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FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

GOVERNMENT

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

SECOND SESSION

ON

S. 3562

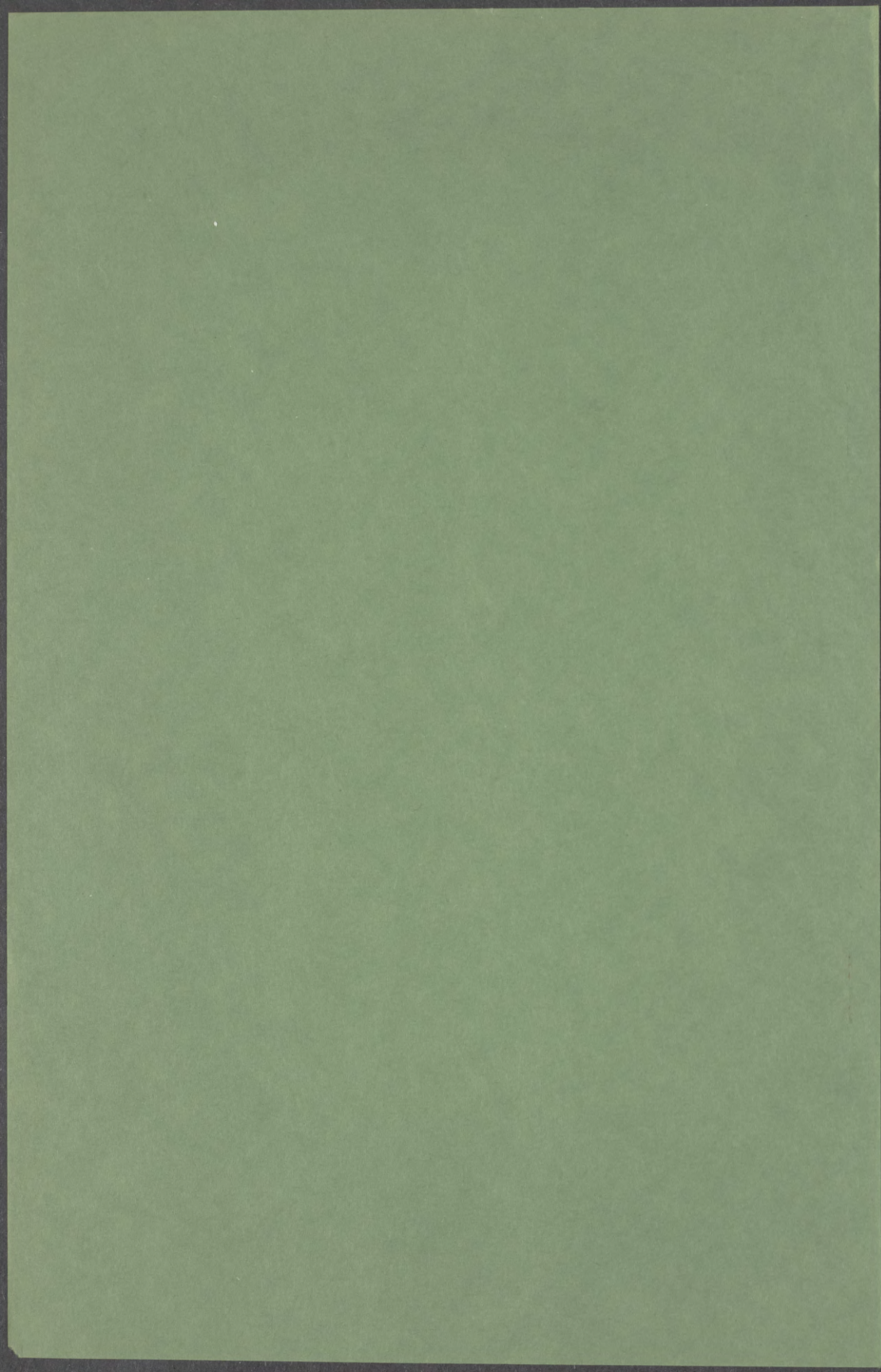
TO PROVIDE A COMPREHENSIVE FEDERAL PROGRAM FOR
THE PREVENTION AND TREATMENT OF DRUG ABUSE
AND DRUG DEPENDENCE

MARCH 26; APRIL 13, 14, AND 15, 1970

PART 2

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





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U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1970

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THE EFFECTS OF DRUG DEPENDENCE ON THE ENVIRONMENT AND REHABILITATION

BY J. H. HARRIS

AND

W. H. HARRIS

Department of Psychology, University of California, Los Angeles, California

Received March 10, 1955

Revised May 10, 1955

Abstract: The effects of drug dependence on the environment and rehabilitation are discussed.

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FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

THURSDAY, MARCH 26, 1970

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

The subcommittee met at 9:05 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes (presiding), Dominick and Schweiker. Staff members present: Robert O. Harris, staff director; Wade Clarke, majority counsel; Jay Cutler, minority counsel; and Richard J. Spelts, minority counsel.

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

The Chair calls Mr. John Ingersoll, Director, Bureau of Narcotics and Dangerous Drugs, U.S. Department of Justice. Mr. Ingersoll, if you will, have your companions identify themselves for the record.

STATEMENT OF JOHN E. INGERSOLL, DIRECTOR, BUREAU OF NARCOTICS AND DANGEROUS DRUGS, U.S. DEPARTMENT OF JUSTICE; ACCOMPANIED BY MICHAEL R. SONNENREICH, DEPUTY CHIEF COUNSEL OF THE BUREAU OF NARCOTICS AND DANGEROUS DRUGS; AND FREDERICK M. GARFIELD, ASSISTANT DIRECTOR FOR SCIENCE AND DRUG ABUSE PREVENTION

Mr. INGERSOLL. On my left is Fred Garfield and on my right is Michael Sonnenreich, Deputy Chief Counsel of the Bureau.

Senator HUGHES. You may proceed as you desire.

Mr. INGERSOLL. Thank you, Mr. Chairman.

It is a pleasure to appear before you today to express the views of the Department of Justice, S. 3562, a bill entitled "The Federal Drug Abuse Dependence Prevention, Treatment, and Rehabilitation Act of 1970."

I think we all recognize that law enforcement, education, research, and rehabilitation are integral and necessary parts of any total drug abuse control approach by the Federal Government.

Some of us emphasize one aspect more than the others because of our current responsibilities. But that does not mean that we are not concerned and interested in the total process.

Speaking for the law enforcement side of this quadrant, I am

pleased with the recent Senate passage of S. 3246, the Controlled Dangerous Substances Act, which is a major impetus toward achieving a more effective and systematic approach in the area of narcotic and dangerous drug law enforcement.

