to be funded during Fiscal Year 1969 is a provision requiring that they serve as a community resource for education and information on drug abuse.

8. We are about to write a contract with a group of researchers in Nevada who will examine and evaluate different techniques of drug abuse educational efforts. The program will coordinate school and community activities and will compare small vs. large group meetings.

9. A series of high school newspaper editors' conferences by regions are planned. In general they will be tied into a university journalism program with drug abuse as a prime topic. It is planned that experts in this field will speak and answer their queries. In turn, they will report on the conference in their student newspapers.

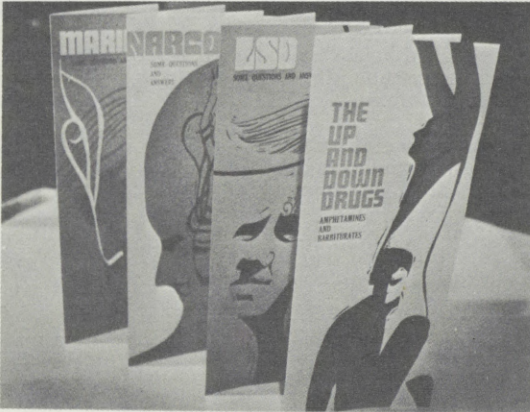
III. For Professionals

1. A quarterly journal, *Drug Dependence*, will be issued, beginning July 1969. It will contain articles pertinent to the subject and abstracts of articles in other journals on drug abuse. This specialized journal will be a concentrated source of information for scientists of all fields.

2. A book is in press which represents the proceedings of a conference held on the effect of LSD on chromosome structure. It contains an up-to-date bibliography on the subject.

3. A grant has been provided for investigators at the University of California at Berkeley to explore new therapeutic approaches to the drug taker. If the approach proves to be successful, it will provide therapists with an additional technique of dealing with drug abusers. In essence it represents an effort to demonstrate that one can "turn on" to life rather than require drugs.

4. The National Clearinghouse for Mental Health Information and the Division of Narcotic Addiction and Drug Abuse are planning to expand the present collection of material in the NIMH computer to include every article on drug abuse in the world literature in the form of an annotated reference. It will then be possible to furnish an investigator with a printout of abstracts of such material on any aspect of this subject.



Four drug abuse flyers used in the campaign.

DRUG ABUSE: EDUCATIONAL EFFORTS

Statement by

GERALD N. KURTZ

Director
Office of Communications
National Institute of Mental Health

I appreciate this opportunity to appear here today to discuss the extensive new campaign against drug abuse being conducted across the country by the National Institute of Mental Health.

There are several aspects to the NIMH education/information effort: A public service announcement series presented in cooperation with the mass media; a program for the educational community, including curriculum development and workshops; a grassroots program to disseminate material and information to parents, youngsters and the general public; a professional communications program aimed at providing the latest scientific findings to physicians and researchers.

We are taking advantage of every channel of communication to reach our widely divergent audiences. The messages, which are custom-tailored to specific target groups, all have one thing in common. They present the facts. We believe that only a factual campaign can bridge the credibility gap which exists in this area.

Thousands of young people are convinced that "drugs are the answer." Their parents and teachers are anxious and alarmed. Misinformation, contradictory information received by our youth, has been widening the so-called generation gap. By presenting the facts without resorting to scare techniques or exaggeration, and by presenting these facts in language and via media appropriate to the audience, we believe we will have an impact.

This week we are launching what we call our "umbrella campaign." Factual public service messages which have been prepared by a national advertising agency -- on a non-profit basis -- have been sent under the auspices of the Advertising Council to radio and television outlets across the country. (See scripts of some of the television spot announcements following this statement.)

I should point out that this material has been pre-tested by the agency before groups of young people, former addicts, and addicts. For the past month we have been conducting a pilot program in the Washington, D.C. metropolitan area. Following two one-half hour segments of a three part film series, "The Distant Drummer," shown during prime time with the cooperation of a network affiliate, television and radio spot announcements were made available to every TV and radio station in the area. The response of the stations was enthusiastic. The spots continue to be used throughout the broadcasting day on most stations.

The public media campaign, which goes national this week, is divided into several segments. Our primary aim is to arm young people and their parents with the facts to help them resist pressures to experiment with drugs - marijuana and LSD. We also have special messages for adults who overuse amphetamines and barbiturates, and a sub-campaign for residents of the inner city exposed daily to the dangers of heroin addiction.

The spots are directed at the potential user in each category, and since our largest target audience is young people, messages are sophisticated and factual and are intended as ammunition for the youngster to resist peer-group pressure.

There was one exception to this: a segment of the campaign aims mainly at middle-class housewives, concerning the abuse of amphetamines and barbiturates. These women, having found ways to exceed the prescribed amount, are probably unaware of the fact that they are serious drug abusers and are potentially in trouble. The approach to them was quite different from our approach to youth. It's harsher....scarier. But this has an interesting side-effect on the youth effort.

The reason is simple: Most young people will say that as long as Mom pops pills all day, and Dad drinks himself into oblivion on the weekend, there's no hard line they can take on drugs that is anything but transparently hypocritical. So when an establishment campaign on drugs seems to go impartially after drug abuse wherever it occurs, even in the parent group, it may win a few more sympathetic ears when it focuses on the young.

In arming the "potential user" with ammunition of resistance, the spots talk in a quiet, rational, totally factual way about the known dangers of using each of these drugs. There is a minimum of witty, slick advertising phrases. Irony is used occasionally, for that is a favorite literary device of the young. In the main, however, the spot simply says: here are the facts you as an intelligent human being need to help you make up your mind. Nowhere do the spots preach, make a moral judgment, or shake a finger.

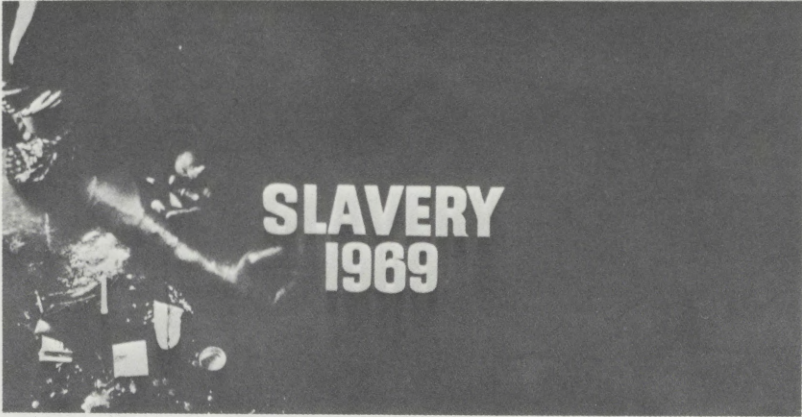
One criterion was carefully applied to everything produced on this project: the spots scrupulously avoid showing any aspect of the drug scene in any light which might be remotely construed as being attractive.

We think the radio campaign is of particular importance. Radio perhaps is the only common communications denominator in trying to reach young people away from home, at school, after school in the suburbs as well as in the ghettos. You see transistor radios on buses and subways, in the streets, at beaches, pools, and playgrounds.

Accordingly, radio spots for a general audience using the same approach as the television material are now being distributed. Currently in production are radio spots prepared from taped interviews with former addicts, who tell their stories. These will be sent out with factual material for the disc jockey or general announcer to prepare his own script.

One of the most dramatic aspects of the campaign is the radio material for the black ghetto. These radio spots were prepared by a youth who is himself a resident of the ghetto now working for the advertising agency. They address the problem in a way that only someone with first-hand experience could communicate. These messages are being selectively distributed to radio stations serving primarily black audiences.

To support the inner-city targeted radio campaign, we have also prepared posters for car cards, billboards, school bulletin boards, club rooms, and the like. A campaign theme of "Slavery" used in ghetto radio spots is carried through in the print media.



A poster in the print media segment of the campaign.

In mid-May another group of spot announcements will be released. In these, leading sports, music, TV, and stage celebrities will discuss facts about drug abuse. And other materials are being prepared for radio and television.

For example, with the help of Otto Graham, who has agreed to serve as a consultant to NIMH, special radio and TV messages are to be recorded by professional and amateur athletic stars for broadcast on a seasonal year-round basis. We are asking cooperation of major professional athletic leagues and broadcasters to program these messages during live broadcasting of athletic events locally. The idea is that a Willie Mays spot would be played for a San Francisco broadcast/telecast of the Giant game and that it will be seen or heard in the city of the Giants' opponents as well.

A contemporary designer well known to today's youth -- Peter Max -- is doing an anti-drug poster, which will be featured with the artist on television. The poster will be printed by GPO and sent to all requesters.

Another poster, designed in the "Graphics of Today" by a young NIMH artist, Mr. Bill Bowman, carries another campaign theme -- one that we consider the soundest argument against experimenting with drugs. It asks, "Will they turn you on, or will they turn on you?" It is now being produced in psychedelic colors. We plan to show these on some 68,000 Post Office trucks during the month of July, and to distribute them widely in schools, recreation centers and so forth. (See back cover.)

Earlier I mentioned the film program, noting the debut of "The Distant Drummer" documentary series in the Washington area. This three-part series, which is being scheduled for prime-time television airing in major U.S. cities, presents the most detailed account of current knowledge about narcotics and dangerous drugs ever recorded on film. Beginning with the history of the poppy plant, these films record how opium has been used through history -- from opium itself through morphine to heroin -- and how man's fascination with drugs has led to epidemic proportion of drug abuse today. These films will soon be available through a drug abuse information film library being established as part of the National Audiovisual Center.

This series, intended for general audiences, will be supplemented with additional films for specific groups which will elaborate on particular problem areas in drug abuse. A group experienced in recording true-to-life events in the ghetto will prepare a film on the abuse of narcotics in the inner-city. A documentary on treatment--what kinds are available, and where--for adults and teenage drug abusers is also being prepared.

New distribution methods are being tried in an effort to get the films before their intended audiences. Along with distribution through the film libraries, the Institute will establish film and equipment loans through community mental health centers.

The distribution of factual literature plays a significant role in the current campaign. More than a million copies of four flyers -- "Marihuana," "LSD," "The Up and Down Drugs," and "Narcotics" -- have been distributed and 4 million more are in press. Already, these flyers have been distributed to schools, community groups, pharmacists and others. Distribution will soon begin to doctors' and dentists' waiting rooms. In addition, the flyers will be used to answer public inquiries generated by the mass media campaign.

They are being translated into colloquial Spanish for Mexican Spanish-Americans and Puerto Ricans and new versions for inner-city audiences are planned. The comic book, "Hooked" -- with more than 2 million copies already distributed -- will be revised, and a Spanish edition produced.

Two additional publications are now in press. The first, "Before Your Kid Tries Drugs," will supply parents with facts on drug abuse. It is based on an

article by Dr. Yolles that appeared recently in the NEW YORK TIMES MAGAZINE. The second, dealing with research at NIMH on drug abuse, will be distributed to college students to provide them with up-to-date findings in the field.

The Family Service Association of America, working with prominent theatrical writers and Actors Equity, is preparing an open-ended play on drug abuse intended for showing before parent and teenage groups by professional companies, college, school and local dramatic groups. After presentation of the play, an experienced discussion leader will conduct a group seminar on the facts about drug abuse. Productions of the play and of the scripts will be made available nationally and at the local level for use by PTA's and other organizations.

In another effort to reach high school students, a series of pilot press conferences and workshops will be conducted this summer and fall. Approximately 1,000 high school newspaper editors will participate in these sessions, where they will meet with experts on drug abuse, professional journalists, high school teachers and college journalism professors.

The students will be asked to evaluate materials being nationally distributed by NIMH and to offer suggestions on new materials they think might be effective. The young journalists at the conferences will write editorials and feature stories and will be encouraged to produce articles and stories for use in their own publications.

Three such conferences have already been approved. Participating universities are Syracuse University, University of Kansas and University of Texas. Proposals are being sought from other universities across the country so that the program can be expanded.

An exhibits program for schools, health fairs, State and County fairs is also being mounted. The exhibits will be the vehicle for distribution of factual literature and for displaying a film version of the television spot messages.

In still another direction, staff of the NIMH Office of Communications is developing materials for the Nation's newspapers, radio, and television for the dissemination of drug abuse information. Fact packets are being prepared for local radio stations, syndicated columns are being made available to daily and weekly newspapers, and material is being assembled for a nationwide editorial campaign on the dangers of drug abuse. An awards program is being developed to accord special recognition for outstanding public service journalism.

In conclusion, I would like to point out that the National Institute of Mental Health has been negotiating with several communications research firms for the development of a study to evaluate our public service campaign, to obtain information on the effectiveness of the messages, use of color vs. black and white, and so forth, to help guide us in the development of followup materials.

The intensive broad-based campaign I have described represents a great collaborative effort. Staff at the NIMH Division of Narcotic Addiction and

Drug Abuse, its Center for Studies of Narcotic and Drug Abuse, and the Office of Communications have been working closely with other agencies, including the Department of Justice and the Department of Defense. We have also, of course, been working with the private sector -- the advertising profession, communications industry and particularly with the National Coordinating Council on Drug Abuse Information and Education and the American Medical Association. The Coordinating Council is comprised of more than 60 public and private organizations, including the AFL-CIO, most professional associations, many civic associations, and scouting, which means genuine citizen participation in our efforts. The role of the Coordinating Council will become especially valuable as the campaign gains momentum. The Council will be undertaking such invaluable projects as film and literature evaluation and to carry on an even broader public program at the local level.

As Dr. Yolles has indicated, drug abuse has reached epidemic proportions in the United States. The programs and activities we have been discussing are just a beginning. We plan to build on the base we have laid.

#

On the following pages are
scripts from seven of the drug
abuse television spots.

LSD--BAD TRIP

LSD: 60 Secs

DOCUMENTARY FILM OF YOUNG ROD SERLING (VO):
MAN HAVING "BAD TRIP".

WE SEE HIM WRITHING IN AGONY. We're going to show you an LSD trip. But you won't see any
psychedelic colors, or hear any acid rock. For this is a bad
trip.

YOUNG MAN'S VOICE:

"I thought it was going to be beautiful and visual. .but it
really turned out to be a "bummer". It was frightening, .
ugly. It affects everyone differently, I guess. It's pretty
sick. . but you don't know what it's like to be in there.
You're out of your head, and you think you're never coming
back. There's nothing you can do about it. Just hold and
roll!"

SERLING (VO):

This shatteringly powerful drug carries with it an extra little
bonus: he may have this bad trip again. . free. .
uncontrollably, without taking any more acid. .without
any warning! If this scene is too strong for you, you can
turn it off. He can't. Not now, nor when he has a
recurrence, in two weeks, or two months. LSD. Will it
turn you on. . or will it turn on you?

N.I.M.H. LOGO



THE FAT DOCTOR

Amphetamines and Barbiturates: 30 Secs

"FAT DOCTOR" OFFICE
SET UP LIKE SUPERMARKET.

"DOCTOR" FILLS BAGS OF
PILLS AND DISPENSES THEM
TO WAITING LINE OF
OVERWEIGHT LADIES.

N.I.M.H. LOGO



ROD SERLING: (VO)

Men known as "fat doctors" do a multi-million
dollar business selling diet pills....

more than 2 billion pills a year.

Amphetamines, barbiturates, hormones,
diuretics, thyroid, digitalis.

Powerful drugs.

Taken in excess, or in dangerous
combinations, they can have severe effects.

Even fatal.

Please. If you take diet pills, talk to
your regular family doctor.

Make sure weight is all you lose.



WHERE ARE YOU THEN

General Drug Abuse: 60 Secs

YOUTH SCENES

ANNCR:

The choice is yours: You can change the world. Or you can cop out.....with drugs. If you're thinking about drugs, then think about this:

DRUG SCENES

SINGER:

What do you do when the music stops? Where are you then?
Where are you then? When you've dropped, full-blown, on
all the mountain tops, Where are you then, my friend?
What do you see when your pupils contract, When you're out
in the alley after your act, And you're not quite whole,
And the straight world's intact. Where are you then, my
friend?

YOUTH VOLUNTEERS

ANNCR:

You can choose to change the world. But for that, you
need your head. Straight. And in the right place. If
you choose drugs instead, where are we then, my friend?

SINGER:

Where are we then?

N.I.M.H. LOGO

SPEED KILLS

Speed: 60 Secs

ACTUAL INTERVIEW WITH CHRIS:
YOUNG WOMAN



". .the happy that I am when I'm straight is so much more beautiful than the happy that I seem to be when I'm stoned. ."

(FADE UNDER:)

ROD SERLING (VO):

Her name is Chris. She's talking about a drug called "Speed."

CHRIS (CONTINUES):

"I think "speed" is a lot worse than heroin. The kids have got to know about "speed." Because they can fall very easily into it through diet pills, and needing something to help them study and stuff. You know, it's crazy. .because the combination of amphetamines and no sleep just blows your memory completely. .and sometimes the crashing is just really awful! For me to stop taking it I had to feel that people were caring. .I was really lucky. I was very close to two people that were really into amphetamines. .and I loved them a lot. .but as far as they were concerned, the only thing that they had was the meth and that was their life. And they're both dead now."

SERLING:

"Dexies," "Bennies," "meth," are all called "Speed" these days.

And people who know "Speed" know "Speed" kills.

N.I.M.H. LOGO

NEIGHBORHOOD JUNKY

Amphetamines and Barbiturates: 30 Secs



TYPICAL SUBURBAN HOUSE.

WOMAN EMERGES WITH KIDS,

HELPS THEM INTO STATION
WAGON,

AND DRIVES OFF.

N.I.M.H. LOGO

ROD SERLING (VO):

This is 74 Langsford Street
home of Mary Clayton.

She's a junky.

She'd be shocked if you called her that.

She just takes a lot of pills:

Amphetamines, to get going.

Barbiturates, to put her to sleep;

Without the supervision of her family doctor. . .

pills which could distort her judgment, and
could become addictive.

Mrs. Clayton's a junky,

and what's scary is, she doesn't know it.

How about you?

Any junkies live in your home?

YO-YO

Amphetamines and Barbiturates: 30 Secs

YO-YO WITH FACE OF WOMAN
ON IT

ROD SERLING (VO):

Amphetamines . . .

Barbiturates . . .

the "up and down" pills . . .

they pick you up when you're down,

they bring you down when you're up.

If you take them, follow your doctor's advice
very carefully.

Because last year, tens of thousands of people
abused these pills. . .

and got all strung out and tangled up.

Some died.

Amphetamines and barbiturates

are powerful drugs.

Too powerful to play around with!

YO-YO GOES FASTER AND FASTER,
STRING TANGLES, BREAKS

YO-YO ROLLS AGAINST WALL
AND BREAKS APART.

CAMERA MOVES IN ON
BROKEN FACE.

N.I.M.H. LOGO





THE TRUTH ABOUT MARIHUANA

Marihuana: 60 Secs

OPEN ON HANDS

ANNCR: (VO)

THEY ROLL A "JOINT"

Why doesn't anyone tell the truth about marihuana?

MAN: (VO)

Smoke pot....and you wind up hooked on heroin!

YOUNG, HIP MAN: (VO)

Man, it's cleaner than alcohol!

WOMAN: (VO)

It's the first step right into the psycho ward.

MAN: (young) (VO)

There's just no reason to keep it illegal!

ANNCR: (VO)

Today, not one of those statements is true. Because to date, not one is based upon scientific fact. Millions of dollars are being spent this year on research to get these facts.

HAND TAKES IT OUT OF
FRAME

SMOKE ENTERS FRAME

But there's one fact you should know now, possession of marihuana in the United States is a felony. Don't treat that fact

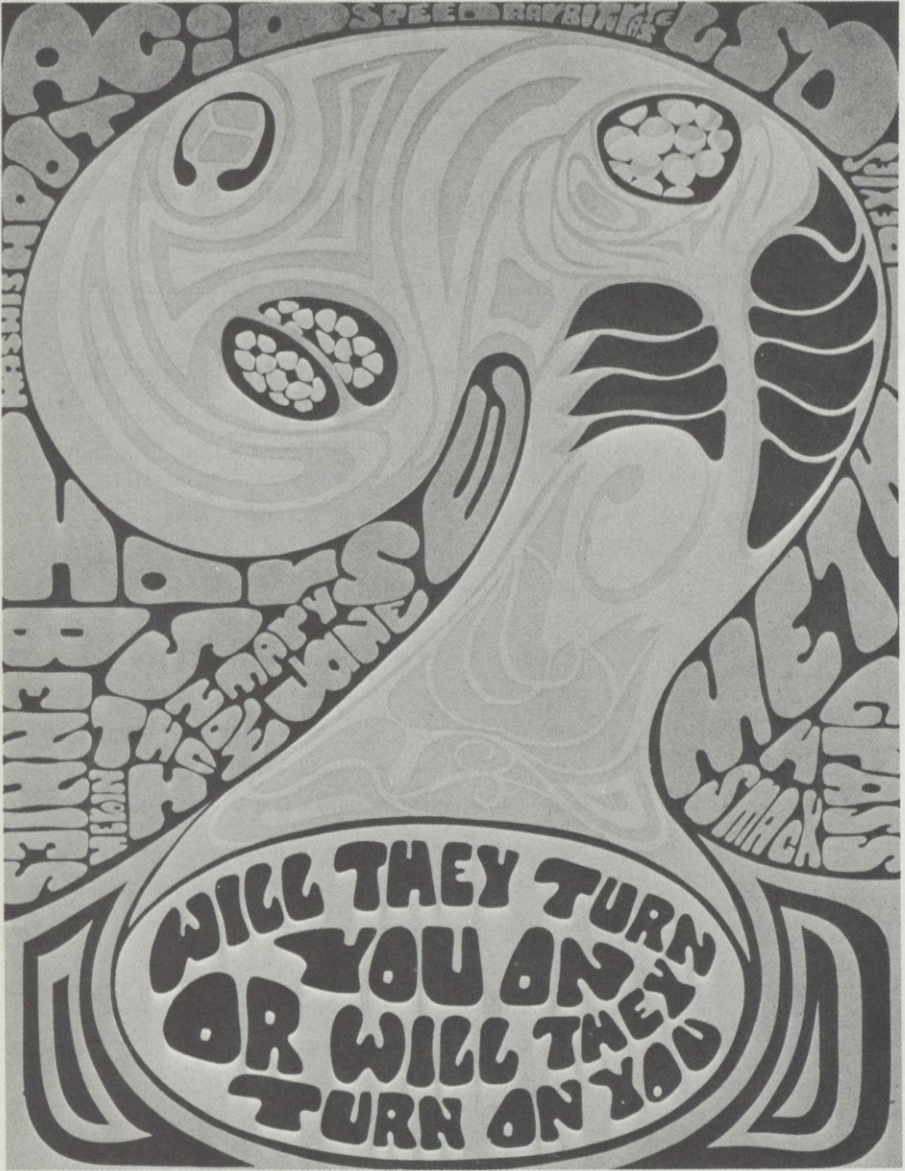
lightly! Conviction, even with a suspended sentence, can, in some states, prevent you from getting a driver's license, furthering your education, landing a government job, or working in a profession.

PAN TO LICENSE
PAN TO EMPLOYMENT
APPLICATION
PAN TO DOCTOR'S
LICENSE

With marihuana, some things that may be important to you in the future, can go up in smoke.

PAN TO "JOINT". STILL
BURNING
MOVE IN ON SMOKE
N.I.M.H. LOGO

And that is the truth!



This poster, in psychedelic colors, stresses one of the main themes in the NIMH drug abuse information campaign.

DRUG ABUSE EDUCATION GUIDELINES AND SELECTED REFERENCES

ACKNOWLEDGMENTS

This book is a cooperative endeavor. The initial cooperation occurred in the joining of the National Institute of Mental Health with two departments of the National Education Association--the American Association for Health, Physical Education, and Recreation and the National Science Teachers Association--in undertaking this project. Their visionary efforts made possible this presentation.

Gratitude is extended to the selected contributors who granted permission to the Drug Abuse Education Project to use their original materials. It is this group of experts who provide the essence of this publication. Their names appear in the Table of Contents and contiguous to their articles.

A substantial portion of the cost of these looseleaf binders and of imprinting them was borne by a contribution from the Schering Corporation whose generosity is gratefully acknowledged.

Whatever clarity this document brings to drug abuse education efforts in the schools is credited to the editorial expertise of Mrs. Margot Davis. Her insight, counsel, suggestions and skill in excerpting and summarizing were vital for appropriateness of the manuscripts. Special appreciation is expressed to Mrs. LaVerne Holt for her help in writing and organizing much of the project's written materials and to Mrs. Ilene Brown for her varityping assistance.

Special recognition is due Dr. Robert C. Petersen and Mrs. Lura Street Jackson who, as Project Officer and Co-Officer for the National Institute of Mental Health, provided the direction, encouragement and guidance so essential in cooperative endeavors.

The research upon which this publication is based was performed pursuant to Contract No. PH-43-68-1471 with the National Institute of Mental Health of the U.S. Department of Health, Education and Welfare.

Marvin R. Levy
Project Director

GUIDELINES & SELECTED REFERENCES

Table of Contents

INTRODUCTION

Fact Sheet: Drug Abuse Education Project
 Report of Conference for Educators on Drug Abuse Education
 Guidelines for Drug Programs - *Marvin R. Levy*
 Philosophy of Drug Abuse Education - *Sanford Feinglass, Ph.D.*
 Fact Sheet on GPO Publication, Task Force Report
 Selected Bibliography

PHARMACOLOGY

Fact Sheets: Depressants
 Hallucinogens
 Stimulants
 Dependence on Barbiturates - *Journal of the American Medical Association*
 Dependence on Amphetamines and Other Stimulant Drugs - *Journal of the American Medical Assn.*
 Drug Dependence: Its Significance and Characteristics - *Nathan B. Eddy, M.D. et al*
 The Use, Misuse and Abuse of Amphetamine-Type Drugs - *Maurice H. Seevers, Ph.D.*
 Psychopharmacology and Opiate Dependence - *Jerome H. Jaffe, M.D.*
 Tobacco (Nicotine) - *Goodman and Gilman*

LEGAL IMPLICATIONS

Fact Sheet on Federal Dangerous Drug Laws
 Current Decline in Respect for Law and Order - *Joseph D. Lobman*
 The Marijuana Problem: An Overview - *William H. McGlothlin, Ph.D. and Louis Jolyon West, M.D.*

PSYCHOSOCIAL CONSIDERATIONS

Drug Use and Student Values - *Kenneth Keniston, Ph.D.*
 Drugs and Personal Values - *Richard H. Blum, Ph.D.*
 The Myth of Alienation and Teen-Age Drug Use - *Winfield W. Salisbury, Ph.D. and Frances R. Fertig*
 The Use and Abuse of Psychedelic Drugs - *Daniel X. Freedman, M.D.*
 Predisposition to Alcoholism - *The Reverend Stan Helm*
 Drugs and Religion - *Leonardo Marmol, D.D.*

RESEARCH

Recent Research on LSD, Marijuana and Other Dangerous Drugs - *Stanley F. Yolles, M.D.*
 Nature and Extent of the Problem - *Richard H. Blum, Ph.D.*
 Study of the Juvenile Drug Offender - *Chester F. Roberts, Jr.*
 Explaining Glue Sniffing and Related Juvenile Delinquency - *Robert C. Hanson, Ph.D.*
 Abstract of Denver Juvenile Court Glue Sniffing Project

SCHOOL PROGRAMS

Recent Research on LSD, Marijuana, and Other Dangerous Drugs - Prevention - *Stanley F. Yolles, M.D.*
 The Drug Dilemma: A Partial Solution - *Sidney Cohen, M.D., Ph.D.*
 Structure of a Telescoped 3-Day Drug Abuse Conference - *Sanford Feinglass, Ph.D.*
 Drug Abuse Education, Program Recommendations of a Team of Kindergarten through Third Grade
 Educators in Marin County
 Non-Verbal Exercises - *William C. Schutz, Ph.D.*
 Considerations for School Programs - *Jean Aron*
 How Can We Teach Adolescents About Smoking, Drinking, and Drug Abuse - *Godfrey M. Hochbaum, Ph.D.*
 Education and Ecstasy - *George B. Leonard*

TEACHING AIDS

NIMH Brochures in Pocket of Notebook

Marijuana

Narcotics

LSD

The Up and Down Drugs

Drugs of Abuse - Food and Drug Administration - in pocket of notebook

Teachers' Guide to Films - *Sanford Feinglass, Ph.D.*Suggestions on the Use of Films in Drug Abuse Education - *Weber and Fiorelli*Film Reviews - *Weber*

Chart on Drugs

TEACHING TECHNIQUES

Suggestions for Educators - *Robert C. Petersen, Ph.D.*Communicating About Drugs - *Helen H. Nowlis, Ph.D.*Communication With Youth - *Joseph F. Maloney, Ph.D.*Address to AAHPER-NSTA Workshop - *David Schwartz, M.D.*Life Without Drugs - *Gilbert Guerin, Ph.D.*

SCHOOL-COMMUNITY RELATIONS

Who Needs Drug Education: Parents or Children - *Ralph Metzner, Ph.D.*Appeal for Early Intervention - *Theodore Rubin*Report of Committee on Marijuana - *California Congress of Parents and Teachers, Inc.*

#

INTRODUCTION

FACT SHEET: DRUG ABUSE EDUCATION PROJECT

The objective of this project is to assist educators in planning strategies for the prevention of indiscriminate use of drugs by young people. The project has been conducted by the American Association for Health, Physical Education, and Recreation and the National Science Teachers Association, two departments of the National Education Association, Washington, D.C. Work started June 30, 1968 under a contract from the National Institute of Mental Health.

Marvin R. Levy, formerly supervisor of health and safety education with the New Jersey State Department of Education, is project director. The staff includes Sanford A. Feinglass, Ph.D., program coordinator; A. L. Braswell, Ph.D., science consultant; Mrs. Dallas Johnson, coordinator of instructional materials; and Joseph Fiorelli, audiovisual specialist.

Members of the advisory committee are Richard B. Blum, Ph.D., Director of Psychopharmacology Project, Institute for Study of Human Problems, Stanford University; Neil L. Chayet, attorney, lecturer at Tufts University School of Medicine; Gerald Edwards, Ed.D., Department of Health Education, Adelphi University; Jerome Jaffe, M.D., Department of Psychiatry, University of Chicago, director of Drug Abuse Division, State of Illinois; Lillard E. Law, Ph.D., Superintendent of Schools, Westfield, New Jersey; Helen Nowlis, Ph.D., professor of psychology, University of Rochester, and director of Drug Abuse and Education Project of the National Association of Student Personnel Administrators; and Joseph Paige, Ed.D., Urban Adult Education Institute, Detroit.

A drug abuse education conference, held in the San Francisco area from October 14 through 25, 1968, was the first phase of the project. It was attended by 19 teachers and teaching supervisors from 16 states. The participants, all of whom had had previous experience in school drug programs or curriculums, were recommended by their school districts for their effectiveness in reaching teachers and students.

Speakers addressing the conference came from the fields of education, medicine, law enforcement, pharmacology and research. Also scheduled were sessions for discussion, observation and group participation. The educators met drug addicts, alcoholic patients in treatment, and alienated young people. They visited a psychiatric center and a juvenile detention center, and at a medical school observed drug experiments on animals. Films and resource materials were reviewed for effectiveness. In all conference experiences, the participants were continuously urged to exchange ideas and voice criticisms.

Following the broad exposure to differing individuals, experiences and viewpoints, participants developed guidelines the educators will use in their own localities and for inservice training programs for teachers and school administrators for school programs for students. The guidelines for inservice programs were put to use in the participants' school districts, with a project staff member assigned to attend each program to assist and evaluate. The reference and guideline material in this binder, along with sets of audiovisual materials including audio tapes and kinescope films reproducing programs from the San Francisco conference, were used in the district programs.

These Guidelines and Selected References are for use in workshops for 300 teachers attending the 1969 national conventions of the American Association for Health, Physical Education, and Recreation and of the National Science Teachers Association. Half of the participants in the San Francisco conference are to attend each of the workshops to assist in the programs.

The Guidelines and Selected References, as well as all audiovisual materials developed during this project, are the property of the project's funding agency, the National Institute of Mental Health.

#

Report of
CONFERENCE FOR EDUCATORS ON DRUG ABUSE EDUCATION

*San Francisco Area, California
October 14 - 25, 1968*

Nineteen educators from sixteen states attended the conference on drug abuse education held in the San Francisco area in October, 1968, as the first phase of this Drug Abuse Education Project. The project is funded by the National Institute of Mental Health to develop guidelines for education on drugs for school-age youth. The conference participants were selected from membership in the American Association for Health, Physical Education, and Recreation and the National Science Teachers Association, the two departments of the National Education Association assigned to conduct the project. The nineteen conferees had had previous experience in drug programs in their local high school districts.

The conference program exposed participants to a variety of individuals, opinions and experiences with the objective of enabling the participants to make decisions, form attitudes, and render judgments about drugs, the people who use them, and the role of the teacher in drug abuse education.

Conferees spent the first week at Mendocino State Hospital, Talmage, California. Residing at the hospital brought association and freedom of opportunity for discussion with staff and with patients in treatment for drug addiction and alcoholism. In addition, the members were addressed by speakers from diversified fields, including:

Speakers from the National Institute of Mental Health

Representatives of the California Bureau of Criminal Statistics and the California Youth Authority

Former assistant district attorney of San Francisco

Professor, School of Criminology, University of California

Chief psychiatrist, San Mateo County Juvenile Probation Department

University of Chicago psychiatrist in charge of the Drug Abuse Division, Illinois Department of Mental Health

Psychiatrist with the Family Therapy Institute, Marin County, California

Psychiatric superintendent, Daytop Village, New York

Psychologist who conducted psychedelic research

Physician who conducted research on human response to marijuana

Catholic priest representing the California Governor's Conference on Youth

Minister discussing drugs and religion

Young physician-author of a medical column published in underground papers

Disc jockey for hippie music

Professor of Health Education, Columbia University

Chairman of Health Education Department, Adelphi University

Denver, Colorado, Juvenile Court Justice

At evening sessions, films pertaining to drug use were shown and discussions were held evaluating them. One evening program featured the music now favored by young people: lyrics in the language and protest themes of youth were distributed and studied. Another evening program presented a psychedelic light show and live rock music to accompany dancing by conference members and hospital patients. A discussion session with the musicians followed the program.

The second week program of the conference provided two days in downtown San Francisco and the remainder in San Mateo County. Experiences included:

Lunch with Haight Street habitués in a street coffee house

Interviewing a talkative young male speed freak, describes as a garbage addict as he took anything

Visit to a hospital psychiatric aid center

Observation of experiments showing effects of drugs on animals at the pharmacology school at the University of California Medical Center

Screening and critiquing more films, leading to the conclusion that many are poor but that portions of them may be combined with other teaching elements for useful programs.

Commitment as a group to spend one day in a Juvenile Hall. Isolation behind a handleless locked door approximated that experienced by detained 12 - 18 year olds subjected to rigid schedules of meals, recreation, and education.

At the end of the conference, the teachers discussed their previously conducted drug programs in the light of the insights and new knowledge gained at the conference. Sub-groups developed guidelines for eliminating previous weaknesses and developing more effective programs. Comments of participants at the conference conclusion and in subsequent correspondence, which indicate some of the new understandings gained, include the following:

'Our thinking was shaken up and we were re-educated.'

'At times I was resentful and didn't know my role. But it was one of the most meaningful things that ever happened to me.'

'I learned how much love and concern are necessary for a good learning situation.'

'I have undergone a great change. The conference was concerned with all of education.'

'My original ideas and thoughts have surely been jolted and a lot of re-education has taken place . . . I plan to conduct workshops starting in mid-November.'

' . . . did much to revitalize for me those things that I believe most fundamental to good teaching. It seems likely that (we) will have a one-day drug institute for 150 teachers and a concentrated institute of five days for 25 - 30 teachers.'

'A golden opportunity to be a participant in a workshop that was surely the work of masters . . . Now the scene is shifting to interested principals and P.T.A. groups.'

'The conference was an experience of a lifetime and one I wish all my fellow teachers could have . . . I've gained a new insight into life, a fresher, cleaner look at things around me, a more understanding respect for humanity, and a greater zest for my work.'

'The two weeks I spent in San Francisco was by far the best educational experience of my whole professional career.'

The educators attending the conference were:

George R. Bartosik
Leader, Drug Education Team
San Diego School District
San Diego, California

Mrs. Catherine W. Binns
Coordinator of Health Services
Atlanta Public Schools
Atlanta, Georgia

William Burcat
Supervisor of Health, Safety &
Physical Education
Camden Public Schools
Camden, New Jersey

James Cantalupo
History Teacher &
Audiovisual Coordinator
Roseville Public Schools
Roseville, Michigan

John A. Caserta
Curriculum Coordinator
Washoe County School District
Reno, Nevada

Mrs. Jimmie Goodman
Consultant in Physical Education
Alabama State Department of Education
Birmingham, Alabama

James L. Garvey
Assistant Director for Health &
Physical Education
Worcester Public Schools
Worcester, Massachusetts

Miss Helen E. Gould
Teacher of Health Education
Baldwin High School
Baldwin, New York

Dr. Einar F. Grell
Director of Science
Half Hollow Hills Schools
Huntington, New York

Raymond A. Hamilton
Assistant Superintendent & Principal
Whitman-Hanson Regional High School
Whitman, Massachusetts

David G. Hufford
Dean of Boys & Director of Pupil Personnel
Riverside-Brookfield Township High School
Riverside, Illinois

Fred B. Kohl
Supervisor of Physical Education, Health & Safety
Kansas City Public Schools
Kansas City, Kansas

Herbert Lewis, Jr.
Supervisor of Health & Physical Education
Jefferson County Public Schools
Louisville
Kentucky

Robert E. Malone
Head of Drug Abuse Education Program &
Science Teacher
Newton High School
Newtonville, Massachusetts

Louis V. Morelli
Supervisor of Health & Physical Education
Broward County Public Schools
Ft. Lauderdale, Florida

John Pickens
Supervisor of Science
Pasadena Independent School District
Pasadena, Texas

Robert L. Prettyman
Chairman of Science Department
North Central High School
Indianapolis
Indiana

Mrs. Constance P. Tate
Science Specialist
Baltimore Public Schools
Baltimore, Maryland

Mrs. Laurel Zakovich
Consultant in Health Education
Aurora Public Schools
Aurora, Colorado

GUIDELINES FOR DRUG PROGRAMS

Inservice and Instructional Considerations

Marvin R. Levy

Introduction

These guidelines for a drug abuse education program were developed by eighteen teachers on the basis of their experiences at the conference in the San Francisco Bay Area October 13 through October 25, 1968.

The guidelines offer suggestions for both teacher inservice programs and classroom activities. There are a variety of ways to pursue teaching; those selected here emphasize communications, peer relationships, self-awareness, perception, and evaluation through techniques used in sensitivity training and encounter groups.

Philosophy

We are a drug using society. A large segment of our population looks to drugs to alleviate a host of physiological, psychological and social discomforts. Young and old alike are inundated with commercial sophisms eulogizing drug products. Within this persuasive cultural milieu, drug abuse is spawned. Education, to be effective, must first recognize the complex historical, social and psychological setting as a powerful stimulus to the use and abuse of drugs.

The best deterrent to drug abuse is the individual's value system and his assessment of the consequences associated with drug involvement. Decision making can be aided when sensitive teacher-pupil relationships based upon mutual understanding, integrity, and honesty are established. Exaggeration, distortion, and sensationalism are propaganda, not education, and have no place in the school.

The nature of the problem is such that the school program must draw together the students, the total school staff and the community. An initial effort must be made with the administrators to insure that cogent school policies are promulgated, thereby enabling the school environment to be relevant to each student's needs, interests, and aspirations. School policies which punish rather than support, alienate rather than enlist, frustrate rather than hearten, injure rather than pardon, sow hatred rather than love, doubt rather than hope, and provide darkness rather than light, are calamities. Those who develop school policies must be fully informed regarding the nature of drugs, psychosocial motivations, legal considerations, and the content and process of their communities' teacher inservice training and student instructional programs.

Intensive teacher inservice programs are essential. In order to present an instructional program which does more than dispense facts, those charged with teaching need a great deal of preparation. Without it, few teachers can analyze the facts and nonsense about drugs and come to decisions. Further, group process training is imperative for developing communication and awareness skills.

Parents and the community should be informed of their roles in preparing young people to mature successfully in our culture, by programs held to increase their participation, understanding and support. It is important that they be convinced that the school plays but one part in the total effort.

The school program for students must begin early. It is no longer appropriate to conceive of drug abuse education as a unit or course only at the secondary level. Concepts, attitudes and behavior are developing during the elementary years and the school cannot ignore this learning opportunity. The program should examine societal conditions that promote drug use and abuse. Drugs per se are not the issue; rather, the issue is why people use them. The program can include the abuse potentials of drugs, the meaning of drugs to the individual, pharmacological properties, and legal ramifications. The intent should be upon an examination of decision-making processes in such a way that the individual becomes more aware of the factors that influence decision making. The program should encompass the principles of group work. Central to the success of the instructional program is the school setting which encourages an acceptance of all children and an understanding of their individual needs which, when frustrated, may lead to drug abuse.

Finally, there must be widespread commitment on the part of the entire school staff, parents and the community to create an open environment where boys and girls feel secure, wanted, loved, and free to express their innermost feelings. The school should be this kind of place.

Objectives

Inservice Program:

1. To develop self-awareness and sensitivity for the feelings of others.
2. To discriminate between fact and fiction regarding drugs.
3. To recognize personality problems related to drug abuse.
4. To develop communication skills necessary for meaningful dialogue with students.
5. To respond to students' questions about drugs with certainty and assurance.
6. To critique audiovisual and printed materials with objectivity toward use in instructional programs.
7. To understand federal and state regulations regarding use of drugs.
8. To differentiate between use, misuse, and abuse of drugs.
9. To develop techniques for encouraging decision-making.

Instructional Program for Students:

1. To exercise control as well as freedom of verbal and non-verbal expression of emotions and behavior.
2. To accept the emotions of others.
3. To increase self-awareness of mental and physical conditions, feelings, and sensations.
4. To develop a sense of personal worth and integrity.
5. To increase psychomotor exploration and multisensory perceptions.
6. To develop decision-making skills.
7. To develop objective and subjective reality awareness.
8. To develop evaluative skills in overt and subliminal influences, such as television commercials.
9. To relate cognitive learnings to behavioral usefulness or relevance.

Program for Parents and Community:

1. To promote understanding of the scope and nature of drug use and abuse in society and in the local setting.
2. To increase understanding of federal and state regulations regarding use of drugs.
3. To eliminate hypocrisy in standards for behavior.

4. To enhance open communication between parent and child.
5. To mobilize public support to provide for community services to augment the school program and to follow up on problems identified in the school program.

Teacher Inservice Program

Recognizing that the ultimate success of any educational program rests upon the teachers, they must be prepared, motivated and informed. All teachers and administrators in the school must be appraised of plans, whether or not they are involved in the program or activities. They should be aware of the objectives, scope and process of the program and of their potential role in influencing students.

Teacher Orientation:

In some situations it may be best to begin with a general orientation program for a large group of teachers and administrators before initiating intensive teacher inservice program. This could consist of two afternoon sessions of approximately 3 hours each covering a basic overview of pharmacology, psychosocial motivations, legal considerations and the role of the teacher.

Inservice Program:

The inservice program should include teachers from several disciplines and grade levels. It should be limited to approximately thirty teachers. A minimum of three full days is recommended for such training, rather than dispensing information at weekly meetings. A concentrated, telescoped inundation is strongly urged. Guidelines for teacher inservice programs are being prepared. It is anticipated they will be available by summer of 1969.

Instructional Guidelines

Basic Program Considerations:

1. The extent of drug use and abuse in the school population should be identified.
2. It is imperative that educators develop greater awareness of themselves and their relationship to the feeling of others.
3. Educators should provide an atmosphere which will encourage:
 - a. Interaction between teacher and students resulting in mutual understanding.
 - b. Opportunities to make real choices based on meaningful and factual information.
 - c. A climate in which alternate routes leading to action are carefully weighed by individuals with full understanding of the decision making process.
 - d. Teacher acceptance of student-made decisions.
 - e. Realization by the students or teachers making decisions of the relationship between factual and social consequences of their decisions.
 - f. Development in each student of the capacity to achieve a fullness of living and awareness of his personal worth and self esteem.
4. The wide accessibility of mood modifying substances makes it imperative that differentiation be made concerning use, misuse and abuse of drugs.

5. Students should be aided in examining the motivation involved in choosing to use or not use drugs.
6. The abuse of drugs is recognized as a medical and sociological problem.
7. Although a drug subculture exists with its own set of values, there are no well defined, identifiable characteristics of the individual drug user.
8. A non-punitive policy should be encouraged in handling drug users in school with possible referral to appropriate school or community personnel for special kinds of help.
9. Many current rehabilitative techniques enable drug-prone individuals to function adequately in life situations.
10. Evaluations of attitudes and knowledge about drugs should be made before and after the program to determine effectiveness with the students.

Instructional guidelines for primary grade students and for junior and senior high students are being prepared. It is anticipated they will be available by summer of 1969.

Teaching Techniques

1. Establish a non-authoritarian, non-threatening environment in the classroom which will allow free flow of information and exchange of ideas and feelings. A non-moralizing, non-dogmatic approach to the subject of drugs should be employed.
2. Involve students actively in the analysis of printed and audiovisual materials on drugs.
3. Opportunities should be provided for frequent teacher-pupil contacts on a one-to-one basis and for daily encounters with groups of students. Controversial subjects and current problems should be discussed in classes such as social studies (i.e., war, politics, racial situations, drugs, urban problems.)
4. Provide a room in school for multi-sensory experiences to be used to maintain open communication. Students might decorate the room and take part in decisions for its use.
5. Use small group techniques extensively, such as:
 - a. Interaction through dialogue.
 - b. Role playing and behavior rehearsals.
 - c. Encounter--Use only with trained leaders.
 - d. Sensitivity training. Only to be used by highly qualified teachers.
 - e. Buzz sessions.
 - f. Critical - incidents.
6. Instead of using entire films, think in single concept terms. Show a portion and discuss, letting students participate in open discussion on good and bad aspects.
7. With caution and advance screening, use personnel from treatment and rehabilitation programs, former drug users, drug addicts or other resource persons from all levels of related backgrounds. Also, make visits to institutions.
8. Collect newspaper stories about drugs. Read in class for biases and discuss.
9. At parent or community meeting, try 'tuning in with kids' technique. Leader has a group of students seated on stage with backs to adult audience discussing, frankly, how they feel about school, teachers, etc. After discussion gets underway, the students are turned around.

10. Have young students identify drugs among non-food substances at grocery store.
11. Consistent with the philosophy of the program, the traditional systems of grading are not desirable in a drug education program, but unit credit should be given.

Curriculum Content

Provide instruction at all grade levels in all curriculum areas which will focus on drugs. Efforts should be made to use factual data and to approach the subject from many directions. The curriculum might include:

I. Pharmacology

- A. Characteristics of drugs.
- B. Effects of drugs.
- C. History of drugs.

II. Psycho-Social Aspects

- A. Recognition of different life-styles.
- B. Role of the environment in the use of drugs.
- C. Role of the individual in society and drug effects upon the individual.
- D. Understanding the different racial, ethnic, and religious groups.
- E. Society's methods of dealing with the drug problem:
 1. Education for prevention.
 2. Education for behavioral changes.
 3. Modern methods of treatment.
 4. Legal approaches.

III. Interpersonal relationships

- A. Personal adjustment
Awareness of self and development of worthwhile self concept.
- B. Peer Interaction
- C. Family Relationships
- D. School and Community Relationships
- E. Role of the individual in society
- F. Life Philosophies

#

Excerpted from

PHILOSOPHY OF DRUG ABUSE EDUCATION

*Sanford J. Feinglass, Ph.D.
Project Program Coordinator*

Society's first attempt to deal with drug abuse was the passage of a lot of laws. The legislation led to a large number of persecutions, prosecutions and arrests. This approach did not provide the benefits that should have accrued from the large expenditure of time, effort and resources.

As it became obvious that legislation did not provide an effective deterrent, society became more conscious of the role that education could play in helping people avoid the difficulties resulting from drug abuse. Having started as a pharmacist and then achieving a doctorate in pharmaceutical chemistry, I attempted a survey of a number of existing drug education programs. I found that the closer I came to a program that was considered excellent, the more that program dissolved into something meaningless or irrelevant. At the same time I attempted to discover what basic philosophy could be found in these programs, be they successful or not, which might be enlarged upon and perhaps made more effective. I found that the philosophy that was being accepted and used as a basis of most drug education programs was that a comprehensive knowledge of the medical and legal dangers involved with the use of certain drugs will equip the average student with the materials he needs in order to make proper decisions about the use of drugs. It is taken for granted that in prospective drug involvement there are a number of medical and legal conditions which endanger both the present and the future of the youth involved as well as the society in which he lives. The decision desired by almost all educators involved with programming is abstinence from outlawed drugs, particularly marijuana, LSD and the narcotic analgesics. In these programs, alcohol is only infrequently mentioned and tobacco even less so, despite the fact that both are illicit to minors.

Analyzing the failure of existing programs, I reached the conclusion that two problems which were built into the strategies used were handicaps to a successful program. They were, first, the desire for abstinence from only a certain group of drugs and, second, that two of the most frequently used drugs were only infrequently part of educational programming.

The next question to arise was whether the validity of three particular precepts often associated with philosophies of drug abuse education could be tested. The first precept was that the medical and legal dangers of harmful drugs were incontrovertibly identified and established. Second, that the medical and legal dangers associated with drugs are not well known to students. Third, that these identifiable and incontrovertible dangers which are unknown to students, when told to them, form some sort of meaningful portion of the decision-making process.

There is considerable danger in conducting surveys at schools to find out what drugs are being used and by how many people. Foremost, the majority of students will lie to questionnaires in such surveys, partly because of suspicion of the surveyor's motives. They have too often seen the results of such questionnaires used in sensational exposures of which they want no part.

To examine the validity of the precept that medical dangers of drugs were incontrovertibly identified and established did not, however, require a survey. This was clearly an invalid proposition. For example, the medical dangers associated with the use of tobacco have only come to light recently. No one suspected emphysema and a number of cardiovascular diseases before the last decade. And it has only been within the last two years, as another example, that we have recognized the danger in the compulsive intravenous use of high doses of amphetamines. People popping pills to try to reduce, stay awake, or study for exams had revealed one set of medical sequelae. But people injecting large doses brought up a completely different medical danger. Thus, consideration of only two drugs, tobacco and amphetamines, clearly demonstrated the possibility of unknown dangers in other drugs, and nullified the precept that drug dangers have been clearly identified and incontrovertibly established.

We were, however, able to find a survey instrument -- the details of which cannot be reported at this time -- that tested knowledge, attitudes, motivations and, to a certain degree, drug usage patterns. This instrument was modified to suit our purposes of examining the other issues incorporated in drug education philosophies.

We found an interesting phenomenon which perhaps should have been suspected earlier but was not. It was that the greater the personal involvement with drugs, the greater was the knowledge of the effects of drugs and the interest in finding out more. A number of students in junior and the early grades of senior high school were found to be reading Goodman and Gilman, the standard text in pharmacology. Further, they were reading professional journals such as the American Chemical Society Journal, American Journal of Psychiatry, and botany journals. They were doing quite a good job of finding out for themselves the effects and the actions of a wide variety of drugs. They learned, for example, that plants growing on the front lawn of the school contained one LSD-like trip in only 100 seeds. These plants were, of course, both licit and free. From reading chemical journals, a few enterprising young people actually synthesized their own drugs. This line of inquiry obviously negated the precept that the medical and legal dangers associated with drugs are not known to students. Incidentally, it was also brought out in this study that the students surveyed tended to react rebelliously against misinformed scare teaching.

As for the proposition that knowing that a drug is dangerous medically and legally is going to deter student use of the drug because such knowledge forms the major basis of the decision-making process--that proposition was not as true as had been thought.

We obtained information on this question partially by asking students to rate drugs according to both dangers of use and to lethality. The students were asked to rate a list of drugs from the most dangerous to the least dangerous. They were then asked to rate the same list of drugs from the most lethal to the least lethal. We found that in the minds of the students, the most lethal drug was not necessarily the most dangerous drug. This was important because there are a number of freely available substances that are tremendously lethal yet may not be considered dangerous in use. For example, strychnine is an extremely dangerous, toxic drug. But you can buy strychnine in the grocery store without a prescription as rat poison. Thus, despite its lethality, society has decided not to curtail the availability of strychnine.

Students were performing the same analysis. They were saying, 'Yes, we know this drug is lethal -- a lot of people may die from misusing it. However, in the way we use it, it may not be as dangerous as a second drug with less lethal potential.' For example, tobacco in itself is not as lethal as some other drugs. The manner of its use, smoking, does however render tobacco a significant threat to health and lives. In this manner, knowledge forms a basis of decision-making. However, the question students are asking themselves is which drugs to use not, as many educators assume, whether to use drugs. That question has already been decided by the general culture.

Parenthetically, students readily volunteered information indicating that the current upsurge in the use of marijuana is a result of the lack of the substantial medical threats which are posed by the majority of other mind-altering drugs. This fact is very likely responsible for the ineffectual role of education to dissuade, so far, marijuana use. Under pressure of external forces, teachers feel compelled to report outrageous and exaggerated accounts of the drug's dangers, thereby reducing their level of credibility to the students. Were teachers able to make simple truthful statements about marijuana and then to engage their students in more meaningful issues, their efforts might have greater effect. Teachers might also have greater influence, through generating student confidence in their objectivity, in deterring more serious drug experimentation.

Further analysis uncovered a number of critical information areas which must be recognized by the educational establishment and society, if either of them is going to deal with drug abuse in a meaningful way. One is the need to define the terms used so freely. The classic definition of a drug is any substance introduced into the body which alters the structure or function of the body. The classical medical definition considers as drugs certain substances which education generally overlooks. What is abuse? The most useful definition for educators is that drug abuse occurs when a drug is used in such a manner as to interfere with the economic, social and physical well-being of the user. For example, someone goes to a party, drinks considerably and proves obnoxious. After a while he receives fewer invitations. This form of drug abuse affects his social well-being. The same is true from an economic point of view. If someone uses a drug to the extent that requires a great financial

investment, this may be considered abuse because it has created economic hardship. The physical effect is obvious -- the traditional medical approach. If the user dies, loses weight, gets hepatitis or becomes psychotic, this is obviously abuse of a drug. It is imperative to recognize then that all drugs have abuse potential -- only with such an orientation can we protect against the confusion of inconsistency.

If one examines the spectrum ranging from abstinence at one end to abuse on the other, one can begin to answer the question, 'Where may education be most effective?' Our research suggests that the most sensitive area for changing trends is the bridge between use and abuse. The first goal is to attempt reduction of the incidence of use to abuse transitions, the second is to convert a use pattern from dangerous to less dangerous, and third, to attempt to diminish the frequency and quantity of use. The most difficult goal and the least important to society is producing abstinence. Note carefully that we are considering all social drug use.

What factors uncovered by our study support this assumption? To students, society appears wrong, if not hypocritical, in trying to preach abstinence to them when the society outside the school is so very heavily drug dependent. It is very difficult for one segment of our society to be told, 'You will have to practice abstinence from drugs,' when they are constantly bombarded with the message directed at the entire society, 'in order to succeed socially, in order to become someone of importance, you have to use drugs.'

The present youth generation has inherited the drug foibles of the previous generation that might be designated 'the tranquilizer generation.' This generation used the sedative-hypnotics in an effort to reduce anxiety and tension, to provide buffer between social and professional lives, and to assist in reducing psychosomatic diseases. It is in this context that students refer to marijuana. Marijuana is the successor to Miltown. If we continually fail to recognize this, the offspring of the Viet Nam generation are going to be even more heavily drug dependent.

For example, in matched samplings of parents and children, a child will say, 'I use marijuana because it relaxes me,' and an adult will say, 'I use alcohol because it relaxes me.' A child will say, 'I use marijuana in a group because it makes me more responsive and open to people and seems to improve a party.' The adults says, 'I use alcohol to facilitate being able to talk to people and get along and feel happy at a party.' If we ridicule every attempt to resist drug dependence -- such as communal or tribal living -- instead of capitalizing on their messages and models we remove, one by one, alternatives to drug dependence. The signs are already appearing above the horizon. The age at which drug experiments occur, the age at which exotic drug use begins, has been steadily dropping. The compulsive use of drugs is increasing. The number of persons who are multiple drug users is rising.

The message is clear; there is a greater relevance (because there is a more immediate personal identification) in discussing the psycho-social implications of drug usage than in discussing the medico-legal nature of drugs. And relevance is a keystone for education. The adult community is guilty of a number of transgressions with drugs. Does it not appear hypocritical to promulgate the philosophy that drug blunders are acceptable if one's age is above 18 or 21? Aside from the apparent hypocritical position, it promotes the unstimulating feeling that 'children should be seen and not heard.'

Research also disclosed among educators a lack of appreciation for the heterogeneous nature of drug users. Program after program identified the drug using sub-adult as a person simply out for kicks, attempting to escape from reality or perhaps suffering psychological inferiority. These were generally the only reasons presented for drug use. In our survey, we were able to identify that students possessed a wide variety of motivations for drug use. Drugs can provide intense and profound experiences for those whose lives have become routine. Drugs are used in a desperate attempt to cope with, not escape from life. To the students, the classic rituals of religion, the state, the family and education are becoming increasingly depersonalized. The current popularity of astrology, oriental mysticism and the free universities are indications of efforts to deal with these failures. Drug taking can also serve as a form of inter-personal ritual. The phenomenon of ritualistic drug use is not uncommon in man's historical record. Therefore, picturing the drug user as a depraved individual makes educational efforts almost worthless. Depravity is less frequent among our youth than many suppose.

Let us examine the results of being shortsighted in dealing with one type of individual. If your action with a rebellious drug user is of a highly repressive nature, such as suspension or expulsion, do you not justify and reinforce his rebelliousness? Such a person might respond, to society's ultimate benefit, if his activities were channelled into constructive forms. We identified a far larger number of motivations than anticipated. This is consistent with the idea that the decision to use a drug for a social purpose is more important than the identity of the drug. The selection of a drug comes as the result of a number of interactions, including availability, curiosity, social contacts, innate belief. But basically, the decision to use drugs is a reflection of the psycho-social milieu surrounding the individual.

The existence of inadequately trained teachers plagued program after program we investigated. Teacher after teacher had been selected capriciously and haphazardly, sometimes protesting and sometimes not, and sent adrift without either guidelines or a constant philosophy. Subsequently and naturally they reached out for anything with the slightest patina of authority in an effort to shift responsibility and avoid controversy and frustrations. 'I'm inadequately trained . . . I've been pressured into this thing . . . I don't know which way I'm going . . . I suspect that the kids know more about this than I do . . . The best thing that I can do then is look for some films or pamphlets and throw these into the classroom.' After reviewing in the neighborhood of 35 drug oriented films, one is led to the conclusion that the majority of them have been and are being made solely to exploit the concern that this country has about drugs. They represent some of the most erotic, lurid and bizarre films to be shown in the classroom. They are highly inappropriate because they are inflammatory. For a variety of reasons, these films breed drug use rather than suppress it.

Another method of avoiding responsibility for deep study of the drug problem is the all-school program. The normal rules of the school are suspended, all classes stop for a day, students assemble in the gym or auditorium, one or two people are invited from the community, and perhaps even one of the films is shown. That was considered an effective program. For how many other purposes besides fire and riot are all the normal rules and regulations of the school abandoned? Are you not saying to the kids that next to fire and riot, dope is very important to the school? In math, history or geography do you bring uncredentialed people in to talk to massed students? A lot of attention on drugs may make students feel that the reaction deserves more study than the subject.

Not only do drugs have social attractiveness, they also possess emotional attractiveness which, again, is usually totally ignored. We have heard in great detail about the person who will swallow LSD because he is attempting to discover himself or define his place in the world. There also exist persons who use drugs because they cause physical and mental changes which fulfill particular emotional needs. Champagne for celebration, tranquilizers before sales meetings or marijuana at a rock concert are examples to consider.

The most important omission in all these programs was a sound evaluative procedure. Success or failure was generally measured by attendance figures, newspaper coverage or approval from superiors. Another measure of success was when the speakers, selected without any consistent screening procedure, all supported the particular prejudices of the person putting on the program. Few attempts at evaluation sought student opinion, documented altered student behavior, or confirmed the initiation of more constructive attitudes in both students and faculty. Indeed, little attempt was made to take advantage of the contributions students could offer. We overlook a most powerful tool in education when we neglect the contribution that can be made towards enhancing communications through utilizing students in drug education. A fear seems to exist that students will use the opportunity to proselytize. This lack of confidence could be due to exaggerated and sensationalized accounts of universal dope usage. Certainly most educators do not denigrate the contributions students are capable of making if given opportunity.

Without careful, sound evaluation, mistakes can neither be repaired nor effective pursuits identified. You have no way of determining if you are discouraging or encouraging drug abuse or having no effect at all. One program devoted about 80% of its time to narcotics despite the evidence that only one student in the school had actually used a narcotic. Further, our survey indicated that the students

had vast repugnance to narcotics, based upon values which existed prior to actual programs. If 20% of the students in your classroom have used a drug, this means that in a class of 30 there are 6 people who measure what you say against their own empirical knowledge. In addition to the six users, there are undoubtedly 20 who know the six as users. Therefore a majority of your audience measures what you say against what they see and hear. If you are inaccurate in one description, you are dis-trusted in subsequent ones.

This and other research into drug education indicates that we should become more concerned with a broader picture -- that a lot of drug use is reflective of general disaffection with the educational process. This is well illustrated by one student interviewed. Asked, 'Do many kids go to school stoned?' his reply was, 'Yes.' The next question was, 'Doesn't this impair your efficiency in school?' The answer, 'Of course it does.' After that, 'Well, then why do you do it?' His answer was, 'I wouldn't be able to stand school any other way.' This is the challenge that must be met not only with drugs but with education in general in this last third of the 20th Century.

#

FACT SHEET ON GPO PUBLICATION
TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE

This report was made by the President's Commission on Law Enforcement and Administration of Justice in 1967. It contains the findings and recommendations relating to narcotics and drug abuse which comprised Chapter 8 of the Commission's report, 'The Challenge of Crime in a Free Society.' Annotations have been added to show the source materials. Several papers submitted by consultants and used as background documentation in preparing the chapter are presented as appendices.

Contents

Sections in the chapter on Nicotine and Drug abuse are titled: The Drugs and Their Regulation; Enforcement; Drug Abuse and Crime; Penalties; Marijuana; Treatment; Civil Commitment; Medical Practice and Addiction; Education.

Subjects in the appendices are Mind-Altering Drugs and Dangerous Behavior; Drugs, Dangerous Behavior, and Social Policy; Proposals for Dangerous Drug Legislation; Treatment of Drug Addiction; Civil Commitment of Narcotic Addicts and Sentencing for Narcotic Drug Offenses.

How to Order

The 158-page 8½ x 10½ in. report is paperbound. It may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, for \$1.00 prepaid.

#

SELECTED BIBLIOGRAPHY

I. Articles

- FLACKS, Richard. *Student Activists: Result, Not Revolt*. Psychology Today. October 1967.
- JARVIK, Murray E. *The Psychopharmacological Revolution*. Psychology Today. May 1967.
Discusses folk psychopharmacology, the chemical era, anti-anxiety drugs, anti-depression drugs, LSD, the birth of psychopharmacology, psychological methods in psychopharmacological research, chemistry and the brain.

II. Books

- BARBER, Bernard. *Drugs and Society*. Russell Sage Foundation, New York 1967 (\$6.50) A book on the sociology of drugs which discusses therapeutic drugs, 'religious' drugs and 'addictive' drugs and points out that substances called drugs must be studied from the physiological, the psychological and social aspects. Includes material on the drug industry, testing of drugs, government control and supervision, police approaches vs the socio-medical.
- BLUM, Richard H., et al. *The Utopiates: The Use and Users of LSD-25*. Atherton Press, New York 1964 (\$8.00). A major study of LSD use in a variety of settings, and of users and non-users. Contains chapters on the psychopharmacological, legal and social aspects of LSD.
- BLUM, Richard, Ph.D. & Associates. *Drugs I: Society and Drugs, Social and Cultural Observations. Drugs II: Students and Drugs, College and High School Observations*. Jossey-Bass Publishers, San Francisco, 1969 (\$25.00 for two volumes). These two volumes contain the results of eight years research by Blum and his associates and include historical, cross-cultural, social and psychological studies on drug use and abuse. They are based on work covering over 200 cultures and 20,000 individual interviews and questionnaires.
- COHEN, Sidney. *The Beyond Within: The LSD Story*. Atheneum, New York 1964 (\$5.95). One of the early psychiatrists to explore the effects of LSD during the past 10 years presents reports on 'good trips' and 'bad trips,' discusses 'good' uses and 'bad' uses.
- COHEN, Sidney. *The Drug Dilemma*. McGraw-Hill, New York 1968 (\$4.95, paper \$2.95). Concise description of drug use, focusing on relationships between the agent, the host, and the setting. Drug abuse progenitors discussed. Excellent advise to parents and educators on dealing with drug problem.
- EBIN, David (ed). *The Drug Experience*. Grove Press, New York 1965 (95¢). First person accounts of addicts, writers, scientists and others regarding cannabis, opium, opiates, peyote, mushrooms and LSD.
- FARBER, S.M. and WILSON, R.H.L. (eds.). *Conflict and Creativity: Control of the Mind, Part II*. McGraw-Hill, New York 1963 (paper \$2.95). Articles by Isbell on the history of American attitudes toward addiction and by Beecher, Hollister and others on methodological problems in research on drugs.
- HUXLEY, Aldous. *The Doors of Perception and Heaven and Hell*. Harper and Row, New York 1956 (\$1.45). In the 1940's, researcher Humphrey Osmond gave Huxley some mescaline, precisely because he counted on Huxley's skill at describing his experiences in vivid detail. He did.
- KLUVER, Heinrich. *Mescal and Mechanisms of Hallucinations*. Phoenix Books, Chicago, Ill. 1966 (\$1.50).
- LINDESMITH, Alfred R. *The Addict and the Law*. Indiana University Press, Bloomington, Ind. 1965 (\$7.50) also Vintage Books (\$1.95). A discourse on the criminogenic aspects of drug laws and police practice with a plea for a new way of looking at and treating drug addicts.

- LOURIA, Donald B., M.D. *The Drug Scene*. McGraw-Hill, New York 1969 (\$5.95). Surveys the drug problem, including history and current medical and sociologic literature. Drug use in England and Sweden is covered. The distinctions between users and sellers and between various types of drugs are emphasized, and changes in the penal code to acknowledge these distinctions recommended.
- MASTERS, R.E.L. and HOUSTON, Jean. *The Varieties of Psychedelic Experience*. Holt, Rinehart and Winston, New York 1966 (\$7.95). Analysis of data based on first-hand observations of 206 drug sessions and interviews with an additional 214 subjects who took the drug in a variety of settings. Discussion of the effects of drug taking with respect to body image, perceptions of other persons, repressed experiences, symbolism, religious and mystical experience.
- NOWLIS, Helen H., Ph.D. *Drugs on the College Campus*. Anchor Books, Doubleday, New York (\$6.95). An exhaustive appraisal in lay terminology which educators may find useful. It covers terminology, attitudes, chemistry, sociology, law, morality and education as they effect both the user and society. The book contains an annotated bibliography, a glossary, and Dr. Joel Fort's comprehensive chart on drugs and their effects.
- POLLARD, John C. and UHR, Leonard. *Drugs and Phantasy, the Effects of LSD, Psilocybin and Sernyl on College Students*. Little, Brown and Co., Boston, Mass. (\$7.50). A series of case studies of LSD, psilocybin and sernyl experiences. Each student subject relates his experiences.
- ROBINSON, M. Nyswander. *The Drug Addict as Patient*. Grune and Stratton, New York 1956 (\$6.95). Physicians who have treated narcotic addicts describe various approaches used in private practice and institutional care. It may be useful to a wide variety of professional people in contact with addicts.
- de ROPP, Robert S. *Drugs and the Mind*. Grove Press, New York 1957 (95¢). A biochemist discusses the mental effects of chemicals in the brain and on the brain. The book is 12 years old, but still valid.
- SCHUR, Edwin M. *Crimes Without Victims: Deviant Behavior and Public Policy*. Prentice-Hall, Englewood Cliffs, N.J. 1965 (\$1.95). The classic plea for attention to public policy concerning abortion, homosexuality and drug-taking.
- SIMMONS, Jerry L. and WINOGRAD, Barry. *It's Happening*. Brandon House, No. Hollywood, Calif. 1966 (\$1.95). Widely read by college students. This sociological study of the goals, ideals and activities of the affluent college drug users is a 'subcultural' study written for the layman.
- SOLOMON, David. *LSD: The Consciousness Expanding Drug*. G.P. Putnam's Sons, New York 1964 (\$5.95). Reprinting of 15 papers on LSD by Huxley, Osmond, Leary, Kast, Unger and others.
- SOLOMON, David (ed). *The Marijuana Papers*. Bobbs-Merrill Co., Indianapolis, Ind. 1966 (\$10.00). Reprint of some classic and out-of-print papers dealing with marijuana. Divided into sections considering: 1) historical, sociological, and cultural; 2) literary and imaginative; and 3) scientific.
- TAYLOR, Norman. *Narcotics: Nature's Dangerous Gifts*. Delta Publishing Co., New York 1963 (75¢) (also Dell \$1.65). Despite the misleading title, a sound lay description of many of the 'mind-altering' drugs.

III. Pamphlets

Narcotics (PHS 1927), *LSD* (PHS 1828), *Maribuana* (PHS 1829), *The Up and Down Drugs* (PHS 1830). Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (5 cents each or \$3 for 100 except *Maribuana* is \$3.75 for 100). These flyers produced by the National Institute of Mental Health use questions and answers to describe each drug and to describe mood effects, physical effects, medical uses, misuses, and research.

