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

HEARINGS

BEFORE THE

…IAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS

OF THE

COMMITTEE ON …ABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST AND SECOND SESSIONS

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, 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, AND RELATED BILLS

NOVEMBER 3, 1969 — WASHINGTON, D.C.

JANUARY 26, 1970 — CHERRY HILL, N.J.

PART 2

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

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U.S. GOVERNMENT PRINTING OFFICE

34-788 WASHINGTON : 1970

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

MONDAY, NOVEMBER 3, 1969

U.S. SENATE,
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 call, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes, Williams and Schweiker.

Committee Staff present: Wade Clarke, counsel to the subcommittee and Jay B. Cutler, minority counsel to the subcommittee.

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

Senator Williams if you desire to make an opening statement you are very welcome to do so.

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

Senator WILLIAMS. Given that opportunity I will, in view of the fact I just happen to have one.

This subcommittee, Mr. Chairman, under your creative leadership, has ignored the advice of the cartoon character Pogo, who reminds us to ask the question so as not to disturb the answer.

The work of this subcommittee over the past few months has certainly disturbed the time honored, and up until now "sacred" answers to the drug abuse problem in this country.

We have questioned the arbitrary laws which have dominated our attitude toward the so-called dangerous drugs and now we have finally heard the Attorney General say, "* * * Prison is not the only alternative."

We have questioned our complacent attitudes toward the use of alcohol, amphetamines, and barbiturates and now discuss all drugs as chemical and synthetic agents we misuse and overuse.

We have questioned our didactic lectures to our children and now we are beginning to listen to them.

We have questioned our own notions of the nature of the problem and now have some new solutions to replace the old, useless answers I hope we have discarded.

Mr. Chairman, I appreciate this opportunity, to get some additional expert testimony on four specific solutions I have proposed in S. 1816, the Drug Abuse Prevention and Rehabilitation Act of 1969.

These proposals are:

1. The use of private resources and initiative in the rehabilitation effort.

2. The need to provide interdisciplinary curriculm for students of medicine, psychology, psychiatry, sociology, social work, and other related fields.

3. The concept of prevention in the education processes on drug abuse, and

4. The need for interagency coordination in the Federal Government.

Mr. Chairman, these witnesses are especially qualified to give us advice on each of these points, and I am sure that their testimony will give an important direction to our legislative task that you are so capably leading.

Senator HUGHES. Thank you very much, Senator Williams. I appreciate your comments about the subcommittee's activities and also your deep concern and interest as displayed not only in the activity of this committee and in the introduction of this legislation but your activities in personally being concernced about programs that can lead to recovery and also education in many other fields.

Senator Schweiker, do you have any comment?

Senator SCHWEIKER. No. I am glad to join your subcommittee, Mr. Chairman. This is my start as a new member of the subcommittee. I appreciate it. I will be glad to hear the witness.

Senator HUGHES. Thank you very much, Senator Schweiker.

The first witness is Dr. Donald B. Louria, chairman of the Department of Public Health, New Jersey College of Medicine and Dentistry, and president of New York State Council on Drug Addiction.

Dr. Louria, we welcome you once again. If you will introduce your colleague.

STATEMENT OF DR. DONALD B. LOURIA, CHAIRMAN, DEPARTMENT OF PUBLIC HEALTH, NEW JERSEY COLLEGE OF MEDICINE AND DENTISTRY, AND PRESIDENT, NEW YORK STATE COUNCIL ON DRUG ADDICTION; ACCOMPANIED BY DR. EDWARD WOLFSON, DIRECTOR OF THE DIVISION OF DRUG ABUSE, NEW JERSEY COLLEGE OF MEDICINE AND DENTISTRY

Dr. LOURIA. With me, Senator Hughes, is Dr. Edward Wolfson who is director of the Division of Drug Abuse for the New Jersey College of Medicine and Dentistry.

I might say we are the only college that has a specific division related to drug abuse.

Senator HUGHES. All right, if you would like to proceed with your testimony as you desire.

Dr. LOURIA. I will make seven points and be quite brief.

First, it does seem to me that the bill we are discussing today is terribly important because it is abundantly apparent that drug abuse has been grossly neglected in the medical school. I think this is crucial for two reasons: One is that there are clearly not enough trained physicians who are interested in the problem of rehabilitation.

The only way that we can possibly solve this, that is the dearth of physicians involved, is to expend money within the medical schools to develop the programs that will allow them to develop the commitment and interest during their 4-year medical school career. I think this is the crucial part of any educational program or rehabilitative program.

The result of this has been that all too often the field of rehabilitation is left not to the trained physician but frequently to uncritical zealots which I think only compounds our problem instead of mitigating it.

Second, I think there is clear evidence now from surveys in Michigan, from Blum's studies on the west coast, that the physician is best accepted as the educator of young people. It is clear that currently law enforcement is having an enormously difficult time in getting to young people and that they themselves when polled will place the physician or the public health educator at the top of the list.

This means, obviously, that if these people are going to be effective educators they have to be trained themselves to do it.

What we in the New Jersey College of Medicine are doing is attempting to involve the students and currently we are in the nascent stages of our program. We have an elective for second-year medical students, now being attended by virtually the entire class, to train them in the various aspects of drug use and abuse.

Secondly, we are employing some of our specially trained students in seminars for schools in the State of New Jersey. We are only able to do one school a month but what we do is have lectures, questions and answers, a survey of the prevalence of drug use, then our students go in to conduct more extensive seminars for the students on a smaller group basis.

Finally, we reassess by questionnaire the impact of our educational program. But I think we clearly have got to expand these programs enormously and I think that the funds available in this particular bill would be tremendously important.

The second point I stress is that cure is terribly difficult if the drug user is committed, especially if he is unmotivated.

What I think we are seeing in the programs in general and the reports of those programs is that those which apparently are having success are inevitably appealing to the motivated addict.

If you look at the California program which dealt with unmotivated addicts, the 1 year recovery, those doing well after 1 year of institutional detoxification was in the range of 33 percent; by 2½ years this had fallen to 16 percent.

New York State has undertaken a massive rehabilitation program to which they have committed literally hundreds of millions of dollars but they must by the very nature of the law deal with the young and the unmotivated.

My suspicion, and I am involved deeply in that since I am the president of the New York State Council on Drug Addiction and we are the major adviser to the program, I suspect that the overall recovery rate will not be anywhere near satisfactory primarily because we are dealing with unmotivated individuals.

In contrast to that take the methadone program which the scientific community accepts as currently the most effective of the rehabilitation programs.

There the number in that program, the percentage doing relatively well after, say, a 2-year period, is about 60 percent.

So, it is perhaps one-third as opposed to two-thirds and that really relates primarily to motivation. So that I think it is difficult to cure an individual who is taking heroin, who is committed to heroin, unless he is well motivated.

I think that is the most crucial point I could make in terms of the current programs which are voluntary in nature. Some of them do very well indeed but they do very well indeed because they are able to select those who are most likely to do well because they are well motivated.

I might say in this regard that aside from heroin for which we have several rehabilitation programs across the country, for the other drugs, LSD, the cannabis derivatives, the amphetamines, we have no effective programs at all.

These problems numerically far outweigh the heroin problem in this country.

Number three, we have to some extent to reorient our priorities. I want to make it clear I am not in any way denigrating the expenditures of large amounts of money for rehabilitation. I think that is mandatory and I think we as a Nation, certainly the Federal Government, have not yet been willing to commit the kinds of moneys that are absolutely necessary if we are going to test the various attempts at rehabilitation if we are going to reach a reasonable number of the heroin users.

I think we have to restructure our priorities because under any circumstances the best of rehabilitation programs has a difficult time for the unmotivated addict.

Therefore, I think just as in this bill there must be a major emphasis on education and for me what that really means in large part is that we have to be willing to spend the moneys to train our teachers.

We would like to see in every high school, and junior high school across the Nation, an in situ expert, a teacher that relates well to the children, who is articulate, who can reach the young people, who is specifically trained in the various facets of drug use and drug abuse.

That can be best done in our medical schools with multi-faceted programs.

So I think this is the most crucial thing we can do.

Furthermore, of course, we have to train our physicians and I have already talked to that.

I think in emphasizing the value of education one needs only to look at what is happening with LSD. A few years ago with all the ebullient and uncritical publicity in the communications media the LSD fad was upon us and grew at an extraordinary rate from say 1965 to early 1968.

Subsequent to that time there appears to have been a leveling off in the abuse of LSD.

I might say tangential to this discussion there are no firm data to indicate, as some have suggested, that there is clearly a declining use in LSD but surely it has leveled off and it has leveled off in large part because we were able to get to the young people with educational programs, especially emphasizing the potential for longtime psychiatric abnormality under the influence of LSD and at least the potential for genetic harm which possibly could be passed from generation to generation.

I think one could put it very simply; if we are not willing to change our priorities to at least give preventive education equal emphasis with rehabilitation, we cannot handle this problem and I do think one can make that statement dogmatically.

Fourth, and absolutely crucial, is that we must expend some of the educational moneys and some of the rehabilitation moneys for evaluation.

Here I think the name of the game is understanding the denominator. I would like to give you an example of that. I am deliberately going to use no names; there is no reason to do so. I think the figures themselves emphasize the point adequately.

There has been one program utilized to initiate an enormous program in one of our cities in which the recovery rate was allegedly 90 percent. Now this was a voluntary program and a perfectly good one.

On assessing the data it seemed clear that the recovery rate was indeed very high if one accepted their criteria, and for the moment I am perfectly willing to do that.

But what we found was the following: 1,800 people had started this program, at least had shown an interest in the program; they had been reached initially. Seven hundred of them actually got into the program and started it, 125 completed it, and 112 of the 125 were doing well. That is a 90-percent recovery rate if one only pays attention to those who have actually completed the inpatient facets of the program; it is then 112 of the 125.

But if one wishes to look at this from a epidemiological viewpoint to develop valid statistics is that we know where public moneys should be expended, so that we know whether a program deserves to be continued, the denominator is essential because then you must in all fairness regard it not as 112 out of 125 but rather 112 out of either 1,800 or 700, whichever of the two you choose, and that means the recovery rate is not 90 percent for that program but somewhere between 5 and 15 percent.

I know of another program in which the recovery rate publicly is estimated at better than 80 percent. On assessment of that program extramurally it turns out that is based initially on seven addicts, five of whom are doing well.

What I am saying specifically is that we have an absolute obligation if we are going to expend public money, if we are going to develop public health policy, not to accept public panegyrics as criteria for dividing of the public funds but rather that we must have extramural evaluation.

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This is not only true with rehabilitation, it is equally true with educational programs. What concerns Dr. Woldson and me is that currently there is an enormous cry to have educational programs in our schools and we are really going off helter-skelter with all sorts of educational programs, many of which may be doing no good, some of which may be doing harm, and we have currently no mandatory evaluation mechanism built in.

So I would urge as strongly as I can that these very important educational funds that you are planning to allot to this program be guided by some form of evaluation mechanism so that we know whether our education is effective and whether or not we have to modify it.

One other point I have to make about the matter of denominator and evaluation: I don't want for a minute to imply that a program that has a 5-percent cure rate rather than a 90-percent cure rate is necessarily a bad program. It does not mean that at all.

What is happening now is that every program sort of takes what is given to it, and we do not yet have any criteria for deciding whether or not a given program speaks to the need of a given addict.

The best thing we can do is have a kind of evaluation that 3 or 4 or 5 years from now will tell us that if you pick five programs you can decide on the basis of predetermined characteristics of the addict which program will speak to the need of which addict. Then we can take a program, a perfectly good one which happens to have a 5-percent success rate and perhaps turn that into a 50-percent success rate.

So we are saying that it matters not one wit whether or not the cure rate is allegedly high or allegedly low so long as they are determined to do something about the addiction problem.

What matters is having the kind of evaluation that will enable us to determine where we can send any given addict to get the most beneficial effect.

Point 5: I would like to mention what we are doing at the New Jersey College of Medicine other than the student program. We currently have been funded by the Federal Government, initial funding of $700,000 for the first year, to run a detoxification service. We detoxify them at the Martland Hospital Center. These are then referred on a randomized basis to seven different voluntary programs. We do not interfere with the program.

What we do is follow the individuals we refer so that we act as an extramural evaluation mechanism. So we are currently detoxifying, referring, following up, and evaluating with each of the seven individual programs independently running its own rehabilitation program.

Second, we are undertaking a variety of workshops throughout New Jersey for teachers. Currently, these, too, are in their initial phases and I think we will have to have a lot more funding if we want to expand to the extent we would like.

We hope to have a far more extensive program in our school. As I indicated, we are planning programs for teachers. Each of these programs costs in the range of $20,000 to run. If you run two a year, that is about $40,000.

I must say currently we don't have funding for those programs although we have just begun and we certainly anticipate that various sources should be willing to fund this kind of program for teachers.

One additional point that I neglected. I think one terribly important thing about your bill is that you are specifically providing funds for voluntary organizations. Having been deeply involved in attempting to get funds for voluntary organizations in New York State for the last 5 years, I can assure you that many of the fine voluntary programs are having an enormously difficult time in obtaining funds just to keep going, let alone expand their programs.

So I think that we need many more funds for these voluntary agencies. Once again, I would just add the caveat that I think funds and programs without evaluation are highly undesirable and can only complicate our already complex problem.

The final two points are: one, that I think there is one area that might be added; namely, research that really relates to the whole problem of our society but not specifically to the points you have enumerated.

That research that I think will have to be funded by the Federal Goverment is an attempt to develop for this Nation new intoxicants which are truly innocuous.

One of the real problems we have is that our escape mechanism, including tobacco and alcohol, really have enormous dangers built in as we are all aware.

We are now proposing adding to those with perceptible dangers another drug with perceptible dangers, namely, marihuana. This is not germane to this discussion, I don't want to get into it unless you would like to discuss it in question and answer, but I think the evidence is overwhelming that marihuana, whatever else you say about it, is not an innocuous drug. Limited harm, of course, that is true; no worse than alcohol, that is true. But we are accepting those points.

The drug subculture and some people have testified that this drug is entirely innocuous. All the data we have had available to us since at least 1850 contradicts those facile statements.

It may have limited harm but it is not a totally harmless drug. My point is that we are asking the wrong question. The question is not whether marihuana is better or worse than alcohol; the question is already whether we ought to add another drug which has its own potential dangers.

For me the answer is no, that I would not be willing to add a drug which has limited dangers.

Our society is drug oriented.

It is clearly not going to change. Drug use is upon us and will stay with us at least for the next few decades. If that be true, then should not perhaps one of our research objectives be the finding of intoxicants which can be introduced to society that hopefully can replace both marihuana and alcohol and which might truly fall or almost fall into the innocuous category?

Kava used in the Polynesian area does really have limited harm. Betel has its own limited dangers but far less than anything we are using. It is primarily a stimulant also used in the South Pacific area.

I would submit it might be well to spend a small amount of money on research in the active ingredients of Betel, Kava and other similar substances in the hope we can find for our drug-oriented society intoxicants people can use and not cause them substantial difficulty.

I think the evidence is overwhelming that none we have now, with the exception perhaps of caffeine, none of our valid escape mechanisms, or legal escape mechanisms and certainly not a single one of the drugs the drug subculture is urging us to introduce legally in our society fall in the innocuous category.

Finally, I do think this is a field in which we can be effective. I think we can mitigate our burgeoning problem in this country. I think if the bill under discussion today is passed, if it is implemented, if the funds are appropriated, that it will be a major step forward for our society.

Thank you.

Senator HUGHES. Dr. Wolfson, would you care to make a statement?

Dr. WOLFSON. No; I think Dr. Louria has covered the major points.

Senator HUGHES. Senator Williams.

Senator WILLIAMS. I think, Dr. Louria, in the beginning you indicated that the New Jersey Medical School was the only medical school that has a division of drug abuse education?

Dr. LOURIA. As far as we know. That does not mean that we know whether or not it is the only one. There are others that have been developing programs during the last 6 months.

I think it is fair to say this, Senator Williams, that very few schools have any formal division of drug abuse.

Again, as far as we know, we are the only one that does. But that does not mean that there may not be one, two, or three others. But I would be very surprised if there are any more than that.

Senator WILLIAMS. Perhaps you did describe how you approach it at the New Jersey Medical School, what students are selected for drug abuse education. How does it operate?

Dr. LOURIA. The drug education program within the school?

Senator WILLIAMS. Yes.

Dr. LOURIA. Again let me emphasize that we are in the nascent phases. Dr. Wolfson and I both joined the medical school in July and the program is just beginning. Essentially it is as follows: One, early in the medical school period in the second year we are running an elective for the medical students.

In the first trimester the clear majority, indeed virtually the entire group with elective opportunity, is taking this elective which is very encouraging. This is a brief elective.

It covers a 2-hour period for a period of 9 weeks and allows them to see some facilities but at least it begins to interest them in the problem.

Then in the third and fourth years they are given elective time and that can be 1 month or up to a year that they can spend studying this or other aspects of medicine that they are particularly interested in and we offer specifically an elective in drug abuse with Dr. Wolfson and his colleagues.

Third, actually at the initiation of the students, which is very pleasing to us, we are involving our students in seminars in the schools in New Jersey. We have been literally inundated with requests for workshops and lectures and we can't possibly fill them.

What we have done is once a month pick a school and first we administer a questionnaire which takes about an hour to fill out. It is run by our data processing unit.

The questionnaire which we have developed contains 80-some questions and tests virtually everything we can, their backgrounds, their drug use, their attitudes toward drugs, their knowledge about simple things such as drug laws.

Immediately thereafter Dr. Wolfson or I go into the school and we give a 1-hour talk on drugs followed by a question and answer period which goes as long as the school wishes it to go and this is usually for a prolonged period of time.

The young people are uninhibited and they are terribly interested. Then because they are never satisfied with that, nine of our senior students who are specially trained in our department, go back into the schools a week later and conduct seminars all day for groups of about 25.

We have just done that once. It still has some bumps in it but we think this is going to be very effective once we can further help our students in conducting these seminars. This is their first experience in this kind of learning process.

But I think they get through to the young people very well, indeed; 6 months later we will go back into the school, have another questionnaire, much shorter this time, which relates primarily to assess the impact of our program on young people.

I think again one of the misfortunes we have is that we can only do it for eight schools a year.

The final point, the most important one, is that as soon as we are funded we plan to conduct two courses a year for teachers. Now there will be 3-week courses, very intensive courses. This will be 3 weeks, 6 days a week, in which we will not only do our own education but the last thing we want is for them to walk out with the Louria stamp or the Wolfson stamp about drugs, because we have our own biases.

Therefore, we will bring in to conduct the program with us a whole variety of experts on all sides of this particularly complex issue. We will train the teachers in a lot of other ways.

In the first place, we will insist on their putting a lot of intellectual input in it. We will train them in being able to communicate to the young people about the drug problem, arm them with plenty of factual knowledge, and then send them back to be in situ experts and counselors in their school and we will accept the responsibility of keeping them up to date every month or two with any new information that comes along in the drug field, any changes, and what we know about marihuana and LSD.

Finally, we are conducting workshops for various groups, industry groups, teacher groups, public health groups, again a relatively small number so far but we hope to expand it as our department expands.

Senator WILLIAMS. In that area is there a place for your institution in educating practicing physicians who did not have this particular educational opportunity when they were at medical school?

Dr. LOURIA. That is a very good point. The answer is that thus far the programs we have developed, really some of the physicians have already requested a chance to come into 3-week intensive education course.

Dr. Wolfson and I spend a lot of our time talking to medical societies about the problems.

Your point is a crucial one, because having somebody watch a movie on drugs or go to a half-day workshop or have one of us get up and harangue them for an hour or two is not the answer in education. It has to be far more intense.