With that act as law, one part of the equation will have been legislatively realized. It is with the knowledge that other aspects of the problem also must be faced that the Department of Justice applauds this subcommittee's interest and efforts to meet, analyze, and resolve these most complex areas of concern.

We are all aware that no single approach, standing alone, will be effective in adequately resolving the burgeoning drug abuse dilemma. I think Dr. Roger O. Egeberg, Assistant Secretary for Health, and Scientific Affairs, of the Department of Health, Education, and Welfare, and Dr. Morton G. Miller of the National Institute of Mental Health made clear in their testimony on March 24, 1970, the progress which has been made, and which is being made, in the areas of education, treatment, and rehabilitation.

These are areas which primarily concern the Department of Health, Education, and Welfare, and the Department of Justice defers to the views of that Department in its area of concern and expertise.

However, I would like to discuss specific provisions of S. 3562 which bear either directly or indirectly on the functions of the Department of Justice in the area of drug abuse control and enforcement.

Certain statements made in the bill's findings and declaration pose potential problems of a prosecutive and enforcement nature to the Department of Justice. The generalization in subsection 101(a) that drug dependence is an illness or disease, for example, goes far beyond the decision rendered by the Supreme Court in *Robinson v. California*.

The inclusion of such a statement in a congressional finding might lead to a judicial decision creating an affirmative defense in a criminal prosecution, which is contrary to existing Federal law.

I might add that such a congressional finding is not in keeping with current medical knowledge and could be a serious impediment to criminal prosecutions. The Department of Justice strongly recommends against inclusion of such a broad finding.

The definition of drug-related offense in subsection 202(g) is in need of modification since as presently drafted, it is too broad and encompasses within its definition the entire spectrum of controlled drugs, from heroin to over-the-counter cough syrups.

In other words it appears that an individual who consumes a quantity of an over-the-counter exempt narcotic preparation, such as paregoric or one of the codeine cough syrups, and commits a crime while under its influence or who engages in criminal activity to obtain funds, would be committing a drug-related offense within the definition of that term.

Such a result clearly could not have been intended. If such were the intent then every prospective criminal would be advised to consume either a tranquilizer or other controlled substance so that in the event of capture, he could say that he was committing a drug-related crime.

The Department of Justice feels that the definition should be seriously modified and restricted to a more limited class of drugs.

Turning now to the provisions of title III, whether there is a need for the establishment of a drug abuse prevention, treatment and re-

habilitation administration within the Department of Health, Education, and Welfare is a matter primarily affecting the Department of Health, Education, and Welfare, and the Department of Justice will defer to their views on this point.

However, I might add that there would be a considerable overlapping of functions between this administration as it would be created by S. 3562 and certain of the agencies within the Department of Justice will defer to their views on this point.

However, I might add that there would be a considerable overlapping of functions between this administration as it would be created by S. 3562 and certain of the agencies within the Department of Justice.

For example, the administration's authority under subsection 302(b) to administer a treatment and rehabilitation program for Federal criminal offenders overlaps with the role of the Bureau of Prisons in this criminal offenders overlaps with the role of the Bureau of Prisons in this area.

Other functions overlap with those of the Law Enforcement Assistance Administration and the Bureau of Narcotics and Dangerous Drugs.

For this reason the Department of Justice joins with the Department of Health, Education, and Welfare in recommending against the creation of such an administration.

Subsection 304(h) authorizing this new administration to cooperate with the medical profession in disseminating guidelines for the use of controlled dangerous substances, poses particular problems for the Department of Justice.

Under both present and proposed law, these guidelines or regulations will generally be prepared and disseminated jointly by the Bureau of Narcotics and Dangerous Drugs in the Department of Justice and the Food and Drug Administration in the Department of Health, Education and Welfare.

S. 3562 would change this by vesting this function within the proposed administration. I feel this change is unwarranted in view of the fact that the present system has proved to be satisfactory.

The subsection goes on further to outline the criteria under which a practitioner can prescribe, administer, or dispense controlled substances. These criteria could be construed to immunize a practitioner from compliance with the regulatory requirements of existing law and would directly conflict with the Controlled Dangerous Substances Act, S. 3246, passed by the Senate on January 28, 1970, and presently pending action in the House.

The Department of Justice strenuously opposes subsection 304(h) as the Senate has already spoken to this issue.

Subsection 306(b), (c) and (d) of S. 3562, which set out the research functions of the proposed administration, would also appear to conflict with the provisions of the Controlled Dangerous Substances Act and as such cannot be supported by the Department of Justice.

Under S. 3246 a person wishing to conduct research using schedule I substances, which are those drugs which have the highest abuse potential and no accepted medical use, must be registered by the Attorney General after he receives the advice in writing of the Secretary of Health, Education, and Welfare as to the competency of the researcher and the merits of the research protocol.

Such a registration can only be denied under certain specified grounds enumerated in section 303(f) of the Controlled Dangerous Substances Act.

S. 3562 would have the effect of transferring this authority into the proposed administration or at the least duplicating the requirements individuals must perform in order to conduct research.

Such a transferral does not take into account the fact that the Secretary of Health, Education, and Welfare presently has the ability and machinery to pass on the scientific qualifications of researchers and their research, and that the Attorney General, through the Bureau of Narcotics and Dangerous Drugs, is best qualified to determine if a researcher has established proper recordkeeping procedures and has undertaken proper safeguards to prevent diversion of controlled drugs into illicit channels.

The procedures established in the Controlled Dangerous Substances Act cover this area, and the Department opposes the intent of S. 3562 in this area.

Section 309 of S. 3562, which authorizes the administration to classify all controlled dangerous substances into one of three classes, is superfluous and conflicts with the drug scheduling contained in the Controlled Dangerous Substances Act. The criteria used for drug placement have no defined or accepted legal meanings. Criteria such as "harmful effects on health" or "significantly contribute to crimes of violence against persons or to other grave felonious conduct," have no defined legal meaning and may be found to be constitutionally deficient because of vagueness.

The Department is opposed to this classification system because it is questionable whether such criteria are legally sustainable, and because the classification system established in S. 3246 is sufficient, both medically and enforcement-wise, for the intended purposes of this act.

I have been informed by letter from the chairman that this subcommittee does not wish a discussion of the provisions in titles IV and VI and the last two sections of title V today.

However, I have been advised that the Department will be afforded an opportunity at a later time to address comments to these provisions, and therefore I will reserve any comments until that time.

In discussing the provisions of title VII, dealing with Federal assistance for State and local programs, the Department of Justice again defers to the views of the Department of Health, Education, and Welfare, since these are areas within their special expertise.