Task Force Report: Narcotics and Drug Abuse. Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402 1967 (\$1.00). Annotations and Consultants' Papers of the Task Force on Narcotics and Drug Abuse, the President's Commission on Law Enforcement and Administration of Justice. Gives recommendations for control, research, education, treatment, civil commitment and coordination of Federal level programs. Could be considered a textbook for educators, college and senior high school students.

IV. Periodicals

Drug Dependence and Abuse Notes. National Clearinghouse for Mental Health Information, NIMH, Chevy Chase, Md. 20015. Published at random intervals. Addressed to the scientific and medical community and other concerned professionals. Contains selected items covering recent developments in the field and identifies citations to the current abstracts available from NCMHI.

UN Bulletin on Narcotics. United Nations Publications, Rm. 1059, UN Bldg., New York 10017, (quarterly, \$2 per year). Official notices of reports of meetings and actions taken by United Nations, including World Health Organization, which related to drugs. Contains original scientific research papers and review articles.

The International Journal of the Addictions. Issued semiannually by the Institute for the Study of Drug Addiction, 680 West End Avenue, New York 10025, (\$6.00 per year). Provides a world-wide forum of exchange among professionals participating in research, training, and treatment in the field of addictions and substance misuse. An international editorial board, comprised of members of the various medical professions, focuses on all facets of substance misuse-drug, alcohol, tobacco and food.

#

PHARMACOLOGY

FACT SHEET DEPRESSANTS

(Sedatives-Hypnotics)

This group includes the barbiturates, the most widely abused among the depressants.

Medical Uses

Barbiturates depress the central nervous system, and are prescribed in small doses to induce sleep. They are also valuable in cases of acute anxiety, hyperthyroidism, and high blood pressure. Because of their sedative but non-analgesic effects, barbiturates are used in treating both physical and mental illnesses.

Abuse

Continued and excessive dosages of barbiturates result in slurring of speech, staggering, loss of balance and falling, quick temper, and a quarrelsome disposition. Overdoses, particularly when taken in conjunction with alcohol, result in unconsciousness and death, unless given proper medical treatment.

While an unsteady gait and speech problems may be signs of neurological disorders, such as multiple sclerosis, such diseases are uncommon among young men. Usually, the appearance of drunkenness without an alcoholic breath indicates barbiturate intoxication.

Although physical dependence does not develop with the dosages normally used in medical practice, it does occur with the excessive doses used by drug abusers. A tolerance is also developed. Withdrawal symptoms usually are far more dangerous than those resulting from narcotics withdrawal.

Names

Barbiturates are known to drug abusers as 'barbs,' 'candy,' 'goofballs,' 'sleeping pills,' or 'peanuts.' Specific types are often named after their color or shape, such as 'yellows,' 'red devils,' 'rainbows,' and 'blue heavens.'

.....

From the Bureau of Narcotics and Dangerous Drugs, Department of Justice, November 1968.

#

FACT SHEET HALLUCINOGENS

This group includes, among other drugs, mescaline, a chemical taken from the peyote cactus; psilocybin, extracted from Mexican mushrooms, and LSD-25, a lysergic acid derivative that is the best known of the hallucinogens.

Effects of LSD

Eating, inhaling, or injecting even as small a quantity of LSD as 1/280,000 of an ounce causes symptoms ranging from hallucinations and distortion and intensification of sensory perception to panic, impulses towards violence, suicidal acts, and psychosis. These effects, totally unpredictable and varying widely from person to person, may last from 8 to 10 hours, and may recur weeks or months later.

Physical effects associated with the use of LSD include: an increase in blood pressure, heart rate, and blood sugar; nausea; chills; flushes; irregular breathing; trembling; and sweating of the hands. Sleep becomes virtually impossible until at least 8 hours after the LSD episode is over; pupils are so widely dilated that the user may protect himself against the light with dark glasses, even at night.

Hallucinogens do not produce a physical dependence; however, the user may develop a psychological addiction.

Medical Use

After nearly 20 years of clinical research and 2,000 papers published in scientific journals, no medical use has as yet been found for LSD. Together with other hallucinogens, it is considered an investigational drug; indeed, its action on the body and nervous system is not yet understood.

LSD as a therapeutic adjunct in the treatment of various mental disorders, alcoholism, or autistic or psychotic children and adults is being tested and evaluated.

Abuse

Sensational publicity has led to increasing abuse by intellectuals, beatniks, non-conformists, and those seeking kicks. A serious medical, social, and law enforcement problem has been created.

The use of LSD can have disastrous consequences, and often requires extensive psychiatric treatment.

Because of growing abuse of LSD, the only licensed manufacturer and investigator of the drug voluntarily ceased manufacture in April 1966.

Since the Government has taken steps to curb the illegal traffic in lysergic acid and lysergic acid amide, chemicals from which LSD can be made, drug abusers use LSD of untested purity and strength. Experimentation with bootlegged 'bathtub' LSD, peddled to the abuser in various dosage forms with an uncertain quantity of the drug and with the possibility of unknown compounds being present, may be even more dangerous than the use of legally manufactured LSD has been.

From the Bureau of Narcotics and Dangerous Drugs, Department of Justice, November 1968.

#

Excerpted from

STIMULANTS FACT SHEET

This group of drugs, which includes the amphetamines, directly stimulates the central nervous system, producing excitation, alertness, increased initiative and activity, and an ability to go without sleep for protracted periods of time.

Medical Uses

Amphetamines are prescribed for overweight patients: in cases of narcolepsy, a disorder characterized by an overwhelming desire for sleep; for Parkinson's disease; and in some cases of minor mental depression.

Abuse

Because the body develops a tolerance to amphetamines, abusers increase their dosages gradually, which wildly exaggerates the normal effects of these drugs and results in excitability, talkativeness, tremor of the hands, enlarged pupils, and heavy perspiration. In serious cases, a drug psychosis resembling schizophrenia develops with delusions and hallucinations, both auditory and visual. These effects are particularly dangerous to long-distance drivers. They may take amphetamines to ward off sleep, and may be unaware of their fatigue until it overcomes them, causing serious highway accidents.

Criminals frequently use amphetamines to increase their courage and alertness during their exploits.

While amphetamines do not cause physical addiction, abusers develop psychic or emotional dependence on these drugs. Continued abuse of amphetamines can cause high blood pressure, abnormal heart rhythms, and even heart attacks.

The Amphetamines

Amphetamines are known to drug abusers as 'pep pills,' 'wake-ups,' 'eye-openers,' 'co-pilots,' 'truck drivers,' or 'bennies.' As with other dangerous drugs, the slang names frequently derived from the shapes and colors of capsules and tablets, their effects, or their uses.

.....

From the Bureau of Narcotics and Dangerous Drugs, Department of Justice, November 1968.

#

Excerpted from

DEPENDENCE ON BARBITURATES AND OTHER SEDATIVE DRUGS

In today's society, anxiety, tension states, insomnia, and other manifestations of stress are common. Many persons seek relief by self-medication with alcohol, and over-the-counter and prescription sedatives. Unfortunately, social acceptance of this kind of self-medication seems to be increasing.

Historical Note

Drug abuse is probably as old as the earliest civilizations. Man has used great ingenuity in identifying substances which ease tensions, but for centuries available agents remained relatively static, limited to botanicals and their derivatives. Then, in the 1850's, modern chemistry opened a new chapter with the introduction of bromides as sedatives. With use, however, came misuse and abuse which often resulted in intoxication and psychotic or delirious complications. The bromide problem began to abate in the 1930's but only because the compounds were replaced by other sedatives, primarily the barbiturates.

The first barbiturate, Veronal, was introduced in 1903, and a large number of others followed in quick succession. The short-acting barbiturates, especially pentobarbital, secobarbital, and amobarbital, came into widespread use within the last 20 to 30 years. Like the bromides, they have been subject to abuse. In the United States, these drugs can be purchased on the black market and are being used either alone or in combinations, particularly with heroin, amphetamines, or alcohol.

The dependence-producing qualities of the barbiturates were not immediately recognized, but they have become increasingly clear since 1940. It should be noted, however, that the long-acting barbiturates, such as phenobarbital, are less apt to be abused than the short-acting barbiturates.

In the 1950's, a new class of drugs, the so-called minor tranquilizers, began to appear. They have a barbiturate-like action and can produce both psychological and physical dependence. They quickly found widespread use, found their way to the black market, and have been abused in much the same manner as the barbiturates. (See the Appendix for a list of barbiturates and other sedatives and hypnotics.)

Definition of the Problem

Barbiturate Production in the U.S.

A survey by the Food and Drug Administration indicates that in 1962 approximately one million pounds of barbituric acid derivatives were available in the United States. This one-year inventory is enough to supply approximately twenty-four 100-mg (1½-grain) doses to every man, woman, and child in the country. An estimated 50% of these drugs were the short- and intermediate-acting barbiturates which are particularly subject to abuse. Since it is considered probable that the available supply mirrors demand, current production of all sedative drugs doubtless exceeds legitimate medical need by a considerable margin.

This statement was prepared by the AMA Committee on Alcoholism and Addiction, reviewed by the Council on Drugs, and approved by the Council on Mental Health.

Reprinted from the Journal of the American Medical Association, August 23, 1965. Copyright American Medical Association.

Use of Sedatives

By Physicians: Each of the barbiturates and other drugs with a barbiturate-like action listed in the Appendix has specific clinical indications in the practice of medicine. Many medical problems, in everyday practice, are efficaciously met by the proper and judicious use of these drugs.

The physician relies heavily on the barbiturates for the treatment of insomnia. These compounds are convenient and reasonably effective, despite certain adverse reactions such as 'hang-over,' development of tolerance, occasional rashes, and paradoxical excitation.

By Patients: Although barbiturates and similar compounds require physician prescription, a number of substances with unpredictable sedative or hypnotic action are available over the counter. Among these are the antihistamines, antiemetics, scopolamine, and bromides.

Abuse of Sedatives

'Abuse' is used to describe self-administration of excessive quantities of barbiturates leading to tolerance, physical and psychological dependence, mental confusion, and other symptoms of abnormal behavior. The groundwork for drug abuse may often be established by therapeutic misuse by the physician; however, many persons will seek drug supplies from sources other than the physician. Excessive use is likely to result in the user becoming wholly dependent on barbiturates to the exclusion of other values in life. Many dependent persons seek to avoid reality, gain relief from tensions and anxieties. They take these drugs in lieu of or in addition to alcohol or opiates. Others follow the same procedure in search of paradoxical excitation and new thrills.

Psychiatric Considerations

Generally any patient whose psychological dependence on a barbiturate drug has reached a degree sufficient to constitute drug abuse has some form of underlying psychopathology. The excessive use of barbiturates usually induces additional psychopathologic changes. The barbiturate-dependent person, in these cases, is directly comparable to the opiate-dependent person.

The underlying reasons why an individual takes barbiturates vary from person to person and may even serve different purposes at different times for the same patient. It should be noted that there are some groups in society, subject to special tension situations, for whom certain forms of 'escape' are socially acceptable. In these groups, barbiturate abuse may be found particularly in adolescents and younger adults. In all cases, however, the drug-dependent person has found something that he knows will give him 'relief' from tensions and anxieties which to him are unbearable.

Barbiturate dependence has one characteristic in common with all other states of drug dependence. It is almost always a chronic relapsing disorder, and cycles of withdrawal and reversion to drug use are likely to occur in most cases. In all cases, continuing treatment of the dependency state and any underlying emotional disorder is essential, even though there is intermittent, periodic, or even continuing drug use.

Patterns of Abuse

Types of Abusers

Essentially there are four types of barbiturate-drug abuse, and they overlap only occasionally.

1. In the first group are persons seeking the sedative (hypnotic) effects of the drug in order to deal with states of emotional distress.

2. In the second group there is a paradoxical reaction of excitation that occurs after tolerance has developed because of prolonged use. The drug now stimulates rather than depresses and is taken to exhilarate and animate the person to so-called increased efficiency.

3. In a third group are persons who take barbiturates to counteract abuse effects of various stimulant drugs, such as the amphetamines. They set up a mutually reciprocating, cyclical pattern of stimulation-sedation.

4. In the fourth category, barbiturate abuse is found in combination with other types of drug abuse, mainly alcohol and/or opiates. Many alcoholics attempt to counteract the withdrawal effects of alcohol with barbiturates. Frequently, alcohol and barbiturates are combined in an attempt to obtain effects that surpass those of either.

Diagnosis of Misuse and Abuse

General

The physician should suspect dependence on sedatives if members of the family report that the patient is sedated, confused, ataxic, incoordinate, and irritable.

Early diagnosis of barbiturate abuse and/or dependence is often difficult. In many cases, drug dependence or intoxication is diagnosed only after hospitalization of the patient for some other clinical condition. Often the first objective finding of barbiturate dependence is the onset of acute withdrawal, perhaps a single, unexplained grand mal seizure brought on by sudden abstinence.

Intoxication

Intoxication with barbiturates resembles intoxication with alcohol. Symptoms and signs include various degrees of clouding of consciousness with impairment of mental functioning, confusion and poor judgment, euphoria or depression, loss of emotional control, irritability, abnormal behavior, and occasionally convulsions or signs of a toxic psychosis.

Withdrawal Syndrome

Sudden and abrupt withdrawal of barbiturates from a person who is physically dependent results in definite abstinence signs and symptoms. Their intensity varies according to the dose taken, the length of time the patient has been physically dependent, the degree of intoxication produced by doses consumed, and individual factors which remain incompletely understood.

Even though no treatment is given, the entire withdrawal syndrome is usually a self-limited condition. Clinical recovery appears to be complete and no organic sequelae are known to occur. However, patients have died during uncontrolled, untreated barbiturate-withdrawal syndromes.

APPENDIX

Hypnotic and sedative drugs comprise a large group of chemically unrelated substances which have the common property of inducing sedation and sleep with small quantities and anesthesia with large quantities. Barbitol and its congeners represent the largest single group of these compounds.

The following drugs are on the US market:

Barbiturates	Drugs With Barbiturate-Like Action
Barbital (Veronal)	Chlormezanone (Trancopal)
Mephobarbital (Mebaral)	Emlcamate (Striatran)
Metharbital (Gemonil)	Meprobamate (Equanil, Miltown)

Barbiturates (cont.)

Phenobarbital (Luminal)
 Amobarbital (Amytal)
 Aprobarbital (Alurate)
 Butabarbital (Butisol)
 Diallylbarbituric acid (Dial)
 Probarbital (Ipral)
 Talbutal (Lotusate)
 Vinbarbital (Devinal)
 Cyclobarbital (Phanodorn)
 Heptabarbital (Medomin)
 Hexethal (Ortal)
 Pentobarbital (Nembutal)
 Secobarbital (Seconal)
 Hexobarbital (Cyclonal, Evipal, Sombulex)
 Methitural (Neraval)
 Methohexital (Brevital)
 Thiamylal (Surital)
 Thiopental (Pentothal)
 Allylbarbituric acid (Sandoptal)
 Butethal (Neonal)
 Cyclopentenyl allylbarbituric acid
 (Cyclopal, Cyclophen)
 Butallylonal (Pernocton)

Drugs With Barbiturate-Like Action
(cont.)

Oxanamide (Quiactin)
 Phenaglycodol (Ultran)
 Mebutamate (Capla)
 Carisoprodol (Soma)
 Hydroxyzine (Atarax, Vistaril)
 Ectylurea (Levanil, Nostyn)
 Ethchlorvynol (Placidyl)
 Methypylon (Noludar)
 Ethinamate (Valmid)
 Chlordiazepoxide (Librium)
 Hydroxyphenamate (Listica)
 Mephoxalone (Trepidone)
 Carbromal (Adalin)
 Bromisovalum (Bromural)
 Chloral Betaine (Beta-Chlor)
 Glutethimide (Doriden)
 Chloral Hydrate (Somnos, Noctec, Loryl)
 Diazepam (Valium)
 Methylparafynol (Dormison)
 Petrichloral (Periclor)
 Buclizine (Softran)

#

Excerpted from

DEPENDENCE ON AMPHETAMINES AND OTHER STIMULANT DRUGS

Stimulant drugs of the amphetamine type have been used in medical practice for the past 35 years. During this period identifiable patterns of abuse and misuse have been established, and it has been demonstrated that, for many persons, these substances have dependence-producing characteristics which can bring about serious clinical and personal problems. However, unlike that with narcotics or barbiturates, over-medication with stimulants does not lead to physical dependence. Abuse of these substances arises from and is perpetuated solely by psychic needs to overcome depression or fatigue or to attain the euphoric and excitatory effects associated with the drugs.

The routes to dependence on stimulant drugs are varied. Some start in the physician's office where a prescription for amphetamine is given as treatment for depression or as an adjunct to weight reduction. Most cases, however, stem from illicit channels where drugs are sold indiscriminately to a variety of customers, such as truck drivers who want to stay awake during long hauls or teenagers and young adults looking for 'kicks.'

The actual incidence and prevalence of cases of drug dependence of the amphetamine type are unknown. Clinical experience in the United States and other countries indicates an increase in amphetamine abuse, ie, unsupervised self-administration. It also has become increasingly clear that many physicians have not fully appreciated the inherent dangers in prescribing these medications, and that in many cases their presumably therapeutic actions can constitute misuse of the drugs.

The degree to which the abuse of stimulant drugs stems from over-prescribing or from black market sales is not known. However, the problem is serious enough to warrant concern and an examination of the use, misuse, and abuse of the stimulants.

Historical Note

The main stimulant drugs are amphetamine and methamphetamine. Both were synthesized in the 1920's. The amphetamines, however, have a much greater capacity for stimulation of the central nervous system. With small doses of amphetamines, this stimulation is limited to elevation of mood and the induction of a state of 'well-being.' As the dosage is increased, apprehension, volubility, tremor, and excitement occur.

It soon became apparent that the amphetamines were effective in retarding fatigue-induced deterioration in psychomotor performance and that, under medical supervision, they had some appropriate use for weight reduction of obese persons. During the past 15 years, a number of amphetamine-like substances have been marketed as anorexiant. These drugs also stimulate the central nervous system to varying degrees and therefore have a potential for psychic disturbance and dependence.

This statement was prepared by the AMA Committee on Alcoholism and Addiction, reviewed by the Council on Drugs, and approved by the Council on Mental Health.

Reprinted From The Journal of The American Medical Association September 19, 1966, Vol. 197, pp. 1023-1027, Copyright 1966, by American Medical Association.

Amphetamine-type drugs were in widespread use before their dependence-producing properties were recognized. However, their ability to cause euphoria, dysphoria, and psychic stimulation did lead to the removal of amphetamine from over-the-counter nasal inhalers. Restricting the legal acquisition of stimulants to prescription medications did not, however, put an end to their misuse or abuse; today these drugs are part of a major medical and social problem.

In 1965, concern in the United States about the growing problems of drug dependence and abuse led to the passage of legislation, supported by the American Medical Association, that gives the Food and Drug Administration authority to control the manufacture and distribution of substances having a potential for abuse, ie, stimulants, depressants, and hallucinogens. The Drug Abuse Control Amendments of 1965 require that detailed records be kept on the manufacture, shipment, and distribution (including pharmacy prescription records) of the drugs covered. This law should be useful in reducing the amount of these drugs diverted to illicit channels. Amphetamine-type drugs are also illegally synthesized for distribution on the black market, and this traffic will be difficult to control.

Definition of the Problem

Stimulant Production in the United States

A survey by the Food and Drug Administration indicated that, in 1962, over 100,000 lbs. of amphetamine and methamphetamine products were available in the United States. The amount in this one-year inventory is enough to supply 250 mg of these stimulants to every man, woman, and child in the country, ie, 25 to 50 doses per person.

Use and Misuse of Stimulants

Amphetamine-type drugs, in the usual dosage range, make most individuals more alert, more wakeful (often to the point of insomnia), and less aware of fatigue, and may produce euphoria or dysphoria. The drugs have some proper medical use in a few situations where an individual 'must' continue to perform adequately for an abnormally long time. The physician should judge carefully what constitutes a 'must' situation.

Physicians are frequently requested to prescribe stimulants for a variety of nonmedical reasons. Controlled studies have shown that amphetamines can drive trained athletes to increased performance in individual events involving strength and endurance. However, it has also been shown that this practice can, by artificially pushing the athlete beyond his normal endurance level, be harmful or even fatal.

Abuse of Stimulants

None of the drugs considered here is legally available without prescription. Large quantities, however, are available on the black market and, for example, thousands of pounds have been confiscated in stops along the nation's major trucking routes. The drugs are also sold 'on the street' in lower socio-economic neighborhoods and in 'beatnik' or 'bohemian' gathering places. The bulk of the illicit supplies apparently are diverted from legitimate channels and handled by fraudulent wholesalers and other 'front' organizations. An unknown percentage is obtained from unethical druggists or through forged or altered prescriptions.

There has been an alarming increase in the number of 'spree' amphetamine abusers, usually teenagers or young adults, who use the drugs in a social setting for 'kicks' or as an 'experience.' Many of these persons combine stimulants with other drugs, including alcohol, and 'experiment' with the effects obtained from the various combinations. Not infrequently, stimulants are taken intravenously by serious drug abusers. More often, they are taken orally in the form of amphetamine-barbiturate combinations.

Patterns of self-medication with amphetamine-type drugs are varied. Some persons start taking stimulants to counteract effects resulting from abuse of barbiturates or alcohol, thus developing a cyclical pattern of sedation-stimulation in which, to a degree, each type of abuse counter-balances the effects of the other. Other persons try to achieve both effects simultaneously. In these cases, the clinical problem is of a dual nature.

Other dependence-prone persons, who have been introduced to stimulants as an anorexiant or to combat fatigue or depression, become chronic abusers. They often obtain their stimulants by 'shopping' from one physician to another. Some develop a relatively mild form of psychic dependence in which, although believing that the drugs are essential to maintain their daily routine, they do not increase the dosage much beyond usual therapeutic limits. The more prevalent pattern of abuse is the one in which the person self-administers the drug with increasing frequency and in increasing amounts to get the desired euphoric effects.

With all dangerous drugs, the principal hazards of self-medication is that the abuser often is incapable of accurately evaluating his performance and is likely to overmedicate--a practice that, in neurotic or dependence-prone persons, often leads to chronic abuse.

Psychiatric Considerations

As with types of drug dependence, abuse of the amphetamine-type drugs almost invariably reflects some underlying form of psychopathology. Amphetamine dependence is a medical syndrome: a symptom complex that usually reflects some form of psychological and behavioristic disorder that has preceded and predisposed the patient to drug abuse. The stimulant is commonly used as an 'adjustive' mechanism to help the person 'deal' with problems of living and emotional difficulties. Abuse constitutes a 'reaching out' for something without which the patient feels relatively helpless, and there is a continuum between what constitutes ill-advised 'self-medication' and full abuse.

The underlying reasons for drug abuse vary from person to person, and the drug may serve different purposes at different times for the same patient. Usually, the amphetamine-dependent patient is, consciously or unconsciously, seeking to attain one or more of the following effects: relief from fatigue, increased mental alertness, a heightened sense of well-being (euphoria), and relief from the emotional tone of depression.

Withdrawal

There is no evidence that persons develop physical dependence to stimulant drugs, and abrupt withdrawal will not produce seizures; nor is it life-threatening, even for large-dosage, chronic abusers or persons with amphetamine psychosis. Depending on the intensity of the abuse, all measurable traces of amphetamine should disappear from the body in from two to seven days.

Although there is no characteristic abstinence syndrome, the abrupt discontinuance of amphetamines is not without complications. Withdrawal can uncover an underlying depression or it may precipitate a depressive reaction, often with a suicidal potential. There also is some evidence that in certain persons amphetamine intoxication can precipitate a schizophrenic episode.

In many persons whose stimulant intake masks chronic fatigue, withdrawal is followed by a two- or three-day period of intense tiredness and sleepiness.

#

Excerpted from

DRUG DEPENDENCE: ITS SIGNIFICANCE AND CHARACTERISTICS

*Nathan B. Eddy M.D., Consultant, National Institutes of Health;
H. Halbach, Dr. med., Chief, Pharmacology and
Toxicology, World Health Organization, Geneva;
Harris Isbell M.D., Professor of Medicine and Head,
Section of Clinical Pharmacology, University of Kentucky;
& Maurice H. Seevers M.D., Professor and Chairman
of Pharmacology, The University of Michigan.*

The Term 'Drug Dependence'

Much thought and discussion have been devoted to finding a term that will cover all kinds of drug abuse. The component in common appears to be dependence, whether psychic or physical or both. Hence, use of the term 'drug dependence' with a modifying phrase linking it to a particular type of drug is recommended for both of the terms drug addiction and drug habituation. This recommendation has been endorsed by the WHO Scientific Group on Evaluation of Dependence-Producing Drugs (1964).

Drug dependence is a state of psychic or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continuous basis.

It must be emphasized that drug dependence is a general term that has been selected for its applicability to all types of drug abuse and thus carries no connotation of the degree of risk to public health or need for any or a particular type of drug control. The agents controlled by international treaties and by national narcotics laws continue to be those that are morphine-like, cocaine-like, or cannabis-like, the use of which may result, respectively, in drug dependence of morphine type, of cocaine type, or of cannabis type. Other types of drug dependence, such as those of the barbiturate and amphetamine types, continue to present problems, and their description under the general term of drug dependence, while it may help to delineate those problems, in no way suggests or affects the measures to be taken to solve them.

Some drugs induce physical dependence, which is an adaptive state that manifests itself by intense physical disturbances when the administration of the drug is suspended or when its action is affected by the administration of a specific antagonist. These disturbances, i.e., the withdrawal or abstinence syndromes, are made up of specific arrays of symptoms and signs of psychic and physical nature that are characteristic for each drug type. These conditions are relieved by re-administration of the same drug or of another drug of similar action.

Many of the drugs that induce dependence, especially those that create physical dependence, also induce tolerance. Both drug dependence and drug abuse may occur without the development of demonstrable tolerance.

Drugs that are capable of inducing dependence may also be associated with psychotoxic effects that are manifested by profound alterations in behaviour. These effects may occur with a single large dose or during the course of continued administration, or they may be precipitated by withdrawal of the drug following continued administration. The pattern of abnormal behaviour is, within limits, characteristic for each drug type, but wide variation occurs in individual responses depending, among other things, upon the preexisting mental state of the person involved.

The characteristics of drug dependence show significant differences from one generic type to another, a situation that makes it mandatory to establish clearly the pattern for each type of drug dependence.

Excerpted from World Health Organization Bulletin, 1965. 32, 721-733.

Characteristics of Drug Dependence

Drug Dependence of Morphine Type

The outstanding and distinctive characteristic of dependence on morphine and morphine-like agents is that the major elements -- psychic and physical dependence, as well as tolerance -- can be initiated by the repeated administration of small doses and increase in intensity in direct relationship to an increase in dosage. This characteristic implies that dependence on drugs of this generic type may be created within the dosage range generally used for therapeutic purposes, and that its mechanism may be set in motion by the first dose administered.

The characteristics of dependence of the morphine type are:

- (a) Strong psychic dependence, which manifests itself as an overpowering drive or compulsion to continue taking the drug and to obtain it by any means, for pleasure or to avoid discomfort.
- (b) An early development of physical dependence which increases in intensity, paralleling increase in dosage. This requires a continuation of administration of the same drug, or an allied one, to maintain a semblance of homeostasis and to prevent the appearance of the symptoms and signs of withdrawal. With drawal of the drug or administration of a specific antagonist precipitates a definite, characteristic and self-limited abstinence syndrome.
- (c) Development of tolerance that requires an increase in dosage to obtain the initial pharmacodynamic effects.

With drug dependence of the morphine type, harm to the individual is, in the main, indirect, arising from preoccupation with drug-taking; personal neglect, malnutrition and infection are frequent consequences. For society also, the resultant harm is chiefly related to the preoccupation of the individual with drug-taking; disruption of interpersonal relationships, economic loss, and crimes against property are frequent consequences. The abstinence syndrome appears a few hours after the last dose, peaks in 24-48 hours. Most severe symptoms usually disappear within ten days.

Drug Dependence of Barbiturate-Alcohol Type

The signs and symptoms of barbiturate and of alcohol intoxication are similar, as are the signs and symptoms of abstinence from these drugs. Barbiturates will suppress alcohol abstinence phenomena, and alcohol will suppress, at least partially, the symptoms of barbiturate withdrawal. The two drugs are essentially additive and interchangeable in chronic intoxications; these similarities justify the term 'dependence of barbiturate-alcohol type', but there are psychological and sociological differences, so that barbiturate and alcohol dependence will be described separately.

Drug dependence of barbiturate type

While dependence on drugs of the barbiturate type presents certain similarities to dependence on drugs of the morphine type, in detail there is a characteristically different picture both during the course of intoxication and during withdrawal. It is a state arising from repeated administration of a barbiturate on a continuous basis, generally in amounts that exceed the usual therapeutic dose levels. There is a strong desire or need to continue taking the drug, a need that can be satisfied by the drug taken initially or by another with barbiturate-like properties. There is a psychic dependence on the effects of the drug that is related to subjective and individual appreciation of those effects, and there is physical dependence requiring the presence of the drug for the maintenance of homeostasis and resulting in a characteristic and self-limited abstinence syndrome when the drug is withdrawn.

Tolerance to barbiturates does develop and, with relatively low doses, it will become evident within seven days. There is, in contrast with tolerance to morphine-like drugs, a limit to the dose to which a person can become tolerant. This limit is a characteristic of the individual patient and varies widely.

During the chronic intoxication of continuing administration, there is some persistence of sedative action, ataxia, etc. through the incomplete development of tolerance, which makes the individual accident-prone. There is also impairment of mental ability, confusion, increased emotional instability, and risk of sudden overdose.

The abstinence syndrome is the most characteristic and distinguishing feature of drug dependence of the barbiturate type. It begins to appear within the first 24 hours of cessation of drug-taking, reaches peak intensity in two or three days, and subsides slowly. Symptoms constituting the abstinence syndrome, in approximate order of appearance include: anxiety, involuntary twitching of muscles, tremor of hands and fingers, progressive weakness, dizziness, distortion in visual preception, nausea, vomiting, insomnia, weight loss, a precipitous drop in blood pressure on standing, convulsions of a grand-mal type, and delirium resembling alcoholic delirium tremens or a major psychotic episode.

In drug dependence of the barbiturate type, the detrimental effect on the individual stems in part from his preoccupation with drug-taking, but more particularly from the untoward effects of large doses of the drug. By analogy, all agents which produce barbiturate-like sedation, because of the relief of anxiety, mental stress, etc., should produce some psychic dependence and, for the reasons enumerated for dosage increase, physical dependence when a sufficient concentration in the organism has been attained.

Drug dependence of alcohol type.

Drug dependence of the alcohol type may be said to exist when the consumption of alcohol by an individual exceeds the limits that are accepted by his culture, if he consumes alcohol at times that are deemed inappropriate within that culture, or if his intake of alcohol becomes so great as to injure his health or impair his social relationships. Since the use of alcoholic beverages is a normal, or almost normal, part of the cultures of many countries, dependence on alcohol is usually apparent as an exaggeration of culturally accepted drinking patterns, and the manifestations of dependence vary accordingly in a characteristic fashion with the cultural mode of alcohol use.

As with other drugs, psychic dependence on alcohol results from an interplay between the pharmacodynamic effects of the drug and the personality problems of the user. Other reasons not consciously verbalized, may include needs to express masculinity, to remove behavioural controls so that aggressive impulses may be expressed, and to blot out completely a hostile, threatening world.

Tolerance to alcohol does develop. During continuous drinking there is a slight but definite increase in the amount of ingested alcohol required to maintain a given blood level. In addition, some sort of physiological and psychological adaptation occurs so that the alcoholic appears less intoxicated and is less impaired in performance tests at a given concentration of blood alcohol than is a non-alcoholic. Tolerance to alcohol, however, is incomplete and never reaches the degree seen with morphine-like agents.

Physical dependence on alcohol definitely occurs, and the abstinence syndrome resulting when the intake of alcohol is reduced below a critical level is manifested by tremors, sweating, nausea, tachycardia, rise in temperature, hyper-reflexia, postural hypotension and, in severe grades, convulsions and delirium. The last-mentioned condition is characterized by confusion, disorientation, delusions and vivid visual hallucinations. The intensity of the alcohol abstinence syndrome probably varies with the duration and amount of alcohol intake.

Drug Dependence of Cocaine Type

Cocaine is the prototype of the stimulant drugs that are capable, in high dosage, of inducing euphoric excitement and hallucinatory experiences. These properties rank it high in the esteem of experienced drug abusers and lead to the highest degree of psychic dependence.

Abuse of cocaine takes several forms. The most common is the centuries-old custom of coca-leaf chewing, which is practised habitually by certain Indians of the high Andes. With this form of abuse,

release of the alkaloid and its absorption generally are too slow or quantitatively too small to induce mental changes that would lead to abnormal behaviour, as described below.

Diminished need for cocaine as a local anaesthetic and control of the world supply has reduced the total illicit use of this drug, but coincidentally there has developed a most dangerous type of abuse—intravenous injection. In the most advanced form, this type of abuse involves administration at frequent intervals, as short as 10 minutes, the user desiring the ecstatic thrills associated with this practice. This type of abuse appeals particularly to persons with psychopathic tendencies, which are often unmasked by the drug. The induced feeling of great muscular and mental strength leads the individual to overestimate his capabilities. This, associated with paranoid delusions and auditory, visual and tactile hallucinations, often makes the user a very dangerous individual, capable of serious antisocial acts. Digestive disorders, nausea, loss of appetite, emaciation, sleeplessness, and occasional convulsions are commonly experienced by cocaine abusers of this type. Long-standing, continuing misuse of cocaine alone at a high level is rare, however. The user reaches such a state of excitement that he voluntarily seeks sedation. A frequent current practice is to antagonize the exciting effects by the alternate administration of morphine or some other depressant drug, or by the injection of two types of drug in combination, the cocaine-heroin mixture ('speedball') being particularly popular.

No physical dependence on cocaine develops and, consequently, no characteristic abstinence syndrome is noted on abrupt withdrawal. But severe depression may occur and delusions may persist for some time after withdrawal.

Since cocaine undergoes rapid destruction in the organism, large quantities can be given during a 24-hour period. Indeed, in man as much as 10 gm daily may be used when the drug is administered in relatively small doses at short intervals.

In summary, then, the characteristics of drug dependence of the cocaine type are:

- (a) Strong psychic dependence.
- (b) No development of physical dependence and, therefore, absence of a characteristic abstinence syndrome when the drug is withdrawn.
- (c) Absence of tolerance; rather, there is sensitization to the drug's effects in some instances.
- (d) A strong tendency to continuation of administration, as in coca-leaf chewing, or rapid repetition of the dose, as in the current practice of intravenous administration. Quantitatively, the effects are strikingly different, according to the mode of abuse.

Cocaine is probably the best example of a substance to which neither tolerance nor physical dependence develops and with which psychic dependence can lead to a profound and dangerous type of drug abuse.

Drug Dependence of Cannabis (Marijuana) Type

It is not known with absolute certainty which of the chemical structures that have been isolated from *Cannabis sativa* L. is responsible for the typical cannabis effects, but these can nevertheless be described as constituting an entity that varies in degree according to the concentration of the active principle or principles in the plant and the preparations obtained therefrom, and to the mode of application. These effects are also producible by certain synthetic substances of similar chemical structure.

Among the more prominent subjective effects of cannabis, for which it is taken occasionally, periodically or chronically, are: hilarity, often without apparent motivation; carelessness; loquacious euphoria, with increased sociability as a result; distortion of sensation and perception, especially

of space and time, with the latter reinforcing psychic dependence and being valued under special circumstances; impairment of judgment and memory; distortion of emotional responsiveness; irritability; and confusion. Other effects, which appear especially after repeated administration and as more experience is acquired by the user include: lowering of the sensory threshold, especially for optical and acoustical stimuli, thereby resulting in an intensified feeling for works of art, paintings and music; hallucinations, illusions, and delusions that predispose to antisocial behaviour; anxiety and aggressiveness as a possible result of the various intellectual and sensory derangements; and sleep disturbances.

In the psychomotor sphere, hypermotility occurs without impairment of co-ordination. Among somatic effects, often persistent, are injection of the ciliary vessels and oropharyngitis, chronic bronchitis and asthma; these conditions and hypoglycaemia, with ensuing bulimia, are symptoms of intoxication, not of withdrawal.

Typically, the abuse of cannabis is periodic but, even during long and continuous administration, no evidence of the development of physical dependence can be detected. There is, in consequence no characteristic abstinence syndrome when use of the drug is discontinued.

Whether administration of the drug is periodic or continuous, tolerance to its subjective and psychomotor effects has not been demonstrated.

Whereas cannabis often attracts the mentally unstable and may precipitate temporary psychoses in predisposed individuals, no unequivocal evidence is available that lasting mental changes are produced.

Drug dependence of the cannabis type is a state arising from chronic or periodic administration of cannabis or cannabis substances (natural or synthetic). Its characteristics are:

- (a) Moderate to strong psychic dependence on account of the desired subjective effects.
- (b) Absence of physical dependence, so that there is no characteristic abstinence syndrome when the drug is discontinued.
- (c) Little tendency to increase the dose and no evidence of tolerance.

For the individual, harm resulting from abuse of cannabis may include inertia, lethargy, self-neglect, feeling of increased capability, with corresponding failure, and precipitation of psychotic episodes. Abuse of cannabis facilitates the association with social groups and sub-cultures involved with more dangerous drugs, such as opiates or barbiturates. Transition to the use of such drugs would be a consequence of this association rather than an inherent effect of cannabis. The harm to society derived from abuse of cannabis rests in the economic consequences of the impairment of the individual's social functions and his enhanced proneness to asocial and antisocial behaviour.

Drug Dependence of Amphetamine Type

The capacity of the amphetamines and drugs with similar pharmacological properties to elevate mood and induce a state of well-being is probably largely the basis for their value and widespread use as stimulants and anorexians. Since such therapy commonly involves continuous and prolonged administration, the users of these drugs may develop varying degrees of psychic dependence upon them. This fact establishes the basis for abuse, where the dosage may be increased in both quantity and frequency of administration in order to attain a continuing stimulation and state of elation. When carried to an extreme, the psychotoxic effects of large amounts of drugs of the amphetamine type may lead to aggressive and dangerous antisocial behaviour.

The abuse of this class of drugs originates in and is perpetuated by the psychic drive to attain maximum euphoria; no physical dependence is created. Qualitatively, the psychological effects are in

many respects similar to those produced by cocaine.

A unique feature of the amphetamines is their capacity to induce tolerance, a quality possessed by few central nervous system stimulants. Although tolerance develops slowly, a progressive increase in dosage permits the eventual ingestion of amounts that are several hundredfold greater than the original therapeutic dose. Apparently, all parts of the central nervous system do not become tolerant at the same rate, so that the user will continue to experience increased nervousness and insomnia as the dose is increased. Although an individual may survive the oral administration of very large quantities, such ingestion may produce profound behavioural changes that are often of a psychotic nature, including hallucinations, delusions, etc. These latter effects are much more likely to occur after intravenous injection than after ingestion. Indeed, the intravenous route is employed for the express purpose of obtaining bizarre mental effects often associated with sexual functions, even to the point of orgasm. This type of abuse has been increasingly frequent in recent years with the changing patterns of drug abuse in various countries.

Although the amphetamines do not induce physical dependence, as measured by the criterion of a characteristic and reproducible abstinence syndrome, it would be inaccurate to state that withdrawal from very large dosages is symptomless. The sudden withdrawal of the stimulant drug which has masked chronic fatigue and the need for sleep now permits these conditions to appear in an exaggerated fashion. Thus, the withdrawal period is characteristically a state of depression, both psychic and physical, which probably reinforces the drive to resume the drug. In this regard, it is much less important and does not compare in magnitude with those that occur with morphine, barbiturates, alcohol and other drugs that create physical dependence. Withdrawal of drugs of the amphetamine type is never threatening to life and requires psychological rather than somatic therapy.

The use of amphetamines by self-administration has increased consistently in recent years, ostensibly as anti-fatigue agents in situations in which it is desired to remain mentally alert for long periods without sleep or rest or to permit increased physical performance. The use of amphetamines as stimulants has also increased markedly in persons who abuse alcohol and/or barbiturates; in many such instances there is dependence on more than one drug. In such cases, the prognosis is poor, the relapse rate is high, and continued dependence on one or more drugs is the rule, especially in prepsychotics or individuals with latent schizophrenia.

Drug Dependence of Khat Type

Khat (*Catha edulis* Forssk.) is cultivated and consumed in circumscribed areas of East Africa and the Arabian peninsula. The common, and quantitatively most profitable, mode of application is by way of chewing the tender parts of the plant in as fresh a state as possible.

Drug dependence of the khat type is, under the circumstances of its traditional consumption by chewing, characterized by:

- (a) Moderate but often persistent psychic dependence as long as its maintenance.
- (b) Lack of physical dependence.
- (c) Absence of tolerance.

The habitual and, in particular, the exaggerated consumption of khat may also, on account of its non-amphetamine ingredients (tannins) damage the individual's health. The social and economic consequences of dependence on khat consist, in the main, of the alienation of the user's funds and the erosion of his working capacity and concern both the individual and his environment as well as the community.

Drug Dependence of Hallucinogen (LSD) Type

Drugs of this type include lysergic acid diethylamide LSD, a semisynthetic derivative of ergonovine; psilocybin, an indole found in a mushroom ('teonanacatl', *Psilocybe mexicana*); mescaline, the most active alkaloid present in the buttons of a small cactus ('mescal', 'peyote', *Lophophora williamsii*), and in the seeds of some morning glory varieties ('ololiuqui', *Rivea corymbosa* L. Hall f.; *Ipomoea violacea* L.), the active principle of which is closely related to LSD. The mushrooms, cactus buttons and the morning glory seeds are used by certain American Indian tribes in religious ceremonies or are employed by medicine men or women of these tribes in treating illness, usually in ritualistic fashion. Such religious and ritualistic use does not seem to lead frequently to drug dependence. The drug possesses a particular attraction for certain psychologically and socially maladjusted persons who have difficulty in conforming to usual social norms. These include frustrated non-conformists and curious thrill-seeking adolescents and young adults. The drugs are taken for thrills ('kicks'), to alter mood, to change and clarify perception, to induce reveries, and to obtain 'psychological insight' into the personality problems of the user. Generally, the drugs are taken orally and in the company of other users. Ingestion of a single dose or of several doses over a period of two or three days is the customary pattern; prolonged or continuous use is unusual. Periodic, rather than continuous, use is favoured by difficulty in obtaining the drugs, rapid development and disappearance of tolerance, and lack of physical dependence on these drugs.

Drugs of the LSD type induce a state of excitation of the central nervous system and central autonomic hyperactivity manifested by changes in mood (usually euphoric, sometimes depressive), anxiety, distortion in sensory perception (chiefly visual), visual hallucinations, delusions, depersonalization, dilatation of the pupils, and increases in body temperature and blood pressure.

Psychic dependence on drugs of the LSD type varies greatly, but it usually is not intense. The thrill-seekers and non-conformists may enjoy the effects of these agents and may wish to repeat them, but if such agents are not readily available, these persons will either do without them or substitute another substance. A minority of users may develop such strong psychic dependence on those substances that they wreck their careers by persisting in using the drugs despite strong social condemnation.

No evidence of physical dependence can be detected when the drugs are withdrawn abruptly.

A high degree of tolerance to LSD and to psilocybin develops rapidly and disappears rapidly. Tolerance to mescaline develops more slowly. Persons who are tolerant to any of these three drugs are cross-tolerant to the other two.

#

Excerpted from

THE USE, MISUSE AND ABUSE OF AMPHETAMINE-TYPE DRUGS FROM THE MEDICAL VIEWPOINT

Maurice H. Seevers, Ph.D., M.D., Professor and Chairman,
Department of Pharmacology, The University of
Michigan Medical School

Stimulant drugs of the amphetamine type are subject to extensive and increasing misuse and abuse in the United States. Estimates suggest 70 tablets of amphetamine and amphetamine-type drugs are produced legally in the United States for every man, woman, and child. This is almost three times the estimated yearly production of barbiturates. This, in spite of the fact that stimulants have less logical value in medicine than depressants. Although illicit manufacture of amphetamines exists and is apparently on the increase, no estimates of production are available. It is safe to state that the total production is greatly in excess of proper medical need. At least 71 preparations of or containing amphetamine-type drugs are available on the American market for prescription use. These are listed in the attached Appendix.

The use of these stimulants chronically in alcohol and barbiturate addicts in an effort to increase mental or physical performance is a most dangerous practice since it permits the subject to take larger and larger quantities of depressant drugs leading to mental and physical deterioration. In the same hazardous category is the regular use of amphetamines in the morning to antagonize hang-over effects from the 'spree' use of excessive alcohol and barbiturates.

Amphetamine-type drugs are prescribed to reduce appetite in weight reduction programs. This is undoubtedly the largest area for physician misuse. The patient begins to abuse the drug compulsively and often seeks other sources of supply to fulfill his increased need as tolerance develops.

Amphetamines in moderate dosage (5-10 mg) are capable of rendering most individuals more alert, more wakeful (often to the point of insomnia), and less aware of fatigue. Dumping large amounts of surplus amphetamines on the post-war Japanese market where it was, at that time, available without prescription, established a serious drug-abuse problem, especially among juveniles. Probably, the greatest use in the U. S. is by truck drivers and students.

A principal hazard of general use of these drugs by self-administration lies in the fact that the user is rarely capable of making satisfactory evaluation of his performance and is most likely to over-medicate, commonly leading to chronic abuse in neurotic and poorly balanced individuals.

The use of amphetamines in athletics is more wide-spread than is generally admitted. In contrast to the situation with mental performance, studies have demonstrated that amphetamines are capable of driving trained athletes to increased performance in individual athletic events involving strength and endurance.

Amphetamines possess capacity to stimulate the central nervous system. In small doses, this is limited to elevation of mood and the induction of a state of 'well-being.' As the dosage is increased, apprehension, volubility, tremor, and excitement occur and with larger doses hallucinations, and even convulsions; the latter being more prominent after large doses given intravenously. Abuse of this class of substances arises from and is perpetuated solely by the psychic drives to attain maximum euphoria. Physical dependence does not develop. Qualitatively, these psychologic effects are similar to those produced by cocaine. However, cocaine is a much more dangerous agent. A unique feature of the amphetamines is their capacity to produce tolerance. This property is possessed by only a few central nervous system stimulants. Although tolerance develops slowly, progressive increments in dosage permit ingestion of amounts hundreds of times greater than the original therapeutic dose.

Presented at the National Institute on Amphetamine Abuse at Southern Illinois University, February 1966

Although amphetamines do not induce physical dependence as measured by the criterion of a characteristic and reproducible abstinence syndrome, it would be inaccurate to say that withdrawal of large doses is symptomless. However, it is not comparable to the withdrawal of morphine, barbiturates, alcohol and other substances which create physical dependence. It is never life-threatening.

Many individuals use amphetamines during interludes between the abuse of other drugs. The Japanese experience demonstrates the impact of amphetamines on social behavior. During the crisis in 1954 when it was estimated that a half-million persons were abusing these drugs, the incidence of all crimes, especially crimes of violence including homicides, increased strikingly from a pre-war level which was remarkably low in this law abiding people.

In closing, it could be pointed out that the amphetamine problem is only one facet of a much larger drug abuse problem which probably involves 5% of the adult population of the United States. The same factors, emotional immaturity becoming manifest more commonly in unfavorable environmental circumstances and precipitated by stressful situations, are common to all types of drug abuse and require the same type of treatment.

APPENDIX

Compounds Containing Amphetamine

Amphaplex (Palmedico)
Amvicel (Stuart)
Amvicel-X (10) (Stuart)
Amvicel-X (15) (Stuart)
Biphetamine (Strassenburgh)
Biphetamine-T (Strassenburgh)
Obetrol (Obetrol)
Obocell (Neisler)
Quadamine (Tutag)

Compounds Containing Amphetamine Phosphate, Monobasic, Racemic

Strascogesic (Strassenburgh)

Compounds Containing Amphetamine Sulfate

Benzedrine Sulfate (Smith Kline & French)
Dex-Sed-10 (Carrtone)
Dex-Sed-15 (Carrtone)
Edrisal (Smith Kline & French)
Nobese (Tilden-Yates)
Phantos Preparations (Cooper, Tinsley)
Edrisal w/Codeine (Smith Kline & French)

Compound Containing Dextro-Amphetamine Phosphate

Obocell (Neisler)

Compounds Containing Carboxyphen

Bontril (Carnrick)
Bontril Timed Tablets (Carnrick)

Compounds Containing Dextro-Amphetamine Hydrochloride

Bamadex Sequels (Lederle)
Curban (Pasadena Research)
Gevrestin (Lederle)
Timed Amodex Capsules (Fellows-Testagar)
Timed Pymadex Capsules (Fellows-Testagar)

Compounds Containing Dextro-Amphetamine Sulfate

Amphaplex (Palmedico)
Amplus Improved (Roerig)
Amsustain (Key Pharmaceuticals)
Amvicel (Stuart)
Amvicel-X (10) (Stuart)
Amvicel-X (15) (Stuart)
Appetrol (Wallace)
Appetrol-S.R. (Wallace)
Daprisal (Smith Kline & French)
Dexalme-S Duracap Timed Action Capsules (Meyer)
Dexamyl (Smith Kline & French)
Dexedrine Sulfate (Smith Kline & French)
Dramamine-D (Searle)
Eskatrol Spansule Capsules (Smith Kline & French)
Theptine (Smith Kline & French)
Thora-Dex (Smith Kline & French)

APPENDIX (Continued)

*Compounds Containing Dextro-Amphetamine
Sulfate (Cont'd)*

Vi-Dexemin (Smith Kline & French)
 Vio-Dex Timelets (Rowell)
 Zamatam (Marion)
 Zamitol (Marion)

*Compounds Containing Dextro-Amphetamine
Tannate*

Nalertan Tabules (Neisler)
 Synatan (Neisler)

*Compounds Containing Methamphetamine
Hydrochloride*

Ambar (Robins)
 Amertal (Merit)
 Amphaplex (Palmedico)
 Carrtussin Syrup (Carrtone)
 Desbutal (Abbott)
 Desbutal Gradumet (Abbott)
 Desoxyn (Abbott)
 Desoxyn Gradument (Abbott)
 Gerilets Filmtab (Abbott)
 Meditussin (Palmedico)
 Methedrine (B. W. & Co.)
 Obedrin (Massengill)
 Obedrin-LA Tablets (Massengill)
 Obestat Ty-Med (Lemmon)
 Opidice (Boyle)
 Secodrin (Premo)
 Span-RD (Metro Med)

*Compounds Containing Methamphetamine
Preparations*

Amphaplex (Palmedico)
 Obetrol (Obetrol)
 Span-RD (Metro Med)

Drugs With Amphetamine-like Action

Meratran (pipradrol)
 Ritalin (methylphenidate)
 Tenuate (diethylpropion)
 Preludin (phenmetrazine)

#

Excerpted from

PSYCHOPHARMACOLOGY AND OPIATE DEPENDENCE

Jerome H. Jaffe M.D.

*Department of Psychiatry, The University of Chicago
Chicago, Illinois*

There is among young heroin users a high incidence of hepatitis, bacterial endocarditis, abscesses, and occasional fatal overdoses, even when pure heroin in known amounts is available for self-administration. The social productivity of these heroin users is also below that of their own peer groups, suggesting that they are either preoccupied with drug use, living from one high to the next, or that in some way their capacity or motivation for productive activity is reduced. In the interest of reducing this antisocial activity and its accompanying social deterioration and human misery, the New York Academy of Medicine in 1955, and again in 1963, encouraged medical research on the use of narcotics in the treatment of compulsive narcotics users.

Methadone Maintenance

To date, the most thorough study of the use of such agents has been conducted by Dole and Nyswander and their coworkers (1965, 1966, 1968). Dole and Nyswander started from the position that it seemed 'reasonable to look for some medication to block the abnormal reactions of addicts of heroin and permit them to live as normal citizens in the community. Any such medication, to be of practical value, must meet a number of stringent conditions: it must eliminate the euphoric appeal of heroin and the abstinence symptoms that draw addicts back to drug use; it must be sufficiently free from toxic or dysphoric effects that patients will continue with treatment; it must be orally effective, long-acting, medically safe, and compatible with normal performance in work and at school and with responsible behavior in society.'

It had been known for more than a decade that low oral doses of methadone would allay the post-withdrawal-abnormality type of narcotic hunger. What Dole and Nyswander were the first to observe was that when the dose of methadone is gradually increased so that it can be given in large oral doses, it induces a cross-tolerance of such a degree that the euphoric effects of other narcotics, even in relatively high doses, cannot be felt. Dole and coworkers have referred to this high degree of tolerance as 'narcotic blockade.' Thus, the pharmacological rationale of the methadone maintenance treatment is based on two actions of methadone: relief of 'narcotic hunger' (of the persistent post-withdrawal abnormality variety), and blockade of euphoric effects.

The technic of stabilization on methadone used by Dole and coworkers consisted of a gradual (6 to 8 week) escalation of dose. When the rate at which the dose is increased is kept below the rate of tolerance development most patients do not experience euphoria or other psychological effects of narcotics, even during stabilization. Since tolerance apparently develops more slowly to autonomic effects, constipation, decreased libido, and increased perspiration may persist for some time after the patient is fully tolerant to other effects. The modal stabilization dose is approximately 100 mg/day.

Reports on the current status of the Dole-Nyswander study (1967) indicate that over two-thirds of the more than 700 former chronic heroin users now in treatment are either working or going to school, or both. Many of these patients have been in treatment for more than three years. The amount of known antisocial behavior among treated patients is remarkably low when one considers that the patients selected were largely those who had failed to achieve abstinence after many years of drug use, repeated withdrawal treatments and multiple jail sentences. The current cumulative conviction rate is reported to be 3%. Another dramatic effect of treatment is the decrease in the frequency of the use of illicit narcotics, verified objectively by means of thin-layer chromatography of urine specimens taken each time the patient comes for medication. It is not clear whether the decrease in heroin use is a result of the 'blockade' of heroin-induced euphoria or the alleviation of 'narcotics hunger,' but the less impressive results obtained with cyclazocine suggest that the relief of 'hunger' may be the more important factor. The acceptability of this procedure is also another of its remarkable features, with

many drug users waiting for an opportunity to obtain such treatment. It is not, however, successful in every case, and 10-15% of patients accepted for treatment are eventually discharged for unacceptable behavior or for failure to progress.

Criticisms of the use of methadone in the rehabilitation of the heroin user have ranged from disappointment with the experimental design of the study to condemnation of the effort on what appears to be largely moralistic grounds. To date, the use of high doses of methadone has been reported by three separate groups (Dole and Nyswander, 1965; Freedman, 1966; Brill and Jaffe, 1967). None of these groups has used a design that would be considered appropriate for more than a pilot study. Other criticisms of the methadone maintenance technic include the charge that (1) it is merely substituting the euphorogenic actions of methadone for those of heroin; (2) it is merely substituting one addiction for another. It would be patently moralistic to reject a useful therapeutic agent merely because the medicine makes the patient feel good. It would also be inappropriate to conclude that patients maintained on methadone require or request frequent increases in dose. Indeed, it is the experience of all who have worked with methadone maintenance that after the stabilization period patients can be maintained on the same dose for months, and in some cases for years.

Patients maintained on methadone are, of course, physically dependent and will exhibit withdrawal symptoms if the drug is discontinued. Obviously, if one chooses to define addiction as being synonymous with physical dependence, then patients on methadone are addicted. However, there is little resemblance between the behavior that patients exhibit while on oral methadone and the behavior of the same patients while on intravenous heroin; and most workers in this field have tried to emphasize that addiction is not an appropriate synonym for physical dependence.

Some narcotic antagonists such as cyclazocine and nalorphine have mild analgesic and psychotomimetic effects. Tolerance develops to these effects, but does not seem to develop to the narcotic blocking action. In common with nalorphine, cyclazocine produces a variety of physical dependence that is in many ways entirely distinct from that produced by any other drugs.

From a pharmacological viewpoint, the patient who takes a narcotic antagonist regularly can expect to avoid the development of physical dependence even if he continues to use narcotics, and the likelihood of a fatal overdose is markedly reduced, if not eliminated. For patients, the idea of being relatively insensitive to narcotics may bolster their capacity to avoid using illicit drugs.

Recent developments: Amphetamine-Antagonists

Can the rationale for the use of narcotic antagonists in opiate dependence be extended to other forms of compulsive drug use? Schuster and Wilson, at the University of Michigan, and the author, at the University of Chicago, have been seeking pharmacological technics for modifying the self-administration of amphetamines, cocaine, and related agents. Among the agents that have been shown to block or attenuate the effects of amphetamines are the phenothiazines, butyrophenones, depleters of norepinephrine, and inhibitors of the synthesis of norepinephrine.

Speculations on the future of Pharmacotherapy in the treatment and prevention of narcotics dependence:

It has been repeatedly observed that many American drug takers use more than one drug (e.g., opiates plus barbiturates and amphetamines), sometimes for synergistic effects, but often because their drug of first choice is not available. It is not unlikely that such multi-drug users would also shift to alternative substances if, because of some pharmacological intervention, the effects of their preferred drug could not be obtained. According to Nyswander (1967), some patients maintained on methadone who began to use alcohol excessively accepted additional treatment with disulfiram as a condition for continued treatment with methadone.

At present the number of compulsive narcotics users under treatment in the United States by all forms of pharmacological therapy combined is still well under 2% of the estimated total number of users. Under the circumstances, it would be unreasonable to expect such treatments to have a

detectable effect on the overall rate of narcotics arrests, the number of hospital admissions, or the crime rate. However, the advent of such patently 'medical' approaches and the generally favorable reports of their effectiveness have already had a major impact on the conceptualization of the problem, an impact that is likely to be felt increasingly over the next few years.

Recently there have been major revisions in the position adopted by the A.M.A.-NAS/NRC Committee on Problems of Drug Dependence (1967) with respect to the participation of private physicians in the treatment of narcotics users. For example, it is now clearly stated that it is ethical for a physician to prescribe narcotics (preferably methadone) to an ambulatory patient who is awaiting admission to a treatment program. As these and other changes become more widely known, we can expect that physicians will show increased interest in the problems of the narcotics user, and that narcotics users will seek and expect more medical treatment from physicians than they received in the past.

#

Excerpted from

TOBACCO (NICOTINE)

Goodman and Gilman
'The Pharmacological Basis of Therapeutics'

About 600 billion cigarettes are smoked annually in the United States alone. The acute effects of tobacco smoking are due primarily to the nicotine content. Next to caffeine, nicotine is the substance most widely used for its effect on mood.

In each of 36 studies summarized in the 1964 Report of the U.S. Public Health Service on 'Smoking and Health,' a positive correlation was observed between the incidence of lung cancer and cigarette smoking: approximately 11 cigarette smokers die from cancer of the lung for one nonsmoker. Further, correlation between the use of cigarettes and cancers of the oral cavity, larynx, and esophagus has been demonstrated. The rate of pulmonary emphysema is also greater for chronic smokers.

The use of tobacco has long been suspected as a cause of Buerger's disease inasmuch as more than 90% of victims of the disease are smokers and treatment is useless if patients continue to use tobacco in any form.

Nasal, pharyngeal and bronchial irritation may occur as a result not only of injection of nicotine but of the irritation from the many other constituents of tobacco or its smoke. Mucosal injury may result from these causes and from the heat generated in smoking.

There is evidence that smoking increases blood pressure and heart rate. And, although there is no proof that use of tobacco causes arteriosclerosis or results in angina pectoris, the induced cardiovascular activity may trigger attacks. Effects of tobacco smoking on motor and secretory activities of the gastrointestinal tract have not been found to be significant, except in unusual cases. A relatively rare sequence to the tobacco habit is a gradual -- or occasionally sudden -- decrease in visual acuity.

As stated above, tobacco's effects are due primarily to nicotine. Nicotine is an alkaloid which constitutes from 0.5% to 8% of tobacco, averaging about 1.5% in cigarettes. It is one of the most potent drugs known and one of the most toxic, acting with a rapidity comparable to that of cyanamide.

Although nicotine in the 19th century was used in American medicine as an emetic, nauseant, expectorant and anthiasthmatic, it now has no therapeutic applications. It acts on a variety of nerve cells and centers and has both stimulant and depressant phases of action. For example, it both increases and slows the heart rate; it affects arteries which can influence heart rate; it can cause changes in blood pressure; it can produce a hormone discharge which accelerates cardiac rate and raises blood pressure.

Nicotine markedly stimulates the central nervous system. Appropriate doses produce tremors in both man and laboratory animals; with somewhat larger doses, the tremor is followed by convulsions. The excitation of respiration is a particularly prominent action of nicotine. Since stimulation of the central nervous system is followed by depression, death can result from failure of respiration due to both central paralysis and to blockade of the muscles involved in respiration.

In some sensitive subjects -- particularly nonsmokers -- the smoking of one cigarette will inhibit a water diuresis for 2-3 hours. Nicotine may result in increased motor activity of the bowel and occasionally in diarrhea. Depending on the dose, the stimulating effect of nicotine on the gut is followed by a stage of diminished intestinal tone and motor activity.

Nicotine is excreted from the body mainly in the liver, secondarily in the kidney, lung and milk of lactating women.

Poisoning may occur from accidental ingestion of insecticide sprays in which nicotine is present. It is said that the nicotine content of one cigar approximates two lethal doses for man, but swallowed in the form of tobacco, nicotine is much less toxic than would be anticipated. Apparently the gastric absorption of nicotine from tobacco taken by mouth is delayed so that vomiting removes much of the tobacco from the stomach.

Tolerance to nicotine develops when the compound is taken repeatedly, as is evidenced by the confirmed tobacco smokers who are unaffected by amounts of the alkaloid which would cause marked symptoms in the beginner.

#

LEGAL IMPLICATIONS

Excerpted from

LEGAL ASPECTS OF DRUG ABUSE

Neil L. Chayet LL.B.

*Member of the Faculties of Boston University Law School,
Tufts University Medical School and Tufts University Dental School*

Answers to the questions of how to stem the tide of drug abuse and bridge the gulf which separates the generations will in all probability not be found in law. And drug abuse itself may only be a tiny corner of the larger problem of rebellion and unrest among youth, yet we must deal with each facet of the problem and when the law ruins lives, fabricates criminals out of whole cloth and debases itself in the eyes of our youth, it must be examined with scrutiny.

The Present Legislative Structure

In surveying state and federal legislative action, one sees a legislative spectrum running from imposition of the harshest penalties to failure to enact any legislation at all. The majority of states approach the legislative control of all drugs in a uniform manner that ignores varying physiological and psychological effects on the body. Federal legislation, unlike the state acts based largely on the Uniform Narcotic Act passed in 1932, distinguishes between 'hard' drugs (opium, morphine, etc.) and the 'soft' drugs (marijuana). Many states subsequently followed this simplistic division of 'hard' and 'soft' drugs. The states continued to use the 'soft' drug classification when the depressant and stimulant drugs as well as the hallucinogens came into popularity. The effect of this was an incongruous jumble of statutory provisions in no way relating punishment to the potentiality for physical harm.

A second basic flaw in the laws of many states, a flaw which follows naturally from the improper classification, is the establishment of penalties which are greatly out of proportion to the crime committed. In Massachusetts, to offer another person a marijuana cigarette and have this person accept it carries a penalty of ten to twenty-five years for the first offense and twenty to fifty years for a second offense. Georgia offers twenty years to life for the first offense, and a mandatory death penalty for the second offense.

One of the most objectionable features of the laws is the fact that a person with a drug problem is discouraged from seeking medical help. Massachusetts law requires physicians and hospitals treating persons suffering from the chronic use of narcotic drugs to furnish the Department of Public Health a statement giving name, address, height, weight, date of birth, color of eyes, color of hair, date treated and the name of the narcotic drug the person used or suffered from. The physician who refuses to comply with this law which constitutes a mandatory breach of the confidentiality of the physician-patient relationship may be punished by a fine of \$2000 or two years in jail for the first offense. The argument that such a statute constitutes an invaluable, indispensable aid to law enforcement has not been borne out by facts and figures which have been requested from the Department of Public Health by the Massachusetts Medical Society.

Federal Law

The Federal law is filled with inconsistencies, although in many areas it has made some progress. Until June of 1968, possession of LSD was not punished under federal law, although manufacture and sale of the substance was. The theory was that it is better for the law to use its efforts to curb trafficking in the drug than it is to punish those who are users of the drug; this made sense and was the beginning of a sophisticated approach to the drug abuse problem. Unfortunately Congress voted to punish possession of LSD in June 1968 by one year in jail or a \$1,000 fine, a penalty far milder than the penalty for possession of marijuana, a substance less dangerous than LSD. One who possesses marijuana may get a possible sentence in the federal penitentiary of from two to ten years. A person who is convicted of selling marijuana without having secured and paid for the appropriate tax stamp is punished by a mandatory five year penitentiary sentence and this sentence cannot be suspended nor the violator placed on probation. The judge has no choice but to send the person away to the federal penitentiary for five years. Apparently Congress has seen fit to escalate the penalties in the realm of LSD, rather than to review the unrealistic marijuana penalties.

Impact of Present Legislation

The question must ultimately be asked as to whether the punitive orientation of the present drug laws is effectively deterring young people from using these drugs. The incidence of drug use as indicated in the spiraling number of arrests and reported in the surveys taken among young people suggest that it is not. The gangster-style raids, the ineffective prosecution, and the inconsistent results of justice, depending upon the orientation of the police, prosecutor and judge, make it clear that we are due for a change.

This is not to say that drug abuse is to be condoned; in fact, drug abuse strikes a blow at the very fiber of our society; if every time a young person is bored or faced with an anxiety-producing situation, he 'turns on' or 'turns off' or whatever the current terminology is, how is he ever going to mature or make a significant contribution to the society which needs his participation and his ideas and his drive so badly? It is far more likely, however, that the answer lies in research, in treatment, in education, and most important, in frank discussion of the problem, than in the application of harsh punitive measures which can do little more than give a criminal orientation to a youngster already severely disturbed.

A New Approach

A reasoned approach to the drug problem must first include an appropriate classification of abused drugs. A fourfold categorization makes some sense: (1) the true narcotics; that is, those drugs which are physically addicting such as heroin, cocaine and morphine. (2) the dangerous hallucinogenic drugs such as LSD, DMT, Psilocybin and other drugs which appear at the present time to be capable of causing severe damage to bodily functioning. (3) marijuana, which leads the list in volume among the abused drugs and which clearly requires special attention by the law and (4) other dangerous drugs, such as the amphetamines and barbiturates. At present, this last category is singled out in the laws of many states, but the other three categories are almost universally lumped under the single classification of 'narcotics' and their use is punished accordingly.

We must inform young people that many of the substances they are being exposed to are dangerous. This is not to say that everyone who has ingested LSD will procreate deformed children, but it appears there is chromosomal damage that could have such result: additional research is needed to causally link these results, but there is enough cause for concern to lead one to say that dealing with a substance such as LSD is extremely hazardous medically as well as legally. There have also been disturbing reports of persons who have suffered sporadically returning effects of the drug and mental disturbance, without an additional ingestion of the drug. Similarly, methadine or 'speed' has been shown to produce organic damage following repeated use. And little need be repeated here about the effects and ruined lives which have resulted from the use of heroin, morphine, cocaine and other drugs for which an actual physical dependence is developed, sometimes with astonishing rapidity.

Research involving these substances has been extremely slow, largely due to administrative red tape which often proves to be an insuperable barrier to the researcher. We are arresting and punishing thousands who are experimenting with marijuana, about which we know extremely little. (More than 25,000 persons have been arrested in California alone, with nearly one third of these being jailed.) Prior to the passage of the Marijuana tax act in 1932, only one clinical study had been done involving marijuana, a study in which 34 known smokers were observed by a committee formed in the Canal Zone. The LaGuardia study in 1944 was the next major effort. In 1967, the Task Force on Narcotics and Drug Abuse of the President's Commission on Law Enforcement and Administration of Justice wrote that many of the articles in medical journals and other publications on marijuana 'are in foreign languages and reflect the experience of other countries with the use of the drug and with other substances derived from the hemp plant. The relevance of this material to our own problem has never been determined. Indeed, with the possible exception of the 1944 LaGuardia report, no careful and detailed analysis of the American experience seems to have been attempted.' Yet, with so little known, we punish so severely. And it is extremely difficult to explain to a youngster why alcohol,

with its resulting destruction of the body and mind, is permitted while possession of a marijuana cigarette carries with it a five year prison sentence. It is clear that our laws with regard to marijuana must be changed; how and on what basis is a more difficult question.

One of the vociferous opponents of the present legislative structure is Timothy Leary. Mr. Leary is the primary proponent of the argument that the use of marijuana and LSD and other hallucinogens is essential to the pursuit of his religion, presently termed the League for Spiritual Discovery, and that the laws prohibiting the use, possession and free trading of the drug are laws that abridge religious freedom and as such contravene the First Amendment of the United States Constitution. The Court of Appeals, in a recent opinion, found that Dr. Leary 'knowingly and purposely' violated the marijuana laws. The court put forth many reasons for its decision; among the most significant was the fact that there was no evidence in the case that the use of marijuana is a formal requisite of the practice of Hinduism, the religion which Dr. Leary professes. Dr. Leary relied heavily on the case of *People v. Woody*. In this case, a group of Navajo Indians were convicted of violating a section of the California Health and Safety Code which prohibits the unauthorized possession of peyote. The case was appealed to the California Supreme Court, which reversed the decision of the trial court and held that since the defendant Indians used the peyote in a 'bona fide pursuit of religious faith, and since the practice does not frustrate a compelling interest of the state, the application of the statute improperly defeated the immunity of the First Amendment of the Constitution of the United States.'

Drug Abuse On Campus

Control of drug abuse on the urban college campuses has been less than successful. Recent estimates of use on the east and west coasts state that between one third and one half of the total student body had used marijuana or LSD more than once. The attraction is no surprise with paragraphs like the following appearing in widely read magazines such as *Playboy*: 'When Dr. Goddard, the head of the Food and Drug Administration announced in a senate hearing that ten percent of our college students are taking LSD, did you ever wonder why? Sure they're discovering God and meaning; sure, they're discovering themselves; but did you really think that sex wasn't the fundamental reason for this surging, youthful social boom? You can no more do research on LSD and leave out ecstasy than you can do microscopic research on tissue and leave out cells.'