They have to be willing to have inputs in it. Parents, too. Just sitting on their backsides and having somebody lecture to them is not the answer. So we have prepared for the medical profession an intensive reading list that we think will bring them up to date without formal courses but as soon as we get our courses off the ground for teachers we plan to initiate courses for physicians.

I think that is terribly important and certainly the educational establishment, the medical schools have really been derelict in this part of physician education.

Senator WILLIAMS. Thank you.

Senator HUGHES. Senator Schweiker.

Senator SCHWEIKER. Thank you, Mr. Chairman.

Dr. Louria, I would like to ask you a few questions. I am not quite clear on the scope of your detoxification work. I wonder if you would explain that briefly.

Dr. LOURIA. What we are doing is that we, of course, are committed to education and to evaluation. We also were very eager to participate in attempting to rehabilitate the really enormous number of addicts within the Newark and the adjacent Essex County area.

So, what we agreed to do was the following, and again, this is under support of the National Institute of Mental Health.

We have established a small detoxification unit. We don't really need many beds. It is four male beds and one female bed because they are only there a few days. They are seen by Dr. Wolfson and his colleagues, requesting detoxification not solely for the purpose of detoxification but for the purpose of referral to one of the rehabilitation units.

One of the two things can happen: Either they are studied, given a physical examination, psychological examination, laboratory work in the outpatient department and then referred directly to the rehabilitation unit or if they need detoxification because they are dependent severely on heroin, then they are brought into the hospital for about a 4- or 5- or 6-day workup maximum, physical workup, laboratory test, psychological testing, testing of their chromosomes, urinalysis to see what kind of drugs they have been taking.

Then by random selection they are allocated to a given program. If they reject random selection they are given the opportunity to choose one of the specific programs associated with us. There are seven programs ranging from the methadone program on the one

hand to a therapeutic community that is relatively less under psychiatric control to one you will hear about immediately after us, Odyssey House, which is run by a psychiatrist, to self-help programs within the community.

So we have several really different modalities that we hope to be able to assess, again with the objective not of saying to them you are successful or you are unsuccessful.

We have assumed that all of these are attempting to do the best possible job they can in the drug rehabilitation area.

It is with the idea of being able through our initial evaluation, through our followup, to let them know just how things are going, how it compares to other programs and hopefully over a period of a few years to be able to select out the addict ahead of time so that we can say "You have these 12 personality characteristics, therefore, you are going to respond best to methadone," or "You are unlikely to respond to methadone and, therefore, you should be in the Odyssey House program or Synanon type program."

Once we have done that we can boost our currently disappointing recovery rate. What we do is we detoxicate, we check the medical complications, we refer, we evaluate, but we in no way interfere with the ongoing programs which are completely independent although we are sort of all funded under the same mechanism that comes to the medical school.

Then we subcontract the funds but do not control the funds. We do not audit the funds, so that we in no way tarnish the independence of the individual rehabilitation unit.

Senator SCHWEIKER. Another question I would like to ask. You said that one of the highest priorities should be preventive education. You also referred to a course you started there at your school with teachers.

Is that the kind you would like to see?

What I am really asking is, what kind of training should these teachers have? How long is that kind of training required, and so forth?

Dr. LOURIA. That is a good point. I want to make it clear I am not suggesting that this is exclusively the way we ought to have education programs.

For example, the National Institutes of Mental Health under the able aegis of Dr. Sidney Cohen have developed a whole series of educational posters, pamphlets, and motion pictures which I think are very much needed. I am all for those. I am all for workshops.

I think that what we really feel is mandatory if we are going to handle this program is to have in every school an expert who really knows the drug scene and knows the faculty and articulates well and relates well to students.

In other words, I think if we go into a school and we educate for a day or a half day or even a few days, that as soon as we are gone, the in situ purveyors, the drug subculture, says "Come on, you don't believe Louria or Wolfson or any of these guys. They are from the establishment and they are lying to you. LSD is no worse than aspirin."

The potential user has no way of critically evaluating that. The potential user, the young people, we find are extraordinarily receptive to factual discussion. They are absolutely intransigently opposed to being lectured to and being told you must do this or you can't do this because it is against the law, period.

They are very willing to accept, to be receptive to data that they can challenge you on, that is factually oriented, and that you can back up and especially if you are willing to have a question and answer period so that there is a real dialog.

I think education can be effective but I think there has to be somebody in situ so that they all the time can know if they have a drug problem, even if they are users that they can go to a specific counselor in confidence and expect some help and advice and knowledge.

That is the thing that we almost never find currently in the schools.

If we accept that premise that eventually we have to train the teachers and the physicians, then I think it is clear that we must have several things in a course. One, you can't do it in a period of less than several weeks, at least I don't think you can.

Two, they have to have the opportunity to visit facilities and really see how rehabilitation programs are going.

Three, they have to have intellectual input. They have to be like any other students or, like we as physicians, they have to be willing to go to the literature and arm themselves with knowledge.

If they are not willing to do that, then the courses will be wasted.

Four, I think they have to really teach themselves how to give talks against drugs so that they are accepted by young people, so that they relate to young people, so that they can initiate an effective dialog.

Senator SCHWEIKER. You mentioned also in your work that motivation is one of the keys.

I wonder what makes up motivation, what we think of as motivation, or what is your conception when you are talking about motivation.

Dr. LOURIA. I wish I could answer that question. If we knew how we could inculcate motivation I think we would be far better off. Though I can't answer I can say this: Motivation at least to some extent with heroin users appears to be age related so that if you take an older heroin user who has been on it for 10 years—the frequent statement you read in the press is that we have taken a whole pile of users who have been on it for 10 years and see how well we did.

We say wait a minute. We say the older an addict is if he survives that long, more likely, to have decided this is the wrong life and be ready to get off.

If you get somebody 30 years old and he has been using drugs for 10 years you are not taking the worst addict but the best addict. In some series as many as 80 percent of the people who used heroin, become addicted to heroin, eventually stop using heroin on their own. That figure is undoubtedly high.

But we do know a certain percentage of people at a certain age begin to grow out of drug use and become motivated. Motivation means simply that they decided this life must stop for them and they want to be cured.

Why this occurs we don't know. It is currently a popular hypothesis that this relates to diminution of sex drive. Apparently heroin

abuse among young people, and this has been assessed in deprived communities, occurs because their aggression is so extensive that one way of handling it is to take a drug like heroin which really reduces aggression.

That is why all these statements about heroin addicts going around and murdering people are untrue; sure, that happens every once in a while but actually heroin addicts are anything but violent people.

One reason is that the heroin does anything but incite violence. According to this thesis they use heroin to control their innate violent tendencies. As their sexual drive diminishes the need for the drug diminishes, too. This may be entirely specious as a thesis.

At any rate, we know that age appears to relate to motivation. What else does, I don't have any idea. All I do know is that if you give me a motivated addict I will guarantee you that the recovery rate in that particular population among the motivated is about three times what it is among the unmotivated.

In New York State we have about 10 percent of the population in the inpatient phase of the program who know that the only thing they want to do is get out and back on the street and use their drug and they spend their time trying to subvert the rest of the program. That is 10 percent who are actively trying to ruin the program.

Another probably 40 or 50 percent are really just waiting to get through their inpatient period to get out because they are angry. They have been referred by the courts, they are involuntarily committed. They are not prepared to accept rehabilitation.

So I think the Narcotic Addiction Control Commission in New York State is now concentrating very heavily on attempting to instill in them the motivation that will allow them to accept rehabilitation.

Senator Schweiker. One of the specific issues before this committee is whether we transfer the authority from the Attorney General to HEW for drug education and also for drug research.

Do you have any views on that?

Dr. Louria. I am sort of going to be evasive on that because I just don't have enough specific knowledge on what kind of program that the Attorney General might have initiated as contrasted to the health units.

I must say that I personally think that HEW is the best place for education programs and for research programs, I think far and away the best place.

I think just the job that is being done by Dr. Cohen and his colleagues with a limited budget would suggest that that is where the expertise is.

I must say from my own limited vantage point that is where I think our funds ought to be placed. Especially with evaluation.

You know, these people have trained experts who spend their whole lives assessing scientific projects. Now that kind of expertise should surely be marshaled for evaluation in the educational field, evaluation in the rehabilitation field.

Given a choice from the little I know, I think that rehabilitation, evaluation and education, and research would best be centered in Health, Education, and Welfare.

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Senator SCHWEIKER. One final question. This is not directly related to our committee but all the Senators have to do something about it, probably very soon.

I would like to get your views on penalties for marihuana use and possession.

Dr. LOURIA. My views are very explicit on that. I think that there is no use repeating what you have already been told about the anachronisms in our law, the incongruities, the fact that the law not infrequently can be vicious.

I think marihuana should not be legalized. I don't care what anybody says, marihuana is not a harmless drug. All one has to do is read the medical literature which documents the dangers for at least a limited number of people.

Our problem is this: We are going to the school saying:

> Marihuana is no big deal. We can fool you with something which looks like marihuana and smells like marihuana, is not marihuana, and give it to you double blind and a lot of you will go off and have trips thinking you are on marihuana when you are not.
>
> We can do it with alfalfa or oreganal, or as the New York Times mentioned, dehydrated horse manure.

So we are saying to them:

> You can tell us you like marihuana and we accept that. Otherwise, you would not be so stupid as to smoke it. You like marihuana and you are using it. You can't tell us it is a harmless drug because that is not true. We can tell you that the limited pleasure you get can be mimicked by something that is not marihuana in a double blind situation. Therefore, since you don't have to have your marihuana, really get off and get onto something more important to you in the society.

If we are going to say to them that it is a minor league drug, how on the other hand can we say to them:

> By the way, if you violate our laws we will treat it as if it were tantamount to rape, mayhem and murder.

So if the minor league drug is a peccadillo the use ought to be treated as a peccadillo.

I think the possession of marihuana ought to incur a penalty such as an assignment to a local poverty program for 12 consecutive weekends and then expunging the sentence from the record.

With the third conviction I would put somebody in jail but never more than 4 months for possession of marihuana.

For sale of marihuana I think it must be flexible. It has to be something from 1 to 10. One for a minor seller, up to 10 for a major distributor, because the fact of the life is if we don't reduce the supply of dangerous drugs, including marihuana, we cannot handle the problem.

So I think we have to have that kind of flexibility. Not long ago I was in one State in the Midwest. They actually asked me there to discuss some people who had been arrested for selling marihuana, $5 worth each. They said:

> What should be done with these sellers of marihuana, who are young people?

I said:

> You know, marihuana sale is against the law, they don't have to do that. Therefore, I think they have to be punished if they are found guilty.

When I got through I realized that I didn't really know precisely what the laws were in that State. I asked them what the law was. They said if he is 16 years and 11 months he will go to a juvenile home until he is 19 and then be free. If he is 17 years and 1 month, he has a 20-year mandatory sentence for selling $5 worth of marihuana.

When I was told that I said, "Forget it; you can't do that to young people. The best thing you can do is reduce the sale to a misdemeanor, give them a suspended sentence."

Then, of course, they will go back to the community and say, "Look, nobody believes the law and they don't punish you." But if the law is that vicious, you can't apply them. So we are now in a state that nobody does believe the laws. That includes the young people, the district attorneys, some of the judiciary, the police, and I think if we are going to handle this problem, we have to make the punishment fit the crime.

I think we can still keep it illegal and yet make our laws fair enough and realistic enough so that they can be applied. I think if we do, the problem will diminish and not expand.

Senator SCHWEIKER. Thank you, Mr. Chairman. I certainly appreciate this very candid and helpful testimony.

Senator HUGHES. Thank you very much, Senator Schweiker.

I have a few questions, Dr. Louria.

I would like to try to cover again with you as briefly as we can—we are taking a lot of time—we hear a lot of talk about putting people in jails and prisons for long sentences.

Are you aware of any program in any prison or any jail or anywhere for the recovery of addicts?

Dr. LOURIA. You mean jail work for addicts? No.

Senator HUGHES. Is there any problem in trying to work with addicts?

Dr. LOURIA. Within the jail?

Senator HUGHES. Within the jail or prison.

Dr. LOURIA. I can only speak for New York State. New York State has its narcotics addiction parole program reaching into corrective facilities. There they are making a major effort within the jail.

I think your point is correct, what we need is rehabilitation, not jail for the user. There is little evidence that jail does well for anybody.

If you take those people who have been through jail and you keep them under very close supervision according to a careful study by the New York City Division of Parole and New York State Parole Department you get about 30 percent recovery with long-range followup good. Thirty percent is the best we can do in the jail setup.

Senator HUGHES. Do you think it is a burden to society to see that there is a program available for someone who is put in prison who is an addict, to try to see that he has a chance to recover?

Dr. LOURIA. Good Lord, I think it is an absolute disaster for the individual, for our society, to put somebody in jail and not to have a major program.

As I indicated, wherever possible, they shouldn't be put in jail. They should be rehabilitated. I am speaking specifically about the heroin problems.

Senator HUGHES. Do you think some additional funds should be directed to that purpose?

Dr. LOURIA. I must say, since we are all hoping that the funds indicated would go through I would say yes, additional funds.

Senator HUGHES. We have also had testimony, which you have listened to, yourself, in other hearings, that drugs and narcotics are available in nearly every major prison in the United States, Federal and State, and most of the large city jails.

Dr. LOURIA. That is right.

Senator HUGHES. So when we put a person in there who is either an addict or an abuser of drugs, dangerous drugs, we are not in effect disconnecting them from the drugs or narcotics.

Dr. LOURIA. Absolutely. As a matter of fact, what one finds is that in many of the hospitals during the initial phases of the program we are not protecting the addict from drug use. They are using it in the jails, they are using it in the hospitals.

I think what we need is intensive long-term rehabilitation. There is no panacea that can be applied over a short period of time.

Senator HUGHES. As a matter of fact, we have had some repeated testimony that some men took their first narcotics in prison.

Dr. LOURIA. Yes, no question I think your point is absolutely correct. Prison without an effective rehabilitation program far more intensive than virtually every prison I know—New York State is the only one I know that has committed enough money to have a program in the prison.

I think unless something such as that is done we don't have a chance. Indeed, New York State would like to get its program out of the prison and into their rehabilitation centers. They have been forced to use their prison because we have not been able to expand it rapidly enough to have it all in the rehabilitation centers.

Rehabilitation and prison by and large are incompatible for the drug user. I am talking only about the user, not the seller.

Senator HUGHES. You mentioned there should be someone in every school, and I am assuming that you realize this could mean tens of thousands of people in this country. Yet I did not detect you said anything about a place to teach or train these expert personnel.

Dr. LOURIA. I think it can best be done by the universities and medical schools. I would visualize that really every medical school in this country should have that kind of obligation. I think that the university can get involved in it equally.

You are right, it is a mammoth problem. So is drug abuse. What we are threatened with now is really having a generation virtually consumed by this growing problem. I think we have got to make that kind of educational commitment or we can't handle the problem.

Senator HUGHES. This would specifically mean you are going to have to adopt a new program in most of our teacher colleges, you would take those people who have applied for such a course in training out of the college, probably transfer to another campus where you have a medical school, develop a new program over a short period of time, perhaps 3 or 4 months.

Dr. LOURIA. What we would hope is that since that kind of disruption would be inconvenient, to say the least, that, say, teachers in training or teachers in the schools or physicians could take off, say, 3 weeks or be given 3 weeks by the local educational board to attend one of these courses.

I really think that if they are willing to have intellectual input, keep themselves up to date, that 3 weeks of an intensive course is enough to do the trick.

Senator HUGHES. It would take a specially designed program to accomplish it, with more money again in a special direction in order to do this.

Dr. LOURIA. Yes, sir, absolutely. I think the moneys indicated in the bill under discussion could be a major start for that. In a sense it is better to start that way so that we can get some judgment as to how effective these programs are and then expand them as our knowledge increases.

Senator HUGHES. You mentioned the private programs as well as public programs and the necessity of coordinating and evaluating private programs.

But you did not suggest something—let us look for the moment at the law enforcement grants to States, for example—the development of an overall State plan to fit private programs to the State plan.

Is this type of thing necessary in the field of narcotics and drugs and alcoholism—I include all three in that—for a State to develop and then to have some coordinating agency in every State through which all these programs fund?

Dr. LOURIA. I think unless there is adequate coordination at a State level and through the State to the Federal level we are going to go off helter-skelter, not knowing where we can best spend our money.

I think it is mandatory to have that kind of coordination. I think it is also mandatory to make sure that the voluntary agencies are adequately supported.

Senator HUGHES. In talking about voluntary agencies and private agencies do you believe it is possible on a per patient basis to enter into contracts to channel funds through a State coordinating agency with private nonprofit corporations or even private hospitals that may supposedly be profitmaking institutions?

Dr. LOURIA. Yes, sir. I think it is entirely possible. Indeed, I think if we are going to handle the problem of the committed drug abuser, it is necessary. Again, I think it should not be done unless we have an extramural evaluation of those programs.

Senator HUGHES. We have had a lot of talk about success rates. I think you know what my question is. What would you consider a success rate in any program?

Dr. LOURIA. That is an impossible question, Senator Hughes, because I think in our stage of the game if a program has a 5-percent success rate, that is not unacceptable so long as it has an evaluation mechanism that will allow us to identify the addict in that 5 percent so that we can give to that program over subsequent years only addicts that fit that program and raise it from 5 to 50 percent or something like that.

I know one point you are driving at, I think anyway, and I know I certainly agree with it, namely, that public statements of success rates are absolutely meaningless unless there is an evaluation committee.

Currently the evaluation committee that has functioned longest is the one in New York City for the methadone program.

As I have pointed out publicly many times, I think there are defects in it but still it is the best we have.

This is one reason that the scientific community is so willing to accept a lot of the methadone figures. If you accept that the enthusiasm of those in the program exaggerates the figures to some extent, the fact of the matter is that they have an evaluation committee sitting over them assessing them.

Some of the data have been not totally extramural. That bothers me. I think the evaluation committee should gather its own data.

The statement I have made over and over again is if you listen to the public panegyrics each program has a success rate that varies anywhere from 60 to 120 percent.

I don't think it has any meaning unless somebody sits down and assesses what they are talking about.

Senator HUGHES. Would you not measure success also, Doctor, in the fact that, let us say you have a young man who has progressed to the various stages of drugs and narcotics and then got on a program and he stays off the stuff for a year and then got back on and came back for further treatment and rehabilitation, wouldn't you say his year off narcotics was a success story?

Dr. LOURIA. Yes, I think so. In this difficult field we have to be willing to accept relapse as a very frequent phenomenon and not feel that relapse per se is failure.

Senator HUGHES. My fear is the fact that the general public in America will look to a success percentage of say 75 percent total recovery as reasonable for funding programs. We can't measure the success of any individual program against the success of another unless we measure the individuals themselves, can we?

Dr. LOURIA. That is absolutely correct.

The only way we can try to get to whatever magic figure the public wants is to figure out by predetermined characteristics which addicts will fit which programs.

I think your point is a crucial one, that no one has any right to say a program with 30 percent recovery rate is a failure. That is not true.

Senator HUGHES. We go to another phase of education. How about adult education? You mentioned the pamphlets, brochures and sheets being put out by NIMH and on television and I have seen a number, of spot announcements, they seem to be increasing, and that they are a necessary part of the educational program.

How do we reach mom and dad?

Dr. LOURIA. I think that is the best way initially. I think the other thing we can do is through education urge mom and dad that if they want to handle the problem in their family that they must educate themselves and that means doing more than listening. It means reading.

I think there are things for them to read; there are brochures, there are books. If they are not willing to have the input they are not going to be able to handle it when it occurs in their own environment.