However, certain of the provisions in section 704, authorizing grants and contracts for the prevention and treatment of drug abuse, overlap with the present functions of the Law Enforcement Assistance Administration.

Paragraphs 5 and 7 of subsection 704(a) authorize the Secretary of Health, Education, and Welfare to make grants or enter into contracts to provide prevention and treatment services in correctional institutions and to instruct the legal and law enforcement professions in the causes, effects, and prevention of drug dependence.

These provisions overlap the functions of the Law Enforcement Assistance Administration through its grant authority and the Bu-

reau of Narcotics and Dangerous Drugs through its current law enforcement training programs.

The Department of Justice questions the need for the appointment of an advisory committee on drug abuse and drug dependence under title VIII and the intergovernmental coordinating council on drug abuse and drug dependence under title IX.

There are already a number of similar committees in existence, such as those mentioned by Dr. Egeberg in his testimony and the Scientific Advisory Committee, under the aegis of the Department of Justice; and the White House Ad Hoc Committee on Drug Abuse, designed to coordinate the activities of the various Federal agencies involved with the drug abuse problem.

In addition section 802 of the Controlled Dangerous Substances Act calls for the establishment of a committee on nongovernmental drug abuse prevention and control, to study the extent to which nongovernmental organizations are involved in the prevention and control of the drug abuse, and advise as to how such organizations can best be fostered.

In conclusion Mr. Chairman, we think that the overall intent and goals of S. 3562 are meritorious, but as indicated during the course of my testimony, many provisions create serious problems for the Department of Justice and require thoughtful reconsideration so that they meet the objectives sought without hampering or interfering with the law enforcement goals.

Further, there should be no conflict between this legislation and the recently Senate-approved Controlled Dangerous Substances Act.

As the President said in his July 14 message on drug abuse to the Congress, relating to the Federal and State legislative programs, what is needed is an interlocking trellis of laws for the Federal-State effort.

So too here—we need a complementary interlocking trellis of laws dealing with law enforcement on the one hand and rehabilitation and education on the other.

That concludes my statement, Mr. Chairman, and I will be happy to answer any questions the subcommittee may have at this time.

Senator HUGHES. Do your colleagues have anything further to offer?

Mr. INGERSOLL. No, sir.

Senator HUGHES. Mr. Ingersoll, is there anything in the bill that you would support?

If so, point it out to me.

Mr. INGERSOLL. Mr. Chairman, my comments have been directed at the Department's position now on the bill, and I think on all other matters we would prefer to defer to the Department of Health, Education, and Welfare.

Senator HUGHES. I prefer that you answer my question. You oppose the legislation completely, do you not?

Mr. INGERSOLL. I think, Mr. Chairman, that the legislation as presently written contains provisions that I have already pointed out that would not permit us to support it. I think that on the other hand, there are many provisions in title III, for example, that I have not singled out for a specific comment that would pose then no problem to the Department.

Senator HUGHES. Do you want to point them out to me?

Mr. INGERSOLL. As I said in my statement, we are certainly sympathetic with the objectives of the bill.

Senator HUGHES. They are well intended but misguided, in other words.

Is that right?

Mr. INGERSOLL. I think there are some modifications and adjustments that could be made that might make the bill more suitable to the Department of Justice.

Senator HUGHES. Would you rather the bill didn't exist?

Mr. INGERSOLL. The bill——

Senator HUGHES. If we just went away and let you and HEW decide what should be done?

Mr. INGERSOLL. I think Dr. Egeberg stated in his testimony that we feel generally in the executive branch of Government that there is adequate legislation to do the work that is necessary to be done, legislation both in existence and pending.

Now, as far as the major interests of my organization are concerned, we of course, support the Controlled Dangerous Substances Act, because we feel that this will enhance the tools necessary for effective law enforcement.

As you know, our activities in the area of education and research are subordinate to those, or at least secondary to those of the Department of Health, Education, and Welfare.

Senator HUGHES. Describe those activities in education and research for me, Mr. Ingersoll. I am quite concerned about those, and on the floor of the Senate I tried to change those unsuccessfully.

I think the entire scientific and medical community opposes the provisions in that bill. At least I have had no one write to me supporting them, or anyone testifying before the committee supporting them either. I feel there is no restriction on your department in this field, and I would like you to tell me about that bill, since you brought it into testimony.

Let's take education first, and then we will take research later.

Mr. INGERSOLL. In the field of education, we intend to do substantially as we are doing now.

Senator HUGHES. How can we rely on that, because there are no restrictions in the bill.

Mr. INGERSOLL. As I recall S. 3246 provides that the Attorney General may undertake education and research programs which are intended or which will assist in the implementation of that bill. That seems to me to be a restriction.

Senator HUGHES. What are the guidelines of the bill that would direct the educational effort? Do you consider the education of 7- and 8-year old children in schools a part of your function?

Mr. INGERSOLL. No, sir; not directly.

Senator HUGHES. That is a part of control of dangerous substances, isn't it?

Mr. INGERSOLL. Section 602 of the Controlled Dangerous Substances Act states that the Attorney General is authorized and directed to carry out educational and research of programs necessary for the effective enforcement of this act.

In connection with such programs, he is authorized to establish methods to assess accurately, and so forth.

He may enter into contracts with public agencies, institutions of higher education, and higher organization.

Senator HUGHES. For that purpose only?

Mr. INGERSOLL. Sir?

Senator HUGHES. For that purpose only?

Mr. INGERSOLL. Yes, or special projects which bear directly on use and abuse of controlled dangerous substances, and in part B——

Senator HUGHES. I would like you or Mr. Sonnenreich, if he wants to, to tell me what you consider your educational functions to be. What do you intend to do under that bill with regard to education. Do you intend to educate children in elementary schools, high schools, or colleges?

Mr. INGERSOLL. Not directly.

Senator HUGHES. How do you intend to educate them indirectly?

Mr. INGERSOLL. We intend to cooperate with other governmental agencies involved with the education of children directly.

Senator HUGHES. How do you intend to do that?

Mr. INGERSOLL. By providing education——

Senator HUGHES. Are you going to conduct classes for teachers, educational classes?

Mr. INGERSOLL. If this is required, yes, sir, we may.

Senator HUGHES. Are you going to conduct classes for physicians?

Mr. INGERSOLL. We may do that, too, sir.

Senator HUGHES. Are you going to conduct classes for psychologists, nurses, ministers?

Mr. INGERSOLL. I would think that would be a more remote possibility, but it is a possibility.

Senator HUGHES. You would not rule that out?