One of the groups that has been struggling hardest with the problem of LSD usage is college administrators, genuinely and justifiably concerned with the illicit use of LSD on campus. The following is excerpted from a statement by John U. Munro, the Dean of Harvard College: 'As anyone bright enough to be at Harvard knows perfectly well, possession or distribution of marijuana and LSD are strictly against the law, and taking the drugs involves users in psychological dangers and contacts with the criminal underworld. The college is prepared to take disciplinary action up to and including dismissal against any student found to be involved in the use or distribution of illegal and dangerous drugs. In sum, if a student is stupid enough to misuse his time here fooling around with illegal and dangerous drugs, our view is that he should leave college and make room for people prepared to take good advantage of the college opportunity.'

It is questionable whether this statement does very much to counter the sense of adventure promised by Dr. Leary in adding the threat of expulsion to the already harsh punishments imposed by the criminal law. Dean Munro's statement was accompanied by an excellent summary of the deleterious medical aspects of LSD, and the colleges do have a definite duty to alert their student bodies to the dangers inherent in the drug. The most effective means of prevention of illicit use lies in the wide publication of such knowledge, combined with the availability of services, psychiatric and other, to which the student can turn if he feels the need to do so. Individual contacts by persons knowledgeable in the field of drug abuse and understanding the student are among the most effective means of dealing with the problem. The instituting of seminars on drug abuse, if properly designed and presented, is another way to approach the problem on a sophisticated and meaningful plane. It is also most important for the college administration and campus security officials to maintain an understanding relationship with the municipal and state police as well as the federal officials. Guidelines should be worked out to prevent insofar as possible the prosecution of students, while at the same time preventing wholesale student violation of the law.

Legislative Progress

There are some bright spots on the legislative horizon. Connecticut has perhaps the most comprehensive and forward-looking legislation dealing with drug abuse. This omnibus act, which took effect on October 1, 1967, covers both marijuana and LSD, but explicitly separates the two according to their respective effects and provides different and appropriate penalties. Section one of the new law separately defines amphetamines, barbiturates, cannabis, cocaine and the hallucinogens. There are also two separate categories, the controller drugs and the narcotic drugs. Possession of LSD is a misdemeanor. For each offense the penalty is up to one year in jail or a fine of \$1,000, or both. Manufacturing, dispensing and transporting the drug appropriately carry a much greater penalty. The focus of the federal law is on the attempt to destroy illegal traffic at its source, rather than on imposition of stringent penalties on the user. Only education and medical treatment can eradicate misuse. Connecticut's new statute has these same goals. There is a penalty for possession, but Connecticut provides specifically for an alternative to a jail sentence, i.e., medical treatment. This is a most significant provision of the law.

Ideal legislation would provide for both medical and psychiatric treatment to cope with the dependency factor and the mental disorder that can be caused by the use of the more dangerous drugs such as LSD or methamphetamine. Connecticut has both. There are in-patient treatment facilities established under the Commissioner of Mental Health. Voluntary admission is provided for, but there is also a provision for commitment by the Court for a period not exceeding twenty-four months.

Research has shown that symptoms induced by LSD can recur weeks or even months after ingestion, and emergency psychiatric treatment may be necessary to deal with a recurring drug-induced psychosis. Connecticut law provides that 'any person who has suddenly become in need of care and treatment in a hospital for mental illness for a psychiatric disorder other than drug dependence, or for drug dependence when his condition is acute and creates a pronounced danger to himself or to the community may be confined in such a hospital, either public or private, under an emergency certificate as hereinafter provided, for not more than thirty days without order of any court . . .'

As previously mentioned, medical treatment and education should be the primary focus of legislative control of possession and usage of substances capable of abuse. Regulation of the drug itself should be relegated to the areas of manufacture, distribution and general traffic.

What is most needed in our law is a means by which first offenders can have their prosecutions suspended by a court in appropriate circumstances, while they undergo out-patient or in-patient treatment as indicated. As for multiple offenders, it may well be that the individual needs the controls which only a jail can provide, and if a person is not mentally disturbed, insists on using drugs such as marijuana, society may justifiably decide to punish such behavior. But every effort should be made to return the person to useful functioning without the use of the prison cell.

A Rutgers Symposium stressed the need for more and better research into the medical, social and pharmacological effect of the various abused substances. It became quite clear that we do not know enough about the effects of substances such as marijuana to call for their legalization, even though no clear evidence of organic damage has been found among those who have reportedly used this drug. However, it was equally clear that we do know enough about such substances to call for a reduction in the seriousness of the criminal penalties attached to the use of these substances. Those who need reminding of the role law enforcement has played in the enactment of the present statutory scheme need only refer to Commissioner Anslinger's remarks before a congressional committee. The Commissioner stated: 'In Florida a 21 year old boy under the influence of this drug (marijuana) killed his brothers and sister. The evidence showed he had smoked marijuana . . . In Chicago recently two boys murdered a policeman while under the influence of marijuana. Not long ago we found a fifteen year old boy going insane because, the doctor told the enforcement officers, he thought the boy was smoking marijuana cigarettes.' Law-enforcement has played a key role in the enactment of repressive legislation; those within law enforcement who realize the futility of many of the practices hopefully will come around and work for constructive change.

It is clear that we need to educate our young people that a healthy society is not a drug-abusing society, and we need to begin this educational process when the person is but a child in our elementary school systems. And finally, we need to point our laws away from mere punishment of the user and towards providing the user with help, medical or otherwise, which will show him that there is much more to life than the false and fleeting kick he may get from a few shreds of a dried weed. The raids, the arrests, and the courts have unfortunately not succeeded.

#

FACT SHEET
on
FEDERAL DANGEROUS DRUG LAWS

Three groups of dangerous drugs -- depressants, stimulants, and hallucinogens -- are controlled by the Drug Abuse Control Amendments to the Federal Food, Drug and Cosmetic Act passed in 1965 and amended in 1968.

The Drug Abuse Control Amendments utilize two methods to curb drug abuse: all legal handlers of drugs designated as dangerous must keep records of their supplies and sales; purveyors of illegal drugs are punishable under the statute's criminal section.

All registered manufacturers, processors and their suppliers, wholesale druggists, pharmacies, hospitals, clinics, public health agencies, and research laboratories must, as of February 1, 1966, or any date thereafter that a drug comes under control, take an inventory and keep accurate records of receipts and sales of these drugs, and make their records available to FDA agents. For the controlled drugs, no prescription older than 6 months can be filled, nor refills be made more than five times in a 6-month period.

Penalty provisions: Illegal possession of the dangerous drugs can mean a maximum penalty of one year in prison or a \$1,000 fine, or both. However, the offender may be placed on probation for a first offense. If he meets the conditions of his probation, the court may set aside his conviction. A second offense allows for probation, but does not allow for the conviction to be set aside. The third offense calls for a maximum prison term of three years or a fine of \$10,000 fine, or both.

A person who illegally produces with intent to sell, counterfeits, or manufactures, sells or possesses dangerous drugs, may receive a maximum penalty of not more than five years in prison or a \$10,000 fine, or both.

Because of the serious consequences of drug abuse among young people, special penalties are provided for those over eighteen years of age who sell or give any of the controlled drugs to persons under eighteen years of age. The first offense carries a maximum penalty of ten years in prison, or a fine of \$15,000, or both; a second offense increases the maximum term to fifteen years or a fine of not more than \$20,000, or both.

Many states have adopted legislation for dangerous drugs similar to the controls at the federal level.

Bureau of Narcotics and Dangerous Drugs, Department of Justice, January 1969

#

Excerpted from

CURRENT DECLINE IN RESPECT FOR LAW AND ORDER

Joseph D. Lohman
Former Dean, School of Criminology
University of California, Berkeley

National crime figures are approaching a point where law and order might well begin to break down, as it did in the notorious frontier west. Crime is currently outracing our capacity to deal with it, increasing four-times as fast as our rapidly growing population and doubling in the past 20 years with no improvement in sight.

Crime Is Heaviest in Urban Areas

It should be apparent that the increasing lawlessness is only a surface symptom of a more deep-seated and more pervasive malaise. It is the newly emergent social groupings of the developing community whose strivings and aspirations have brought about a new condition of confrontation within the society. In the 'greatcity' impersonal relations and individual detachment are the prevailing condition. The individual works, plays, and worships at places remote from where he lives. The individual has become, more than ever before, a face in the crowd -- bored, lonely, part of the great market for vice and crime.

Enormous metropolitan concentrations consist of people newly settled and for the most part strangers to one another. They do not know their neighbors, let alone relate to them in any continuing or effective way. The anonymity, the strangeness, the impersonality of the great metropolitan communities have created mobility and fluidity of life and a sense of detachment, even irresponsibility, on the part of every individual to everyone else. In the boredom, dullness and chronic frustration of this new urban society, the individual counts for little. He becomes a ready customer for any exciting answer to his dull and uneventful existence. Correspondingly, the police are confronted by widespread desires for gambling, sexual gratification, thrill giving or pacifying drugs, freedom from the effects of unbridled competition, and other sundry restraints. In view of the current chronic confrontations between the law and the population, it is instructive to recall an observation made shortly after the repeal of the Prohibition amendment by a leading American criminologist, Donald R. Taft. He said: 'American culture does not demand or approve obedience to all laws The slogan 'obey the laws' is never meant to be taken without qualification. It is but a slight exaggeration to say that most conservative people believe that other people should obey most of the important laws most of the time The injunction -- 'break no laws' -- is not obeyed even by the most meticulously moral.'

Lack of respect for law very often is assumed to be evidence of a willful disregard for legitimate authority and of personal defect and shortcoming However, it may well be that what we observe as 'disrespect for law' is a normal reaction of normal people to an abnormal condition.

For example, there is much said these days about the estrangement of the young and the old; we speak of young people's being alienated and estranged from adult community. I should like to suggest that this estrangement, this alienation, of individuals can be regarded in a quite different way. It will profit us, for a moment, to examine the agencies, institutions, and organizations to which we uncritically subscribe, and to apply the notions, which we have applied to individuals, to the institutions themselves. I believe it might properly be suggested that even as we speak of persons as

.....

Published in FEDERAL PROBATION, December 1967

being estranged and alienated from the conventions, the norms, the institutions of society, we may be confronted in the current day by a crisis of these same institutions. For it can be seen that the institutions are not necessarily as one with the changing social scene. They do not readily reflect in themselves the trends, and so there are, indeed, stresses in education. There are stresses in welfare. There are stresses in law enforcement. It is these crises and the dilemma of our traditional services which need to be made explicit.

One might appropriately refer to the traditional services as alienated and estranged from some people -- indeed, many people -- rather than always the reverse.

Traditional Structures Are Being Changed

Some very profound changes of revolutionary proportions are taking place in American society. These changes are responsible for structuring the relations of certain individuals to us even as our administrative organizations have structured our relations to them. It is important for us to see that problem as it is posed in context. The contemporary American revolution involves, among others, three factors that have challenged the traditional institutional structures: the explosive rate of population increase; the doctrine of civil rights, an ideological force which has no precedent in recent history; the impact of technology which is producing a shape of things for which we have not bargained and which is profoundly affecting great numbers of the population. These tremendous changes are more than facts in themselves -- they are the condition for the creation of a new pattern of human relations in this country. We often find it difficult to perceive this new pattern, primarily because our relationships are traditionally structured and we are disposed to maintain the traditional structure.

Crime Is Adaptive Behavior

Crime, though a nonconformist expression, is as much a reflection of the patterning of social life as are the conformist expressions of society. In truth crime, like other behavior, is a reflection of the community. In this sense, it is important for us to recognize that juvenile delinquency and other mass expressions of youthful behavior, are a projection of deep-seated processes at work in the life of the community. Over one-half of the United States population will soon be under 25 years of age, and 60 percent of serious crime is committed by those 18 years old and under. The society which produces the conformist and conventional middle-class youngster also produces the nonconformist, deviant or delinquent youngster who is not effectively engaged by the conventional institutions of society.

The nonconformists are not qualitatively different from other young people. They are not persons who are necessarily unable to adjust and who cannot have effective relations in any kind of social context. The truth is that many whom we tend to regard as maladjusted are, as a matter of fact, frequently in a remarkable state of adjustment. Such people may, indeed, be extremely socialized in groups at variance with the norms and standards of other groups in the society. If they are socialized with reference to exotic and questionable groups, we must see this as the reality, rather than treat them as persons unable to adjust. The point is that social problems are more frequently a conflict between groups rather than a conflict between individuals and a group. Conflict is resulting today from the emergence of significant pools of collective experience, taking on the proportions of subcultures, which are, almost by definition, in many respects in opposition to the wider culture.

Lives at Odds With Life in the Community

Negro-Americans, Mexican-Americans -- indeed, youth in general -- live in a world which is apart from the total social world of others. They participate in a lesser degree in the general life of the community, and thus there develops among them a definition of life, in some measure, at odds with the life of the community.

Our problem youth, whatever the nature of their problem, are not objects, independent of and unrelated to our treatment of them. A youngster who is singled out for attention is regarded by the community as being somehow different. Consequently, he develops a different attitude toward himself, and others

view him differently. Dealing with him may create a new set of social relationships, whereas not so dealing with him may mean, in fact, that he is not distinguished from others in the ongoing processes of society.

It is ironic that segregation in the United States today, after the passage of the antisegregation laws, is far more widespread than when segregation legally existed. One reason, of course, is that greater numbers of people are involved. The second and more important is that a subtle *de facto* system of discrimination has come into existence. Many people are inclined to question the propriety of the civil rights movement. Why, they ask, do Negroes feel it necessary to mount a civil rights program when they have already been emancipated from the traditional system? White Americans believe that nonwhite Americans have achieved their victory and established their positions as free, independent, and equal citizens. This simply is not so.

Consider the Negroes' position in large cities in terms of residence. More Negroes live under conditions of residential segregation today than 20 years ago. Negroes have moved into all the northern cities, but as they have moved in, the whites have moved out to the peripheral suburban areas. This has created a new pattern of social relations whose distinguishing feature is greater segregation of whites from Negroes and Negroes from whites than ever before in our history.

Lack of Opportunity

With reference to the changing technology, automation has produced results very different from those generally assumed to be the case. It is a popular belief that Negroes have achieved new occupational opportunities and status. The truth is that Negro unemployment ranges from 12 to 20 percent in many communities; in some communities as many as 40 percent of the youthful nonwhites are unemployed. These figures are in sharp contrast to the national unemployment rate of 4 to 5 percent. In certain respects, since the end of World War II, the position of the Negroes with regard to employment has deteriorated rather than advanced. The Negro, therefore, is deeply concerned about employment, but the suburban whites who see Negro pickets in front of grocery stores and factories do not understand the reason for concern. Negroes picket because they know that things are not as good as they are declared to be, but whites do not understand this fact.

Marginal Groups in an Affluent Society

It is, indeed, ironic that a society at the height of its affluence should find it necessary to mount a war on poverty. In our society of today there are large groups of people who are not necessary for the maintenance of the affluent society. We are no longer dependent on the sweat and toil of many people in order to assure productivity. Why do we now focus on the marginal groups if they are not needed economically in the affluent society? We must concentrate our attention on them because the condition of their marginality has produced deprivation, and deprivation is a phenomenon which generates problems. The subcultures are, in short, the problem-solving answers to situations of stress and trial. The subculture, is to many individuals a solution to their life's problems. It is their means of making life tolerable. I refer to something more than physical environment, something more than the slums that we see as an environmental problem for many of our youngsters. I refer to the way in which people live their answers to their problem, respond to the lack of jobs, answer to their condition of deprivation forced upon them. Their answers are the positive, organizing principles of their lives and they bring their answers into the school, the playground, the factory, and the law. In this background lies the significance of the behavior of the Negro child from a black ghetto. If he is combative or inattentive, it is almost a certainty that a significant cultural pattern is there. His defiant attitude has in his milieu a survival value and his hostility is a partial answer to the situation in which he finds himself.

We may ask, 'Why is it students have no sense of shame and guilt as young persons formerly exhibited?' It appears to many that they have become cold, callous, inhuman agents without the essential characteristics of the youth which they remember. But there is a sense of shame and guilt. Shame reinforces nonconforming behavior. In the current cultural communities of America, a variety of subcul-

tures has made shame and guilt problematical. The power of the subculture to effect this reversal of values and norms is not fully appreciated.

New Patterns of Population Concentration

The tremendous population flux and growth of recent years brought on, between 1950 and 1960, a new pattern of population concentration in the major cities of the United States. The 12 largest cities of the United States lost nearly 2 million white residents who were replaced by 2 million Negro residents in that short 10-year period. This transformation was accompanied by a disproportionate change in the youth population within those cities.

In 1951, one out of every 10 children in the 12 largest cities of the United States was identified as culturally disadvantaged by the public schools. Today, it is more than one in three. Projecting the trends, it now appears the ratio may well be one in two in the major metropolitan centers by 1980.

The Need To Be Wanted

The problem of young people, generally, is not wholly different from that of minority group youth. Many young people relate to the adult community in such ways as to suffer low self-esteem. They must compensate by developing attitudes, norms, and values which give them a sense of worth and importance. More frequently than is good for society, this turns out to be a condition of defense, a condition of rebellion, rather than a condition of identity with the adult culture.

The changing social scene has made it difficult or impossible for the young to attain the chief hope of every self-sustaining individual, namely, the realization of personal work satisfaction. Paul Goodman stated the issues succinctly: 'It's hard to grow up when there isn't enough man's work.' In normal conditions a large part of security comes from knowing that your contribution is useful and uniquely yours. Earlier generations in the United States have been needed because the life of the family -- bread on the table or coal in the kitchen range -- depended on their contributions. Even for the slum child, scavenging along the railroad tracks to get coal was needed.

But in these times, in these United States, we no longer have, for the most part, the same needs for our children. To a large extent youth has been transformed from an economic asset for the average parent into his greatest economic liability.

Youth itself, feeling insecure because of its marginal position in a society that no longer depends upon it for economic survival, is tempted to use the power this reversal between the generations has conferred on it to be accuser and judge of its elders. Hence, we witness the ubiquitous pattern of rebelliousness in present-day youth. This rebelliousness is manifest, to be sure, in a plurality of ways by different kinds of deviant patterns, including on the one hand, crime and delinquency, on the other hand, radical and conservative political activism of every hue, and still again, a variety of Bohemian life-styles.

The remedy of the failing respect for law is not a simple one. In our democratic system, the power to make and implement the law lies with the majority of the community. The young, the poor, and the minority groups have frequently viewed the law as not of their making or to their interest. The young, the poor, and those of minority status have been sharpest in their protest, most militant in their behavior, and least respectful of the law.

In going our separate ways and abandoning so many to an excluded life of deprivation we are realizing the selfishness of individualism of which De Tocqueville forewarned the democracies. This individualism has its extreme expression in the polarities of youth and age, of black and white, of the affluent and the poor.

Our remedy for disrespect for law is not to be found in merely admonishing the populace and seeing all who oppose it as without reason. Our remedy will be found in a greater dialogue and a fuller participation in the counsels and decisions of the majority by those who have been and continue to be excluded from the making and implementation of the law. The remedy is in 'just laws,' democratically designed and sensitively enforced.

#

Excerpted from

THE MARIJUANA PROBLEM: AN OVERVIEW

William H. McGlothlin, Ph.D., and
Louis Jolyon West, M.D.

Current knowledge of the use of marijuana, its physical and mental effects, and its relation to crime and to other drug use are reviewed. The authors feel that a reappraisal of the social and legal policies regarding marijuana use is needed in view of the rapid increase in its use despite the severe legal penalties prescribed.

The combination of a very rapid increase in marijuana use and the severe penalties prescribed for violation of the marijuana laws has brought about a social crisis. These two phenomena are not necessarily independent. The extreme legal penalties and the gross exaggerations of the consequences of marijuana use as fostered by the Federal Bureau of Narcotics make it an ideal target for rebellious youth to point to as an example of adult hypocrisy.

Physical and Mental Effects

No long-term physical effects of marijuana use have been demonstrated in this country, although more current studies are needed before this issue can be resolved with any degree of certainty. Eastern studies of chronic users, who consume several times the amounts generally used in this country, report a variety of cannabis-induced physical ailments. Conjunctivitis is the most frequent, followed by chronic bronchitis and various digestive ailments. Sleep difficulties frequently occur, as is the case with opiate users in this country. It is interesting to note that from 25 to 70 percent of regular hashish users in two Eastern surveys reported some impairment in physical health due to the use of the drug.

There have been several cases of marijuana-induced temporary psychosis reported in this country. Panic reactions are not uncommon among inexperienced users, and such reactions occasionally develop into a psychotic episode. These very rarely last more than a day or so, and they do not usually require hospitalization.

On the other hand, in India and other Eastern countries, cannabis has long been regarded as an important cause of psychosis. One study reported that 25 percent of some 2,300 men admitted to psychiatric hospitals were diagnosed as having cannabis psychoses; of the total male admissions 70 percent of the patients admitted to smoking cannabis, and one-third were regular users. These studies are definitely not in agreement with the findings in this country, and many Western authorities question the adequacy of both the diagnoses made and the methodology of the studies themselves.

While systematic studies of the recent wave of young marijuana users are not yet available, clinical observations indicate that regular marijuana use may contribute to the development of more passive, inward-turning, amotivational personality characteristics. For numerous middle-class students, the subtly progressive change from conforming achievement-oriented behavior to a state of relaxed and careless drifting has followed their use of significant amounts of marijuana.

Relation of Marijuana to Other Drug Use

Although present-day marijuana use has not been shown to predispose to heroin use, it does play a role in initiation to other potent drugs, particularly LSD. To the extent that marijuana contributes to a general disregard for the realistic consequences of behavior in young persons, its use increases the probability of the abuse of other more dangerous drugs. Many marijuana users would welcome the opportunity to try hashish and, if it were available, many would probably continue to use it in prefer-

Read at the 124th annual meeting of the American Psychiatric Association, Boston, Mass., May, 1968. Dr. McGlothlin is research psychologist, U.C.L.A. Institute of Government and Public Affairs, Los Angeles. Dr. West is chairman, department of psychiatry, University of Oklahoma School of Medicine. Some of the work reported was supported by Public Health Service grant MH-13484 from the National Institute of Mental Health.

ence to the low-potency marijuana. Of course, the use of hashish does not necessarily lead to excess any more than does a preference for distilled liquor over beer or wine. However, the history of mind-altering drugs shows that excessive indulgence increases sharply as more potent preparations of a given drug become available.

Social Policy

Social policy with respect to marijuana and other psychoactive drugs has many dimensions. The most basic issue is whether or not the prohibition of behavior whose direct effects are limited to the individual is within the function of the state. Those who feel it is not argue that the state has no more right to intervene with respect to the use of harmful drugs than it does with regard to harmful overeating.

Those who take the contrary position argue that the harms are not limited to the individual but burden society in a variety of ways; hence the state is entitled to prohibit its use in the public interest.

An objective assessment of the threat or benefit to society resulting from the non-medical use of a drug should consider: physiological effects resulting from occasional or chronic use; tendency to produce physiological or psychological dependence as a function of period use; release of antisocial behavior; effect on motor activity, especially driving safety; and tendency to produce long-lasting personality changes. Other relevant considerations are: cost; ability to control and measure potency; convenience of mode of intake, oral vs. intravenous, for example; capacity for self-titration to control effect; protection against overdose; availability of an antidote; specific effects attainable without unpredictable side effects; predictable length of action; hangover or other short-term properties which may spill over to affect work or other activities; ability to return to normalcy on demand; and ability to detect the drug, as for monitoring drivers, etc.

One of the most neglected questions in evaluating drug effects concerns the individual benefits which motivate the user. Drug use in many instances may well be an attempt to alleviate symptoms of psychiatric illness through self-medication. In some cases, marijuana use might postpone or prevent more serious manifestations of an illness. Especially for recreational drugs, such as alcohol and marijuana, an objective assessment of user motivation should consider: effectiveness in producing pleasure, relaxation, and aesthetic appreciation; enhancement of appetite and other senses; enhancement of interpersonal rapport, warmth, and emotionality; utility of variety or newness of perception and thinking; and enhancement of enjoyment of vacations, weekends, or other periods devoted to recreation, rest, and pleasure.

In considering the effectiveness of legal sanctions against the use of a drug, three related questions must be considered at the outset: 1) How many persons would abuse the drug if legal controls were removed or not adopted? 2) Do the laws deter use, or perhaps encourage it, as has been suggested with relation to rebellious youth? 3) Is the drug abuser a sick person who, if one drug is prohibited, will find another drug or some equally destructive behavior as a substitute?

Clearly, if the law protects against a non-existing harm, society is better off without the law. The recent elimination of all laws pertaining to written pornography in Denmark, for example, apparently resulted in no ill effects. The incidence of marijuana use as opposed to LSD use supports the position that legal penalties are by no means the overriding determiner of drug usage. The number of persons who have used marijuana is several times that for LSD and is increasing in spite of severe penalties. LSD usage is apparently declining because of concern over the hazards rather than because of any deterrent effect of the relatively moderate laws.

The argument that the drug abuser would simply find another means of escape or self-destructive behavior if the drug were not available is probably only partially correct. It is clear that persons are more vulnerable to the abuse of drugs at certain times in their lives, such as during adolescence or other highly stressful periods. If a potential drug-of-abuse is unavailable at these times, an undesirable chain of events may well be avoided.

Concerning the kind of drug-control laws which should be enacted and enforced, there is general agreement that the government has not only the right but also the obligation to enforce certain practices with regard to the distribution of drugs.

Regulation, as opposed to prohibition, permits the orderly control of potency and the conditions of sale, such as age of purchaser, hours of sale, and licensing. It also permits taxation and eliminates the support of organized crime as well as the criminogenic aspects of forcing the user to deal with illegal sources. On the other hand, prohibition of sale clearly indicates social disapproval, whereas open sale does not.

Arguments for criminal sanctions against the drug user primarily stress: 1) their deterrent effect and 2) the aid such laws give to enforcement agencies in apprehending sources of supply. Major arguments against such laws stress that enforcement inevitably encourages the violation of constitutional guarantees of privacy, as well as various other practices, such as informers posing as students, hippies, or other potential drug users, which are ethically questionable though technically legal.

The social control of drug use is most difficult to handle via legal means when the drug in question permits both use and abuse: e.g., alcohol and marijuana. The problem of penalizing the majority because of the abuse by the minority was specifically dealt with by the Supreme Court at the time of the Volstead Act. The Court ruled that the state had the right to deny access to alcohol to those who would not abuse it in order to remove the temptation from those who would abuse it.

On a few occasions, exceptions have actually been carved out of the law to permit use of a drug otherwise prohibited: e.g., sacramental use of wine and religious use of peyote by the Indians. More frequently, society has informally disregarded the enforcement of the law for various groups, conditions, or in certain districts of the city. For example, during the 40s, police frequently overlooked the use of marijuana by jazz musicians because they were otherwise productive and did not cause trouble. Another means of allowing use but controlling abuse is through compulsory treatment.

Conclusion

What is especially needed is a concerted effort to produce congruence among the various drug policies and laws. What we have at present is an assortment of approaches which are not only lacking in consistency but often operate in clearly opposite directions. Much of the incongruity is based on unrecognized attitudes and fears which must be made conscious and explicit before a congruent policy can emerge. One means of forcing some of the most glaring inconsistencies into perspective is to treat alcohol abuse and drug abuse as a single problem.

Part of the lack of congruence among drug policies in this country may be due to the fact that economic and technological factors are changing at a faster rate than are cultural attitudes and values. The drug laws in this country have always been an attempt to legislate morality, although they have been justified in terms of preventing antisocial acts. These laws and attitudes evolved at a time when the Protestant ethic and the competitive achievement-oriented value system were very much in dominance. The freely chosen, passive withdrawal to life of drug-induced fantasy was an extremely threatening concept.

Now we are told we are verging on an economy of abundance rather than scarcity; an age of automation will eliminate half or more of the labor force necessary for the production of goods. The concept of work will have to be redefined to include non-productive pursuits which are now considered hobbies; a guaranteed annual income program will likely be in effect within five or ten years. The children of today's middle class have never experienced a depression or any appreciable difficulty in satisfying their material needs. They do not share the materialistic value system to the same extent as their parents because they have little fear of material deprivation.

There also appears to be an increasing acceptance of pleasure in its own right rather than as something that needs to be earned as a reward for hard work. If the age of economic abundance, automation,

and greatly increased leisure time becomes a reality, excessive drug use will be seen as a threat to the individual -- not as a threat to society.

In conclusion, whether or not the age of abundance arrives, social policy, with some minor reversals, will probably move in the direction of permitting greater individual freedom with respect to drug use. Society will promote the concept of allowing adults the privilege of informed decision. The crucial problem that will remain is that of protecting those who are too young to make an informed decision.

#

PSYCHOSOCIAL CONSIDERATIONS

Excerpted from

DRUG USE AND STUDENT VALUES

*Kenneth Keniston, Ph.D.
Associate Professor of Psychiatry
School of Medicine, Yale University*

In the comments to follow, I will argue that student drug use is closely related to pressures on American students, and is but a variant of values that are shared by many and perhaps most American undergraduates today. To be sure, only a small minority turn towards drugs; but the members of this minority group are but first-cousins to the more normal college student. In particular, the student drug-user shares with his non-drug-using classmates an active search for meaning through intense personal experience.

In order to understand the values shared by many American college students, we must begin by considering some of the pressures that affect today's students. With regard to drug use, two pressures are particularly important: the pressure toward cognitive professionalism, and the pressure toward psychological numbing.

Cognitive Professionalism

The past two decades have seen a revolution in our expectations about college students. Rising standards of academic performance in primary and secondary schools, the baby boom of the war, the slowness with which major American universities have expanded their size, -- all have resulted in increasing selectivity by the admissions offices of the most prestigious American colleges and universities. Furthermore, once a student is admitted to college, higher admission standards have meant that more could be demanded of him; students who a generation ago would have done 'A' work now find themselves doing only 'C' work with the same effort. The sheer volume of required reading and writing has increased enormously; in addition, the quality of work expected has grown by leaps and bounds. Finally, for a growing number of young Americans, college is but a stepping stone to professional and graduate school after college; and as a result, consistent academic performance in college increasingly becomes a prerequisite for admission to a desirable business school, medical school, law school or graduate school.

Not only have academic pressures mounted in the past generation, but these pressures have become more and more cognitive. What matters, increasingly, to admissions committees and college graders is the kind of highly intellectual, abstracting, reasoning ability that enables a student to do well on college boards, graduate records and other admission tests, and -- once he is in college or graduate school -- to turn out consistently high grades that will enable him to overcome the next academic hurdle. And while such intellectual and cognitive talents are highly rewarded, colleges increasingly frown upon emotional, non-intellectual and passionate forms of expression.

In contrast to these cognitive demands, there are extremely few countervailing pressures to become more feeling, morally responsible, courageous, artistically perceptive, emotionally balanced, or interpersonally subtle human beings. On the contrary, the most visible pressures on today's students are, in many ways anti-emotional, impersonal, quantitative and numerical.

Increasingly, then, one of the major pressures on American students is a pressure to perform well academically, to postpone and delay emotional satisfactions until they are older, to refine and sharpen continually their cognitive abilities. As a result, students today probably work harder than students in any other previous generation; a bad course or a bad year means to many of them that they will not get into graduate school. Taking a year off increasingly means running the danger of getting drafted and being sent to Vietnam.

This paper was presented at National Association of Student Personnel Administrators Drug Education Conference, Washington, D.C., November 1966

Thus, while the systematic quest for cognitive competence occupies much of the time and effort of the pre-professional student at today's selective colleges, this pursuit does little to inform the student about life's wider purposes. One of the peculiar characteristics of professional competence is that even when competence is attained, all of the other really important questions remain unanswered: what life is all about, what really matters, what to stand for, how much to stand for, what is meaningful, relevant and important, what is meaningless, valueless and false. Thus, for many students, the pursuit of professional competence must be supplemented by another, more private and less academic quest for the meaning of life. Academic efforts seem, to a large number of students, divorced from the really important 'existential' and 'ultimate' questions. In this way, the student's private search for meaning, significance and relevance are experienced as unconnected with or opposed to his public exertions for grades, academic success and professional competence. How students search for significance and relevance of course varies enormously from individual to individual; but as I will later suggest, drug use seems -- to a small group of students -- a pathway to the pursuit of meaning.

Stimulus Flooding and Psychological Numbing

Every society contains pressures and demands which its members simply take for granted. Thus, the pressure for extremely high levels of cognitive efficiency seems to most of us a necessary and an even desirable aspect of modern society. Our response to the second social pressure I want to discuss is even more unreflective and automatic. This second pressure has to do with the sheer quantity, variety and intensity of external stimulations, imagery and excitation to which most Americans are subjected. For lack of a better label, I will term the condition one of increasing 'stimulus flooding.'

Most individuals in most societies have at some point in their lives had the experience of being so overcome by external stimulation and internal feelings that they gradually find themselves growing numb and unfeeling. Medical students, for example, commonly report that after their first and often intense reactions to the cadaver in the dissecting room, they simply 'stop feeling anything' with regard to the object of their dissection. Or we have all had the experience of listening to so much good music, seeing so many fine paintings, being so overwhelmed by excellent cooking that we find ourselves simply unable to respond further to new stimuli. Similarly, at moments of extreme psychic pain and anguish, most individuals, 'go numb,' no longer perceiving the full implications of a catastrophic situation or no longer experiencing the full range of their own feelings.

This psychological numbing operates, I submit, at a great variety of levels for modern man. Our experience from childhood onward with the constantly flickering images and sounds of television, films, radio, newspapers, paperbacks, neon signs, advertisements and sound trucks, numbs us to many of the sights and sounds of our civilization. The exposure of the most intelligent men to a vast variety of ideologies, value systems, philosophies, political creeds, superstitions, religions and faiths numbs us, I think, to the unique claims to validity and the special spiritual and intellectual values of each one: we move among values and ideologies as in a two-dimensional landscape.

In all these respects, modern men confront the difficult problems of keeping stimulation from without to a manageable level, while at the same time protecting themselves against being overwhelmed by their own inner responses to the stimuli from the outer world. Defenses or barriers against both internal and external stimulation are, of course, essential in order for us to preserve our intactness and integrity as personalities. From earliest childhood, children develop thresholds of responsiveness and barriers against stimulation in order to protect themselves against being overwhelmed by inner or outer excitement. Similarly in adulthood, comparable barriers, thresholds and defenses are necessary, especially when we find ourselves in situations of intense stimulation.

Thus, in at least a minority of Americans, the normal capacity to defend oneself against undue stimulation and inner excitation is exaggerated and automatized, so that it not only protects but walls off the individual from inner and outer experience. In such individuals, there develops an acute sense of being trapped in their own shells, unable to break through their defenses to make contact with experience or with other people, a sense of being excessively armored, separated from their own activities as by an invisible screen, estranged from their own feelings and from potentially emotion-arousing experiences in the world. Presumably most of us have had some inkling of this feeling of inner deadness and

outer flatness, especially in times of great fatigue, let-down, or depression. The world seems cold and two-dimensional; food and life have lost their savor; our activities are merely going through the motions, our experiences lack vividness, three-dimensionality, and intensity. Above all, we feel trapped or shut in our own subjectivity.

Each of the two pressures I have discussed -- cognitive professionalism and stimulus flooding -- evoke characteristic responses among today's American students. The pressure for cognitive professional competence leads to a search for meaning in other areas of life; the feeling and fear of psychological numbing leads to a pursuit, even a cult, of experiences for its own sake. And use and abuse of psychoactive drugs by students is closely related to these two themes in student values.

The Search for Meaning

Among today's self-conscious students, the statement, 'I'm having an identity crisis' has become a kind of verbal badge of honor, a notch in the gun, a scalp at the belt. But although the term 'identity crisis' can be easily parodied and misused, it points to fundamental issues of adolescence in all societies that are particularly heightened in our own society. Since academic pursuits, on the whole, tell the student so little about life's ultimate purposes, students are turned back upon their own resources to answer questions like, 'What does life mean? What kind of a person am I? Where am I going? Where do I come from? What really matters?'

To understand this search for meaning, we must recall that many of the traditional avenues to meaning and significance have dried up. Traditional religious faith is not, for most sophisticated undergraduates, a means of ascertaining the meaning of life: traditional religions often seem to students to be worn out, insincere, or superficial. Similarly, the great classic political ideologies, whether they be political liberalism, conservatism, marxism, or fascism, arouse relatively little interest among most undergraduates. Nor does the 'American Way of Life,' as epitomized by 100% Americanism and free enterprise, stir most students to enthusiasm, much less provide them with answers about life's ultimate purposes.

One by one, then, many of the traditional sources of meaning have disappeared at the very same time that academic life itself, because of its intense pressure and professional specialization, seems to many students increasingly irrelevant to their major existential concerns. Where, then, do students turn?

The Cult of Experience

The cult of experience has often been discussed as a defining characteristic of American youth cultures. Central to this cult is a focus on the present -- on today, on the here-and-now. Thus, rather than defer gratification and enjoyment for a distant future, immediate pleasure and satisfaction are emphasized. Rather than reverence for the traditions of the past, experience in the present is stressed. Psychologically, then, such human qualities as control, planning, waiting, saving, and postponing on the one hand, and revering, recalling, remembering and respecting on the other, are equally deemphasized. In contrast, activity, adventure, responsiveness, genuineness, spontaneity and sentience are the new experiential values. Since neither the future nor the past can be assumed to hold life's meaning, the meaning of life must be sought within present experience, within the self, within its activity and responsiveness in the here-and-now.

Disaffiliation and Drugs

The two student values I have discussed -- the search for meaning and the cult of experience -- are intimately related to the pressures I have outlined earlier. The search for meaning is made more urgent by the amount of time and energy the average student must spend in pre-professional academic pursuits that often appear to him irrelevant to his basic concerns. And the cult of experience is intensified by the fear or feeling in many undergraduates that, instead of becoming more open to themselves and to experience, they are becoming increasingly numbed and closed off from all that is exciting and beautiful. Both of these values are, as well, related to the use and abuse of drugs by students. For such is the cultism and propaganda that surrounds drugs, especially the hallucinogens, that many students have come to feel that states induced by these drugs will automatically produce a revelation of life's meaning,

or at least an experience which itself will be highly significant and illuminating. Similarly, to the undergraduate who feels himself unduly walled-off from experience, drugs like the hallucinogens and the amphetamines (which intensify and alter ordinary states of consciousness) may seem a chemical sledge hammer for breaking out of his shell.

Obviously, despite the congruence of drug use with important student values in American colleges, the vast majority of American students do not seek meaning and experience primarily via psychoactive compounds. Despite the presence of some values which are consistent with drug use, most students have other values that argue against drug use. It is only a minority who are persuaded to choose drugs as a primary means of searching for meaning.

I doubt that it is possible to present an exact portrait of the type of student who is likely to use and abuse drugs. My own experience with student drug-users convinces me that there are many different motives for drug use and abuse, and there are many different factors -- psychological, sociological, cultural and situational -- that determine whether one student will use drugs while another will not. But despite the diversity of student types who may become involved in drug use, there is, I believe, one type that is particularly prone to drug abuse. I will call such students 'disaffiliates,' and will summarize some of the factors that predispose these students toward drug abuse. The defining characteristic of the disaffiliate is his generalized rejection of prevalent American values, which he rejects largely on esthetic, cultural and humanistic grounds. Such students are rarely political activists, and they are rarely concerned with the issues of economic, social and political justice that agitate many of their classmates. For these students, the problem is not political or social, but esthetic: American society is ugly, trashy, cheap and commercial; it is dehumanizing; its middle-class values are seen as arbitrary, materialistic, narrow and hypocritical. Thus, those conventional values which deem experimentation with drugs -- or experimentation of all kinds -- illicit are strongly rejected by disaffiliates; for them, what matters is somehow to seek a way out of the 'air conditioned nightmare' of American society.

A second characteristic of disaffiliates is a more or less intense feeling of estrangement from their own experience. Such students are highly aware of the masks, facades and defenses people erect to protect themselves; and not only do they criticize these defenses in others, but even more strongly in themselves. These feelings of estrangement are often accompanied by considerable depression and a strong sense of personal isolation. Indeed, depression following the loss of an important relationship is commonly found in the immediate background of the student who begins to abuse drugs. For the student with intensified feelings of estrangement from himself and others, drugs that promise to heighten experience seem a tempting way out of his shell.

A third relevant characteristic of disaffiliates is a fantasy of fusion and merger, which contrasts sharply with their current feelings of estrangement. In the background, many of these students have a concept of an almost mystical fusion with nature, with their own inner lives, or above all with other people -- a kind of communication that requires no words, a kind of oneness with nature or the world that has characterized intense religious experience for centuries, a special kind of automatic oneness with another. For an undergraduate with an especial longing for oneness with others, the hallucinogens are especially tempting. For one characteristic of the drug experience is a weakening or breaking down of the boundaries of the self such that many individuals in fact report feelings of oneness, merger and fusion with others.

On several grounds, then, the disaffiliate is strongly attracted by drugs.

Drug Use and Student Values

It will not do to repudiate students who misuse drugs as moral lepers and addicts without trying to understand their motives for drug use, and the values and goals they pursue. These motives are rarely simply anti-social or thrill-seeking. On the contrary, they almost always involve a legitimate (if misguided) search for ultimate meaning and contact with the world. In dealing with individual drug users, then, we must attempt to provide the student with alternate routes to attain his valid goals.

Although student drug users are a small minority, they point to the inability of our society to enlist the commitments of a talented minority. If we could understand why, it might point not only to how we could 'cure' drug users, but, even more important, how we might 'cure' colleges and society.

As for counseling student drug users -- potential and actual -- I think it important to acknowledge that the question of drug use is, in the last analysis, not a medical issue, but an existential, philosophical and ethical issue. Student drug users are, as a group, extremely knowledgeable about the possible bad effects of drug use; they can usually teach their counselors, deans and advisors a good deal about the potential bad side effects of drugs. They will argue -- with considerable validity -- that society does not prohibit the use of other psychoactive compounds (e.g., alcohol, tobacco) which in some ways are far more dangerous than many of the hallucinogens or amphetamines. In the last analysis, then, whether one chooses or not to use drugs in full consciousness of their possible bad effects and the legal implications of drug use, becomes an existential rather than a medical decision. It is a matter of how one chooses to live one's life, how one hopes to seek experience, where and how one searches for meaning. To be sure, I doubt that we can hope to persuade students that drugs are ethically, humanly or existentially undesirable if they are not already persuaded. But I think we can at least help the student confront the fact that in using drugs he is making a statement about how he wants to live his life. And we can, perhaps, in our own lives and by our own examples, suggest that moral courage, a critical awareness of the defects of our society, a capacity for intense experience and the ability to relate genuinely to other people are not the exclusive possessions of drug-users.

In the long run, those of us who are critical of student drug abuse must demonstrate to our students that there are better and more lasting ways to experience the fullness, the depth, the variety and the richness of life than that of ingesting psychoactive chemicals. Consciousness-expansion seems to me not the sole prerogative of psychoactive compounds, but of education in its fullest sense.

Thus, insofar as we can truly and honestly help our students to become educated in the fullest sense, we will be able to provide alternative routes to the pursuit of meaning, the quest for experience, and the expansion of consciousness. Obviously, much of what passes for education in America fails to accomplish any of these high objectives. As long as it continues to fail, I suspect that drugs will continue to be a problem on our campuses and in our society.

#

Excerpted from

DRUGS AND PERSONAL VALUES

Richard H. Blum, Ph.D.

*Director, Psychopharmacology Project, Institute for
the Study of Human Problems, Stanford University*

I am here to talk about values and drug use. For myself, I cannot divorce the notion of values from the business of motives and of the social and historical context. Let me start by making an observation. It is simply that drug use today is in many ways not different from drug use not only yesterday but two or three thousand years ago. The motives associated with the use of drugs occur again and again. In this regard I suggest that in traditional societies the introduction of drug use has been associated with two radically different kinds of goals, or if you will, values; that is, for religious or medical purposes.

The religious orientation has essentially been an expanding one. It proposes that there is something more in this world than the ordinary self and that the person can have access to that greater power. The person with this orientation uses drugs because he desires to experience that power, to get close to it, to know what it is. It may be an ecstatic supplement in the sense that one has experiences ordinarily denied. One has an orgy or a delight or a spasm of joy, whatever you want to call it, or it may be a profound mystical experience or simply a sensitive and beautiful feeling.

The other theme, the medical theme, has been that of healing or pain killing. It does not seek to supplement ordinary life but rather to bring the person back to where he once was or to put him in a position where he can function adequately. Traditionally the use of psychoactive drugs has been for the relief of pain and anxiety. These, the tranquilizers as well as the narcotics, comprise the largest category of drugs used medically.

We were involved in some pilot studies of normal population drug use. To me a critical question is what do ordinary people do? What is the norm? What happens? What is the convention in our society with reference to the use of drugs? When I say drugs I mean psychoactive drugs, those drugs which alter mind and mood and cycles of sleep and wakefulness. Having done this other work, we have been involved in the last year in the studies of student drug use. We have only preliminary data.

Let me share with you, if I may, some of the troubles we run into when we are trying to assess student drug use. The drugs in our college studies have covered quite a broad range. We have been interested in the stimulants, the mild ones and the strong ones, in the analgesics and the opiates, in tranquilizers both mild and strong, in the psychoenergizers or anti-depressants, in the hallucinogens (which, by the way, rarely cause hallucinations), and we have been interested in the intoxicants. In addition, we can't help but be interested in tobacco since that is a very common addicting drug if we dare to use the word 'addiction'.

A second problem is getting adequate data once we know what drugs we care about. People often don't know what they have been taking. Certainly, over their lifetime they would be unlikely to know their exact history of drug use. Even if people do know at least some of the substances they have been taking, they may not be willing to tell you about it. So we can get under-reporting when we ask some students about what they really did yesterday or what it is they plan to do tomorrow.

Another problem which you may run into on your own home grounds, is access to institutions. For

This Paper was presented at National Association of Student Personnel Administrators Drug Education Conference, Washington, D. C., November 1966.

instance, we are trying to study high school drug use, yet it will be a cold day in hell when they let us in any high school to do our study -- and for a lot of good reasons such as the fears of the board of trustees, the newspapers, and the community.

Another problem we have, which is a technical one but which really interferes with much discussion, has to do with the definition of 'use'. 'He is a pothead. He is a user,' meaning that a student when, nineteen, did one evening, in company with others, illegally acquire and illegally possess marijuana and further did take three puffs of a 'joint'. That can be one definition of a drug user. Or again, 'Yes, he is a real LSD user,' which might mean that a student took LSD once two years ago and wouldn't touch it now for love or money. So when we talk about use we have to be careful to specify what kind of use.

As we approach our college populations we are well advised to discriminate between those who have used an illicit or exotic drug in an exploratory fashion, and those who are committed users, the people whose lives are built around drug use.

Now, assuming that we have found out what is happening on the campuses with regard to drug use, let us consider some of the premises upon which we are beginning to operate, one of which is that students in some colleges are using more drugs without medical supervision.

Our concern then is over the social use of drugs, in particular the exotic and illicit drugs, not alcohol or tobacco even though those are potentially dangerous indeed. From an epidemiological standpoint one should also ask, 'Are students using more drugs in approved ways as well?' That is, are alcohol and tobacco more used than five years ago, or are medically prescribed drugs being used more often as well? One suspects that with increasing medical care and with the increasing reliance of physicians on pharmacotherapies that there may also be a simultaneous growth in the medical as well as the non-medical employment of these substances.

Another premise which brings us together with a shared concern is that there are ill effects which are associated with drug use.

Another thing that many of us assume is that what is bad about drug use is not just a matter of physiological or psychological ill effects but, rather, that it is part of an unsettling social package. One sees illicit use occurring in association with other social trends in student behavior, trends not approved by some of us, trends which can jostle or shake us up a bit. It may be that the entire pattern of conduct 'bugs' us and that student drug use is something on which we can focus our worries. Implicit in that worry may be our awareness that there are changes in values and standards which go beyond beards and sandals, changes which reflect fundamental challenges to social codes which adults hold and which the elders think students also ought to hold. Here we are asking ourselves, what is acceptable conduct? What is an acceptable goal in life? What are acceptable means to those goals?

Unquestionably, student use of exotic drugs in any regular way does itself challenge conduct standards that many thought were pretty stable, standards one thought were going to stay with us for awhile.

Let us say that these premises which may account for college administration worry about drug use are correct. This is not to say they are, but let us act as though they were, at least until the data are in. Now let us consider the increasing frequency of drug use among students.

In assuming that drug use is increasing among students to an unknown point, it is less and less easy to make generalizations about the characteristics of users; more different kinds of people are involved. In the old days, two years ago perhaps, one could propose that people smoke pot because they are rebellious characters, thumbing their noses at the system and trying dangerous behavior. That was all very fine to say as long as pot smoking was highly disapproved and had to be rebellious. But now when you have campuses where 'X' number of kids are using pot and it is the thing to do, the student would be ashamed if he did not. It would be foolish to assume that one particular kind of personality

or attitude or social background is associated with what is now popular experimental behavior. That is to say on some campuses anyone can be expected at least to try marijuana regardless of whether he continues with that behavior later.

We already have diversity in student conduct and we shall get increasing diversity. As we all know, the kinds of people who are going to be innovators and the kinds of people who are going to be followers are likely to be different from one another in many ways. So it is we must not lump the motives and personalities of student drug users in one common category. Diversity there will also be the rule.

A problem rarely mentioned and which we must call attention to when we accept our premise of expanding drug use, is the role of physicians in contributing to the expanded use. From our pilot survey we have some evidence that the people who became exotic drug users, and this tends to be a well-educated young sample in a normal population, had larger exposure to medical care. Their parents had been more interested in giving them drugs, they had been taken to the doctor more often when they were kids, and they learned to take drugs. They had become drug optimists, if you will, and I suspect many of us are drug optimists. We give a great vote of confidence to the pharmaceutical industry and to modern medicine. So we should not overlook the role of the physician as an instructor in drug use. We believe we can control our insides with these little capsules. It is a very simple belief -- yet its ramifications are immense. How could we expect our children not to take drugs if this is what we have taught them?

Things I worry about and I gather that you worry about are dependency, or addiction as it is sometimes called, crime, immorality, traffic accidents, psychosis, suicide, illness, some kind of physiological change, tissue or metabolic change either acute or chronic, personality changes of an undesirable sort, or a shift in social conduct or values of what would be undesirable, also include the embarrassment, pain and tragedy of arrest for the individual or the embarrassment for his family or his institution.

We cannot be too fast in leaping to the statement that the kind of illicit drug use we are concerned with can be shown to lead to such things. Indeed, I have been struck by the lack of data about the relationship between risk and drug use.

There is a lot of nonsense floating around about drugs. For example, it is quite clear that heroin use is illegal and associated with all kinds of delinquency but it is not at all clear that heroin use leads to crime, since it is the delinquents who use heroin in the first place. That they stay delinquent cannot be blamed either on heroin or on the law making heroin illegal.

These kinds of cautions must be foremost in our minds before we go leaping into the fray with warnings to kids about what is going to happen if they use such and such. Usually we do not really know. The whole problem of assessing risk has to be related to different kinds of people using a drug, dosage, kinds of circumstances, and so forth. Then, if we knew all of that, we could say, 'Okay, Jack, if you take this drug in this way, here are the probabilities of it going sour.' Given the absence of facts and given also our common sense that these powerful agents can do damage, one of the most important things to be aware of, it seems to me, is the sense of alarm which outweighs the evidence at hand. The public assigns very peculiar priorities to their worries about drugs and the most peculiar priority is to put heroin at the top of the list. There are very few college students who will ever take it, and there are fewer who would become dependent if they did.

Considering public alarm over student drug use, we cannot help but face the special risk which is generated by public anxiety itself. That is the risk of our being forced to be premature in our actions. We are all in a spot. The danger is that we will act impulsively when the parents call and say 'What are you doing? What kind of a university is that? I heard there is marijuana on the campus. Stamp it out!' The alarm is a demand upon us, yet we should be very cautious not to let emotion drive us into corners.

We talk about risks, but let us not forget that most of the psychoactive drugs employed these days are used because of benefits. We use barbiturates to go to sleep, we use tranquilizers to reduce agitation in hospital wards. We use aspirin to get rid of headaches, we use alcohol for pleasure. Let us not overlook the fact that there are benefits associated with use. If not, there would probably be very few users and neither a pharmaceutical nor a liquor industry. And so it is that people enjoy marijuana and they enjoy LSD.

What we must do is to balance the benefits against the dangers, but in alarm let us not speak as though we were unaware of the reasons for the being of these substances. Of course, we should also not forget that some of the benefits are a placebo effect.

In summary, we believe that exotic drug use is increasing, and we know that risks as well as felt benefits are there. We care enough about our students to want to reduce any dangers they face, yet we hesitate to restrict their freedoms and indeed, we may be unable to restrain their conduct by administrative action. The question of the efficacy of disciplinary, punitive or controlling actions as a means of influencing drug use goes beyond the consideration of student conduct, extending to the current state and federal laws as well. Although I think one can show an influence of the criminal law on the supply and distribution of drugs and quite possibly on decisions initially to use or not to use a drug, I am dubious if the punishment-control method makes much of a dent upon the convinced or committed user group. If that is the case, it would mean that we do not lose much by our reluctance or inability to apply sanctions against drug use.

I think the course best open to us in dealing with student drug use is that to which we are -- in conjunction with our students -- all dedicated. That is education. We are all educators and we must have great hopes for knowledge as a means of guiding lives or we would not be in the business. Why not then remain consistent to our calling and to our beliefs and emphasize fact-finding and information-giving as means to acquaint students with the significance and effects of exotic drug use? We can also be aiming, as we do in much of education for civilization, at the development by students themselves of group norms and inner standards which sensibly guide their conduct.

I further suggest that educational efforts not be limited to students alone, but directed at the drug gatekeepers. Here I mean physicians, parents, pharmacologists in our laboratories, our campus professors and the graduate students. I suspect we shall find that with each new socially used drug these people will be the channels for learning attitudes, use, and sources of supply. If we want to have an impact we must talk to those who are models, those who are the opinion leaders for them -- and that is as it must be -- for education is a business of exchange, a dialogue, not a one-way street.

#

Excerpted from

THE MYTH OF ALIENATION AND TEEN-AGE DRUG USE: COMING OF AGE IN MASS SOCIETY

Winfield W. Salisbury, Ph.D. and Frances R. Fertig, B.A.
Department of Sociology, San Jose State College
San Jose, California

The Concept of Alienation

The meaning of the term alienation, as used here, is a state of rejecting the dominant culture and its institutions. Political activists, hippies, and compulsive drug users, in terms of this definition, are very likely to be alienated. Most high school and college students who experiment with marijuana are not. The majority of them are quite normal, probably superior, teen-agers.

Characteristics of Teen-age Drug Users

Consider briefly what the typical teen-age drug users are like.

They are white. They are upper-middle and middle-class. In a high school predominantly upper-middle class marijuana use (depending on the grade) varied from 16 to 31% for boys, and 12 to 28% for girls. In a lower-middle class high school, the boys' use was 6-12%, and the girls' use was 3-6%.

They are affluent. They tend to be humanitarian, and to value self-exploration. They are rarely 'rebels' or 'revolutionaries' against our society; they are intent (albeit often clumsily) upon expressing fulfilling values they have learned in the home. Their parents have emphasized the humanitarian goals of self-actualization, individuality, autonomous decision making, the value of self-expression, creativity, concern for others, and spontaneity.

Motives Behind Drug Use

Looking beyond the social myth which stereotypes young drug-users in terms of alienation and emotional disturbance, what motives do we see operating in their behavior which would cause them to view 'tripping out' or 'getting stoned' as desirable?

The curiosity drive is one good reason.

A second factor is that drugs are medicine. When asked to 'explain' (i.e., 'justify') their behavior, teen-age drug users often point to the fact that commercial drug industries advertise continually the benefits of taking pills for every kind of physical or psychic discomfort, including such vague ills as 'nervous tension.' Young people realize that drugs can be abused but often feel that their parents' use of tranquilizers, barbiturates, amphetamine and alcohol is more irresponsible and dangerous than their own use of pot and LSD.

A third item is that drugs are fun. In the authors' interviews with teen-age drug users the most common response to the question of 'Why?' was, 'It's fun!' In spite of the Protestant Ethic, there has developed in America a pleasure-seeking ethos. With the help of alcohol and 'pep' pills, parents are often pursuing fun themselves with the energy of the Furies. If we reject 'grass' in the face of this hypocrisy, what sort of respect will we have left to draw on when a student starts using LSD, 'speed' (amphetamine) and 'smack' (heroin)? If a teacher is to oppose our fun-oriented ethos, he must have a thoroughly examined philosophical position from which to do so. How many of us can say this? And, if we do not oppose the right to have fun, on what grounds are so many of us judgmental and indignant about the use of marijuana by students?

Next comes sensuality. This is really a sub-category of 'fun,' but a very special one. We mentioned above that the senses of touch and taste have been very neglected in our culture. Therefore, the exploration of them provides a special fascination for young people. Almost every marijuana

.....

party, and many LSD trips, involve a period when everyone gets the 'hungries' and explores as wide a variety of taste delights as is available. More crucial, however, is the increase in cutaneous sensitivity, because one aspect of this is sexual stimulation. Our inquiries have not revealed much interest in sex during LSD trips. There is no doubt, however, that teen-agers have discovered that pot makes the exploration of sex more delightful. As far as we can tell, this has not meant an increase in sexual exploitation or carelessness. The hippies, whom the mass media use to create this kind of impression, seem to have been emotionally disturbed and sexually rebellious before dropping out into the drug subculture.

The problem, it seems, is that teenagers are more permissive about both drugs and sex than are older generations, so that it is easy to read into the situation a causal connection that is not necessarily there. This is a generational change that parents themselves have helped to create. Child-rearing methods advocated by Dr. Spock may have helped to further the revolution. Today, parents themselves, although sometimes unwilling to admit it, are more permissive about sex and sensuality than they were twenty years ago.

Religious experience may be another motivation. In the controversy over the use of psychedelics, young people have been given no credit for their very sincere interest in religious experience. Timothy Leary in the spread of LSD based his appeal on the idea that these drugs had the potential to create the mystical experience, given the proper psychological set, setting and guidance. From this, it was said, would come crucial insights into personality problems and emotional hang-ups, as well as a new vision of life in terms of loving relationships.

Many serious scholars believe that LSD does produce an experience similar to those described by the great mystics. Testimony to this effect has been made by Alan Watts, Allen Ginsberg, Dr. John Aiken, Huston Smith and William Stace, a Princeton professor, considered the foremost authority on mystical religion in the United States.

Adolescence at Mid-Century

The aspects of American Culture which support the permissive use of drugs -- the enjoyment of leisure, the desire for self-development, and the curiosity about the nature of the inner self -- have been accentuated by the conditions under which the current generation of teen-agers have been raised.

The most dramatic revolution of the past 25 years is the emergence of an advanced information technology creating new concepts in space, time, and human relationships. Today's students are the first generation to be raised on TV, cinemascope, stereo sound, and transistor radios. As Marshall McLuhan has described, the electrified mass media give us instant communication; messages race to bombard our senses from everywhere. Thriving on the information explosion, youth create happenings, environmental art which amplifies the simultaneous stimulation of all the senses.

Next in importance is the increasing automation and cybamation of work and education. Our youth have not only observed technology streamline their schools and their fathers' jobs; they have now come to expect as a matter of course vast changes in their work and leisure situations. This is the first generation to be prepared psychologically for a 'science fiction' future.

Another crucial influence is the birth control pill, a piece of technology which creates new attitudes and expectations about sexuality in teen-agers. Again, this is the first generation to grow up with the knowledge that virtually 100% effective birth control is available.

The H-Bomb is yet another influence shaping the world view of today's youth. An unprecedented familiarity with world events and the obvious failure of our society to deal with the H-Bomb and other world crises have produced disillusionment among the young.

Another consideration is the fact that contemporary adolescents were born and raised after the appearance of Spock's child-rearing manual. The children born during and since the baby boom

following World War II have been reared in a lenient, affectionate atmosphere with freedom to explore and do things for themselves. Teen-agers reared in a permissive family atmosphere expect the system, (i.e., the school, the government, industry, etc.) to provide them with conditions for self-development and creativity. These 21st century kids are rudely shocked when they run into our 20th century authoritarian bureaucratic enterprises (consider the heavy-handed authority of the principal in most secondary schools today).

A final condition which must be considered is the wealth, the leisure and the indulgence available to children in this same period.

The next thing to consider is what kind of teen-age subculture will be created by these conditions.

Negative Aspects of Teen-age Subculture

First are a few traits which we have evaluated as negative.

Irreverence toward the past. Young people today tend to ignore tradition and have no heroes and are ignorant of past social movements similar to those they start themselves. It never occurs to them that anybody in the past has tried to form a utopia, formed a commune, discussed the value of freer sensuality, thought of having a companion before marriage, or started a peace movement.

The old judgmental-conformity aspect of teen-age subculture still seems to be with us. At some high schools there is a lot of pressure among teen-agers to use drugs; those who are not prepared emotionally may be pressured into using them.

Like their elders, they are leisure and consumption-oriented. This showed very prominently in the Haight-Ashbury this summer during the 'Summer of Love.' The older hippies were concerned about developing a creative community around the concept of doing your own thing, the thing being some kind of work in which you contributed to the community.

What happened when 10,000 teeny-boppers and college students rolled into the Haight-Ashbury? Doing their thing for them, meant to consume; and they consumed everything in sight -- they ate all the Diggers' food; they wore all the Diggers' clothes; they took in all the free concerts they could get; and they wandered around, picking and chomping the flowers in Golden Gate Park. By the end of the summer, the Haight-Ashbury was a community drained of its resources.

Positive Aspects of Teen-Age Subculture

Among youth today there is an awareness of hypocritical use of tradition. The upper-middle class teen-age leaders, especially, see most of the hallowed traditions of this country as delusions. They have begun to recognize, through their growing interest in Eastern mysticism -- their awareness of the concept of 'maya' which translates best as 'social illusion' -- that ideals of this kind are nothing but verbal traditions, made up games. And the question is: is the game worth the candle? They are beginning to look at the game and the candle, and will not docilely accept the hallowed traditions. The current peace movement demonstrates that one of these questioned hallowed traditions is the idea that you should be willing to die for your country without questioning the moral value of the war.

They are espousing a number of primitive Christian precepts, which find their epitome of expression in the more responsible, older hippie community -- that is, the hippie community organized around a concern with mystical experience, and the community of love.

Young people are naive about the world because they have been 'ghettoized' in suburbia. Upon going out into the larger community, they are shocked by the hypocrisy of their elders.

The fourth positive trait is romanticism. Young people have begun to look for a kind of tribal identity, and may come to look on their peer group as a tribe. This has always been characteristic

of teen-agers, but now there seems to be a kind of nostalgia developing among youth for the simple life exemplified by the American Indian and the frontier community.

Another part of youth's romanticism is its anti-technological bias. These are the children that have been put through the IBM machine routine ever since they arrived for kindergarten. They have gone to huge bureaucratic schools, high schools and colleges and universities. They are getting sick of the anonymity and lack of personal attention.

A part of romanticism is the great suspicion of society's 'ego games.' Again and again we have heard young people attack viciously the kinds of games their parents play in business, in marriage, in social climbing, and so on. They are still quite naive, and they are not aware of the games they, themselves, play -- with their elders, themselves, or each other. But at least there is an increasing awareness that most of our interacting is based on games and facades, and maybe this will lead someone in some distant future to create a culture free of games of exploitation and manipulation.

The next characteristic involves what the anthropologist Gregory Bateson called the cultural ethos -- the psychological orientation of youth subculture. There are five of them and they are briefly:

An awareness of others. Young people today dislike 'ego trips.' Grass makes you quiet, amenable, sociable; alcohol makes you obnoxious, noisy and aggressive. Young people value a kind of 'empathy' which they consider subtle but realistic. They want to see the real person behind the role, and they talk in their lingo about 'auras' and 'vibrations.' Some identify 'vibrations' as spiritual perceptions, but they may legitimately involve some sort of sensitivity to subliminal perception -- or just projection.

They value self-actualization. This value seems to reach its epitome among young drug users and in the hippie community. One of the corollaries of this value is that society -- and particularly its school system -- should not interfere with the exploration of new experience. In fact, like the permissive and indulgent families they have come from, young people feel society should provide the space, the time, and the tools necessary for this. When they find that instead, the bureaucracy interferes with exploration and self-actualization, with the creative working out of their own individual and unique patterns, they become indignant.

A fourth aspect of the new ethos is the permissiveness toward sensuality. A.S. ('After Spock') parents began to feel guilty about making their children feel repressed. They worried that Freudian theory might be right, even though they were still pretty inhibited themselves. Along with this reduction in repression, our students probably got more cutaneous stimulation during nursing, and during infant care in general, than previous generations.

Fifth, they have certain dislike for what they call hang-ups. They seem to want to remain more flexible than their elders. They do not like rigidity, and do not want to be identified with a role.

Drugs and the Social Reaction

With this picture of modern American youth subculture, perhaps we can better understand the current interest of the young in exploring the use of marijuana, LSD, and other psychedelic drugs. It is our thesis that drugs that increase sensitivity and awareness were bound to appeal to young people involved in the kind of cultural milieu just described. Young people who value self-exploration, sensuality, sharing, tenderness, who want to be sensitive while they see their parents hung-up in self-delusion and exploitive games, and who are skeptical of their elders' competence while they want to create a better world, are going to value increased sensitivity above the nerve-deadening effect of alcohol.

Older people see marijuana as having all sorts of evil potential and peculiar effects, while they themselves are popping down prescription pills with a far more damaging effect than marijuana could ever have. Young people, being more aware of the recent literature and having read some of the scientific studies on marijuana, know that the Narcotics Bureau description of it is absurd. When the police department's public relations officer comes to talk to school classes, and tells them marijuana is a narcotic and a very dangerous drug, they simply tune out.

Unfortunately, when he also tells them that heroin is dangerous, or that methamphetamine is dangerous, a certain number believe that they are being fed the same old baloney and proceed to experiment with these dangerous drugs.

When we raise the question of the cause of the alienation of young drug users and how we can combat it, the question may be completely off base. The alienation, to the extent that it occurs at all, is largely a function of the social reaction to drug use. Teachers and parents refuse to communicate with the young about the problem, and to recognize the fact that many students regard smoking marijuana as a normal kind of social activity which is not dangerous to their health or their morals.

If we are going to handle this problem adequately, teachers, counselors and school nurses must learn to overcome their fear of intimacy with their students and begin to communicate with them. Edgar Friedenberg, in his study of a Midwestern high school, *The Vanishing Adolescent*, found that most of the teachers were afraid of intimate relationships with their students. Most of them, he felt, were motivated by a fear that their aura of authority would be undermined. He found the students were bitter about the absence of any nitty-gritty discussions of life's real problems. Most of them regarded the high school program as 'irrelevant' to their lives, and remained only to obtain the 'certificate' passport to jobs and college. This problem, frankly, rather than any inherent quality of the drugs, is the reason that academic motivation drops precipitously with the excessive use of marijuana. It does not de-motivate the artists and writers who use it, because they are involved in creative work which has deep, personal meaning.

Whatever the reason, the fact is that most teachers are afraid to get involved in discussing their students' real, personal problems. Such discussions are emotionally strenuous and most teachers are already overworked.

Yet, if we are to give our young people the ability to face the real world, and if we are to break the vicious circle of the self-fulfilling prophecy in drug abuse, we must learn to confront our students honestly. We must learn the scientific facts about the drugs so we can confront them with meaningful evidence rather than outworn prejudice. With this combination of courage and information, a meaningful dialogue between young people and their teachers and parents can begin. The process of legal suppression can never be a substitute for this dialogue.

#

Excerpted from

THE USE AND ABUSE OF PSYCHEDELIC DRUGS

Daniel X. Freedman M.D.
Professor and Chairman of the Department of Psychiatry,
University of Chicago

Magic, drugs, drama, festival rites, utopian ideologies, and (with biological regularity) dreams have abetted man throughout history in his unceasing urge to transcend limits and escape dreary reality or anxiety. Given the prevalence of such wishes for omnipotence, it is not surprising that drugs play a role not only in the behavior of individuals, but in social and ideological processes. The reported consequences of drugs such as LSD range from isolated awe or benign or even bored surprise to shifts of values. They range from transient to long-term psychoses, to a gamut of confusional states and depression, to varieties of religious or aesthetic experience and insight, to clique formation and ritual. There are now conflicting reports of therapeutic efficacy in alcoholism, depression, character disorders, and severe neurosis. There is also a mushrooming psychedelic culture. This underlies the tribal motions (or Brownian movements) of young and aging dropouts, rebels disavowing society's 'games' if not all (nonmusical) instrumental behavior. The paraphernalia of fringe fashions, music, and art comprise the trappings and trippings commercialized as psychedelic 'go-go.' Some serious theologians and some hippies, as well as our peripatetic prophets, now seek the drugs as a promoter of love, of religious or self-enhancement; apparently Western society will be a Zen elysium. Enthusiasts are sincere and private, or provocative and evangelistic, and there are variant subgroups whose rapidly evolving ideologies and behavior are as yet unrecorded.

The Psychedelic Dimension in Behavior

The recurrent historical theme is that certain drugs are compellingly related to 'learning,' to self-revelation, and that they are involved in some mystical, often ritual, use. The American Indian states that 'peyote teaches.' This theme does not dominate ordinary accounts of marijuana usage. The potent preparations of cannabis--charas and ganja--are an exception and have been used in India to enhance contemplative states as well as for a 'high,' and are not without paranoid and other psychotomimetic effects. Apparently there is a continuum of effects along the dimension of self-revealing and ritual usages.

To the extent that there are classes of agents which reveal normally suppressed components of the mind--exposing these dimensions to our attention--we can say that both use and abuse stem from an amazed response to a drug-induced subjective experience. If this is what Humphrey Osmond meant by the term 'psychedelic' (or 'mind manifesting') it is an apt though not novel description. Whatever the outcome, the mode of functioning and experiencing called psychedelic--or psychotomimetic--reflects an innate capacity (like the dream) of which the waking human mind is capable. The fact that a certain class of drugs so sharply compels this level of function (with all the variability inherent in less organized states) and does so for a chemically determined package of time is what intrigues the bio-behavioral scientist.