Senator HUGHES. Would it be helpful at the beginning of every school year to have a packet sent home, make sure it got delivered, that was sent home to the parents in every family, that would give them a list of reading material they might get from the library plus some suggested noticeable signs they might look for in their own home, in their own medicine cabinet, for example?

Dr. LOURIA. I must say we had not actively considered that. I think it is a great idea. I think we will now consider it. That really is an excellent suggestion. I think that ought to be done.

Senator HUGHES. Of course, it requires more money.

Dr. LOURIA. Everything requires money. It does; but that is a relatively inexpensive way of getting to the parents and potentially getting a lot done.

Senator HUGHES. At what age do you think this ought to start; in junior high school?

Dr. LOURIA. It depends on your community. If there is no problem I think you can wait until the latter part of junior high or senior high.

If there is a problem in the community—and it certainly is true all over New York and New Jersey—I think you have to start by the fifth or sixth grade if you want to get to them.

Senator HUGHES. Another point you did not mention. I would like to ask you about the community mental health programs and particularly funds right now for construction.

Do you think this is the area we ought to be spending our money or do you think merely mental health centers or units particularly that can handle this alone should receive funds under this?

Dr. LOURIA. I think it has to be both. Of course, you are better aware than I that the community mental health programs are still in their beginning phases. Many of them have not made the judgment that they will have as a major focus alcoholism and drug abuse.

Now I think that currently funds will have to be given in both areas, to community health centers and to groups outside, to universities, for example, to medical colleges, to private organizations, aside from community mental health centers.

Eventually I think our goal ought to be to have all of this under the aegis of the local community mental health center, both alcoholism and drug abuse.

Senator HUGHES. On programs of recovery it was said that there were things being done with heroin, there were things being done in some areas of usage but very little being done in the field of amphetamines or "speed," which is one of the most dangerous expanding uses in America today.

It seems to be almost totally neglected. These do destroy brain cells apparently, people do go on rampages and suffer a letdown. What do we need to do?

Dr. LOURIA. This is one of the prime reasons for preventive education. What we need to do about the amphetamine problem and the others, is to do research on how to rehabilitate them. We don't have that now and so we have to reduce supply and have intensive preventive education.

I think the point is crucial and it is true with LSD, too. Except for individual psychiatric therapy we have no rehabilitation program for pot heads, acid heads, or methedrine users.

Again, we have to focus on prevention and reduction of supply and really hitting the purveyors if we are going to control it.

Look at Sweden. Sweden decided to try to treat it with maintenance initially. All they did was double the problem. Then they stopped.

Now they are going to therapeutic communities. There is not a single therapeutic community which has been evaluated in regard to treatment of amphetamine abusers.

So I think we don't know what to do in regard to rehabilitation. That is why we had better prevent it as best we can.

Senator HUGHES. How much money is being spent in the State of New York in these fields?

Dr. LOURIA. In the State of New York, education at a State level about $1 million. Several hundred thousand, perhaps, in New York City. In addition to that, carrying charges for the narcotics addiction control commission, about $45 million a year. The initial building program something over $200 million.

Senator HUGHES. The reason I ask that, New York State has about 9 percent of the total population of the country. When you look at California, that is 10 percent. Naturally, they have the heaviest concentration of problems, where the most people exist, and I think we have the biggest problems along the east and west coasts primarily.

What happens in a State like mine when it comes to splitting the almighty dollar where we have no programs? I had a call from a lady the other day saying we were rejecting youngsters for treatment of narcotics and drugs in our local hospitals.

She called me, she had nine. She wanted to know what she could do with them. I had to tell her I didn't know because I don't know a place in our State.

I look at the funding in these bills. I realize it is a massive step that has not been taken before. It is totally inadequate?

You know, I think educators, State authorities, parents, really underestimate enormously the problem in certain areas.

I was recently at a school in the Midwest where as I went to school they said, "Well, we don't have any problem here." We got there and I am sure they had some just because of the questions out of the audience.

I remember the first little girl got up and said something such as, "If I smoked grass and dropped speed during the week, what happens if I use acid on the weekend?"

Right away I thought they have a little more problem than they recognize in that school.

I think you are right. Everybody has the problem, no community is immune from it and we had better face up to it and place our funds in the appropriate priority right now.

Senator HUGHES. The whole point of my question is that while we need massive programs in New York and California and probably many of the Eastern States, we also can't abandon places like Iowa, Indiana, Nebraska, and South Dakota.

As we start dicing up this dollar to the extent that the battle goes on for it, it won't even be significant, will it?

Dr. LOURIA. I think that we need the money to utilize them throughout the country, absolutely. There are certain areas where the problem is worse. It is worse in New York State, California, and New Jersey.

I agree with you, if we are going to treat this problem properly, if we are going to train our teachers, then the money has to be spent in every State in the United States.

Senator HUGHES. If we can develop through research, and I am not sure whether we have now, an ability to identify what happens to a youngster—say, one that they carry into an emergency ward unconscious, obviously with some sort of drug reaction—wouldn't a national bank of information like we have on poisons be of importance in this country for local private physicians all over the country where we can call medically, 24 hours a day, and have the information on X, Y, and Z, and do something about it?

Dr. LOURIA. Absolutely. One of the points Dr. Wolfson and I have been stressing is that every medical society throughout the country is obligated to have a hot line not only for the young people to call but for the parents to call and ask questions or get advice on a specific intoxication. We need that kind of information 24 hours a day.

Senator HUGHES. The danger of death at that point is extremely high if someone is intoxified and they come in and no one knows what it is and it may be hours before you find out.

Dr. LOURIA. That is right. Most of the ones who die, die before they get to the hospital, say from an overdose of heroin. Our problem is compounded by having some come in comatose. He can't give his history. His friends have no idea what he feels. We have to be cautious because if we give him the wrong medication we can kill him.

Senator HUGHES. That was brought home to me recently. I was speaking at a convention. One of the men attending the convention had an emergency call. He and his wife were both there and their 16-year-old daughter had taken some sort of pills from some kid. They had been at a party. She was unconscious. She was lying in the hospital. They didn't even know what it was. I didn't know of any way to tell them where they could find out what it was.

Dr. LOURIA. Very difficult. The toxicology analysis comes back after the acute period. So you have to make the decision without adequate information. That is one of the tragedies of the Woodstock Festival. People were taking they knew not what so long as it had promise of intoxification.

Senator HUGHES. Are there any more questions?

Senator SCHWEIKER. I have one question.

Senator HUGHES. Senator Schweiker.

Senator SCHWEIKER. You were asked about rehabilitation in prisons. I don't think we got into the Federal area.

What about the facilities at Fort Worth and Lexington? Are you at all familiar with those and what is your evaluation of Federal rehabilitation prisons?

Senator HUGHES. I did not include those prisons, I am sorry. But they are not always prisoners when they go there.

Dr. LOURIA. I have not been to Fort Worth. I have been to Lexington. What I can say is that, namely, the followup program has not been satisfactory in the past. So that people going to Lexington go back to their same milieu without adequate follow-up or provision.

This is one of the facets in their very high rate of recidivism. Having said that, that is really all I can say because I haven't been through there in the last 2 years and I just don't know enough about the recent modifications.

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Senator SCHWEIKER. Another question relates to the GI problem, the administration problem, have you had any experience or have you any opinions as to what we should or should not be doing in terms of VA facilities or GI's, and so forth?

Dr. LOURIA. You mean in terms of rehabilitation programs?

Senator SCHWEIKER. Yes, education for that matter.

Dr. LOURIA. I think education is terribly important. You are speaking mostly about the returnees from Vietnam and use of drugs there?

Senator SCHWEIKER. Yes.

Dr. LOURIA. Most of this in Vietnam is marihuana and there really is not any effective rehabilitation program for marihuana users. Most of them don't need it. They just need respect with our laws to stop the drug.

About half the Vietnam marihuana is adulterated with opium. Thus far, despite the rumors, we have not seen any significant number of cases, and I am hedging on that a bit, I am almost ready to say we have not seen any cases, from addiction from the use of Vietnam marihuana.

We have seen addiction of people returning but not people who got hooked by smoking marihuana. If these do occur they are very small numbers.

I don't think it has to be centered in the veterans hospital. I think it is better to do it elsewhere in the university or mental health facilities.

Senator SCHWEIKER. In your professional opinion, what is the link between marihuana usage and hard drugs? Could you just give us your views on that?

Dr. LOURIA. It is one of the reasons, Senator, why all these facile statements about legalizing marihuana and everything else will go away are patently ridiculous as far as I am concerned.

The old statement by Mr. Anslinger that marihuana leads to heroin was never true at the time. You can document that easily by the number of marihuana users around the world who don't use herion.

That statement, unfortunately, gets more and more true in the current milieu of multidrug use.

The best study is one from Stoney Brook in which they contrasted use of LSD and use of marihuana. What they found when LSD was popular and the danger was not fully known, they found when you use marihuana once a month your chance of using LSD was 20 percent; once a week, 49 percent; once a day, the chances of using LSD was 82 percent.

What it amounts to is in America today the more deeply you become involved with drugs and committed to the drug scene, whether you get involved deeply with marihuana or anything else, the more likely it is you will use multiple drugs and among those nowadays this will include heroin.

Of the people who use a lot of marihuana, in the range of 10 percent play around with heroin. That does not mean they get addicted but they play around with heroin.

That figure is certainly not very far off. I think the old idea of legalizing marihuana and everything else will go away just makes no sense because we are in a completely new drug era and that drug era is multiple drug use.

Senator SCHWEIKER. Thank you, Mr. Chairman.

Senator HUGHES. Thank you very much, Dr. Louria and Dr. Wolfson. We appreciate again your helpfulness.

The Chair calls Dr. Judianne Densen-Gerber, accompanied by James Murphy, director, Odyssey House, Inc., and Alton Johnson, administrator, Odyssey House, Inc.

Senator WILLIAMS. Mr. Chairman, we are most fortunate to have folks here from Odyssey House. I am anxious, among other things, to hear how the expansion program in New Jersey is going.

I welcome you with deep appreciation, having spent not enough time but some time observing this group working particularly with what I consider great success at Odyssey House in New York.

Senator HUGHES. You may proceed with your testimony, Doctor.

STATEMENT OF DR. JUDIANNE DENSEN-GERBER, EXECUTIVE DIRECTOR, ODYSSEY HOUSE, INC.; ACCOMPANIED BY JAMES MURPHY, DIRECTOR, AND ALTON JOHNSON, ADMINISTRATOR, ODYSSEY HOUSE, INC.

Dr. DENSEN-GERBER. We would like first to say that our method usually of educating and sharing and treating is to have a dialog so that I hope we will have a dialog with you rather than make formal statements and allow the expertise that we have gained in this field to come out in response to the things that you would like to know.

The first way we usually begin is by telling the people about ourselves. This may be an unusual way to do things but we find that when we begin to converse, if you know a little bit about us it will be better.

I am Judianne Densen-Gerber, executive director of Odyssey House. Prior to coming to Odyssey House I was educated in Vermont. From Vermont I went to Columbia Law School, graduated in 1959. From Columbia Law School I studied medicine at New York University. Then took an internship and psychiatric residency.

By this time I was on my sixth pregnancy so I took the residency at Metropolitan Hospital. Confronted with the sixth pregnancy I went to the head of psychiatry and I said to him:

> Really, I do think I have to take maternity leave.

He said:

> Don't take maternity leave. Go into the addiction service. We already have 17,000 admissions in 6 years with eight known cures at a cost of $84 a day at that time.

The attitude then was to say they never get better anyway. So if you spend an hour or 2 hours or 3 hours it really doesn't matter because they just can't get better.

When we got down there, there was myself and Dr. Shavino from Senator Williams' State. We were testing methadone maintenance and we were having abominable results.

I suppose I could only mention that it seems to me if one changes a scotch drinker to a bourbon drinker one does that. If one changes an opiate heroin user to a synthetic opium user one does that.

We decided to attempt to do some type of attitudinal change. Within a period of 8 months we had 22 young men and women who were living clean. Because of lack of funds these 22 people on a Monday morning were discharged from the hospital without warning.

At this time we had $3.82. I was sent as the chief resident to the emergency room. I bring to your attention the danger of funding so rigidly that things which work are stifled.

At this time 18 young men and women, one of whom was 8 months pregnant, came to my home and confronted myself and my husband. He said we believe what we have said. We are going to take the step of making a commitment to them. These were 3 of the worst days of our lives. My husband is the deputy medical examiner of the State of New York. He asked me to bring to you the fact that in 1966 we had 31 teenage deaths from opiate use.

In 1968, we had 71 teenage deaths. In 1969, we had 72 teenage deaths during the summer alone, and 170 deaths of teenagers since the first of the year.

He says in addition we will have over 1,200 deaths from narcotics abuse alone in the city of New York. This is the leading cause of death in 16- to 35-year-olds, yet we continue to deny the existence of this epidemic.

We estimate in New York City a minimum of 25,000 teenagers alone are using opiates and yet there is not a single dollar in adolescent treatment beds in the State of New York.

This is the kind of information which I hope we will share with you and begin to show you that we are treating addiction primarily through means of denial rather than accepting the problem, working with the problem and getting the problem solved.

The problems of addiction are not easy problems. They are problems of angry young people who do not believe. They are problems of difficulty in communication. They are problems of dialog across the generation gap, across the racial gap, across the cultural gap.

When you mention the problems in your own State, we have been contacted by the State of Utah to set up a program. I would never have imagined that in a State such as Utah there would be need for our type of service. Approaches that are so simple such as Operation Intercept for marihuana bring us to the fact that what it has done has indeed made marihuana more scarce so that now a reefer of marihuana is $1 in our city schools and a bag of heroin also is $1.

The child is given the choice of a reefer or a bag of heroin, he chooses heroin. We are seeing more and more youngsters. We will testify today of our own experience with the adolescent treatment unit, the first of its kind, without a penny of funding of any sort.

We opened with 35 beds. We had 44 children the day before it opened. We still have nine children sleeping on the floor. We take from all States. We take without waiting; we take without regard.

I will mention briefly that we have a budget of $1.4 million a year. We began 3 years ago with $3.82. Of that $1.4 million, $316,000 comes from the New York State Narcotics Addiction Control Commission.

We have been unable in the State of New York to receive any Federal money because private agencies do not receive Federal moneys in the State of New York. That $316,000 is based on an operational level of 1966. We have not been evaluated since 1966.

We believe that one of the ways of evaluating the success of a program is the fact that it expands. If it can expand without money it

truly must have some basis of success. We get $9,000 for New Jersey from the Department of Justice and $116,000 through NIMH to the New Jersey College of Medicine and Dentistry.

We work without program, without building, and without staff able to receive funds from the State of New Jersey.

We have at the present time and we speak from the expertise of 210 beds and 4,000 outpatients. Our Harlem Store Front sees 950 addicts per month. Last year it was 5,175 addicts.

To reiterate, $1 million of our annual budget must come from private sources. Unfortunately, most of the staff must spend at least one-half the time finding the money to feed, to clothe, and to go on rather than to treat.

In addition, only $441,000 come from Government sources. Of our $1.4 million, at least one-third goes to education and that will be further elaborated. In referring back again to the Harlem Store Front, the 950 addicts that come across those store fronts cost us $21,000 a year to maintain which is actually funded in large part by the many sightseeing tourists. That brings us visitors from all over the world to see us at the site. That is how we get our money.

I want to share with you that the 17 addicts who began Odyssey House used $400,000 of opiates a year. This is actual drug use, meaning $1.2 million of crime. If we extrapolate from that figure we estimate we have crossing our doors in New York City in the Harlem Store Front alone $353 million worth of crime each year.

This particular store front has never been chosen to be funded by New York State. Why? Because it started after 1966, it is not eligible for funding.

We will also speak to you about the question of evaluation but I prefer that my colleagues do that since it is much more pertinent to their own experiences. I guess this is all I can tell you now.

Mr. MURPHY. I would like to start off first by introducing myself. I am James Murphy, 23 years old.

My background and history is that I started using drugs at the age of 13. From 13 to 20 I used marihuana, barbiturates, codeine cough medicines and amphetamines, LSD, DMT, and eventually heroin for the last 2 years I was using drugs.

During that time, I managed to somehow or other finish high school and worked mostly in banks and worked in banking institutions on Wall Street, at one time actually being responsible for $30 million in negotiable securities despite the fact I was using $30 worth of heroin a day.

During this time, over a period of 7 years, I sought assistance for my addiction, mostly due to pressure from my family and pressure of an increasingly larger habit.

I tried detoxification in hospitals on several occasions, private psychiatrists, private psychologists, counseling service, local priests, family, family doctor, all to no avail.

During this period of time, of those 7 years I remained free of drugs 8 days while I was being detoxified in the hospital.

Upon entering Odyssey in 1966, as Dr. Densen-Gerber pointed out, my sense of ever becoming rehabilitated or changing or not using drugs was at a point where at 20 I was ready to make the decision as

to whether I would start selling drugs in New York City or whether I would move to next door England where I could get drugs that were readily available in a fairly legal sort of way.

So that upon coming into the program I was really faced with a decision as to whether I really wanted to live or die or maybe the third alternative which was to vegetate.

I would like to make some brief statements at this point before passing the microphone over to Mr. Johnson.

Although we have a very serious situation in Vietnam, and which in no way do I underestimate as being very serious, we have lost approximately 35,000 young people since our involvement in Vietnam, at this time in New York City there are at least, according to the most optimistic figures, at least 100,000 heroin addicts who are walking around who might as well be dead.

I think we have looked and looked at the addiction problem and talked more and more about it. I think addiction in a very general sort of way is the lack of involvement.

One of the things I would like to do today is to become involved in every way I can with whatever answers I have, trying to create more involvement concerning this problem.

Mr. JOHNSON. My name is Alton Johnson. I am 21 years of age. I have been with the program now for about 21 months. I completed treatment after about 19 months. I am now a salaried staff member and working as administrator of the Odyssey House project.

I began using drugs at the age of 14. I began smoking marihuana and drinking alcohol. This led to about 2½ years at which point I began shooting mainline heroin. I shot heroin for about 2½ years.

At this time I was attending the Bronx High School of Science in New York City which happens to be one of the exclusive public schools in New York City.

I was able to graduate and I was accepted in City College. At this time I was still addicted and decided that I would not attend City College.

However, I did attend a community college in New York City for about 2 months. Because of my addiction, however, I was forced to drop out.

After this I took on jobs at such places as the New York Stock Exchange and First National City Bank in New York City.

I worked for a period of about a year and once again because of my addiction I was forced to stop.

From that point for about 6 to 8 months I drifted in the streets. I was not living with my parents, and I just continued to use heroin. Finally, I was arrested twice, once for possession of heroin and once for petty larceny. My parents threatened to place me in the New York State program under the NACC.

I decided to come to Odyssey, not really to get treatment but to avoid going to jail or avoid going to NACC.

I did and I remained there for approximately 2 weeks at which point I split from the program, thinking that I would not use drugs again and I would not really be going to jail for at least another 8 to 12 months.

My parents then forced me actually to return and I have been, like as I said before, I have been there for the past 21 months.

Personally, I have found that while shooting heroin I was not interested really in rehabilitation, methadone, or any other program which would have relieved me from my addiction.

I was only interested in keeping my addiction going, to keep me from being sick and to keep my habit flourishing. I did not look at rehabilitation programs as something that would assist me in any way.

I thought that most of the programs that were in existence were a farce. I did find at Odyssey the feeling of warmth and a feeling of togetherness and a feeling of group participation for the same end which was discontinuation of using drugs.