Mr. INGERSOLL. No, sir. Our purpose in our orientation in this area is to acquaint people, indeed the general public, with, No. 1, the legal aspects of drug control and, second, to teach them to recognize symptoms of drug abuse in their environments and how to deal with them.

Senator HUGHES. Do you think the Department of Justice is better equipped to do that than the Office of Education?

Mr. INGERSOLL. No. As a matter of fact, the Office of Education is involved in a program now which will have as its goal the education and training of teachers.

Senator HUGHES. You are willing to let them educate teachers?

Mr. INGERSOLL. Yes, indeed, but we are willing to contribute to that program as requested.

Senator HUGHES. How do law enforcement officers finally get to be law enforcement officers?

Mr. INGERSOLL. In our agency, sir?

Senator HUGHES. In any agency, through a process of education?

Mr. INGERSOLL. I think the roots to law enforcement are many.

Senator HUGHES. Do you direct the law enforcement division at the University of Iowa how to train and educate people?

Mr. INGERSOLL. No, sir.

Senator HUGHES. If you do not do that, which would seem to be

more important to me than educating teachers to educate children under the Justice Department, how do you make a relationship?

Mr. INGERSOLL. Did you ask if I directed education?

Senator HUGHES. Does your Department do it? Do you extend guidelines?

Mr. INGERSOLL. We do assist.

Senator HUGHES. How do you do that?

Mr. INGERSOLL. We provide material, we provide speakers. The Department across the board will provide this kind of assistance to an institution or a State and local agency or other Federal agency.

Senator HUGHES. Why aren't you willing to do that in the field of drug abuse education, to supply people to speak, rather than to take over the educational field?

Mr. INGERSOLL. We are not taking over the educational field.

Senator HUGHES. In my opinion you are, and I think there is no limitation in your bill to it.

Mr. INGERSOLL. That is certainly not the intent. I have testified several times on this bill in both Houses, and I think that we have made our position and the intent of the Department is amply clear on this point and other controversial points.

Senator HUGHES. Maybe I am just particularly stupid, you know. That is a potent possibility. But I would like you to clarify for me how you are restricted in that bill. You talk about technical forming of language and the prosecution of law. How is that language technically formed to restrict you anywhere in education?

Mr. INGERSOLL. The preamble, sir, states that the Attorney General is authorized and directed to carry out educational and research programs necessary for the effective enforcement of this act.

Senator HUGHES. I have read that completely, sir, and I understand that. Now, can you tell me how that is unrelated to the education of children, if you chose to interpret it that way?

Mr. INGERSOLL. I think that the education of children is an important, vital part of the drug abuse education program that the Federal Government must take on.

Senator HUGHES. It would be necessary to the enforcement of this act, too, wouldn't it?

Mr. INGERSOLL. The Department of Justice and BNDD should contribute to this program of educating children, but this doesn't mean that our 800-odd agents can, or will participate in the classroom instruction. We feel as a matter of policy that that is better taken care of by teachers and professional educators.

Senator HUGHES. Can you tell us specifically what your Bureau would add to the drug education efforts which would not duplicate what HEW is already doing?

Mr. INGERSOLL. This may be related to law enforcement, but one of the areas that we can discuss are those drugs which are under control and the reasons for their control, the level of control, and so on.

Senator HUGHES. Isn't that a medical problem?

Mr. INGERSOLL. Not entirely, sir.

Senator HUGHES. Well, as far as the child is concerned, is that a medical problem, primarily? The reasons for controlling the drugs are medical, aren't they?

Mr. INGERSOLL. I think there are other reasons, too.

Senator HUGHES. The abuse of it, yes, but the medical reasons, or the chemical reasons——

Mr. INGERSOLL. Is because of its pharmacological effects on the individual, and then the effects of the individual on the welfare and safety of society.

Senator HUGHES. Right. Isn't a doctor the man who capably decides that?

Mr. INGERSOLL. Again, I am not—I am not—I don't understand the line of questioning that we are engaged in, Senator. Are we talking about what the role of our Bureau is in the education of children, or are we talking about who should classify drugs?

Senator HUGHES. We are talking about both, apparently, and I am not attempting to classify drugs, but you are talking about the educational process and I am assuming that the educational process gets into this, if we are talking to children and you participate in that, you are going to talk about why we control drugs.

Mr. INGERSOLL. Mr. Chairman, I have indicated before that the Bureau of Narcotics and Dangerous Drugs agents or representatives do not go into classrooms to talk to young children about drug abuse. We develop and feed information into programs through the Office of Education, our own responsibility and knowledge, which then is prepared in the form that is suitable for passing on to teachers who then are trained as to how this information should be passed on to young children in classrooms.

Senator HUGHES. How does that knowledge differ from the knowledge that is held by the scientific community in relationship to drugs?

Mr. INGERSOLL. Our knowledge is primarily legal in character.

Senator HUGHES. Give me an example of how you would do it.

Mr. INGERSOLL. The law. The laws pertaining to the control of narcotics and dangerous substances.

Senator HUGHES. In other words, you are going to talk about the laws that control the drugs?

Mr. INGERSOLL. I think at some level of education, this is an important thing; yes, sir.

Senator HUGHES. And not——

Mr. INGERSOLL. But I am not saying we are talking about it. We are providing the information to the programs which will be transmitted directly by other people. From the experience of our agents on the streets, we can provide information concerning which drugs are abused by young people and others, how they are abused, what they look like, what their pharmacological properties are.

Senator HUGHES. Describe your research endeavors under this bill.

Mr. INGERSOLL. Again, this is restricted to the kinds of research activities which are necessary to the enforcement of the act.

Senator HUGHES. What do you construe that to mean. Excuse my interruption. Go ahead.

Mr. INGERSOLL. Primarily, research activities would be directed toward drug identification. If we find new drugs on the street being abused, which are previously unknown combinations, one of our functions and responsibilities is to identify the components of that substance and to determine whether or not it should be subjected to controls.

In the area of law enforcement, our research program is concerned with such matters as where drugs are diverted, at what points in the legitimate distribution channels are substances such as amphetamines and barbiturates diverted into illicit channels.

We are also concerned with the kinds of other criminal activity that drug abusers and addicts are involved in. In our responsibilities for control, we are presently, and will continue, to develop methodology whereby the drug abuse liability potential can be determined through laboratory and other kinds of analysis and research.

Senator HUGHES. Do you have any research contracts out now?

Mr. INGERSOLL. Yes, sir.

Senator HUGHES. Do you have any in the field of marihuana?