What is so striking about the experience of this 'religion' of the mind? Two features are obvious: the nature of the experience, and the contrast with ordinary experience. It is my impression that one basic dimension of behavior latently operative at any level of function and compellingly revealed in LSD states is 'portentousness'--the capacity of the mind to see more than it can tell, to experience more than it can explicate, to believe in and be impressed with more than it can rationally justify, to experience boundlessness and 'boundaryless' events, from the banal to the profound.

The sense of truth is experienced as compellingly vivid, but not the inclination to test the truth of the senses. Unlike the sleeping dreamer, the waking dreamer is confronted with the coexistence of two compelling and contradictory orders of reality--with the interface of belief and the orderly rules of evidence.

In any case, it clearly has been tempting to snatch some good from psychedelic effects. It also can do little harm, given such an ample smorgasbord of claims, to seek perspective by concentrating on what-if anything-is common to all of these varied effects of LSD. What must be described is a multi-potential state which, in its most general sense, can underwrite a variety of outcomes: religious feeling and conversions, states of hyperception leading to inspirational insights, to psychosis, to exalted states, or perhaps to behavior or value change. Some of the modes of experience--the styles--which characterize the drug experience can be linked to the outcome or to the style of life commonly centered around drug taking: whether this frequently persistent 'hangover' of drug effects represents new learning, or reinforcement of the ongoing trend of goals and adaptations, or more complex mechanisms is not now known. Beyond impressions which are hardly sanguine about long-term use, evaluated data on the drug experience are still lacking.

Some Features of the Drug State

During the first four-and-a-half hours of the drug state there is generally a clear-cut self-recognition of effects--an internal 'TV show'--which is followed by another four or five hour period in which a subjective sense of change is not marked but during which heightened self-centeredness, ideas of reference, and a certain 'apartness' are observed. At 12 to 48 hours after ingestion there may or may not be some letdown and slight fatigue. There is no craving for a drug to relieve this and no true physiological withdrawal, as is the case with opiates, alcohol, and certain sedatives and tranquilizers. Tolerance does occur, requiring three or four days of abstinence for recovery of full sensitivity to the drug.

It is the intense experience without clouded consciousness--the heightened 'spectator ego' witnessing the excitement--which is characteristic for these drugs in usual dosages. Thus there is a split of the self, a portion of which is a relatively passive monitor and a portion of which experiences. Some people seem to repeat this long after the drug state; they turn away from the prosaic world, or else are turned away by society as well as turned on by the drug. They may find a clique or a group which tolerates this disposition.

During the drug state, awareness becomes intensely vivid while self-control over input is remarkably diminished; thus there is the lurking threat of loss of inner control, of the 'dying of the ego' so often reported in bad trips or in phases of mystical experiences with the drug. Customary boundaries become fluid and the familiar becomes novel and portentous. The loosening of boundaries and carelessness or an indifference to the habitual and customary may characterize certain chronic drug abusers. This may border on a supercilious posture of superiority which the elect of many cults can assume (or which the outsider feels to be the attitude of those who know something he does not).

Events--internal or external, memories or perceptions--take on a trajectory of their own; qualities become intense and gain a life of their own. Redness is more interesting than the object which is red; meaningfulness more important than what is specifically meant; connotations balloon into cosmic allusiveness; the limits of sobriety are lost. Sexual experience may or may not remain 'sexual.' The very definition of the importance and stability of the external world shifts. And, after the drug state, we may find more tolerance for ambiguity and a diminished readiness for the quick answer; we also can find an associated inability to decide, to discriminate, to make commitments.

Most neurotic symptoms have been viewed as misguided attempts at cure, and it may be that for many the drug experience--like certain symptomatic acts--represents a beginning which, without luck or expertise, cannot easily come to a useful conclusion. Thus many of the immediate after-effects of LSD could depend largely on the motive for taking the drug and in fact could be transient rather than transforming. How to reinforce any shifts in attitude which do occur with the drug without running the risk of repeated drug sessions is a largely unstudied issue. One good 'trip' does not predict a second.

Since judgment is not enhanced during the drug state and since isolation or apartness, even when sanctioned by a minority group, bring their own problems, it is clear that persons who continually overvalue the experience of the drug state could develop or reinforce patterns of poor practical judgment.

The consequences of long-term and frequent use of the drug-- at present the rarest form of experimentation with LSD--would probably have to be evaluated in this context.

In the drug state, the experience of compelling immediacy diminishes the normal importance of past and future. It also is related to the overvaluation of 'nowness,' the pursuit of the novel in certain youth subcultures. The ability to see the familiar in a new light, the temporary loss of normal anticipations, may be relevant to the still poorly understood creative process. Yet there is nothing about the drug effect which specifically enhances the synthetic and organizing facility. It is, in fact, the need for synthesis--not the ability to synthesize--that is enhanced in the drug state.

An important feature of the state is an increased dependence upon the environment for structure and support as well as greater vulnerability to the milieu. With the loss of boundaries, persons or a group are used for such elemental functions as control--for helping one to know what is inside and what is outside, for comfort and for binding and balancing the fragmenting world. Persons or objects in the environment have positive or negative value in quite elemental terms: for example, as threats or as anchors in maintaining control. Persons are seen as objects--either to be clung to or to be contemplated in an essentially self-centered, aesthetic, or ideologic frame of reference. The claims for a different perspective on personal relationships have to be evaluated in terms of how this is integrated into the user's life, as well as in the internal rearrangements of his values.

With the fusion of self and surroundings some of the strain between harsh authority, social limits, and personal strivings can for the moment be transcended or dissolved. At the same time there is a leaning on others for structure and control. Hence, when the drugs are taken in a group setting, the breach with reality can be filled by the directive mystique and support of the group. This is, in part, why I have termed these drugs 'cultogenic.'

Adaptations in The Drug Experience

There are different modes of coping with the drug state which could be called protective. One protection is not to fight the multiplicity of experiences during the drug state. When the traditional defensive operations come too strongly into play temporary panic may ensue even in relatively stable people. Thus a certain yielding and surrender of ambition and personal autonomy help some individuals to have a good experience, but this requires, if not group support, a special kind of personal strength.

The drug experience is compelling; it is hard to convey but incredibly vivid. No doubt the rearrangements of reality which can occur produce a memorable experience, but one is reminded of Sidney Cohen's remark that most people get what they deserve or what they are equipped at the time to experience.

The Need for Synthesis

One scientist experienced his peripheral vision to be enhanced during the drug state. He commuted daily, reading on the train. For months after the drug, he was bothered by the telephone poles which flashed by his train window; he could no longer suppress what normally is background. Similarly, the unconscious 'background' to thoughts and feelings can emerge. The mind provides constancy wherever the sense organs deal with variability. We anticipate or correct for the images on our retina to keep the world stable and ordered; the hand stretched eight inches before one may appear small, though on the retina or camera it is large. LSD appears to affect such perceptual anticipations as well as more complex regulatory systems. It rearranges our ideas of order.

In a state of altered consciousness where control over awareness is diminished, there is no way to bind the intensities experienced and symptoms may ensue. Thus people may 'act' to produce vivid consequences or experiences in order to see them in a new light and grasp thereby for control. What often is lacking in this repetitive remembering or acting is the element of guidance, correction, reflection, and structure which leads to authentic self-mastery. This may be the chief source of danger of LSD--the lack of structure and autonomy and the traumatic and potent intensity of individual experiences.

Thus 'acting out' behavior with or without a drug often compels external control, correction, and guidance and appears as a provocative accusation against authority. The young do not merely 'turn on' themselves, but seem to display great anger at the guides who, they feel, failed them. They thereby keep a link--and a very strong one--to the very strictures which had previously absorbed them, just as a misbehaving child is tied to his parents by evoking their involved irritation or punishment. Some kind of continuity with reality is sought. The bridge may be a book as it was with Huxley, silent synthesis or change of values and tastes, or the understanding of a group or person. In the Native American Church, the Indian utilizes all these elements--religious explanation and adherence, specific ceremonies, and the group with its ideology--to integrate the experience which serves a purpose in the total fabric of his life. The Indian does not accordingly seek a simple 'high' or thrill with the drug.

The Scope and Dangers of Illicit Use

We should recall that the increasing problem of drug abuse in most countries is with alcohol, followed by the barbiturates, amphetamines, opiates, and mild tranquilizers. In this context the consequences to national health of hallucinogens are not as yet truly startling--either in terms of the utility of LSD or its harm. This is an interesting generation, but they have not as yet gone completely to pot. Estimates of the incidence of psychedelic drug 'use,' however defined, are always vulnerable to criticism. They range from one to 15 per cent on certain campuses. Figures higher than five per cent probably do not distinguish single trials from habitual use, nor LSD from other drugs of abuse; for example, proselytizers frequently tell us about the 'inevitable' increase in the use of marijuana and LSD. Only a small fraction of persons who have taken the truly potent hallucinogenic drugs can be said to constitute a reliable base for study of long-term users. The problem is that some are always first discovering the drug (available now for 20 years) and acclaiming it while the silent others are experiencing disillusion after a year or two of absorption. Still others actively seek or passively accept one or two experiments.

Reports of chromosomal changes in preparations of lymphocytes raised in tissue culture are not identical with 'genetic damage' or clinical disease. Apart from unwarranted biological inferences, the reliability of such findings is not at all established; nor do we as yet know the relationship to dose, to common stimulants, or to drugs related by structure or behavioral effect. Similarly, a finding of LSD-induced stillbirth or stunted growth in rats is not identical to fetal anomalies or germ cell damage. Effects in mice may differ; rodents may differ from man. Similar reports of effects of other drugs (including reserpine) should be evaluated prior to sanctioning alarming reports about LSD. Nor does the persistence of hippocampal discharges for several weeks following LSD, in cats trained to avoid shock, indicate long-term brain changes or brain 'damage' in man. Reserpine, in fact, produces more dramatic persisting effects in the hippocampus, and without the intervention of shock. Neither the history of folk usage of psychedelics nor the past 20 years of medical and lay use of LSD have, as yet, produced clear and reliable evidence of somatically dangerous consequences of the drug in man or of a plethora of psychedelic monsters among the offspring of users. While such important research continues, caution about publicity is warranted on both scientific and humane grounds lest we further panic the susceptible.

The Drug Mystique

My current opinion is that the chief abuse of LSD is irresponsible, alluring, and provocative advertising by the bored mass media. Couched in the language of drugs, an ideology has been insinuated into youth culture by a band of articulate writers and vagrant professionals. These have replaced the old medicine show with an updated campus version complete with readings and tempting arguments, if not pills, to sell: 'Tune in, turn on, drop out.' A drug mystique has been welded to the serious shifts and strains inherent in the experience of the potentially most unstable group of any society--the adolescent and young adult.

We need not determine whether this is indeed a 'now' generation valuing honesty, love, direct confrontation, uncomplicated action, and avoiding ideologies in favor of simple justice. These values, however germane to the LSD experience, were not born from the drugged mind. The Pied Pipers of

LSD--peddling a drug which can enhance poor judgment--would lure youth from the acquisition of competence, or even from the serious study of man's attempts to deal with the two orders of reality in his personal development and in his religious, artistic, philosophical, and scientific endeavors. If we attempt to account for the fact that the greatest abuse has been among the well-educated--or those who might be--we would in all honesty have to question the strange tolerance for these psychedelic follies in campus cultures. Forgetting both Freud and James, many of our teachers and intellectuals are either entranced or perplexed by stories of LSD-induced revelations. They appear neither to have learned, nor to teach, from experience.

Motives for Use

The motives for LSD use are varied. Sociologists refer to problems of commitment and alienation and add thereby to the younger generation's verbal mythology. We might remember that wild analysis and 'psychoing' characterized youth of previous generations, as did self-experiments with hypnosis even in the nineteenth century. Curiosity about the mind, about what can be experienced, about who one is, and will be, is expected. A 'need to feel,' a pervasive sense of being constricted, seem characteristic. One wonders whether the consequences of a 'boundary-less' or destructively permissive upbringing leads to a lack of distinctions, a deficient recognition of self-experience, and a frenetic search for it.

Some college students clearly tried the drug as part of clique activity; taking the drug puts the student one-up; he has 'been there.' It can provide the basis for a loose group cohesion. For this group, magical transformation of reality, omniscient union rather than the painful confrontation of separateness and effort, is a lure. Old limits can be dissolved and--with a single gulp--philosophical infants are transformed into sages. The frustration of years of inexperience are replaced by an intense arcane experience; it is as if the secrets of the parental bedroom are instantly transcended by the mysteries of the drug! The tables are turned as the young turn on; now it is the parents who stand by in perplexed, uncomprehending, and fascinated impotence.

Others sincerely feel they should confront an experience advertised to be so important. They can be dared by accounts of pleasant or assertedly profound experiences. They see the drug as an emotional fitness test, somewhat analogous to physical fitness. The issue for many is 'control.' They experiment with the right to drink and test their ability to stop. At this age they are doing the same often with cigarette smoking, studying, or with masturbation. In general they are rehearsing their strength and autonomy at a time when their lives are largely unwritten. Many behaviors of this age constitute a probing for consequences--an impatient attempt to leap the barriers of time, to seize now the fruits and risks promised in the future. This underlies many of the grimmer statistics of the 18 to 25 age group, including accidents and suicide.

#

Excerpted from

PREDISPOSITION TO ALCOHOLISM

*Reverend Stan Helm
Mendocino State Hospital
Mendocino, California*

One of the problems of the great emphasis on drugs in our society today is that we forget that alcohol is a drug. We get things out of perspective by over-emphasizing the problems of drug use (which are very critical) but, much to our relief, are able to forget the problems of alcohol which are a hundred more times critical in our society. It may not always be that way, if present trends continue, but it is now.

The approach that we now use is a behavioral and social approach rather than thinking of alcohol as a disease. There was a time when that was a fairly useful concept because it did break down some of the stigma after being labeled an alcoholic. That is a large part of the problem, by the way, the labeling process. I suspect that applies to drug addiction as well as to mental illness.

The general estimate of alcoholics now in our society is four and one half to five percent of all the adult citizens in the country. The proportion of male to female alcoholics is decreasing. It is probably around four and one half to one. It used to be higher than that. There are multiple causes, just as there are in the field of mental illness. We have to look at alcoholism as we do other types of behavioral difficulties as part of a long process. It generally takes a fairly long time of fair quantities of drinking to get into trouble. Some seventy-five percent of our population of adults are said to be users of alcoholic beverages now. There are a number of human differences in the reaction to taking any kind of substance. This goes for drugs of all types. Many of these things are probably questions of heredity or biochemical make-up, or social-cultural development, demands and expectations that are ours by reason of our existence in a particular culture.

In our own studies, we took a group of 200 patients. We now have a report on that group of people based on their own reports about their childhood, family life and other factors. Their major problem in growing up, they said, was due to either economic problems or parental incompatability. Very few of them said alcohol was a problem in their family life, even if their parents drank. In general, they present themselves as having a happy kind of childhood and existence. According to them, their families, brothers and sisters, and teachers liked them. They were fairly good students, remembered school in a pleasant way, felt they were happy-go-lucky children. They went to Sunday School regularly without too much pressure and they report this kind of experience in their background. That leads us to believe they were afraid of hostilities and extremely sensitive to approval or disapproval. Some of them may drink to lessen that intensity and that kind of feeling. Our group surprised us because they used a wide range of drugs other than alcohol. They may go from one type of drug to another. Most of them stay with a sedative type of drug, not the stimulant.

This project has led us to believe what we have felt from the beginning that the emphasis on alcohol and alcoholism is a misleading emphasis, just as the use and misuse of drugs is misleading in a sense. The emphasis must be on people and their problems and conflicts and difficulties. The use and misuse of whatever it is is somehow an attribute of that particular underlying difficulty. When we used LSD here as a research product, we found that under the LSD experience only two of our patients reported thinking or images about alcohol. What they did report were other types of conflict with people or feelings or particular situations in their backgrounds with which they were in conflict.

Excerpted from Remarks to participants of 'Project Inundation,' a leadership training program in drug abuse education, June 1968.

We tried to differentiate the kinds of personalities we see most often. Men are in more difficulty than women because of their drinking. They are 'in thicker' than women. They have suffered more loss. They have less social resources. They have more conflict and they have more difficulty in achieving some different kind of life. Women have more normal kinds of personality patterns; they are in less psychic difficulty generally speaking. That is obviously not true for everybody, but it is generally true.

Most people we see have little tolerance for frustration. They have difficulty in coping with stress or withstanding anxiety. Emotional tension and conflict are present -- in family relationships especially. There are strong feelings of alienation in their community or their family or, something significant, they have high energy levels but poor impulse control.

There are some unique problems that arise for women, as we have seen in our own group of women alcoholics. How do you assert yourself without alienating men? What is a feminine person in such a world as this? How can you recognize your dependency needs and realistically meet them without being dominated excessively or without being unhappy about it? How can you accept the fact that you are feminine? How can you achieve depth in interpersonal relationships? How can you reduce anxiety by non-destructive methods? How can you find relief from guilt without depression or despair? How can you achieve less sensitivity to the feelings or expectations of other people, to be tougher in some degree? How can you achieve a personal sense of security without undue reliance on others? How can you lessen the need to control others by devious and various means? How can you express hostility towards others without self-destruction or guilt or alienation? Those again are not unique questions only of alcoholics, but they are questions to alcoholics.

In approaching the field of alcoholism we adopt a type of attitude that is consistent, open, non-critical and non-punitive. If punitiveness helped, everyone would have been helped a long time ago, because they have certainly had plenty. So, the basic approach to this particular type of problem is not permissiveness, but simply non-punitiveness. One of the basic problems of all alcoholics in our society is that doors have been shut to them and the normal things that would have been open to them have been unavailable. You go to an out-patient hospital dealing with mental problems and let them find out that you are an alcoholic or drug user and see how far you get in their set-up. You find that you are out on the street again. If these doors were open, it would be a lot less difficult for our society.

#

Excerpted from

DRUGS AND RELIGION

*Leonardo Marmol
Marin County Mental Health Service, and
Marin County Council of Churches*

Religious people have been using drugs in connection with their rituals and ceremonies since time immemorial. These range from the simple fermented fruits of the nearby vineyards to the highly complicated chemical formulas used in black magic and witchcraft, both of which had roles in the ancient religions of the world.

My work with so-called 'drug abusers' has put me in contact with many men and women who report their drug-induced experiences using religious terminology and calling them mystical experiences. I have also met some intelligent, creative, hard-working people who have had experiences with mind altering chemicals they insist on explaining in terms of religious meanings. Let me also state that my work has also brought me into contact with young men and women who have literally blown their minds with drugs, and have become outright psychotic.

This is a problem of the use of drugs these days: we find such contradictory results from the use of the same drug in different individuals.

This paper therefore does not give definitive answers to the questions which the drug scene poses. It is only a 'progress report' on some of the religious issues raised by the drug scene. This aspect of the drug problem has received less attention than the chemical or psychiatric aspects.

First of all, let me clarify that the word drug is used in this paper to refer to the psychedelic or hallucinogenic substances. Mostly used for attaining mystical states of mind are peyote, mescaline and the Mexican magic mushroom on the natural side; and psilocybin and lysergic acid diethylamide (LSD 25) on the synthetic side. Some people have used marijuana for religious purposes; but by and large, the serious seekers of religious insights consider marijuana a merely recreational drug.

In spite of medical evidence to the contrary, there are many people who use these drugs and report positive, enlightening experiences of a mystical or religious nature without any evidences of psychopathological effects upon their ego functioning. What are we to think of these psychedelic cultists who claim to have been in contact with the Ground of their Beings as a result of the chemical action of LSD or mescaline upon their brains? Can we dismiss these people as merely 'being stoned' and not having much to say to us? I think not.

Let us define some terms at this time. In a lecture delivered at a meeting of the Board of Theological Education of the Lutheran Church in America, held in 1963, Dr. Timothy Leary defined the religious experience as follows:

The religious experience is the ecstatic, incontrovertibly certain subjective discovery of answers to four basic spiritual questions.

1. The Ultimate-Power Question: What is the Ultimate Power or Basic Energy which moves the universe, creates life? What is the Cosmic Plan?
2. The Life Question: What is life, where did it start, where is it going?
3. The Human-Destiny Question: What is man, whence did he come, and where is he going?

.....

Excerpted from talk presented, October 1968.

4. The Ego Question: What am I? What is my place in the plan?

Dr. Leary goes on to point out that religion is the systematic attempt to provide answers to the questions subjectively, in terms of direct, incontrovertible, personal experience. A Jesuit scholar, Father Elmer O'Brien, in his book *Varieties of Mystical Experiences* gives criteria for evaluation. The next question is whether LSD experiences can be called mystical or religious. Some researchers other than Dr. Leary think so. I have interviewed five people whose psychedelic experiences met at least four of the six criteria named by Father O'Brien.

In an article published in the *Journal of Religion and Health* in 1966, Drs. Walter N. Pahnke and William A. Richards described a study on 20 Protestant seminary students who had no prior drug experiences. They administered a dose of psilocybin to half the group, and a placebo to the other half using the double-blind procedure. They all attended a Good Friday service at Harvard Divinity School. They found that the subjects who had received psilocybin experienced phenomena that were apparently indistinguishable from, if not identical with, certain categories defined by the typology of mystical consciousness.

In a more recent study Dr. Joseph J. Downing, program chief of the San Mateo Community Mental Health Services, and the Rev. William Wygant Jr., Protestant Chaplain to the San Mateo County General Hospital, questioned 42 persons who had ingested from 0.87 to 5.0 micrograms of LSD per pound of body weight and found that:

1. 60% stated their religious feelings were changed.
2. 60% trusted God (or life) more; 35% trusted people more.
3. 40% indicated their understanding of the teachings of their own church had changed, largely toward an increased understanding of doctrine.
4. 40% expressed less anxiety regarding death.
5. 30% felt a greater conviction of the existence of a supreme being.
6. 80% stated they were more secure people.
7. 50% indicated they were freer, more tolerant, or less guarded. 60% felt their personal conduct had changed for the better; 30% believed their moral standards had changed toward increased personal responsibility.
8. 40% felt a different relation between themselves and other people.

A challenge of the psychedelic cults to organized Judeo-Christian orthodoxy is that the drugs seem to be able to do for the individual that which the churches can only say they do when they talk about salvation, grace and forgiveness. The fact is that more and more Christians and Jews are finding that by coming every week to church, by singing the old hymns in slow, monotonous unison, and listening to the preacher read prayers from a book and expound on his favorite pet peeves, nobody is attaining mystical/religious experiences. The younger generation is asking how come the Church fails to turn them on. Can these experiences be attained without the use of drugs? Maharishi Mahesh Yoga and Meher Baba say yes and hundreds of young people are flocking to hear their messages.

The Eastern religions have insisted that God is 'immanent' in both man and nature. That He is within all of us; and we need only to concentrate, meditate, introspect deep into ourselves and we will find Him. This particular theology has been termed pantheism, the notion that God is to be found in everything in the Universe, and outlawed by Western theology.

But the Western Church has always had a radical mystic movement which kept raising its ugly head here and there, much to the embarrassment of theologians and bishops. Since Thomas Aquinas

reclaimed Aristotle for the Church in the thirteenth century, mysticism has been out, and empiricism and reason has been in. Now, the psychedelic cultists are forcing the issue to the fore. They claim purely subjective experience as the result of the mind altering qualities of chemicals, and from their own unconscious they come up with a unique encounter with what they insist in calling the Ground of their Beings. Their psychedelic experiences seem to validate 'immanence' rather than 'transcendence'; monism rather than pluralism; reincarnation rather than resurrection; Nirvana rather than heaven; Maya rather than hell; ignorance rather than evil; liberation rather than salvation; and self-knowledge rather than grace, redemption and atonement.

Note that these are Western men and women, the great majority of them White, Anglo-Saxon Protestants. Trained in orthodox Western Christian environments, educated in middle class American school systems. They pop a capsule of LSD and come up with Hindu, Budhistic and Zen ideas. This is a pretty serious challenge to many things we hold as dear as motherhood, apple pie, and progressive education.

Where do we go from here? It is probable that the use of drugs per se will go out of vogue as a fad, but that the challenge they have posed to Christianity will remain.

I think that the East and West must entertain the possibility that they have both been wrong by insisting upon an Aristotelian 'either/or' dichotomy. I think that God is both immanent and transcendent; that the Universe has both monistic and pluralistic aspects to it. I think that we need to re-think our whole religious establishment to make it more of an 'ego religion' instead of either 'superego religion' or 'id religion.' Ego religion (like good psychotherapy) ought to be a system of mediation rather than a system of repression. I think that what we are seeing in the psychedelic religion, which I consider to be id-religion, is a kind of Gnosticism which is a reaction to a belly-full of Puritan repression. May I remind you that the basis of Puritanism is the fear that somewhere someone might be happy and having fun?

I think that Western Christianity has to come off its intellectual other-worldly worship forms and get down to more gut-level earth-related type of confrontation between man and man, and man and God. We must develop the kind of ego religion that is conducive to the kind of ecstasis that is not escapism or world-denying, but is rather problem-solving and world-affirming, with a real experience of joy involved.

That is the kind of religion that would keep its cool in the face of id demands for pleasure and super-ego demands for pain and punishment. That does not give in completely to either, but rather allows each its proper place. The kind of religion that would make room for the visions and the dreams, but also for the discipline and the ethical values.

In the old days, the mystics (those who saw visions) were always old men, that is, those disciplined and trained through long years for the ascetic life. And in the old days, all the 'young men' could do was to dream dreams about what they were going to do when they became adult.

These are the new days. Our sons and daughters are our prophets who call us on our evil ways. Now it is the young men who see visions, without the discipline of asceticism. Our technology has given them a chemical that does this for them.

I think we should listen to the new prophets and study their visions.

#

RESEARCH

RECENT RESEARCH ON LSD, MARIJUANA
AND OTHER DANGEROUS DRUGS
Part One

*Stanley F. Yolles, M.D., Director,
National Institute of Mental Health, PHS*

In early 1967 there was considerable concern regarding the extent of the LSD problem in the United States, particularly in light of reports that the number of users was increasing at a rapid rate. NIMH supports several studies designed to measure the extent and trends of LSD and other hallucinogenic use. Preliminary findings from these studies indicate that we have witnessed in the past year a significant decline in LSD use in the United States.

Our evidence would indicate that a key factor in explaining this decline has been the availability of factual scientific information based on research findings which suggest that LSD can cause severe psychotic reactions and may cause chromosomal changes not only in the cells of the user but also, for women, in their children.

Conference on Toxic Effects of LSD

Five months ago, the NIMH convened a meeting of the country's leading research experts to evaluate the information then available regarding the toxic effects of LSD. The final report of the proceedings is being completed. I would like to discuss briefly some of the highlights.

The discussion indicated that with several exceptions, the evidence for persisting psychologic damage from chronic LSD administration is minimal. One exception is the observation that chronic users (when not on LSD) showed uniformly lower thresholds to auditory stimuli. This suggests the possibility that sensory overload may be a problem for the chronic LSD user even when he is not ingesting this drug.

Several workers have described the phenomenon of recurring hallucinogenic experience without recurrent ingestion of the drug. In some instances users of LSD without taking the drug have recurrent paranoid episodes, at times accompanied by vivid hallucinations. The significance and extent of these reactions are not as yet fully known.

Through a continuing problem, admissions to psychiatric units of persons with so-called 'bad trips' are declining. Dr. William Frosch, who reported in 1966 that there was a rapidly rising rate of such admissions to Bellevue Hospital in New York City, now informs us that the admission rate for such cases at his hospital has declined.

Some investigators in the past year expressed concern about possible outbreaks of new forms of acute and/or chronic organic psychoses related to hallucinogenic drug use. The consensus of those present at the meeting was that there is not sufficient evidence to justify this concern. However, modification of the usual therapy for acute hallucinogen-caused psychoses is indicated. The results in terms of terminating the acute psychotic reactions are in most instances good.

Chromosome Damage

Considerable public attention has been focused on the relationship between LSD and chromosome damage. These reports are alarming because of the association of chromosomal damage with leukemia-type syndromes and birth defects. The types of chromosomal changes noted in some LSD users have been observed in survivors of the Hiroshima atomic blast and in other persons exposed to high doses of ionizing radiation, all of whom have an increased likelihood of developing leukemia-type syndromes.

Excerpted from Testimony Before the Subcommittee on Juvenile Delinquency of the Committee on the Judiciary, U. S. Senate, March 1968.

The initial report of chromosome damage possibly attributable to LSD by Dr. Maimon Cohen of the University of Buffalo School of Medicine sparked a flurry of research activity around the effects of hallucinogenic drugs on chromosomes *in vivo* and *in vitro* and upon the offspring of exposed human and animal subjects.

The NIMH is currently supplying LSD to 20 investigators engaged in research of this type. The initial report of Cohen referred to the production of chromosomal abnormalities in human white blood cells (lymphocytes) cultured with LSD. These changes were not observed when LSD was not present in the medium (although similar changes have now been observed when such cultures have been made with thorazine, aspirin and caffeine).

Dr. Cohen's findings were confirmed nearly immediately by Drs. Irwin and Egozcue of the University of Oregon School of Medicine. They additionally reported chromosomal abnormalities in the circulating lymphocytes of several hippies in the Portland area. Dr. Herman Lisco of Harvard University has reported identical changes in persons who had been exposed to psilocybin, another hallucinogen.

Similar human *in vivo* reports about LSD were made by Drs. Cohen, Frosch, and Hirshhorn. Their findings, however, were not confirmed by several investigators at the University of California, by Dr. David Hungerford of the Cancer Research Institute in Philadelphia or by Dr. Albert Kurland's group at Spring Grove State Hospital. In the several studies where chromosomes were examined before and after LSD administration in man, the Irwin and Cohen findings could not be replicated.

If LSD does in fact cause chromosomal abnormalities in man, the significance can only be learned over time. Similar changes occur after certain viral illnesses; but in these conditions the effects are short-term and are not associated with serious pathological consequences. Long-lasting chromosomal damage of this type has been reported in persons exposed to atomic radiation and in other individuals considered highly vulnerable to leukemia. In considering the leukemia-causing potential of LSD we must consider that long-term studies in identified individuals are mandatory to determine whether such changes are long-term and a prelude to leukemia. Short-term chromosomal changes may not have any pathological significance.

Birth Defects

Observations of chromosomal abnormalities led to several animal studies to determine the effects of LSD on offspring in several animal species. In the mouse and the hamster, when LSD was administered early in pregnancy, there was a significant increase in the number of spontaneous abortions and birth defects. Contradictory reports have appeared about such findings in the rat. Experts in this field tell us that it is impossible to generalize from one species to another with regard to drug effects upon the fetus. Thalidomide, for example, failed in several animal studies to present birth defects across species lines although it did produce birth defects in man.

There have been a number of newspaper articles which have attempted to relate LSD to reported birth defects. . . . Evidence that hallucinogenic drugs can cause birth defects in exposed humans is at best presumptive at this time. Reports from animal studies and *in utero* chromosomal investigations suggest a possible link between some birth defects and maternal ingestion of LSD. The investigators themselves would be the first to argue that their findings are not definitive. . . . However, in light of the preliminary findings, one should add to the usual warnings about LSD use particular emphasis on the possible hazards for women in the childbearing ages.

Surveys of LSD Use in Colleges

Five percent of the college students polled admitted using LSD, with a range among individual colleges of 2-9 percent. LSD users are much more likely to have also used marijuana as well as other drugs such as amphetamines and barbiturates. Conversely, only a small percentage of those who have used marijuana also use LSD. LSD users tended to be 'experimenters' with only 30 percent of the sample 'serious' LSD users.

We now have some data about the characteristics of the student drug user. The academic standing of the occasional user was better than average, while the heavily involved drug users had lower than average grades. There is a relatively small group, perhaps 3-4 percent of student drug users, for whom taking drugs is no longer a question of 'just being in,' but whose problem of drug abuse represents a complicated and severe psychiatric problem. There is a decline in the number of admissions to college health services of students with psychotic reactions secondary to LSD use.

Problems of Research on Marijuana

A key problem in the field of research on cannabis is the lack of a standard product. For results of scientific investigation to be reproducible, researchers must have available agents whose chemical constituents and potency are identical. There is tremendous variability in black market cannabis. Seized materials may be adulterated with other plant or chemical materials. The potency of cannabis varies according to its age and where it is grown. The recent synthesis of a number of tetrahydrocannabinols, the chemically active constituents of cannabis, shows promise in expediting research in the field.

Surveys of Marijuana Use in High Schools and Colleges

Surveys of high school and college drug use indicate that approximately 20 percent of the college students questioned reported some experience with marijuana. It is estimated that about two million high school and college students have had some experience with marijuana. Generally more men students reported involvement. Of those reported having ever used marijuana, 65 percent had used it less than ten times with 'once or twice' the commonest response. Fully 50 percent of those who have tried marijuana experienced no effects. This finding may be a function of at least four factors, (1) the agent may not have been potent, (2) frequently effects are seen only after repeated use, (3) the expectation of the user had a significant effect on what he experiences, (4) the social setting in which use takes place has an effect on the response.

Our evidence would indicate that in contrast to decreasing use of LSD, use of marijuana has been increasing.

The United Nations estimates that in 1950 there were 200 million users of marijuana in the world, mainly in India and North Africa. In the United States, we are not quite sure of the exact extent of the problem. Estimates as high as 20 million have been made, but it is much more likely that in the neighborhood of 4 to 5 million persons have used it at least once.

Effects of Cannabis

Marijuana is considered to be a mild hallucinogen, taken by the usual route of smoking, occasionally by ingestion. It may induce a mild euphoria and lead to heightened suggestibility and faulty perception, really an exaggerated notion of thinking more clearly, profoundly and creatively. It is known to cause reddening of the membranes of the eyes, rapid heartbeat, muscular incoordination, unsteadiness, drowsiness, and distortion of time and space perception.

In acute intoxication, especially when ingested, it may also produce visual hallucinations, pronounced anxiety, paranoid reactions and transient psychoses lasting 4 to 6 hours. It generally tends to lessen inhibitions and creates for the user a false reality based on his wants, his motivations, or the set. In this respect it is similar to LSD but its effects are not as potent.

The muscular incoordination and the distortion of space and time perception commonly associated with marijuana use are potentially hazardous since the drug adversely affects one's ability to drive an automobile or perform other skilled tasks.

We do not know enough about the long-term effects of marijuana use. As in the case of tobacco, it is possible that there are serious consequences of chronic use which will only become apparent through careful long-term studies.

One needs to be particularly concerned about the potential effect of a reality distorting agent on the future psychological development of the adolescent user. Normal adolescence is a time of great psychological turmoil. Patterns of coping with reality developed during the teenage period are significant in determining adult behavior. Persistent use of an agent which serves to ward off reality during this critical development period is likely to compromise seriously the future ability of the individual to make an adequate adjustment to a complex society.

#

Excerpted from

NATURE AND EXTENT OF THE PROBLEM

Richard H. Blum, Ph.D.
*Director, Psychopharmacology Project, Institute for
 the Study of Human Problems, Stanford University*

First, I want to tell you, so that you can understand my biases and be forewarned about them, some of the kinds of things we have been doing in the drug research area, for it is important for you to know the kinds of limitations and blinders that I wear.

We have been involved primarily in studies of the social and psychological aspects of drug use. Some years ago we started by doing some cultural studies attending to the cultural context of alcohol use in Greece. Then we got interested in the problem of LSD use and did a series of studies on people using LSD, what they were like and why they were using it, what changes seemed to occur and what it meant to be using this drug.

Since drug use is not restricted to one drug or very rarely restricted to one drug, our LSD work was really a study of people who were involved in the 'drug movement', as it can be called, or in the exploration of exotic drugs. That phenomenon has expanded so rapidly that whatever we studied three or four years ago is by now ancient history. As you know, in California especially, two years is a long, long time.

In traditional societies one finds the simultaneous use of drugs for healing and religious ends. In such societies one also finds, but more rarely, a third orientation associated with the individual use of drugs. Here the drug is associated with a decrease in the individual's ability to function and in his capacity for both work and experience, as seen in the disabled drug user. Such inadequacy is sometimes disguised behind a philosophy of drug enjoyment or a commitment to a drug-using group. I do not think we should overlook this function in those who use drugs ostensibly for other purposes. It may well be that people want to withdraw.

But in looking at the secular use of drugs, which is what we are concerned with in their non-medical use on the campus, we must be cautious and not become overly psychological in attributing reasons to drug users. The substances being used are all social drugs. They are part of the social scene. They are part of what people do together. Anybody who smokes a cigarette in a conversation or who takes a drink with others knows this. Thus when we talk about newly popular drugs, like LSD or marijuana, we must note that some of the reasons for their adoption have to do, in part, with their function in sociability. The diffusion of drugs must be examined as a social exchange and as a learning phenomenon.

Some aspects of drug diffusion seem fairly consistent from campus to campus and are even consistent over the last few thousand years. For example, young people usually learn to take drugs from people who are older. Females tend to take them from males. People with higher status give them to people of lower status. Leaders distribute them to followers.

Given such patterns, it is hard to infer a single set of values or motives in the diffusion of drugs on campuses. Indeed as drug use becomes common among students, one can say that a sophomore is exhibiting normal social behavior in taking marijuana for the first time from a senior. Normal of course by no means implies that it is wise.

This Paper was presented at National Association of Student Personnel Administrators Drug Education Conference, Washington, D. C., November 1966.

Another important feature which we find in the study of committed drug users, as opposed to people who are merely experimenting, is that the reasons for continuing to take the drug are frequently different from the reasons for starting it. For example, one starts to smoke because one's friends and parents smoke, because it is the thing to do, or because one is sociable or curious about smoking. But the cigarette can become very personal. One gets to need the cigarette. Those of you who have become cigarette addicts are aware that the present desire to stave off withdrawal symptoms, to stay content, to suppress tension, or just to have something to do with your hands, is quite different from the original exploration and sociability that led you to smoke your first cigarette.

Perhaps we can examine the functions of drug use. What does it do for the guy? How does he act? What seems to be happening? What does his group do and what impact does it have on the social system of which it is a part? Then at the same time we are free to ask the previous questions: What is it that the drug user says he believes, says is his motivation for use? We can compare his actions with his statements and test them for consistency -- and as part of this analysis watch our own counter-reactions to his behavior and statements, since our own reactions may very well be part of the system which underlies that which is happening among student drug users.

I suggest that one of the fundamental orientations which might be used to discriminate those who continue to use drugs (LSD in particular but marijuana and some of the others too) from those who reject their use is an inside versus outside orientation. Introversiion and extraversion are terms for what we are dealing with here. In interviews with and observations of drug-using people, one senses an emphasis on the value of what is going on inside their heads, on looking at it, and on the importance of internal experience. But among non-users, I think there is more interest in external experience, in what is going on between people, with an emphasis on looking for explanations and for directions and solutions on the outside. In our LSD study this seemed very clear.

As alternate terms for inner-outer or for introversion-extraversion, one can say egocentric versus other-centered, selfish versus sociable, or profound, sensitive and esthetic versus materialistic and shallow. The terms you use depend on what system you buy and how you feel about it. In this initial concentration on the inner orientation, let us assume for a moment that there may be some worth to this category of experience. What are the satisfactions or values associated with an emphasis on internal experience? The kind we had better consider first -- which I think are rather important -- are essentially psychopathological functions.

Some people hurt themselves or others and can be said to be screwed-up characters. If we will accept this for the moment as a definition of 'psychopathology', I suggest that some proportion of drug users, students and others, are fouled-up people. The drug serves them not in an unscrewing function but perhaps in a pain-reducing function. When a doctor ponders when to give morphine he weighs the utility of the drug in terms of its capability to reduce pain. In the case of a disturbed student's pondering when to self-medicate with a social drug, he may also weigh its utility for pain-reduction. His value or aim is, 'I don't want to hurt.' He is not pursuing pleasure; he may merely hurt less than usual when on drugs.

A student I know is a very capable and sweet guy. He is also a rather heavy user. He uses it, he tells me -- and I have also watched him -- whenever he is going to be with a group, because he gets nervous and tense otherwise. A little LSD or marijuana calms him down and allows him to function. Others of us might take scotch or cigarettes but LSD does that for him. Such psychopathology as his is minor, but without much looking we can see serious illness among some drug users. Another important way of using drugs has to do with the partial resolution of maturational difficulties, of some of the difficulties of growing up. Many human beings are stuck with psychosexual complexes. A guy or a girl during college years can be exposed to all kinds of relationships and impulses which do not get handled as he would like. By using drugs he can sometimes succeed in reducing not only the anxiety but also the desire. An example, it is a curious thing that there is among the users of the mind-altering substances a lot of talk about 'making out,' about sex and free love -- but damned little activity. I think that the function of the drug in reducing sexuality cannot be ignored. It is not that sex is no longer important but rather that the student can accept a new value, one which says, 'It is all right to be nonsexual and to concentrate on other things.' That may or may not be a neurotic solution.

Another pathologically relevant use of drugs has to do with the reduction of intimacy in human relationships. In this society you cannot get away with that without lying. We are supposed to like each other. The acceptable thing is to go out and mix and be a good guy, get along, be affectionate or at least smooth, to love a lot or a little -- but above all to seek and be with others. The use of drugs may remove people from intimacy and may do it in a way which can be lied about very easily, because they say, 'I am becoming more intimate. I am feeling loved. I am a lovely guy. You are a lovely guy. We are lovely together.' Saying that, they crawl back into their shells where they do not have to look at one another again. One achieves this 'lovingly' and has not hurt anyone and has learned a new value system to justify one's pathology. I watch it often. I believe it to be there. If it is, I will be delighted; if it is not, I will not be surprised.

All drug use certainly cannot be conceived in terms of individual pathology, nor can all use be explained simply in terms of private feelings, or neurotic or even psychotic idiosyncrasies. We therefore have to deal with interpersonal pathology, the nasty things people do to one another with or without excuse. Drugs do not produce any special new nastiness in human beings. We are all capable of all kinds of misbehavior without taking any drug. One of the great dangers, one of the great nonsenses in criminology and other fields is to blame bad behavior on drugs. You will hear someone say, 'He took heroin and became a bad boy.' The fact is that if he is a bad boy and takes heroin, he remains a bad boy and is going to stay a bad boy until something else -- not heroin -- happens. That he treats people badly can be accounted for not in terms of drug use but in terms of how others have treated him. Thus much psychopathology is really an interpersonal phenomenon. Much behavior under drugs is nasty, take the aggressive drunk for example, and we dare not ignore it. But the chances are that it is the person and the situation, not the drug, which are accountable. The drug just changes the emphasis.

Another thing that happens in drug use -- it is not pathological but human and does not bode well for society -- is the ethnocentrism one sees in the development of drug-using groups. As in any other social group, an emphasis can be placed, call it tribal or fraternal, on valuing the insider and on denigrating or rejecting the outsider. In studying the way-out drug users one just cannot miss this characteristic. It hits you in the face and does not make for good conversation or pleasant relationships. For the in-group fellows a drug can become a symbol of group-belongingness and worth. That in-group feeling is accentuated simply by the realities of illicit drug use, which require a pseudodelinquent tie and a wariness about the punishment potential existing in the square out-group society. After a group has clustered about a supply source it can develop defensive justifications which say, 'Wonderful, a fine bunch of people we are, but those who want to cut off our drug supply or to punish us are very bad fellows indeed.'

Now let us look at some other aspects of use. We must not ignore the religious and mystical functions which students attribute to drugs and the religious and mystical experiences which they say they had under drugs. Nobody knows really what goes on inside anybody else's head, not even with the aid of an EEG machine. When something new happens in our heads, as in a drug reaction, one has to interpret it. That interpretation can be helped by teaching. There is no doubt that drug users tend to teach each other what is going on inside the head. Somebody joins a group of kids and whether by accident or propensity, he likes them. They say to him, 'We use marijuana or LSD and we are having a religious experience.' They give him the drug in a setting where his experience is formulated as a religious one and he believes that is what happened. On the other hand, when one's brain is turned off by a response to toxic drugs one has to substitute something else, something to lean on and to interpret the world with. At that moment of organic anxiety, it is critically important for somebody to come in with supports, with a belief system to replace that which disappeared when the complicated circuits were shorted out.

I will run through a list of other things that I think are relevant to the use of drugs by students, and which we can see have belief systems built around them. One aspect is the disillusionment, the unhappy response of disillusionment with a harsh life and an unkind society that comes one day to all young people. Living anywhere is hard work. Living in a competitive society is hard work and often not much fun. It is very nice to find a way out through the back door or any other door we can find. A new system of values which promises a way out will be attractive. Some of the drug culture mechanisms allow one a private way out while maintaining a public facade of accommodation, for it does not go all the way out, just part of the way out.

Another function of the drug we see expressed is a creative and esthetic one. Drug use is equated with beauty and sensitivity. Some quite competent artists feel a debt to LSD or pot for freeing them or for helping them to be creative. These are the reports of their personal experiences. When competent artists say that, we must respect their beliefs even though we suspect they owe more credit to themselves and less to the drug.

Another aspect of drug use has to do with our much-vaunted rationality. I think students are tired of rationality and things associated with it -- foresight, control, discipline, the Protestant ethic bit, grace gained only in later life -- for they are hard to live with. To be irrational, to be allowed to have an ecstatic experience, even a mushy one, that is not so bad if one must live with the rational computer night and day, as these kids are beginning to have to do.

I might add that this is happening to some students while they watch their own parents, older friends, their teachers and deans, and say, 'Is that going to be me? Help, I want out!' You may call that irrational until one day you also have had it and when that day comes you also look for the door that leads out.

Another set of notions I suspect may be associated with student drug use are those delightful feelings of invulnerability, the beautiful young belief that 'Nothing can hurt me.' Some have ways of proving it. 'I climb mountains because I will not be killed mountain climbing, or I will drive ninety miles an hour because my car has a special charm.' Drug use represents for some what a psychiatrist would call a counter-phobic response. For others, the invulnerable feeling results only because they had had a good life, well protected and pretty sweet, and they just never got the idea that something bad might happen.

Another drug-relevant element that I think is part of the 'I am a beautiful child' syndrome is the notion that 'I am basically a fabulous person, and if I don't feel that way at the moment I can become that way by just seeing further into my real self -- the pure one uncontaminated by the adult cesspool world.' That hope of being beautiful or complex is certainly understandable. It is a poetic desire, although others might call it vanity.

Another drug-relevant element which I think is part of the value-system, although I do not know how many people subscribe to it, is part of a new morality. The new morality prizes private experience, inner sensation. It values freedom, art, nonrestraint, pacificism, protection of life, and nonaggressiveness. The new morality is associated with anarchistic beliefs, expressed optimism, a feeling of separateness from the adult world, and not too much respect for the sacred cows of middle-aged folk. Of course, there can be irony in the new morality, as in the old. It values life and it values others, but an emphasis on inner experience can put the person in the position of not really being able to act in a way that can be of any help to another. The irony can be a feeling of private love unassociated with the capacity to love or to engage in a genuine community life.

Ironically too, one value that is rarely set forth is that of fun. A lot of people take a drug because it is fun, yet it is a curious fact that so few can admit to it. People employ ideologies to excuse their simple pleasures or to justify pain, when that occurs.

In the new morality may also be found the 'cool rebellion.' To use marijuana or LSD confronts colleges and parents with something that shocks the hell out of them. One cannot ignore the fact that there is shock and rebellion in what is done, but this is a rebellion conducted for the most part behind the privacy of one's own walls. Such rebellion, an undeclared war, if you will -- and I do not mean to exaggerate its importance since we all go through rebellions -- has the delightful capacity of letting one be a rebel without being identified as such, or letting one's most significant act occur in such a way that nobody can clobber the rebel for it.

A final aspect of student drug use is critically important. It can put us in an awkward position, for the university is a place where people are supposed to do new things. The university is an institution for innovation, a place where the old is supposed to be analyzed and challenged and where, when the old is not any good, one learns to throw it out. The university is a land of hope and promise. It

demands experimentation. So it is that a university is a place to do experiments which fail and experiments that succeed. That value is one which the kids have learned and I think we are all glad they have. We cannot forget that out of ten experiments which they conduct -- intellectually, socially, or personally -- we are very lucky if they win on one, because in winning on one presumably all of us have gained a bit and benefited. Nevertheless, they are going to be losers on the other nine.

We hope to let them continue their experimentation and to be able to tell us to go to hell. At the same time we must try to warn them from what we know, if we know it, when a particular experiment might go sour in such a way that they are no longer able to conduct further social or personal experiments. Let us guide our drug programs by these lights.

#

Excerpted from

STUDY OF THE JUVENILE DRUG OFFENDER

*Chester F. Roberts, Jr.
Associate social research analyst
California Youth Authority*

Years of public attention to the field of drug law enforcement have produced a long list of persistent assumptions which have never been adequately proved.

It is commonly believed, for example, that the use of marijuana and/or dangerous drugs inevitably or often leads to opiate addiction. This is an unproved assumption. Here are some others:

Drug use leads the user to a life of crime and delinquency.

Once a person starts using drugs he usually becomes 'hooked' for life.

Drug use is primarily found in association with social and economic deprivation and among minority groups.

For some time it has seemed to observers of the drug scene that such statements, frequently found in pamphlets for the general public as well as in technical papers, are over-exaggerated and oversimplified. If such generalizations are actually invalid while being accepted as operational assumptions, the adequacy of control or treatment measures based upon them is open to question.

It would seem desirable, then, to examine some of these propositions in greater depth. Given a group of teenagers who have experimented with the less addicting substances, how many actually go on to heroin use and how many do not? What is the relationship between drug use and other forms of delinquency among the group? Could we, by contrasting those who progress to heroin use with those who do not, come up with a typical progression in the addictive pattern, and could we identify the decision points that influenced the paths the individuals took?

The Study

The Juvenile Drug Offender Project was initiated by the Institute for the Study of Crime and Delinquency in cooperation with the California Youth Authority specifically to provide answers to such questions. Names and addresses were obtained of all juveniles under 18 arrested in 1960 and 1961 by the Los Angeles Police Department for first-time marijuana or dangerous drug violations. There were 866 all told; 428 were first arrested in 1960, 438 in 1961. 'Rap sheets' for each person were obtained from the California Bureau of Criminal Identification and Investigation, so that any prior or subsequent arrests could be determined, including charges and disposition. Personal characteristics and background information such as sex, age at time of initial drug arrest, ethnic background, and residence census data were also obtained.

The subsequent arrest records were traced through 1965. Thus, each arrestee had a minimum of four years of follow-up, while some had nearly six years.

Subsequent Drug Arrest Histories

If it were true that marijuana and dangerous drug use usually led to opiate addiction, we would expect that a substantial number of the arrestees would be subsequently arrested for opiate use. This expectation was not confirmed by the data. Of the 866 arrestees, 57.9 percent had no subse-

.....

Reprinted from YOUTH AUTHORITY QUARTERLY, Winter 1967.

quent arrest for drug involvement. Thirty percent were subsequently arrested only on marijuana and/or dangerous drug charges (the same type of charge for which they were originally arrested). Only 12.1 percent of the arrestees were subsequently arrested for opiate involvement.

The data also contradicted the notion that once a person is involved with drugs he cannot break the involvement, since more than half the group avoided any subsequent drug charge. (However, it must also be assumed that many of those addicted to narcotics began their involvement with marijuana and non-addictive drugs.)

The study indicated that girls were less likely to be subsequently arrested on a drug charge than were boys; persons from a Mexican-American background showed a greater tendency to re-arrest, especially on opiate charges.

Drug Arrests and Residence

The 1960 arrestees were identified in terms of their area of residence. Of the 415 persons for whom residence data were obtained, 118 (27.6 percent) were dwelling in areas classified as 'standard-and-above' socio-economic level, while 297 (72.4 percent) were found living in areas classified as 'less-than-standard.' The re-arrest data indicated that those from the less-than-standard areas were less likely to be subsequently arrested on any drug charges and less likely to be arrested on opiate charges, than were those from the better neighborhoods. Thus, the general notion of a necessary association between drug use and deprived socio-economic conditions would seem to be in need of qualification and revision.

Drug Offenses and Delinquency

The relationship between drug involvement and other forms of delinquency was examined both in terms of (1) arrests prior to the initial drug arrest, and (2) non-drug arrests subsequent to the initial drug arrest.

One of the major suppositions in outlawing certain drugs has been that the drug user must resort to burglary and theft to obtain the money necessary to his habit. Other studies have emphasized association between drug use and crime in impoverished and deprived areas. A more general notion holds that drug users are simply more prone to criminal activity due to their lack of self-control and moral restraint.

More than half the cohort (58.2 percent) had never been arrested prior to their initial drug arrest. Of the remainder, 164 (18.9 percent) had records showing three or more prior arrests. For this latter group it would appear that drug use was only incidental to earlier and continuing delinquent careers.

Analysis of the subsequent arrest records of the group indicated that 154 (17.8 percent) were never subsequently arrested on either a drug or non-drug charge. Apparently for this group the initial drug involvement did not lead to any subsequent known delinquency. The largest proportion, 347 members (40.1 percent), were subsequently arrested only on non-drug charges and no known continuance of an involvement with drugs is recorded for them. For this group, although it might be argued that earlier drug use is associated with their beginning delinquency, there is no evidence that drug use is basic to their continuing delinquent careers.

For 42 of the cohort members (4.8 percent), only drug arrests are subsequently recorded. Thus, only for the remaining 323 cohort members (37.3 percent) is a continuing association of drug use and other delinquency found. Of these, however, 176 (20.3 percent) had records of prior delinquency arrests. Thus the beginning of their delinquent careers can hardly be directly attributed to their drug involvement. This leaves only 147 of the total of 866 (17.0 percent) for whom causal relationship between drug involvement and non-drug delinquency might reasonably be supported. Even among this latter group such relationship is not positively supported by the data. It would seem

that rather than stating that drug involvement leads to delinquency, the more valid statement should read that delinquents frequently become involved with drugs during the course of their careers.

An interesting finding of the study suggests why association between drug use and criminality gained credence. Those youths who combined drugs with non-drug delinquency were arrested more often and for more serious offenses than were drug-free delinquents. One explanation is not that the use of drugs leads to a greater degree of delinquency, but rather that the use of drugs by delinquents makes them more prone to apprehension by the police. Thus, there might appear to be a closer association between drugs and delinquency than the broader outlook supports.

The somewhat surprising relationship between residence in a 'standard-and-above' neighborhood and a greater tendency to be subsequently arrested for drug opiate violations, was noted earlier. One explanation might be that persons from poor areas tend to be arrested more for non-drug offenses. This hypothesis was not supported by the analysis. Rather, persons from the better neighborhoods were re-arrested for non-drug offenses just as frequently as were persons from the poor areas.

Other findings from the study showed that persons initially arrested on a marijuana charge were more prone to a subsequent drug charge than were those initially arrested on a drug violation.

Conclusions

As noted earlier, the primary purpose of the Juvenile Drug Offender Project was to test certain commonly held notions concerning the social and individual consequences of drug involvement. In reconsidering those propositions for which the data were relevant, it was found that they were either inadequate, oversimplified, or exaggerated. The data presented in the study, then, provide evidence casting doubt on a number of generalizations widely held by lawmakers, police, judicial authorities and general public concerning drugs and their effects.

On the positive side, the findings of the report point up the widespread lack of reliable knowledge concerning drug abuse and drug abusers needed for development of meaningful control and rehabilitation programs. Many of the common beliefs which data in this report tend to contradict, started simply because there were no more reliable alternative explanations available. To cite an example: the idea that marijuana use inevitably, usually, or often leads to eventual opiate involvement. Over the years investigation of the background of persons arrested for opiate use disclosed earlier use of marijuana. Investigators could accurately make the statement, then, that 'nearly every opiate user started his drug career with the use of marijuana.' Even though this is true it does not follow that the use of marijuana must lead to eventual opiate use. This interpretation of a time-sequence association as constituting a causal relationship is unacceptable on both logical and scientific grounds. Similar types of reasoning would seem to be at the base of the other propositions cited at the outset of this article.

What is called for by the report is more reliable information concerning drugs and their effects, the long-term consequences of drug use on various types of individuals, and the consequences of decisions made in relation to drug abuse by the police, the courts, and correctional agencies.

#

Excerpted from

EXPLAINING GLUE SNIFFING AND RELATED JUVENILE DELINQUENCY

Robert C. Hanson, Ph.D.
Institute of Behavioral Science, University of Colorado
Boulder, Colorado

This paper will discuss characteristics and motivations of glue sniffers, based primarily on an exploratory study of 36 Denver glue sniffers and of a contrasting group of 64 non-sniffing, non-delinquent peers.

The 36 male, Spanish-American glue sniffers were participants in the Denver Juvenile Court Project. The contrasting group of 64 non-sniffing peers were members of an eighth grade gym class at a junior high school in a middle class neighborhood.

Known Characteristics of Glue Sniffers

Gordon Barker and Thomas Adams (in 'Glue Sniffers,' Sociology and Social Research) compared a group of glue sniffers with a random sample of non-sniffing delinquents at the Lookout Mountain School for Boys. They concluded:

Extremes in certain categories appear to characterize the glue sniffer in viewing him individually and as a group as indicated in the following: Glue sniffing is most likely to occur among ethnic minority young males who are very poor achievers in their academic settings. These boys come from broken homes residing in high delinquency areas with an average of seven to eight other siblings. The residence of the families is urban. The control of the parent over the child is limited and the dependence upon other delinquency-prone youngsters is common.

This study indicated that glue sniffers are not essentially different from other juvenile delinquents. Rather, the factors that produce juvenile delinquency in general also operate to produce glue sniffing as one more form of delinquent activity. Contemporary theories of deviant behavior can thus be expected to provide a range of factors which are pertinent to the explanation of juvenile glue sniffing behavior and related delinquency.

An Orientation to the Glue Sniffing Problem

Like most other types of delinquent behavior, glue sniffing is learned from peers. The attitudes and behavior patterns of the glue sniffing group differ from attitudes and behavior defined as proper by the larger society. This implies that at least some of the normative standards of the larger society have not been communicated to, or accepted by, these youngsters.'

How has this breakdown in the transmission of legitimate norms and the failure of the social control system occurred? Contemporary theories of deviant behavior provide a variety of answers to this question.

Consequences of Family Disorganization

It is a well-established fact that the families of glue sniffing youngsters are disorganized from the point of view of the larger society. In Denver, almost all of the families with glue sniffing members are multi-problem families in some kind of dependency relation with the social agencies of the community.

The majority of families with glue-sniffers are characterized by a lack of normal husband-father involvement. Many of the families directly expose the children to deviant attitudes and behavior, such as excessive drinking, sexual promiscuity, and older sibling truancy and delinquency.

A consequence of such disorganized family conditions is that the children fail to acquire the attitudes and norms defined as proper and legitimate by the larger society. Another probable consequence of such conditions is that personality inadequacies are produced in many children. Lack of normal recognition

and affection from both a father and mother may produce low self-esteem, low ego strength, a sense of frustration and lack of well being in the home environment. Such a situation primes the child to depend on the status and affection he receives from neighborhood companions.

Failure in the School System

In our society the second most important socializing institution is the school. The attitudes and standards of behavior expected in the larger society (i.e., middle class, Anglo society) are propounded by teachers and the texts the children study.

But the school system has evidently failed to socialize and control the children who become glue sniffers. Glue sniffers typically display a record of failure, high rates of absence and truancy, low grades, and discipline problem histories. They experience neither recognition nor affection in the school system, but rather, again, a sense of frustration and failure.

Failure in the school system is to be expected frequently when the child comes from a different cultural tradition and usually first has learned Spanish rather than English. Furthermore, the values and attitudes he is exposed to in a lower class neighborhood are likely to be different from those of school authorities and school books. In general, he is poorly prepared to adapt to the competition and ambitions expected of middle class children.

Differential Association and Escape Behavior

All normal adolescents seek recognition and affection from their peers. The close friends of an adolescent exert a tremendous influence on his attitude and behavior quite apart from what he has learned at home and at school. The adolescent who is failing at school and finding little affection in the home is even more dependent on a group of peers for some kind of recognition and affection. In order to gain status as a member of a neighborhood group, he will have to conform to the attitudes and behavior patterns of the group as a whole. If glue sniffing is part of the behavior pattern of the group into which he desires entrance, and he starts associating with group members, then he will be exposed to glue sniffing and other delinquent behavior patterns of the group. It is highly probable that the neophyte will soon engage in glue sniffing activity; otherwise, members will withhold the recognition and affection which pulled him into associating with them in the first place.

This kind of formulation follows from the theory of differential association which holds that delinquent behavior is learned in a context of intense personal association with others already delinquent. The theory has been criticized for failing to explain why some individuals in the same family or neighborhood don't become delinquent when essentially the same conditions are provided for all.

For glue sniffing, the question is: why do some kids become glue sniffers when others in the same family or neighborhood do not? Although several hypotheses can be advanced in the attempt to answer this question, I will discuss only the one which seems most plausible to me in the light of our Denver experience. This hypothesis might be called an ecological or 'availability' hypothesis. Once glue sniffing has been introduced into the neighborhood, most likely by a glue sniffer whose family has moved to the neighborhood, differential association theory applies. The sniffers are such as we have described: they come from disorganized homes, are failures at school, have little adult supervision of behavior, and lack firm legitimate standards of behavior. The potential glue sniffer is in similar circumstances. By virtue of normal interaction with kids in the neighborhood, the potential glue sniffer will hear about or observe glue sniffing, perhaps when he and the sniffers are both truant from school. The opportunity to learn the behavior is thus available. The potential sniffer is seeking companionship with peers in the neighborhood. The only restriction to his learning to sniff glue then, it seems to me, is whether the sniffers feel inclined to pursue further association with the non-sniffer. If they do, and he also desires to continue association with them, he will eventually begin to sniff glue when they do.

The Labelling Process

Once the association with glue sniffers is firmly established and his glue sniffing has begun, the beginning sniffer will find himself labelled a glue sniffer by his associates, his family and by school and legal authorities. Then his glue sniffing becomes an expected attribute of one of his social roles: his companions expect it; family members, teachers, and police authorities expect it as part of the social role they assign to glue sniffing delinquents. We can then anticipate that glue sniffing behavior will be maintained until the group changes its attitude and behavior patterns or, if the group breaks up, until some other more powerful expectation or more desirable alternative replaces the glue sniffing behavior pattern for the aging adolescent sniffer.

In summary, it is obvious that if society is to prevent glue sniffing from occurring, conditions in the family, school, and neighborhood must change for the many adolescents who are the potential glue sniffers at the present time.

#

Excerpted from

**ABSTRACT OF DENVER JUVENILE COURT
GLUE SNIFFING PROJECT
(July 1965-67)**

Problem

The inhalation of airplane cement fumes for the purpose of intoxication occurs among adolescent boys and girls throughout urban areas and at all class levels in American society. Alarming numbers of intoxicated youth came to the attention of the courts, schools, and other civic agencies in the late 1950s. It has since been determined that many cases were habituated users of glue. In Denver, about nine out of ten cases were boys who lived in slum-like, deteriorating neighborhoods. Over ninety per cent of known users were Spanish-American boys, usually from large, multi-problem families. The boys were frequently truant from school, had failed one or more years, and were likely to fail again.

Theory

Chronic intoxication through the habitual use of glue is a possible adolescent response to continual frustration produced by family disorganization and school failure. Normal socialization processes which typically produce conformity to the norms of the larger society are disrupted for children from unstable homes with language and values different from those of Anglo middle class society. A potential glue sniffer, hampered in his psychological and social development by repeated frustration at home and school, and exposed to deviant patterns of behavior in both home and neighborhood, is likely to depend on neighborhood peer group relations in his search for recognition and affection. If a neighborhood peer group engages in glue sniffing then the adolescent who joins the group will be exposed to glue sniffing behavior. Should he wish to remain in the group, social control pressure from higher status members will require him to learn the glue sniffing activity. He will then be labeled a glue sniffer by society, which leads to the expectation that he will continue to sniff glue until the group breaks up or until it changes its pattern of activities.

Alternative Rehabilitative Approaches

The theory just presented suggests an obvious rehabilitation prescription: restructure the social relationships and the socialization experiences of the glue sniffer in the home, at school, and among neighborhood peers. The objectives of such restructuring should be to help the glue sniffer develop a more favorable self-concept and a pattern of coping behavior to deal with current frustrations without resorting to glue sniffing as an escape, and to change his attitudes and actions from his current acceptance of and engagement in delinquent behavior, preferably by changing the structure and activity patterns of his neighborhood friendship group.

In contrast to a control group of glue sniffers who were assigned to court probation counselors in the traditional manner, three experimental groups of glue sniffers were set up to test the relative effectiveness of alternative rehabilitation approaches.

Group I consisted of a natural friendship group in a deteriorating Spanish-American neighborhood. All eleven members of the original group were known to the Court as delinquents and heavy glue sniffers. A regular court probation counselor was assigned to work in the neighborhood in an attempt to change the attitudes and behavior of the group as a whole. In addition, members of this group were assigned a special teacher in their junior high school from whom they received instruction and individual counseling as a regular class three hours each day. Both court and teacher counselors were guided in the group approach by an experienced group techniques consultant. Both counselors established relations with and received cooperation from the parents.

Group II was originally composed of a natural group of seven neighborhood friends from a different run-down Spanish-American neighborhood. With one exception, these boys were not known to the

Court, and, while glue sniffing was obviously occurring in the neighborhood, original members were reluctant to admit that they used glue habitually. The group was counseled by a young Spanish-American college graduate. Over time, he established good relationships with the parents of the boys. He also received guidance in the group approach from the Project's group techniques consultant. As in Group I, the primary objective was to effect changes in delinquent attitudes and behavior by changing relationships and experiences of the group as a whole. This 'local leader group' did not have the advantage of special help in the school system.

The primary effort in a third experimental group was devoted to intensive therapeutic work with thirteen known delinquent glue sniffers and their parents. The counselor was a young college graduate with a social science background. He was guided in his therapeutic efforts by an experienced case-work consultant. In this approach, nothing could be done to affect the attitudes and behavior of the glue sniffer's neighborhood friends. Help with school problems was given on an individual basis.

Finally, in the Control Group, only the brief face-to-face interviews with a Court probation counselor could count as attempts to effectively manipulate the socialization experience of known glue sniffers.

Results

A series of behavioral, attitudinal, and psychological tests were administered to the original members of all four groups. Approximately one year later, the same tests were administered to the current members of all groups. Court and school data provided additional objective measures of behavioral changes. Since group membership changed over time due to residence changes, increases due to new glue sniffers in the neighborhood, absences during the period the tests were given, and so on, complete data on each original case was impossible to obtain. The results therefore were restricted to those cases in each group for which test results were available at both measurement periods. For each test, change in a 'favorable' direction was defined. For each group the average amount of favorable or unfavorable change was computed.

A Change Trend Summary table shows that the School Dynamic Group changed in a favorable direction on 34 of 42 measures and the Local Leader Group changed in a favorable direction on 28 measures. These results contrast with the 16 favorable changes in the Individual Therapy Group and 10 favorable changes in the Control Group. In the latter two groups, the tests indicate increasing delinquency proneness despite a year of intensive therapy or traditional probation counseling.

The trend results provide strong evidence for the conclusion that the group approach is superior to the individual case approach in attempts to rehabilitate glue sniffers. The dramatic superiority of the School Dynamic Group in objective measures of favorable change in behavior indicates the effectiveness of continuous help and support in the school system.

Recommendations and Conclusions

First, a group techniques professional should be employed to train and guide probation counselors assigned to employ the group approach in neighborhoods with chronic problem glue sniffers.

Second, some counselors should move into community centers or other facilities in neighborhoods known to contain large numbers of glue sniffing boys. It is difficult, but possible, to organize known glue sniffers into a solid supportive group and to change group standards and patterns of activity.

Third, special educational experiences should be provided for glue sniffers and other under-achieving children who reflect anti-social symptoms. A special teacher should be assigned to conduct class on a group approach basis, providing both instruction and counseling, and to work in conjunction with the group techniques professional.

Fourth, when functioning groups begin to emerge in neighborhoods and in the school, meetings with parents and other family members should be held. The objective of such meetings would be to gain

family member support for the goals of the group approach, including more productive social and school performance and the development of healthy self-concepts. When family members become aware of the improved performance of the teenager, perhaps there will be an improvement in relations between him, a (former) glue-sniffer, and his parents and siblings.

Fifth, a boy who has changed his behavior to a socially acceptable and personally healthy pattern should be released from probation but allowed to remain in the group, should he desire, as a model for others and for his own further support and self-growth through participation in the group. Perhaps two years of involvement in this process will be necessary for the average habituated glue sniffer to stabilize the gains he has achieved.

Sixth, a similar group approach program can be developed for glue sniffing girls. Joint boy-girl programming should be developed to provide constructive learning experiences in heterosexual relations.

#

SCHOOL PROGRAMS

RECENT RESEARCH ON LSD, MARIJUANA,
AND OTHER DANGEROUS DRUGS

Part Two—Prevention

*Stanley F. Yolles M.D., Director,
National Institute of Mental Health, PHS*

Prevention and Education

Prevention and education efforts aimed at the student population demand careful preparation and implementation. Even high school students are extremely sophisticated about drugs. We are constantly impressed at speaking appearances before high school and college audiences about:

1. The extent of accurate knowledge mixed with misinformation about all drugs, not just LSD and marijuana, but barbiturates, amphetamines, etc.; and
2. The suspicion with which students approach information supplied by 'official sources.'

Scare techniques are not only ineffectual but even detrimental to conveying needed information about hazards of drug abuse. With the present incidence of marijuana use, many students have either experienced or observed first-hand the effects of this drug. They know that psychoses or other grave consequences are not an inevitable concomitant of smoking one marijuana cigarette.

To be effective, a preventive educational effort must be carefully tailored to specific population groups and must be based on the best educational and scientific footing available.

The NIMH is now developing a variety of materials as part of its education efforts. Films for television as well as small groups, film strips, pamphlets, etc., are being prepared. We have consulted with leading experts in the communications industry as well as educators so that our materials will be instructive, effective, and scientifically sound.