At present we have approximately 140 patients in treatment, both in New York and New Jersey. I would like to reiterate what Dr. Densen-Gerber spoke about on kids in New York City.

She said there were approximately 125,000 in the entire city of New York. Actually, 2 months ago we spoke to a health officer from central Harlem who estimated approximately 25,000 specifically from the central Harlem area under the age of 18 addicted to heroin on a daily basis.

At that point, Judy, Jimmy, and myself got a little angry and decided we would set up our adolescent treatment unit.

In our own facility we found we had approximately 41 kids under age of 18 with about five or six under the age of 16.

We moved them up to our Bronx facility which has a capacity of 35. Although we were actually in a sense breaking the law, breaking the rules set down by our charter and by the codes of the NACC, we decided that with the problem at hand the only thing we could really do was set up a facility to treat these kids.

Since then our number has increased from 41 to about 46 and we do have about seven or eight kids right now sleeping on floors.

We have not received any funds for this facility and in fact, the NACC has told us that funds will not be thought about for the adolescent treatment unit until 1971 when the budget will be reevaluated by the State of New York.

I personally feel that with $54 million that the NACC has this year for treatment of drug addiction and for prevention and education our budget only calls for $343,000 and I am sure that it in some way, with the problem, the proportions that it has reached some, funds could possibly be found at the New York State level or Federal level, if possible, to help us treat these adolescents in New York City.

I guess I will refer back to Dr. Densen-Gerber.

Dr. Densen-Gerber. What is shocking to me is not necessarily that we are not funded in the adolescent unit but the fact that if I see a child of 16 I may treat that child.

If I see a child of 15 or 14 or 13, there is no place that child can be treated within the State of New York, there is no special facility for an adolescent and actually adolescents are sent by the NACC out on their own recognizance and many of them do die on the rooftops.

I think this represents the prevailing attitude which has to be changed. People are not pieces of paper. People are not subject when ill to waiting until 1971 when a new budget is thought of.

The realities are that we must begin to think of these problems in relationship to the fact that it is endemic, that a child of 13 with the need to conform to peer pressure is not affected by the child to the right and by the child to the left. The addiction does not stay only in the ghettos.

Our community education program must be funded by people who can pay for our services. We can do education in the independent private schools. We have done it in Michigan, we have done it in Ohio, we have done it across the Nation.

We cannot, however, do it in the public schools because they cannot pay. This is the reality that is constantly confronting us. I think the questions we want to raise are questions of how new approaches will be stimulated, new attitudes will be stimulated.

I don't think that even the Senate can continue with the attitude that it has. It has to think of new creative approaches.

In New York State, $81 million was appropriated for a 3-year period. For me as a New York State taxpayer, $81 million is a lot of bread. Out of that $81 million, very little is channeled into any program offering the challenge of creativity, of innovation.

We need to find nuances. I am not saying that the therapeutic community of any one particular answer may provide the answer for all. All addicts are not the same.

The reality is that the money is being used along traditional orthodox lines, State lines, bureaucratic lines, lines which do not encourage creativity, do not encourage innovation, do not encourage meaningful program-solving.

We have begun a program in which we try to go one step back before addiction or we try to go to the 9- and 10- and 11-year-olds because if you only treat the addict, once he is hooked, you are treating someone who is already involved.

By the time you finish treating him there are three more to take his place.

The realities are that addiction is only the refuge of a group that is angry, restless, apathetic, feeling futile, feeling without worth in a world that is almost feeling the same way.

Addiction is but a single representation of what is happening in our colleges, what is happening in our peoples, what is happening in our ghetto.

We must begin to look for methods of speaking across what we call bridges. Let me explain that. We do not believe that people learn from someone who is here and someone is here. People only know you if you talk their way.

If you wish to talk to the black community I must talk to someone like Alton who in turn will translate for me.

I must speak to someone who is a bridge between one world and another world. In other words, I am not talking about all blacks, I am talking about the black who at this time is angry, who has never communicated with the white, who does not understand the white.

It becomes, in a sense, ridiculous to talk, of course, of transculture lines. I think this can best summed up by remembering our history books in which when Marie Antoinette was asked about the people not having bread she said give them cake.

I challenge you and ask the question why do we continue to give cake, why do we continue to use our terms and our concepts on people here who have not learned to respond?

We must begin to listen and to speak through bridges to people who will respond. For instance, let me give you an example of what happens in New York.

In New York we have a $1.2 million NIMH grant for the Lower East Side. This grant was given without an on-site visit. The Lower East Side is the most heavily serviced with voluntary agencies of any community in New York City.

The money was put where the private agencies and the private sector was functioning. It was put to establish a governmental program. Albeit perhaps to compete or albeit perhaps not to treat. Why are there no programs in Harlem? Why are there no programs in Hunts Point? Why does the Federal dollar go to compete with the private dollar?

These questions I bring to you only because this is what happens.

The facts are that unless there is a mandate to encourage the private sector we will have nothing but Government prisons, Government hospitals, and Government tradition.

Let me give you an example of the kind of thing that occurs in governmental medicine.

An NACC prisoner in shackles and chains became very agitated, broke both legs and an arm. He had to be transferred to Montview Hospital. He was in a cast up to his waist for 1 year and his arm was in a cast.

During this time, because of the rules, he had an around-the-clock guard. He had three guards at a cost of $24,000 of taxpayers' of New York. He could not move. That $24,000 could have treated 4,000 outpatients.

This one person did not need around-the-clock surveillance. We must again and again be good husbands of our money, of our attitude.

I think maybe, Jimmy, you could talk a bit about evaluation. Remember, $54 million in New York City for this year, not one single adolescent treatment bed in New York City.

If you had malaria in New York City and you had 25,000 malaria victims, would we say we have to wait until the budget could be redone?

I just don't understand the concept.

Mr. MURPHY. One of the things that has personally got me very uptight is the fact that we have the situation in New York which may be unique at this time but I think one that should never be duplicated anywhere else. That is on the local level, State level, and city level we have two agencies that deal with narcotics addiction.

Both of them are the funding umbrellas or funding agents for the private sector involved in the treatment of addiction in New York.

As I stop here it is excellent, the only problem is if I go a little bit further and say that they also maintain their own programs. Just from a normal point of view in order to maintain your own program and fund others it is almost an impossible thing to do unless done purely on a research level task to modify, try out new techniques of treatment and to compare demonstrated effectiveness of treatment.

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This has not been done in New York State. What has been done is huge custodial care program which I think is the best way to describe it, in which they pour in lots of money with very little results.

The thing that affects me most from the standpoint of evaluation is treatment. In many of the recent New York papers we have seen that cure or rehabilitation is no longer the accepted word but now due to, I would assume, many pressures, the word is now "control" whereby if you use heroin once a week, once a year, you are okay, you are controlled.

I have met very few heroin users who had to be hospitalized or incarcerated who were able to use it once a week or once a year.

Not only that, but I think once again we are addressing ourselves to the problem of the drug rather than the person. I think that a longtime ago the first thing that I saw, which in a sense gave me an attitude that lasted a long time, was watching the various cartoons on TV or the movies and all of a sudden the hero is in trouble and out of his pocket he pops a magic pill or pops a magic substance, swallows it. About the only thing he didn't do was inject it, and I think that may be coming shortly. This was how he solved all his problems.

So that I think we have to address ourselves really to the attitudes that we, as the people involved in the treatment and the people who need treatment, have to look for. What attitudes are we developing?

I think the need for evaluation from a treatment standpoint has to be broad but realistic. I don't think that we should sell ourselves or undersell the addict. I think one of the figures Dr. Densen-Gerber did not mention was among the 17 residents in the Odyssey program we estimated that they spent approximately $400,000 a year in drugs and for $400,000 a year they had to produce $1.2 million of stolen property a year. That was among 17.

So we are dealing with people in a sense that certainly can function if channeled in a proper direction.

We are also dealing with people who don't believe in anything. One of the things I was asked upon entering the program is what did I believe in.

It may sound rather ridiculous to say it, but I couldn't find a thing I believed in. I could start with myself. That was the last thing I believed in.

So I think we have to make broad criteria but at the same time make realistic criteria. You can't be a little bit pregnant. You can't use heroin once a week and not have many severe problems that not only in a sense make the problem worse for you or make the problem continue but also affect other people.

Heroin in a sense is one of the most infectious diseases we have among us at this time, heroin addiction. But I think the attitude which goes along with heroin addiction is what primarily has to be changed.

I think criteria should be set up, the main criteria being that the person be drug-free, that they be working and that they not be involved in any crime.

I think as a bare minimum this would have to be the criteria adopted for whatever program it may be with the exception of the methadone maintenance program where drug-free might be changed to "Under medical supervision drugs would be permitted."

In the way of evaluating programs insofar as dispensing funds I would tend to say that each program should be allowed to be as innovative and creative as possible.

What should be evaluated is the results based on the criteria which that particular program has. I think one of the things we have gotten involved in in New York amongst many programs is due to not only the lack of funds but also the pressure created by the public at this time regarding the problem is that we don't in a sense separate our own criteria for treatment or for completion of treatment.

I think from many standpoints insofar as developing an effective method of treatment we have to view many different types of criteria which each program uses.

I think one of the things that young people, if I might be brash enough to speak for young people at this time, are reacting to is fast, efficient and cheap ways of dealing with every problem.

I think in dealing in fast, efficient and cheap way one of the things that happens or one of the possible dangers is that people become numbers, people become statistics and they are no longer related in a sense to the people they are with, but solely for what they can produce.

I think in order to do this we have to include this within our overall evaluation or address ourselves to this particular aspect of the problem.

Dr. DENSEN-GERBER. I will say about the concept of attitude which is so important, one of the questions that was asked a prior witness was about Lexington and the jails and the fact of drugs and that we cannot keep them drug-free.

The answer came, well, we have to protect them and we cannot protect them in certain ways.

At Odyssey we protect no one. What you can do is guide, stimulate, you can provoke. The addicts must make the attitudinal changes, himself.

The whole traditional way of doing for is what people are actually against. We must help them to do for themselves.

This is not any official program that I know of. There are few programs which are based on encouraging dignity. Our entire concept of welfare aid, everything else, is actually I believe psychiatrically very damaging.

They do not help the person to gain dignity, to take charge of his own destiny. We are not encouraging our young people to do for themselves, to think for themselves, to be responsible.

We are getting only the nihilistic reactive anger of self-destruction, turning inward.

You spoke of Woodstock. Woodstock had no outer violence because the inner violence was so great. Man can only function if he is social. Drugs are antisocial in every sense of the word.

I think also we have not seen in our own experience that voluntary incarceration does any harm. Our great success is with the voluntary patient. Our greatest success is the ghetto. Our greatest success is keeping them in the ghetto.

The realities are that it is not the building, it is not the place, it is not the swimming pool. It is the human contact, it is dialog, it is the quality of the relationships, the interpersonal relationships, which train the child, which cure the patient and which will make a success.

You spoke also about education. Education is tremendously important but even education needs revamping. You talk about money in the medical schools. Belleview, where I trained, would not even hear of a drug program.

The realities are that New Jersey Medical College is the first. My question is who will train the doctors? Until we open our eyes and begin to think in new terms, we are really in difficulty.

My question is as to what new term, in what new ways we can all benefit.

I think we really have to look at the fact that we are a drug-taking Nation and we have the highest death rate.

Let me sum up with something that comes to me from the wall of the morgue, the reality is that I believe changes will come from the morgue, believe it or not, because with so many dying we will have to face the fact that this is with us.

Senator HUGHES. Dr. Densen-Gerber, we want to thank you very kindly for your testimony, and Mr. Murphy and Mr. Johnson. But the hour is growing late. Senator Williams and I have decided in the interest of concluding the testimony this morning that it would be better if we sent written questions to you than if we took the time at this point to ask them.

With your permission, we will leave the record open and submit written questions to you on the basis of your testimony or anything else we think may be pertinent to this particular legislation that we are dealing with.

We do want to thank you for coming down here and testifying.

Senator HUGHES. The Chair calls Mr. George B. Griffenhagen, assistant executive director for communications, American Pharmaceutical Association, and Secretary of National Coordinating Council on Drug Abuse Education and Information, Inc.

Mr. Griffenhagen, you may proceed with your testimony as you desire. As you note, the hour is getting late. You can handle it whichever way would be the best for you.

STATEMENT OF GEORGE B. GRIFFENHAGEN, ASSISTANT EXECUTIVE DIRECTOR FOR COMMUNICATIONS, AMERICAN PHARMACEUTICAL ASSOCIATION, AND SECRETARY OF NATIONAL COORDINATING COUNCIL ON DRUG ABUSE EDUCATION AND INFORMATION, INC.

Mr. GRIFFENHAGEN. Thank you, Mr. Chairman.

I am George B. Griffenhagen, registered California pharmacist, and assistant executive director for communications of the American Pharmaceutical Association and editor of the "Journal of the American Pharmaceutical Association."

I am also the founding president and current secretary of the National Coordinating Council on Drug Abuse Education and Information, Inc.

I appreciate the opportunity to appear before this special subcommittee of the U.S. Senate, and to specifically comment on the "Drug Abuse Prevention and Rehabilitation Act of 1969" (S. 1816) which was introduced by Senator Harrison A. Williams, Jr., of New Jersey, and others, on April 15, 1969.

I wish to emphasize that I am appearing here today as an individual, and not as an official representative of either the American Pharmaceutical Association or the National Coordinating Council on Drug Abuse Education and Information.

I feel that I might be more helpful to you by calling upon my experiences working with each organization, rather than to simply limit my remarks to those of one or the other organization.

Though I am not appearing on behalf of either organization, perhaps a brief word about each organization is in order. The American Pharmaceutical Association is the national professional society of pharmacists.

Its approximately 50,000 members are practicing pharmacists, pharmaceutical educators, pharmaceutical scientists, and pharmacy students.

APhA is deeply committed and already engaged in a variety of programs and activities toward bringing under control the growing abuse of dangerous drugs and other substances in this country.

More than 50,000 copies of our "Drug Abuse Education . . . A Guide for the Professions"—a copy of the second edition is available to each member of this committee—have been distributed through the country by APhA as well as by the National Institute of Mental Health and the Bureau of Narcotics and Dangerous Drugs.

We are now producing a slide resource kit on drug abuse education under contract with the Department of Justice, and APhA is sponsor of National Pharmacy Week, the observance of which this past October 5 to 11 was devoted exclusively to drug abuse education.

But perhaps our most important contribution in this area is the conception of the National Coordinating Council on Drug Abuse Education and Information, which grew out of a National Conference on Public Education in Drug Abuse sponsored jointly by the American Pharmaceutical Association and the Food and Drug Administration and held in Washington, D.C., January 10–11, 1968.

The council, consisting of national governmental, professional, educational, youth, service and religious organizations, was officially created on July 22, 1968, and on May 1, 1969, the council was incorporated under the District of Columbia Non-Profit Corporation Act "to facilitate education and information regarding drug abuse on a national scale."

On June 16, 1969, the National Coordinating Council received formal notification that it is exempt from Federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code.

In addition to voluntary contributions made by member organizations, the treasury was supplemented by a $50,000 2-year grant from the Thomas B. Fordham Foundation and smaller grants from the Smith Kline & French Foundation and the McGraw Foundation.

With prospects of contracts from Federal agencies and grants from other foundations, the council authorized the hiring of an executive director as well as establishing separate offices for the council.

On July 24, 1969, Peter G. Hammond, former senior legislative assistant to Senator Harrison A. Williams, Jr., of New Jersey, was selected as the council's executive director.

Assuming his position on September 1, 1969, the offices of the council were moved from the headquarters of the American Pharmaceutical Association—where they had been temporarily housed—to suite 1317, 1750 Pennsylvania Avenue NW., Washington, D.C. 20006.

The National Coordinating Council on Drug Abuse Education and Information, Inc., has thus been officially launched as an independent organization with 66 current member organizations, a list of which is supplied for use of the subcommittee. You see they go all the way from the American Legion to the Urban Coalition.

(The list referred to appears on p. 479.)

In opening these hearings on July 23, 1969, Chairman Harold E. Hughes stated:

> . . . we have a staggering responsibility. We dare not fail. The health approach—the business of treating desperately sick people, rehabilitating addicts, preventing the growth of drug abuse and alcoholism—has had a very low place on the totem pole of our public priorities. But let me tell you this. In the hearts of the people of the United States, these subjects have the highest priority that you can imagine.

Fortunately, the U.S. Congress now recognizes the magnitude of the problem. Dr. Stanley Yolles, Director of the National Institute of Mental Health, recently told this committee:

> A conservative estimate of the total involuntary social costs of narcotic drug abuse amounts to $541 million per year. Unfortunately, it is not possible to provide an accurate estimate of the total narcotic and nonnarcotic drug abuse cost to society.

But Dr. Yolles estimated:

> It is probably five times the narcotic drug estimates, hence in the range of $2 to $3 billion per year.

As evidence of congressional concern, over 40 bills have been introduced since January 3, 1969, sponsored by over 150 Senators and Representatives.

Bills now pending would increase Government expenditures in the area of drug abuse education and rehabilitation to $30 million in 1970, and about $1 billion over the next 5 years.

This seems a modest investment, if wisely spent, to counteract a cost to society of nearly 20 times that amount.

But greater coordination of drug abuse education efforts is essential to make maximum use of any expenditure of funds.

It has been our experience that there are now so many groups running in so many different directions that it is often producing at worst more confusion than help; and at best, much duplication of effort. The first place to start with coordination of drug abuse education seems to be at the governmental level.

Since the record appears to be already well documented with the fundamental needs for drug abuse prevention and rehabilitation, I wish to address myself in particular to title IV of S. 1816 entitled "Coordination of Drug Abuse Control Programs."

Senator Williams was kind enough to mention the fact in introducing his bill last April that I had convinced him, "that one of the biggest problems at the Federal level is one of coordination."

I should point out that my recommendation for Federal coordination is not a new idea. The President's Advisory Commission on Narcotic and Drug Abuse in its final report in 1963 recommended, "that

the President appoint a special assistant for narcotic and drug abuse from the White House staff to provide continuous advice and assistance in launching a coordinated attack."

The President's Advisory Commission went on to point out:

> There exists an Interdepartmental Committee on Narcotics established in 1951, consisting of the Attorney General and the Secretaries of State, Defense, the Treasury, and Health, Education, and Welfare. This Committee has met spasmodically since its inception. Its last report was on January 10, 1961—its first in five years. The Committee is apparently now moribund. The Special Assistant should consider revitalizing this Committee for . . . the coordination of interdepartmental activities.

Instead of following the recommendations of the 1963 President's Advisory Committee, Federal agencies have moved forward independently—each vying for its share of funds and authorization.

Many people think only in terms of NIMH and BNDD as having active roles in drug abuse prevention. The activities and programs of these two agencies are, of course, well known.

The NIMH programs were reported in considerable detail in the Congressional Record of April 23, 1969 (H3008–12), and a descriptive catalog of the current drug abuse information-education materials available from the National Institute of Mental Health is now available.

The Bureau of Narcotics and Dangerous Drugs has published a variety of educational pamphlets, funded a variety of research and educational programs and is conducting an interesting experiment right here in Washington, D.C., to involve the business community in drug abuse education.

The Food and Drug Administration long has been involved in research and education in developing public respect for drugs.

One of its most notable contracts was the drug education project conducted by Dr. Helen H. Nowlis, current president of the National Coordinating Council on Drug Abuse Education and Information, Inc.

The project resulted in the most useful book, "Drugs on the College Campus" (Anchor Books, 1968).

FDA's new color-illustrated book entitled "Drugs and Your Body," designed for intermediate school use, also is a most useful contribution.