Mr. GARFIELD. Yes; we have one study in cooperation with the Defense Department at the Holoman Air Force Base on determining the behavioral effects of marihuana. It is our understanding that that base will be closed in September, and in view of the increased activity on the part of NIMH in the area of marihuana, as the President recently announced—there will be an increase of \$1 billion in their activities—we will terminate our studies on marihuana at Holoman.

Senator HUGHES. What is your total budget for research?

Mr. GARFIELD. \$900,000 for research and \$300,000 for the control of drugs.

Senator HUGHES. Will you furnish to this committee a list of the research contracts you have got, and for what purposes they are being conducted?

Mr. INGERSOLL. Yes, sir.

(The information referred to follows:)

BUREAU OF NARCOTICS AND DANGEROUS DRUGS RESEARCH PROJECTS FOR FISCAL YEARS 1969 THROUGH 1971

FISCAL YEAR 1969—RESEARCH PROJECTS COMPLETED THIS YEAR

1. *Title.*—Rutgers Symposium on Communications and Drug Abuse.

2. *Description.*—The Symposium will be designed as a three day meeting consisting of formal presentation of original papers by experts in the field, followed by discussion period during the day and informal discussion sessions during the evening aimed at increasing understanding and assimilation of material presented during the day. This Symposium will cover the preparation and presentation of authoritative findings in the communications field in at least six areas in order to supply answers to the following questions:

- (1) how can we better communicate our messages about drugs to bring about a greater understanding of their potential for abuse and their proper use;
- (2) how can the use/abuse of drugs be deglamorized;
- (3) how can we develop efforts to increase the prevention of abuse by use of all types of communications.

3. *Contract.*—Contract Number J-69-12.

4. *Contractor.*—Rutgers University, New Brunswick, New Jersey.

5. *Term of Contract.*—June 30, 1966 to April 14, 1970.

6. *Project Cost.*—\$27,000.

7. *Publication.*—The proceedings of this meeting will be published later this year. Publication information not available as of this date.

1. *Title.*—To substantiate methodology developed for the self-administration of drugs by primates.

2. *Description.*—At the Hazleton Laboratories Dr. William Coate is utilizing operant conditioning techniques for the purpose of evaluating behavior before

and after the administration of drugs but in this case the drug is being administered by inhalation through the natural respiratory passage. To accomplish this the animal is equipped with a helmet into which aerosolized preparations of drugs are delivered. There is a difficulty in this particular technique because of the physio-chemical nature of some drugs which make them insoluble and, therefore, difficult to aerosolize. The drugs under study in this contract are cocaine, dextramphothamine, methylphenidate and fluphenamine hydrochloride.

3. *Contract Number.*—J-69-9.

4. *Contractor.*—Hasleton Laboratories Falls Church, Virginia.

5. *Term of Contract.*—June 28, 1969 to February 28, 1970.

6. *Project Cost.*—\$17,917.

7. *Publications.*—No publication to date.

FISCAL YEAR 1970 RESEARCH PROJECTS

1. *Title.*—Show the human drug abuse potential of several compounds.

2. *Description.*—Based on the fact that animals will administer to themselves drugs which give them pleasure, Dr. Findley has succeeded in showing that Rhesus monkeys with in-dwelling venous catheters will become addicted to the commonly known barbiturate, Seconal, by self-administering the drug. That the animal is addicted is evidenced by the appearance of a classic abstinence syndrome when the drug is withdrawn. Once it was known that the monkey could addict himself by self-administration of a drug, Dr. Findley began to do research utilizing this same method to investigate the monkey's interest in self-administering Librias. To date preliminary data indicates that the monkeys will self-administer chloradiapoide, but it is too early in the experiment to draw any conclusions concerning the possibility of his physiological addiction to chlordiazopride. Many more animals will need to be investigated before significant results become available.

3. *Contract Number.*—J-69-13.

4. *Contractor.*—John Hopkins University, Baltimore, Maryland.

5. *Term of Contract.*—November 30, 1969 to June 30, 1970.

6. *Project Cost.*—\$22,000.

7. *Publications.*—No publication to date.

1. *Title.*—Study the cytogenetic effects of dangerous drugs in human beings.

2. *Description.*—To study the effects of LSD on genetic factors in young women. The study population includes young women who have taken LSD, who show fractured or abnormal chromosome patterns in blood and skin examination, and who are pregnant. The patients are followed through the pregnancy, delivery and post natal period. The new babies born are given pediatric care and also are studied genetically by blood and skin biopsy for effects of the LSD on their genetic material. Two major findings are beginning to evolve from the study, namely, the high incidence of abortion and higher than normal involvement of ONS defects in the full term live infants.

The babies show fractured or abnormal chromosome patterns at birth but this seems to correct itself with time. Whether any abnormalities will appear in these children is not known or can be predicted.

3. *Contract Number.*—

4. *Contractor.*—George Washington University.

5. *Term of Contract.*—6 months.

6. *Project Cost.*—\$40,000.

7. *Publications.*—No publication to date.

1. *Title.*—Study and Evaluation of Patterns of Family Behavior Related to Drug Abuse.

2. *Description.*—Dr. Blum is hoping to assess the influence of family attitudes and training on drug using students compared with the peer group influence. Groups of drug using students were identified and contact was then made with their families, parents, brothers and sisters. The same procedure was used in

a control group of known drug using students. Some of the sub-groups in the study population will be Mexican-American families, Negro families, low-income white families and an elite group and a hippie group. In both studies the interviewers were trained and part of the technique of the study involves the duration of the interviews and/or the frequency of them so that the information to be gathered will not be cursory or superficial responses to a set of questions. Currently these studies are approaching the end of the second year. During the first year the questionnaires were designed and validated in a small population. During the present year interviewing of the larger study population will be completed and finally next year, which is the last year of the study, the data will be coded, computerized and analyzed.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—Stanford University.

5. *Term of Contract.*—15 months.

6. *Project Cost.*—\$83,237.

7. *Publications.*—No publication to date.

1. *Title.*—Obtain information regarding the nature and characteristics of the sources of supply of illegal drugs used by young people.

2. *Description.*—Dr. Blum is attempting to study the characteristics of young drug peddlers and their young customers. This study is oriented, particularly, to the young drug dealer on a college campus rather than the professional syndicated drug pusher on the streets. Study is being conducted by trained interviewers with the use of validated questionnaires and will hope to provide data to answer the questions of why this particular occupation is attractive to the young people involved in it and what psychological characteristics in their make up contribute to their choice of this particular business.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—Stanford University.

5. *Term of Contract.*—15 months.

6. *Project Cost.*—\$58,333.

7. *Publications.*—No publication to date.

1. *Title.*—Drug Abuse Model.