Alienation

In trying to understand scientifically the problem of drug abuse, one must look beyond the specific problems of such agents as LSD, marijuana, amphetamines and barbiturates to some of the underlying causes of widespread drug use and abuse. We live in a drug-oriented culture. From aspirin to sleeping pills, from tranquilizers to 'the pill,' Americans of all ages are ingesting drugs in greater variety and number than ever before. If we are to get to the root of this problem of drug abuse, we must investigate and identify the underlying problems which lead people to choose to distort or ward off reality with drugs.

One way of conceptualizing the problem is to view drug abuse in the student population in the broader context of the nature and extent of 'casualties' of the educational system. Through our interest in school and college mental health, suicide prevention, and alcoholism, we have become increasingly aware that a fair percentage of our brightest and most competent youth are not 'succeeding' in their encounter with the higher educational system.

Behavioral scientists use the term 'alienation' in describing the cross-generational disease epitomized by the youth-coined term 'don't trust anyone over 30.' Alienation has been characterized as: 'rebellion without a cause . . . rejection without a program . . . a refusal of what is without a vision of what should be.'

Excerpted from Testimony Before the Subcommittee on Juvenile Delinquency of the Committee on the Judiciary, U. S. Senate, March 1968.

Lapses in communication between generations were noted by Greek philosophers over 2,000 years ago, and more recently were manifested in American society by the so-called 'lost generation' of the 1920's and the 'silent generation' of the 1950's. However, the current problem of alienation in the United States is wider, deeper, and more diffuse than at any previous time in our history. It affects the rich and the poor, the college student and the school drop-out, the urban and the rural youngster. The number of persons, both young and old, beset by alienation is far greater than ever seen in any previous generation.

Because many alienated youngsters question the relevance of major societal values and institutions, they find themselves unable to learn from the various opportunities that presently are available to them. As Freedman and Brotman point out . . . 'To ask one of the youngsters, as one of the authors did, 'Where's the action?' elicits a scornful answer: 'There's only action if you have a high.' The implication is clear; what is meaningful is the subjective state. If an undrugged state is defective, myopic, why not alter perception through drugs and create a new 'reality?' Some youngsters who feel helpless to accommodate to or change an unacceptable world, consciously choose to alter their own . . . Their most frequent statement is that life is a 'drag.' It lacks meaning for there is no engagement; the future is unknown but certainly horrible. Since you cannot alter the world or determine the direction in which it will go, you must alter your state of consciousness and perception, that is, see and experience the world through a 'high.' Any alteration is acceptable, and thus, the barbiturate user can describe to you the joys of a 'drowsy high' and the amphetamine user will talk about the 'high' he gets on benzedrine--and likewise for the LSD, marijuana, and heroin abuser. All that is important is in one's subjective state. Perceptions and beliefs of the square world or the non-drug world are superficial, distorted, meaningless . . . This rejection of many goals of society, the unwillingness to model themselves on any stable adult leaders and the inability to acquire the necessary attitudes and skills for responsible adult behavior, make urgent the development of new and innovative approaches to bridge the intergenerational gap.

If this is not done, there are serious dangers that large proportions of current and future generations will reach adulthood embittered towards the larger society, unequipped to take on parental, vocational and other citizen roles, and involved in some form of socially deviant behavior. If we are to solve the problem of drug abuse, it is critical for us to focus on and try to solve the root causes of alienation.

#

Excerpted from

THE DRUG DILEMMA: A PARTIAL SOLUTION

Sidney Cohen M.D., Ph.D.
 Director, Division of Narcotic Addiction and Drug Abuse
 National Institute of Mental Health

The Parents

One of the great myths of the day is that if a child goes wrong, becomes a drughead, for example, this must be due to parental failure. If the cause is not deprivation or neglect, it must be overprotection or possessiveness. At times it appears that the line between insufficient mothering and maternal smothering is nonexistent. This peculiar notion stems from the strong lay and professional indoctrination with the Freudian tenet that what happens in infancy determines subsequent behavior.

Unquestionably, substantial numbers of children are maltreated, abused, overcontrolled, or spoiled. This does not mean that they are completely incapable of overcoming these childhood handicaps. The individual has some responsibility in such matters. In addition, a large group of quite well-brought-up, characterologically sound children are 'turned on' to drugs by their associates. It is difficult to discern how a parent can be blamed for these events.

Somewhere between 'I don't care' and overprotection is the parental attitude which best permits the child to develop and grow up. He grows by solving problems, by learning from failure and defeat as well as from success and reward. This opportunity to become resilient by encountering and coping should not be denied any growing creature. When help is needed, the parent-child relationship ought to be so open and trusting that it is used for assistance, information, and advice. This is just as true for the issue of drug taking as for every other problem. Naturally, it would be best if drug usage could be discussed before the event, but the youngster should feel capable of talking about it afterward without fear of excessive emotionality or rejection. An open attitude need not mean acceptance of an act which the parent considers harmful. Approval is withheld, but condemnation should not be on an irrational basis. Sufficient data are at hand to point out quietly the personal, legal, and social hazards. Most often a single experience with drugs represents nothing more than the exploratory behavior of youth. If drug taking becomes habitual, it usually represents either a gratification which the young person should have been able to derive from daily living or an evasion of life experience due to inability or unwillingness to meet life's day-to-day rebuffs.

Those most attracted to drugs are those who are bored, cannot enjoy, or cannot tolerate stress and frustration. The drug fits their emotional discontent and removes the necessity to plan, to struggle, to endure.

The parent who drinks to excess will have an impossible task in persuading his son or daughter to desist from drug usage. It is true that his act is legal and his child's is not. Nevertheless, the legality of alcoholic intoxication is not a strong argument to a child -- or anyone else. Harsh and punitive attitudes make some children compliant, but many others rebel and become more involved in drugs as an act of defiance. Making obviously untrue statements about drugs is worse than useless. The child will tune out those who are patently trying to frighten him into desisting.

A difficult situation occurs when the young person is part of a group of drug users. Its members reinforce each other's drug taking. They become 'authorities' and can outtalk parents. They may go on for some time before anything untoward happens. In such an instance a parent can hardly expect his child to abstain unless their relationship has been an unusually good one. What is more likely

.....

Excerpted from 'The Drug Dilemma' by Sidney Cohen, M.D., McGraw-Hill Book Company 1969
 Used with permission of McGraw-Hill Book Company.

is that a critical moment will arise when the parent can step in and effectively help his child to stop using drugs. This moment occurs when someone in the group is hurt, arrested, or decides to break away from the drug scene for philosophic or personal reasons.

The parent has a final responsibility which he cannot delegate to the school, the court, or the psychotherapist. However, he may have such feelings of guilt (sometimes unjustified) when his child becomes a 'head' that he continues to support his offspring's deviant way of life. The parent is not necessarily guilty for a youngster's character deficit. Other people and circumstances have had powerful impacts on his character formation, too. It does not seem logical to underwrite an undesirable drug habit. Rather, the attitude should be, 'I love you and I will help you, but I won't support you if you persist in behavior which I believe to be detrimental to you.'

Should a parent ever report a child's illegal behavior to the police or commit him for mental hospitalization? This question can only be answered on a highly individual basis. If the youngster is involved with physically addictive drugs and will not voluntarily seek help, it may become necessary to take over the decision-making responsibility. If one's offspring has become a 'pusher,' it may be justifiable to notify the authorities. Certainly, if he has broken with reality and has no insight into his condition, commitment to a hospital may be the only proper step. Much depends upon his age; if he is a minor, the parental responsibility is greater.

Most of the arguments which youngsters use to justify their bedrugged episodes are specious. Others are partially true, and a few are valid. The most convincing statement that can be made is your way of living. Striving for security, so important in times of hardship and poverty, is an inadequate goal during periods of relative affluence. Those of our middle-class children who do not need to struggle to obtain food and shelter find such an outmoded aspiration unacceptable. It is a feeling of existential meaninglessness which attracts some people to the drug state. The acquisition of a sense of meaningfulness is the antidote.

Sometimes a young 'dropout' wants to drop back in after a year or two of the hippie game. The family relationship ought not to be so embittered that he cannot ask for help to find his way back. A line of communication should be available to him.

The School

It seems reasonable to insist that usage or trafficking of any illegal drug not be permitted on school grounds. Furthermore, psychological dependence upon mind-altering psychedelics, stimulants, sedatives, and intoxicants is contrary to the goals of the educative process, whether excessive use be on or off campus. If a place of learning is where one's intelligence, capabilities, and skills are developed and enhanced, then habitual displacement of consciousness, reality testing, and reasoning ability is antithetical to its goals. The frequent use of any drug can result in impaired performance. Indeed, a single use of some classes of drugs is associated with a temporary decrement in psychomotor functioning. Of all drug users, only those who indulge in the psychedelics claim consciousness expansion. From the observations of many who have studied this issue and from the reports of many who have gone the psychedelic route for years, chemical consciousness expansion is, in the main, a myth. The so-called revelations and enlightenments are all too often illusory.

If the educator is to learn anything from the current striving for drug-induced perceptual, emotional, and cognitive changes, it is that important areas of human experience have been neglected by our child-rearing and child-teaching practices. Many of those attracted to the drug experience suffer from *anhedonia*, the inability to derive pleasure from ordinary existence, and *alienation*, the inability to find a meaning within or outside oneself. These are serious deficits, and in a young person they lead to serious disorders of behavior or character. From childhood through adolescence we are failing (1) to provide goals appropriate to our times, (2) to train the emotions and the senses, and (3) to set limits. Therefore, goallessness, an inability to enjoy, and an attenuated sense of social responsibility predispose to chemical escape, chemical hedonism, and the search for chemical enlightenment.

The teacher, in addition to making the educative process as interesting, constructive, and alive as possible, can also have a great influence on the decision to take or continue to take drugs. He is often the confidant when parents are lacking or have failed to accept their role. The teacher may be the first to learn of, or notice, aberrant behavior due to drugs. He may be able to persuade his pupil by presenting factual information.

In schools where the administration believes that no drug activity is present, there may be reluctance to rock the boat by opening up the subject. The likelihood, though, is that more drug activity is going on than comes to the awareness of the authorities. The teacher, as a more neutral person than the parent, can counsel or refer the student to a counselor. A school counselor may form a group of students involved in drugs. One or more students who have passed through their drug honeymoon and have come back are very helpful in such situations.

One element that must be emphasized in all discussions about drugs is that their use is stupid, not smart or 'in.' The regular user even of nonaddictive drugs is in a state of maturation arrest. The drug solves his problem; he does not learn to solve problems and endure dissonance in his environment. Many drugs leave the student goofy, unable to function. This is hardly a groovy way to exist. Those drugs which are supposed to expand one's consciousness all too often fail to do so, especially if one is young and unprepared.

The growing brain is more vulnerable to all chemical agents, and temporary, perhaps even sustained harm can result. Permanent harm to the brain cells after exposure to large amounts of psychedelics is a possibility that is now undergoing intense study.

It is in peer groups that drug taking spreads. The teacher may become aware that one or a few individuals are proselytizing. An epidemic may be prevented by quick action in such instances. School authorities should make the school area a difficult place to obtain or use drugs. It is too much to expect that school authorities can be responsible for activities off the campus.

The question of confidentiality rarely comes up, but it may. If a student approaches a teacher as a friend to discuss his drug problem, he must be warned about the teacher's duties in the matter. It is to be hoped that it will be possible to listen without disclosing, but school regulations may prevent this. Under such circumstances the student must be clearly told beforehand. A certified school psychologist or psychiatrist has the advantage of being able to keep patients' statements as privileged communications. Referral to such a person will safeguard the student.

A repertoire of disciplinary measures with some built-in flexibility is preferable to rigid, mandatory punishments. The campus supplier of LSD and Methedrine is not in the same category as the youngster who has been persuaded to try a 'reefer' and whose negligence has resulted in his detection. Strangely enough, the penalties for both offenses are equal -- they are felonies. Unfortunately, school authorities may have no choice in the matter. They are often required to report every breach of discipline. It may be well to make students aware that a felony involves lifelong consequences beyond incarceration. This should not be done as a threat, but rather as part of setting forth the realistic here-and-now risks connected with the misuse of certain drugs.

The Therapist

All too often the psychotherapist is faced with a young patient who does not want to be treated, but who has been forced into the office by anxious parents. Little can be done if the patient is not motivated to change. All too often he is at a phase of his drug taking cycle when he is deriving satisfaction, euphoria and release of tension from the chemical he is using. He is feeling no pain; what more can therapeutic intervention offer? If it happens to be one of the psychedelics, he has a feeling of subjective wisdom far beyond that of the therapist. He has a pseudo-philosophic jargon which can put many a therapist down. If, somehow, the patient cannot be motivated to examine himself and his reasons for overusing drugs, little can be accomplished. The patient is unlikely to remain in treatment, and it is the parents who should be counselled about their attitudes at this point.

Sooner or later, after a few bad trips, a psychotic break or disillusion with the drug way of life, the patient will want out. Perhaps it is merely that he sees the circular, pointless nature of his existence. At this moment the skilled therapist who knows something about the nature of the psychedelic experience can perform a valuable service. It is not a matter of starting anew; the drug experience of the past months or years must be carefully examined to learn as much as possible from it. Thus a bridge is built that leads the patient back into an enjoyment of this world and a living of this life in the best possible manner. These are the most difficult of patients for they were engulfed in the psychedelic life because of their unfulfilled needs. They have tasted great gratifications in their responsibility-free, hedonistic existence. Now the therapist must help them become more responsible, find more significant goals and begin the long hard process of psychological maturation. The immaturity which caused them to seek the magic pill must be modified. These are valuable people, often very bright, and with many contributions that they can make. After a period of individual therapy a psychotherapeutic group may be at a place where they can find the values of the human interaction.

The Legislator

The control of the drugs mentioned in this book is necessary, especially for the juvenile. Passing laws can have a beneficial or a harmful effect depending upon the wisdom of the legislation. With the current upsurge of drug misuse especially in those of school age, it would seem reasonable to apprehend the supplier of these minors rather than to focus on catching the juvenile user or possessor. The maker, the smuggler, the pusher and the transporter must be found and punished. The penalties for use and possession of a drug like marijuana are excessive. Marijuana, a weak hallucinogen, is punishable with penalties greater than LSD at this time. Consideration ought to be given to proposals to place marijuana on the dangerous drug list rather than under the Narcotics Act as at present.

The mere passage of laws, of course, as a device to eliminate noxious behavior, is an ineffective technique. The hope that a decree will abolish undesirable conduct in a democratic society is just as naive as the expectation that a chemical potion will magically change character. What is needed in addition to sagacious laws, is public education and public cooperation with the laws. Somehow these must also be obtained.

Puncture of a Myth*

A scrutiny of the past suggests that the abuse of novel mind-altering drugs tends to be cyclic, with a rise and a fall which is not clearly perceived except from a distance. The proposition that we have experienced periodic surges and declines in drug taking behavior before is no plea for complacency. An active effort to teach the individual and society how to enjoy and endure without euphorants and escapants is essential. Setting the drug abuse problem into a historical perspective simply avoids the myth that things were never as bad as now. This myth happens to be prevalent among the drug subculture. It betrays a profound and potentially disastrous ignorance of the history of man.

*'Cyclic Psychedelics' by Dr. Cohen, in 'Editor's Notebook,' American Journal of Psychiatry, September 1968.

#

STRUCTURE OF A TELESOPED 3-DAY DRUG ABUSE CONFERENCE

*Sanford Feinglass, Ph.D.
Project Program Coordinator*

One way in which a school or school district can discover the nature of its drug problem and begin to devise methods and assemble information to attack the problem is through a three-program conference.

The conference should include both teachers and students. The smaller the group, the greater the opportunities for individual discovery. About 20 teachers and an equal number of students are probably best. The teachers should be selected on the basis of, first, assigned responsibilities in the drug area; second, demonstrated rapport with students; third, significant administrative or policy-making roles. The student group should be a stratified random sample of the student body. Efforts should be made to include students who are influential in shaping student body opinion. If possible abstainers as well as students whose illicit drug experiences are restricted to alcohol and tobacco should be included. Otherwise, any disaffections with education or with society revealed by students are likely to be blamed solely on the effects of drug use.

Each program should comprise a full day. The most logical day is Saturday. Vacation time or holidays are next best, but less practical and sometimes complicated by examinations immediately following them which may put students under extra pressure.

The site chosen should be neutral and not a school room. The idea is to encourage truthful student participation. All participants must commit themselves to stay through the entire sessions and to attend all of the programs.

Modern teaching methods that endeavor to generate high audience interest can be employed. Further, discussion of these methods can lead to development of rewarding modifications by the participants. Amherst approaches, discovery techniques and teaching machines come to mind most readily.

The first day's program might be concerned with control of drugs. This program would explore not just police arrest statistics but the historic decisions leading to legislation, the basis upon which law enforcement officers operate, and the manner in which such operations are performed. The mandated controls exercised by pharmacy and medical boards, state and federal food and drug agencies, and motor vehicle departments, should not be overlooked. An anthropologist or sociologist can be presented, and not restricted to drugs. His presentation can point out that most daily activity is the result of a balance between the individual's personal desires and the control required by civilization.

In order to maintain credibility and assure maximum effectiveness, each speaker should be restricted to his own special field. Thus, a physician from the state medical board should discuss the activities and position of his agency and not become involved with the behavioral aspects of drug abuse or the social motivations of youth. Even if he happens to be qualified in these other aspects of the topic, he should withhold his remarks until the time scheduled for that topic. Each representative should discuss what his agency hopes to achieve by its actions, the cost of the actions, and how efficient they are in reaching their goals. Key words should be defined and generalities reduced to specifics. For example, if the word felony is used, the group should understand the meaning of the term and of the long-range consequences that may persist beyond the period of incarceration. To give another example, the differences in meaning to a physician, a policeman and a drug user of a term such as drug abuser should be made clear.

The second day's program could be an intensive analysis of the pharmacologic, behavioral, social and medical aspects of drugs. Persons with clinical and research background would participate. A drug-by-drug exploration is appropriate with one qualified person per drug or per natural drug group. Again, specificity should be respected. A speaker with extensive clinical and research experience

with narcotic addicts should defer comments and avoid answering questions about, for example, hallucinogens. To be sure, the narcotics expert is qualified to state that LSD is not an opiate. But to strain expertise and burden speakers by requiring a barbiturate expert to discuss the stimulants diminishes his credibility and effectiveness. This points to the possibility that high-status individuals holding eminent positions may not be qualified for programs such as those under discussion here. Without firsthand experience, an individual can contribute only his qualified interpretation of other people's work and the accuracy of his remarks is difficult to evaluate with certainty.

It is axiomatic that an anesthesiologist has more ability to judge medical testaments than a musician. However, someone who has studied the effects of marijuana under controlled circumstances is usually preferable to both on a drug abuse program. On the other hand, a particular musician may contribute greater insights into the causes and effects of marijuana use than either the anesthesiologist or the marijuana researcher. Practical experience, in other words, must be considered by a conference planner along with abstract knowledge.

In all presentations, distinctions should be carefully maintained between the effects of light, moderate and heavy doses; between one-time, periodic and compulsive use; between the effects of oral, inhaled and injected drugs. The contribution to drug effect of the anticipation of the user and the conditions surrounding the episode of use should also be differentiated.

Discussions of tobacco and alcohol must be included. To omit these drugs from honest discussion is to ensure student hostility. The fact that we live in a heavily drug-dependent culture and an exploration of the nature and extent of that dependence would also be appropriate on this program. Adults have many of the same drug problems as sub-adults: to explore these problems together is to cooperate in seeking solutions.

The final program can take up the role of education in drug abuse. By this time all participants have shared two learning experiences, having received information from the same sources simultaneously. At this meeting a film might be shown. Both teachers and students should have opportunity to express freely their views of its meaning, effect and veracity. The possibilities of initiating a school program on drugs might be considered or a present program, if there is one, evaluated. Its strengths and weaknesses can be studied in terms of such questions as: Is the program relevant? Is it conciliatory or offensive? Does it fulfill student needs or legislated mandate? Another possibility for exploration is the contention of many students that school is a ghetto or prison. What effect has this on drug taking, alienation and disengagement? Can conditions in the school not related to drugs be modified to produce an atmosphere more engaging, exciting and attractive to students?

The joint discussion by faculty and students of the significance of a film or a drug program to the decision-making process can lead to revealing and exciting discoveries. Hopefully, the disclosures of the two preceding programs, if they have been properly selected and judiciously conducted, will provide the basis for reasonable and meaningful dialogue.

Programs such as those visualized here require a good deal of effort to locate effective resource persons. What is wanted is not opinion -- particularly opinion based on hearsay, vested interest, or personal bias -- but justifiable position. Firsthand experiences, research, or educated observation are to be sought by the conference planner. Balance is achieved not by including the extremes, but by analyzing various dimensions of the specific goals.

Where can one begin to look for program participants? One place might be programs in the community which deal with the target population -- for example, a halfway house, community research project, or drug treatment program. Do the local public health services, department of health education and welfare, or college or universities -- especially individuals in the community who have written on topics important to a discussion of drugs? Such disciplines as pharmacology, chemistry, sociology, anthropology, psychology, psychiatry, law, and law enforcement are possibilities.

Those in contact with drug users may have important contributions to make. Among them are operators of cafes and meeting places frequented by students, disc jockeys and other molders of youthful opinion, ministers or youth counselors, employees of drug treatment centers. Many people see the drug problem from many viewpoints. The program planner must decide on the validity of these viewpoints after seeking out at least a majority of the possible views rather than restricting himself to the recommendations of a single discipline. Finally, and most importantly, the program planner must seek the viewpoint of students. They may suggest sources unknown to others, but very relevant to themselves.

#

Excerpted from

DRUG ABUSE EDUCATION

*Program Recommendations of a Team of Kindergarten
through Third Grade Educators in Marin County, California*

Introduction

Education that will prepare a child to avoid drug abuse in a drug-using culture must begin at an early age. It will need to include both process and content in order to counteract potential drives to drug abuse as well as youthful ignorance about drugs and their potential effects.

Intensive teacher education is essential if teachers are to respond to children's questions with certainty and assurance, avoiding the exaggeration, distortion and sensationalism that nullifies effectiveness of educational efforts.

The best deterrent to drug abuse is thought to be an individual's own value system and his assessment of what physical damage might result from drug use. There are a variety of ways to present information and instruction in these areas, and the suggestions herein are not intended to be exhaustive but merely to indicate the scope of the subject and to suggest approaches and a point of view. Teachers will build upon the ideas presented here, applying their own versatility to them.

Teacher Education

Teachers' information concerning dangerous drugs should include the following:

1. Facts - Teachers should be informed on what is fact and what is non-fact in the drug area. For example, they should be aware that:
 - a. The long-range physical and mental effects of marijuana are not fully understood, although widely varying assertions are made offering extreme points of view.
 - b. Use of illegal drugs is reported by law enforcement representatives to be moving from ghettos to increasing incidence in affluent societies.
 - c. Dangerous drug use is the principal reason for 25% of the arrests of children under fifteen: it accounts for 16% of the arrests of those eighteen and older.
2. Courses - Although primary teachers have limited occasions to impart specific drug information to their students, the need seems to be increasing. It is therefore recommended that primary teachers take courses in drug information.
3. Reading - Teachers are encouraged to consult and keep up with the books and other literature published concerning drug abuse. While reliable information about drugs currently used by youth is a little difficult to obtain and evaluate, educators must strive to keep abreast of the constantly changing drug scene.
4. Attitude - Abuse of drugs frequently stems from feelings of inability to communicate, to be an integral part of the world. Real personal honesty, self-awareness and comfort with emotions are essential to effective communication. Becoming more prevalent are workshops which lead toward these communication skills. They are variously called 'encounter groups,' 'awareness groups,' or 'sensitivity training.' Their purpose is a deep, continuous experience with communication. A beginning to the development of communication abilities can be obtained through the book, *Between Parent and Child* by Ginot.

Oftentimes the most important and best-remembered teaching is that which occurs incidentally, perhaps involuntarily. In the area of drugs, teachers need to be prepared to respond correctly and

with naturalness to frequently impromptu questioning.

While specific teaching on the drugs most frequently abused is likely to occur in the primary grades only in response to children's specific questions, the teacher needs a good background in the intelligent and wise approach to drugs. With it he can prepare children to face and absorb the variety of information that will reach them later on.

The approach to teaching about drugs should be in terms of understanding of and respect for substances, not in a scare context. Poison prevention is taught in the primary grades as well as later. Again, without applying scare tactics but by dealing in facts, a teacher might discuss such things as the overdose of a commonly available substance such as aspirin. Actual experiences can be used to explain the functions of substances.

Whenever medications are discussed, proper use and the need for direction from a physician in using them should be explained. In a context of discussing home safety, the teacher might discuss reasons medicines should not be left out and available. Similarly, class discussion can include the need for ventilation when using glue.

Teaching Strategies Relating to Drug Education

Certain personality characteristics have been observed in young people who have abused drugs. These individuals have generally been described as showing or having shown problems in communication, passivity and low frustration tolerance, lag in social development, qualities of emptiness and apathy, to be isolates, poor relationships with peers, and to be exploitive of adults, impoverished in inner resources, and desirous of outside stimulation. Further, it has been noted repeatedly that the recurring cry from children is adult failure to accord them dignity and to be honest with them. Accordingly, optimum teaching strategies should aim to foster development of the whole child through such precepts as the following:

1. Avoid producing guilt, which acts to reduce one's sense of personal worth. Encourage free verbal expression of any emotion.
2. Accept emotion. Emotions are real and compelling. Suggesting alternate ways of handling crisis situations is preferable to suppression or repression of vividly experienced feelings. Discussion of such feelings is advantageous.
3. Know the child. Efforts made to become personally acquainted with the child will be invaluable. Acquaintance with the parents of each child helps in this understanding. It is worth keeping in mind that older children have complained repeatedly and bitterly that they experienced a loss of individuality in their school experience.
4. Encourage choices. The act of making decisions is something in which children could use much more practice than they get; opportunities for affording this are infinite. For example, 'Do you want the blue paper or the red paper?' or 'Do you want to do this problem or that one?', etc. Such activity is important in the development of a feeling of individual worth.
5. Be self-aware. Awareness and acceptance of one's own temperament and style sets a valuable example to children. It is no more desirable for the teacher to be depersonalized than for the child. By being himself, the teacher sets an example -- teaches by percept -- a great lesson in self-acceptance.
6. Know your rights. It is a corollary to #5 to teach by percept that one can demand one's own rights in situations. The child cannot take all the teacher's attention, nor all of the teacher's time, nor does he really want it though he may try to get it. A teacher will help the child by assisting him in finding limits in his demands on the teacher's time as well as by setting limits on behavior.

7. Imaginary adventures and excursions. Such activity is useful in developing inner resources as well as helping children to distinguish between objective and subjective reality. Such activities (which may be based on actual experience, musical experience, a picture, etc.) should not be confined only to kindergarten, but should be enjoyed throughout the primary grades.
8. Perception -- broadly and intensively considered, multi-sensory. Increasing work is being done in visual perception, but this can be greatly expanded and enriched. Experiences in perceiving and reporting what is seen, heard, tasted, smelled or touched and kinesthetic experiences of lifting, pushing, pulling, etc. -- all these contribute to a sense of selfness.
9. Learning to evaluate -- This activity cannot be begun too early. Children need to become critics in the present day world with its onslaught of stimulating experiences. Discussion of TV shows and their accompanying commercial messages is one method of encouraging evaluations.
10. Role-playing and creative drama -- the experience of putting oneself in someone else's shoes as well as imagining situations helps in the child's development of his own individualism.
11. Appreciation of learnings. Review with a child the things he has learned and of their possible usefulness or relevance to his life helps to place them in a meaningful and favored context. Correlary to this, it might be commented that explanations to children prior to teaching them something -- a unit or skill, for example -- can give a child more reason for trying to learn the material than simply presenting material to be learned because the teacher ordains it.
12. Including the student in the evaluation portion of a parent conference gives him knowledge of what is said and opportunity to contribute. This may help to allay possible feelings of insecurity or guilt in the child.

Following is a statement regarding one suggested method of countering drug abuse -

NON-VERBAL EXERCISES

Purpose

If drugs are to be placed in perspective, common attributes of some currently used and abused drugs will need to be interpreted in relation to human nature. The hope is to engage a method of teaching that allows students to learn specific mental and physical skills which afford them the same result as do many drug experiences. Many of the reasons given by users for their abuse of drugs conform to normal, healthy human needs and behaviors and their enhancement.

Some of the effects of drugs such as marijuana and LSD are said to be:

- a tendency for less verbal behavior or non-verbal activity
- increased self-awareness of mental and physical conditions, feelings, and sensations
- improved non-verbal communication with others
- relaxation - lessening of tension in the mind as well as the body

Summary

Non-verbal exercises and activities utilized to produce the above reactions might lessen people's need to satisfy oftentimes repressed human needs by use of drugs.

Note: Examples of non-verbal exercises taken from 'Joy' by William C. Schutz, are given on the following pages.

#

Excerpted from

NON-VERBAL EXERCISES

taken from

JOY

William C. Schutz, New York
Grove Press, Inc., 1967

Lack of ability to communicate, to make friends, to feel part of the human race, are given as among important reasons people turn to drugs such as marijuana and LSD. The following non-verbal exercises are examples of teaching techniques intended to give students some of the mental and physical experiences of contact and closeness with others that are attributed to the effects of drugs.

One of the widespread human problems of modern society is making contact with other humans. Painfully few methods for meeting others are socially acceptable, a condition that makes for much human heartbreak. Furthermore, the discomfort in verbally engaging another person, in knowing 'what to say,' or what to do to prolong and develop an association, is a serious problem for far too many. The agony of this situation is underscored in the extremes found in psychotic patients, many of whom simply have not learned how to enter the human race, how to make contact with another person. When the issue is one of learning how to join with others, several methods have proven useful.

I. Feeling Space

All members of the group are asked to gather close together, either on the floor (which is preferable) or sitting in chairs. Then they are asked to close their eyes and, stretching out their hands, 'feel their space' -- all the space in front of them, over their heads, behind their backs, below them -- and then to be aware of their contact with others as they overlap and begin to touch each other. This procedure is allowed to continue for five minutes.

Usually there are a variety of clear reactions. Some people definitely prefer to stay in their own space and resent as an intrusion anyone coming into it. Others feel wary about intruding themselves in others' space for fear that they are not wanted. Still others seek out people and enjoy the touch contact. Where one person is inviting, another may be forbidding and simply touch and run. Discussion following this activity is usually very valuable in opening up the area of feelings about aloneness and contact.

II. Blind Milling

Feeling space helps to open up the area of conflict between being alone and being together. A next step is to explore more fully the nature of the other people, still non-verbally. This can be done by having everyone stand up, shut his eyes, put out his hands and just start milling around the room. When people meet they explore each other in whatever way and for however long they wish. Slow accompanying music often enhances this experience.

Frequently the feeling is more general than individualized. That is, the experience is more significant for encountering the generalized other -- the group -- than it is in contacting individuals. For this reason, this method frequently enhances cohesive ties within a group. Moreover, it often sharpens awareness of the other people as human beings. If some individuals seemed of little interest before blind milling, their identity and interest as people seem to be enhanced after it.

III. Roll and Rock

One of the central issues of affection is trusting the feelings of others. The other side of this trust is the ability to gratify and give pleasure to someone who trusts. When it is important to demonstrate or test trust, or to find a mode of giving pleasure to someone, the roll and rock is an excellent device.

The person in need of trust-testing stands in the center of the group, with all other members forming a circle around him. The group is asked to pass him around the circle from person to person. He is to close his eyes, try to relax every muscle in his body, and try to give himself over to the other group members. The group members then pass him around the circle several times. Often he is stiff and controlled at the beginning, but begins to relax as the circuits increase. Then the others pick him up and hold him at chest level parallel to the floor, supporting all muscles. It is usually best to have his hands and arms rest on his chest and stomach, and let his head fall back naturally just holding two fingers under it to take away the tension on his neck. Then he is gently swayed back and forth, the group members being careful to make as little noise as possible. Continuing the swaying motion, the group begins to lower him until he is placed gently on the floor. All hands are removed from the body slowly and tenderly.

A two-person variation of this method may be used to test the trust of one person for another. In this technique one person turns his back on another and lets himself fall backwards and be caught by the other. The feelings of trust or distrust are usually felt very clearly in this situation.

#

Excerpted from

CONSIDERATIONS FOR SCHOOL PROGRAMS

*Jean Aron
Mental Health Department
Santa Clara County, California*

It is almost a maxim of every generation that there shall be some form of oppositional movement of the young when the values their upbringing has imposed on them seem to them no longer appropriate. In today's oppositional youth movement, which is tied to a society which sees itself in transition, the drug scene is superimposed upon that basic scene. There is no basic difference between the young drug user and the young non-drug user. There are common factors between the two groups -- rebellion, hostility, the identity problem, the adolescent crisis. However, these things tend to confuse those of us who wish for a clear and quick separation and a foolproof pre-identification of the potential young user. In 1967 I conducted a survey at two Santa Clara County High Schools. I came up with a bunch of numbers and it pleased some people and panicked others, but it really wasn't very useful. The potential young abuser is not likely to be revealed by anything so simple-minded as a response to a questionnaire concerning his habits, and his non-user friend joins him in aloofness bordering on anger.

The most meaningful data comes from comments, and I mention two: 'This test isn't worth giving, you might gain a few statistics...sure...but what does that prove? After you've got the numbers, what are you going to do, write a book? I'm sure that's going to help solve the problem of drugs.' This from a senior female who is a self-described non-user. The next is from a senior male, who by his own description is a heavy user of both acid and grass. 'Are adults really so aloof from children that they have to use a questionnaire to find out what we're doing and why we're doing it? Adults should talk to children directly rather than rely on the studies of someone else to tell them what their kids are doing on the streets and in the homes.'

Both of these young people referred to the lack of communication with adult society. A member and a non-member of the drug scene sharing such similar attitudes points up a communication dysfunction in the total social and cultural milieu in a way that we can't ignore.

We can also infer feelings of distress and frustration. All youths are not drug users, but some of them are and that number is increasing. And all youths who are drug users are not abusers; some of them are and that number is increasing. As adult professionals and experts, if we are to educate so as to prevent, we have to use the information the kids give us to increase our awareness. Only then can we begin to hope to develop effective drug education programs. We have to be able to distinguish between pathology and rebellion, and most important be able to explore with students the non-drug alternatives for the attainment of legitimate goals that are often sought through drugs.

Observers of the drug scene have broken down the young drug users into three general types -- one would be the experimenter, the kid who is really satisfying not much more than his very normal curiosity and having had the experience may or may not go on to become a social user of, primarily, marijuana. This is the type most important on which to center attention. These people are most vulnerable and apt to go too far in their search for the legitimate goals of either kicks or self. Adolescence is a crisis time anyway - it's enough to get through it with your head and skin in one piece without confusing the issue with the addition of drugs.

Then there are the lonely empties. These young people are losers. These have intra-and inter-personal conflicts so they come prepared with almost a pre-psychiatric disposition toward dependence on drugs and on something which is destructive, either emotionally or physically. The last group is not out for kicks, not out for self. They are out to feel less bad, looking for negative euphoria.

It is becoming less easy to make generalizations about the characteristics of users. In the old days, perhaps two years ago, one could suppose that people smoked pot because they were rebellious

characters, thumbing their noses at society in trying dangerous behavior. That was fine as long as pot smoking was highly disapproved of and had to be rebellious. But now there are campuses where 'X' number of kids are using pot and no one gets too up tight about it -- it's the thing to do or at least to say that one has done. In this case it would be foolish to assume that only one kind of personality or attitude or social background is associated with what is now popular experimental behavior. For example one girl said: 'I feel that drugs and grass are things that kids use just to make a name for themselves -- good or bad, they want the name.'

Since we are concerned about the dabblers, the most vulnerable group, I wonder if we shouldn't turn inward and take a harder look at ourselves if we are going to be effective interveners. How can we construct good, sound, valid curriculum, if we, ourselves, are not in a very good position regarding our own feelings? It would be well for us to recognize drugs with the greatest abuse potential -- heroin, amphetamines, LSD, and alcohol -- in that order and to stifle our cultural outrage at the idea that somewhere someone might be having fun with marijuana. If we were to have a more appropriate perspective, users and potential users might be inclined to listen when we talk to them. I think I've come to the conclusion that the marijuana controversy is based much more on myth than on fact and has seriously hampered the development of a sound educational program about the more dangerous drugs.

My feeling is that there are two basic principles which have to be accepted as bases for drug education with potential for success. First, there is honesty -- the sifting of fact from myth and fantasy to bring into balance the sense of alarm which so often obscures and overshadows the evidence at hand. It is the responsibility of a school system to provide its instructors with all possible information about drugs and to create a climate for open discussion. An important facet of honesty in addition to straight facts is the willingness to say, 'I don't know' and 'let's find out.' The second point is the important one, the necessity for a non-moralizing approach that will lessen the credibility gap between adults, the users of alcohol and tranquilizers, and youth, the users of acid and grass. It is a common notion that young people experiment with drugs because they have not been properly informed about the evils of drugs. That may have been true in the past but is no longer a fruitful approach. The traditional scare lectures delivered by uniformed officers and picturing the dope fiend as a perverted, demented, lost soul can only fall on very, very, tuned-out ears. Further, the potential young user no longer comes from the lower socio-economic classes, but are now the socially advantaged youth, the young intelligentsia. They are informed. They are curious about the new exotic drugs. They put down moralistic teaching methods.

The medical and legal profession might acknowledge their ignorance of certain drugs and their effects; policemen might stop referring to all drugs as narcotics; legislators might pause to consider before passing more suppressive laws in this area; and citizens and parents might begin to educate themselves rather than being passively indoctrinated by extreme moralists on the one hand and the superficial information provided by the news media on the other. I would suggest that all faculty, and all administrative personnel at every junior and senior high school, and perhaps 5th and 6th grades, be required to take a basic course in the primary problems of drug abuse. This must be supplemented by encounter groups, sensitivity training, teachers getting to know themselves, people getting to know themselves and each other. This is the human model. It's not the legislative, the medical model or the social model. The goal would be the creation of case finders, not just of drug problems, but of student problems in general with sensitivity to the problems of growing up. If you know yourself, if you're sensitive to yourself, you have increased your own mechanisms to cope with stress and with strain and are more capable of passing on that feeling and to instructing a young person to attain it for himself.

For the professional counseling staff of the school system as well as the school doctors and school nurses, I propose that there be an intensive training program in the current methods of treating drug abuse. This includes prevention and intervention. From the experience that I have had at two or three Santa Clara County high schools, the faculty that can be persuaded to engage in encounter and sensitivity group activity became better people. They passed attitudes and feelings on to their students in terms of how to be more human, how to be more relaxed. These students are not

isolated. They're not just in school. They move around so what you do in teaching mental health is to create mental health educators in students who can then react in their own little milieu, in their own little culture.

It is important to have creative time in the school setting -- not for a course on group dynamics, not for a period for F block or Y block devoted to something called open discussion. There are very few kids who are going to fall into that trap -- but a school can make time available when experienced, sensitive teachers are willing to simply be there for students to use the time as open discussion. If the kids will spend maybe five or six minutes on drugs and then talk about themselves, where they are and where they are headed. It is possible to talk about the whole scene of human relationships and still get in your hidden agenda of drug information.

I get a strong feeling that many of the young people who come through my office are committing emotional suicide. You pick up phrases and hear them over and over again. 'Why bother?' 'Noone listens.' 'I've been told I'm supposed to do all these things and I haven't done anything yet.' 'I don't know what I'm going to do, I don't know what I want to do.' They're bored, some of them. Some of them are in serious emotional trouble. They are confused and their feeling of emotional suicide is very much like the traditional cry for help. I get reports back from parents, 'I didn't know anything was going on, I did not have the slightest idea she was doing all these things.' Yet in a confrontation with the parents and the adolescents together, you hear the kids saying, 'I don't understand how you couldn't know I was doing this -- I left this around -- I was behaving thus and so. How could you not know something was wrong?' It is a cry for help, as much as a cry for attention.

We can learn how to communicate. It starts with us. We can change ourselves as professionals, and as people. You can make yourself a different kind of teacher. It is possible for a teacher in a classroom of thirty kids to maintain intimate relationship with the major portion of that classroom. It is possible to learn to be an accessible, warm open human being -- not as a panacea for every kid's problem that ever came along, but at least for someone who is willing to listen. I think you can increase your effectiveness as a teacher and I think you will have better students.

#

Excerpted from

HOW CAN WE TEACH ADOLESCENTS ABOUT SMOKING, DRINKING AND DRUG ABUSE?

*Godfrey M. Hochbaum Ph.D.
Public Health Service, HEW*

For thousands of years man has found a variety of means to cope with the drudgeries, pressures, boredom, and fears of every day life. The need for such means is an inseparable part of human nature, and only the form and use of these means have changed from one culture era to another.

In short, smoking, drinking, or the use of various drugs can under certain conditions serve some constructive, useful, and satisfying purpose, just as I believe, they can be normal activities and should be approached as such rather than as abnormal or as necessarily due to some abnormality in the people using them.

The reason we disapprove of them and attempt to control their use is that the benefits, pleasures, and satisfactions they may yield are outweighed by the health hazards they create for the user and in many cases by their threat to a healthy society.

According to a number of studies, smokers, including adolescent smokers, report that cigarettes help them to relax, concentrate, tolerate anxiety, feel more at ease in awkward situations, and so forth. Such benefits are reported with such frequency and consistency that we cannot doubt their validity. Just because these benefits may be psychological does not diminish their reality or their importance to the smoker.

We can say the same about drinking. Some boys drink because under the influence of alcohol they are able to shed inhibitions, uncertainties, or feelings of inferiority and begin to feel free, manly, and reckless. The fact that excessive drinking engenders a variety of health and safety hazards should not obscure the fact that the drinker may enjoy it and even temporarily benefit from it in some ways.

The nonsmoker or nondrinker often finds these facts difficult to understand and believe. He tends to see only the negative, unhealthy, dangerous side. When he is called upon to teach children about such matters, he will tend to present a one-sided picture which conflicts with what many of the children think, do, and experience. Indeed, even educators who may themselves smoke or drink occasionally often focus on the unhealthy and hazardous aspects of these habits, in their well-meaning zeal to convince children of the risks they are taking and of the benefits they can reap from abstinence, and disregard or even deny any pleasures or satisfactions that may be obtained from them. Such an attitude can obviate any hope of educational success, and such an approach backfires easily and often. A person's strongly held beliefs and attitudes are rarely changed by a one-sided, aggressive attack on them. Indeed, as often as not, such an approach tends to reinforce the original beliefs and attitudes. A more balanced approach, which, instead of attacking a person's beliefs, guides him to examine and reassess them himself, is more promising. In other words, educational efforts should present all sides of the argument fairly, give all the known facts and aspects, and attempt to stimulate the student to play the role of the final arbiter--hopefully led by the educator to do so intelligently and with a sense of responsibility for his own well-being.

As long as we harp on the evils and hazards of smoking, drinking, marijuana, LSD, or sex and deny the pleasures and satisfactions that some adolescents derive from them, these adolescents will think--and perhaps openly say--that we do not know what we are talking about. Our educational efforts will seem unreal to them since what we tell them does not fit reality as they see it and as they themselves have experienced it.

The same holds true for classroom instruction. Unless the teacher can present his topic--be it smoking, excessive use of alcohol, abuse of drugs, sex or what have you--in all of its aspects and dimensions, positive and negative, good and bad, desirable and undesirable, he will lose many of his students. Adolescents, because they are in a period of life where they search out and examine many issues

which adults have come to view as settled, are very sensitive to lack of candor, to incomplete presentation of facts, and to biased attempts to lead them. They reject quickly, readily, and totally a source of instruction, be it a person or presented material, if they doubt its reliability, honesty, and sincerity.

Visualize a child who is told in school about the bad effects of drinking but knows that his mother has a cocktail ready for his father when he comes home, which (as the child may hear often) helps him relax after a hard day's work and be a more pleasant person to have around. In such a case, the child has somehow to resolve the conflict between what his teacher tells him and what he sees to be the facts of the outside world.

Another difficulty arises when the teacher attempts to affect the child's behavior by appealing to motives and standards which are less meaningful to him than those offered by his peer groups and other influences and which he may neither share nor accept.

For example, in driver education courses, we stress the hazards of driving at excessive speeds. We regard this emphasis on the risks of such driver behavior as a powerful deterrent because we adults value our health and our lives and usually avoid exposing ourselves unnecessarily to dangers. But for many adolescent boys, this thrill of taking risks and of thereby proving one's manhood and impressing girls and other boys is titillating, desirable, and satisfying. Therefore we actually appeal to values which for us are persuasive reasons to drive carefully but which for many boys are equally persuasive reasons to do exactly the opposite. Honest puzzlement is the response we must expect when we use our own values as arguments with adolescents who do not share and may not even understand these values.

Smoking, the use of alcohol or of hallucinogens, and other similar activities have become symbols of rebellion against established adult standards and authority. It is in the nature of rebellion that disapproval and repression strengthens and intensifies the movement. Forbidding smoking or prosecuting a boy for using LSD could easily make these things seem even more important and desirable to some adolescents. There are risks involved when we fail to understand the thinking and the attitudes and values which are characteristic of adolescents.

Scientific facts, no matter how convincing they may seem to us, often fail to persuade children. One reason is that facts, even when learned, are viewed within the framework of existing motivation, feelings, and emotions. Facts that are in accord with what one already accepts, are accepted; facts that run counter are frequently rejected, quickly forgotten, or interpreted in such a way that they are more in line with what one wants them to mean. Thus, to the person who is already motivated to take some preventive action against a given disease, an additional incentive is provided by telling him that one million Americans die every year from the disease because it was not diagnosed early. But the person who for one reason or another rejects such preventive action may reinterpret the same statistics as meaning that many more millions do not contract this disease, and thereby obtain additional justification for not taking the action.

Clearly, knowledge of facts by itself does not necessarily change attitudes, beliefs, or behavior. Much depends on how and in what context such facts are presented.

This poses a difficult problem, particularly in respect to such controversial, emotionally potent problems as drinking, smoking, and the abuse of drugs. Knowledge gained in the classroom on these subjects is valuable, even essential. But one cannot rely on this alone if one wants to assure that the facts are accepted and applied by the students to their out-of-school behavior.

Once we have come to understand the complexity of the problem, we can turn to ways of dealing with it more effectively than if we shut our eyes and think it is just a question of giving people more information with the notion that knowledge will do the trick.

I would like to illustrate how one can draw logical and practical implications from our knowledge about adolescent health behavior. The following will not attempt to represent all possible implications. It will only illustrate how one might go about drawing such implications.

We have seen that the habits with which we are concerned do provide the adolescent with a variety of pleasures and satisfactions and fulfill certain needs. Once we acknowledge this fact, it may be possible to identify other, less hazardous ways by which adolescents could obtain the same benefits and pleasures. Here again, one must be cautious not to impose the adult's viewpoint but to stimulate and guide adolescents to generate their own ideas and develop their own means of accomplishing this end. If they invest their own efforts and their own creativity, they will be much more likely to follow through and to draw their peers into such activities.

Secondly, we talked about some teenage behavior as both a demonstration of being grown-up and an expression of rebellion against adult authority. Both of these usually do not really begin to occur until the early teens. By that time the child is exposed to a multitude of social influences from his peer groups. These often influence, stimulate, and reinforce undesirable health habits and frequently prove more powerful than any instruction on smoking, drinking, or drug abuse that the school may offer at the same time.

However, if we began to instill in the child proper attitudes and values with respect to these habits long before adolescence, we could fortify and help him resist such influences later. Take, for example, tooth brushing. The child learns to brush his teeth long before he understands the health reasons. When he is old enough to learn and understand the health reasons, he can easily accept them because they fit in with an already established habit. In fact, they help to strengthen the habit. In the same way I believe that by proper means we can instill in children certain attitudes and ways of looking at smoking and drinking when the child is still very young. It can start with using doll play in pre-school years, and it can go through all the school years. By the time the child becomes a teenager, there would have developed within him a ingrained way of looking at such matters. As he becomes exposed to other influences toward smoking, drinking, and similar behaviors, these influences will be contrary to his normal way of thinking. Therefore, education in this area should start as early as possible--both in the home and in the school.

Thirdly, direct attacks on people's attitudes and habits often fail and actually arouse resistance. Actually, the harder we attack, the more obstinate and the more extreme these views often become. But if influences could be brought to bear on such a person more subtly and without his being conscious of being 'attacked,' he will be more receptive.

Schools have many opportunities to do just this. Long before formal instruction on smoking or alcohol or drug abuse is offered--and such courses clearly are (or at least are seen by many students to be) direct and authoritarian attacks--more subtle influences could be exerted.

For example, physical education courses offer many opportunities to insert references to the effects of cigarettes and alcohol on physical fitness and attractiveness. Other courses could do the same. History is full of illustrations of battles lost, empires disintegrated, leaders defeated because of indulgence in various detrimental health habits. Courses in biology allow references to the physiological effects of nicotine and alcohol.

If such educational messages are systematically planned with the cooperation of the entire school staff, attitudes could be created long before adolescence which could enable many children to resist temptations they will be exposed to during their adolescent years.

We have seen that facts alone are not decisive factors in changing attitudes or behavior, but they could be if presented in a context that makes them meaningful. For example, statistics offered in the classroom on accidents and deaths resulting from driving under the influence of alcohol or the number of people dying each year from lung cancer will not have much impact on teenagers. In fact, demonstrably it does not even have much effect on us adults. Highway statistics on how many people

die during Labor Day weekends on the highway have not led many drivers to drive more carefully. But one can observe that drivers, after passing the scene of a smashed car, slow down. People change attitudes or behavior very rarely on the basis of statistics. They change their attitudes and behavior in response to personal experiences.

In relation to school health education, visits to hospitals to see cancer patients or having an emphysema patient visit the classroom may have more impact than all the statistics. A teenage boy who was crippled in an accident while driving under the influence of alcohol will be more persuasive than a booklet from the Children's Bureau. In short, the more immediate and personal a demonstration is, the more effective the facts themselves will become.

There is some evidence that many adolescents take up smoking or drinking or drugs, not because they particularly want to or enjoy it, but because they consider it a mark of adulthood, or because they believe that it gives them some status among their peers or in the eyes of the other sex, or because other teenagers talk them into it. Many of these young people may be glad to give it up if they just knew how they could do it without losing face in the eyes of their peers or without surrendering some of these benefits.

These boys and girls would probably be quite responsive to any help teachers can give them. In some schools, clubs or other organizations are formed which do not actually forbid smoking or drinking but deliberately create an atmosphere in which such activities are considered childish or stupid and are frowned upon. If such organizations can be made attractive and prestigious in the eyes of enough students, those who do not choose to smoke or drink in the first place and those who are eager to shed such habits can find a congenial peer group which provides them with a good deal of social reinforcement.

There are many who do not engage in undesirable health habits but are on the verge of yielding to the temptation to try one or another. Psychological research has shown that during this period of indecision, almost any influence may suffice to swing the decision one way or another. It is this group with which medical and other facts may have a decisive influence.

Then there are youngsters who really are already captives to their habits; they may already have become habituated to and acutely dependent on cigarettes, alcohol, marijuana, or what have you. Some of these one will find totally and completely adamant to any attempt to change their habits and one may have to forget about them. But others may indeed have tried but found it impossible. These boys and girls need and should be provided help with the problem through individual counseling or perhaps some sort of psychotherapy.

We referred earlier to the difficulty of making classroom learning relevant to the outside life so as to provide for a carry-over to the latter. One of the reasons mentioned is that many children--and particularly those who represent our most difficult problem cases--see the classroom as a world separate from the real world in which they live. Since this image is hard, perhaps impossible to change, it might be easier to change the situation. One might, for example, consider discussion group approaches instead of the more typical lecture approaches of the classroom and move from the classroom setting to more informal settings. What if groups were assembled in homes of teachers or children, in fraternities or dormitories, or in other places which do not have a school atmosphere? The teacher or other experts could function as resource persons while the discussions were led by students themselves. In fact, the more closely both the physical environment and the style of instruction maintained in such groups resembles situations in which these adolescents usually move and in which they are exposed to undesirable influences we wish to counteract, the more effective the discussions are likely to be.

Psychosocial research of the last few years has helped us to understand somewhat better why adolescents smoke, drink, or abuse drugs. This new understanding has taught us that there are no simple explanations nor single or simple answers. But if we carefully analyze these problems and search for appropriate implications from the psychological and sociological sciences, we can generate new ideas as to how to cope with the challenge.

#

Excerpted from

EDUCATION AND ECSTASY

George B. Leonard

This material on ways educators can make learning a more enjoyable experience is included here in the belief that use of more creative, innovative educational methods would result in less need for many of the adult concerns and legal restrictions on the non-social behavior of young people. These excerpts are only fragments of a 13-chapter book which describes today's schools, explores the human potential, shows how environment affects development, suggests how to visit one's child's school, and describes a school in 2001 A.D.

WHAT IS EDUCATION?

Teachers are overworked and underpaid. It is an exacting and exhausting business, this damming up the flood of human potentialities. What energy it takes to turn a torrent into a trickle, to train that trickle along narrow, well-marked channels! Teachers are often tired. In the teachers' lounge, they sigh their relief and offer gratitude to whoever makes them laugh at the day's disasters. This laughter permits a momentary sanity-saving acknowledgment, shared by all, that what passes for humdrum or routine or boring is, in truth, tragic. (An hour, of which some 50 minutes are given up to 'classroom control.' One child's question unanswered, a hundred unasked.)

How do teachers bear their tragic task? They learn to look away. They hasten to a way of talking that lets them forget their problems. What cannot be solved is named. Once named, it does not seem to need a solution so urgently -- perhaps never. James 'acts out.' (He is mad as hell at his teacher.) Melissa is an 'underachiever.' (So be it.) Some teachers take to acting, generally in the later grades where the lecture system (best way to get information from teacher's notebook to student's notebook without touching the student's mind) flowers fully. Retiring behind a psychic proscenium arch, the actor-teacher is forever safe. His performance flourishes. He plays for laughs and outraged looks.

What a job this is we give our teachers! Do not blame them if they fail to educate, to change their students. For the task of preventing the new generation from changing in any deep or significant way is precisely what most societies require of their educators. They are our valiant slaves, condemned to perpetuate the very system that victimizes them. They are sometimes bewildered, sometimes angry, often tired. If education is a process that causes real change, not just in one's ability to manipulate symbols but in every aspect of one's being, then what today's educators are called upon to do may be many things, but it is not education.

And yet, there are moments of learning even in school. 'Have you ever noticed,' a teacher said, out of the blue 'how sometimes there are teachable days?' 'I know sometimes they are teachable,' a second teacher mused. 'Some days, it's different,' the first teacher continued, 'The whole thing's different. I don't know why.'

How many of those times do you remember? Something happens. How many teachable days? One out of a hundred? Then you are of the favored.

But there are teachers, a few of them, who can make something happen almost every day. I have seen more than my share of those masters who, in terms of our small expectations, seem to be miraculously gifted. I have sat in a child's miniature chair in the back of a third-grade room, my heart racing, while the class learned simple arithmetic. And I have been changed.

How many such teachers in your lifetime? How many who changed your life? Two? Three? Count yourself lucky.

'Education and Ecstasy' (Delacorte Press, 1968) is used with the personal permission of the author, George B. Leonard, senior editor and West Coast editorial manager of LOOK. Mr. Leonard is also educational consultant and vice-president of Esalen Institute of Big Sur and San Francisco, California.

So here we are. And there our children sit, counting out a few seconds of learning for every hour of waiting for a bell to ring, waiting for a kind of teacher they may have never known, waiting for something to happen. If only their waiting could be merely neutral, we wish. If only they could sit there, learning nothing, without ill effects! There are not neutral moments. Even in those classrooms where the education some of us might hope for is impossible, a kind of shadowy, negative learning is going on. Some pupils learn how to daydream; others, how to take tests. Some learn the petty deceptions involved in cheating; others, the larger deceptions of playing the school game absolutely straight (the well-kept notebook, the right answer, the senior who majors in good grades). Most learn that the symbolic tricks their keepers attempt to teach them have little to do with their own deeper feelings. The activity that masquerades under the name of 'education' actually seems to serve as a sort of ransom to the future, a down payment toward 'getting ahead' -- or at least toward not falling behind. Lifetime-earnings figures are pressed upon potential high school dropouts. Dropouts and graduates alike have had plenty of practice in fragmenting their lives -- segregating senses from emotions from intellect, building boxes for art and abstractions, divorcing the self from the reality and the joy of the present moment. No need to look for obscure psychological explanations for modern man's fragmentation; that is what his schools teach.

Over the years, reformers have tried to stop the fragmentation. The greatest among them was John Dewey. Dewey recognized that education is a process of living and not a preparation for living. He believed that education is the fundamental method of social progress and reform.

But Dewey did not provide educators with the hard-honed tools of true reform. He was fascinated with the notion of 'interests,' which he felt would automatically manifest themselves in children when they were ready to learn something. This notion, somewhat misinterpreted, led a generation of teachers to wait for children to show signs of 'interest' before they moved ahead and thereby woefully to underrate their capacity for learning. Progressive education was a useful, humane and sometimes joyful reform, but it was not the true revolution in education that the times then needed and now demand.

For the most part, the schools have not really changed. They have neither taken up the retreat of the past's prime educators (family, farm, village, church, guild) nor significantly altered the substance and style of their teaching. The most common mode of instruction today, as in the Renaissance, has a teacher sitting or standing before a number of students in a single room, presenting them with facts and techniques of a verbal-rational nature. Our expectation of what the human animal can learn, can do, can be remains remarkably low and timorous.

All that goes on in most schools and colleges today is only a thin slice of what education can become. And yet, our present institutions show a maddening inefficiency even in dealing with this thin slice. In recent years, there has been a small net gain in U.S. students' performance in the basic subjects. But this has been accomplished only at the cost of a large increase in gross effort -- more and more homework assigned under threat of more and tougher exams, to force students to learn, on their own, what most of today's teachers have long since realized they cannot teach them. A visitor from another planet might conclude that our schools are hell-bent on creating -- in a society that offers leisure and demands creativity -- a generation of joyless drudges.

There are signs the schools will not succeed in this drab mission. Already, the seeds of a real change are germinating -- on college campuses, in teachers' associations, in laboratories of science, in out-of-the-way places that will be discussed in later chapters. This reform would bypass entirely the patchwork remedial measures (Spanish in second grade, teachers in teams, subject matter updated) that presently pass for reform. It cuts straight to the heart of the educational enterprise, in and out of school, seeking new method, content, idiom, domain, purpose and, indeed, a new definition of education. It is a new journey. To join it, you had best open your mind to unfamiliar solutions and throw out of the window every prior guideline about what human beings can accomplish.

The prospects are exhilarating, though it is becoming dangerous to write about them, if only because nowadays it is so hard to stay ahead of reality. The following prospects are in the realm of possibility:

Ways can be worked out to help average students learn whatever is needed of today's subject matter in a third or less of the time now required, pleasurably rather than painfully, with almost certain success.

Ways can be worked out to provide a new apprenticeship for living, appropriate to a technological age of constant change. Many new types of learning having to do with crucial areas of human functioning that are now neglected or completely ignored can be made a part of the educational enterprise. Much of what will be learned tomorrow does not today have even a commonly accepted name.

Ways can be worked out so that almost every day will be a 'teachable day,' so that almost every educator can share with his students the inspired moments of learning.

Education in a new and greatly broadened sense can become a lifelong pursuit for everyone. To go on learning, to go on sharing that learning with others may well be considered a purpose worthy of mankind's ever-expanding capacities.

If education in the coming age is to be not just a part of life but the main purpose of life, then education's purpose will, at last, be viewed as central. What, then, is the purpose, the goal of education? A large part of the answer may well be what men of this civilization have longest feared and most desired: the achievement of moments of ecstasy.

Western civilization has traditionally eschewed ecstasy as a threat to goal-oriented control of men, matter and energy -- and has suffered massive human unhappiness. Other civilizations, notably that of India, have turned their best energies toward the attainment of ecstasy while neglecting practical goals -- and have suffered massive human unhappiness. Now, modern science and technology seem to be preparing a situation in which the successful control of practical matters and the attainment of ecstasy can safely coexist; in which each reinforces the other; and in which, quite possibly, neither can long exist without the other.

Do discipline and mastery of technique stand in opposition to freedom, self-expression and the ecstatic moment? Most Western educators have acted as if they did.

The new revolutionaries of education must soothe those who fear techniques no less than those who fear delight. Many a liberal educational reform has foundered on lack of specific tools for accomplishing its purposes -- even if a tool may be something as simple as knowing precisely when to leave the learner entirely alone. Education must use its most powerful servant, technique, in teaching skills that go far beyond those that submit to academic achievement tests. Even today, as will be seen, specific, systematic ways are being worked out to help people learn to love, to feel deeply, to expand their inner selves, to create, to enter new realms of being.

What is education? The answer may be far simpler than we imagine.

To learn is to change. Education is a process that changes the learner.

The first part of our definition of education calls on the educator to view his work as consequential, not theoretical or formalistic. Asking himself, 'What has changed in the student, and me, because of this particular experience?' he may have to answer that what has changed is only the student's ability to recite a few more 'facts' than he could before the session. He may find that the student has changed in wider and deeper ways. He may have to admit that the student has hardly changed at all or, if so, in a way that no one had intended. In any case, he will not ask himself the wrong questions ('Wasn't my presentation brilliant?' 'Why are they so dumb?')

Viewing learning as anything that changes the learner's behavior, the educator will expand his domain a thousandfold, for he will realize there are hardly any aspects of human life that cannot be changed, educated. He will see clearly that, if the educational enterprise limits itself to what is now ordinarily taught, it will be pursuing failure in the coming age.

Learning involves interaction between the learner and his environment, and its effectiveness relates to the frequency, variety and intensity of the interaction.

Guided by this second part of the definition, the educator will pay far closer attention to the learning environment. The environment may be a book, a game, a programmed device, a choir, a brain-wave feedback mechanism, a silent room, an interactive group of students, even a teacher -- but in every case, the educator will turn his attention from mere presentation of the environment to the response of the learner. He will study and experiment with the learning process, the series of responses, at every step along the way, better to use the increasing capacities of environment and learner as each changes. Observing the work of what have been called 'master teachers' in this light, he will find that their mysterious, unfathomable 'artistry' actually comprises a heightened sensitivity to student responses plus the use of personally developed, specific, flexible techniques. The educator will work out ways to help every teacher become an 'artist.'

Education, at best, is ecstatic. When joy is absent, the effectiveness of the learning process falls until the human being is operating hesitantly, grudgingly, fearfully, at only a tiny fraction of his potential. Excellence, as we speak of it today, will be only a by-product of a greater unity, a deeper delight.

Schools and colleges, until now, have served a society that needed reliable, predictable human components. Educational institutions, have been geared to stop learning. Perhaps half of all learning ability is squelched in the earliest grades, where children find that there exist predetermined, unyielding 'right answers' for everything, that following instructions is what counts and, surprisingly, that the whole business of education is mostly dull and painful.

With the bulk of learning ability wiped out in early childhood, the schools can proceed at their own leisure to slow and then still what is left of each human component's capacity to change. The process of formal education itself is kept in motion by punishment or the threat of it, and by two main positive motivators: narrow competition and eager acquisition.

A society that encourages competition and acquisition is almost sure to encourage aggression -- and violence -- as well. This may be seen on a national scale in the drive to acquire territory, wealth or status -- especially by means of war or colonization. Preparing young men in the behaviors needed for these activities has become perhaps the most powerful shaper of education -- and of life's purpose.

'Right answers,' specialization, standardization, narrow competition, eager acquisition, aggression, detachment from the self. Without them, it has seemed, the social machinery would break down. Do not call the schools cruel or unnatural for furthering what society has demanded. The reason we now need radical reform in education is that society's demands are changing radically. If education continues along the old tack, humanity sooner or later will simply destroy itself.

A world in which everyone will be in touch needs people in touch with themselves. Where the actions of one can drastically affect the lives of those far distant, it will be crucially important that each person master the skill of feeling what others feel. This skill, more than new laws or new politics, will soon become crucial to the survival of the race. Such empathy is possible only in one deeply aware of his own feelings. The future will very likely judge nothing less appropriate than detached, fragmented, unfeeling men. Such men have done their work.

The first thing schools can do to reduce narrow competition, eager acquisition and aggression is to stop teaching them. Grades, tests, prizes, honors have proven woefully inadequate as motivators for learning.

Eager acquisition and aggression may seem more difficult to reduce. Thus far, the emotions and actions associated with them have been highly reinforcing. With life's rewards lodged outside the self, the acquisition of extraneous tangibles or intangibles has naturally been synonymous with success.

Neither punishment nor diversion answers the problem in education. Acquisition will slow when technology creates a condition of plenty rather than deprivation for all. Aggression will quiet down when aggressiveness stops being rewarded.

Still, a faster, more positive remedy is needed. It is joy, delight, ecstasy, the ancient, potent cure so long feared by civilization, now so specifically and obviously prescribed. Joy resides within the self and is the most relevant of reinforcers.

The emerging mode of life promises to be so challenging, so vivid, so intense as to render the old life extremely dull. The end of 'job' means the end of the eight-hour day and the beginning of the 24-hour day.

We cannot guess what the distant future will ask of its schools, but perhaps we can step far enough into the future to see what our children already need. Schools for what?

- . To learn the commonly agreed-upon skills and knowledge of the ongoing culture (reading, writing, figuring, history and the like), to learn joyfully and to learn that all of it, even the most sacred 'fact,' is strictly tentative.

- . To learn how to bring creative changes on all that is currently agreed upon.

- . To learn delight, not aggression; sharing, not eager acquisition; uniqueness, not narrow competition.

- . To learn heightened awareness and control of emotional, sensory and bodily states and through them, increased empathy for other people, perhaps the most common form of ecstasy.

- . To learn how to learn, for learning is already becoming the main purpose of life.

Such activities may seem to lead far from the school in which your youngster is now enrolled. And yet, in the deepest sense, they spring from the original American impulse toward hope and individual fulfillment.

THE FUTURE NOW

We can journey through time to the year 2001 and envisage education that will be truly ecstatic. In our school of the future, we can easily imagine children wandering as 'free learners' from one educational environment to another. We can see them playing learning games with computers, re-creating Faraday's experiments, living as Malaysian natives. Our happy children of a time to come can learn with ease such things as reading, writing, and figuring, then go into areas of education that today have no commonly accepted name. They can interact freely with educators, parents and each other.

Such a school will not exist in 2001 A.D. because it represents too conservative a conception. By then, it will be possible to offer far more. But it can exist today.

The new education can start to grow in your child's school this week. In fact, all the bits and pieces of it already can be found somewhere in the U.S., though no one has yet pulled them together into a unified educational environment. For the sake of convenience, we may list four 'principles' to guide us toward our school of the future -- the new learner, the total environment, technological aids to education and the new domain. Here are some living examples of each.

The free learner concept has become a favorite at the 'free universities' scattered around the nation. But it has been hard to make that concept work in higher education. Those who have lived the academic life are prone to specialty and theory. The academic approach to free learning usually has turned out to be either negative or esoteric.

Experimental colleges remove exams, grades and units -- a good first step, perhaps. Too often, however, they fail to add new educational situations to take their places. And they pay too little attention to building total, involving environments.

Free universities have sometimes replaced courses in literature, history and the like with courses such as 'Consciousness and Society' or 'The Search for Identity' -- another good move, perhaps. But these are still courses, with teachers and students, not real learning environments. There is great pressure for reform among the brightest college students and faculty, and a great deal of energy for experimental projects on many campuses. But the unfettered free learner may well emerge first in the lower grades.

During one of my visits to a free-learning school in New York City, I saw a six-and-a-half-year-old named Alan who had invented a learning environment for himself, so efficient, involving and complete that educators at all levels might well learn from it.

I learned that Alan's 'work' involved a project of grand proportions: he was creating a picture history of every major war the U.S. had fought, from the Revolutionary War through Vietnam. When Alan needed further information about some battle or mode of warfare, he would take a book about the campaign, retire to a corner and read eagerly. No 'motivation' problem here. Or he would go to the art room and paint combatants' flags and insignias, or model tanks and warships in clay. In the woodshop, Alan would build appropriate armaments. In the gym, he would invent war games. Or, in a perfectly reasonable switch, he would organize peace marches, with hand-lettered signs.

Perhaps not by accident, Alan's headquarters (a corner where he had built an impressive fortress) were located within easy hearing distance of the table where an educator read aloud about and discussed history, geography, evolution, etc. While the educator read, Alan would continue his work, hardly seeming to notice the 'lesson,' but actually taking it all in. When the educator left, Alan would rush to the table, scan the written material, look at the pictures, study the specimens, then mutter: 'I must get back to my work.'

Reading was no problem for Alan. Since he worked -- at his own pace and when he wished -- with a programmed instruction booklet, he didn't have to waste his time sitting listening to others labor over words. As for math Alan drops by about once or twice a week. He works the problems and then verbalizes the concept as well as anyone there. After five or ten minutes, he says, 'I must get back to my work.'

I do not like to think what would happen to a child like Alan in a conventional school. Forget the psychological pain and consider just the inefficiency -- not only for a child like Alan but for all children. If human beings are unique, then any system of fixed scheduling and mass instruction must be insanely inefficient. For an educator of courage and flexibility, the free-learning situation is not only more educationally efficient but eventually easier to handle. Best start with the youngest. Children who have been sat upon for years in conventional classrooms might simply explode for a while when first placed in the free-learning situation. Still, experience with transfers to free-learning schools has shown that children quickly adapt. It is only to the uninitiated observer that the free-learning situation may sometimes seem, on the surface, noisy and confused. The conventional classroom may seem quiet and orderly on the surface. The noise and confusion there are in the minds of the children.

It now seems clear that free learning in the early grades is not only possible but also compatible with even the unambitious, narrow 'academic' goals that constitute present-day education.