The Office of Education has awarded contracts under the Education Professions Development Act to train ex-addicts as drug specialist counselor aides and contracts under the Elementary and Secondary Education Act to develop innovations in drug abuse education programs.

The Office of Juvenile Delinquency and Youth Development (HEW) received authorization to make grants under the Juvenile Delinquency Prevention and Control Act of 1968, and it is my understanding that the Secretary of Health, Education, and Welfare has directed this office to make drug abuse prevention its No. 1 priority.

The Department of Defense has developed a comprehensive drug abuse education program (as reported in the Sept. 9, 1969, issue of the Congressional Record) including distribution of 133,000 copies of a basic reference handbook entitled "Drug Abuse: Game Without Numbers," and distribution of 3½ million copies of a pamphlet entitled "Drugs and You."

The Navy, the Air Force, and the Office of Information for the Armed Forces have all produced useful films.

The Veterans' Administration Department of Medicine and Surgery created a staff for alcoholism and related disorders in 1967 "to promote rehabilitation of alcoholic and drug abuse patients," and in October 1969, they published "A Review of VA-Sponsored Research Projects and Published Articles on Alcoholism and Drug Abuse."

The Office of Economic Opportunity has been involved in drug abuse treatment, rehabilitation, and education programs practically since its creation in 1964, and on October 10, 1969, the Senate Committee on Labor and Public Welfare amended the Economic Opportunity Amendments of 1969 (S. 3016) to include "a new special emphasis program to rehabilitate drug addicts and abusers."

The amendment, if enacted by Congress, will authorize programs "to find solutions to prevent and treat all forms of drug addiction and drug abuse."

The amendments were adopted unanimously by this Senate committee.

The National Institute of Law Enforcement and Criminal Justice of the Department of Justice operates a Center for Crime Prevention and Rehabilitation which is very much involved in drug abuse prevention, particularly as it relates to narcotics.

And the National Academy of Science and National Research Council have long been involved in narcotic prevention and treatment programs. And I haven't even mentioned the roles of the Department of Labor, the Treasury Department, and other departments and agencies.

I do not wish to leave the impression that the variety of programs which I have mentioned are wasteful. We must spare no effort as we seek solution to the drug abuse problem. But, I am concerned with a lack of intergovernmental coordination in our efforts.

In recognition of this problem, the American Pharmaceutical Association at its annual meeting in May 1969, officially went on record stating that:

> If the Government does not consolidate its educational programs on the use and abuse of drugs in one agency, then some interagency committee *must* be established to provide a unified program.

Because so many governmental agencies are involved in drug abuse prevention, they have all been invited to membership in the National Coordinating Council and many of these agencies are current members of the Council.

But better intergovernmental coordination is needed—and it is needed now. Our council was faced with the problems resulting from a lack of intergovernmental coordination when we considered a proposal for a nationwide advertising campaign on drug abuse for submission to the advertising council.

Fortunately, through Charles B. Wilkinson, Special Consultant to the President, a joint proposal for an advertising campaign has been submitted and accepted by the advertising council.

The nationwide campaign will be coordinated under the direction of the White House, with one representative each from HEW, Justice, DOD, and our National Coordinating Council reviewing all material.

This is only one small step toward better intergovernmental coordination, however. Few of the bills that have been introduced so far have tackled this matter as forthrightly as Senator Williams has in S. 1816.

When Dr. Nowlis and I appeared before the House Select Subcommittee on Education, we recommended that the "Drug Abuse Education Act of 1969" be modified so that all governmental departments and agencies involved in drug abuse education be brought together as a working body.

Fortunately, the bill as reported out by the committee, and passed by the House only last Friday, October 31, provides for an "Interagency Coordinating Council on Drug Abuse Education."

Even though the Secretary of Health, Education, and Welfare "may from time to time designate such other departments and agencies having a substantial interest in the field of drug abuse education" to serve on the Interagency Coordinating Council, only HEW, Justice, NIMH, and the Office of Education are specifically identified in the bill (H.R. 14252).

A council that "shall advise in the coordination of the respective activities of (all) Federal departments and agencies concerned in drug abuse" as described in H.R. 14252 should in my opinion be more specifically detailed as to composition.

Senator Hatfield introduced a companion bill to the "Drug Abuse Education Act of 1969" on October 9 (as S. 3015 which now has the same language as H.R. 14252, as passed by the House).

Senator Hatfield's bill has been referred to the Senate Committee on Labor and Welfare. Assuming that this subcommittee will (or already has) received the "Drug Abuse Education Act of 1969," hopefully, Mr. Chairman, you and your committee will see the wisdom of incorporating Senator William's proposal (title IV of S. 1816) in any and all legislation involving drug abuse prevention, whether it be increased research, improved education, expanded treatment and rehabilitation programs, or this much needed area of counseling and referral services.

I would only hope that the title of the Interagency Council as incorporated into the Meeds bill would be retained.

By establishing a Federal Interagency Coordinating Council that could work with State and local government counterparts, as well as with the private sector, including the National Coordinating Council on Drug Abuse Education and Information, Congress would finally be adopting a recommendation made exactly 6 years ago by the President's Commission on Narcotic and Drug Abuse.

On this seven-man President's Commission was Dr. Roger O. Egeberg, and consultants and advisers to the Commission included the Director of NIMH; the Commissioner of FDA; the Commissioner of the Bureau of Narcotics; Commissioner, Federal Bureau of Customs; Director, Federal Bureau of Prisons; and the Executive Secretary, Committee on Drug Addiction, National Research Council-National Academy of Sciences.

The 1963 Presidential Commission conclude their report with this advice:

> The Commission is mindful that control of the drug abuse problem is a most difficult matter * * * We lack considerable knowledge about the causes of drug abuse and how to treat it * * * The Commission has set forth a comprehensive program of Federal action on drug abuse (and) it can make this contribution by adopting the recommendations contained in this (1963) report.

Many of the recommendations of the 1963 Commission report have been implemented, but its very first recommendation (that is the coordination of Federal programs by the White House) remains to be fully implemented. Implementation of this by giving full consideration to Senator Williams' proposal is, in my personal opinion, essential.

Thank you, Mr. Chairman.

Senator HUGHES. Thank you very much for your testimony. Senator Williams, do you have some questions?

Senator WILLIAMS. Well, for more reasons than just the conclusion you stated, I find your statement most helpful, particularly in its breadth, in its description of the breadth of attention, the scattered attention to the whole responsibility of dealing with the problem of drugs. It was an excellent statement. I appreciate it.

Mr. GRIFFENHAGEN. Thank you, Senator Williams.

Senator HUGHES. I would like to ask a couple of questions, primarily to fill in information which you have in your testimony.

On page 7, the first paragraph on the page:

> The Veterans' Administration's Department of Medicine and Surgery created a Staff for Alcoholism and Related Disorders in 1967 to promote rehabilitation of alcoholic and drug abuse patients, and in October 1969, they published "A Review of VA Sponsored Research Projects and Published Articles on Alcoholism and Drug Abuse."

I have found with this subcommittee that really in the veterans hospitals in this country there is damn little being done for either one. They may be publishing materials and programs but I think that primarily what they have been dedicating themselves to is writing about it.

They have six or seven alcoholism programs in the country in various hospitals, yet they concede 1 of every 6 beds in the VA hospitals is filled with an alcoholic.

This does not look like a minor problem. It looks like probably the major problem they face as a single problem.

In drug abuse I have had no testimony that they are doing much of anything.

Do you have different information?

Mr. GRIFFENHAGEN. Only the information that has been supplied by the Veterans' Administration and through this very current publication, Mr. Chairman.

Senator HUGHES. I have also found other current publications by agencies of Government that set out programs, that say how you do this and what we are going to do, and when you question the people about the programs they are doing nothing.

Do you have any information that in any of these instances you mentioned something is being done other than writing a program?

Mr. GRIFFENHAGEN. Yes, a number of them, Mr. Chairman. The Department of Defense program, for example——

Senator HUGHES. Tell me about that one. What are they doing?

Mr. GRIFFENHAGEN. Pardon?

Senator HUGHES. Tell me about it. What are they doing?

Mr. GRIFFENHAGEN. On page 6 of my testimony I summarized, but I omitted because of time, reference to the September 9, 1969, issue of

the Congressional Record which says DOD has distributed 133,000 copies of a basic reference handbook entitled "Drug Abuse: Game Without Numbers," and distributed 3½ million copies of a pamphlet entitled "Drugs and You."

The Navy, Air Force, and Office of Information of the Armed Forces have produced useful films and in the September 9 Congressional Record there are some three or four pages of information on other programs.

They do have an Interdepartmental Defense Committee, by the way, with representatives from the Army, the Navy, the Air Force, all serving on this interdepartmental committee.

Senator HUGHES. Have you ever done any research to see who got these copies and what they did with them after they got them?

Mr. GRIFFENHAGEN. No, but I wish somebody would do more research into what all the various agencies in the Government are doing or claiming to do.

It seems to me that one of the most important first steps is to find out what every department and what every single agency in the Government is doing in this area of drug abuse prevention.

Senator HUGHES. A nice way to get rid of a problem is to print up a couple hundred thousand pamphlets and distribute them and then do nothing else and then write a nice report about the distribution of the pamphlets and about how well, you know, we are reaching the people with the program.

If we are reaching someone I would like to find out who and how. We keep quoting these great programs we have that are doing so much.

I am willing to be convinced if someone will come over here from the Department of Defense and convince me.

Mr. GRIFFENHAGEN. Mr. Chairman, I think I can speak on behalf of the National Coordinating Council of Drug Abuse Education and Information that if we had some funds, the National Coordinating Council would be very happy to undertake a survey of all of the programs that are claimed and actually in operation and even undertake an evaluation of the program that are being undertaken or claimed to be undertaken by various departments and agencies of the Federal Government.

Senator HUGHES. I would like to ask you a question and it is unrelated to your testimony that you gave here today, Mr. Griffenhagen, but it has come up in testimony repeatedly before this committee and other committees: we have had numerous statements of the fact that pharamaceutical companies are manufacturing great quantities of drugs that are being shipped supposedly into Mexico and then back into the United States in the black market, much of it not even going out of the country but being turned around and coming back.

What is your association doing about that?

Mr. GRIFFENHAGEN. First of all, the American Pharmaceutical Association is a professional society of pharmacists and not to be confused with the manufacturing association.

Senator HUGHES. Do you think you have an interest in the manufacturing association?

Mr. GRIFFENHAGEN. We have an interest in the distribution of drugs to the general public. We have a very great concern in this particular problem that you spoke of. A great deal of effort has gone into establishing controls over the manufacture of drugs.

A great deal of emphasis has gone into the control on the ultimate distribution, the dispensing of dangerous drugs on prescription through the pharmacies of the United States to the general public. Not enough emphasis has gone into this middle area of shipment from the manufacturer to the ultimate dispenser of the drugs to the public, whether it be community pharmacy or a hospital pharmacy.

There are many, many examples of areas where not only are the drugs being shipped outside the United States and then shipped back into the United States but there are examples of where drugs are shipped by mail within the United States. Someone simply signs his name "M.D." on an order and ships to some manufacturer and he will receive 10,000 amphetamine tablets or 10,000 barbiturate tablets and these go into illicit channels.

I think a great deal more concern needs to be given to this area of mail, not only a prohibition of mail distribution from the manufacturer to the pharmacy, the wholesaler, or the physician but perhaps even mail order prohibition of prescription medication from a pharmacy to the general public.

Senator HUGHES. Do you think it would be possible, and again I think this is an area of concern more related to the last question of yours, to develop nationally an identification procedure for every individual?

We use the social security number in a lot of ways and through the computer systems we are gradually cross-indexing and licensing everything we are doing, even on a State level, so that you get an application one place, you just cross-index it, you check it against other places to see what they are doing.

I am talking about identification of purchases of prescription drugs and narcotics which is certainly a primary concern to the people you represent today and the identity of the person actually buying, forgery or whatever it may be, refilling of prescriptions, the telephone prescription procedure, and so on.

Much of this is necessary in order to be able to take care of patients that actually need drugs and need them hurriedly and may be somewhere else and they have to do it on call.

Have you done any research in the area of national identification, one time, lifetime identification of an individual?

Mr. GRIFFENHAGEN. Yes, Mr. Chairman. The Department of Health, Education, and Welfare has just released the National Drug Code Directory, which has established a numbering system as a precise identification code for the drugs themselves.

There certainly is no reason in my mind why a similar type of system could not be established for the manufacturer, for the wholesaler, for the physician, for the pharmacist, for every step along the lines of legal distribution.

Now the Food and Drug Administration does have a registration system for the manufacturers of all drugs including amphetamines and barbiturates. I think this needs to be expanded. I think your suggestion is an excellent one.

Senator HUGHES. I think it works two ways. You look at diabetes or hypertension or any one of the half dozen very common things. People may live for 20, 30, 40 years in need of constant medication, of yearly checks for side effects in a hospital someplace.

Yet they find themselves traveling with great difficulty. For example, they may have forgotten their needs, they may find themselves a thousand miles from home unable to fill a prescription.

It would be a difficult situation even with the airplane, you can't get it mailed to you many times.

I should think it would be possible to devise a means whereby a person could be issued this type of medication, something that could be identified nationwide or they could make a limited purchase.

Mr. GRIFFENHAGEN. This is what this National Drug Code number is intended to do, to simplify the third party insurance payment programs, the ordering of drugs, the identification in case of accidental poisoning, to establish data processing retrieval systems for drug interactions, contraindications, and adverse side reactions of drugs.

The National Drug Code Directory was just issued within the past several weeks. Again, I think your suggestion of now going into the area of a similar type of code systems for everybody in the legitimate distribution channels would be a most helpful one.

We do have the problem, however whether it is by name or by numbers, to make sure that any transaction that takes place from the manufacturer to the ultimate user is a legitimate one and does not get into the illegal market.

Senator HUGHES. I think primarily my concern here is that the legitimate users of these substances are being placed in more difficulty than the illegitimate users in some instances.

It becomes more and more difficult for the legitimate user who has no other way and would not know where to go if he wanted to.

I don't want to abandon that in the process of trying to tighten screws on everything else that we need to take care of, the legitimate needs of people who may die, go into a state of shock of may suffer greatly if they are unable to meet their needs at some particular location at some particular time.

I happen to be one of those people. That is why I am concerned about it. Because I have left home without thinking to take along what I had to have with the particular problem I have, a medical problem.

Mr. GRIFFENHAGEN. We couldn't agree with you more, Mr. Chairman.

Senator HUGHES. You have choices, you have to find a doctor your doctor knows or get on the phone and get something flown to you or something or else go home.

Mr. GRIFFENHAGEN. I could not agree with you more. The American Pharmaceutical Association did submit testimony within the past several weeks to Senator Dodd's committee on the legislation which they are considering.

I think the whole thrust of our testimony was right along the lines you have expressed.

Senator HUGHES. I think that as we pursue the needs of trying to educate, and to establish recovery programs we don't want to get entirely out of focus the legitimate uses of all these substances that have extended life, that have made life bearable and have actually been such a great improvement in everything from mental health to diabetes. Undoubtedly, it is going to open other doors in the field of alcoholism and perhaps some day in the field of narcotics addiction.

Whether there is an imbalance that may result in this type of thing we don't know yet.

We don't want to get all out of balance and think it is all evil. It is not all evil. We want to keep it in balance legitimately and for what good it does.

I want to thank you very much for your testimony today. Again, I would like to leave the record open, if I might, to submit some questions to you at a later time by my staff or myself or Senator Williams.

Thank you very much.

Mr. GRIFFENHAGEN. Thank you, Mr. Chairman, and thank you, Senator Williams.

(Whereupon, at 12:35 p.m. the subcommittee recessed, to reconvene subject to call of the Chair.)

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

MONDAY, JANUARY 26, 1970

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS,
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Cherry Hill, N.J.

The subcommittee met at 10 a.m., pursuant to call, at Kenney's Suburban House, Ellisburg Circle, Route 70, Cherry Hill, N.J., Senator Harrison A. Williams, Jr., presiding.

Present: Senator Williams.

Senator WILLIAMS. I would like to open with a short statement that generally frames the concern of our Nation as it is expressed through the Congress of the United States and specifically as it is focused through the Senate Subcommittee on Alcoholism and Narcotics.

OPENING STATEMENT

The problem of drug abuse has finally gained the nationwide attention it must have if we are to begin to take the necessary steps to prevent drug abuse and if we are to rehabilitate the drug abuser.

Last April, I introduced in the Senate the first Drug Abuse Prevention and Rehabilitation Act. In order to direct special focus on this issue, the Senate's Labor and Public Welfare Committee organized a Special Subcommittee on Alcoholism and Narcotics. The subcommittee has held hearings in Washington, in New York, Colorado, California, and now in New Jersey.

These hearings have a twofold purpose. First, we in Congress must learn whatever we can about the problems of drug abuse, not only from the physicians, educators, and public officials but, more importantly, from those who have been there—from the former drug abuser. Secondly, we must direct the public's attention to both the magnitude of the problem and how close to home it may strike.

One of man's most important discoveries was the realization that he could heal his wounds and cure his illnesses with chemical substances and compounds. He took this realization into the laboratories and clinics, and what came out was the harbinger of our modern medical miracles.

Man created pills.

The pioneers of the American frontier had pills, salts, and oils when they moved west. The apothecary shop was a fixture on colonial main street. American medicine matured as doctors learned to harness the

power of the pill and make it work for good health. We learned how to use pills and liquids to heal tissue, kill pain, stop unwanted bleeding, reduce pressure, and otherwise improve the body's functions.

Unfortunately, modern Americans tend to abuse the privilege of the pill. Housewives take sedatives, sleeping pills, and, of course, "the pill." Truckdrivers take pills to stay awake on the long overnight hauls. Students take pills to pep them up and keep them awake as they cram for exams. All of us turn to aspirin, vitamins, and other "beneficial" pills. Advertisers tell us that we can relieve tension, end acid indigestion, restore youth and sex appeal with pills—so we buy more pills.

The national average is an incredible 29.5 drugs per medicine cabinet.

Most—if not all—of this pill taking is legitimate and often helpful. What is appalling is the fact that our willingness to "pop a pill" has, in turn, prompted a national frenzy in illegal drugs, addictive substances, and possibly fatal experimentation with "the stuff." We face the prospect of a coast-to-coast catastrophe—a drugged society.

Evidence of the mounting crisis in drug abuse is all around us: Some authorities say that 30 percent of college students have tried marihuana at least once; that 400,000 Americans may be using it regularly. The New York Times recently estimated that 100 million Americans use some form of mind-altering drugs, including excessive alcohol, amphetamines, barbiturates, and tranquilizers. In 1967, 61,792 drug arrests were made in California alone for illegal use of drugs.

One often hears that there are more than 50,000 heroin addicts in the United States, but—that only reflects the number reported to the Government. In New York City alone, estimates on the number of heroin addicts run from 30,000 to 100,000—"depending on who is keeping score."

Last year, 5 million "5-grain units" of illicit drugs were seized at borders and ports of entry in our country. The total weight of all drugs confiscated for the year—including marihuana—hit 35 tons. The costs run from a "nickel" bag of marihuana for $5 to as high as $50,000 for a point of heroin. It has been calculated that New York City's addicts must raise from $500,000 to $700,000 per day to support their habit. To do so, many turn to robbery, shoplifting, burglary, forgery, and prostitution.

Although these figures are important, particularly as they relate to escalating problems of crime and health, we too often concentrate on the statistics and forget the people. The human cost is more staggering and more tragic. Drug abusers seldom live successful lives—by their own standards or anybody else's. Over a period of time, they lose interest in schools, jobs, and family.