2. *Description.*—The purpose of this contract is to pressure a system analysis of drug abuse prevention and control. It is designed to provide a framework (model) in which the major dimensions of the drug problem may be examined and interrelated. The dimensions will incorporate at least these primary classes of variables defining the drug problem: Extent and patterns of drug use and abuse; the channels and economics of distribution of both legal and illegal drugs; methods of control, and the effects of drug addiction and abuse on society. The consequences of applying particular pressures for control of the problem will be compared and assessed, including monetary estimates where feasible. In addition, the available data will be evaluated for its competence and quality and future research needs identified.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—University of California.

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$65,000.

7. *Publications.*—

1. *Title.*—Incidence Study.

2. *Description.*—The purpose of this contract is to develop a method for studying prevalence, incidence, and patterns of illicit use of dangerous drugs, i.e., determine the feasibility of using sample survey techniques for measuring the prevalence, incidence, and patterns of drug use and abuse and develop reliable and valid measures that can be used in household interviews of the population, 14 years old and over. Using the method developed the investigator will conduct a pilot study in one metropolitan area of a representative sample of the population 14 years old and over.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$72,000.

7. *Publications.*—

1. *Title.*—An Immunologic Approach to the Detection of Psychoactive Drugs in Body Fluids.

2. *Description.*—The following steps will be followed by the contractor in an effort to develop a methodology.

(1) Organic synthesis techniques will be utilized to chemically attach the tetrahydrocannabinol to a protein of high molecular weight either directly or through a polyanion or a polycation. The resulting molecule is a protein complex which may have the ability to stimulate the immunological system to produce antibodies.

(2) The protein complex resulting from the organic synthesis (1) above will be administered to rabbits by standard techniques. If it is stimulating the immunological system in the rabbit will produce antibodies after proper sensitization.

(3) Rabbit serum will be drawn and analyzed for antibodies either by complement-fixation, agglutinin or other standard test procedures.

(4) Specificity of the test will be determined by comparing responsivity of the animals to the stimulation of the various isomers isolated from the cannabinal plant.

(5) The particular isomers to be studied will be decided by mutual agreement between the contractor and the project officer.

Data from this research will assist enforcement efforts which rely on the skills of forensic chemists in detecting and measuring tetrahydrocannabinol. Development of the method proposed in this contract will enable the chemist to monitor the amount of tetrahydrocannabinol in experimental animals and subsequently in humans.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—Collaborative Research.

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$32,000.

7. *Publications.*—

1. *Title.*—New York City Accountability Study.

2. *Description.*—The present proposed contract involving the New York City drug store audit project is simply to get adequate EDP programs written, so that already formulated mathematical analyses of the audit data can be run on the Justice Department equipment. The end results or purposes of the overall project, of which the proposed project is an interim stop, are as follows:

1. The collection or sample of individual store errors may enable us to denote limits to acceptable errors, beyond which further action should be taken for corrective purposes.

2. By correlating the error index of an entire drug with the error index for one form-strength combination of the drug for each store, it may be possible to find that less than the complete drug needs to be audited as an indicator of the error acceptability or unacceptability for the entire drug. This could save much time and effort in the auditing process in the future.

3. Tables and graphs showing average receipts, sales and inventory for each of the drugs by month will be displayed as part of a drug flow system using unbiased estimates for the entire city of New York. This is a precursor of a system that could be accomplished for any drug and including the entire drug flow system involving all four levels of distribution and the entire United States.

3. *Contract Number.*—Contact Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$15,000.

7. *Publications.*—

1. *Title*.—To substantiate methodology developed for the self-administration of drugs by primates.

2. *Description*.—At the Illinois Institute Technology Research Institute a variation has been worked into the self-administration experimental design such that the animals are taught certain operant conditioning types of behavior, primarily, response to an avoidance type situation. The animals work at this behavior task for eight (8) hours, similar to the behavior of humans, who work eight (8) hours in an office or in the home, for example. Finally, at the end of the eight (8) hour session the animals continuing to work will receive drug at each lever press. The variable in this experimental design simulates the stress which humans undergo by routine work and the purpose of this experiment is to see whether the animal's work will increase his desire for drugs after having been stressed. If the drug relieves the stress and tension obviously the animal will welcome the opportunity to self-administer it. If no subjective good feeling results, the animal will not self-administer.

Particular attention is being paid to the drug methoqualone, which is a depressant type drug used for sedation and which is also incorporated into amphetamine preparations for the purpose of allaying over stimulation of the amphetamine when these drugs are used as appetite deterrents. Evidence is accumulating that some "benefits" are received from drug use because of the pattern of self-administration that results.

3. *Contract Number*.—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor*.—Illinois Institute of Technology Research Institute.

5. *Term of Contract*.—1 year.

6. *Project Cost*.—\$37,461.

7. *Publications*.—No publication to date.

1. *Title*.—To test methodology developed for the self-administration of abusable drugs by primates.

2. *Description*.—A methodology study which utilizes chimpanzees is being conducted by Dr. Walter Pieper at the Yerkes Primate Center at Emory University. Here the chimpanzees have been taught to smoke tobacco cigarettes. The cigarettes are placed in position via an automatic dispersing device outside the cage and the animal need only suck on a tube inside his test chamber. After the animals have learned to smoke, the tobacco cigarettes are injected with "red oil," which is the molecularly distilled extract of marihuana. These are then substituted for the normal tobacco cigarettes. It is not difficult to teach the animals to smoke but some difficulty has been encountered in teaching the animals to drag on the cigarettes for a long enough duration of time and to inhale deeply and hold the smoke in the lungs for a long enough time for challenge of the active ingredients to pass from the cigarettes to the blood stream. Incorporation of certain operant techniques by the animal as a result for a long enough drag and a long enough inhalation seems promising as a way to circumvent the difficulties.

3. *Contract Number*.—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor*.—Yerkes Primate Center.

5. *Term of Contract*.—1 year.

6. *Project Cost*.—\$30,000.

7. *Publications*.—No publication to date.

1. *Title*.—Physiological (EEG) Method of Predicting Abuse Potential of Drugs.

2. *Description*.—The contract will provide data consisting of EEG tracings and an analysis of these tracings will show the OMS affects of the drugs administered. The drug effects may consist of shifts in the frequency of the potentials, the amplitude of the potentials and the time duration. Unique to this contract and the specific reason for it is the method of spectral analysis used. It will be done by computer techniques which are sure sensitive than the usual frequency-type analysis employed in the field and also less time consuming.

3. *Contract Number*.—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor*.—University of California.