The total environment has been a central theme throughout this exploration of education and ecstasy. No act of learning exists in a vacuum. It is only when the learning environment is viewed and acted upon as a whole that education can become truly efficient and joyful. Most schools do not run 24 hours a day. But the inspired participation of parents can help link the broken days together. The best innovative schools tend to draw parents closely into the circle of learning.

The total environment, the inescapable connections between everything within an educational setting, should quickly become apparent to those within large corporations who are now analyzing education in terms of systems engineering. Thus far, the systems people have tended to dial into their systems only those aspects of education that currently are considered the school's domain. However, if the new educational engineers keep their feedback circuits open, that is, if they truly keep learning from what they are analyzing, I feel it inevitable that their concern will widen.

The question remains, can a total, controlled environment really change human behavior? If proof is needed, an organization called Synanon offers proof positive. Not the most deep-rooted character disorders or the most 'hopeless' forms of drug addiction or even 'human nature' have proved immune to its powerful, 24-hour-a-day educational techniques. And education is precisely what Synanon's leaders conceive their work to be.

Its structure is hierarchical, even paramilitary, yet it pursues the highest human freedoms. In one of its educational settings (Synanon Game), a lowly new member may be praised for screaming insults at the director; in another, he may be asked to have his head shaved for muttering far less to his immediate boss.

Synanon was founded in 1958 by Charles 'Chuck' Dederich as a way of dealing with drug addiction. Dederich got an old house on the beach at Santa Monica, Calif., and set up a tightly structured living situation in which the addict had to face the direct short-term and long-term consequences of his every act. The value system on which Dederich based the Synanon reinforcement system was the one preached (but not lived) by the outside society -- absolute honesty, personal responsibility, cooperation, love. History gave Dederich little chance of success: every therapy since Freud had been all but helpless against the character problems of addiction. Dederich, however, offered not therapy and theories, but attention to living, i.e., education in a total environment, designed to change people. What happened? Of all addicts who have come to Synanon, more than half are still 'clean.'

By tackling the impossible, Synanon has affirmed, beyond any doubt, the power of a changed environment to change (educate) human beings.

Education's new domain is not bound in by the conceptual, the factual, the symbolic. It includes every aspect of human existence relevant to the new age. We don't have to wait for the twenty-first century. Experimenters all around the U.S., and in other nations as well, already have established beachheads in the new domain. Powerful and respected institutions have begun to show strong interest in helping education break out of the old subject-matter trap.

The one place you would go to find most of the new domain drawn together in some sort of coherent whole is an unlikely institution Esalen Institute at Big Sur, California.

Just as Synanon reflects the crusty personality of its founder, Chuck Dederich, Esalen reflects Michael Murphy, its youthful president and co-founder, with Richard Price.

Esalen's open-mindedness and inspired eclecticism are probably what account for its having become since its modest beginnings in 1961, the freest marketplace for new ideas in the behavioral sciences of our time.

More than 650 Esalen seminars and workshops have revealed that the new domain is alive with all

sorts of activity. In fact, almost every new area of education imagined for our school of the future has been explored to some extent at Esalen Institute. A residential program was started in September, 1966, in which graduate-level fellows spend nine months as full-time free learners in the new domain. They practice meditation, intensified inner imagery, basic encounter, sensory awareness, expressive physical movement and creative symbolic behavior.

Since so much of Esalen is truly experimental, nothing can be guaranteed to 'work.' Yet most people who participate come away with the conviction that they have somehow been changed.

Nothing is 'typical' in the rich diverse new domain of Esalen. But the Esalen experience in its many manifestations shows that a new education is possible. It is not important that educators, parents and teachers follow the Esalen example or that they aim toward our school of the future. It is important they know they can change more in their schools than the window dressing. They have a real choice -- now.

The free learner in a total school environment will tend to serve as a check against error in selecting hardware. If an educational environment does not work in this setting, the educator finds out about it soon enough. Not so with students chained to their desks by day, overloaded with homework by night and forced to take exams against their will. Hardware might also be judged on how it enhances the learner's pleasure. Even on narrow, practical grounds, joy of learning will generally prove to increase efficiency of learning. Beyond efficiency, technological aids to education might be judged on how well they fulfill the new joyful educational goals.

In any case, the technology is on its way, and we can make what we will of it. For several years, Dr. Omar Khayyam Moore has been using various versions of a computerized 'talking typewriter' to teach children as young as three to read, write, spell and compose little stories. Dr. Patrick Suppes of Stanford University is among the other researchers who are using the computer and the learning console to increase the ease and efficiency of conventional education. At the Brentwood Elementary School in East Palo Alto, Calif., students learn language and math skills from electronic tutors. Suppes' young learners communicate with the computer not only through a keyboard but by using a 'light pen' to touch right answers on the display.

These projects, in comparison to what they can become, must be looked upon as crude and rudimentary. They lack, most of all, a sense of fun, of sheer delight. Their developers may be too enthralled with the hardware itself to view that rare if quite urgent vision of learning as ecstatic, as an art form.

Such a vision is realized in some of the most powerful learning environments I have visited, the light-and-sound ballrooms that were first developed in San Francisco in 1965. The Fillmore Auditorium and the Avalon Ballroom overwhelm the senses at first impact.

The chief learning derived from these marvelous environments is about the nature of the possible. This learning is sensory, somatic and conceptual, if you will. Fillmore was not designed by pedants to teach in a dutiful, limiting, linear fashion. It was designed by a new breed of artists to produce ecstasy. And an ecstatic environment, providing appropriate materials, can produce a learning rate fantastic by all present standards.

There is no technical reason that something combining computer-assisted instruction and the Fillmore Auditorium could not be set up right now. The computerized learning displays could be arranged around the inner wall of a circular building. A skilled light-show team, working from an elevated platform in the center, could produce a constant, 360-degree light show.

Visionary? It may seem so to those who persist in omitting the Dionysian factor from the educational equation, who are willing to tolerate countless physical and psychic dropouts, who can bear for our schools to limp along in their present agony. I am saying that we can create a better education now.

My talks with leading educators and visits to schools throughout the country have convinced me that U.S. education is nearing a time of dramatic change. The wonder is, when you think about it, how long our schools have managed to stay the same.

A certain caution in educational matters is quite understandable. One school child is far more complex, embodying far more variables, than NASA's entire satellite communications network. Baffled by this complexity, and inhibited by a reluctance to 'experiment' with children's lives, educators feel justified in clinging to methods that have been developed, hit or miss, over the centuries -- even when those methods are shown to be inefficient. Others take refuge in education's old conservative function of passing along the culture's median knowledge, values and ways of perceiving -- just when these things are shifting faster than we can perceive.

Now, it is clearly possible to opt for true alternatives. Every educator, parent and student has a stake in this project. All will help determine whether our schools become flexible, humanistic and joyful, or whether they must first become more rigid, monolithic and doctrinaire. In either case, change they will. In building the new, we might start with three assumptions that by now may have a familiar ring:

1. The human potential is infinitely greater than we have been led to believe. Acting on this faith, we shall find that even small and simple efforts can yield us great gain.
2. Learning is sheer delight. Education devoid of the ecstatic moment is a mere shadow of education. We may assume that, when learners are apathetic, bored or just matter-of-fact, something is drastically wrong and that the wrong can be remedied.
3. Learning itself is life's ultimate purpose. Today, schooling determines so much, even such matters as eventual earnings, status and neighborhood. But look beyond extrinsic rewards into the core of existence. In the future, a man's ability to learn and keep learning joyfully from birth to death will define the quality of life itself.

The student upheavals at large universities in recent years have been directed at the present institution of higher education itself. Though parents are only just now becoming aware of it, conditions in the early grades are far more crucial. The experiments of Krech at Berkeley, showing that educational deprivation actually stunts the growth of the cerebral cortex, are being validated at more and more laboratories. Your child robbed of his brain tissue?

Conventional mass movements, with militant demonstrations, banners and simplistic slogans, often lend new life to the extreme positions they oppose. The new technology brings us new modes of change.

We start, then, not by merely attacking existing educational environments but by building new ones. How? The ways are many.

One example: A foundation or other funding agency interested in changing the face of American education now has that opportunity. The innovative agency (or group of agencies) can help set up just a half-dozen early-educational schools, starting with the four years from three through six and adding a new age group every year. These schools might start with principles such as those explored in the preceding chapters. But they would by no means seek standardization. Each would be encouraged to learn from its learners. They might vary widely as to geographical region and type of neighborhood. Up to three of the six might be located in ghettos, and I would expect the 'deprived' children here to outperform students in the best conventional suburban schools, on their own terms, as well as do things conventional educators have not dreamed of. Most important, all of this would be accomplished without any of the usual pressures on the learners.

Faculties in the model schools would not be limited to professional educators. The professionals, like all others involved, would have to show their willingness and ability to break set, to help

create a new, ever-changing climate of learning. People from diverse fields would be invited to participate, especially members of the burgeoning new breed of generalists.

Up against the giant bulk of the U.S. education establishment, a half-dozen experimental schools may not sound like much. With educators, parents and students looking for new approaches, as few as six radically different -- and successful -- schools could transform education everywhere.

But this is only one of a spectrum of strategies. Changes can come one step at a time. Teachers can work toward making their own classrooms into free-learning environments and can create there new modes of human relations. They can start with something as simple as taping a classroom discussion. The playback is a revelation to most teachers. They are amazed to learn how much they talk, how little chance their students have to respond. Teachers can also gain useful feedback in encounter-group sessions. Several encounter experiments are under way in U.S. schools in an attempt to get teachers ready for change. Many individual schools already are pushing into new educational territory. They deserve attention and support.

Reforms are possible, inside and outside of established institutions, when the reformers assume the best and then act, when they build rather than just protest. It is not necessary to wait for official approval at every level. It is not necessary to wait for experts.

With automation, increasing amounts of human energy are rapidly becoming available. Individuals, families and organizations now have the opportunity to create new cultures within a lifetime. There is little time for delay. We may have reached the moment, as many have suggested, when the basic alternatives lie somewhere between sweeping reform and self-destruction. The future guarantees no kindness to those who, in the name of 'reasonableness' or 'practicality' or out of fear of being presumptuous, fail to make the larger proposals.

We must at last confront ecstasy itself, that essential educational ingredient we most desire and most fear. It is deeply-embedded, this societal teaching. Joy threatens things-as-they-are. Ecstasy, like nuclear energy, is dangerous. The only thing that may turn out to be more dangerous is shunning it and clinging to the old ways that are dragging us toward destruction.

Perhaps it is time for scholars and pundits to engage in the serious study of delight. What are its dangers, its uses? I would suggest three primarily negative considerations as a beginning:

1. Ecstasy is not necessarily opposed to reason. Yet it may help light the way toward relationships, societies and educational systems in which reason and emotion are no longer at odds.
2. Ecstasy is not necessarily opposed to order. On the other hand, it may help us redefine order. Our free-learning and joyful school represents a far higher, more elegant form of order than does a school in which 'order' is forced and artificial.
3. Ecstasy is neither immoral nor moral in itself. At times, forms of ecstasy have powered some of mankind's most destructive movements. The Third Reich, for example, exhibited a certain ecstatic mania.

With ecstasy, as with all potent forces, context is crucial. Ecstasy is education's most powerful ally. It reinforces, and is the substance of, the moment of learning.

Knowing this, the master teacher pursues delight. Even those best known as great lecturers have turned their lecture halls into theaters, shameless in their use of spells and enchantments.

When men must serve as predictable, prefabricated components of a rigid social machine, the ecstatic is not particularly useful and may, in fact, erode the compartments so necessary for the machine's functioning. But when a society moves away from the mechanistic, when an individual functions as

a free-roving seeker, when what we now term 'leisure' occupies most of his hours, ecstasy may usefully accompany almost every act. Technology is preparing a world in which we may be lifelong learners. In this world, delight will not be a luxury but a necessity.

Every child, every person can delight in learning. Every educator can share in that delight. The methods are available. The needs for reform are clear. The chief obstacles are simply inertia and low expectations. Actually, a new education is already here, thrusting up in spite of every barrier built against it. Why not help it happen?

#

TEACHING AIDS

Excerpted from

TEACHERS' GUIDE TO FILMS

Sanford J. Feinglass, Ph.D.
Project Program Coordinator

This guide has been prepared for use with drug abuse films presented in classrooms. Its intention is to provide through a question and answer format, objective, scientific information concerning drugs and drug usage. The material can be used by teachers to encourage meaningful dialogue, broaden the base of audiovisual material, and stimulate homework assignments and research projects for students. The guide is based upon suggestions arising from screenings of the film 'Drugs and the Nervous System' by teachers, students and authorities in medical research and clinical research. It is emphasized that answers are not comprehensive but are designed to create proper attitudes. Teachers should direct students toward the ideas represented by the answers rather than employ the answers in an absolute manner.

Question: Is aspirin a drug?

Answer: A drug is any substance other than food which is used to change either the structure or function of the body. In this sense a wide variety of materials are to be considered drugs: vitamins, hormones, antibiotics, narcotics, the solvents in glue, and even agents which may not be widely used medicinally, such as marijuana and beverage alcohol. The word drug does not necessarily describe something bad.

Question: Is aspirin a dangerous drug?

Answer: This is a relative question. In terms of possible harmful effects, aspirin has been responsible for a number of deaths and is particularly lethal to children. Physicians and pharmacologists classify the hazard potential of any drug according to a device known as the therapeutic index. The therapeutic index compares the doses required for lethality with those doses that are required to produce a desired effect. A drug with an effective dose very close to a lethal dose is considered to be potentially more hazardous than one with a wider margin between the two dosage levels. There are, however, considerations other than fatalities which must be weighed in discussing dangerous effects of drugs. Chronic toxicity occurs when damage to the body is not apparent until the drug has been used continuously over a relatively long period of time. Another form of danger in the usage of drugs is the potential that some drugs have for being abused. The quality that makes one drug possess a greater potential for abuse than another is not clearly understood. However, certain drugs, by their interaction with the mind of the user, may lead to harm of a social or economic nature rather than physical damage. For example, a person who becomes obnoxious due to over-indulgence finds himself ostracized socially. This social effect would be a harmful result of the use of alcohol and would constitute alcohol abuse. In the case of heroin, some people have reported spending \$50 to \$100 a day in order to maintain their addiction to the drug. Such an economic hardship would be considered an abuse. Spending a portion of one's life in a penitentiary or jail is another possible harm resulting from the use of certain drugs. Certain dangers inherent in the use of drugs may not be sensational or even apparent. There is the definite possibility of subtle danger from the alteration of the personality or behavior patterns of an individual. This alteration may not come from the pharmacological effect of the drug but from the social situation of a drug's use.

Question: The narrator states, 'Only a doctor knows which drug to use or how much to use.' The film, however, shows that aspirin may be used to treat a diseased state without the suggestion or intervention of a physician. Why is this procedure socially acceptable, or is this procedure socially acceptable?

Answer: Many drugs are available only upon the written prescription of a licensed practitioner. Certain drugs can be purchased without consulting a physician or producing a prescription. A third group of drugs are unavailable for any human use. Aspirin is a drug which our culture permits to be

sold at any time without a prescription or the intervention of a physician. Presumably, this is because our culture has learned the indications for the proper use of aspirin. The majority of aspirin is used for the reasons shown in the film, for the treatment of headache or for minor aches and pains. However, there are occasions when aspirin has been abused (for relief of tensions, for example) and has even resulted in death. Consider, also, that by self-medication with aspirin, a diseased state requiring a more specific drug may escape the attention of a physician until it is too late.

Question: Although strychnine is an extremely dangerous drug, as suggested by the film, it may be purchased without a prescription. Isn't such a state of affairs irrational?

Answer: A sufficient fund of cultural information is available about certain poisonous drugs which tends to prevent their misuse. Strychnine has in certain cases been used for homicide as well as suicide. Society has determined, however, that such occurrences are infrequent enough not to require the banning of strychnine-containing preparations. A majority of persons who buy strychnine do so for a specific reason -- to eradicate pests. Most people who buy rat poison are not even aware that the bait may contain strychnine. The intended use of the drug outweighs the consideration of knowing the name of the drug. There are other drugs available on the same basis. Ant poison has an extremely dangerous drug known as arsenic; caustic lye is in drain-cleaning preparations; ammonia is used for cleaning glass products; volatile solvents are present in glues and lighter fluids; chlorine occurs in bleaches. These materials are classified and are, in small doses and under certain specified conditions, used by physicians for the treatment of disease. The culture using them has devised certain criteria for the limits of their use. As the film suggests, no one would select strychnine as a breakfast cereal. On the other hand, some drugs used by individual cultures affect the central nervous system in such a manner as to alter the perception of the outside world for purposes unrelated to medical practice. In this class we include Kava, Khat, marijuana, cocaine, alcohol, opium, and other substances producing similar effects. In each case a culture has chosen a drug which it understands and can set limits on use.

Question: The film suggests that one obtains only unpleasant feelings from glue. Is this true?

Answer: Obviously not, for if the feelings were only unpleasant, glue would not be used in the manner described. It is true, as the film also states, that glue sniffing is an extremely dangerous act. Glue contains volatile solvents which have been shown to damage the brain, heart, liver, and kidney. A person can become tolerant to the effects of these solvents and require increasingly larger amounts of the substance to produce the original effect. Glue sniffing is another example of the abuse of a drug that is not illegal. The sniffing of glue may cause one to become euphoric. This term describes the sense of well-being, the calm, and the pleasant feelings which may occur through use of the drug, but it is a dangerous procedure. The sniffing of cleaning fluid, gasoline, or lighter fluid is comparable.

Question: Among the group of drugs known as depressants, the film mentions only the barbiturates and heroin. Are there other depressant drugs which may be abused?

Answer: Yes. The most frequently abused depressant drug is unquestionably alcohol. Tranquilizers are occasionally abused and addiction to the so-called minor tranquilizers is not unknown. In the United States there are approximately six million people under medical care because of the effects of chronic alcoholism. There are, additionally, 30 to 40 million other Americans who have at one time or another, because of excessive use of alcohol, suffered some form of social economic harm. It has been estimated that 20% of absences from work are the results of the effects of alcohol. For a number of years, 4% of the users of alcohol have, on autopsy, demonstrated cirrhosis of the liver. Alcohol has been associated with 50% of automobile accidents. Alcohol can be an addicting drug: definite and recognized painful experiences accompany abstinence by alcohol abusers.

Addiction is also encountered with the minor tranquilizers. These drugs have demonstrated a rather high potential for being abused. In this category are agents such as Equinil, Miltown, Librium and Ultram. These agents are supposed to be available by prescription only. As of this writing, unauthorized possession of these drugs is not a crime at the federal level but the drugs so possessed may be

confiscated. In the year of introduction to the United States, the sales of tranquilizers amounted to \$150 million.

Question: The film indicates that under certain circumstances a barbiturate user may commit violence. Is this possible in the light of the fact that barbiturates are depressant drugs?

Answer: Being depressants, barbiturate effects are similar to those accompanying the use of alcohol. There may be difficulty in thinking, speech patterns are on occasion disturbed, psychomotor effects are such that the user may appear to be drunk. In addition to these signs, the barbiturate abuser often develops changes in personality. These may include an increased level of irritability and hostile and paranoid ideas. In rare cases, the barbiturate addict may idiosyncratically be moved to action although in most cases actual hostile and provocative behavior is absent. Since they are depressants, barbiturates decrease the likelihood of such activity during the time the drug is acting but some of the hostility and paranoid ideas may carry over into the 'normal' state. Long term addicts generally show a thick-slurred speech, ataxia in walking and standing, and loss of hunger.

Question: What are deaths from overdosage of barbiturates due to?

Answer: Generally, deaths from overdosage of barbiturates are due to respiratory depression. The person simply stops breathing.

Question: The film suggests that the only reason for youthful use of depressant drugs is obtaining kicks. Does this conclusion seem reasonable?

Answer: 'A complex combination of pharmacological, sociological, and psychological forces undoubtedly interact in a particular individual to produce abuse of or addiction to barbiturates.' (Hearings on the Drug Abuse Control Amendments of 1965.) This should open discussions of motivation and produce topics for student research projects.

Question: The film states, 'The strongest and most dangerous drug is heroin.' What does this mean? Is the statement factual?

Answer: No. The question asks for a measure that has not as yet been invented. If by 'strongest' is meant the drug that achieves its effect in the smallest dose, the answer is no. If by 'most dangerous' is meant that heroin produces the greatest amount of physical damage, the answer is no. This question, like the previous question, allows the teacher to deal with a student's ideas and opinions of drug usage and the causes of drug usage. It should be emphasized that words such as 'strongest,' 'most dangerous,' and 'kicks' are indefinable and vary with each individual person's understanding of drug effects and his knowledge of the causes of drug abuse. The teacher should adequately prepare to recognize and deal with specific terminology, and to transmit these definitions to the student.

Question: Is morphine the most helpful drug for the relief of pain as suggested in the film?

Answer: No. Some of the recently developed synthetic drugs not only relieve pain in doses smaller than morphine but, in addition, the patients suffer fewer side effects. More important than even this consideration is the type of pain being treated. In certain types of pain aspirin may be much more helpful than morphine since it may not only relieve the pain but also affect the cause of the pain. For rheumatoid arthritis aspirin is considered superior to any of the opiates.

Question: In using heroin, does a state of drowsiness follow the good feeling; the sequence stated in the film?

Answer: No. Occasionally, users of heroin (and dependent upon the dose administered) will experience euphoria without going on the 'nod.' In other cases, particularly after one has become addicted to heroin, euphoria may no longer be achieved and drowsiness may be the only state reached.

Question: Can, as the picture states, tolerance to heroin form quickly?

Answer: Tolerance develops in proportion to the dose used, the frequency of dosage, and individual response. Tolerance may occur rapidly or slowly, according to the pattern of drug use.

Question: Why is heroin as expensive as the film describes?

Answer: Because of the limited availability and the normal dynamics of supply and demand, the price of heroin has risen steadily over the years. The price increase is a measure of the effectiveness of legal controls on the distribution of heroin.

Question: Is the addict more of a threat to society when under the influence of narcotics or when the narcotic action begins to wane?

Answer: As is indicated in the film, the narcotic addict is more of a threat to society as he approaches and proceeds through the phases of withdrawal. The addict in withdrawal requires the administration of a narcotic in order to prevent physical discomfort. It is during abstinence that most addicts are presumed to engage in antisocial behavior in their efforts to obtain funds to purchase additional narcotics.

Question: Is opium, as stated in the film, the only source for narcotic drugs?

Answer: There are several available narcotic or opiate drugs which are totally synthetic in origin. Such drugs as Demerol, Dolophine, and Dilaudid, as well as the non-narcotic drugs Romilar and Darvon, are synthetics based upon the chemical structure of the naturally occurring narcotics.

Question: The film states correctly that tolerance is the necessity of administering larger doses of a drug to achieve the original drug response. Does this phenomena continue on towards infinity?

Answer: No. There comes a time when the individual adjusts himself by finding a balance between the pharmacological, sociological, psychological, and economical considerations of drug usage.

Question: Is death from withdrawal of narcotics a usual phenomena?

Answer: Deaths resulting from the use of narcotics are usually due to overdosage. Few individuals (generally only those who are physiologically debilitated) are fatalities because of narcotic withdrawal. Such is not the case, however, with barbiturates and alcohol in which the morbidity rate during abstinence is considerably higher than with narcotics.

Question: The film shows a cup of coffee in discussing stimulants. Can coffee and the alkaloid it contains, caffeine, be considered abused drugs?

Answer: People can and do become psychologically dependent upon caffeine. Some signs of abuse include irritability, argumentativeness, small tremors and convulsions. Occasionally, heart irregularities have accompanied caffeine overdosage.

Question: What other stimulant drugs are occasionally abused?

Answer: Among the other stimulant drugs abused are cocaine, mescaline, STP, MDA, and TMA.

Question: The film states that the amphetamines are used medically for the treatment of depression or tiredness. Are these conditions considered valid medical applications of a drug?

Answer: If the tiredness or depression is interfering with the normal daily activities of the patient and amphetamine is administered to the individual with the intention of improving his performance, the drug is being prescribed for social or economic purposes. The ethical question of the medical use of

drugs for economic or social purposes may be debated endlessly. Persons may self-medicate themselves for social or economic reasons. Some tired or depressed person may decide to use amphetamines without the intervention of a physician. How, then, are lines drawn to decide which drugs may be used for such purposes and who determines their necessity? It is in answer to this last question that the current legislative and moral debates in drug use and abuse are occurring.

Question: What does the narrator mean by the comment, 'Two other drugs disturb the nervous system seriously,' in referring to marijuana and LSD?

Answer: The question is designed to allow participation on behalf of the students in the discussion. The terminology used is intentionally inexact. One can discuss whether the word 'serious' should be used to define actual permanent damage or to connote a profound effect on the nervous system, or whether it means affecting just a small portion or the functioning ability of the central nervous system.

Question: What drugs other than marijuana distort the appearance of the world?

Answer: The film states marijuana and LSD 'distort the appearance of the world.' However, in recalling earlier portions of the film, one should realize that all the drugs discussed in the film alter, distort, or change the appearance of the world. The spatial-temporal distortion caused by marijuana and the loss of judgment supposedly accompanying the use of LSD are phenomena common to many of the mind-altering or perception-changing drugs.

#

Excerpted from

SUGGESTIONS ON THE USE OF FILMS IN DRUG ABUSE EDUCATION

*David O. Weber, Film Consultant
California Department of Public Health, &
Joseph Fiorelli, Audiovisual Specialist*

Users of LSD say that the quality of a trip depends on several factors. One is the grade of acid taken. Another is dosage -- a fledgling will almost certainly fly on 250 micrograms, while the same amount may barely get a hardened tripster off the ground. Two other essential factors are the 'set' and the 'setting.'

Set means the ideas, the mood, the rationales a user carries with him into the experience. If he is fearful, antagonistic before he begins his trip, he is likely to have a bummer.

Or, if the setting is wrong -- unpleasant physical surroundings, bad vibrations from those around him, distracting noises or lights or music -- even a positive set can be negated.

The use of drug films to educate young people about dangers of drugs can be compared with the use of LSD.

First, the quality of films, as of drugs, varies widely. Many films still in circulation have lost their potency through age. Hats, hems, automobiles, outmoded slang, may distract from and vitiate the message, no matter how timeless. Or, a film which is up-to-date visually may be hopelessly marred by jingoistic phrases and atavistic attitudes. 'Know your dealer,' they say in the streets. Applied to films, this translates to know something about the producers of films whose use is contemplated and, if at all possible, sample the dose in advance by pre-viewing them before an audience that will not be harmed if the film is bad.

In addition to quality, drug abuse films vary in type. Some take the sociological approach, warning against the loss of income, status, dignity, even freedom (if jailed) attendant upon addiction. Some are purely descriptive of drugs and their effects. Some show in great detail the ways drugs can be abused. Some maintain a studiously clinical distance. Some are dramatizations, some documentaries, some lectures, some cinematic essays. Most are a combination.

Some project a tone of moral outrage, others a tone of cool scientific detachment. Some attempt to deal with a broad spectrum of drugs -- these are fewest in number and probably the most needed -- others treat only one drug or one class of drugs. Needless to say, none of these films will give audiences identical trips.

It might be worthwhile to ponder in advance what functions a film should perform:

For example, is one purpose of a drug film to show teenagers how heroin is prepared and injected, how marijuana is smoked, how glue is inhaled -- so that they can recognize and avoid these situations when encountered? Should a film be propaganda, supplying the moral element to the classroom's dispassionate discussions?

Should a film, because it lists a lot of doctors as consultants, be considered unimpeachable authority? Or should it be questioned, and if necessary demolished, in the presence of its audience? As set down, of course, these are loaded questions. Unfortunately, most drug films are similarly loaded.

The next consideration in selecting a drug abuse film, to continue our LSD metaphor, should be the set. What's the mood and character of the audience? Obviously, rural junior high school students will find little to identify with in a film about big-city junkies. Nor will ghetto blacks do much but cackle at the cinematic drug despair of an affluent, blond, sports-car-driving Kampus-King protagonist. Only through careful assessment of the set of an audience can a film user hope to turn it on meaningfully.

Finally, the setting must be such that the trip will be good, not bad. Most drug film audiences are captive. They can't question the film about obscure points, they can't argue with it (though they can catcall and mutter). If their boredom threshold is breached, they nod off.

Guides to the use of films are difficult to set forth because each teacher and teaching situation is different. However, there are some basic rules that if followed improve chances of success.

A good rule to start with is to be as wary of films as of drugs. Some precautions to be kept in mind are: Don't trust a film to be good just because someone says it is: no one film is good for every situation . . . Don't trust even a good film to contain only accurate information . . . Don't trust one expert: consult several.

If possible, preview a film before ordering it. That failing, request delivery several days in advance of the scheduled showing in order to view it, preferably with a few teachers or students whose opinions and reactions will be helpful.

Do not hesitate to use only portions instead of complete films, filmstrips, or tapes. Imaginative teachers have put together excellent shows by combining parts of several films.

Before a showing, check equipment to be sure it is mechanically and optically satisfactory. Ideally, back-up projectors and sound equipment should be on hand in case of an equipment breakdown. If there is a breakdown and no back-up, it is usually better to postpone the presentation entirely than to interrupt it for a lengthy repair job.

Room arrangements should be checked to assure sufficient darkness and satisfactory viewing from all seats. Materials should be racked and ready so that the film showing can start immediately after the introduction. If something intervenes between the introduction and the showing, the meeting should be brought back into the proper setting by a reintroduction.

Generally, no film should be used for educational purposes without oral introduction or explanation. The introducer can tell the purpose of the film showing, reasons for selecting the film, what to look for in it, what questions or reactions will be discussed after the showing.

Ample discussion time should be scheduled to follow film showings. The discussion period may contribute more to the desired objectives than the film showing.

Nothing should be permitted to interrupt a film showing. Unless latecomers can enter without distracting the audience, the entrance door should be barred.

Where practical, audiences should be kept small. In intimate groups, comments and criticisms come more freely, and there is opportunity to correct errors, misunderstandings, and inaccurate inferences.

Some think that, for teaching purposes, all films should be shown twice, with a discussion period in the middle and perhaps another one following. It is a possibility to be considered.

The reviews that follow attempt to give information more helpful to teachers than the three-line blurbs given in film catalogs, which are generally the only information and guidance available on which to base decisions on what films to order. The reviewer is a layman, not professionally involved with either drugs or films. He has tried to be honest and open-minded, and to see the films through youthful eyes, since those are the eyes most likely to be focussed on these films. However, he is a cautious adult 30 years old, and therefore cannot be universally trusted.

Names and addresses of the film producers are given, and of the distributors where known. Prints of most can probably be borrowed through state or local Health Departments, Film Libraries, or Boards of Education.

* * *

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It contains a report on the state of the Union and the progress of the war against the rebellion. The President mentions the success of the Union arms and the determination to suppress the rebellion.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 3, 1862. It contains a report on the state of the Treasury and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

3. The third part of the document is a report from the Secretary of the Interior, dated January 3, 1862. It contains a report on the state of the Interior and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

4. The fourth part of the document is a report from the Secretary of the Navy, dated January 3, 1862. It contains a report on the state of the Navy and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

5. The fifth part of the document is a report from the Secretary of the War, dated January 3, 1862. It contains a report on the state of the War and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

6. The sixth part of the document is a report from the Secretary of the State, dated January 3, 1862. It contains a report on the state of the State and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

7. The seventh part of the document is a report from the Secretary of the War, dated January 3, 1862. It contains a report on the state of the War and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

8. The eighth part of the document is a report from the Secretary of the State, dated January 3, 1862. It contains a report on the state of the State and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

9. The ninth part of the document is a report from the Secretary of the War, dated January 3, 1862. It contains a report on the state of the War and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

10. The tenth part of the document is a report from the Secretary of the State, dated January 3, 1862. It contains a report on the state of the State and the progress of the war against the rebellion. The Secretary mentions the success of the Union arms and the determination to suppress the rebellion.

Excerpted from

FILM REVIEWS

David Weber

(Previewed for Drug Film Festival, University of Stanford, May 1968)

. . . Previews in approximate order of production . . .

ESCAPE TO NOWHERE

1968 16mm. color 25 min. *Sponsored by the San Mateo (California) Union High School District, Dr. Leon M. Lessinger, superintendent, executive producer. Produced by Professional Arts, Inc., P.O. Box 8484, Universal City, California 91608. Dr. David W. Parker producer. Rental Price: \$27.50/3 days.*

Intended Audience: Sr. High School Students, Adults.

Technical Quality: Excellent

Summary of Content: 'Her name is Debbie,' the narrator says. 'She's 16 years old and she's a real girl, not an actress. She lives in New York, but sometime ago she left home and friends and school to seek and find her own personal Nirvana, using drugs as her principal passport . . .'

In answer to the narrator's questions, Debbie soliloquizes about the aimlessness of her adolescent wanderings, about what it's like to be an aging 16-year-old in 1968, and about the major role drugs play in her life. The camera follows her as she hitchhikes . . . strolls alone through an aquarium, a museum, a bookstall, an art gallery . . . plays with children in a park sandbox . . . eats a solitary hamburger . . . sits pensive on a bench. In the next-to-last scene she injects heroin into her arm. Debbie says she first smoked marijuana at 14 or 15, then progressed through hashish, pills, LSD and methamphetamine to heroin.

Scenes of Debbie's peregrinations are interspersed with cameos illustrating the social milieu: a middle-aged televiewer drinks beer and smokes while a newscaster bombasts about drugs . . . popcorn-munching moviegoers stare goggle-eyed at 'freaked-out hippies frolicking in the deadly fumes of marijuana.'

Chemical formulas for methamphetamine, tetrahydrocannabinol and heroin introduce capsule descriptions of the dangers of these drugs. Several youths offer standard apologia for drug experimentation.

Some of Debbie's thoughts:

The adult media 'get the straight dope about drugs, but they put it across wrong. Most kids will just believe what another kid tells them.' . . . 'One thing I've always wanted is to go back to when I was three or four.' . . . 'I use smack once a week, sometimes twice a week. If I'm really nervous or uptight I use it to calm down . . . Yeah, I'm in too far now. I think I am.'

Evaluation: The trouble with this film is that while Debbie's plight is affecting, it's hard to distinguish most of her problems from those tormenting any sensitive, intelligent, urban adolescent in 20th century America. The film seems to be suggesting that drugs made Debbie the way she is. Mixed up, lonely, unfulfilled. But it is doubtful that young viewers, deep in their own private struggle with the world, would agree. It is clear that drugs haven't solved any of her problems. But they don't seem to have particularly harmed her, either (at least as much as the wheedling narrator strains to imply -- and his saccharine tones deserve a special sneer.)

The film tries to probe the attitudes which lead to drug use, but it's hard to imagine a teenage viewer changing because of Debbie's experience. The attitudes that lead to drug experimentation are normal and healthy -- curiosity about one's drug-ridden world, a desire to plumb the deepest folds of one's developing psyche. Why did Debbie make that final mis-step? The film can't tell us.

* * *

THE DISTANT DRUMMER-- A MOVABLE SCENE

1968 16mm. color 22 mins. *An Airlie Production, Murdock Head M.D., executive producer. Sponsored by the National Institute of Mental Health, the George Washington University School of Medicine and Public Affairs, the District of Columbia Medical Society and the American Academy of General Practice Alfred M. Freedman M.D., consultant.*

Intended Audience: Adults

Technical Quality: Good

Summary of Content: Robert Mitchum, representing the Establishment, narrates this survey of the current youth scene. Escapism and rebellion, especially as manifested in drug abuse, provide the focal points.

LSD-use, the film declares, is on the downswing. The new directions are meditation and methedrine. Injecting powdered methamphetamine crystal into the bloodstream induces a 'six-hour surge of euphoria,' but may also provoke a lasting psychological dependency.

The common drug denominator among dissident youth, the film notes, is marijuana which though it may be less harmful than alcohol, is undeniably illegal.

There are other universal anti-Establishment manifestations among the young besides drug-use, Mitchum declares, such as hippies, commune-dwelling dropouts, religious pilgrims, leather-jacketed motorcycle toughs. The 'International beatnik set,' a sort of obverse jet-set, is examined. Its members -- whether London hippies, Amsterdam provos, or coeds on a Wanderjahr from Wilkes-Barre, Pennsylvania -- know what cafe is 'in' in Istanbul (Yener's), where to buy a lid in Rome (the Spanish Steps), and who's guru in Katmandu.

Today's youth is selfish and escapist, declares a Santa Monica minister. Psychological illness resulting from drug abuse is being seen with increasing frequency, says a New York psychiatrist. An English parent laments the death of his ostensibly conformist 21-year-old son from an overdose of heroin. But don't equate drug-taking with mere long hair, warns a UCLA psychiatrist and youth expert. 'We as straight society,' Mitchum urges, 'must reach out to young people and help.'

(Note: The version previewed carries a six-minute trailer, an interview with Dr. Stanley Yolles, Director of the National Institute of Mental Health. Dr. Yolles says that two-thirds of youthful drug-experimenters are merely curious, that dissemination of accurate information has led to the decline in LSD abuse and should have similar effects for other drugs, and that the best way a parent can help his children is by establishing open communication in the home.)

Evaluation: Good for adults who have been on vacation in Lapland during the past six years. And probably interesting for those who wonder what their daughter did in Europe last summer. Basically, though, the film seems made to set grey heads tsk-tsking. The advice is: talk to your kids, listen to what they say, try to offer them alternatives.

* * *

THE HIPPIE TEMPTATION

1967 16mm. color 51 mins. (Part I, 31 mins., Part II, 20 mins.) Produced by CBS News, Warren Wallace, producer and writer. Distributed by McGraw-Hill Films, 330 W. 42nd St., New York 10036.

Intended Audience: General, Sr. High School

Technical Quality: Excellent

Summary of Content: The 'Summer of Love' -- that brief, wild flowering of the hippie ethos in San Francisco's Haight-Ashbury district in 1967 -- is surveyed by television cameramen and narrator Harry Reasoner.

Why do people become hippies? 'Look around you,' replies the editor of an underground newspaper. 'Nothing works.' Society offers only empty jobs and meaningless, shoddy material rewards. 'Life should be a joy,' he argues. But LSD may not bring the joy its users desire, the film points out. Two youthful LSD-experimenters who freaked out are interviewed, in juxtaposition with their distraught parents.

In Part II, Reasoner talks with members of the Grateful Dead, a rock band, harbingers of the new, hippie life-style. The physician-director of the free Haight-Ashbury Medical Clinic says youths drop out 'as a result of some deprivation in their middle-class lives -- usually intellectual deprivation.' 'The movement seems to be growing,' Reasoner concludes. 'The use of drugs is spreading. There is danger that more and more young people will listen to the call . . .'

Evaluation: There is a lament heard frequently in San Francisco these days. It goes something like this: 'Gee, whatever happened to all the good hippies? The ones who used to live in the Haight? They were so nice and gentle and productive, remember?' This sort of film is what finally helped swamped the Haight. Shown on network television, it brought hordes of lost pilgrims streaming in from Dubuque and Cincinnati. Flowers don't flourish when the ground is trampled by crowds.

The film is an absorbing documentary. In this accelerated age, however, it is already as outdated as a World War I newsreel. The Haight has gone to seed -- a teenage slum inhabited by meth-heads, Hell's Angels and 12-year-old runaways. There are excellent arguments against ingestion of LSD, but they are vitiated by the sequences dealing with the young freak-outs. One mother, whose daughter attempted suicide, found the most disturbing aspect of her child's drug-taking to be the fact that she changed. Another subject explains that LSD made him see that God is in everything. Such an unfashionable announcement soon landed him in a neuropsychiatric ward.

* * *

MARIJUANA

1968 16mm. color 34 min. *Produced by Avanti Films, Los Angeles, Max Miller, writer/producer. Not cleared for television*

Intended Audience: Jr. & Sr. High School Students (College & Adults)

Technical Quality: Good

Summary of Content: Pop-singer Sonny Bono, clad in orange-lame Nehru jacket and sipping coffee, conducts viewers through this contemporary examination of the pros and cons of marijuana use.

The film opens with scenes of a teenage pot party. The police burst in. As the kids are handcuffed and wrestled out the door, they scream justifications for the legalization and consumption of marijuana. The arguments are then isolated, each providing the lead-in for a discussion of one particular aspect of the marijuana controversy.

Sonny admits that alcohol and tobacco are both drugs which are legal but frequently abused, denies that this makes a case for legitimization of another. The film ends with exhortations by a series of young people condemning the use of drugs and urging involvement in society's struggles.

Evaluation: This is an attempt to deal with the subject of marijuana calmly and even-handedly in the voice of a protagonist calculated to enlist the sympathy of teenage viewers. Unfortunately, the attempt fails.

One reason is the choice of narrator. Sonny Bono is one of that group of aging pseudo-teenagers who appeal primarily to the youngest, most naive set of pop-music fans -- the teenyboppers.

Further, some of the film's statements are of questionable validity. In short, this film, which seems on the surface to be a dispassionate analysis, comes through as uncompromising propaganda. To educate against the use of marijuana is not the same as to educate about marijuana. It is doubtful that many young viewers will be anything but angered when they emerge from seeing this attempt.

* * *

THE MIND BENDERS -- LSD AND THE HALLUCINOGENS

1968 16mm. color 26 min. *Sponsored by the U.S. Food & Drug Administration. Produced by Vision Associates, Lee R. Bobker, writer/director. Loan Source: PHS Audiovisual Facility, Chamblee, Georgia 30005.*

Intended Audience: Sr. High School & College Students, Teachers, Adults, General

Technical Quality: Excellent

Summary of Content: Young LSD users tell why they took the drug, what it did for them, how it affected their lives. UCLA psychiatrists Duke D. Fisher and J. Thomas Ungerleider, and NYU Medical School professor Marvin Stern, warn of the hazards: bum trips, recurrent flashes, impulse to drop out.

Since the beginning of time, the narrator notes, man has had a desire to alter his perception. Some of the powerful chemical substances by which he is able to accomplish this are psilocybin, mescaline, DMT and LSD -- the hallucinogens. The film concentrates on LSD: it is extremely potent, but its perception-changing mechanism remains largely a mystery. It has caused abnormal

and premature births in one study of five guinea pigs; it has been associated with chromosomal breaks in human users; it may cause psychological dependency in some users. It may also be a vehicle for good. An LSD-treatment program for alcoholics in Kansas City is examined. Other experimental therapeutic uses for LSD are mentioned. The film ends with this caveat for casual experimenters: 'The facts suggest caution, and a careful counting of the cost.'

Evaluation: A sober examination of a topic which all too often provokes intemperance, this is an objective film, permitting LSD users to recount their experiences without apology. The facts -- that there are very few facts but lots of opinions -- speak for themselves.

Visually the film is superior: artistic color scenes bridge the interviews, which are shown in black-and-white. This use of black-and-white when dealing with human subjects involves the audience more deeply with the people on the screen. Results: Teachers charged with indoctrinating young students against LSD might best steer away from this film. The young LSD-takers have obviously not suffered overt brain damage, livid psychological scars, or pangs of remorse. College students, professionals, teachers and quavering parents, on the other hand, might profit from a viewing. For purposes of exploring the actual state of LSD affairs, recommended.

* * *

BEYOND LSD

1968 16mm. color 25 min. Produced and directed by Paul Burnford. Medical consultant J. Thomas Ungerleider, M.D. Distributed by Film Associates of California, 11559 Santa Monica Blvd., Los Angeles 90025.

Intended Audience: Adult (also advertised for Jr. & Sr. High School Students)

Technical Quality: Average

Summary of Content: Anxious middle-class parents express their fears that long hair, strange clothing, raucous music signal the irreversible plunge of their children into a shadow life of LSD abuse, degradation and crime. Not necessarily so, they are reassured by a friendly neighborhood counselor, if the parents substitute reason, patience and understanding for hysteria, lies, petty niggling and rule by fiat.

A psychiatry professor urges the parents to try to understand a teenager's struggle with his anger, his sexuality and his emerging identity. Drugs let him hide this struggle from himself -- but adult sympathy can forestall his recourse to such a refuge. Let drugs be discussed openly so they lose their appealing aura as forbidden fruit. Skip the non-essentials in dealing with teenagers, he counsels. Don't get uptight about clothes, fads, hairstyles, eating habits, speech mannerisms. 'They have no basic importance and are certainly not worth endless arguments which only convince a youngster we can never understand him.'

Evaluation: A film of value for adult audiences -- PTA groups, Rotarians, etc., especially middle-class adults. The acting is clumsy and strained, a defect that adults may be able to overlook though it will probably get in the way of the message for many. The subject is less drugs than a plea for level-headedness in family relationships.

* * *

LSD: INSIGHT OR INSANITY?

1968 16mm. color 28 min. A Med-Cine Production, written by Richard S. Scott, M.D. and Max Miller, producer/director.

Intended Audience: Jr. & Sr. High School Students, Adults, General

Technical Quality: Above average

Summary of Contents: Eight doctors and a pharmacologist involved in LSD research explain and illustrate their findings. Consensus: LSD remains largely an unknown quantity and its unsupervised use is dangerous. The possibility that LSD exercises damaging genetic effects on humans is emphasized. Teratogenesis (production of deformed offspring), carcinogenesis (production of cancers) and mutagenesis (production of successive generational damage) are cited as some of the results of LSD experiments on animals. Visual material includes deformed fetuses borne by guinea pigs dosed with LSD and photos of chromosomal breaks and abnormalities associated with human LSD ingestion.

The film closes with former U.S. Food & Drug Commissioner James L. Goddard warning that LSD experimentation is like playing Russian roulette. In the film's final shot the gun fires. Narrated off camera by singer Sal Mineo.

Evaluation: Well-produced, excellent color effects and illustrative material for scientific findings. Terminology is relatively sophisticated and though explanations are clear in general, some confusion will probably arise among younger or less advanced viewers.

Scientifically the film displays weaknesses. There is tricky inference that LSD use is linked to human cancer. There is no indication of how great a dosage of LSD animals were given to produce the vivid foetal abnormalities shown. The film worries that no one emerges from an LSD experience without undergoing some change -- in philosophy, life-style, etc., but avoids the question whether such change might not be for the better.

The final scene, like much of the non-scientific material of the film, may weaken the overall effect for skeptical viewers. They are told that the question of LSD's properties remains unanswered, but the final bullet contradicts the premise. Another instance of an 'open mind' that is really closed.

* * *

DRUGS & THE NERVOUS SYSTEM

1967 16mm. color 18 min. Produced by Churchill Films, 662 N. Robertson Blvd., Los Angeles 90069.

Intended Audience: Jr. & Sr. High School Students, Adults

Technical Quality: Excellent

Summary of Content: Animation is combined with photographic vignettes to illustrate the effects of various classes of drugs on the human body and mind. The use of aspirin to relieve pain is a vehicle to introduce viewers to the nature of drugs and the workings of the nervous system. The film then discusses glue, stimulants (amphetamines), depressants (barbiturates), opium-derivatives (morphine, codeine, heroin), marijuana and LSD. Therapeutic uses, effects sought by abusers and the results of abuse of each class of drugs are explained. At the conclusion the narrator queries, 'What do you think?' about the character of young people who abuse drugs.

Evaluation: Though the final inference is pretty clear, the film attempts to be factual and non-judgmental. A rational, clinical tone is maintained throughout. There are some scientific weaknesses, for example the information on aspirin. The narrator suggests that users of marijuana

may ultimately wish to experience greater thrills -- the sort of chestnut that has a tendency to undermine the film's reliability in the eyes of sophisticated students. For the same reasons they would probably view skeptically the emphasis on those rare and sensational instances in which LSD users have died because they felt God-like enough to step onto freeways, or fly out of windows.

The youths depicted in the film are pre-teen or very early teenagers. Thus it would seem most suitable for junior high school students. The pictorial excellence of the animation is the film's chief virtue.

* * *

NARCOTICS -- THE INSIDE STORY

1967 16 mm. color 12 min. Produced by Charles Cabill & Associates, Inc., P.O. Box 3220, Hollywood 90028.

Intended Audience: Jr. & Sr. High School Students

Technical Quality: Average

Summary of Content: Young teenagers playing on a beach are used to illustrate the functions of the five senses and the central nervous system. The effects of drugs, classified as either stimulants or depressants, on the central nervous system -- the 'Inside Story' -- are then examined. Drugs discussed include narcotics, LSD, marijuana, tranquilizers, sedatives. The visual material is clinical -- experimental animals, doctors, laboratory test-tubes -- rather than sociological. Viewers are warned of the dangers of drug abuse, exhorted not to impair their senses, urged to exercise their sixth sense, common sense.

Evaluation: An exceedingly simplistic approach, with a consequent reduction in level of appeal, which is probably no higher than fourth grade youngsters for whom, it might be added, very few suitable films on the subject are made.

* * *

FROM RUNAWAY TO HIPPIE

1967 16mm. color 18 min. Produced by The Cinema Verite Co., 3116 16th St., Room 27, San Francisco 94103, in cooperation with NBC News.

Intended Audience: General

Technical Quality: Good

Summary of Content: A documentary about the hippie movement, its squalor and drug-based way of life. Originally shown as three six-minute segments on the NBC television Huntley-Brinkley Report. The first segment records the action at teenage glue-sniffing parties, and interviews the mother of two participants. The second follows three subjects to San Francisco's Haight-Ashbury, where they migrated in search of LSD, et al. A love-in, an acid wedding, the parade of gawking tourists, a crowded pad are depicted. The final segment discusses rural hippie communes, where compatible drop-outs return to nature, 'sharing their rice, their beans, their hepatitis, their venereal disease.'

Evaluation: More entertaining than instructive. Little analysis of drugs or effects. Practically guaranteed to turn off teenage audiences who strive to preserve their image of the hippie: free man,

devotee of love and truth, enemy of the greedy establishment, seeker for God in the acid-activated brain. Any such frontal assault on the image is deeply resented.

* * *

HELLO AMERICA

1967 16mm. B & W 29 min. Produced by The Cinema Verite Co., 3116 16th St., Room 27, San Francisco 94103; Johann Rush, producer.

Intended Audience: Teachers, Adults, Professionals

Technical Quality: Average

Summary of Content: The camera attends two parties where teenagers sniff glue, act drugged. (Excerpts from this film are used in *From Runaway To Hippie*.) According to the narrator, the four major factors common to most glue-sniffers are: too much free time; mass hysteria surrounding rock music groups whose members are known drug users; awareness that other teenagers are 'turning on'; nothing else to do (no other way to get high). Unsatisfactory home life and parents who don't know where their children go are also cited.

Not recommended for showing to persons under 21, the producers advise.

Evaluation: The moral, that glue-sniffing is bad, is implicit in the incoherence, the loss of physical coordination and the agonizing 'crash' recorded by the camera. (A crash is a painful reaction as the drug wears off or too much is inhaled.) But it is not certain that this message would come through to young viewers. There are times when the glue-intoxication appears attractive, and curiosity could be aroused to see what it feels like. These youths find the experience pleasant enough, to continue experimenting, thus providing a peer-group precedent.

College students and adults, however, would probably come away with little desire to emulate the subjects. The approach is honest, letting the images speak for themselves, but the film would benefit from cutting.

* * *

THE SEEKERS

1967 16mm. color 30 min. Sponsored by the New York State Council on Drug Addiction. Produced by Myron Solin. Distribution by the State of New York Narcotic Addiction Control Commission, Albany 12203.

Intended Audience: Sr. High School Students, Young Adults

Technical Quality: Average

Summary of Content: Young ex-drug-users and ex-addicts, members of an organization known as Encounter, discuss the unpleasantness of their lives when they were taking dope. They are filmed chatting among themselves, before groups of straight high school students, and with hippies. They condemn drugs vociferously and across the board. The hippie life is dismissed as a cop-out from responsibility to act against adverse social conditions. There is a short sequence in which a young girl who used LSD has her chromosomes checked. The types of genetic damage LSD may cause is explained. Otherwise the approach is sociological, non-technical.

'The question,' the young audience is warned at the film's conclusion, 'is how stupid are you going to be? You can be a little bit stupid, you can be very stupid, or you can be the least stupid possible.'

Evaluation: A film young viewers would probably enjoy -- and which might have some influence on them. How much and what kind, though, is open to question. This sort of put-down of drugs by people who have used them may be effective, but there is a little glint of pride at the back of these kids' eyes and a tinge of self-congratulation in the assurance with which they now lecture others. One point that emerges from the film is that drug users can quit of their own volition, contradicting doom pronouncements.

Among the film's flaws: it is too long; some scenes are confusing -- a moving reconciliation scene between a young husband and wife is emotional but pointless.

* * *

HOOKED

1967 16mm. B & W 20 min. Produced by Churchill Films, Inc., 662 N. Robertson Blvd., Los Angeles 90027.

Intended Audience: Jr. & Sr. High School Students

Technical Quality: Good

Summary of Content: Young ex-addicts tell of their experiences when using drugs -- heroin the ultimate narcotic in each case. The youths are attractive, articulate, of mixed racial and social backgrounds, and project an air of honesty and painfully-earned expertise. They are filmed in various institutional settings -- jails, halfway houses -- but the camera focuses on their faces. Their statements are grouped by general subject -- how they got started on drugs, what it feels like to get arrested, what it feels like to kick the habit, what their families went through as a result of their addiction. There are no dialogues, only individual reminiscences. The pace is fast. There is no narration.

Evaluation: An excellent film, principally concerned with heroin. The reminiscence form gives authority to the opinions. The look, jargon and relaxed intensity of the subjects should generate empathy among high-school-age viewers. Absorbing for any audience. The film's impact is derived from its lack of extraneous moralizing and the reiterated theme: 'I never thought it would happen to me. I thought I was, you know, something special.'

* * *

LSD: LETTVIN VS. LEARY

1967 16mm. B & W 54 min. Produced by WGBH-TV, Boston, for the National Educational Television Network. Distributed by NET Film Service, Indiana University AudioVisual Center, Bloomington, Indiana.

Intended Audience: General

Technical Quality: Average

Summary of Content: Former Harvard psychologist Timothy Leary expounds the doctrine of his league for Spiritual Discovery to an audience at Massachusetts Institute of Technology. MIT professor Jerome Lettvin, M.D., scientist, humanist and former mental hospital senior psychiatrist, rebuts.

Leary: The proper aim of man is to tune in to the ancient cellular wisdom of his 2-billion-year-old body. We have been narcotized by print, by society, by conventional education. So we need an antidotal sacrament -- LSD. Sure there are risks; everything worth doing involves risk. But there

is no substantive evidence that LSD causes damage. Marijuana should be legalized too. Turn on, tune in, drop out.

Lettvin: The problem is whether the navel really replaces television. Forbidding marijuana is nonsense, of course. But the psychedelic drugs are something else. They give no guarantee that judgment will be returned once it has been taken away. Users pay for their vision of the self by a loss of the noetic function -- the critical faculty that distinguishes man from all other creatures. The LSD experience resembles, frighteningly, the temporal lobe syndrome that characterizes axe-murderers and epileptics. A group of physicists who took psilocybin were unable to do theoretical work for six months afterwards. LSD insight is cheap -- but it is bought dear.

Evaluation: A curious and amusing confrontation between two fascinating characters. Leary, the slightly stoned Irish leprechaun, wearing loose Indian garb and smiling benignly, squats cross-legged before a candle. Film clips supposed to evoke the LSD experience flicker in the background. Lettvin, the amiable Jewish master, rumpled and charismatic, prowls the stage tossing off erudite quips. It is entertaining -- but not particularly enlightening. The film might be of use in provoking discussion among college audiences but it is too sophisticated for most high school audiences or conservative parents.

* * *

LSD-25

1967 16mm. color 27 min. Sponsored by San Mateo (California) Union High School District. Produced by Professional Arts, Inc., P.O. Box 8484, Universal City, California 91608. Dr. David W. Parker, producer. TV Rights Reserved.

Intended Audience: Sr. High School Students, College, Adult, General

Technical Quality: Excellent

Summary of Content: The chemical compound LSD-25 is given a voice to tell viewers of its nature and effects. Scenes illustrate the narrative. False information about the drug is rebutted, the facts of its unpredictability and unknown properties are emphasized. Illegality, uncertainty of dosages, bum trips, recurrence of effects, alterations in brain-wave tracings following use, possibility of associated cell and chromosomal changes -- are some of the dangers cited. The strange thing, LSD concludes, is that a user's reaction depends, 'not on my chemistry, but on his. But that's his problem, not mine.'

Evaluation: A balanced and relatively judicious presentation of the case for the prosecution. Visually superior although tending to the flashy. The ingenuity in production technique pleases the eye but fuddles the brain. Skeptical viewers, TV-wise and advertising-canny, may suspect its adroit packaging as the hallmark of propaganda. But allowing LSD to plead both sides of its case gives an excellent example of what a mass-appeal drug education film can be. Recommended.

* * *

LSD

1967 16mm. color 28 min. Produced by the Bureau of Medicine & Surgery, U.S. Navy. Loan source: Audiovisual Branch, U.S. Navy, Pentagon, Washington, D.C.

Intended Audience: Servicemen

Technical Quality: Average

Summary of Content: Lt. Cdr. Walt Miner of the U.S. Navy Medical Corps delivers a lecture on the history, properties and effects of LSD. **Intended audience:** the man who is considering taking the drug, and the man who must decide whether he wants to go to sea with a crewmate who has. **Emphasis** is placed on the drug's phenomenal potency; its ability to create a mental state resembling insanity; the possibility of recurrent effects without further drug use; the risk of permanent psychosis, suicide, genetic damage; the unreliability in stressful military situations of a one-time LSD user. For the seaman, Dr. Miner says, an alcoholic binge is infinitely less harmful than an LSD trip.

Evaluation: Because he is an accomplished speaker, Lt. Cdr. Miner makes the lecture technique an absorbing and distinctive approach to filmed drug education. His careful tone and reliance on presumably documentable cases give this film credibility and persuasiveness. The film contains excellent analysis of an LSD trip (effects and time sequence). **Drawbacks for non-military situations:** the audience is assumed to be seagoing and familiar with heavy drinking. **Points of contention:** emphasis on the possibility that LSD-users may already have damaged themselves irreversibly; emphasis on the absolute unreliability, for Navy purposes, of anyone who has ever used LSD; and emphasis on the comparative harmlessness of alcoholic excess.

* * *

FIGHT OR FLIGHT

1967 16mm. color 16 min. *Sponsored by the International Association of Chief of Police in cooperation with the U.S. Bureau of Narcotics, produced and distributed by J & F Productions, Inc., Suite 700, 1401 Walnut St., Philadelphia 19102.*

Intended Audience: Jr. & Sr. High School Students

Technical Quality: Good

Summary of Content: Reminiscences of former addicts now resident at New York State's Day Top Village rehabilitation center are interspersed with narration and illustrative vignettes. **Emphasis** is on the evil effects of heroin and LSD, with marijuana, pills, alcohol and cough medicine receiving passing mention. **Viewers** are warned against seeking resolution of adolescent and familial conflicts in drugs, against following the gang willy-nilly. Drug abuse leads to crime, automobile accidents, death and running around without any clothes on, the film points out. The sufferings of drug-users' families are recounted by a mother and a wife. One young ex-addict declares that 'it's nonsense that pot and LSD aren't habit-forming, that users can stop any time. It's just not that way.'

Evaluation: A compact, skillfully produced film -- but one with the brittle educational sheen of institutional short sequences about gas heating or ceramic nosecones. The color is vivid and the scenes hold the viewer's attention, but the film seems unlikely to evoke any deep or lasting response.

* * *

FDA SPECIAL REPORT: DRUG ABUSE -- BENNIES AND GOOFBALLS

1966 16mm. B & W 20 min. *Cleared for television. Produced by Food & Drug Administration, U.S. Dept. of Health, Education & Welfare. Free Loan Source: Public Health Service Audiovisual Facility, Atlanta, Georgia 30333, Attn: Distribution Unit. Purchase Source: Precision Film Laboratories, 21 W. 46th Street, New York 10036.*

Intended Audience: General

Technical Quality: Average. Beginning to be outdated.

Summary of Content: Hollywood actor Paul Newman narrates this FDA report on nationwide abuse of amphetamines and barbiturates, and legal steps being taken to curb it. Four people -- including a truck driver who experienced severe hallucinations, a pillhead who suffered physical and mental deterioration, and a Death Row inmate who capped a drug-fed crime wave with murder -- tell of their experiences.

Evaluation: Subdued, authoritative, competently produced. Technical information comes quickly and verbally, may be hard to grasp and retain. Although recently produced, this film already has an outdated quality. Dramatic impact is slight, especially for younger audiences.

* * *

LSD: THE SPRING GROVE EXPERIMENT

1966 16mm. B & W 54 min. Produced by CBS News, John Sharnik producer/writer. Presented by McGraw-Hill Text-Films, 330 W. 42nd St., New York 10036.

Intended Audience: Sr. High School & College Students, Adults, Professionals

Technical Quality: Good

Summary of Content: At Spring Grove State Hospital in Baltimore, controlled experiments are being conducted using LSD as a therapeutic tool in psychiatric treatment. The film documents the program through two subjects, a 48-year-old housewife who suffered an acute paranoid breakdown, and a 33-year-old male alcoholic. Their subsequent return to useful life is covered. Both, six months after treatment with LSD, were functioning healthily. Although still experimental, the program suggests that LSD can be a boon to society as well as a bane.

Evaluation: An extremely moving insight into the intensity of the LSD experience. The film suggests some of the reasons users frequently become convinced of the drug's religious powers. 'I found God,' the housewife declares upon emergence from her trip. The viewer, an absorbed semi-participant, is afforded some understanding of her statement.

The film provides an excellent balance to cries for total LSD suppression. It is properly cautionary, however, in emphasizing the care and supervision surrounding this clinical application.

The film is of doubtful application to general school needs -- it is neither calculated nor likely to persuade students to abstain from LSD. It could, however, prove interesting to PTA or teacher groups trying to grasp the appeal of the drug and the evangelical fervor of its advocates.

* * *

HIDE AND SEEK

1966 16mm. color 14 min. Produced by the Center for Mass Communication of Columbia University Press, 440 W. 110th St., New York 10025; produced and directed by Julian Krainin; psychiatric consultant, Dr. Ronald R. Fieve, Columbia University. Purchase Price: \$150

Intended Audience: Jr. & Sr. High School & College Students

Technical Quality: Average

Summary of Content: A boy in his late teens describes his life as a heroin addict wandering the seedier streets of New York City. The narration sounds authentic, but it is unclear whether this is a case history or fiction. The youth begins with marijuana, tries heroin on a dare, ends up addicted, alienated.

Evaluation: A skillfully photographed, thematically imaginative but ultimately weak film. The boy's wishy-washy wistfulness, enhanced by wistful music and wistful meanderings, swamps the film. The approach may be good in that extremes are avoided -- he experiences neither physical ecstasy nor total moral collapse -- but it is dramatically unsatisfactory. A first-person account of the emptiness of the drug-centered life, it may prove useful in discouraging some young experimenters.

* * *

NARCOTICS -- WHY NOT

1966 16mm. color 15 min. Produced by Charles Cabill & Associates, Inc., P.O. Box 3220, Hollywood 90028. Technical advisors: U.S. Public Health Service, California Bureau of Narcotics, California Rehabilitation Center, Los Angeles Sheriff's Dept.

Intended Audience: Jr. High School Students thru Adult

Technical Quality: Average

Summary of Content: Dramatizations of drug-taking, arrest, etc. are interlaced with reminiscences by 16 male and female ex-addict residents of the California Rehabilitation Center at Corona. Emphasis is placed on the unpleasantness of the drugged state and the addict's life, with secondary weight given to the pains of arrest and imprisonment.

Evaluation: Relatively straight-forward approach from law-enforcement angle. Interviewees, however, look like hardened criminals. Some interviewees have faces partially hidden, further distancing viewers and casting shadows on their candor.

* * *

NARCOTICS: PIT OF DESPAIR

1965 16mm. color 28 min. Produced by Film Distributors International, 2223 South Olive St., Los Angeles 90007. Mel Marshall, producer.

Intended Audience: Sr. High School Students.

Technical Quality: Average

Summary of Content: A dramatization of a clean-cut youth's downfall from two benzedrine tablets to heroin addiction and prison.

A college athlete has problems. His grades are poor. He begins taking pills. He drinks too much beer, smokes cigarettes, dances with a fallen woman who persuades him to try marijuana. Soon he is failing in his studies, kicked off the track team, and psychologically dependent on marijuana. Next he tries heroin, becomes addicted, finally goes to prison. Once out, he saunters over to see the pusher again. 'There Is No End,' the title tells us at fadeout.

Evaluation: A poorly-paced, heavy-handed rendition of a time-worn theme. Few if any youthful viewers are likely to be convinced. They would, however, probably get a lot of laughs.

* * *

SCENT OF DANGER

1962 16mm. color 13 min. Produced by Gordon Newsfilms, San Francisco. Sponsored by the Hobby Industry Association.

Intended Audience: Adults, Professionals, Civic Groups

Technical Quality: Average

Summary of Content: 'A small minority of boys, those with weak personalities who need a crutch to build up their confidence,' sniff glue, this film tells us. Moreover, they sniff lighter fluid, wood dough, cosmetics, paint thinner, kerosene, hair spray, medicated inhalers -- in short, almost anything containing aromatic hydrocarbons. Meanwhile, we learn, the hobby industry has launched a nationwide campaign of research to reduce glue's adverse effects when sniffed, to urge shopkeepers to keep their glue watched and locked away, and to promote local action.

Evaluation: There is little analysis of the causes or effects of glue sniffing how it might best be combated. Of minimal usefulness to anyone.

* * *

TOMORROW MAY BE DYING

1960 16mm. B & W 23 min. Produced by the Cinema Department Graduate Workshop, University of Southern California, University Park, Los Angeles 90007.

Intended Audience: Sr. High School & College Students

Technical Quality: Fair. Out of date.

Summary of Content: A dramatization of drug experimentation, reckless driving, rolling drunks, and other antisocial pastimes. The central character is a nice girl who acquires a heroin habit and a pregnancy from her pusher boyfriend. He abandons her. She can't risk a hospital birth for fear of arrest, but the doctor warns that the baby must receive hospital care because it is hooked too, and may die of drug withdrawal. She is led off by police to kick her habit.

Evaluation: The plot is amorphous and hard to follow. The acting is about what would be expected of college drama students. The film's attitude toward drugs is ambiguous. Heroin is obviously bad, pills only a little less so. Skirt lengths date this relatively recent film. The focus is fuzzy.

* * *

THE LOSERS

1960 16mm. B & W 31 min. Produced by the Columbia Broadcasting System, Jack Landau producer/writer/director. Distributed by Carousel Films, Inc., % Association Films, 600 Grand Avenue, Ridgefield, New Jersey.

Intended Audience: General

Technical Quality: Good

Summary of Content: Produced by CBS News, this film employs the documentary style -- interviews, a narrator shot in various location backgrounds, illustrative footage showing seedy neighborhoods, an arrest, jail, a hospital, a morgue, a high school classroom -- to blanket the subject of drug addiction. The film opens and closes with scenes of the New York City morgue, where a body is being filed away, the fatal result of acute intravenous narcotism or an overdose of heroin. The moral is that drug experimenters are flirting with death.

Evaluation: As in any attempt to cover a broad topic within a short time, this film suffers from superficiality. The producers try to compensate by projecting a steady tone of disapproval. The narrator often speaks of drug abuse and abusers with heavy scorn. The emphasis coincides with that of law-enforcement agencies -- drug use creates a crime problem. Fear is the emotional instrument. The production is smooth and professional. Although nearly nine years old, the scenes have not dated badly. The film is, however, unlikely to persuade, and would probably serve best to solidify already firm (and traditional) opinions.

* * *

SEDUCTION OF THE INNOCENT

1960 16mm. color 10 min. Produced by Sid Davis Productions, 2429 Ocean Park Blvd., Santa Monica, California; produced with cooperation of the Santa Monica Police Dept. and the Santa Monica Unified School District.

Intended Audience: Junior & Senior High School Students

Technical Quality: Below average; beginning to date

Summary of Content: The film depicts the progress of a young woman from casual experimentation with pills (seconal, tuinal, bennies) to marijuana use to heroin addiction. As the denouement approaches, she has lost her looks. She takes to streetwalking. She is arrested, experiences withdrawal pains. Drug abuse, the narrator promises, 'will lead to a life of hopelessness and degradation, until she escapes in death.'

Evaluation: Flamboyantly overdramatic, with pompous, funereal narration. Scientifically inaccurate. There is a scene which provides good guidance for the preparation and shooting of heroin. The stages of the girl's character-disintegration unfold with rather startling, and amusing, rapidity. A resort to the big-scare technique, this film is unlikely to scare anyone but parents and the exceptionally timid.

* * *

THE ADDICTED (Part II -- CRIMINAL OR PATIENT?)

ca. 1958 16mm. B & W 28 min. Produced by CBS News; Distributed by Association Films, Inc., 600 Grand Ave., Ridgefield, N. J. 07657.

Intended Audience: General

Technical Quality: Good

Summary of Content: The second segment of a two-part series about drug addiction originally shown on the CBS Television series 'The Twentieth Century.' (Part I was not reviewed.) Walter Cronkite narrates.

The heroin addict is, almost by definition, a passive personality. His goal is oblivion: escape from his problems by 'going on the nod.' While under the drug's influence he will almost certainly be incapable of violent crime and will not even rival the alcoholic as a menace behind the steering wheel. Ex-addicts are interviewed to bolster these contentions.

On the other hand, addiction forces the user to spend great sums of money to maintain his illegal habit. Result: almost one-half of all reported crimes in major cities are associated with drug abuse. One interviewee supported a \$30-a-day habit for 10 years by shoplifting \$200 worth of merchandise daily.

Punitive measures have clearly failed to prevent addiction, concludes New York City Commissioner of Corrections Anna Cross. She says, 'We must create a climate in which addiction will be considered a medical-social and health problem,' not a crime problem.

Evaluation: A well-produced documentary in support of the contention that heroin addiction, once established, merits treatment rather than punishment. The film is noteworthy for the enlightened stance it took for its day -- a stance still only partially accepted ten years later. Thus it probably remains useful for viewing by adult civic groups or the like -- groups in which stereotypical attitudes toward drug addiction may prevail. The film is, however, beginning to date.