Drug abusers have few friends who are not also on drugs. They simply have neither the time nor the energy to keep up normal social contracts. Their only purpose becomes the search for enough drugs to keep "high" and to duck the agony of being suddenly deprived of drug support.

There is no doubt that the abuser deprived of drugs suffers greatly. But the worst of it is that whether "high" or looking for his next

"kick"—he has lost control of his life. He has given up the power to decide and to act—the very things that make him a human being.

At what point do you lose control? No one knows. But the worst mistake is to assume you can stop once you start. There is probably not one drug abuser alive—or dead—who did not say, "I won't get 'hooked.' It can't happen to me." It can—and it does.

My bill will provide for the establishment, development, and maintenance of prevention, treatment, and rehabilitation centers for drug addicts and drug abusers. It will encourage drug abuse education curriculum programs for students of medicine, psychology, psychiatry, sociology, and other related fields; and it will strengthen the coordination of drug abuse control programs by establishing a national council on drug abuse control.

As everybody here knows, while the Senate of the United States is focused here today on drug abuse and an understanding of the needs for rehabilitation and prevention, in Washington today, it is focused on legislation which is being considered and probably will be voted on.

One of the important provisions in the drug bill now pending on the Senate floor, which deals basically with the criminal aspects of the use of drugs, is a provision that would reduce the criminal penalities for those who are found to be in possession of marijuana, heroin, and other drugs; reducing the criminal sanctions there, but increasing the criminal sanction for those whose job is morally heinous, those who are the pushers, the sellers, the distributors of the dangerous, most dangerous drugs.

We will proceed now with the hearing schedule. Mr. Richard Russo, who is director of the New Jersey Bureau of Drug Abuse and Narcotics Addiction, will be our first witness.

Mr. Russo, we certainly appreciate your experience, knowledge, and wisdom being brought to our deliberations here today. You are the director of the New Jersey Bureau of Drug Abuse and Narcotics Addiction.

STATEMENT OF RICHARD RUSSO, CHIEF, NEW JERSEY STATE BUREAU OF NARCOTICS ADDICTION AND DRUG ABUSE

Mr. Russo. I would like to correct that one statement, Senator. It is a peculiar title, but I am chief of the Bureau of Narcotics Addiction and Drug Abuse. It is backwards from what you indicated.

It is a real pleasure for me to be here today and to speak very briefly about the problems as we see them in the State of New Jersey. I would like to present a very brief survey today of the drug dependency problem or the drug scene as we see it in New Jersey from what I would consider our vantage point. I would like to discuss briefly, if I may, in three sections or three phases the extent of the problem, what is New Jersey doing about the problem, which, of course, would lead into the third phase, which is our needs.

Drug abuse in New Jersey is no longer a species which is exclusively indigenous to the urban ghetto, as we thought several years ago. It has taken roots in the suburbs, in the intellectual and academic communities. It is a social affliction that has become more difficult to handle because of a contemporary mood of permissiveness in our society.

The drug abuse problem is not unique to any single segment of our society in New Jersey nor is it restricted to any particular locale. There are no boundaries. The problem affects affluent as well as the disadvantaged youths, the student as well as the dropout, and it is prevalent in the ghettos, suburbs, college campuses, high school campuses, and so forth. It has attracted an articulate body of thinkers that have sprung to its defense, something which it never had before.

This disturbing spread of drug abuse has been demonstrated and there is growing concern among people like yourselves and people like myself to do something about it.

You are probably aware that we do not have figures in New Jersey and we cannot tell you accurately the number of individuals who are drug-dependent. We do know the number of convicted narcotic offenders. These are individuals who are convicted of narcotic crimes, and these are reported by the local police through the State police reporting system, and they are available.

There are some 6,000 narcotic convicted offenders in our State. But you will probably hear later today, if you have not already heard, from some of the ex-addicts speaking to you that for every known addict there are probably 5, 10, 15, or 20 others that have not come to the surface. Therefore, if you wanted to use a medium figure, say, for every known addict there might be 10 unknown addicts, addicts that have not come to the surface at this particular time; we might be talking about a number in excess of 50,000 in the State of New Jersey.

The Federal Bureau of Narcotics and Dangerous Drugs in Washington tells us that New York has half of the addicts in the country. They tell us that California, Illinois, and New Jersey comprise the second largest concentration.

One must keep in mind, when talking about addicts statistics, that their accuracy depends on four criteria: One, the registry or reporting system, if any exists at all; two, the special training to detect the abuse by the contact agencies, whether it be the law enforcement, the courts, medical, and volunteers; and three, the cooperation of the contact agencies to report; and, four, the interpretation, evaluation, and the projection of the available statistics.

I would like to go on, if I may, to briefly describe section 2 of what I mentioned a few seconds ago: "What is New Jersey doing about the problem?" Before I do, however, I would like to paint, if I may, a panoramic picture or develop a common frame of reference around the universe of drug dependency in our society.

Let us look at drug dependency, if we may for a second, as a huge, big triangle with equal sides. The triangle has equal sides, and each side is dependent on the other two sides, and yet no single side is totally independent. If we look at this huge triangle, one side of the triangle we can identify as enforcement. I think that enforcement in the State of New Jersey has done a tremendous job with the resources at hand.

However, I further believe that they need additional help to stop the contraband movement of drugs. I further believe that enforcement alone will never stop the contraband movement of drugs. But I do think that in our society and in New Jersey we have to give additional support to the side of the triangle which I identified as enforcement.

I am going to leave that side of our triangle now and go to the second side of our triangle, which I am more directly involved in, and that is the treatment or rehabilitation side of our triangle of drug dependency universe. In New Jersey, like many States, we have a number of programs and activities, all of which fall within three major treatment modalities or three major treatment methods. Those three major treatment methods again are not totally exclusive, but let me identify them for you.

There is the psychiatric method of treatment, the counseling type—professional counseling type of treatment, No. 1. No. 2, the chemotherapeutic or the drug replacement kind of treatment which we are trying to accomplish in the State of New Jersey, and many other States are trying also. This is replacing one drug for another drug.

The third kind of treatment is the therapeutic community concept, which utilizes the reality therapy, the ex-addict oriented program.

We have, as I mentioned, in New Jersey all three of these modalities.

I would like just for a second to very briefly go through some of the programs which New Jersey has in these three modalities. There is a therapeutic community which operates in Jersey City, better known as Liberty Village, which has approximately a 225-bed capacity, which has four or five outreach centers either in operation or contemplated to be in operation in the not too distant future.

In Jersey City, there is an outreach center; in Union City; there will be one or two probably in Newark, in Asbury Park, and so on.

The department of institutions and agencies, the department with which I am presently associated, has a 76-bed unit at the Neuropsychiatric Institute in Skillman. This is inpatient detoxification. It is also the center for the State's chemotherapeutic or drug replacement program, better known to most of you as a methadone program.

The NPI unit also has an application clinic in Newark as an application method or station.

We began just January 1 of this year a 32-bed inpatient therapeutic community program at the Marlboro State Hospital, which is not totally functioning yet, which does not have any residents, but we are beginning to build a staff.

In the bureau with which I am associated, we assist in developing county clinics and a fiscal mechanism is established by law whereby the State provides 75 percent of the salaries for these clinics and the county board of freeholders provide 25 percent of the salaries and other costs such as heat, light, and rent, and so forth.

These aftercare facilities are developing throughout the State, not as rapidly as we would like but we do have either programs operating or commitments from counties to operate aftercare clinic programs in Union County, in Bergen County, in Middlesex County, Morris County, Passaic County, Essex County, Mercer County, Burlington County, and in Camden County.

I want to say that all of these are not operating at present but we have commitments for operation of these hopefully within the not too distant future.

The New Jersey College of Medicine and Dentistry is running an interesting program primarily for the model cities area of Newark, which involves an inpatient detoxification unit, which involves transferring of patients to several other private agencies in the Newark area for treatment.

They are also developing a narcotic registry for the Newark area. They are developing educational courses in the schools and for the medical students within their jurisdiction. They are developing an outreach clinic in the Newark area and they are also developing an extramural evaluations program which I believe is most important.

The agencies I have mentioned up to this point are all official governmental agencies.

I want to mention a few private, nongovernmental agencies, which may be receiving some Federal support or may not, but primarily functioning with nongovernmental money, nongovernmental funds. There is Newell, which has a center in Newark and one in Passaic. There is a Narcotic Addicts Rehabilitation Center Organization, better known as NARCO, which operates in Atlantic City. There is a Drug Addiction Rehabilitation Enterprise, better known as DARE, which operates in Newark and Island Heights.

There is Mount Carmel Guild, which operates in Newark, St. Dismas Rehabilitation Center, which operates in Paterson; Integrity, which operates in Newark; Odyssey House, which is operating in Newark.

There may be other agencies that have developed within the last 2 or 3 weeks—they develop rapidly—which I have not mentioned, but these are, I believe, by and large, the treatment and rehabilitation agencies in the State of New Jersey.

Let me say that although when I review this list, it may seem long and it may seem effective, we definitely do not have nearly the resources that we need to treat the number of people that we believe need treatment in this State. We definitely need additional manpower, additional funds to support all of these agencies, and, as an example, the one I mentioned first, Liberty Village, the next fiscal year, will probably need substantial amounts of money in order to perpetuate their program.

The Neuropsychiatric Institute, involved in the methadone maintenance program, definitely needs additional funds and staffing. Methadone is one of the modalities that has to be perpetuated and probably should be increased to handle the certain few addicts, hard-core addicts that should be placed on methadone.

Without going to each one, I know the Medical School of New Jersey next year, next fiscal year, will be in some difficulty unless they can come forth with some additional resources.

We strongly believe that all the treatment modalities I briefly mentioned are essential at this time in order to reach the variety of different drug dependent people. When I say "drug dependent people," I am speaking of the experimenter, the soft or hard drug user; you know them as well as I.

There is no monolithic approach to this problem. We therefore recognize and support all of the treatment approaches within the boundaries of New Jersey. We must provide guidance, direction, and leadership to all. We must also develop a strong extramural evaluation program in order that in subsequent years we will be in a much better position than we are today to identify perhaps certain programs as being most effective for certain addicts or drug dependent people.

Allow me to, if I may—I spent more time than I wanted to on the second part of the triangle, which was treatment and rehabilitation—I would like to go to the third portion of the triangle, which completes the universe of drug dependency as we see it.

This is preventive education. We have probably done the least in the area of preventive education. We have probably spent fewer dollars, fewer man-hours in preventive education than we have in the other two areas, and I don't mean to infer that enforcement and treatment should be reduced in size and scope. Enforcement and treatment should be increased, but we must begin to develop throughout the entire State of New Jersey concrete, positive preventive education. Programs to enforce and to treat without becoming involved in preventive education seem somewhat ridiculous. We have only scratched the surface in the preventive education area. We must concentrate very strongly in this area in the not too distant future, hopefully very, very soon.

In the department of education, the medical schools of New Jersey, our own department and institutional agency, we have begun and only begun to scratch the surface in these areas, and if we need support in any one of these three areas right now, I think it is in preventive education.

Our needs are tremendous. They are almost overwhelming.

Perhaps it is because of my bias, having been trained in the field of public health, that I find the public health concept of prevention as most appropriate at this particular time. Let me define what I consider the public health concept of prevention. It encompasses three major areas: primary prevention, which is education; information; and training.

A second concept of prevention is case findings, identification, and control. Tertiary prevention is treatment and rehabilitation. Every individual that you treat and you rehabilitate is not going to coerce 10 other individuals to go on the drugs, so therefore that is very definitely involved in the total prevention picture.

An effective prevention program encompasses all three sides of the triangle which I spoke to you about very briefly this morning. We must begin now.

In conclusion, I think in New Jersey, Senator, our needs can best be summed up in the brief statement in your legislation, S. 1816, which I believe you referred to earlier; because drug abuse and addiction is increasing, there is a lack of adequate facilities to prevent drug abuse. We must rehabilitate those who seek and need treatment. There is a lack of authoritative information and creative projects directed to educate people, so that we need very, very definitely what is identified in the title, the findings and the purpose of your legislation.

I would like to close, Senator, by quoting from Edmund Burke, who, two centuries ago, said: "The only thing necessary for the triumph of evil is for good men to do nothing."

We are good men. The evil is drug dependency. I think our charge is crystal clear.

Thank you very much.

Senator WILLIAMS. Thank you very much, Mr. Russo. Many questions come to my mind. We very much appreciate the broad and comprehensive sweep of the situation as it is in New Jersey. I would

like to move on with the next witness that is before the committee but would hope you can stay and perhaps we can discuss specific matters which you talked about later. Certainly it would be interesting to know just how your division gears up at the beginning of the year with requests to the executive for support for the various programs associated with the triangle that you so clearly described so we would get an idea of the resources that you feel are needed from the people of the State through their government. But I believe it might be most efficient to get on to the other witnesses now and we can come back to you.

Mr. Russo. Thank you, Mr. Chairman.

Senator Williams. Our next witness is Dr. Charles E. Brimm, who is a Camden doctor.

Dr. Brimm, we know of your work in the Camden area. You are a doctor meeting the needs of this community in the area of drug addiction. Your experience is essential to our further understanding; for further action through our work here on the Senate subcommittee.

STATEMENT OF CHARLES E. BRIMM, M.D., CAMDEN, N.J.

Dr. Brimm. Thank you, sir.

When one speaks of "drug abuse," we usually apply this term to either misuse or illicit use of the drugs. This application is usually for both the misuse and illicit use.

Senator, the drugs we are speaking about are either classified as narcotic or dangerous drugs, and this is a group we have been working with here in the county.

There are two basic questions that we have to ask ourselves before we go into a program like this. One is: "Who is the addict; what is the addict or the drug abuser?"

The sociologists speak of assimilation into specifics, into special life styles of great drugtaking, while medically we speak of a group of people or group of users who have a physical dependence, psychological dependence, and tolerance toward this group of drugs. Literally, one speaks of habitual use and effects of detrimental threats of an individual which are potentially harmful to morale, public morale, safety, health, and welfare.

Concerning the drug addict, in reference to physical and psychological dependence, one should note that a person may be physically dependent on a substance not considered a part of the drug problem. A very good example of this would be the people who are dependent on alcohol. One can also become emotionally dependent in many cases on drugs not listed as habit-forming but these substances may affect one's consciousness, such as substances used to escape from reality, or adjustment toward simple pleasures and these are the tranquilizer drugs.

Medically, before we start treating the addict or working with the addict, we have to think of certain legal aspects of it and what does the law say on the rights of the physician to prescribe or administer narcotic drugs to narcotic addicts. This question raises quite an issue, which has been warmly debated.

How and by whom is the concept of legitimate medical practice defined? Does legitimate medical practice mean the same as the practice

accepted and followed by the majority of the doctors in the community or of that by official spokesmen of the medical practice? If so and if there are adverse legal consequences attending departure from medical practice, how can new ideas or new techniques safely be developed?

The American Medical Association, together with the National Research Council of the National Academy of Science have adopted and issued several statements concerning use of narcotics in medical practice. They state that continued administration of drugs for the maintenance of addiction is not a bona fide attempt to cure. In other words, withdrawal of the drug must be accomplished before rehabilitation phases of treatment can begin.

Withdrawal is most easily carried out in a drug-free environment or specialized ward, an installation for narcotic addicts. Under certain circumstances withdrawal must be carried out in other agencies or institutions. They do believe that it is ethical to administer maintenance doses of the new drug methadone, which is a synthetic narcotic, to an addict who is awaiting admission to narcotic facilities and to administer limited doses to an addict in the process of withdrawal.

This is a program which we instituted last year when we became involved with Camden County and with Father Walsh.

In our work with addicts, we find they usually voluntarily come in for treatment because of one or another of four reasons.

First, the addict may come to the center to beat a rap. This addict is usually under the threat of being sentenced or placed in a correctional institution and has the choice of either receiving treatment or serving sentence. Most of these addicts prefer to take treatment rather than take the sentence.

The second group that we meet come in merely to reduce the size of the habit. We find these addicts over a course of time increase their tolerance load for the drug and, therefore, the habit is becoming extremely costly. Frequently, they find they can no longer obtain money to support the habit and, therefore, desire to reduce intake, thus they come to the clinic to reduce the habit so they can again rehabilitate at a lower level of usage.

The third group we find come because they no longer get the desire for a thrill or, as they call it, the addicts say, they no longer "take off." Usually we find with these addicts their veins are collapsed so they are no longer mainliners. These are the addicts who are giving themselves drugs intermuscularly.

The fourth group is the group that honestly desire to kick the habit and this is the group that we find that we have the best results and the most success. Nevertheless, as physicians I don't think we should disregard any group in trying to attack the problem.

In all four of the previous listed groups we find three common denominators. There is the element which we call the addictive personality, for the lack of a better word. We find there must be a situation or proper circumstance for the drug, for use of the drug, and, third, we find there must be the availability of the drug.

Without any one of these three elements, one can easily see how difficult it would be to become an addict.

The question now arises: "Should an addictive personality be interpreted as the cause of addiction or is it a consequence of addiction?"

At the present time no definite answer can be given. Dole and Neiswanner, who are the physicians in New York working on the methadone program, believe that through the evidence that they have secured with the methadone maintenance treatment with the blocking agents, that this trait or addictive personality is really a consequence of addiction and not a cause.

This can be demonstrated by a substantial number of addicts who have been rehabilitated on a medical program using methadone.

Other workers in different areas state just the opposite and they believe that the trait or addictive personality is really the cause for addiction and that this addictive personality must have the desire for the addict to meet the need for escape from reality.

In our experience, we find addiction is a symptom of personality maladjustment, although at the present time we have not been able to identify any typical addictive personality. Our work with the addicts has been quite diversified in that we have been able to work with many addicts from suburban and middle-class areas and also with addicts from the low-income urban areas.

We have found that one of the unusual things is that they have a common denominator as far as the "cop out" is concerned. A good example of this is, they had a middle-income young addict from the suburbs who was quite intellectual and after several sessions with him, before he was to go to Stillman to finish detoxification, he came out and said, "Doc, really the whole problem is based on our society today. We have a schizophrenic society."

So you can see he is quite an intellectual fellow. So he says, "Society verbalizes in one direction while at the same time acting in another almost in an opposite direction."

Later on in the program we ran into a chap from the ghetto and he said basically the same thing, but with a different verbiage. He said, "Doc, it is based on the thing. They are doing nothing but shucking and jiving."

Senator WILLIAMS. Did you understand it when he said it?

Dr. BRIMM. Yes, I did because the area from which he is from is the area I grew up in and practiced in and worked in.

Senator WILLIAMS. I guess what I really mean is what does "shucking and jiving" mean?

Dr. BRIMM. He meant that society merely was saying one thing but actually doing another.

Senator WILLIAMS. Is this hypocrisy that he was talking about?

Dr. BRIMM. He was talking about hypocrisy.

Senator WILLIAMS. Excuse me, continue.

Dr. BRIMM. In conclusion, sir, we must reglamorize the role of the addict that the addict has invented for himself before we attempt to help him. We must create programs which are attractive to the addict even though they may not be easy.

This task of detoxification for addicts must be made possible, but meaningful. Hospitalization, medical treatment is not enough because frequently upon discharge the patient often finds himself in the same painful environment which led to his addiction. Thus, in conclusion, I believe that addiction can possibly be prevented, one, with minimal health programs to reduce the number of susceptible persons; two, continued effort to reduce the availability of the illegal drug;

three, through treatments which reduce the number of addictive persons, that these bring the drug and susceptible persons together and by improving the conditions of the deprived area where the addict is most common.

In conclusion, I think that those programs must incorporate the use of the ex-addict, for one cannot help another in the ascent from hell unless one has joined him there.

Thank you.