5. *Terms of Contract*.—1 year.
 6. *Project Cost*.—\$10,500.
 7. *Publications*.—
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1. *Title*.—Diversion of Controlled Drugs from Legitimate Channels.
(To be handled by Compliance and Investigations Division.)
Information from M. K. Durrin.

FISCAL YEAR 1970 CONTRACTS CONTINUED IN FISCAL YEAR 1971

Relationship of Addicts and Incidence of crime, \$100,000; 1 year.
Economic and Social Costs of Drug Abuse, \$70,000; 1 year.
Diversion of Controlled Drugs from Legitimate Channels, \$100,000; 1 year.
Yorke's Primate Laboratory—Emory University, \$30,000; 1 year.
Nationwide Survey of Drug Abuse, \$100,000; 1 year.
Collaborative Research, Inc.—Immunological Techniques, \$50,000; 1 year.

NEW PROJECTS, FISCAL YEAR 1971

1. *Title*.—"Detection of Clandestine Labs by Remote Sensing".
2. *Description*.—One approach to this problem that has been suggested is use of certain highly purified crystalline substances that change characteristics when exposed to other compounds. These changes are then electrically detected, amplified and provide a read-out.

Other techniques are straight infra-red or ultra-violet recordings.

3. *Contract Number*.—
 4. *Contractor*.—
 5. *Term of Contract*.—1 year.
 6. *Project Cost*.—\$50,000.
-

1. *Title*.—Develop Data on Drug Injuries.
2. *Description*.—There is need to know the extent of drug injuries ranging from youthful one time drug users to the long term narcotic addicts; from mild transient symptoms to serve long lasting effects; from physical to psychological problems; and, covering all pharmacological categories of CMS drugs.

3. *Contract Number*.—
 4. *Contractor*.—
 5. *Term of Contract*.—1 year.
 6. *Project Cost*.—\$75,000.
-

1. *Title*.—Development of an Improved Nationwide Drug Abuser Reporting System.

2. *Description*.—To provide an unduplicated count of narcotic addicts and other drug abusers throughout the nation. To explore the register as an epidemiological tool and to provide fiscal and manpower requirements of such a register.

3. *Contract Number*.—
 4. *Contractor*.—
 5. *Terms of Contract*.—1 year.
 6. *Project Cost*.—\$35,000.
-

1. *Title*.—Blood and Tissue Measures of Hallucinogenic Drugs and/or Their Metabolites.

2. *Description*.—The purpose of this contract is to establish methods for forensic use. Very little has been done in this area partly because these drugs have no medical use. Emphasis in this contract will be on hallucinogens other than LSD.

3. *Contract Number*.—
4. *Contractor*.—
5. *Term of Contract*.—1 year.
6. *Project Cost*.—\$75,000.

1. *Title.*—Personnel Studies—Determine Characteristics of Personnel that Contributes to Professional Enforcement.

2. *Description.*—A series of small studies is needed to aid the Personnel Division in selection of special agents. (A beginning was made in the Critical Incidents Study in 1969). Solid facts are needed on the characteristics of agent candidates and on training programs associated with later performance on the job. One such problem is the prevention of breaches of integrity by agents who may compromise their allegiance to law; the narcotics officer is vulnerable to such breaches by the nature of his work. Equally essential is a study of characteristics related to positive performance, job tenure, and promotion potential.

The planning of research design and development of instruments will be carried out jointly between Division Staff and a personnel psychologist on contract from a university or private research firm. Collection, analysis and interpretation of data will be carried on in-house by Division Staff in studies where strict confidentiality or security is concerned.

3. *Contract Number.*—

4. *Contractor.*—

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$40,000.

1. *Title.*—Develop and Maintain a System of Reporting by Professionals on Drug Abuse.

2. *Description.*—A System will be developed to utilize key medical examiners, coroners, forensic pathologist, toxicologists, student health medical officers, etc., to report for control and regulatory purposes documented cases of abuse of non-controlled drugs.

3. *Contract Number.*—

4. *Contractor.*—

5. *Term of Contract.*—1 year.

6. *Project Cost.*—\$75,000.

1. *Title.*—A Study Comparing Patterns of Criminal Behavior of Narcotic Users with Non-Narcotic Users.

2. *Description.*—The major goals of the contract are: (1) To compare rate of arrests for serious crimes allegedly committed by narcotic users with rate of arrests for serious crimes allegedly committed by non narcotic users. (2) To determine whether a change in the pattern of criminal behavior of narcotic users from less serious crimes to more serious crimes has occurred. (3) To determine dispositions of cases of narcotics users brought to trial for committing serious crimes.

3. *Contract Number.*—Contract Not Yet Consummated. Therefore, information not yet available.

4. *Contractor.*—

5. *Term of Contract.*—1 year.

6. *Project Cost*.—\$85,000.

7. *Publications*.—No publication to date.

1. *Title*.—The Underground Press.

2. *Description*.—The objective of this work is to determine what effect the news media have had or could have, on the decision of young people to become engaged in drug using, or on the contrary, to avoid drug use.

3. *Contract Number*.—

4. *Contractor*.—

5. *Term of Contract*.—1 year.

6. *Project Cost*.—\$25,000.

1. *Title*.—ESG Studies *—University of Texas, Galveston.

2. *Description*.—These studies correlated laboratory experiments with marijuana with human effects. Animal EEG effects and behavioral changes are investigated and these changes are then related to similar information in human users. Since manipulation can be done with lab animals, successful treatment can then be used on humans.

3. *Contract Number*.—

4. *Contractor*.—

5. *Term of Contract*.—1 year.

6. *Project Cost*.—\$75,000.

Mr. INGERSOLL. I might point out, Mr. Chairman, that some of the research projects that we have been carrying on in the last year and a half or two years, since BNDD was organized, were ones that we inherited when the former Bureau of Drug Abuse Control was transferred to the Department of Justice.

We didn't want to terminate this research, because we felt that that would be wasteful and we would lose information. However, at the conclusion of these research projects, we are terminating them and our research program is being more mission oriented. In addition to the examples I gave you a few minutes ago, we are attempting to develop improved technology that will assist in the enforcement program.

One example of this is the development of better field kits to identify drugs in the field that are seized and we are working presently with a number of States on pilot marihuana eradication projects in those areas of the country where marihuana grows wild at this time.

Senator HUGHES. Would you then indicate to me when you furnish that, the number you are intending to phase out and when their final dates will be?

Mr. INGERSOLL. We will indeed.

(The information subsequently supplied follows:)

PLANS FOR BUREAU OF DRUG ABUSE CONTROL

The Bureau at this time does not plan to renew its contract in fiscal year 1971 with George Washington University to study the cytogenetic effects of dangerous drugs in humans. In addition, at the end of fiscal year 1970 two methadology studies in abusable drugs will be concluded.