* * *

MONKEY ON THE BACK

1956 16mm. B & W 27 min. *Produced by the National Film Board of Canada, Grant McLean, producer. Distributed by McGraw-Hill Films, 330 W. 42nd St., New York 10036.*

Intended Audience: General, Adults

Technical Quality: Average

Summary of Content: A dramatized account of the life and drug-induced death of a Canadian heroin addict. Based on an actual case history.

Evaluation: A calm, well-acted production, but one with little application to most educational needs. The main character is an adult, and a poor source of identification for youthful viewers. The approach is sociological, with emphasis placed on the theme 'addiction is a disease.' Of doubtful suitability for school-connected groups.

* * *

THE DANGEROUS DRUGS

Ca. 1956 16mm. color 22 min. *Sponsored by the Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles 27, produced by Ronald Munns.*

Intended Audience: High School Students, Adults, General

Technical Quality: Poor, Outdated.

Summary of Content: The Honorable Ronald Reagan, now Governor of the State of California, narrates this examination of the problems of barbiturate and amphetamine abuse. Dramatic vignettes illustrate common forms of abuse: youths at a party pop pills for a thrill; a woman doses herself fatally; a truck-driver trying to stay awake suffers hallucinations, crashes. Withdrawal from barbiturate addiction is called more painful and dangerous than withdrawal from opiate addiction. 'The solution,' the film concludes, 'lies in widespread education. Then and only then will legislation be developed to cope with this menace.'

Evaluation: The film is a dog, its pace a drag. All in all, a most unsatisfactory effort.

* * * *

NARCOTICS: A CHALLENGE

1956 16mm. color 25 min. *Sponsored and distributed by the Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles 90027. Produced & directed by Gilbert Lasky, with financial assistance of the National Woman's Relief Corps, Auxiliary to the Grand Army of the Republic, Inc.*

Intended Audience: Teachers, Jr. & Sr. High School Students, Adults

Technical Quality: Below average

Summary of Content: Narrator Lowell Thomas exhorts teachers to grapple with the drug problem, provides a quick survey of the problem, classifies drugs as opiates (heroin, morphine), marijuana, cocaine and the 'dangerous drugs' (barbiturates, amphetamines). The pattern of drug abuse among the young is dramatized as usually beginning in poorer neighborhoods where a boy with a problem -- sexual, economic, family -- turns to drugs. Gambling, truancy and theft are part of the pattern. Marijuana is a common starting point. 'Usually' the boy then 'looks for a bigger kick' -- heroin. Goofballs and bennies serve as stepping stones to heroin too, we learn. The protagonist of the screen drama

becomes addicted, is arrested by police because his arms show needle marks, suffers withdrawal, returns from prison to his old haunts.

Evaluation: A poor, outdated film which even the long-suffering teacher would probably not suffer long.

* * *

DRUG ADDICTION

1951 16mm. B & W 22 min. Produced by Encyclopedia Britannica Films, 2494 Teagarden St., San Leandro, California, in cooperation with Juvenile Protective Assn. of Chicago and the Wieboldt Foundation; consultant, Andrew C. Ivy, Ph.D., M.D. Television rights reserved.

Intended Audience: High School Students, Adults

Technical Quality: Average

Summary of Content: Opiates, marijuana and cocaine are described, their properties and effects depicted by animation. Drug addiction is presented as a crime problem dramatized by the story of Marty, a handsome, dutiful youth who one day smokes a marijuana cigarette. In a trice he advances to heroin, graduates to addiction, and ends in the grasp of a policeman after looting a hardware store. The film urges larger law enforcement staffs, stringent penalties against narcotics peddlers, and increased education about drugs, especially among young people.

Evaluation: A well-meaning but hopelessly outdated film which merits retirement to the archives. Marty's story is enough to make a viewer want to go right out and get hooked.

* * *

THE TERRIBLE TRUTH

Early 1950's 16mm. B & W 10 min. Produced by Sid Davis Productions, 1418 N. Highland Ave., Hollywood, California

Intended Audience: High School Students

Summary of Content: Elderly judge talks with a pretty, middle-class teenage girl who, he says, has just come out of jail where she kicked a heroin habit. Her downward spiral is dramatized from a couple of puffs of marijuana to a syringe full of heroin to marriage with a pusher to addiction to prostitution to theft, etc. The girl narrates. The judge concludes with a plea to young American boys and girls.

Evaluation: The implicit moral of this film is that old chestnut argument that one taste of any drug will probably lead to heroin addiction and a life of crime. The movie is woefully out of date. An earnest pitch from an aged judge is unlikely to evoke any deep response from youthful viewers.

#

*CHART LISTING DRUGS,
MEDICAL USES,
SYMPTOMS PRODUCED
AND THEIR
DEPENDENCE POTENTIALS*

(over)
(Question marks indicate
conflict of opinion)

Chart Listing Drugs, Medical Uses, Symptoms

NAME	SLANG NAME	CHEMICAL OR TRADE NAME	SOURCE	CLASSIFICATION	MEDICAL USE	HOW TAKEN
HEROIN	H., Horse, Scat, Junk, Snow, Stuff, Harry, Joy Powder	Diacetylmorphine	Semi-Synthetic (from Morphine)	Narcotic	Pain Relief	Injected or Sniffed
MORPHINE	White stuff, Miss Emma, M. Dreamer	Morphine sulphate	Natural (from Opium)	Narcotic	Pain Relief	Swallowed or Injected
CODEINE	Schoolboy	Methylmorphine	Natural (from Opium) Semi-Synthetic (from Morphine)	Narcotic	Ease Pain and coughing	Swallowed
METHADONE	Dolly	Dolophine Amidone	Synthetic	Narcotic	Pain Relief	Swallowed or Injected
COCAINE	Speed Balls, Gold Dust, Coke, Ber- nice, Corine, Flake, Star Dust	Methylester of benzoylecgonine	Natural (from coca, NOT cacao)	Stimulant, Local Anesthesia	Local Anesthesia	Sniffed, Injected or Swallowed
MARIJUANA	Pot, Grass, Loco- weed, Mary Jane, Hashish, Tea, Gage, Reefers	Cannabis sativa	Natural	Mixed actions	None in U.S.	Smoked, Swallowed, or Sniffed
BARBIT- URATES	Barbs, Blue Devils, Candy, Yellow Jac- kers, Phennies, Pea- nuts, Blue Heavens	Phenobarbital Nembutal, Seconal, Amytal	Synthetic	Sedative- Hypnotic	Sedation, Relieve high blood pres- sure, epilepsy, hyperthyroidism	Swallowed or Injected
AMPHETA- MINES	Bennies, Dexies, Co-Pilots, Wake- Ups, Lid Proppers, Hearts, Pep Pills	Benzedrine, Dexedrine, Dexoxyn, Methedrine	Synthetic	Sympatho Minetic	Relieve mild de- pression, control appetite and narcolepsy	Swallowed or Injected
LSD	Acid, Sugar, Big D, Cubes, Trips	d-lysergic acid diethylamide	Semi-Synthetic (from ergot alkaloids)	Hallucinogen	Experimental Study of Mental Function, alcoholism	Swallowed
DMT	Businessman's High	Dimethyltryptamine	Synthetic	Hallucinogen	None	Injected
MESCALINE		3,4,5-trimethoxy- phenethylamine	Natural (from Peyote)	Hallucinogen	None	Swallowed
PSILOCYBIN		3 (2-dimethylamino) ethylindol-4-ol-dihy- drogen phosphate	Natural (from Psilocybe Mushroom)	Hallucinogen	None	Swallowed
ALCOHOL	Booze, Juice, etc.	Ethanol ethyl alcohol	Natural (from grapes, grains, etc. via fermentation)	Sedative hypnotic	Solvent, Antiseptic	Swallowed
TOBACCO	Fag, Coffin nail, etc.	Nicotina Tabacum	Natural	Sedative ?	Sedative, Emetic (nicotine)	Smoked, Sniffed, Chewed

Produced and Their Dependence Potentials

USUAL DOSE	DURATION OF EFFECT	EFFECTS SOUGHT	LONG-TERM SYMPTOMS	PHYSICAL DEPENDENCE POTENTIAL	MENTAL DEPENDENCE POTENTIAL	ORGANIC DAMAGE POTENTIAL
Varies	4 hrs.	Euphoria Drowsiness	Addiction, Constipation Loss of Appetite	Yes	Yes	No
15 Milligrams	6 hrs.	Euphoria Drowsiness	Addiction, Constipation Loss of Appetite	Yes	Yes	No
30 Milligrams	4 hrs.	Drowsiness	Addiction, Constipation Loss of Appetite	Yes	Yes	No
10 Milligrams	4-6 hrs.	Prevent Withdrawal Discomfort	Addiction, Constipation Loss of Appetite	Yes	Yes	No
Varies	Varies, Short	Excitation Talkativeness	Depression, Convulsions	No	Yes	Yes?
1-2 Cigarettes	4 hrs.	Relaxation, In- creased Euphoria, Perceptions, * Sociability	Usually None	No	?	No
50-100 Milligrams	4 hrs.	Anxiety reduction, Euphoria	Addiction w/severe withdrawal symp- toms, possible con- vulsions, Toxic Psychosis	Yes	Yes	Yes
2.5-5 Milligrams	4 hrs.	Alertness, Activeness	Loss of Appetite Delusions Hallucinations Toxic Psychosis	No?	Yes	Yes?
100-500 Micograms	10 hrs.	Insightful experi- ences, Exhilaration, Distortion of Senses	May intensify existing psychosis, panic reactions	No	No?	No?
1-3 Milligram	Less than 1 hr.	Insightful experi- ences, Exhilaration, Distortion of Senses	?	No	No?	No?
350 Micrograms	12 hrs.	Insightful experi- ences, Exhilaration, Distortion of Senses	?	No	No?	No?
25 Milligrams	6-8 hrs.	Insightful experi- ences, Exhilaration, Distortion of Senses	?	No	No?	No?
Varies	1-4 hrs.	Sense alteration Anxiety reduction Sociability	Cirrhosis Toxic psychosis neurologic damage Addiction	Yes	Yes	Yes
Varies	Varies	Calmness Sociability	By Smoking, Emphysema Lung Cancer, Mouth & Throat Cancer, Cardio- Vascular damage, Loss of Appetite	Yes?	Yes	Yes

TEACHING TECHNIQUES

Excerpted from

SUGGESTIONS FOR EDUCATORS

*Robert C. Petersen, Ph.D.
Center for Studies of Narcotic and Drug Abuse
National Institute of Mental Health*

No single pamphlet, book, or film can train educators to be effective in dealing with the problems of drugs. But because there is much speculation and considerable confusion surrounding the topic, this article has been prepared by the staff of the National Institute of Mental Health (NIMH) to provide suggestions that may be helpful in drug abuse education. We hope that the suggestions contained herein will be supplemented by ideas from teachers throughout the country as they develop better ways of helping their students deal with the problem of drugs.

Help Avoid Panic. While drug abuse is a definite and probably growing problem in the United States, it is important that we remain levelheaded about it. Teachers are in a particularly good position to encourage, by their example, a thoughtful approach by parents, students, and the community. Present evidence suggests that the vast majority of youngsters who experiment with marijuana, the most popular illegal drug of abuse, do so on a one-time experimental basis.

Keep Lines of Communication Open. One of the best ways of dealing with the drug problem is prevention. Encouraging an atmosphere in which the student feels free to confide in parents and teachers and to discuss his concerns is an important first step. Obviously, the size of present classes often makes personal contact difficult. At the same time, if the student realizes that his parents and teachers are making a genuine effort to understand his point of view, this realization is likely to help him in the process of growing up.

Although difficult to do, it is important to avoid being moralistic and judgmental in talking about drugs and drug users. To be effective, prevention ultimately must be based on each student's decision not to use drugs because they are incompatible with his personal goals. Emphasizing that no authority, whether school official or police officer, can make that ultimate decision for him may help the youngster clarify his own personal responsibility. It may also help to reduce the adolescent tendency to view drug abuse as an act of rebellion.

Many adults, including teachers, feel uncomfortable and defensive about discussing drugs with teenagers. This is sometimes due to awareness of our own inconsistencies in the use of everyday substances like tobacco and alcohol. Nevertheless, there are good and convincing arguments against the use of drugs which can be stated in terms that are persuasive to youth. For example, some teenagers see the use of drugs as one way of developing heightened self-awareness or of enhancing their inner freedom. Pointing out the inconsistency of these goals with becoming in any sense drug-dependent -- on tobacco, alcohol, marijuana, or other drugs -- may help them resolve the problem. Similarly, if they are to improve the society of which they are critical, they can only do so by remaining a part of it rather than by chemically 'copping out.'

Because the abuse of drugs frequently carries with it heavy legal penalties, it is important that youngsters be made aware of the possible long-term ramifications of drug use. Some young people, feeling keenly that certain drug laws are unjust, advocate violating them as an act of civil disobedience. Thoughtful discussion of the implications of civil disobedience, and of whether the use or possession of drugs is sufficiently important to them to justify such risks, may be helpful.

Excerpted from article in *Journal of the N.E.A.*, March, 1969.

Avoid Creating An Atmosphere of Distrust and Suspicion. Like many parents, some teachers, anxious to discourage drug abuse, are likely to assume that any departure from the preferred styles and customs of the majority is indicative of drug abuse. Youngsters who have tried or are using drugs come in all sizes and shapes -- with short as well as long hair, and conventional clothes as well as eccentric dress. So do those who don't use drugs.

Since the problem of teen-age drug abuse embraces a wider range of substances than those prohibited by law, even an attitude of active suspicion and continuous surveillance, were that possible, would not eliminate the problem. It would, however, almost certainly destroy the climate of trust and confidence essential to the intergenerational communication that is desirable in preventing abuse.

Be Well-Informed about Drugs. Drug-use advocates frequently use the scarcity of scientifically reliable information as a basis for arguing that marijuana and other drugs are harmless. The absence of complete agreement based on reliable evidence that a substance is harmful does not demonstrate its harmlessness. Frequently relatively long-term use of a substance is required before its public health implications are apparent. Cigarette smoking provides an obvious example. American experience with marijuana is of relatively short duration. Foreign research studies, while often difficult to interpret, suggest that long-term use of marijuana may be detrimental to the health of users.

The social problems of adding another intoxicant of unknown long-range implications to our present difficulties with alcohol may be usefully discussed. The problems of allowing a harmful drug to become popular and then subsequently making it illegal might be stressed. It might also be useful to discuss some of the originally unsuspected deleterious effects of drugs, such as birth defects resulting from use of thalidomide.

Use Drug Education Materials as a Springboard to Discussion. Good films, pamphlets, and other materials can open the way to useful student-teacher discussion. Arguments of students who advocate use of drugs deserve a hearing and a thoughtful rebuttal. A student's apparent conviction often masks considerable uncertainty about the worth of his arguments. Summarily rejecting the advocate's points may alter his classroom verbal behavior, but is unlikely to change his thinking. Open and candid discussion of the strengths and weaknesses of various points of view on drug use, by contrast, is likely to help him make a decision on reasoned grounds.

A student-run program to prevent drug abuse may be valuable in enlisting the interest and efforts of the entire student community in prevention activities. Teen-agers are frequently more responsive to the mores and values of their own group than to the values of the adult world. Students who are former drug users can often be effective in deterring drug use among their peers.

Recognize Your Role as A Model. Because teen-agers seem to be engrossed in the activities of their own age group, we may forget that teachers often play a significant role as models for their development.

It may be helpful for the teacher who presently smokes or formerly smoked to freely acknowledge the difficulties he experienced in attempting to give up the habit. Emphasizing that it is not easy to alter persistent habits may be of value. Habits such as use of tobacco and alcohol can illustrate the highly persistent nature of habitual behavior despite strong rational grounds for change.

Adults can also serve to demonstrate that it is possible to live a rewarding life without the use of chemical substances to add meaning or excitement. The adult who is 'turned on' by life without recourse to drugs is one of the best deterrents to drug abuse.

Encourage Interest in Alternatives to Drug Use. Youngsters who find satisfaction in other activities are less likely to find drugs appealing. Many young people feel keenly the problems of our contemporary world. They need to be involved in activities that have personal meaning. Such activities as working for a political party or in programs for slum children can serve as concrete contributions for coping with contemporary problems.

Adolescence is for many youngsters a lonely time. The teen-ager who is unable to find his place in some orthodox group sometimes turns to drug use as a means of finding a kind of group acceptance. The student who is isolated or is having more than the usual difficulties in gaining acceptance will sometimes respond very well to special interest from his teachers. Particularly for the student with a poor home situation, a sympathetic teacher can provide a model of an understanding adult who has no need to escape into a state of drugged unreality.

#

Excerpted from

COMMUNICATING ABOUT DRUGS

Helen H. Nowlis, Ph.D.
Professor of Psychology
University of Rochester

The area of the use and abuse of drugs is a good example of the role of biases, even among professionals. Specialists in each area look at the total problem and see it primarily from the perspective of their own theoretical background, major involvement and experience. Thus the medically trained see in bold relief the medical aspects of the problem. But even within this one point of view, there are differences in emphasis depending on whether one's special interest is research or clinical practice, psychiatry, psychopharmacology or public health. The same can be said about the many other specialists who get into the act: the psychologists, sociologists, anthropologists, enforcement agents, social workers, ministers and journalists. Each one tends to ask different questions and to seek answers in different ways. It reminds one of the proverbial blind men and the elephant.

It is no wonder, then, that the layman, the legislator, the college administrator, the college student, faced with a multitude of points of view, resorts to selective perception, and chooses that position which does the least violence to his own established pattern of attitudes and beliefs. But a position arrived at in this way only leads to further problems when it must be defended or acted upon in the face of questions or objections from other people who have arrived at other positions through their selective perceptions with a different set of attitudes and beliefs as a screen. One of the complicating factors is that adult patterns, having persisted for a longer time, tend to be more elaborate and more firmly held than those of college students.

I would like to suggest that we talk about 'marijuana,' 'LSD,' 'barbiturates,' 'amphetamines,' 'alcohol' and avoid such awkward general categories as 'narcotic,' 'drug' or 'medicine'. Such categories are laden with such a variety of attitudinal excess baggage that clear communication and discussion are virtually impossible.

The second attitudinal problem which makes clear thinking and communication difficult when we are considering complex issues arises from our tendency to think in terms of opposing categories, a tendency which Charles Osgood calls psychologic. For example, we tend to label things and people as good or bad. In the process, we may apply the label to the thing on the basis of what it is not rather than what it is.

In the interest of good communication, let us check some of our excess baggage and not talk about 'good drugs' and 'bad drugs', 'safe drugs' and 'dangerous drugs', even 'drug effects'. It would be difficult to find a single drug which is not potentially dangerous for some people, under some circumstances, at some dose level. A reaction to any drug is basically the result of the interaction between an ingested or injected chemical and a physically and psychologically complex individual. It is a function of dose, of pattern and length of use of the drug, of the physiological and psychological condition of the individual, of the situation or circumstances under which it is taken, of who administers it, of the expectations of the person who administers it as well as of the person who takes it. In some instances, with the proper circumstance and expectations, placebos -- normal saline solutions, sugar or lactose pills -- may relieve post-operative pain, produce hallucinations, do most anything that a drug might do.

Based on remarks made at National Association of Student Personnel Administrators Drug Education Conference, Washington, D.C., November 1966.

It is interesting to note in passing that the drugs controlled by the Food and Drug Administration are those 'with high potential for abuse' -- not bad drugs or dangerous drugs. It is not the drug but a particular use of a drug that is dangerous.

One other fact that we should note here is what is generally referred to as 'side effects'. Virtually every drug has other effects, sometimes harmless, sometimes annoying, sometimes harmful.

While we are considering terms which should be defined if we are to think and communicate effectively, we should clarify the terms drug use and drug user. Much of the confusion that exists in the reporting and interpreting of statistics and in journalistic generalizations has arisen because of lack of definition of these terms. A large number of the so-called drug users have merely used drugs on one of a few occasions. In contrast to these there does exist a group for which I would prefer to reserve the term user. Students make a clear distinction between those who briefly experiment with a drug and those for whom use of the drug has at least temporarily become an important factor in their lives. The latter they call 'heads' -- 'pot heads' (marijuana), 'acid heads' (LSD), etc. The danger in not distinguishing between the casual experimenter and the 'head' is that it can lead us to erroneous generalizations and assumptions both about the students and the drugs. Drug user is also one of the terms that carries heavy excess baggage.

As a social psychologist, I would like to talk about the dynamics of communication in any educational process. As Lasswell suggested years ago, there are at least three important factors, none of which is simple and none of which can be neglected: 'Who says What to Whom?' Our program, looked at from the point of view of good communication, is already hampered by lack of clarity in the information we wish to convey, by the excess baggage I was speaking of earlier, and by the heterogeneity of the student groups with which we will be working. It is most important that the communicator be aware of the dynamics of his role, that he be equipped with the best current information and resources in the area of drug usage and drug effects, and that he understand the variety of differences in motivational and attitudinal status of his students.

First, it is most important for communicators about drug use to have made a sincere assessment of their own goals and motivations. We may define the issues and present the best and most objective information as frankly as we can and then trust the student to make his own decision. On the other hand, if we have already decided what students should do and we feel that the risks in letting them make their own decisions are too great, we may selectively use information to explain or justify our position. Either approach is defensible and each presents its own problems, but all concerned should be aware of which position is being taken. We run into all kinds of problems if we waiver from one to the other or appear to be operating under one approach when we are really operating under the other. You cannot say, as so many parents do: 'You decide -- as long as you decide my way.' In the area of the use and abuse of drugs by college students, either position presents complex problems.

Second, the communicator must have clearly thought through the issues in his own mind. It is probably wise to clearly separate the question of the dangers or abuse of individual drugs, both physical and psychological, from the question of legality. When a presentation of the untoward effects of a drug, even the potential untoward effects, is designed to support the illegal status of the drug, battle lines are drawn on the basis of individual rights vs. arbitrary authority and invasion of privacy, and none of the relevant issues is open to rational, unemotional consideration.

Third, effective communication has been shown to be a function of the prestige of, respect for and credibility of the communicator. It has been demonstrated that attempts at persuasion based on a high fear appeal are generally ineffective and may boomerang, especially with subjects of high intelligence. This type of appeal almost invariably casts doubt on the credibility and motivations of the communicator. An audience which becomes concerned with testing credibility will be distracted from the real issues presented in the communication.

The final factor that should be mentioned with respect to the communicator is the fact that if an audience has some knowledge about or attitudes toward an issue, all sides of an argument should be fairly presented. This does not necessarily mean that there should be dramatic confrontation between diametric opposites. It does mean that, as a minimum, the evidence for opposing views should be fairly presented. Neither does this mean that the communicator should not present his own considered view together with the reasons for it. In fact, one of the necessary functions of a teacher or an administrator is to draw conclusions, take a stand, but it should be clear that this stand is taken after careful consideration of all points of view.

The second term in our model, the What, needs little further comment at this time. I hope I have left you with the impression that we have no nice neat package to present. In the absence of facts, there is no need to pretend that we know. We can present hypotheses, trends, hunches as long as they are labeled as such and presented as tentative, awaiting data which will support or refute them.

The nature of the listener, the Whom in our model, is a critical factor. A good speaker always likes to know something about the type of audience he is confronting. So, too, we should keep in mind some of the salient characteristics of current students. But here again we must not categorize too generally. There is really no such thing as a typical student. Students vary on many parameters. The student's decision to use or not to use drugs will be based on a variety of motivations and expectancies and will differ from individual to individual and group to group. However, there are some general characteristics which apply to many students in many institutions. Most of them are intelligent, critical, and quick to question and to detect hypocrisy. These young people have been brought up in an age of the pill. Drugs are widely accepted as the cure for all ills. It should not be surprising that some of them turn to drugs in seeking individual solutions to or in avoiding problems with which our complex society confronts them. Growing out of the civil rights and anti-Viet Nam involvements, there are an increasing number who are essentially anti-legalistic and feel that any law which is stupid or 'immoral' should not be obeyed. In the majority of these students there is more of an intellectual commitment than a commitment to action, but they are forced by their position to support the right of others to take drugs even though they choose not to seek or accept the opportunity themselves, primarily because they have other strong values and motivations with which drug-taking is not consistent.

There is no one answer as to why students are interested in and take drugs, particularly the hallucinogens. Among those usually listed are curiosity, rebellion, the desire to improve social relations, to find meaning in life, to be reborn, to experience the cosmic, to expand consciousness. It is not productive to deny the feelings and motivations to which these drugs appeal. They exist. Are there other ways, legal and less dangerous, to respond to them? Is this not one of the challenges to education and educators?

#

Excerpted from

COMMUNICATION WITH YOUTH

Joseph F. Maloney, Ph.D.
 Director, Urban Studies Center, University of Louisville
 Louisville, Kentucky

Attention, frustration and deep discontent with contemporary living patterns are a widespread characteristic of our times, not of one generation.

But the discontented young are quicker than their elders to disown established patterns that offer no spiritual food. They are quicker because they are less rooted in the past.

Essentially, the young we tend to worry the most about are the rebels -- the ones who reject not just our life styles, but us -- us either as hypocrites or clods. Perhaps they are more conscious of our basic values -- our spiritual principles -- than we are. They are sensitive to the seeming contradiction between what we preach and what we actually do, how we actually live.

In a widely discussed recent article in *The New Yorker*, Richard Goodwin well describes the cause of widespread discontent throughout much of our society. This article may be one of the most provocative and consequential of many a year -- I urge you all to read it.

Last year the Urban Studies Center conducted a rather extensive study of the so-called generation gap, with surprisingly broad and intensive cooperation from the young adults themselves. The report closely parallels Goodwin's conclusions -- that there is a rejection of our life patterns as being shallow, hypocritical and irrelevant to truly basic values.

Our generation -- and the one before ours that shaped our attitudes -- has been successfully preoccupied in producing wealth and in making staggering progress in the advancement of the physical sciences and mechanical arts. Presumably we did so to acquire the means to better carry out our underlying spiritual values. But to the young we have become exhausted through our efforts to acquire these physical powers, or so 'programmed' in pursuit of wealth and a secure freedom from poverty that we have lost sight of our objectives, of our underlying values.

It's our generation that is hung up on manners and appearances -- because we have had to struggle to obtain an economic and social status -- a sense of social security. Our self-doubts are what account for our use of drugs in the form of sedatives -- in alcohol -- and in tobacco, which we know are dangerous and damaging to our health.

And we are hung up on race and sex -- not the young. And they are less concerned or troubled about sex than we. They rightly think us stupid for having done so badly in racial matters.

How many of you ever have two ounces of whiskey within two hours of driving a car? Was the Kinsey Report about our or today's young generation?

It's becoming common now to talk about a generation gap as a communication gap. I suggest that the communication gap is mostly one-sided. I suggest the young understand us better than we understand them -- better than they communicate to us. They tune us in and understand our language, but we do not necessarily understand the words they use or the patterns with which they use words. More, they communicate in a style that we reject as outrageous, thoughtlessly rejecting their thoughts because they are not presented to us in our style.

Borrow the best of the Beatles' LPs -- 'Sgt. Pepper's Lonely Heart Band.' Listen to it carefully, but only after you have studied the words, which are printed on the album. In 'She's Leaving Home,' 'When I'm Sixty-Four' and 'I Get By With A Little Help From My Friends,' they show -- and our children understand -- quite an insight into our problems.

Outline of address made at in-service meetings on drug abuse of Jefferson County Public Schools held in Louisville, January, 1969

They are not politicians, in that they are incapable of inventing and working diligently for a new system. They reject without being able to design a well-thought out substitute. They are not philosophers because they cannot synthesize a comprehensive and systematic approach to life. They certainly don't talk like the politicians we are used to, and they don't produce logical arguments or rhetoric like our honored prose literature.

But they are poetical. They do have sharp insights into truth, which they do express very imaginatively and suggestively, rather than precisely. We made them poets. We subjected them to the TV, radios and radio media as the message that has molded their patterns of perception and intellection. The Saturday morning TV cartoons have exposed them to more mind-expanding fairy tales -- talking animals and heroes easily seen as such -- than we were exposed to. Bozo the Clown has had more influence on them than our grandparents and parents had time to read to us. Because we must have a commercial every six minutes or less on TV and every three minutes on the radio, they are accustomed to short, explosive communications. And the commercials themselves, the most expensive and professional communication form we have devised -- are no more than 60 seconds. They see fast -- they have been trained that way before they get to school. They see things in extremes -- the commercial is punchy, and the interval between commercials is too short to develop complicated arguments or to distinguish shades of gray.

They understand our language style -- but reject it. Rhetoric is boring. Distinctions are evasions. We take too long to say little -- and much of what we say is trivial.

Look at the tremendous intellectual and spiritual problems teachers must wrestle with. Ladies may wear evening pants and party pajamas to presidential inaugural balls -- but they are too risqué for high schools. If a faculty prohibits slacks for girls they will merely confirm the not altogether unfounded student opinion that the faculty is from another world, a world of the past -- a past irrelevant to modern life.

The students -- the young -- reject us as authorities -- and they are right. In formal logic, the weakest argument is one based on authority. (Even the Pope is having his internal problems here.) Our progress in science and technology and the contemporary contradiction between alleged principles and action -- all should lead the young to question our behavior pattern as the ideal model. As teachers, we are successes not in proportion to the conformity of our students to our habits of dress, grooming or social action. Rather, we should assist them in questioning our behavior in the light of our fundamental principles. Some adults are quite good at presenting the two different points of view. This 'translation' was done magnificently in 'The Graduate,' a high-grossing, but quite subtle movie -- one the young understand very well indeed.

Drugs are a form through which the young can escape -- from us. Let us help the young in their searches for a better way to live in accord with our principles. Let us give them love and understanding -- with a hope, and a prayer, and a request directed at them as well as heaven. Let them do better than we have done in developing a life that adheres to basic spiritual values. If we love them let us love them for themselves -- not as mirror images of what we think we are. We drive a few to drugs, more to despair and fundamental frustration and discontent. All of them need more of ourselves and less of our manners.

It's paradoxical. Our use of alcohol, drugs and even tobacco are all forms of escape through sedation. We worry about the young and their use of drugs, which are used for 'mind-expansion.' We can help steer them from their drugs if we stop living as if we preferred sedation. We must wake up and live in today's changing world instead of trying to sleep in the past -- even the immediate past.

Youth will seek life. Let them find us among the living. Then -- and only then -- can we share life together.

#

Excerpted from

ADDRESS TO AAHPER-NSTA NATIONAL
DRUG ABUSE EDUCATION WORKSHOP
BELMONT, CALIFORNIA

*David Schwartz M.D., Director, Psychiatric Services
Hillcrest Mental Health Unit
San Mateo, California*

Youth are experts in illusion. They also are experts in the illusions of adult values, ways of living and patterns of behavior. They are students of illusion. I think what they are willing to say is that illusion has its realities and reality is an illusion. This is a difficult concept to grasp, and for me to tell you in about three minutes, but think about this. The reality of the illusion is exemplified by the drug experience. In this illusory experience of the drug, one experiences intense, direct, powerful, personal experiences, and still acknowledges that it is an illusion. These youngsters don't say that this life is the real reality. They know it is unreal. They have a detachment, an experience of getting into an illusion, yet experiencing it powerfully.

Adults tend to think of the realities of their lives as the real realities. And this is what kids are challenging. What is so real about your values? What is so good about it? What is so good about the way you're living today is what they're saying. Adults who have committed themselves to given paths of behavior, patterns and systems, as it were, have to perpetuate the reality. A kid hasn't committed himself to a given reality pattern. He's going through a process of change. He can experience change much more vividly than most adults can. Adults try to screen out deviations from their reality. And so when I say that the youngster knows the reality of the illusion, and the illusion of the reality, I think this is what the poetry of the kids is, what the music is all about, and what your kids are telling you.

Now what can an adult do, knowing that he's committed to certain realities? For one thing, he can begin to get honest with himself about the absurdities of the reality. To open up his own mind, to learn to listen to young people, so that when a kid starts talking about absurdities he hears the presentation of the young person challenging a system, a value system, or a pattern of behavior. Then, young people will feel more comfortable about listening to what you think about reality. It's a two-way proposition. The kid can say 'but your reality is an illusion. Not only that, but when I get into drugs, I experience a different kind of reality, that is induced by the drugs!' You do not have to be a drug-taking adolescent to hear young people talk about the illusions of contemporary society and the unreality of your life. And when we begin to have dialogues, and to listen to our kids, we realize that we're being challenged. Possibly one of the greatest things young people could study in any kind of curriculum, whether they be drug users or not, is your willingness to explore the illusions of contemporary society and the reality. This would turn more kids on, if for example they could find an adult willing to explore perception. How do we perceive? Science teachers have a tremendous opener in terms of getting into optical illusions, auditory discrimination studies, and techniques of how we perceive. Explore the nature of illusion, of art and so forth. This is a great vehicle to offer the kid an opportunity to say, 'Look you're right, you don't see what you think you see, you don't hear what you think you hear.' This would give a kid a chance to share with you certain experiences he has had on drugs.

If we want to convince a kid that our reality has some good points, then we had better stay with our feelings and honestly share our feelings with him. A person can say, 'This is how I feel. It's transient, it changes, but this is how I feel.' A kid will respect that. You're not telling a kid 'this is how you should feel.' You can say 'this is how I feel,' and then maybe they can tell you how they feel. The greatest vehicle that adults have found, to get into feeling levels and honest communication, and to understand the nature of the illusion, is the encounter and sensitivity T-group experiences that have developed. There you make a game out of reality, you change roles, you experience feelings directly and you blow your mind. In an intense encounter experience in a safe arena, where there are a few ground rules, adults find that they can let go of some of their realities

and maybe experience some illusions--very vivid experiences. I think it's a tip-off that adults don't have to take drugs to understand the nature of an illusion. They can encounter one another, in the school or even in their classes, with their pupils. This vehicle, this medium, will probably bring you closer to what the young people are experiencing and feeling. It is here where sham, defenses, typical behavior patterns are dropped and people get into themselves. And that's why the encounter group is beginning to catch hold with such intensity. The one thing adults have found, perhaps, is that here they can sort of strip away this so-called 'reality' business they're so hung up on, and get honest with one another because their defenses have been lowered. I'm not saying that everyone can run an encounter group, and that sensitivity groups are the answer for everything, but it's a good start. Within your own school system you should begin to develop techniques of honestly sharing and confronting your kids. It is dishonesty that kids are continuously protesting about. It's the boredom that they're resenting in their schools. Finding stimulating ways of communicating with one another is the key to any educational process, and especially the drug use education program.

#

Excerpted from

LIFE WITHOUT DRUGS

Gilbert Guerin, Ph.D.

*Director, Pupil Personnel Services for the Novato
Unified School District, Marin County, California*

A game you can play as a teacher in school is to contemplate how we might cope with life if we didn't have drugs. It is an interesting exercise because drugs are a method of coping with life. One thing I've seen over the last ten years is that many individuals have found this the only way to cope with certain situations.

Drugs are interesting things but as the kids put it, 'It's a mixed bag.' Drugs keep people alive, they probably will help keep our population under some sort of control, they reduce pain, fight disease, so forth. But the problems of drugs are insidious. Take the arthritic patient and the use of aspirin. Aspirin is probably one of the best fighters of pain for an arthritic patient. It causes a problem, though, when taken in the early stages of arthritis. One of the activities an arthritic is supposed to do is exercise in order to keep muscles and joints moving and inhibit swelling. If the symptom is masked the patient doesn't know he has arthritis or forgets it, and the disease can become progressively worse. In this case the drug that is supposed to make life more pleasant for him has made the disease worse.

One of the other problems we face today is that we tend to over-use drugs. You take a child to see a doctor -- the child has a slight rash on his face. You are not sure if it bothers the child but it does bother you. You try protozone ointment and find that the rash goes away. Four days later the rash is back again. A little more protozone ointment and the rash is gone again. If you are lucky you may run into a second physician who suggests that you get a tube of lanolin and the next time the child goes to bed, wash his face and put the lanolin on and see what happens. Nine times out of ten the rash will not reappear. A mild medication was better than a strong drug, so there has been over-use of a drug.

Among youth there is excessive use and excessive involvement in all kinds of activities, one of which is drugs. Within the last year 2,000 students at a rock concert took a pill that was passed out to the group. Quite a few got sick. They didn't ask what the pill was, they didn't check anything. Somebody passed out the pill to the group and they all ingested it. It could have been nothing or some deadly drug.

In Marin County some boys put marijuana in a jar and let it ferment for 2 weeks. They then took a hypodermic needle, siphoned off the fermented juice and stuck it in their arm. The kids had no idea what had happened to them when they ended up in the hospital. The newspaper charged marijuana as the major culprit but anybody in his right mind knows that if you took any leaf, stuck it in a jar, sucked it off and put it in your arm, you are going to have trouble.

Let's take a typical 12-year old child today. He has injections for illnesses, tetanus, diphtheria, allergies. They ingest all kinds of oral drugs, they watch TV and they see all kinds of advertisements for drugs. They watch their parents, and see all kinds of drug usage. One night at age 12, the child can't get to sleep and is moaning and thrashing. The mother gets an aspirin and a glass of water. She says, 'Here's something to make you feel better,' and gives the child the aspirin.

Now, let's play the game -- 'Life Without Drugs.' What bothers me is not that the child has learned to use aspirin as a way to go to sleep -- later on she will find that there are better drugs than aspirin to make one sleep. What she hasn't learned is all the other coping devices for going to sleep when

Excerpted from talk made at San Francisco Conference of this drug abuse project, October 1968.

one has trouble or no drugs are available. The mother might have rubbed the child's back and tried to soothe her. She might have discussed with her what might have happened during the day to upset her. If the child was willing to talk about the problem, some sort of solution might have been reached. If it had been a problem for which no solution was possible, she might have tried something that although out of vogue today could be helpful. It's called 'thought stopping.' You say to yourself 'stop it!, stop it!' -- a technique used by psychologists with people who have compulsive thoughts.

None of those things occurred. What the child learned was that you go to the medicine chest, you get a pill, and that's the way you go to sleep. It seems to me that a way to help the child is to break this attitude into component parts of (1) cognition and (2) affect. Cognitions are beliefs, facts, etc. Affect is feelings, warm-hostile-neutral-ecstatic, etc. Put this case in this framework. The beliefs around drugs tend to be fairly positive -- the child understands that aspirin will relieve symptoms. She also remembers her mother in a sweet voice handing her a pill so the feeling of warmth and love is also associated with the drug.

Now, what can we do in the classroom? On the cognitive level we can convey information on possible harmful results of drugs. If we are good teachers we probably can also impart some 'affect' signals. In talking to students about using drugs to go to sleep -- from aspirin to the sleeping pills -- you may convey the feeling that this is kind of bad stuff, and not the way to handle the problem of sleeping. If students identify with you, if they model your behavior at all, they may accept not just the knowledge about the drug, but the kind of feeling you have about the drug. The next time he can't get to sleep, he has new knowledge ... drugs can be dangerous. He may also have a feeling that he does not want to use them. While dealing with knowledge and affect, you could also have discussion by students or with students as to what alternate behaviors could help students solve their problems, to lessen conflict as to what to do.

Another example could be discussion on why kids use drugs. A third grade class within four or five minutes would probably lay out most of the immediate reasons ... to rebel, to fight back -- to gain certain kinds of experiences -- to act tough -- because they like the feeling of drugs -- because their buddy asked them and they can't say no. Almost any group of kids will give you this ... you don't have to lecture it out. Put one example in a classroom -- one that affects a lot of kids ... 'They cannot say no when their buddy asks them to do it.' Transmitting the information known about drugs can persuade the student he does not want to use speed or whatever it is. If the teacher is lucky, he may also gain feelings against drugs, of not wanting to use them. But then he gets caught in a jam with his buddy and his buddy really puts the pressure on him and he can't say no. He says he'll just try it once, it won't hurt. What could have been done in the classroom? What is called behavioral rehearsal -- it was once called role playing. Kids talk about the problem of how to say no to your buddy. The kid in this way finds out that he can say no because he acted it out in the classroom.

In short, there are two things that can be done in the classroom that generally aren't done. One is to examine alternatives as might be done with the girl who can't sleep. The other is to use behavior rehearsal. Consider what would happen if a football team just sat around -- if the coach lectured them and then sent them out into the opposition. They would get smashed and smeared. That's what happens to teams without practice.

#

SCHOOL-COMMUNITY RELATIONS

Excerpted from

WHO NEEDS DRUG EDUCATION: PARENTS OR CHILDREN?

*Ralph Metzner, Ph.D.
Staff Psychologist, Mendocino State Hospital
And Editor 'Psychodelic Review'*

The question 'Why do kids take drugs?' needs to be analyzed further. We need to ask 'What kids?' and 'What drugs?' The reason for taking a drug initially may be quite different from the reason for continuing to use it. What was once indulged in out of curiosity, rebellion, or peer-pressure may turn into an addictive or dependent pattern, depending on the properties of the drug in question.

The teen-agers who gravitate towards alcohol as their favorite recreational drug are essentially following the adult pattern. They identify with the adult values dominant in our society: aggressiveness, competitiveness, boisterous sociability, fun and pleasure through activities, sports.

A noticeable shift in popularity is occurring, from alcohol to marijuana, which is now probably the most widely used 'drug' in the school, outside of tobacco. The effects of marijuana are said to be primarily on the senses, a heightening of perception and sensation. The continued use of it is part of a value system which emphasizes aesthetic sensitivity, non-conformity in speech and dress, fun and pleasure through interpersonal intimacy and communication. Somewhat the same values are involved in the use of hallucinogens such as LSD, though because of its notoriety, only the more adventurous and curious are likely to use it.

Amphetamine ('speed') is probably more prevalent than LSD, though less than marijuana. It seems to appeal to those youths who are oriented towards activity and energy but have no outlet for expressing these goals. 'Speed' subjectively gives the illusion of accomplishment, without the actuality. It provides an escape from frustrated ambition.

Narcotics, such as heroin, are likely to be found primarily in schools in lower class, multiracial areas, where their use may represent an escape response to extreme social deprivation and prejudice.

What Are the Dangers?

In discussing dangers, one must consider not only the physiological and psychological aspects, but also the socio-legal context.

Alcohol is undoubtedly the most dangerous drug available. The legal sanctions against its use are minimal.

Marijuana presents a different picture. Relatively little is known about its effects, though recent researches and reviews have argued that it is probably less dangerous than alcohol, perhaps safer than tobacco.

Even so conservative as body as the A.M.A. issued a statement that the dangers of marijuana have been grossly exaggerated. But we have here a situation in which socio-legal definition is at variance with scientific opinion.

Because of a long and probably erroneous association with narcotics, marijuana usage is punishable as a felony on the federal and state levels, and can lead to long jail terms and ruined careers. This is a real danger, which the schools have a responsibility to point out to the young, even though scientific opinion does not support it. Major changes in marijuana legislation are being actively considered at the present time, and the next few years will probably see a considerable diminution in the severity of legal sanction applied to the marijuana user.

The hallucinogens, since they are much more powerful than marijuana, are also more dangerous. The danger is not physical: there is no convincing evidence of physiological damage. The alleged

effects on chromosomes are disputed by many experts. The danger lies rather in indiscriminate usage by persons who are not prepared and who take these drugs without competent supervision and control. The possibility of a schizoid personality being precipitated into a psychotic break must always be considered. The legal-social penalties are relevant here also. The Federal law prohibits its sale and manufacture, not its possession for personal use.

Methedrine ('speed') is probably the most damaging of popularly abused drugs, as far as physical and psychological health are concerned. Its action is to stimulate the emergency energy-reserve (sympathetic system) of the body. When these are exhausted and not replenished by food and sleep, the system begins feeding on itself. Most observers feel that brain damage results from prolonged use of intravenous Methedrine, although the occasional amphetamine pill is probably harmless. The psychological changes -- paranoia, anxiety, restlessness, confusion, inability to concentrate -- tend to remain for as long as several months after withdrawal.

The addicting qualities of the true narcotics such as heroin are well known: the junkie needs the drug to feel normal, and he must continue to increase his daily dose. Deprived of a continuous narcotic supply he goes through extremely unpleasant and painful physiological and psychological withdrawal reactions.

What Should Be Done?

The school teacher and administrator are constantly faced with the demand to 'do something' about drug use in the school. The most common response is to invite so-called experts to lecture students on the evils of drugs. The experts are usually representatives from the local narcotic bureau or the district attorney's office. Too often they are not experts at all, and any youngster who has kept his eyes and ears open is well aware that the facts he is being presented are confounded with many lies and mistakes. Consequently he becomes suspicious and tends to reject everything the experts say.

Deterrence by fear does not work, especially when it is plainly based on ignorance. To the extent that drug usage is motivated by rebelliousness, which should, after all, be the privilege of youth, prohibition and persecution will only increase it. It is commonplace that the surest way to increase sales of an obscene book is to condemn it.

We must respect the intelligence of the young and attempt to give them an unbiased, factual picture of drug use, including all drugs, and including the socio-legal consequences. In this way the youngster is able to weigh in his own mind the supposed pleasures of marijuana against the Draconian legal consequences. Current methods of punishment and repression will not work and will only increase the alienation and the communication gap between young and old.

#

Excerpted from

AN APPEAL FOR EARLY AND INTENSIVE INTERVENTION

*The Honorable Ted Rubin
Denver Juvenile Court
Denver, Colorado*

It is clear that if drug-abusing youngsters are to be helped, the entire spectrum of community agencies and child-serving resources must be heavily involved. This includes the police, the schools, community centers, mental health agencies, and the courts. Municipal and state legislative bodies must play a vital role by insuring that any legislation concerning substance abuse will be of such a nature as to not give these children the additional problem of being labeled a delinquent.

As a Juvenile Court Judge, I am concerned that so much time is allowed to lapse between a child's first symptoms of oncoming difficulties, and the time corrective action is taken. Children's problems intensify each day they are forced to attempt to cope with the traditional programs in schools and other agencies.

My first plea, therefore, is to the schools. It has been hypothesized that a potential glue-sniffer can be detected when he is in the third grade and approximately eight or nine years old. When a child begins to work at a level significantly beneath the achievement of his first two school years and beneath his measured intelligence, recognize the fact that you are dealing with a child whose self-image and self confidence is being destroyed, and do everything within the school's power to help this youngster.

My second plea is to the community and recreation centers. The child who withdraws or the child who shows off and creates havoc is frequently the child who needs special attention -- give him every opportunity to earn attention in a positive manner. This child may be the one who does not fit into a regularly-scheduled group. Rather than exclude this child, bring him into the group or develop a new group to include him. Provide discussion and creative activities to the most imaginative extent possible.

My third plea is to caseworkers. In working with glue-sniffers and similar children, concentrate maximally on family counselling. Help each family member to cope better with his own problems, and to understand how these problems add to those of other family members.

My fourth plea is to the mental health services. Don't expect this child or his family to come to your clinic regularly, nor to seek insight into their problems. Go out to them.

My fifth plea is to police officers. These children most often come to the attention of the police because of substance-induced intoxication. In these instances, to the degree feasible, take the child to his home. Insist that a community agency provide him and his family with effective service.

And a sixth plea is to my fellow jurists in juvenile courts. An habituated glue-sniffer will not stop this practice because you warn him or threaten him. Nor will he attend school daily though you warn him of the consequences. Traditional probation and traditional delinquency institutions do not reach him. Far more total and prolonged intervention is needed. Arrange it.

#

Excerpted from

REPORT OF COMMITTEE ON MARIJUANA
CALIFORNIA CONGRESS OF PARENTS AND TEACHERS, INC.

A committee to study marijuana was appointed by the president of the California Congress of Parents and Teachers, Inc. in November 1967: 'To inquire, as laymen, into the present law and its application regarding possession, use, sale, and transport of marijuana; statewide incidence and trends of arrests; the medical and social significance of its use; and what instruction is given in the public schools regarding it--in order to develop factual information an informed opinion for use in determining CCPT's stand on legislation.'

Members of the committee collected, studied, and shared available reports, opinions, and related articles from newspapers, magazines, and professional journals; evaluated educational materials and methods used in teaching about marijuana; and researched the history, current status and ramifications of the law pertaining to the subject. During four days of deliberations, 14 persons met with the committee to present particular aspects of the subject. This report presents conclusions reached by the group and recommendations suggested.

Sale and use of marijuana in California and arrests of juveniles and young adults for these offenses have increased to a point of grave concern. Marijuana seems to be generally available to college, high school and junior high school students throughout the state, and is both plentiful and inexpensive. Users come from all segments of society irrespective of cultural heritage or economic position. Reasons given for use vary widely, including the problems of the completely anti-social; those seeking vehicles for 'mind-expansion' or escape; and the majority are first-offenders or thrill seekers whose curiosity leads them to experiment as one would try a glamorous new fad.

As the committee studied the subject, it was obvious that much of the material accepted as valid through the years was only opinion, and proved to have no substantiation. For example, research shows that most marijuana users have not been pushed into the habit--they seek it out; marijuana use and crime are not necessarily related; it is not always true that marijuana-users become criminals, but rather that criminals are often marijuana-users; experimenters with marijuana are not automatically 'hooked' for life--thrill seekers give it up and don't go back.

All available evidence shows that there has not been adequate medical and scientific research to determine how harmful or harmless marijuana actually is, or what effects its use may have. It is time for a thorough study to be made. Research in California has been hampered by inability of researchers to obtain the raw material legally. The dearth of facts has let adults to hysterical preaching, using exaggerations and scare tactics, rather than teaching with certainty and assurance. Results show that youth no longer trust adults' information regarding marijuana, but through peer groups or their own personal experience, establish their attitudes and opinions. Arguments used to deter youngsters from experimenting with drugs, or even using them regularly, are practically undone by what the young people see for themselves. For example, adults' continued use of cigarettes, which have been proven dangerously harmful, and alcohol, with its well-known problems of addiction, auto accidents, mental illness, broken homes, etc. Illegality has emerged as the only valid argument to prevent a child from beginning to use marijuana, so his answer has often been that 'getting caught is stupid.' To some, the law has become a challenge to try to beat, and many have lost respect for it.

A survey of high school students in one area showed that only one-half of one percent of those polled believed that the present laws against use of narcotics and dangerous drugs are adequately explained in school. Schools are required by law to teach about narcotics, but teachers are given no preparation for this and many are understandably reluctant to instruct in a subject about which there is so much controversy and so little factual information, as with marijuana.

Present law makes conviction for the first offense of possession of marijuana a felony, with a mandatory sentence of from one to ten years in a state prison. In addition, the criminal record of a felon follows him all the rest of his life: he can never serve on a jury; never be an officer in the armed

March 1968

forces; never hold a position for which he need be bonded; he must register with the police wherever he lives; may find it very difficult to obtain some jobs, particularly those requiring a license. The maximum penalty for the first conviction of a misdemeanor is one year in the county prison and/or \$1,000 fine. No lifelong penalties follow a misdemeanor conviction. The age of the offender in large measures determines the disposition of the case. If under 18 years of age, the juvenile court has jurisdiction, and juveniles are not subject to felony conviction. If between 18 and 21 years, the court decides whether they shall be treated as a juvenile or adult. If treated as an adult, the felony penalty would hold. After age 21, the felony conviction must be imposed. The study committee feels that the seriousness of a felony conviction in many cases may be unwarranted, and that the court should have the flexibility required to handle each case on its merits.

Marijuana, along with other drugs, has been given wide publicity through mass media. The sharp rise in arrests is attributed by some to police pressure, 'political noise,' and public attention. Some concern is felt that those handling narcotics' problems treat them quite differently from other offenses; for example, a youngster picked up for possession of marijuana is nearly always referred to probation, his name is often used in newspapers, and he may be expelled from school. None of these is necessarily true of other law violations.

The emphasis on law enforcement and punitive measures has not been successful in controlling or reducing marijuana use. Established community centers offering factual drug information and counseling in an honest, straightforward manner to students, teachers, parents, and other concerned persons have met with interest and enthusiasm. Personnel in such centers should be chosen for their sensitivity and ability to relate to young people. Various points of view should be represented in an advisory capacity to the program developed for the center--fields such as medicine, religion, education, public health, and psychology--with law enforcement cooperating, but not monopolizing the operation. Objective information about all drugs and their abuse potential can be distributed to individuals or in seminars and conferences. Young people seem to have respect for the medical or psychological viewpoint, but tend to 'turn off' law and authority figures.

The committee agreed conclusively that use and abuse of marijuana, or any drug, is a complex problem; but is actually only a symptom of much larger problems of our society in these times. Why do people need drugs except for medical purposes? Prevention of drug abuse requires that we meet an individual's needs before he reaches that stage of desperation.

#

Dr. MILLER. In the area of education, we have supported several projects aimed primarily at teachers, in an effort to educate and train teachers about the problems of drug abuse, and particularly to enable them to deal with this difficult kind of issue in a classroom situation.

Through one contract, we developed a curriculum with the active assistance of the Office of Education and classroom teachers, which will be distributed on a nationwide basis shortly.

Additionally, we have prepared materials, for the National Education Association Journal, which reaches approximately 1 million teachers, an insert which I also have here, which provides basic information to the teacher in the classroom.

In the area of scientific communication, we have at NIMH the National Clearinghouse for Mental Health Information which has within it the largest single store of abstracts in the area of mental health, and particularly on drug abuse.

In July of 1969, we published the first issue of what we hope will be a regular publication, Drug Dependence, which includes short articles as well as abstracts of articles from scientific publications, which will be distributed widely to the professional field.

Senator HUGHES. Dr. Miller, do you have any specific programs to recommend to the medical schools of America?

In talking privately with most physicians—that you talk to privately—I find that most of them talk about this subject drug abuse and narcotics, and are increasingly concerned about their share of responsibility for prescription drugs and narcotics, which is also a very sensitive area right now, and many times leads to other things.

Is anything being done in this field?

Dr. MILLER. Not specifically. We certainly have identified this as a high priority area when we have the funds and staff to develop this particular activity.

I would like to add, though, that there are many mechanisms for introducing the subject of drug abuse and addiction into the medical school curriculums.

Many of our 16 programs that we are now supporting for community projects to treat and rehabilitate addicts are located in medical school settings. As a result, students will be exposed to addicts in learning to treat them. I think it is an important mechanism for improving the capacity of our future physicians to deal with this problem.

Senator HUGHES. Do you think this is true in alcoholism also?

Dr. MILLER. Yes.

Senator HUGHES. Do you think that in the future this must be developed as part of the curriculum of medical schools?

Dr. MILLER. Yes; I think this whole area is something that deserves high priority in the medical schools, as well as in other health professional schools.

Senator HUGHES. What are you doing in the way of films in the field of alcoholism? How many projects do you have approved by the advisory committee and so on?

Dr. MILLER. In terms of films, sir?

There is one grant application for a film on alcoholism that has been approved.

Senator HUGHES. Why hasn't it been produced?

Dr. MILLER. To my understanding, Senator Hughes, there are specific departmental regulations bearing on the production of films under grants for public distribution.

As I understand it, this particular grant has not yet been approved.

Senator HUGHES. I have been informed that the Appropriations Committee this year specifically told you to change that regulation so that this could be accomplished.

What action have you taken?

Dr. MILLER. This is not a regulation of the NIMH, sir. It is a departmental regulation.

Senator HUGHES. Have you taken any action to recommend inter-departmentally that it be changed?

Dr. MILLER. To my knowledge, sir, the request, or a new request for clearance, for approval of this particular grant has been forwarded, or is in the process of being forwarded to the Department.

Senator HUGHES. Do you think it is an important step that should be taken?

Dr. MILLER. On the basis of our experience with the previous films which we supported under contract, narcotic films, I think this can be a very effective mechanism for reaching the public and educating the public about a specific problem.

Senator HUGHES. Mr. Black, do you concur in that?

Mr. BLACK. Yes, sir.

Senator HUGHES. Are you going to take steps to try to get this released?

Mr. BLACK. Senator, I must confess that I am not familiar with the status of this particular proposal from the Institute, but I can assure you that it will be looked into carefully.

Senator HUGHES. Mr. Black, the Yarborough bill, S. 2608, which I cosponsored along with a number of other Senators, was introduced July 14, and we still don't have a report from the Department on this particular piece of legislation.

We would like to have a detailed explanation of the Department's opposition to S. 2608 and a formal report on it.

I frankly don't understand the delay in getting anything on it now.

Mr. BLACK. Well, Senator, the reason for the delay is that, as I am sure you and members of your staff are aware, we have requests for reports on hundreds of bills. We have to assign them some order of priority.

Senator HUGHES. What order of priority—

Mr. BLACK. The guesswork on the order in which we think they will be coming up. As I said in our testimony, we hope to get it to you as quickly as we can. Obviously, we guessed wrong on this one.

Senator HUGHES. What order of priority do you give narcotics on the health problem in America?

Mr. BLACK. We give narcotics a very high order of priority. That is not the basis on which we write the reports, select the order of writing them.

Senator HUGHES. I thought you just said you had an order of priority.

Mr. BLACK. In which we make the reports. This is an order of timing in which we think the issues will be coming up for hearing.

Senator HUGHES. In other words, you are trying to second-guess the committees in Congress, instead of the priorities of the problem?

Mr. BLACK. Customarily, when a committee is preparing to hold hearings, if our report has not been submitted, we are prodded. We move along as quickly as we can on those. We have literally hundreds of bills awaiting reports, and this, of course, is very complex legislation. The process for reports requires considerable clearance and is not something that is done in a day.

We will get our report to you as quickly as we can.

Senator HUGHES. According to the staff, we have 69 bills in the health field pending before committee and you—the Department of Health, Education, and Welfare—have reported on roughly 10 of these. Now in the field of education, we have 61 bills pending before committee and you have only reported officially on one of these. On some of these—roughly 10 in the health and education field—the administration has testified before the committee.

This bill, S. 2608, is from the chairman of the Labor and Public Welfare Committee of the U.S. Senate. Would you deem that a priority matter you should get a report in on?

Mr. BLACK. I deem it an important bill, and we are working on the report, Mr. Chairman.

Senator HUGHES. Give me an estimate of when you expect to have it over here?

Mr. BLACK. I will ask Mr. Ellenbogen, for the Legislative Division, to give you an estimate on that.

Mr. ELLENBOGEN. We have referred it. When the request came in, we acknowledged it and referred it to the Assistant Secretary for Health and Scientific Affairs.

Senator HUGHES. Whom did he refer it to?

Mr. ELLENBOGEN. That was referred in that office to Dr. Novitch, who is the person who is a special assistant in the field of drugs. Whether he in turn referred it out or not, I wouldn't be able to tell you without inquiring, but he usually, in a matter of this kind, would refer it to the Health Services and Mental Health Administration, and they in turn ask the National Institute of Mental Health to work on it.

The Food and Drug Administration might also have an interest in this, and he would coordinate their views, and we eventually get a report.

We have not yet received a proposed report, but it is actually being worked on at this point, I think in the National Institute of Mental Health, or at a higher level in the Health Services and Mental Health Administration.

When it reaches us, we will review it and analyze it, and then it will come to the General Counsel, to the Assistant Secretary for Legislation, through the Secretary to the Budget Bureau for advice as to the relationship of the report to the program of the President.

In this instance, I think the Bureau will ask the Justice Department for comment on that proposed report, and we, of course, have no control, except by prodding, over that process.

In this instance, of course, we will make it our business to let them know, as they already know, that this committee is most interested in this report.

Senator HUGHES. I might add, not only most interested, but most impatient.

Mr. Black, you are at the top of this pyramid—

Mr. ELLENBOGEN. May I add, Senator, that it is our experience that when a committee believes that a bill will become active, under consideration, to inform us either by telephone or a letter. Most of the letters we get, as in this instance, are simply form letters. As Mr. Black pointed out, there are hundreds of bills, and maybe thousands, in the Department from the House and Senate, more in the House.

Mr. BLACK. I think, Senator, this is a problem that is more serious in our department than perhaps any other, because we have a study made in the last Congress by my predecessor that shows approximately one-third of the bills introduced in Congress touch our department in one way or another and we are asked for reports on them.

As I say, it is a logistical problem, and it involves a good deal of guesswork on the order in which these things are going to be brought up.

Many bills, as you know, are introduced and that is the last you hear of them, and the reports on those are not forthcoming.

Obviously, we recognize the importance of this bill. It is simply a question of logistics. It is a time-consuming process, as Mr. Ellenbogen explained.

You may recall that on my last appearance here, I indicated we have a tremendous volume of health legislation coming up for extension in the next year, and we would like to work with this committee in scheduling the order in which these will be considered.

My information from your staff was that the next major effort here would be in the area of regional medical programs.

The drug abuse hearings we were informed of last Friday evening. Perhaps with more notice we could have speeded up our efforts to get the report expedited.

Senator HUGHES. How long were you working on the administration bill in the field of narcotics, Mr. Black?

Mr. BLACK. The administration bill in the field of narcotics has been in the works since almost the beginning of this administration.

Senator HUGHES. You were aware of the problem of narcotics then and the priorities of it?

Mr. BLACK. Indeed.

Senator HUGHES. You were not unfamiliar with the fact that legislation was before this committee and that we were going to be holding hearings, were you?

Mr. BLACK. I was not.

Senator HUGHES. Certainly you realized we were going to be calling such hearings and calling on you and your department for professional testimony, and for something to reinforce the positions that we have here.

I, of course, have elicited the testimony of the Department of Justice, and I want to express my appreciation. I don't see any reason to pursue further at this point a bill that you haven't reported back to us on. We need a report so that we can consider it along with the

administration bill, which I think you espoused 100 percent here this morning. Although you said you had some places you would change in it, when I asked what you would change, I didn't get a reply, as I remember.

If you would care to tell me what you would change, I would like to have it a part of the record.

Mr. BLACK. As I told you then, Senator, I think our department would favor a more flexible approach to the question of penalties than the bill provided.

Senator HUGHES. Can you tell me how that relates to health—the penalty avenue of it? I tried to pursue that with Dr. Miller. Your section is dealing primarily with the health of the American public, and the only thing you would change is penalties? You wouldn't change anything with regard to health in the administration bill?

Mr. BLACK. The administration bill in this particular regard is primarily, as you know, a codification of the enforcement statutes. As I pointed out before, this does not represent our total approach to drug abuse from the health standpoint. That is why we are putting the Community Mental Health Centers Act at the top of our list on bills we are trying to get before you.

Senator HUGHES. You agree that the administration approach has been one primarily of enforcement?

Mr. BLACK. No, sir; I do not agree with that. It is a combination of enforcement and health, as the President pointed out in his message.

Senator HUGHES. Didn't you just say that the essence of the bill dealt with enforcement?

Mr. BLACK. If I did, I did not mean to leave that impression, Senator.

Senator HUGHES. I think you did.

Mr. BLACK. I was trying to make the point that it is not our total approach to the drug-abuse problem, as you indicated in one of your previous questions to me.

I think from the standpoint of our department, the interests of the scientific and medical community are represented in the areas where they are affected.

Senator HUGHES. Dr. Miller, I would like to ask you a couple of questions, and then I will get on here.

Within the last week, you have, of course, been with Dr. Yolles and perhaps Dr. Cohen when they testified as professionals that they could not support the administration bill in its present form.

Dr. MILLER. I was not with them.

Senator HUGHES. Did you read their testimony?

Dr. MILLER. Yes, sir.

Senator HUGHES. Do you agree with it?

Dr. MILLER. Yes.

Senator HUGHES. As a professional?

Dr. MILLER. As a professional.

Senator HUGHES. Thank you very much.

Gentlemen, I appreciate your coming here today, but I want to speak in all candor to you. The testimony you have presented this morning is as disappointing and inadequate as any we have received in these hearings.

At the time of our first hearings in July, we asked Secretary Finch to testify and were told by your office that HEW had not yet formulated a policy on drugs and narcotics, that the Secretary had requested that he be permitted to testify in September, at such time as the Department policy in this all-important field had been formalized.

The statement you gave this morning does not really reflect the determination I had hoped to see, or to meet, on what the President himself has described as one of the most critical problem areas in the country.

I think what you said, in effect, is that there is not money for this important problem at this time. If you want to correct me, I will be glad to be corrected.

Mr. BLACK. Well, I would like the record to show this: As I indicated earlier, our department, and this administration, do have a policy reflected first of all in this piece of legislation which is before another committee, which will be reflected further in the other legislation we expect to have soon.

As I said earlier in my testimony, we do not minimize the critical nature of this problem. I think that was the thrust of the President's message. He said it was a problem to be approached by our department, the Justice Department, and by other departments in the Government.

We have certain responsibilities in the fields of education, training, treatment, research, which we intend to carry out not only as we have been, but to extend and expand our efforts.

I think you will find that our performance will show that.

There is not, Senator Hughes, I would say to you in all candor, as much money for this program as we would like to spend, or that we could spend usefully. But this program is not alone in that respect. As I pointed out earlier, there are economic realities. There are spending ceilings imposed not just by this administration but by the Congress of the United States.

Senator HUGHES. How many people are dying a year from alcoholism and drug abuse in this country, without treatment, without concern, and without even compassion?

Mr. BLACK. I don't have those figures. Perhaps Dr. Miller does.

Senator HUGHES. Do you have them, Dr. Miller?

Dr. MILLER. Too many, Senator Hughes. From alcoholism, it is estimated there is a minimum of around 11,000 deaths a year.

As far as narcotics and other dangerous drugs, we don't have firm data. I will attempt to supply for the record whatever data we do have relating to deaths from these agents.

(The information requested and subsequently submitted, follows:)

DEATHS FROM USE OF NARCOTICS AND OTHER DANGEROUS DRUGS

Since there is no systematic reporting of deaths related to narcotic use, the information supplied below must be considered incomplete. It should be pointed out that these data do not include deaths from physical side-effects of heroin use, such as hepatitis, or other infection related to use of contaminated needles.

TABLE I

Data from: *New York City Journal of Medicine*, Vol 66, No. 18, September 15, 1966, article by Dr. Milton Halpern, chief medical examiner for New York City.

Deaths from narcotism

1950 -----	57	1958 -----	118
1951 -----	80	1959 -----	158
1952 -----	126	1960 -----	199
1953 -----	100	1961 -----	311
1954 -----	102	1962-66 -----	none available
1955 -----	103	1967 -----	170
1956 -----	133	1968 (first 6 months) -----	450
1957 -----	99	Month of June, 1969 -----	103

TABLE II

New York City narcotics register data

	<i>Number of deaths</i>
1966 only:	
Male -----	664
Female -----	132

TABLE III.—DEATHS BY POISONING AND SUICIDES, NEW YORK STATE

	1965		1966		1967	
	State	New York City	State	New York City	State	New York City
Total analgesics and soporifics.....	256	117	275	178	257	136
(a) Opium and derivatives.....	21	21	1	0	0	0
(b) Barbituric acid and derivatives.....	108	3	73	4	82	4
(c) Salicylates (aspirin).....	90	86	162	160	107	99
(d) Bromides.....	4	4	1	1	1	1
(e) Other analgesics and soporifics (other than (a)-(d)).....	33	3	38	12	67	32

Note: New York City statistics are included in New York State statistics (a)-(e).

Mr. BLACK. Senator Hughes, I want to say that we are fully aware of your personal interest in those areas. We have indicated before that we applaud you for it. I think you are going to be a very effective spokesman—you already are, and you will be more so—in the Senate on behalf of those causes.

I think you know from your conversations with Dr. Egeberg and others that you have some strong allies in those areas in which you are interested.

I want to say also, however, that the areas in which you are interested, areas in which we are also interested, are problems among many. We have, as I indicated—

Senator HUGHES. Is alcoholism the third-greatest killer in the country, as has been reported, and do associated, or related causes, such as cirrhosis of the liver officially go on the death certificate?

Mr. BLACK. It may well be, but there are people in our department who would tell you more money could be spent on the No. 1 and No. 2 killers.

Senator HUGHES. I would support that, also.

Mr. BLACK. There are people who would say that more money could be spent in every area our department deals with.

Senator HUGHES. Let me ask you: Is there any area that you are spending as little on? It is not your fault. I am not trying to say it is your fault. I am talking about the responsibility of the people of America. It is their responsibility in the final analysis, Mr. Black, and that is the point I want to make. Unless we speak out long enough and loud enough, we are not going to get priorities that we need.

I know you would like to give higher priorities to these two areas. I know Dr. Egeberg would, and I think the Secretary would. I am going to be a burr under the saddle, and some people are going to buck before we are through.

You are never going to get the money in your department unless we pursue it this way.

Mr. BLACK. I would indeed agree to it. As I indicated in my prepared testimony, this problem is not one that is going to be solved by our department or the Justice Department. It is going to be solved with the departments working together with the Congress and with the American public, as you have indicated.

I think some of the things we would like to see done are going to have to wait until the economic picture has changed.

Senator HUGHES. I am not willing to wait, Mr. Black. I am not willing to let inflation, or Vietnam, or anything else take precedence over the tragedy and destruction caused by those diseases. We have priorities, and one priority that ought to be reset is that we take care of the health problems in America with the money we have to do it with. We have the money if we spend it correctly.

It is not your fault, it is the responsibility of the Congress and of the people of America to see that we reorder these priorities.

I do not mean to be harsh with you personally, but I do feel strongly about these needs and the abandonment of our social structure.

I know you care, and I know we care, and it is time we gave this the priority that it should have.

Because I think there is a decided difference between the approach taken by the chairman of the committee, Senator Yarborough—which I endorse—and the one endorsed by the administration and the Department of Justice, I want to ask Dr. Miller a professional question again.

Do you agree that the Department of Justice is better equipped to engage in the classification of dangerous drugs? Should not the Department of HEW be the one that bears that responsibility?

Dr. MILLER. Speaking as a professional, Senator Hughes, I would have to agree that scientific determinations relating to drugs are most appropriately vested in scientific persons in scientific agencies, primarily health agencies.

Senator HUGHES. Thank you.

Mr. BLACK. May I comment for the record on that point, so it will be complete. This is a debatable issue. It has been debated for years in and out of Congress. The Congress in 1968 agreed to the transfer of this authority to the Justice Department. The administration bill leaves it there, but it includes some language that I would like to read to you to show that it is not a decision that is going to be made—

Senator HUGHES. It has been read into the record about four times, by Mr. Ingersoll yesterday, and I am sure you would read the same thing at this point. If you want to, go ahead.

Mr. BLACK. Well, it is important language to the Department of Health, Education, and Welfare.