Senator WILLIAMS. I have just one observation, Doctor. I am delighted that you can stay with us through the balance of the hearing this morning and I think it might evolve that with Director Russo, and with you, we might, after the other witnesses come in, have a summary with you two gentlemen.

As you know from our title, this subcommittee is concerned with both alcoholism and narcotics. In alcohol we have found the problem of the disease of alcoholism and witness after witness has told us that arresting this disease absolutely depends on the ill person recognizing his disease and having a desire for cure.

There are no halfway drinkers among those who for chemical and other reasons are alcoholics. It is "no booze at all," no halfway measures. There are no social drinkers. They have a disease. The only way it can be arrested is recognition of the disease they have that inexorably goes on to death or insanity and recognizing that and wanting to stop.

The thing that will continue their disease is the taking of alcohol, any alcohol. Is it like that with drugs?

Dr. BRIMM. I don't think we can say the same thing with drugs, because I think that you run into different types of personalities and I don't accept this wholeheartedly with alcoholics either.

I think with some drug addicts they will have to be on some type of maintenance. There will be a few who probably will have to be on methodone, which would be the same as if you could find a beverage or stimulant which would be a substitute for alcoholism but I think with the addicts we have worked with, the best results have been those we detoxified cold turkey.

Most of them that were cold turkeyed, which is without any medication at all, they are the ones, they say you are getting easy when you go toward the methadone program. They are the ones we get the best results and those who are the ones that generally give up themselves after the program, that they have kicked the habit.

Senator WILLIAMS. One question on methadone. That is not a dangerous drug, it is a synthetic drug, it is a replacement drug for those who are on dangerous drugs, is that right?

Dr. BRIMM. Yes, but I think danger—this is a matter of semantics. It is dangerous to misuse or abuse. I think if properly used, I think it is a useful drug. If improperly used, it is a dangerous drug.

Senator WILLIAMS. Does it attack any vital organs?

Dr. BRIMM. One of the pharmacological factors of the drug is it acts as a blocking agent. It decreases the desire or craving for heroin, but it is an addictive form of drug.

Senator WILLIAMS. Methadone.

Dr. BRIMM. Yes, with the patient actually becoming addicted to methadone.

Senator WILLIAMS. Everything we say could lead to more discussion. I think we can appreciate very much your testimony and we are glad you can stay with us and we will move on with Father Walsh.

Now we will hear from Father Edward Walsh, acting director of the Camden Drug Abuse Center.

STATEMENT OF REV. EDWARD WALSH, ACTING DIRECTOR, CAMDEN COUNTY DRUG ABUSE CENTER

Father WALSH. Thank you, Senator Williams. It is a pleasure to be here today.

I think this is the beginning of a problem that has been going on for over a year, which I have been involved in, and Dr. Brimm was modest about what he has been doing and what he has been trying to do. We have treated over 100 addicts in Camden County. Let me state these are not inner city people as they were referred to. These are suburban people.

The purpose of the Camden County Drug Abuse Center is to establish an induction treatment center for addicts and prevent drug abuse in Camden County. We are also receiving people from other counties, too.

Our goal is to identify, confront, control, prevent, and destroy drug abuse problems, the time schedule for the implementation depending upon the wishes of our good freeholders. We will let you know when we will be able to handle more of the people.

I think everybody realizes that we are living in a drug society. Drugs have become a cause among teenagers, a crusade, a symbol of rebellion, a new and powerful method to shock their elders.

Their parents, of course, do not understand. Their parents can understand drinking. It is of their generation, but drugs are puzzling and frightening. Teenagers who turn to drugs want to puzzle and frighten, but not realizing the consequences.

To help overcome this, we must have educational and rehabilitation programs, not just one-shot programs, but ongoing. This is a beginning today. You have to start somewhere. Remembering, as the addicts I have talked with, it is not a drug problem but it is a people problem.

Next, you are going to hear from a number of my friends. They will give you a little background on their lives. I will give you their first name when I am introducing them. The first group is going to be from Liberty Park. It is called "New Jersey Regional Drug Abuse Agency." The site is at Liberty Park and it has nine buildings. It has administration, educational, and vocational buildings, detoxification infirmary, a dining hall, a gymnasium, and three dormitories. It is located in Jersey City within sight of Ellis Island and the Statue of Liberty.

They have a number of out-reach centers. The Essex County Out-Reach Center is located at 54 Spruce Street in Newark. The Hudson County Out-Reach Center is located at 507 26th Street in Union City. The Monmouth County Out-Reach Center is at 804 Main Street in Asbury Park. The Middlesex Out-Reach Center is located at George's Road in New Brunswick.

So, at this time, I am very happy to call my good friends from Liberty Park who will give you a little background on what they are doing and what other people are trying to do to help other people.

We will first hear from Carl.

Mr. CARL. Good morning. My name is Carl. I won't mention my last name. I am 24 years old, originally from New York City. I have been an addict roughly 11 years.

Out of the 11 years I spent like 6 of those years in jail.

I am from New York, Harlem, and just recently moved to New Jersey about a year or so ago. You know like in the neighborhood I grew up in there weren't too many addicts at the time and I more or less like—well, the guys I looked up to were addicts. You know, they had money, girls, they had cars, they had this and that. I wanted it.

I felt that the only way I could get it was doing whatever they did. So I got onto drugs.

School. In school I did all right. I did fairly well. Family life was mediocre. There was like a lack of communication between me and my mother. It was just me and her because my father died. He was also an addict and died in 1953 of an overdose. Since then I have been in and out of jails, spent 6 years, and the only thing I learned in jail, this is a misconception that a lot of people have. They feel that a jail is the only place for an addict; the only thing I learned in jail was how to, you know, break into somebody's store without getting caught, you know, and different ways of conning people. That is the only thing I learned.

I have been in Liberty Village roughly 8 months. I have learned a lot about—I read a lot of things I didn't understand about. There is a lot of things I have done I don't like, but I have to accept it and the only thing I can do now is I try and change it.

Liberty Village is like a therapeutic community similar to Day Top Centers and places like that. We have staff members there from these different concepts. We have a residential director from Day Top and others.

I have been in and out of hospitals about 10 different times, 10 different occasions, in New York and New Jersey. The only thing, well, I didn't really learn anything. As a matter of fact, one hospital I went in I came out with a bigger habit than when I went in.

Like I said, jails I didn't get anything.

This is simply a beautiful thing. You more or less like—you get to, like, understand yourself. You don't really. Well, I didn't know too much about me. I didn't feel too good about me. The only way I could overcome the bad feelings about me was more or less stuffing, getting high. This way I wouldn't have to look at myself and accept me.

I would like to turn it over to Danny.

Mr. DANNY. Good morning.

Senator, my name is Dan. We would use our last names, but it is better to keep it on a friendship basis. Carl explained a lot about himself. My life was similar to Carl's.

I used drugs for 12 years. I am termed what I guess doctors would put a label on as being a hard-core heroin addict. I used drugs for 10 years, psychedelic drugs, LSD, any name you want to call it, I used

it. As far as I recall, I have been in the drug agency called Liberty Village 4 months now and this is the first time in my life that I have seen that I could live from day to day without being dependent on any type of drug.

We use no drugs down at Liberty Village. The only time we have use of drugs is for the detoxification unit. After that, we make it on our own.

Like the doctor said before, about a fellow copping out, because he couldn't go along with the program, we could hang it on anything. We could say that our mother looked at it as being too long and didn't like it.

Here at the Village we set ourselves up to kid one another about things. We grow up with our sores to mature as men. If our feelings get hurt, we can't pass it off with a bag of dope. We will face the problem, stand up to you like people do everyday in society and cope with it, not fall back and hide behind a bag of dope.

As far as the program goes, it is a constant 24-hour environment, like a family environment. We stay there because it is our house. We make the rules as far as getting promoted to different jobs, which gives us a chance at responsibility, something which we tried to run from all of our lives.

As far as Carl, I am closer to Carl than I guess all of the people out in the audience sitting next to one another, because I know things about Carl which he never even told his family, things that drove him so mad he couldn't even talk about, and we identified because we did the same things, so we were not ashamed to admit things to one another.

If I wanted to leave this program, I would have no pressure at all in leaving, but I know I was a dope fiend. We can never forget that. He gets it like alcoholics. Once you forget that you are an alcoholic and that it is a disease and try to kid yourself by having a little cocktail after meals, you are on your way back to being an alcoholic.

So we know we were on drugs and can never forget for a second we are dope fiends and if we try to kid ourselves into maybe smoking marijuana or a little grass, you know the slang words, then we would be heading back into the gutter.

We know we are only an inch from the gutter. What keeps us from going back to the gutter is that we found we could exist and live like human beings. We can look at each other and say we are making it day to day. We know we live from day to day and could fall. That is just what you don't want to forget.

We know what we want out of life. This is the first time, like I said, in 12 years that I see a chance to get what I want, like being here and speaking to all of you people, because everybody seems to say, "It does not happen to me, it happens to the neighbor. It is their problem."

This is not true. I am from a middle-class family. I never needed money. My family is pretty well off, that is a slang expression. But this was far from using drugs.

As far as eliminating drugs, you can't do it. For instance, people on diets give themselves five to ten diet pills in the morning or a few beers at night so they can feel relaxed and get their work done. This is just some form of escape.

Even as far as sleeping at night, they can't sleep, so they take a few sleeping pills and maybe a few beers and then feel good about themselves and yet they turn around and tell their kids, "Don't do as I do, but as I say."

In our house at the Village we don't preach that. If I tell somebody not to do something, we usually say, "My back yard is clean, I don't do it." I use myself as an example. There is where you have identification with the ex-addict like our director and others.

I hung around with these fellows while they were using drugs 9 or 10 years ago and thought I couldn't be cured, until I had seen them running this program. I just looked at them. I was amazed. I knew if they could do it, I didn't see any reason in the world why I couldn't.

I would like to turn it over to my brother.

Mr. EDDIE. Good morning. I would like to start off by saying there is hardly anything I can say, you know, about the program, because they have said it all.

I would like to say something, a little something about myself. I am originally from Havana and have been here about 10 years. My family life was, well, like prewar my father was captain of police in Cuba, like I was really well off in Cuba.

I went through schools and so forth. I came over here and started going to school, but I didn't feel right, you know, like with the language problem and everything. So the first thing for me to do was to identify with everything, and I would hang out on the corners and so forth.

Before I knew it, I was like smoking reefers. It was like everybody was doing it, so I did it. From then on it went from one thing to another to pills and from there to cocaine and heroin and, like I stayed, on heroin.

Like I started when I was 14 and I am 21 now. Since then on, it has been like I have been in and out of jails, like my parents, like, they don't—at this moment now they see I am doing something for myself. They have changed their minds, but a couple of months ago they didn't want anything to do with me.

It is hard for me to say, like everything I will do, but if I can boil it down to one thing, like one hole, it is the hardest thing a man can go through.

I have been in Liberty Village for 3 months now and it is just beautiful. I can say I am a little nervous. That is all I can say, it is really beautiful. The whole thing, let me kick this out because it is important. It is the identification like with the staff with itself.

I knew our director and everybody else, I knew them, too, like Danny did and when I seen them, that is what gave me the push to say, "If they did it, why can't I" and that is why I think I stayed.

Thank you.

Father WALSH. Now I am going to bring three of my friends who are from down here in south Jersey to give you some of the local scene. As we listened to the people I have talked to addicts and "I have never been there" and this is one of the phraseologies they have used. "I have never been there," but maybe I can begin to relate to them. But it is necessary, in my thinking, from dealing with these people that we need the ex-addicts to have any sort of workable program.

So at this time I will call on my friends from down here in south Jersey and I am just going to refer to them by first names.

Would you please come up. We will first hear from Ed.

Mr. Ed. Good afternoon, Senator, and welcome.

As they refer to me, I am "Ed." Well, to give you a little background on myself, I started experimenting with drugs while in college. So I just want to break it down that it is not all the lower class that are initially starting out with drugs. This was 10 years ago.

Eventually, I made it through, but it was a real hangup. We don't have the facilities as they do in north Jersey to work with the addict and we do it on a local scene from house to house and corner to corner, and sometimes in vacant houses and sometimes I find addicts in alleys. I pick them up and take them home, because quite often we find that with the young addict it is experimentation and they have a mental drug hangup.

Normally, they look to me as a father image, a brother image. I guess it is what you would call "generation gap." I am the generation gap.

I try, I have tried to educate Dr. Brimm and Father Walsh as far as the street lingo, how the addict functions, how he thinks, what he thinks about. I was fortunate. I escaped most jails. I wouldn't say it was ingenuity, because I was still an addict.

I fooled a lot of people, but eventually all addicts fall and I fell with the rest.

I have been working in this program for approximately 18 months and, as we say, the drug has no color line. It reaches into the ghetto, the habit reaches into the middle class, and unfortunately it reaches into the upper class. I don't know if you are aware of it or not, but drugs are actually destroying the establishment itself. They have relaxed the drug laws, which I wholeheartedly disagree with, but unfortunately you can't change times.

With the south Jersey area, we have a lack of communication with the political establishment. I hate to open up, I guess you would say, a "Pandora's box" and put myself on the spot, but that is our problem here. I hope that through this small meeting we will eventually have a center in south Jersey.

We have worked with individuals from Gloucester County, Burlington County, even as far as Atlantic County. They come up because they have no one to relate to, as they say in the TV commercial, "I have kicked the habit and I am glad I did."

I can't say very much because if I say too much, they may cut me off. But I feel that if you help us by trying to let us give you some form of education as far as help to the addict, we can change the majority of addicts into exaddicts. I had the help of Father Walsh and Dr. Brimm.

Unfortunately, everyone does not have that kind of help spiritually—Father Walsh; medically—Dr. Brimm, and through them I try to relate to the younger individuals, since my thing is "preventative education." I try to relate to the younger individuals why drug abuse exists.

They feel as though by experimenting with drugs, it will place them on a higher pinacle with the individuals out in the street. As my counterparts from Liberty Park mentioned, they see the money, the

automobiles, the flashy clothes and they feel as though, to be on this same plane, they have to use everything that these individuals use; namely, drugs.

I feel as though that most individuals, if you can relate to them yourself that you are the Drug Rehabilitation Commission, I find out through most families when I speak with them that they mention to me, "Well, what can I do after the problem strikes?"

We try to find and seek out the individuals while the problem is very minor. Quite often we have individuals whose habits are larger than you can even conceive, unbelievable proportions. But we try to work with each and every individual.

I myself, I was so far out I was at the mental breakdown stage. I had changed from "Ed" the human to "Ed, the walking hypodermic needle." Three quarters of my day was spent doing what, in the addict lingo, is called "chasing." I was going after the heroin. The other quarter of the day I was trying to devise means and money for purchasing.

I did things that I have to laugh at, because I don't believe them myself, but I did some good by joining this program. I feel as though I am doing good from now on and will continue to work with the drug program here in south Jersey only with your help.

Thank you.

Miss KAREN. My name is Karen. I am not really a very good speaker, so I really don't know exactly what to say, but I just wanted to come out.

I am basically from a middle-class family also. I have never been an addict more or less in words like I was using drugs, but mostly for psychological reasons. It is not anything. I was not physically addicted, but sociologically addicted in things like LSD and grass and things like that.

I have been working with addicts. I was working with them for 3 months over the summer out West where the programs there are very well developed and very informal and I am not much for formality, so I am not exactly sure what to say or what to do here more or less, you know.

I feel that people should be more relaxed and more—well, there is such a striving to be better and be, you know, what you are going to represent and what you are going to be and everything, that if people would just be more interested than just remaining—if they would ask themselves or give more feeling and be in a more spiritual aspect and find out what their real drive is, you can't replace what is really there with anything other than what you really feel. You can't strive for something that you aren't. I feel this is more or less the problem.

Your parents come up to you like "You have to be better than I was. I have to give you more and you have to have more." This is the result, I guess, of the Second World War, depression, or whatever. They wanted to give their children more. But instead of giving them—well, they got so hung up with material things, instead of giving what the people really need, which is the feeling of being.

Father Walsh wants me to tell you of the doctor. Well, the first time I really got turned on to drugs, I had a nervous breakdown like and I was getting really bad headaches. I was working also in a hospital and one doctor was giving me demerol for the headaches, which at that time was as an experiment. This is where—if you can experiment with

drugs, I mean the legal experimentation can be dangerous also because he was giving me demerol, which kills everything in you, you know, like all pain and everything and, accidentally, I guess it was, I became addicted and withdrew from that.

But I knew the feeling more or less, the feeling of escape which I never had really looked for before and then from the feeling of escape I wanted to more or less get back into myself and what I really was and that is why I was using psychedelics. And the doctor, I think, who was discharged from the hospital—well, you know, it can happen through other means than illegal things.

Speaking about the trip, I can't really explain what LSD is. I mean, it has been in experimentation for a long time and everything I ever heard, even doctors say on it—well, you should be medically assisted. Psychiatrists use it. It is more or less like being hypnotized. It is not escaping, you are just developing your sixth sense.

You see beyond what you normally could. If what you see is bad and you are a nervous person basically, like I was, you can really mess yourself up. Like, as I say, well, OK, the easiest thing, I have reached my spiritual height, I have reached everything. I know where I am not and it is best that you now be just dead and get it over with, so this must be where people dive out windows.

Luckily, the people I have known have said to me it is not time to die yet. We will keep you going and we will keep helping you like we are helping you. I know a lot of people who have overdone it and really, you know, they are in hospitals.

One guy can't talk. He forgot how to talk on a trip. It is more or less, like you say, you take these drugs, you can't become physically addicted to LSD, but like after a while you begin to realize what you are searching for is not material and you are getting this feeling of searching for a material thing, so you actually get very critical about the thing and you have to find a new way of searching.

Once you stop it, once you stop the incidence of what is dangerous about it, you are completely broken because people—you relate against the real world as it is right now. This may not be the real world. I don't believe in the real world. I believe this is the man-made world and you are relating to the man-made world again on a more spiritual level and it can accept you, like you are completely broken because people are telling you what you feel is not really real and it is really real, but it is hard to keep it steady. So you have to develop a way to get yourself back together. The real basis of why the world is created and why it is here instead of what I created is controlling me and that is actually what is happening, what people have created is controlling them more or less than them controlling themselves.

I guess that is all I can say.

Father Walsh. Thank you, Karen.

John?

Mr. John. My name is John. I have been using drugs for 7 or 8 years now, taking grass and heroin and LSD, everything.

What I am doing now is going through this rehabilitation trying to get myself back together. The drugs have really put me down. I felt just like I walked myself out of my life. Through rehabilitation I hope to go back to school and get a college education and when I was on drugs, I went to Skillman for help and they detoxified me.

I kicked my habit "cold turkey" and I stayed there for 2 months and when I came out or the same day I came out, I went and took another shot which put me in the hospital, and I laid in the hospital for 2½ months.

Well, this got me this bad arm right now and, well, it will be a long time before it comes back.

Well, we are really getting rehabilitation through Father Walsh and Dr. Brimm. I hope everything will be all right soon.

Father WALSH. Thank you, John.

John is on the road to recovery and we are very proud of John because of the advances he has made within the last month and a half and we are hoping that we are going to see John on the road to recovery where he is going to be a very useful citizen, we know that.

So I have presented my friends, Senator Williams, and I know we are running over our schedule here.

Did you want to bring up this next? Where are my friends from Liberty Park?

Senator WILLIAMS. Yes, I was hoping we would have Carl, Danny and Eddie back here and here they are. I don't know of any schedule we are running over unless there is a schedule that somebody didn't tell me about.

Father WALSH. I think the biggest problem is the restaurant, getting the dinner, getting prepared.

Senator WILLIAMS. This will give them more time.

Father WALSH. I don't know how the audience feels, but I hope it is interesting and this is what you came here today to hear.

Maybe we could go into some of the questions and answers. There is one question in my mind and I think it is in the minds of a lot of people here: "What facilities are available for treating a 13-, 14-, 15-, 16-, 17-year-old teenager who is hooked on drugs?"

We have them here in the county, but there are no facilities. I wonder if somebody may be able to address himself to that.

Mr. DANNY. I would like to answer. In our programs we have fellows as young as 16 in the program. Before I get to that, I would like to point out the importance of us being here as far as voicing our own opinions on how we feel about drugs.

It is dangerous. I had my best man when I got married die from an overdose. As far as I feel, you know, we may live through it, but we know how serious drugs are and that is the message I want to get across to people, that it does kill, drugs kill. I won't try anything that will kill.

As far as our rehabilitation program for young fellows, we have fellows in the program about 16 years old. It is hard for us, like, to identify with them, because they say, "You are a lot older than I, you are not hip." I have to come back with, "You are on psychedelic drugs" and I familiarize with him. I show him he does not have to go through life like me and put himself in jail.

He might not have that chance. He might walk out the door and die the next day.

I would like Carl to speak.

Mr. CARL. As far as like young kids, the only facility I know that they have is Odessy House for kids like under 16. Somehow like, well, our program is getting the Government involved and we can't take

anybody in there under 16, but that is where the biggest problem is, the kids of 16, who definitely need something because they can't come to places like ours.

Senator WILLIAMS. Dr. Brimm?

Dr. BRIMM. About the 16-year-old, we have worked with some kids under 16 in our program, although we have not actually been authorized, I don't think lately we were allowed to, but what we have been doing is getting permission from the parents and trying to work with the parents and the kids.

In fact, we have one girl who is 12 years old, who was hooked on heroin and we had a glue-sniffer who was 7 years old that we worked with.

Senator WILLIAMS. Doctor, could I clarify something. Danny or Carl mentioned Federal funding and you associated that with the age cutoff.

Mr. CARL. Yes.

Senator WILLIAMS. Is that one of the reasons as you understand it?

Dr. BRIMM. It is a legal thing.

Senator WILLIAMS. It is a legal matter. We will have to find out whether it is Federal prohibition for going below 16, but what is your funding, Doctor?

Dr. BRIMM. We have no funding, we have not received a cent from anyone.

Senator WILLIAMS. Now that round of applause, of course, if you are doing it yourself, that is good. But does the applause mean you don't want any funds?

Dr. BRIMM. No. The point is we have been applying for it. It goes back to what the urban kids said, maybe they are shucking and jiving, sir. [Applause.]

Senator WILLIAMS. Yes. Before we are through this morning, there are two things I must carry back from our friends here who have talked to us so much, advice from them on how we all can be significantly helpful and in a most effective and efficient way.

Now Liberty Park has been described beautifully here and maybe that is the kind of program that should be more broadly available throughout the country. That is one thing that if you all would think about when we finish up, the last thing, we will swing around and you give it to us like you think it should be, what we can do to help.

Now we have not finished on the other. Father, did you want to run down on this?

Father WALSH. The number of questions here. We are going to have an afternoon session, too, so a lot of the questions, I think, we will try to answer them this afternoon. Specifically, I think if you just go into the next part there, some of the questions yourself which you want to talk about then maybe Mr. Russo could comment on the teenage problem, what is being done across the State or if anything is being done regarding the teenager, 12, 13, 14, 15 and 16. "Where can they be detoxified besides Liberty Park?"

Mr. RUSSO. Unfortunately, we do not have facilities specifically for the youngster, particularly with reference to the inpatient facilities. The aftercare, the outreach program which we are involved in, there is no age limit for individuals who make themselves available for

these professional and paraprofessional services, but inpatient facilities, detoxification facilities, specifically for the youngster, are pretty difficult to come by in the State of New Jersey.

Father WALSH. Here is another question. "How can one set up a drug abuse center in New Jersey in the county?"

We have people from other counties and probably they are interested in setting up drug abuse centers and what is the procedure that one must go through in order to implement a feasible workable program?

Mr. RUSSO. I think I mentioned briefly in my previous presentation that we on the State level are in a position to enter into contractual agreements with county boards of freeholders to assist in developments of outreach centers. Our fiscal involvement in these outreach centers is that we can support the program of 75 percent of personnel cost and the county must then bear the other 25 percent of the cost, and any other additional costs.

I don't want to go into details on how you set these up, because I don't want to take your time. Please call me if you are in a position where you need a center in a particular county and I am sure we will work with you in assisting you to develop whatever is most suitable for your needs.

Mr. DANNY. I would like to take time to invite everybody to Liberty Village. We have open house on Saturday and I would like everybody to come down and see what we do for ourselves. As far as young people in drug use, we have parents on Tuesday night. Whether or not they have children in the environment, we teach them about drugs and go out on speaking engagements. We chart like 10 a week and we have been trying to extend ourselves to reach the people.

I am sure we are doing a good service.

Father WALSH. A question for the ex-addict, "How would you reduce temptation to young people so they won't start on drugs?"

Does somebody want to come in on this?

Mr. CARL. Well, that is a very hard question to answer. That is like a social thing. People basically use drugs on things like dependency, they depend on it. It is like—in other words, they are missing something on drugs like a replacement, you know, like when I started I felt I was limited. There was not too much I could do.

The only thing I could see that would stop me was maybe someone else or something eliminating, you know, this feeling. So I felt like I had reached my point. I was not going to do anything else and I didn't like what I had. You know, it is a social thing.

You have to start from the top and come back down.

Mr. EDDIE. I believe that to do something like that, help us and we will help others, really.

Mr. DANNY. The only thing I can say, the best example for me is my life through drugs and what I see happen to friends around me.

You know it is hard for me to sit here and talk about my friends, because you know we are very close. When you see a fellow die like in your arms and there is nothing you can do about it, fearing the police and being arrested, selfish things, thinking about yourself.

I guess that is what hit me, that I could turn around and do something for myself and maybe help other people through my mistakes.

Senator WILLIAMS. May I ask this question.

In testimony, time and time again, I hear the alcohol part of our work and we hear people say somewhat responsive to this, somewhat responsive to this question, that they remember there is nothing so bad that a drink won't make worse.

Mr. Danny. Yes.

Senator Williams. Is there some element of that in drugs, too, things cannot be so tough that you just can't make it tougher with drugs?

Mr. Danny. As far as, like, us using a drink to block out what really happens in your life, I can identify with all of my brothers here, because in our program, we run what is problems, where eight or 10 of us get together and talk and we go as far back as 12 or 15 years ago, back through childhood, and talk about all the things that bother us, homosexuality, our inadequacies, everything that happens that throws us into jail, which we wouldn't even tell a priest, you know, Father. But we really like to relate to one another because in that way it does not feel bad, being like I am like another member.

So I start talking and all of the fellows say, "How could he do anything like that?"

Once they get a little comfortable, pretty soon Carl will identify with what I do and Eddie. Then they see it is not that bad. Then, too, the ex-addicts that are on the staff and run the staff, they will help us sort of like kick the ball off when we talk about ourselves and look at them and use them as a model.

They can live through experiences that we all know ourselves from when we had to escape from ourselves, in the use of drugs, any form, or even alcohol, like where we had to face something and had to accept the fact that we did it, it was part of our life and as far as we are concerned, it will never happen again.

We should not feel bad about what we did, because it is in the past, and we will in time just recall it and keep in mind only what we are going to do today.

Father Walsh. Here is another question: "What kind of policy should a board of education establish to handle suspected drug abusers?"

I will try to give you some of the thinking going on in the State and some of the ideas that are being projected.

If there is found in the school a suspect that is using drugs, a policy must be established in the school. If the policy is that the individual is referred to the guidance director or the principal, this policy must be followed out. If the policy is, they call in the police, this policy must be carried out.

If the individual is the principal's son or daughter, there can be no lines drawn. It has to be one policy. My feeling is the policy should be that there should be a guidance and then the guidance directors should be trained in what programs are going on in their area. This is one of the ideas we want to get into Camden County.

When there is a suspect, they can be referred to our drug abuse center. There, they are going to get some sort of rehabilitation. When we send them to the police station or wherever it may be, usually it is just into the jails and there is no actual rehabilitation going on in the prisons right now or in the city or county because we are working with them.

Another question: "Why aren't the dangers of drugs more publicized, such as there are few drug addicts over 40, because by that time they are usually dead?"

I think the question itself is the answer itself, most drug addicts have a very short life. Maybe somebody would like to respond to this, the lifespan of a drug addict.

Mr. CARL. They say like usually a drug addict, when in the middle thirties, he will stop the habit because his veins will collapse and he has nowhere to stick a needle. But as far as the publicity goes, a lot of publicity, I don't know. A lot of kids read the papers and they look at drugs as more or less a status symbol, read about doctors using drugs.

It is not good to publicize it, but it is not being publicized the right way. I don't know the right way, but the way they are doing it now, it is wrong. It looks like a status thing and these kids look up to addicts.

Mr. DANNY. What I learned, as far as my life, the way I see people and know people, the only thing that could happen would be they would continue to be drug addicts, that is, if they are not shot in breaking and entering, in robbing a drugstore, and if they are not shot or killed in some way, they will either die from an overdose or vegetate.

That is all drug addicts do, vegetate by the use of drugs and not doing nothing or going to jail.

Most of my friends are in prison doing 5 to 10 or 15, and that is usually what happens.

Miss KAREN. Out West, they have had a program for a long, long time. They have had it, they have had clinics set up quite a while, and all of the people I have met there of my generation were more down on drugs and all of the rock musicians and if you listen to them, they are all scenes about being killed and if you shoot, you are "down" and things like that, that you are ruining everything and destroying yourself and you are not really with it.

Out there in the West it is more like "Let's get into a more natural thing again and stop drugs."

I think this does a lot of good, because I went to rock festivals, and they were throwing their packs into the trash cans and I think this is an awfully interesting start.

Senator WILLIAMS. Do you mean by that to say that the status is changing from "you are in," that you would be in to get off or to stay off drugs?

Miss KAREN. Definitely. Like in California, the thing is if you take drugs, you are not. The heads don't take drugs. I mean they are totally straight during medication and drugs are definitely a "down."

Mr. DANNY. Maybe that is right and maybe out there it is that way, and I am glad you said it. But as far as I can see, we are after the hard-core addicts that are already on drugs and that are physically dependent, and the other addicts in the State, which are so many, but I guess maybe because their families have politicians and politician pulls and so on, maybe their name does not come up in the papers, but maybe they want to wait until their sons are dead.

But as far as the rock festivals, I am not too hip and all I know is the problems I see in the streets around me and people around me. The

young fellows that are 16 and 17, they are like, you know, I tried to talk to them. I tried to put my heart out to them. They look at me, they don't believe me. They don't believe me.

Maybe they have to go out and go to prison and die before they will wake up and understand that "Tomorrow, I might not be here."

Maybe that is the incentive. As far as I can see, we are trying to do a whole lot, because if we can stop them now, like they are just getting off to themselves and using drugs on weekends and maybe we can cut them out altogether if we make them aware now of what they are heading for.

Miss KAREN. That is what I mean. This had all happened before this took place. They have had this thing for a long time and out west they were instructed a long time ago, long before our session here. They realized the problem a lot faster because the West was the more progressive, I suppose, but they saw the problem and they started this way by making it look more unappealing than appealing, like if you wanted to be like the heads, you would not take drugs.

Father WALSH. Explain what a "head" is, Karen.

Miss KAREN. Here on the east coast, they refer to heads as people who take drugs. Out on the west coast it is the people who know where their heads are at, like, you know, they are together, they know what they are doing and love other people and are more or less trying to bring the world back together. That is what I referred to as a "head" on the west coast.

Father WALSH. Thank you.

Here is another question: "As an ex-addict, did you experience the highly dramatic withdrawal symptoms as shown in the movies or do you think withdrawal can be accomplished under nonmedical guidance?"

What is your opinion? Just how painful is the withdrawal and how can it be done? Can you kick it by yourself or do you need help? That is what it boils down to.

Mr. CARL. Basically, it is the individual. I kicked the habit. It took me 9 days without medication. I kicked the habit.

I had used trasquilizers, but this only makes it worse. I have done it 10 or 12 times, but the last time it was like hell and that was the last time.

Mr. DANNY. All I did, it is all dependent on what you are up to to kick it cold turkey. If you kick heroin, cold turkey. You will have diarrhea and won't sleep for maybe 4 weeks and be deteriorated from not using the right food.

I kicked the barbiturate habit sucking the red and blue ones which I am sure you have seen the doses that they use for sleeping medication. I took 20 or 25 a day, which I was dependent on. When I went to jail, I didn't get medication. I was having convulsions and I was lucky to have a friend in the cell block, otherwise I would have probably swallowed my tongue and died.

Mr. EDDIE. The last habit I kicked was cocaine. It was like a uneasy feeling. I couldn't sleep or eat. Is was like that for about a week and a half. I finally started calming down. It was like I would see things, I would flash, you know, like you take LSD, you see things. That happened to me.

They gave me shots of demerol. My pressure was high and my pulse high and fast, and it took me about a week and a half to get back together like.

Father Walsh. Another question: "Is it true that a significant majority of addicts start their addict process with pot or pills?"

Mr. Carl. Well, I found that like most of the addicts at Liberty we started out smoking reefers, 95 percent. You have a lot of reefer smoking, people that just smoke reefers, the tube.

Now there is this question of legalization of marihuana, which is like outrageous. It is crazy. Like I said, everybody who smokes reefers does not necessarily go to stronger drugs. But the majority of addicts start out, you know, smoking marihuana, pills, and stuff like that.

I started off with marihuana that myself and I went to pills, you know, goofballs and then to heroin and cocaine and other stuff, and I never used LSD. But I don't know about legalization of marihuana because, you know, a lot of people don't smoke marihuana simply because it is against the law and a lot of people that do smoke it go on to heavier drugs. So why take a chance with legalization of marihuana, if you have like, I don't know, man, it is crazy.

Mr. Danny. I would like to go along with Carl. We go out on numerous speaking engagements and one question I am always confronted with is "I believe marihuana is not that bad."

The only thing I can say is maybe it is not bad, until you shoot heroin. You should fool around with marihuana and in 5 years if you are still alive, ask me the same question. As far as legalizing marihuana, that is the first step in an addiction war, to legalize drugs.

If you legalize all of the barbiturates, then it gives them what they really want. That is how I feel.

Mr. Eddie. Take me, for instance. I started like you say some fellow at school that gave me half a cigarette. I smoked it in the bathroom. Right after that, like the next day I had a full one, a whole cigarette and I smoked the whole cigarette and I was real happy and so on and so forth.

The week after I smoked—I bought a $5 bag and smoked the whole bag on the weekend, and then after that, I bought two bags and smoked two bags and so on and so forth until I went up to the 1 ounce and smoked an ounce of reefer every week.

After that, like I just could not smoke no more, because I was coughing my head off from cigarettes and marihuana, so I took pills and more pills and after awhile I did do nothing so I went to cocaine and that is the way it goes and it will do it.

I just want to then make the people aware that in Camden County, which I am primarily here concerned with, that the individuals are not starting on a reefer.

The individuals in our community in Camden, in Collingswood and Haddonfield are starting out with the hard-core drugs, the heroin.

Because marihuana is not accessible, marihuana is not coming into our county. Individuals in the high schools, in the junior high schools and we even had some in the elementary schools that are starting out taking the heroin through the nose, they are doing here what they call snorting, and some individuals have graduated to the needle, but I just wanted to make you aware that not in all occasions do they start with marihuana and the problem we have here is that many individuals are starting with heroin.

Mr. DANNY. I would like to say one thing, if I may. As far as the heroin and all of that, I was surprised in your question. "How did you get started on drugs? Who is the pusher that hands you out in the school yards? Did he have a bar of candy?"

I get that on numerous occasions. What it really is it is not the pusher like people think. Every user is a potential pusher, not in the sense he wants to hook people but he might go down to the schoolyard and smoke a reefer and does not want to do it alone because there is nobody to identify with how well he feels so he might turn-on somebody next to him.

Every drug addict starts five drug addicts or more. As far as the pusher, I just like to straighten that out.

Miss KAREN. I wanted to add one thing: I guess New York might be like it is on the west coast which I basically had, you know.

Most of the concern I had with drugs was there because there the pusher was doing everything and if people there are dependent on legalizing as far as I know in Canada, and I think if they did legalize it, it would take the fascination of it away and more or less present people with the dangers instead of saying "You are going to jail" because I found a lot of people on the west coast on grass don't touch another thing because they are satisfied with it and if they did not have access to a pusher pushing them one and saying, "Oh, OK, heroin will give you a better high," then they would be satisfied just like people with alcohol.

Alcohol has been prohibited, too. Just because it is illegal does not mean it settles the problem because it is not that simple of a problem.

You can't throw people in jail because it wrecks them and makes them 10 times worse. I found it out with a guy in prison for 2 years for 1 pint and it's ridiculous.

Father WALSH. Thank you, Karen.

At this time I would like to turn the microphone back to Senator Williams.

Senator WILLIAMS. I just want to conclude this morning's part of the subcommittee hearing with our thanks, with the thanks of the committee, and really the gratitude goes to you and does not start with the Senate Subcommittee on Alcoholism and Narcotics. I certainly appreciate the efforts of local groups, such as the Health and Welfare Council of Camden. You have added immeasurably to focusing the necessary public concern on the growing problems of drug abuse.

This record will be published and the information that you have given us here will be used not only in the legislative process in our country. It probably will go beyond our country to other areas. I can't tell you how grateful all who are helped by this information from you are to you.

So thanks and good luck. [Applause.]

Father WALSH. Thank you, Senator Williams.

MEMBER ORGANIZATIONS—NATIONAL COORDINATING COUNCIL ON DRUG ABUSE EDUCATION AND INFORMATION, 1211 CONNECTICUT AVE. NW., WASHINGTON, D.C.

Alcoholism and Drug Addiction Research Foundation
American Academy of Pediatrics
American Association for Health, Physical Education and Recreation
American Association of Colleges of Pharmacy
American Association of Junior Colleges
American Association of Poison Control Centers
American College Health Association
American College of Apothecaries
American College of Physicians
American Correctional Association
American Council on Alcohol Problems, Inc.
American Dental Association
American Federation of Labor and Congress of Industrial Organizations
American Legion
American Medical Association
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American Orthopsychiatric Association, Inc.
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American Society for Pharmacology and Experimental Therapeutics
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Association of Food and Drug Officials of the United States
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International Association of Chiefs of Police
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Lions International
Medical-Surgical Manufacturers Association
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National Association for Retarded Children
National Association of Boards of Pharmacy
National Association of Broadcasters
National Association of Chain Drug Stores
National Association of Pharmaceutical Manufacturers
National Association of Social Workers
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National Congress Parents Teachers Association
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National Council of State Pharmaceutical Association Executives
National Council on Alcoholism, Inc.
National Council on Crime and Delinquency
National District Attorneys Association
National Health Council
National Jewish Welfare Board
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National Safety Council
National Wholesale Druggists Association
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Optimist International
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Society of State Directors of Health, Physical Education and Recreation
Student American Medical Association
Student American Pharmaceutical Association
U.S. Jaycees
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Urban Coalition
Bureau of Narcotics and Dangerous Drugs
Department of Defense
Food and Drug Administration
National Institute of Mental Health
Office of Economic Opportunity
Office of Education
Veterans' Administration

(Whereupon, at 12:25 p.m., the subcommittee recessed, subject to call of the Chair.)