Senator HUGHES. The importance I see in that language is that you are in an advisory capacity and they do not have to accept your advice.

Mr. BLACK. It is highly unlikely to us that the Attorney General would make one of these classifications in total disregard of the advice of the Secretary of HEW.

Furthermore, he is acting on the advice of the Scientific Advisory Committee established in the act, which I believe has nine members, seven of whom are from the scientific and medical community. Only two of them are from the legal community.

Senator HUGHES. Some of them have testified.

Mr. Ingersoll, the Director of the Bureau of Narcotics and Dangerous Drugs, stated his belief that HEW should have a greater responsibility than it now has in educating our population to the danger of drugs.

If the Department of Justice is willing to say this, do you agree with it?

Mr. BLACK. I agree with it. It is in the President's message. It is directed that we expand our role in education, and as I said earlier in my testimony, Dr. Miller has already testified before a House committee that we do hope to expand our role in education.

Senator HUGHES. Gentlemen, I want to thank you very kindly for your patience and your testimony and for agreeing with my impatience in some of these areas as we have visited here this morning.

I am going to be in touch with Dr. Egeberg and schedule an appearance for him if possible.

Mr. BLACK. I am sure he would be glad to be here, and we are sorry he could not come today. We will try to work out an appearance for him, because he has much to contribute on the subject.

Senator HUGHES. Thank you, Mr. Black.

Mr. BLACK. Thank you.

Senator HUGHES. We call Dr. Daniel Freedman of the Department of Psychiatry, University of Chicago School of Medicine.

You may proceed with your statement as you desire.

STATEMENT OF DANIEL FREEDMAN, CHAIRMAN, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF CHICAGO SCHOOL OF MEDICINE, CHICAGO, ILL.

Dr. FREEDMAN. Senator Hughes, this committee has already heard the best informed testimony available on drug abuse. I think it could be mandatory reading for the public.

Our overstimulated society suffers not only from drug abuse, but from morbid "drug interest." Sensationalized and publicized, this has naturally generated frantic appeals for help. These are reflected in a flood of hasty, partial, misdirected and fragmented legislative proposals.

Yet, if we pause to collect our senses, a simple first step is close at hand. The Yarbrough bill (S. 2608) in essence contains this. If Congress can focus on its bald clarity, we can retrieve a legislative and administrative mess and make a fresh start toward converting morbid drug interest to healthy drug attitudes.

The principle is in three parts: (1) matters pertaining to health, education, and research are the primary function of the knowledgeable health agencies; (2) enforcement of laws related to illicit drug manufacture and traffic is the primary task assigned to the Attorney General; (3) both the Secretary of HEW and Justice are obliged to consult and collaborate for the purpose of advancing public health, each respecting the expertise which is appropriately lodged in each Department. That is the basic package.

The facts are that the basic resources for an intelligent response are at hand in the instrumentality long authorized by Congress. I refer to the Department of Health, Education, and Welfare with its National Institutes and with its National Institute of Mental Health (with Centers for Alcohol Studies and Narcotics and Drug Abuse), with its FDA and with their total combined vast experience in tapping the Nation's community of informed pharmacologists, behavioral and social scientists, physicians, psychiatrists, and pharmaceutical experts.

The Yarborough bill transfers authorities from the Department of Justice and redirects primary authority for research, education, and administrative regulations precisely to the agency equipped to generate sound knowledge. This is of prime importance. Upon this one principal, all chances of credible and effective drug abuse legislation, administration, research, and education rests.

Adherence to this simple principle will bring some clarity to any future approach. It will bring support of the community of experts who—almost to a man—are alarmed at other bills.

All proposals, large and small, should be matched against this one principle. The question to ask of any piece of drug legislation is: Are we relegating fundamental health and research matters to the direction of police or health officers?

These matters not only affect our youth but the very practice of medicine, its basic sciences and its fundamental clientele: the American public. Why do we not now have an arrangement whereby each agency knows its limits and competencies, where each is not only authorized but accountable for doing whatever governments can do to meet this pressing public problem?

The answer—to be mercifully brief with an ugly history—goes back to the drug abuse amendments of 1965, a time when the LSD problem had surfaced, been advertised, and had spread; at the time the wave of marihuana interest was just beginning its now visible swell.

That law was well conceived. Responsibilities and penalties for hallucinogens, sedatives, and stimulants were properly allocated. We erred in not giving it time to work, and in retrospect, in not arranging for sufficient funds, personnel, and mandatory collaboration between FDA and NIMH.

Nevertheless, the facts are that LSD use did begin to decline. While real progress ensued with the Narcotics Addicts' Rehabilitation Act of 1966, LSD penalties were escalated in 1968 (as the epidemic was on the real decline) and the Reorganization Act No. 1 of 1968 shifted responsibility for potentially dangerous drugs to Justice. The intent was to streamline enforcement and not to diffuse expertise. In the process, however, lines of responsibility and authentic expertise have indeed become confused. The present bill (S. 2608) corrects this.

Few of us now doubt the absolute necessity of a transfer of authorities. This transfer will accomplish credibility, confidence, and effectiveness for whatever follows.

We do not doubt the sincerity of any dedicated public servant's wish to deal effectively with drug abuse, but the spectre of history repeated (in which drug abuse was entirely locked up within an enforcement bureau) has been faintly visible—and not hallucinated. President Nixon has rightly said that it is a “common oversimplification” to consider drug abuse as a law enforcement problem alone. Only one bill, the Yarborough bill, effectively and unequivocally gives meaning to that assertion.

Certain specific features of the Yarborough bill warrant the careful attention of physicians, the entire biomedical research community, and chemical industries which use products that happen to be also in pharmaceutical manufacture.

The Yarborough bill does not overemphasize control of the legitimate traffic in chemicals or the use of drugs in medical practice. It does not attempt to control basic test tube or animal research with chemicals. Rather, it focuses on uncomplicated control of the illicit manufacture and traffic in potentially dangerous drugs, which is precisely the problem we should be trying to address.

The unwitting philosophy behind other measures is astonishing in its simplicity and simply overwhelming in its consequences to American life and privacy! In effect, with these bills no one can touch the precursors, let alone the final produce (the drug), without a Federal “license.”

All sedatives, stimulants, many tranquilizers used in various aspects of hospital and office practice (potentially even antihistamines) can in effect be “licensed.” Drugs useful for reversing the effects of morphine could be classified with heroin simply because of chemical similarity—not real pharmacological effect. The physician specifically is federally licensed; anyone in possession of these drugs in minute or large quantity requires a “license” in the form of a prescription.

Anyone studying the effects of sedatives in a frog's eggs—or more cogent animal or test tube research—may require a Government review of his research proposal as well as a license. Anyone transferring a medicine from his medicine cabinet to a family member turns himself and his family into an enclave of criminals in the eyes of the law.

All and each of us is liable to scrutiny at the level of what commonly are some very private and innocent (if sometimes unwise) transactions. All of this to be able to achieve a total paper control and monitoring of drug traffic. And all of this paper control of lives and persons is to cope with illicit traffic and use.

To conceive of the powers to intrude on privacy or legitimate activities that this confers on mortal enforcement officers boggles the undrugged imagination!

In the attempt to be comprehensive, drafts of this administration's legislation should have included nutmeg, flower seeds, gasoline, glue, perhaps paint, and since I cannot keep up with those drafts, they may have done so by now.

I suggest a very close and precise reading of the text of bills based on this totality philosophy. I have urged this on the bill drafters

whose intent, after all, is to create a sensible law. What is worrisome is that an omnibus law, written with technical carelessness, may become an ominous one.

The Yarborough bill is clear in defining authority. Secondly, it is modest but realistic as a fresh start in legislation. There is a third important feature: The adjudication of the pharmacological actions, dangers, and abuse potential of a drug (for example, a medically valuable one) is primarily to be in the hands of health rather than enforcement officers.

In order to streamline drug enforcement operations, are we to establish a scientific institute of NIH proportions in the Department of Justice? In all reality, would a medical and scientific community be readily recruited under such auspices?

Many operational matters require administrative judgment and action and authentic medical and scientific judgment. Under the Yarborough bill, this is assigned to the health agencies with appropriate advisory committees and consultation with the Attorney General.

Most bills provide a scheduling of drugs according to their dangerousness. Once a particular drug is scheduled, all penalties and regulatory strictures are to fall in line. This might seem a great administrative convenience. S. 2637 has classified marihuana and LSD—but strangely, to my medical knowledge, not peyote or mescaline—as unsafe for use under medical supervision.

Without detail, this simply is not exactly true or well founded. It could retard the acquisition of new knowledge. For progress, drugs are—and should continue to be—used experimentally under local hospital as well as special Federal safeguards. We do, I believe, still have an FDA with special procedures for investigational drugs and we should use it—not pretend it is not there.

There are many chemicals, useless commercially or therapeutically, which in the course of basic biological and chemical and test-tube research are requisite tools. For any given drug, it should be possible to schedule penalties for illicit use; make reasonable regulations for its research use; appropriate regulations for manufacture and the setting of quotas. The criteria for each of these different functions can differ.

In brief, overly rigid scheduling will lead to a hornet's nest of problems. The only bill allowing some sensible flexible procedure is the Yarborough bill. The Secretary of HEW—section 402 of S. 2608—is permitted to add, change, and delete or reschedule a substance after advice and consultation, and also to permit a judicial review in accordance with FDA procedures, if requested.

For the Yarborough bill, quota-setting powers are properly under HEW, but I believe manufacturing quotas for a number of drugs other than narcotics (such as amphetamines) should be—while not mandatory—permitted with appropriate prior consultations.

I have been told that guidelines for evaluating drugs make it legitimate for the decisions of the defining agency to have the force of law. I am not certain that section 402 is adequate here.

Persons conducting research with narcotics or marihuana must register under this bill, but what is at stake is a simple provision of safeguards for drug diversion—not a potential surrender of all

notes, papers, et cetera, from every conceivable research laboratory in every university and institute in the country.

The public should properly be protected from the menace of researchers and physicians engaging in illicit commerce. But if 8 billion amphetamine tablets are manufactured yearly, where does the diversion in fact occur? If Congress has ever received a single piece of objectively sound operations research—examining the salient sources of diversion and procedures for controlling diversion, I am not aware of it.

Drug abuse is a serious and costly problem. So is its enforcement. Should we rely on hearsay or routine statistics in order to construct omnibus control laws, which, like babies, may have teeth before they have wisdom? If our society is to be totally controlled in our contact with common drugs in order to safeguard public health, we should know that no other procedure is possible.

Research and drug abuse education clearly should not be under the direction of the Attorney General. The use of S. 2608 of the National Advisory Mental Health Council to authorize grants and contracts is wise. NIH has had 20 years of experience with scientific peer review and Council overview for grants and often for contracts. If this is not done, a governmental officer who might be narrowly informed but strategically placed could let contracts to inferior agents—or for special outcomes—a waste of resources at the least.

The Yarborough bill recognizes this in its provisions.

We believe the enforcement agency could be authorized—after such review—to conduct, or to have conducted, operations research on its own enforcement tactics and problems. They can continue to educate law officers and to use HEW aid in this. Law officers so educated can be in touch with social science researchers in a useful rather than obstructive way.

To chemically identify drugs brought in from the streets by agents is also a legitimate function for an enforcement agency either to do, or to have done elsewhere in Government; or lacking this, through properly reviewed contracts.

A provision of S. 1895 is strongly recommended for this bill: to authorize researchers to withhold the names of subjects and to possess and distribute drugs where required for research without fear of Federal or State prosecution. This feature will permit field investigators to get information the public really wants without turning research investigators into informers (or criminals if they ethically insist on withholding personal information).

Penalties for marihuana should remove the minimum mandatory sentencing as recommended for some years now by every body of experts commissioned to study the issue. I believe those proselytizing for the legalization of marihuana ought to have an authentic chance to ponder the real problems of drug dependency without playing games with the establishment's myths and mistakes. This change in penalties could put the marihuana problem where it properly belongs—up for serious study rather than the tragic and escalating cops-and-robbers routine.

Today youth do not believe police and they doubt authentic expert information, and they even avoid physicians when they are in trouble, and we must earn the right for them to believe us. No cigarette smoker

or wine connoisseur believes really in his vulnerability to becoming dependent or misusing the effects of his favorite drug. Most of us, unfortunately, believe simply the testimony of our senses; if there are no immediate ill consequences, we assume all warnings are moralistic manipulations to induce conformity.

I believe that everything that we have observed in the way of social and psychological consequences of alcohol could conceivably occur with marihuana. Paranoid states and panic are less likely without alcohol than with marihuana, and the withdrawal delirium of alcohol would not occur with marihuana.

But I want those advocating legalized marihuana to assess for us, the public, what the social costs of legalization would be. They should be willing to risk exposure to many to becoming casualties. So far they have not demonstrated a lack of casualties, if we take excessive "drug interest" as our measure. Prohibition—lest we forget—did indeed work in terms of a reduced number of casualties, even though it displeased those who wanted the freedom of relaxing with alcohol.

By returning the penalty structure to the 1965 regulations in classifying marihuana as a mild hallucinogen, we would have a chance to be both honest and cautious. By changing the penalty, we offer proper perspective and definition: marihuana is not a narcotic; its possession is not equivalent to rape or murder; nor is its widespread use at all proven to be safe simply because a few or many mild doses are enjoyed.

We have no need to fool youth, nor do we have a need without a thorough look to repeal marihuana and accept the financial and social costs of dependency and abuse, by which I mean the foolish and escapist exploitation of a drug's effects. We must be aware of the costs to the development of will and competence, which is the most crucial consequence of drug interest in youth—whether the drugs are amphetamines, LSD, marihuana, or long periods of alcohol use.

I take exception to what can be an administrative encumbrance in S. 2608. The wording should permit community mental health centers to proceed with treatment, research, and education. It clearly should not constrain grants and contracts to be awarded solely through this mechanism nor encourage programs to be set up in mental health centers, where they are not needed or not feasible.

Flexibility is required, and HEW should review the best proposals for effective education and research quite independent of their link to a community mental health center. We also suggest that the phasing of funds be reviewed. Trained personnel must be available for new positions which are authorized, and knowledgeable experts in drug abuse are indeed thinly spread. If we move too fast, we will have disappointing results. This is a serious matter.

Congress will have to watch three matters in this matter—perhaps through committee review. One is the diverting of congressional intent by enforcement agents encouraging different actions on the State level than is policy on the Federal level.

After the drug abuse laws of 1966, model bills were sent out from Federal agencies advocating more rigid penalties than the Federal. This double message is intolerable and can defeat all that Federal funding aims to accomplish.

Since much of the facts of life will be lived outside of congressional scrutiny, administrative and bureaucratic monkey wrenches should be watched.

A second important point is the allocation of funds and the unfreezing of positions to accomplish whatever is recommended from these Halls. We are on the way to creating an edifice of paper promises in the entire health area—simply because the trained manpower, unfrozen positions, salaries and grant moneys, and training and research apparatuses are, in fact, not available.

Third, Congress should require what is needed, but also protect its Government scientists and administrators from impossible expectations and hysterical demands. Who can function effectively if political hot water is constantly threatening a Government scientist doing a scientific job?

I trust we can begin to articulate the pellmell and piecemeal approach to the drug-related aspects of our entire health system. An orderly and stepwise approach is required. A national commission relating to the entire spectrum of regulations of all drugs (legitimate as well as illicit), from manufacture to research and clinical testing, is long overdue. We legislate too hastily without regard for the consequences and without genuine contact with the variety of involved parties, let alone funding for our proposals.

The escalating reverberations of such cycles are now far beyond simple control. We all face the heavy task of settling down and soberly acquiring knowledge. No society can completely control what a population of 2½-year-olds, or their elders, will put in their mouths.

Rather, we must all consider how we behave about our drug taking, about the purpose and value of experimenting with our mind and moods. Our society's job is to establish safe customs around the use of our permitted drugs, such as alcohol, which bring tragedy in highway carnage, as well as disease.

We have hardly established the customs that would safeguard the uses of alcohol. What is not easy to do—either for purposes of legislation or for counseling children—is to make an honest assessment of the risks and gains in the recreational use of new drugs.

Drug problems are, in part, "people problems" and our society must learn to acknowledge human vulnerability and foster sensible attitudes. This is the only good legislative beginning that many of us can seriously consider.

Senator HUGHES. Dr. Freedman, I thank you for a very comprehensive and enlightened statement. You have obviously studied the main bills that are before the Congress on this subject matter and tried to pick the parts of each which you felt it would be the better for the people of this country to consider.

I think primarily that what this committee is allowed to consider—and, of course, we are not considering at this point the elements of the Dodd bill, which you mentioned in two areas of your statement—is a redirection of policy, and I think it would be helpful to us if you stated for us again the differences between the direction of the administration bill and the Yarborough bill.

Can you restate that?

Dr. FREEDMAN. There are too many medical judgments that have to be made right down the line, judgments that require pharmacological

and toxicological information, especially in the business of classifying drugs and knowing how they are in fact used or useful.

If this is the responsibility of an agency in HEW, they can spell drugs correctly, which I can assure you is not done in some of the bills I was referring to. They cannot only spell the names correctly, but they can understand where the action is with drugs, and this cannot be done by an enforcement agency, unless we create a new one. This is possible. FDA is an enforcement agency with scientists in it, but even FDA has trouble staffing itself with informed people who know what these drugs are all about.

I think, given the governmental structures we have now, given the history of what happens when an enforcement bureau starts to deal with drugs that are also used in medicine, with medical properties, I think the wisest thing to do is use your best resources. They are there.

Senator HUGHES. In the field of education, would you have any specific recommendations to make?

Dr. FREEDMAN. Yes. Give some of us who have been out in the front-lines some relief. When you think of all the PTA's and meetings and, if you will pardon me, legislative hearings—for the few of us who happen to be in this area and attending these, life is not very reasonable anymore.

I think some of the things I have seen coming out of NIMH are very good. This is going to take a long time, this education. It can't always go under the name of drug education.

Even our social science courses, for example, in high school ought to be talking about fads.

It had an advertiser; the advertiser was the Elite Press in fads, each trying to beat the other one. They were trying to tell what is happening, and this spread the news, and people were gullible. They believed things about LSD that they will say today about marihuana. They simply do not know the costs of drug dependency.

I think that none of us admits that we might be dependent on drugs. The fact is that any of us risk abusing alcohol at some juncture in our lives.

We could have better education about fads and fashions, about pharmacology in high school texts. There is no reason, really, not to know how a drug is developed. We really have two cultures in that respect in our society.

So I think the education takes place on a broad level as well as the specific kind of education which has to do with drugs that are out on the street.

We probably even have to recognize that the underground press does a fairly good job in educating some of its clientele about what to avoid.

Senator HUGHES. Dr. Freedman, I think you have made such an excellent case in your statement that I have no questions to ask you.

I appreciate very much your testimony and your willingness to come here, and I realize the pressure of time on you. Since I have been chairing this subcommittee, I have suddenly become a popular after-dinner speaker, too.

I find, as I am sure you do, most parents, all over this country, are scared to death. Every time I go home, different parents approach me

and say, "I found Johnny with some marihuana. What on earth am I going to do about it?"

Dr. FREEDMAN. The only way to get them to start is to sit down and talk. Drug taking by individuals is sometimes a method to confront their parents with something, something entirely different from the marihuana.

Senator HUGHES. Part of the problem is that Dad is sitting there with a martini while Johnny is talking about marihuana.

Dr. FREEDMAN. It may be that both symbolize something else they want to talk about. They both have different problems. We need to get generations to at least abide each other; I think a lot of excitement we hear has really not to do with the drugs themselves, but the behavior. It sounds pretty simple.

I will say one thing, Senator. The more you are in this field, the more you end up sounding like a person, talking of principles, self-control, and self-limitation.

Senator HUGHES. I sounded like that on alcoholism for years.

Thank you.

The Chair calls Dr. Richard Brotman, professor, Department of Psychiatry, New York Medical College.

STATEMENT OF DR. RICHARD BROTMAN, PROFESSOR, DEPARTMENT OF PSYCHIATRY, NEW YORK MEDICAL COLLEGE

Senator HUGHES. We appreciate your being here, and you may proceed with your testimony as you desire.

Dr. BROTMAN. Thank you, Senator.

The astonishing rise in drug use, both legal and illegal, in recent years has presented this society with one of its most urgent and baffling problems. It is a problem which admits of no total solution, for the term "drug use" refers to a bewilderingly complex phenomenon. It is a phenomenon which involves many types of drugs, used by different kinds of persons for numerous reasons, leading to a broad range of physical, psychological, and social consequences.

Given this complexity, a variety of programs are needed to attack the problem through treatment, training, education, and research. Let me say a few words about each of these areas.

In regard to treatment, we must recall that most drug use is of a moderate functional or recreational variety, creating few difficulties for the user. Sometimes, however, drug use can produce disastrous results: toxic psychoses caused by amphetamines, panic reactions brought on by strong hallucinogens, or life-threatening overdoses of barbiturates or opiates. Thus, treatment programs are needed to care for persons who suffer from the ill effects of drug use.

As to training, we must bear in mind that not all persons who have a drug-related problem present themselves at a special drug treatment program for care. They may first become known to a school, a social work or welfare agency, a church, or a general medical facility. In a real sense, the workers in such organizations become the first line of care, and their response to the drug user may determine whether his problem is treated or allowed to worsen. Thus, training programs are needed to enhance the skills and understanding of persons who come into contact with drug users.

In planning education on drugs, we must realize that, except when medically prescribed, the decision to use a drug is a personal one. Each individual must calculate for himself the benefits and risks of taking a drug. This calculation is often based on limited or erroneous information. In order, then, to reduce the probability of persons inflicting harm on themselves, we need up-to-date educational programs on drugs. These programs should be aimed at the general public and at special "populations at risk," such as students.

Research, up to now, into the pharmacological, psychological and sociological aspects of drug use has been quite limited. We need extensive programs of research to illuminate the chemical properties of drugs, their effects on physical and mental functioning, and the social conditions relevant to drug use. Only in this way can we achieve a comprehensive understanding of the causes, concomitances and effects of drug use.

Because the bill under consideration would generate necessary programs in all of these areas, it should be enacted into law.

This bill, the Yarborough bill, establishes the appropriate platform for such programs. Drug use is primarily a health matter, and it is proper to build these programs by disbursing funds under the Community Health Centers Act and the Public Health Service Act. In particular, existing community mental health centers are ideal bases for new programs related to drugs. In the first place, they can bring a broad range of professional skills to bear on the problem.

For example, in the community mental health center-based drug programs we operate at New York Medical College, the staff represents the fields of medicine, psychiatry, psychology, law, sociology, nursing, education, social case work and community organization.

Second, the community mental health centers are closely related to other agencies in their geographical areas. This can generate collaborative efforts which have a broad impact on diverse populations. At our own center, we have conducted programs in conjunction with public and private schools, social work agencies, welfare centers, citizen action groups, churches, hospitals, and the district attorney's office.

The bill should be enacted for another reason; namely, it represents an approach to the control of drugs which respects individual liberty, while at the same time discharging society's responsibility to protect its citizens against self-inflicted harm.

All too often an unduly restricted set of alternatives is offered when the issue of control is raised. On the other hand, there are those who would, in the current youth phrase, let a person "do his own thing," as long as he harms no one else. On the other hand, there are those who equate control exclusively with criminal sanctions and would jail people to save their health.

But surely these alternatives do not exhaust the possibilities. Even youngsters will admit that there are limits to permitting someone to "do his own thing." In conversation with them, I have found that they wouldn't allow a person to commit suicide, or permit a child to wander out into traffic. In short, they recognize that society has the right to intervene in an individual's life to prevent self-inflicted harm when that individual is not mature enough to recognize the consequences of his behavior or when that harm is great or irreversible.

Similarly, excessive reliance on criminal sanctions as a deterrent to self-harm has severe limitations, both practical and philosophical.

Practically, the laws seem to have deterred very few people from using drugs. Recent studies have shown that anywhere from 6 to 74 percent of the students in particular schools have used illicit drugs, mainly marihuana. The studies have also shown that many students believe marihuana use should not be punished by law. For example, in one survey of 10th-grades conducted by our own center, over 60 percent agreed with the statement: Each mature individual should be allowed to decide for himself whether or not to use marihuana."

It is abundantly clear, then, that young people, by their attitudes and behavior, have repudiated the very laws we rely on as deterrents. And if they do not perceive the drug laws as legitimate, there is little sense in our clinging to the belief that good health can be promoted through criminal sanctions.

I think the time has come to infuse the drug laws with a little humanity and make them consistent with current scientific information. At the very least, criminal penalties for the personal possession and use of marihuana should be removed.

The greatest risk to the physical and mental health of a marihuana user is not from the drug itself. Rather, it is the possibility of spending months or years in prison, or having his education, career, and family life disrupted by a criminal conviction.

There are those who say that at least some criminal penalties should be applied to marihuana use on the grounds that the drug leads, for example, to psychological dependence or an unproductive existence. I share their concern, but it should be remembered that psychological dependence and unproductiveness are conditions not in themselves subject to criminal sanctions. I think it is dangerous to use the criminal law indirectly to control behavior which is not otherwise illegal.

As a mental health professional, I find myself in what seems to be a common dilemma. I do not advocate marihuana use, but neither do I advocate putting youngsters in jail. The bill before us should be passed into law precisely because it will help solve this kind of dilemma. By supporting programs geared to current patterns of drug use and tailored to the features of specific communities, the bill will lead to the development of forms of social control more effective and humane than the narrow alternatives of unrestricted drug use versus jail sentences.

In particular, it will encourage efforts at preventive education, which seems to me our greatest hope, in the long run, for controlling the abuse of drugs. I recall that in his July 1969 message to Congress, President Nixon said that, given adequate information about drugs:

The overwhelming majority of young people can be trusted to make a prudent judgment as to their personal course of conduct.

In this I fully concur.

Preventive education in the field of drugs can take many forms and be aimed at many populations. Secondary schools, especially, are a strategic site for the development of preventive programs. They offer the opportunity to reach large numbers of young people in their formative years and, at the same time, permit indepth presentation and discussion of information about drugs.

What would a model program of preventive education look like—one located, let us say, in a typical high school?

First, curriculums in regular courses of study should be utilized as the major channels for communicating information about drugs. Drug curriculum materials should not be limited to hygiene or health education courses as they have in the past but should be included in social studies, science, English, and all other courses. This will provide teachers and students with the proper framework and materials to study the problem in its fullest context.

Second, in each school a cadre of administrators, faculty, and service personnel should be trained to operate the program. If a school is to establish a preventive program which has duration and continuity over time, it cannot depend on the presence of outside drug "experts." Instead, it must develop a cadre of people knowledgeable about drugs within its own ranks.

Third, students should be directly involved in the design and execution of the program. The experiences of our center in drug education convinces me that students have valuable contributions to make in this role. They are able to inform teachers of changing currents in the youth "scene," thereby keeping program content up-to-date. They provide insights into the social and moral issues which concern young people. And they are positively ingenious at devising classroom presentation methods which complement the usual lectures and movies.

We have learned that there is an enormous amount of virtually untapped good will, intelligence and energy which students will put to work in the development of educational programs. So every time we start to scare ourselves by saying that the schools are filled with drugs, we ought to stop and remind ourselves that what the schools are really filled with is kids. And we ought to remember that it is our responsibility to provide these youngsters with a framework, a means, by which they can understand and overcome the problems they face.

Approaches of this kind, which the bill before us will make possible, rather than policies of fear and reprisal, offer the real hope for the solution to the drug problem.

Senator HUGHES. Doctor, you used the terminology "fear and reprisal" in your last sentence.

Would you consider the administration bill one of fear and reprisal?

Dr. BROTMAN. I am not really acquainted with the bill. But I do know, that fear and reprisal is part of the game in drug use. It has to be, if there are enforcement groups involved in it.

Senator HUGHES. On the subject matter of education and schools, what do we do when schoolchildren go home and start talking about drugs with their parents, and the parents don't know anything about it?

Dr. BROTMAN. It is difficult to describe a good program of parent involvement or parent education, because of the hang-up that the parents are in as a result of the present laws that exist and the result of the fear that exists as well as the lack of knowledge that exists.

I think we know most kids know more about drug use than the teachers do. We do know indeed if a teacher or faculty is trained, that they can begin to know at least as much as kids.

The question of parental involvement is a very complex one, because the community comes into it, and political questions come into it, because, after all, drug addiction has been made into a huge political problem.

Parents are caught up in this as well, and in many of our programs where youngsters present programs that they have developed in schools to their own parents, these youngsters will be attacked by their parents for taking a role in something that the parents think they should not be involved in.

So I would say at this point if I were to put my money on an appropriate place for training and education, it would be with the faculties of schools, so that the interaction between themselves and students can be a meaningful one. I am rather despairing of the hope that parents can have much to do in the next few years with the developments among these kids.

Senator HUGHES. One concern I have is the effect of the happiness of a father or mother. What happens when a father or mother finds their child using marihuana.

They blow the roof off, and characterize it as bad as the use of heroin.

This creates a division there. There is no way we can structure the program to get to parents adequately, other than a broad, general program.

My experience has led me to believe that students know more about the illicit use of narcotics than their parents ever heard of.

I would also ask, do you know in your broad range of experience, Doctor, any institutional setting in prison for the recovery of narcotics addicts that is workable or working?

Dr. BROTMAN. No, sir

Senator HUGHES. I am not aware of any. The time limitations are very restricted. How long does it take in your professional opinion, for an adequate recovery program for a heroin addict?

Dr. BROTMAN. Sir, I think there are a whole variety of different kinds of heroin addicts, and no one has attempted typology, though we tried to play with one in our own place.

I think if one talks about four classes of heroin addicts, some of them are called conformists, some of them are two-worlders, some of them are hustlers, who are low conventional and highly deviant, and some of them are very uninvolved. They are neither highly deviant nor highly conventional.

All of these are heroin addicts. These are a variety of life styles that people use even when they are addicts, and approaches to these people have to be different, as they are different.

I think that just as in our hospital we have a majority of people who come in whom we call uninvolved—that is, by definition they are, because they are mentally ill.

When we go out into the street, we see a variety of them who are neither ill nor criminal, except by definition of the law, and I think you have to try to develop some kind of idea what the different types are.

I think, therefore, when you stick a man in jail, he is going to be clean for a while, not for too long, as you said earlier, because there is just as much drug in jail as there is on the street. And I don't think that you get any real cures, whether it be 6 months or a year or 3 years.

You can't prescribe for whom the best kind of treatment can be developed. That has not been done yet. It should be done. It would

be a good idea to establish a classification of drug users and treatment courses.

Senator HUGHES. In other words, you have a very complex illness, physical, and mental.

Dr. BROTMAN. Right, and a living situation.

Senator HUGHES. And you have to attempt to correct it all.

Dr. BROTMAN. You have to start somewhere. I think, prevention would be a heavy area for involvement, as opposed to treatment.

Senator HUGHES. Prison wouldn't be a very good place to correct that.

Dr. BROTMAN. No, sir.

Senator HUGHES. Now, because of the heavy court loads here in the District of Columbia, as we heard yesterday, most of these cases are brought to the lower court and handled as misdemeanors, with a year's sentence in a hopeless situation in a hopeless place, and nothing can be done about it.

Dr. BROTMAN. Because of the law, youngsters who are caught, by a whole variety of means, must be caught on the horns of a dilemma. They are either criminal or they are sick. They cannot be anything else.

Now, professionals in this field either have to be on the side of one or the other. Think of what it must mean for us who receive hundreds of young people from courts or from district attorney's offices who are not sick, and who for all intents and purposes neither are they criminal, but we must somehow or other, for their sake, in collusion, establish the fact that they are sick. It is bizarre.

Senator HUGHES. Yes, it is. I came across this so many times when I was Governor of my State for awhile. When you look at the record of a man who has applied for employment, and you see one of two things, drug abuse or rape, he is through for life as far as obtaining any professional status or anything else. As a youngster he has been branded with this charge that he probably will never recover from.

Do you find that also in your experience with these people?

Dr. BROTMAN. Yes, sir. In one study we did in New York, without naming the agency itself, an agency of enforcement that is very co-operative and very related, the 600 youngsters between the ages of 16 and 19 who were arrested for marihuana offenses in 1 year, last year, these youngsters were of all upper-middle-class parents from upper-middle-class areas—none from the slums.

These youngsters, because of their background, did go through arrest, and they did come to arraignment, but they never went beyond it. They received special care. Of these youngsters, we discovered that 40 percent of the 600 had never used marihuana at all, but had been on the scene where marihuana was used.

I think an important lesson to be learned from this is that there aren't good guys and bad guys among the kids anymore. They are all together.

Senator HUGHES. I think this is one of the dangers when you are trying to walk a reasonable road and construct reasonable legislation. I am extremely concerned. I don't know whether you were here earlier when we talked to the representatives of HEW about priorities.

Dr. BROTMAN. Yes; I was here.

Senator HUGHES. What priority do you give this problem? I am

not trying to match it against cancer or anything else. I am just saying the problem is so massive and growing, actually like an epidemic.

Dr. BROTMAN. I think it is enormously high priority. Our medical school gives it high priority. We put our best people in it.

We live in East Harlem, or Yorkville section, which is a very high-income section—we serve both of these areas, we are right in the middle. We have as many problems in the southern tier as we do in the northern tier of East Harlem. We have as many problems in the suburban communities as we do in the inner-city.

Senator HUGHES. I am familiar with your background, so I know you know both sides of this picture. Is there a different enforcement procedure among the middle-class marihuana users and the slum users?

Dr. BROTMAN. Well, it has changed recently, and I haven't been in the other part of it for a few years. But there used to be indeed different procedure. There are different procedures, it is quite obvious. On the other hand, things are changing. There is a surprising amount of rigorous enforcement by police in upper middle-class communities and in suburban communities.

Indeed, that has become very, very popular, and I am quite surprised to find that there is very little screaming and hollering from the middle-class parents, and I think that is part of the hangup. I think they are scared to death as well, and very often to turn to law enforcement for help, since they are generally the ones on the scene who want to handle it.

Most of the health professionals want to run away from it.

Senator HUGHES. Have you experimented with a police program which takes young users without prosecution if they walk in for help and ask for it?

Dr. BROTMAN. We have done it informally.

Senator HUGHES. What about the treatment after arrest? Are they treated the same after arrest, the urbanite and the ghetto kid?

Dr. BROTMAN. No. We say they are, but there are far more resources that the kid can have if he has got some money than if he doesn't, and there is no question about that. Our own center tries to keep it equal, but in general the middle-class kid does not face the same risk. He can always go to another state or go away 3 or 4 weeks until the heat is off and then come back.

Senator HUGHES. We had testimony that there are parents in urban situations who were actually supplying money to their youngsters to buy heroin because they found they were hooked, and the parents were scared to death. They were afraid to turn to a doctor for help. They supplied them with money to make their buys and prayed they didn't get caught.

How can we reach a situation like this, in view of state laws in many instances, as well as Federal?

Dr. BROTMAN. I don't think as long as we have the kind of laws that have been developed over the last 40 years that we can get to the basis of that problem.

The law has to be changed, or we will be chasing our tails, as we are now.

Senator HUGHES. What would you advise a parent to do when they find they have a youngster on heroin and the youngster asks them for help?

Dr. BROTMAN. I would ask them to bring them to a service close by

that takes cognizance of this and can stand between the two forces. I think you can do it on a treatment level, case-by-case.

Senator HUGHES. Do you think that when parents find the youngsters using marihuana that they should seek psychiatric help, or medical advice, if they are able to talk to them?

Dr. BROTMAN. I think that is the clue. I think you put your finger on it. I think you have to stay with the kid and keep close to him. By the time he is 13 or 14, he will leave you, anyway. But if you stay close to him and don't make a fuss about his hair, he might talk about the important things.

I wouldn't go up the flue on it and break communication with a kid and make it the kind of issue that it should not be. That is the important thing, and I don't know whether you go to a psychiatrist to improve communication, or you go to your minister, or your friend, or your grandma.

To me, it is important that you go to somebody who has communication with the kid. There are plenty of people in the professional field who are very far from it, and that is why we have to educate them, too.

Senator HUGHES. That is an interesting point. You mentioned hair. In many schools it seems to be a very critical issue. They are expelling students. In my own State recently a high school administration disciplined 30-something boys whose hair didn't meet the standards. Some of those kids defied the administration.

What relationship do you see?

Dr. BROTMAN. I see most of my colleagues growing long hair, including myself, and I think it used to be the docs and the cops, and now I think it is the jocks and the docs.

But I think there is a growing awareness of the school personnel, at least on the east coast, that you don't make a big issue out of fashion and hair, that there are probably more important things to do.

I think the kids are teaching us this. I think we are learning from them. I think in a year or two we may have learned very well, and I think the long sideburns and the hair and the marvelous fashion and the fruitful language that these kids have, and the poetry that is within them is permeating the school curriculum. If it gets to the State capitals and becomes part of the curriculum in the next 5 years, we might be saved.

Senator HUGHES. I once made the statement that I was more concerned about long faces on parents than long hair on children.

Dr. BROTMAN. I made a statement that I was hard on drugs and soft on kids, and when I left the auditorium, there was a large sign on my car with tacks in the handle.

Senator HUGHES. Your point is that we are driving these kids out and forcing them to rebel further, isn't that right?

Dr. BROTMAN. I think so, yes.

Senator HUGHES. When you adopt a rigid policy. I think both of us understand the need for discipline and conformity.

Dr. BROTMAN. Yes.

Senator HUGHES. Thank you. Your testimony has been helpful.

The Chair called Dr. Dana Farnsworth, director of university health services, and Henry K. Oliver, professor of hygiene, Harvard College.

Dr. FARNSWORTH. Henry K. Oliver has been brought back to life after a century of absence.

STATEMENT OF DR. DANA FARNSWORTH, DIRECTOR, UNIVERSITY
HEALTH SERVICES, HARVARD UNIVERSITY

Dr. FARNSWORTH. I am speaking as a citizen on my own behalf and not as a spokesman for any of the institutions or organizations with which I am associated.

Secondly, I would like to say that the testimony of my two colleagues, Dr. Freedman and Dr. Brotman, pleased me very much because I agree so strongly with practically everything that both of them said in a broad, general sense, and certainly in philosophy and spirit.

I wish to testify in favor of Senate bill 2608 and to summarize the reasons which cause me to believe that this bill should be enacted into law. First, I shall outline the reasons why a new approach to the solution of the drug problem is essential.

(1) The use of drugs for other than medicinal purposes is increasing rapidly, particularly among young people, and spreading geographically from urban to suburban and rural areas as well as chronologically to increasingly younger persons.

(2) The misuse of drugs by those who may have obtained them legitimately for medical reasons is increasing, though the problem, if I could summarize it in another sense, is not that of drugs. It is the problem of people who are using drugs to express their feelings that exists in other areas.

(3) The laws governing the manufacture, distribution, and control of drugs of all kinds are difficult to enforce, in part at least because of grave inconsistencies in penalties for their infractions. This has been brought out by my colleagues earlier.

(4) The concept of enacting stricter laws and heavier penalties does not appear to be effective, especially among consumers of drugs. That is as mild as I can make that statement.

(5) The use of drugs for nonmedicinal purposes has become one of the ways by which individuals may—

(a) express their disapproval of some aspect of society with which they disagree or

(b) react to personal conflicts of an emotional nature.

In terms of the questions that you were asking Dr. Brotman, it is one of the ways by which they can get their parents to pay attention to them, and, as one of them said: "Unless my parents think I am taking marihuana, it isn't as good."

(6) Present programs of drug education have not been notably successful, at least not on a wide scale.

Senate bill 2608 appears to me to reflect an accurate recognition of these facts and to provide an effective variety of programs and procedures.

It is particularly important, in my view, that programs of drug education should put strong emphasis on the reasons why people do take drugs rather than concentrating so strongly on why they should not take drugs. This is brought home to me in some of the activities of my colleagues in my own department at Harvard, who, in giving courses to students, find that as soon as they work for a long time investigating the properties of drugs and what they do, and they come to the conclusion on their own that drugs cannot do for them what they could not do better without them, then they lose their

enthusiasm for them, and frequently stop. As a matter of fact, they nearly always do.

This gives further impetus to my feeling that education is better than punitive attitudes.

In the present climate of opinion among young people, any device designed to frighten them by showing them the disadvantages of drug-taking is all too often immediately rejected as still another evidence of the hypocrisy and untruthfulness of older persons. The facts that penalties for use of some of the milder drugs, marihuana in particular, are often much greater than those for use of more dangerous drugs, and that most legal codes classify marihuana as a narcotic when it is not, give some credence to their contentions. Likewise, threatening statements about the results of marihuana use, in the absence of sufficient sound scientific knowledge, confirm many of them in their views.

No evidence has yet been demonstrated, in my view, that extensive use of drugs for self-realization increased creativity, or that attainment of mystical states of consciousness has been beneficial for more than a few isolated individuals, and then only temporarily.

Even on the treatment of alcoholism on which LSD was supposed to have had a good effect, as one of my colleagues said, that has flunked out now, too.

Certainly it has had effects on many individuals, and on society, that are a little short of disastrous. Any of the mind-altering drugs can (and in the long run certainly will) cause a loss of the ability to concentrate, to set realistic goals and devise means to achieve them, to distinguish what is real from what is illusory, and to communicate effectively with other people. Even a single dose of such drugs can cause at least short-term personality disintegration and panic, and in unstable individuals can cause severe and long-lasting mental illness.

When young people learn that they can receive nothing from drugs that is not more safely and effectively available by other means, I believe their interest in drugs will decrease. In other words, I am very uneasy about the effect of drugs, and I feel very deeply that we must protect the youngsters.

What I do disagree on with so many persons, and agree on with my colleague about, is that young people are the best judges once they are given the facts.

The provisions of this bill, containing as they do plans for research, training of personnel, surveys and field trials, evaluation of programs, and treatment of drug-dependent persons, should serve to help correct many of the basic lacks and defects in our present programs. A balance between law enforcement directed toward purveyors and education for the potential consumers should be more effective than too great dependence on tactics alone.

In my view, we have oversimplified the problem by emphasizing the punitive aspect, particularly on users; that hasn't worked, and is actually having the opposite effect.

It is of particular importance that the provisions of title IV, section 402, be carried out, namely, an accurate determination of the relative harmfulness of all kinds of drugs when used without medical supervision, and establishment of legal penalties consistent with the degree of harm the substances may cause.

I have made a plea for that particular thing to be done in a specific term, sitting in this exact spot, before Senator Dodd's committee a year ago. And I was so pleased to find it in this bill.

Since the prevention of drug misuse is such an enormous task and the money to accomplish it is limited, it is essential to use whatever resources are allocated as effectively as possible. In my view, money spent along the lines given in Senate bill 2608 will be far more productive of good results than a corresponding amount spent on punitive measures taken against users. Harshly punitive laws are tending to increase the use of marihuana and other drugs as well as foster disrespect for laws and authority generally. A program of research, training, education, evaluation, and the development of appropriate teaching materials should pay dividends over a long period of time and produce positive rather than negative results.

On comments two of my colleagues made on a question you asked, the question of who should be involved, I think everyone has to be involved, all of our institutions, and one of my chores at the moment is being chairman of the committee on mental health of the American Medical Association, and we have developed a book on drug dependency for physicians, but other people can read it, too. It is the kind of thing that should be left to be stolen around dormitories, because if we give it to them, it is part of the establishment and they won't read it.

Senator HUGHES. Could you leave one for me to steal, too, Doctor?

Dr. FARNSWORTH. Either way.

(The document referred to may be found in the files of the subcommittee.)

Dr. FARNSWORTH. I have also been working with clergymen for a number of years, and in one of our recent publications we are dealing with drugs.

So if you ask me a question as to what the priority of the drug problem is, I will ask you before you answer it in saying that the problem that the drug misuse represents is the highest priority in our society at the moment—not drugs, but the misunderstanding between the older persons in our society and the younger persons in our society. These are not all divided in terms of youth, but you get the idea there that this particular problem of how do we learn to trust one another instead of believing the worst of one another. I consider that the major problem facing the United States today, as well as most of the other countries in the world, where we have been suffering for quite a number of years from displaced priorities.

I very much hope that this bill will be enacted into law.

Senator HUGHES. I would like to ask you similar questions to those I asked other persons here.

Are you familiar with the administration's proposals in this field?

Dr. FARNSWORTH. I tried to get copies of the bills. I have had verbal summaries of them, and I read one of them hastily while I was waiting, and I can say that I think the emphasis is far too great on the punitive aspect.

Senator HUGHES. The primary responsibility is with the Department of Justice. What is your professional opinion about that?

Dr. FARNSWORTH. I think it is in the wrong place.

Insofar as dealing with persons who are pushing, or the purveyors of drugs, yes, they have to take care of that. But the basic problem

comes under health, education, and welfare and the first two of those particularly, health and education. And it automatically includes the third.

Senator HUGHES. We have had some statements that I didn't pursue before about the restrictions on staff capacities and salary capacities, and so forth, and the question about whether professional people would work in the Department of Justice in these fields?

What is your opinion? We need to give this a priority. We certainly need to support, to expand, so we can take care of this problem, in education as well as in the medical field.

The approach the administration is taking doesn't allow this, in my opinion. Do you think so?

Dr. FARNSWORTH. I don't think so. I am very much disheartened by the apparent increase, or resurgence of the punitive attitude, particularly toward the potential consumers of drugs. This is going in the wrong direction, and it will have, I think, unfortunate results if that particular philosophy prevails in this pending legislation.

Senator HUGHES. You heard me mention earlier, Doctor, the problem of education. I think we have the means to educate young people, and can develop the expertise to do that well over a period of time, but reaching parents is another problem, as you have already mentioned.

Dr. FARNSWORTH. Yes.

Senator HUGHES. And then, after reaching parents, there is the problem of establishing communication between them and their children.

Do you have any recommendations for educating adults?

Dr. FARNSWORTH. I am engaged in two projects which I think are in the spirit of what you are referring to. I think there is a need for a good monograph for parents of middle-class and upper-class children on the question of their attitudes toward the children, what has gone wrong, where does the communication break down, what do children basically need if they are going to grow up and be self-reliant and in control of themselves?

However, those of us in this field are somewhat unable, or somewhat unskilled, in getting this kind of information across to large numbers of people, and particularly unskilled in dealing with those who come from what has come to be called the deprived classes.

So there is another group that I am concerned with that is going to work on the development of a monograph in that area of developing appropriate family attitudes among families in the crowded areas in the ghettos, and so on.

Now, if we can get appropriate support, and I think we can get it from the professional people, but appropriate support for getting this material organized and getting a certain consensus, then I believe we have mechanisms for dissemination of this material throughout the United States, through parents, through our schools, through the colleges, through the clergy, through the National Parent Teachers Association, and literally hundreds of other organizations.

I have talked with the officials of many of these, and I have tried to help as consultant in many of them. They desperately want something authoritative, something that makes sense, something that they can understand, but this is not enough, you see. Knowledge is only a

prelude to learning. There then has to be locally centered provisions for people to talk about the way they feel.

Parents talk with one another, or with representative children, and then as they are prepared to learn through appropriate materials, then they can learn faster than if they go into these discussion groups just ready to resist and say, "No," and stop the arguments before they start.

I have epitomized in a very few sentences a very complex problem, but I don't think it is insoluble. It is insoluble only if we fail to recognize it is a problem and fail to establish priorities more in favor of human beings and less in favor of material things.

Senator HUGHES. Do you think it is possible to conduct an adequate program of recovery for addicts in a prison?

Dr. FARNSWORTH. Impossible. It is a graduate school for further learning, further criminal techniques, and they are more effective than they would be before.

Senator HUGHES. What should the priority be for an addict who is stealing and burglarizing to support a habit. Imprison him for stealing, or try to rehabilitate him?

Dr. FARNSWORTH. The former is an admission of defeat. The latter, if properly done, would be hopefully productive. Not always, of course. Any form of treatment for any complex situation has its shortcomings, but I can't think of any other area than in the field of penology itself where we as a society have pretended that we didn't know anything about the human beings involved.

If one wanted to be more or less suspicious, we have in a sense said that there is no use applying what we know about human nature to drug addicts.

Well, drug addicts are pretty well just like the rest of us, and they can be reached.

Senator HUGHES. Can I assume, then, that if there were facilities and personnel, you would favor an alternate sentencing that would allow these people to be placed in a position——

Dr. FARNSWORTH. I am a bit confused as to this phrase "alternate sentencing."

Senator HUGHES. It has been developed in the field of alcoholism.

Dr. FARNSWORTH. If an individual had a choice between punitive measures, where he could voluntarily go to a place for treatment, I would prefer it. But I do not know how to get that done. This is an area where I wish we had a way by which the drug addict would want to go to the institution for treatment on his own, just as I would like for the chronic alcoholic to be able to want to go.

But if the institutions are set up, and are run by informed people, friendly people, competent people, I think the problems of getting persons to go into the rehabilitation would be vastly fewer than they are now.

Senator HUGHES. What I was thinking isn't part of the legislation that we are considering, but it is in my own State of Iowa. We established a hospital ward for chronic alcoholics. The ward is not a prison. It is a ward. They are patients. It is used for a training facility for the medical school. The nurses, social workers, and everyone else are actually exposed to the process of treatment, research, and follow-through. It is a comprehensive program that establishes some sort of a unit,

and it seems to me it should work as well in narcotics as it does in alcoholism, if it could be handled under that type of supervision and instruction.

I am asking a professional question, because we are all searching as to what we might be able to do in the future as well as in the present.

Dr. FARNSWORTH. I think that it is possible for us to develop programs for drug addicts that will be as effective as those for alcoholics. Neither is effective enough.

One handicap that I might mention is that of the attitude of professionals themselves toward drug addicts. It is even more negative than toward alcoholics.

Senator HUGHES. They are in real trouble, then.

Dr. FARNSWORTH. Part of our job is to alter our own attitude so that we do not become prejudiced toward a person merely because he chose a certain vehicle to indicate that he was in trouble. I think we can do that.

Senator HUGHES. Again, I am asking—and if you don't know, please answer that way—are there many physicians who become addicted to narcotics because of heavy pressures of work and continuing long hours and who usually administer drugs to themselves?

Dr. FARNSWORTH. The evidence would suggest that those who have ready access to drugs become addicted in higher proportion than any others, and in this case, I am led to believe by papers that I have read and talks that I have had with some of my colleagues who have studied it that the instances of physicians becoming addicted to drugs is quite high, and maybe among the highest in our society.

Senator HUGHES. We have had testimony by physicians during the course of their medical training. Many doctors have appeared before me and testified that they were not trained about the recoverability of an alcoholic, but received more prejudice against him in the training period than any hope that he might be treated as a normal patient. Is this true in narcotics, too?

Dr. FARNSWORTH. I think it is. When I think about my own experience in medical school, what I learned about alcoholism was very little, and about drugs less.

When I was thrown into this 10 years ago, I had to proceed as if I had no contact with it at all in medical school.

I expect my experience is not too much different from that of people who graduate from medical schools in the 1940's and 1950's. Even now I am not too sanguine about the quality of the educational process. I know what the intent is, but as to the effectiveness of education in the medical schools, it is not up to where it should be yet.

Senator HUGHES. The point of my question is that if we get into the educational process, we are going to have to reach into the training of the professions as well—

Dr. FARNSWORTH. Absolutely. Not first, not last, but simultaneously.

Senator HUGHES. Along with the rest of their studies, they should be made knowledgeable in these areas.

It has been stated that the drug scene is changing so rapidly in recent years that is almost impossible to keep current by any literature that is available. Impossible to keep on top of the changing usage patterns, the fads that Dr. Freedman referred to. Is this true in your experience?

Dr. FARNSWORTH. Yes. Most of the material written is approximately a year old at best, and some of the concepts are much older than that, and I do not believe that it is possible for any of us to keep up as to what is going on in this field, because we are overwhelmed with problems, and there is a paucity of hard data. And this is why we desperately need what the students call "hard facts" to supplement what they say, so that we don't have to sound like preachers, and we don't have to moralize, because that is what turns the youngsters off.

Senator HUGHES. I want to thank you very much, Dr. Farnsworth, for your testimony and your willingness to appear. You have been very helpful.

(The following letter was subsequently received for the record:)

AMERICAN MEDICAL ASSOCIATION,
COUNCIL ON MENTAL HEALTH,
Cambridge, Mass., October 8, 1969.

SENATOR RALPH W. YARBOROUGH,
U.S. Senate Office Building,
Washington, D.C.

MY DEAR SENATOR YARBOROUGH: As you may know, I testified in favor of Senate Bill 2608 before the special subcommittee on alcohol and narcotics with Senator Hughes presiding. I am enclosing a copy of my prepared statement, which gives the main reasons for my support of the Bill which you have sponsored. I should reiterate that I spoke as a private citizen and not on behalf of the American Medical Association or other organizations with which I am associated.

I should like to comment somewhat further on the wisdom and practicality of Senate Bill 2608. I belong to that group which is very disturbed about the increasing use of drugs for other than medicinal purposes. Although I consider marijuana to be one of the less harmful drugs that are so used, I consider it to be quite dangerous and that under no circumstances should it be legalized. I part company with many persons who believe that punitive measures directed toward users as well as purveyors will solve the problem. My experience, direct and indirect, strongly suggests that harsh and unreasonable laws directed against users serve to increase the use rather than decrease it. I would, therefore, like to express myself in strong support of your efforts to change our laws in such a way as to emphasize education for users and legalize penalties for purveyors. This does not mean that I think that users should have no deterrents to such practices, but that young people should not have their futures jeopardized because of temporary unwise and unpractical use of the various forms of marijuana.

With best wishes for continued success in your efforts to bring sense out of a very chaotic situation,

Sincerely yours,

DANA L. FARNSWORTH, M.D., *Chairman.*

Senator HUGHES. The chair calls Mr. Neil Chayet, Assistant Professor of Legal Medicine, Law-Medicine Institute, Boston University.

STATEMENT OF NEIL L. CHAYET, ASSISTANT PROFESSOR OF LEGAL MEDICINE, LAW-MEDICINE INSTITUTE, BOSTON UNIVERSITY

Senator HUGHES. Mr. Chayet, would you proceed with your testimony as you desire?

Mr. CHAYET. Thank you, Senator.

I would like to speak to you today primarily as a practicing attorney, which is how I spend about 90 percent of my time. And as a practicing attorney, I have defended many young people, and have

been involved with them and their families on charges related to drug abuse, most of which have been marihuana and LSD, with a few heroin charges.

I have also represented researchers, and it is unfortunate that researchers in this day and age have to secure attorneys to help them with their research, which happens often, and is going on right now.

I also represent a good many physicians, who, under Massachusetts law, are forced to report people who come to them seeking assistance. And I will also refer to that in a few moments.

My own State of Massachusetts, in looking at the statistics, I found last year that we had 5,000 individuals arrested for narcotics offenses. This is including marihuana.

It is very difficult for me to justify the laws of my State in that we have a statute that makes it a crime, a felony, to be in the presence of marihuana without knowing it—to be in the presence of such a drug without knowing it carries a 5-year penalty. To knowingly possess marihuana only carries 3½ years. I am unable to justify this differentiation.

We have problems in that if an individual gives a marihuana cigarette to his roommate, it is 20 to 30 years, and 25 years to 40 years for the second offense. That for marihuana.

Senator HUGHES. That is for possession?

Mr. CHAYET. Transferring, if a college student gives it to his roommate.

There is no provision in any of these laws, with the exception of your particular bill, there is no distinction between the commercial seller and the casual or stupid seller who is making \$10 acting as middle man.

Twenty-five years might be given to a professional pusher, but to the casual transferrer of these drugs, it seems to me it is a different situation.

I would like, as an attorney, to repeal many of these laws. I find it impossible to repeal these laws, because I am trapped by the system. And here is the way it works, as I am sure you are aware.

Two days prior to trial I receive a call from the district attorney saying will I plead my client guilty if he will recommend probation. Many people who want to become test cases find they don't want to be when they are arrested, and they want to plead guilty. They are afraid they might otherwise end up with a prison sentence, and I must advise them as an attorney to plead guilty.

They are arrested at gunpoint, they face 5, 10, 20 years of sentencing. And they feel they have gotten off with this arrangement. But they have not gotten off. They very quickly find out what it means to be a convicted felon.

First of all, the driver's license disappears immediately, as a matter of course. It is very difficult to get a driver's license back for the individual. It may become impossible for them to practice law, or medicine, or to pursue many of the goals which they want to pursue. They now have to answer yes to the question, "Have you been convicted of a felony?" And they have to say, "Narcotics," because marihuana is considered a narcotic under Massachusetts law.

Let's consider that an individual becomes sick in Massachusetts and wants to go to a physician for assistance. He runs into the statute

that requires the physician to report him within 72 hours to the department of public health, which must make this information available to the Commonwealth or the U.S. officers who require it. The police and Federal agents go through this routinely.

It is a breach of the patient-doctor relationship. This kind of a statute does away with this protection.

This carries a 6-month jail sentence and a fine for the doctor.

I have a friend who wants to test this. He calls the district attorney and says, "I just treated a narcotics addict whom I am not going to report to you."

About half the physicians report it, and the others don't.

One of the best psychiatric clinics in the country is reporting marihuana users admitted to this facility. This information goes to the police, and it is a mandatory breach of the patient-physician relationship.

So there is a great deal of reporting, and I am opposed to this kind of legislation.

Let me move to research. I represent Norman Sindburg and Dr. Andrew Weyle. Their study was the third study involving marihuana in this country. One was a Canal Zone study in 1935; the La Guardia report came out around the same time.

It took us 8 months to secure a Federal tax stamp from the Government. As I said before, it doesn't seem to me that a researcher who wants to work with a drug that is being used by 12 or 13 million kids ought to have to get a lawyer and fight battle after battle to do research in a carefully structured manner.

Then when I had the Federal permission and the tax stamp, I found there was nothing in the State law which allows research, so I therefore wrote to the Boston Police, the State police, and the attorney general's office. I asked for permission to do this research without fear of arrest.

The Commissioner wrote back to me and said: "Thank you very much for informing me that you are going to be doing marihuana research at such and such a time at such and such a place."

I didn't know how to interpret that.

The State police said: "You cannot do this in the State of Massachusetts."

At that time, Elliot Richards, who was attorney general, said he would throw the weight of his entire office behind us.

We are working with the present attorney general to get the same permission. We shouldn't have to go through this.

As far as the Federal situation is concerned, I think you have heard a great deal about the minimum mandatory. It is incredible to me that a bill, S. 2637, is put before this Congress with minimum mandatory penalties retained within that legislation. I cannot understand it. I am informed that the Justice Department stated: "Well, this is a matter for Congress to determine. We will leave the current penalties in because we don't know what else to do."

I would like to relate one very brief case history, a case that I defended in the Federal court of a young man who had no prior criminal record whatsoever. He sold to an agent. He was making \$10 for each sale. He sold to a person that anyone except my client would have known as an agent. And the individual liked what he had bought and

said to this young man: "Could you sell me some more tomorrow?"

The young man returned with more the next day and was arrested and indicted for two separate offenses of sale, and was indicted before two separate Federal judges. The first carries a mandatory sentence of 5 years, and the second carries a mandatory minimum of 10 years. And the Government was actually intending to proceed to find him guilty of the first sale and then try him on the second indictment, which was before a second judge, on a second sale.

There was a case that I was going to be able to appeal. Probation was not allowed. I felt it is an unconstitutional invasion of the judicial power to say in the case of a first offender, who was not a professional seller, that the judge cannot have any discretion over this individual.

Once again, I was frustrated by calls from the assistant U.S. attorney, saying that they would be glad to drop the transfer charge.

We were prevented, and I am glad for the sake of my client, we were prevented from appealing this type of legislation.

As far as the bills are concerned, I have read 2637, and I have read the Yarborough bill, 2608. As far as I am concerned, the Yarborough bill is the only bill which I have seen before the current session which takes a creative and innovative step for doing something about this problem.

I don't think the classifications belong, and I am speaking now as a lawyer, I don't think the classification mechanism should be in the Justice Department. I think it belongs with Health, Education, and Welfare. I don't think the Justice Department should be able to say to a researcher who has been approved by HEW: "You can't have the drug, because we know something about you that HEW doesn't."

They should not be able to review researcher protocol, they should not be able to license research. This should be the Department of HEW.

I listened with incredulity when I heard this morning that HEW won all the points of the debate with Justice. There is something wrong with the debate, I would suggest, if HEW won all the points which they were looking for.

I would say this. S. 2608 does lump the marihuana under the Federal, Food, Drug, and Cosmetics Act.

There is one thing in the administration bill which ought in some way to be worked into the system if possible, and this is the first-offender treatment, which I am very much in favor of.

A young person who has no prior contact with the law ought to be given one chance, it seems to me, and this is what the first-offender treatment would do, not putting him on probation, not giving him a suspended sentence, but treating him—expunging the criminal record, so he won't have this criminal record. And I would favor such an addition to 2608 if it is at all possible. And I realize the jurisdictional difficulties of adding this into this bill at this particular time.

I think the control, the setting up of classifications by HEW is where it belongs, and I am glad to see no long listing of preconceived nothings of drugs like there is in the administration bill.

I think, also, that the entire mechanism, the rationale of the medical usefulness of a drug, it seems to me, is not the most important thing. That is how you get heroin and marihuana in the same schedule. The most important thing, it seems to me, is the impact on society and the

impact on the individual. It seems to me this 2637 bill completely ignores that.

I have an editorial, Senator. I received your bill late yesterday and did not have a chance to prepare a formal statement, but there is an editorial which I believe you have a copy of, which appeared in today's Globe. And I would like to emphasize what I said in the last paragraph, that Congress now has a choice to widen this gap that exists between our generations by the passage of S. 2637 in the present form, and so forth.

Thank you, sir.

Senator HUGHES. You sound like an exceptionally good lawyer. Have you ever had a client in prison for using narcotics?

Mr. CHAYET. No, I haven't, Senator. I have come awfully close. The one case that I mentioned to you about the fellow where the U.S. attorney dropped the penalty and the charge of transfer and said they would recommend probation, we appeared before the judge, and the judge said: "I have had it with marihuana users. I am not going to accept the recommendation of the U.S. attorney."

Naturally, a shock wave went through the courtroom.

The judge said: "Have you any last words?" The fellow stated that his wife was pregnant and asked what would he do about her.

The judge called a 5-minute recess and came back in and accepted the U.S. attorney's recommendation.

Senator HUGHES. Have you had any exposure, or do you have any knowledge of any treatment facility in a prison that has helped any narcotics addict or drug abuser?

Mr. CHAYET. I represented one fellow picked up under the influence of heroin with a loaded revolver on the day Senator Kennedy was killed.

I finally secured his admission to Synanon, and got permission of the judge for him to go to California to enter this institution, and I am told he has done superbly.

It seems to me that establishing a ward in a university hospital, while it is certainly in the right direction, may not be exactly the right thing to do. It seems to me we have got to find out what treatment method is there of helping people like this.

Now, AA is successful.

Senator HUGHES. Synanon isn't institutional treatment either. It is not within an institution.

Mr. CHAYET. It is a unit and a method of treatment, as I understand it, and this is what I would like to stress. To take an alcoholic or drug addict and merely place him in a State hospital—as I say, this is one step, and it is certainly better than jail. But I think many of the people within our State hospital systems don't know how to treat narcotic addicts, and I think systems such as AA, or Synanon, systems which make use of these people themselves and turn them to working together to combat this problem are very, very effective.

I am thinking of one judge who established an AA unit within the court. In other words, through his judicial power, he forced people to attend these meetings within the court, and had much better success, statistically proven success, with alcoholics, for example, than people who were sending them again and again to drying out centers in State hospitals, which is so prevalent.

Senator HUGHES. State hospitals—I did not attach the same meaning to the university hospital as I do to the words “State hospital.” There is a definite division of those in my State, and the State hospitals, or State mental institutions, and not too successful in the treatment of alcoholism and narcotics.

But, actually, I know of no place in my State where narcotics addiction can be handled properly, or of any funding that is available so that it can even be attempted. And yet the problem is there. And where these people are going, I have no idea. It is a tragedy, a real tragedy that we haven’t placed some priority on it.

My question was to the point of the punitiveness of the law and the recommendation of imprisonment that you have so eloquently spoken to.

What happens to the addict when he is in prison? Testimony here has indicated that narcotics are more readily available in the jail than on the street.

When we are talking about dealing with humans today, we are certainly doing nothing for that person.

First of all, I think Dr. Freedman mentioned: “Are we talking about the drug, or are we talking about the reasons?”

I appreciate your willingness, Mr. Chayet, to come down here and testify this morning. Your legal opinions and your very close interest and exposure to this, I think, have given us an insight that we couldn’t have received otherwise.

Thank you very much.

Mr. CHAYET. Thank you very much.

Senator HUGHES. I would like to enter into the record your entire editorial article, “The Academic View,” by Neil Chayet. That was on September 15.

Thank you.

(The document subsequently supplied follows:)

[From the Boston Globe, Sept. 15, 1969]

MARIJUANA BILL NEITHER CURE NOR BRIDGE

Mr. Chayet is a practicing attorney, a member of the faculties of Boston University School of Law, Boston University School of Medicine, Tufts University Schools of Medicine and Dental Medicine, a member of the staff of the Department of Psychiatry of the Massachusetts General Hospital, and a member of the Review Committee of the Center for Studies of Narcotics and Drug Abuse of the National Institute of Mental Health.

Never before has there been a greater gulf between young and old, child and parent, student and teacher. This breach may be broadened at committee hearings in Washington on the major drug legislation now before the Congress, where great polarity of views on the subject of drug use and the law are certain to be presented.

As a result of our present drug laws, thousands of young people throughout the nation have become convicted felons. In Massachusetts, there were 4057 drug cases brought before the district courts last year, and in California, 31,000 adults and 15,000 juveniles arrested for marijuana violations alone.

It is true that few first offenders are being jailed, but those who have received probation and suspended sentences have already felt what it means to be a convicted felon; loss of driver’s license is automatic and admission to the professions of medicine, law and the attainment of many other goals may become impossible.

Have the Massachusetts penalties of five years for being in the presence of marijuana and 3½ years for possessing marijuana, and the Federal penalties of

2-10 years for possessing marijuana deterred young people from using these substances?

Perhaps some have been deterred, but the overwhelming evidence is that marijuana use has spiraled, affected only by the law of supply and demand. And there is disturbing evidence that when marijuana is in short supply, use of other far more dangerous drugs, such as heroine, LSD and methamphetamine (speed), increases.

The bill sponsored by the administration (H. 2637) perpetuates much of the same harshness and irrationality which resulted from the hysteria of the 1930's, culminating in the passage of the Marijuana Tax Act. This law has now fallen for the most part, as a result of the recent Leary case which held that to force a person to buy a tax stamp to possess marijuana violates his privilege against self-incrimination because when he secures such a stamp, he is immediately subject to arrest by state authorities for possession of marijuana.

This opinion has created much uncertainty and hence the rush towards new legislation, which will be based on the interstate commerce clause of the Constitution, rather than the tax clause.

H. 2637 continues the 2 to 10 year sentence for possession of marijuana, for any sale or transfer of marijuana with or without commercial gain, the mandatory minimum penalty of five years in the Federal penitentiary is retained in the new legislation. This means that a college student who gives a marijuana cigarette to his roommate must receive a five year penitentiary sentence and his sentence cannot be suspended and he cannot be placed on probation. A judge should have the discretion of granting probation to such a person if he feels it is merited; this discretion is taken from him under both existing laws and the proposed legislation.

The bill also provides for a no-knock search policy that would allow agents with an appropriate warrant to enter dwellings unannounced by breaking down doors or windows to seize evidence which might be disposed of before entry.

Marijuana is improperly classified under the proposed legislation. Whatever can be said about marijuana, it should not be classified along with heroin, cocaine or LSD, drugs which are far more dangerous. The earlier drug bill filed by Sen. Dodd called for a two-year study of marijuana by the National Institute of Mental Health before assigning it irrevocably to any category, but the administration bill rejects this approach and lumps marijuana with the most dangerous of substances.

This is not to say that marijuana should be legalized because we certainly do not know enough about this substance to take this step; but we do know enough about it to realize that to impose penalties which are harsher in some respects than laws relating to treason, manslaughter or rape, is ridiculous.

The administration bill would also hamper research by allowing the Justice Department to review research protocols; this should remain the sole province of the Department of Health, Education and Welfare, although the bill does assist research by preventing state harassment once Federal permission for the research is granted. Also, the bill does provide that a first offense relating to possession may be deemed a non-criminal offense, which is an important step forward.

We have enough felons in our nation. The time has come to deal with drug abuse by communicating with young people, by explaining to them that a high percentage of drugs bought on the streets are fake substances or outright poisons, and that a person can do very little to change a society that badly needs changing if he is continually tuning out of that society.

Congress now has a choice—to widen the gap by passage of H. 2367 in the present form, or to bridge it with good sense and reasonable amendment. The youth of America are our most precious asset. Let us remember this as we regulate this most crucial area.

Senator HUGHES. At this time I wish to thank all the witnesses for their time and trouble in preparing and appearing at this hearing. The hearing is now adjourned.

(Whereupon, at 12:30 p.m. the hearing was adjourned.)

to the fact that the committee has not yet received the necessary information to make a final decision on the matter. The committee has been informed that the necessary information is being gathered and that a final decision will be made as soon as possible. The committee has also been informed that the necessary information is being gathered and that a final decision will be made as soon as possible.

The bill sponsored by the administration (H.R. 1000) is a bill to amend the Internal Revenue Code of 1954 to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income.

The bill contains provisions for the taxation of certain income and for the taxation of certain income. The bill contains provisions for the taxation of certain income and for the taxation of certain income. The bill contains provisions for the taxation of certain income and for the taxation of certain income.

The bill also contains provisions for the taxation of certain income and for the taxation of certain income. The bill also contains provisions for the taxation of certain income and for the taxation of certain income. The bill also contains provisions for the taxation of certain income and for the taxation of certain income.

The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income.

The bill also contains provisions for the taxation of certain income and for the taxation of certain income. The bill also contains provisions for the taxation of certain income and for the taxation of certain income. The bill also contains provisions for the taxation of certain income and for the taxation of certain income.

The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income. The bill is designed to provide for the taxation of certain income and to provide for the taxation of certain income.