Senator HUGHES. Will you also indicate plans you have for new research projects that have not yet been developed? I am assuming you are intending to increase your budget in research.

*First-year study to be funded by LEAA.

Mr. INGERSOLL. As a matter of fact, we are not. Our request in fiscal 1971 will be about the same as it is this year.

Senator HUGHES. All right. Indicate to me in what areas you intend to research. If nothing else, it would help allay concerns I have about lack of research restrictions in that particular bill.

I want some limitations, as much as we can get in the record, on precisely what you are trying to do or what your intent is. At a later date, if you do take off in some new direction, I at least am intending to have you back to explain why.

I obviously feel the administration does not want this bill under any circumstances, and I think that was conveyed by HEW and your own testimony. Your testimony is very concise and to the point, and I appreciate that, because it will be helpful to us as we go through this bill to try to improve on it and make some changes that are necessary.

We certainly don't want to do anything that would impair your effectiveness in the fields you are working in. I want to assure you of that, and where we may have differences, we will try to work those out logically between us if we possibly can.

I am going to repeat a couple of statements that the President has made. No. 1, in his July 14 message, as you quoted, he said there have been common oversimplifications in the law enforcement program alone.

Attorney General Mitchell, on September 15, stated:

The Department of Health, Education, and Welfare has the primary functions of providing for research, education, and treatment in the field of drug abuse.

I assume you agree with those statements.

Mr. INGERSOLL. Yes, indeed, absolutely.

Senator HUGHES. You don't have any differences of opinion with either one of those statements?

Mr. INGERSOLL. No, sir.

Senator HUGHES. So you understand the need that this subcommittee has as a subcommittee of the Labor and Public Welfare Committee to look into these areas and act in accordance with its best judgment in proposing legislation in these areas when they find it to be necessary.

Is that really true?

Mr. INGERSOLL. Mr. Chairman, I always welcome legislative inquiry into our programs; it is of assistance to us in sharpening and defining our goals and objectives as well.

Senator HUGHES. In your prepared statement you state that the statement in section 101(a) that holding drug abuse as a disease goes beyond the holding in the *Robinson* case.

Would you summarize the case and provide a copy of the decision for our records?

Mr. INGERSOLL. Yes, sir.

(The information subsequently supplied follows:)

SUMMARY OF ROBINSON V. CALIFORNIA *

ROBINSON V. CALIFORNIA, 370 U.S. 660

In a new approach to the Eighth Amendment's ban on "cruel and inhuman punishments," the Supreme Court declared that sickness may not be made a

*Extracted from *The Criminal Law Revolution, 1960-1969*, The Bureau of National Affairs Inc. (1969), p. 13.

crime, nor may sick people be punished for being sick. Since narcotics addiction is a sickness, a state cannot make it a punishable offense any more than it could put a man in jail "for the 'crime' of having a common cold."

Only Mr. Justice Clark and Mr. Justice White voted to uphold the conviction. Mr. Justice Stewart, who wrote the majority opinion, said "It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A state might determine that the general health and welfare required that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See *Francis v. Resweber*, 329 U.S. 459.

"We cannot but consider the statute before us as of the same category. In this Court counsel for the State recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily. We hold that a state law which imprisons a person thus afflicted as a criminal even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment."

Mr. Justice Harlan was "not prepared to hold that on the present state of medical knowledge it is completely irrational and hence unconstitutional for a State to conclude that narcotics addiction is something other than an illness nor that it amounts to cruel and unusual punishment for the State to subject narcotics addicts to its criminal law." However, he agreed that the application of the California statute was unconstitutional in this case.

Dissenting, Mr. Justice Clark felt that California's "enlightened program" relative to narcotics addicts—including both the criminal and civil provisions—"is inherently one of treatment and lies well within the power of a State."

Also dissenting, Mr. Justice White was not at all ready to place the use of narcotics beyond the reach of state criminal laws. He did not consider the defendant's conviction to be a punishment for having an illness or for simply being in some status or condition, but rather a conviction for the regular, repeated unlawful use of narcotics immediately prior to his arrest.

SUPREME COURT OF THE UNITED STATES

No. 554.—OCTOBER TERM, 1961.

Lawrence Robinson,	}	On Appeal from the Appellate Department of the Superior Court of California, County of Los Angeles.
Appellant,		
v.		
California.		

[June 25, 1962.]

MR. JUSTICE STEWART delivered the opinion of the Court.

A California statute makes it a criminal offense for a person to "be addicted to the use of narcotics."¹ This appeal draws into question the constitutionality of that provision of the state law, as construed by the California courts in the present case.

The appellant was convicted after a jury trial in the Municipal Court of Los Angeles. The evidence against him was given by two Los Angeles police officers. Officer Brown testified that he had had occasion to examine the appellant's arms one evening on a street in Los Angeles

¹ The statute is § 11721 of the California Health and Safety Code. It provides:

"No person shall use, or be under the influence of, or be addicted to the use of narcotics, excepting when administered by or under the direction of a person licensed by the State to prescribe and administer narcotics. It shall be the burden of the defense to show that it comes within the exception. Any person convicted of violating any provision of this section is guilty of a misdemeanor and shall be sentenced to serve a term of not less than 90 days nor more than one year in the county jail. The court may place a person convicted hereunder on probation for a period not to exceed five years and shall in all cases in which probation is granted require as a condition thereof that such person be confined in the county jail for at least 90 days. In no event does the court have the power to absolve a person who violates this section from the obligation of spending at least 90 days in confinement in the county jail."

some four months before the trial.² The officer testified that at that time he had observed "scar tissue and discoloration on the inside" of the appellant's right arm, and "what appeared to be numerous needle marks and a scab which was approximately three inches below the crook of the elbow" on the appellant's left arm. The officer also testified that the appellant under questioning had admitted to the occasional use of narcotics.

Officer Lindquist testified that he had examined the appellant the following morning in the Central Jail in Los Angeles. The officer stated that at that time he had observed discolorations and scabs on the appellant's arms, and he identified photographs which had been taken of the appellant's arms shortly after his arrest the night before. Based upon more than ten years of experience as a member of the Narcotic Division of the Los Angeles Police Department, the witness gave his opinion that "these marks and the discoloration were the result of the injection of hypodermic needles into the tissue into the vein that was not sterile." He stated that the scabs were several days old at the time of his examination, and that the appellant was neither under the influence of narcotics nor suffering withdrawal symptoms at the time he saw him. This witness also testified that the appellant had admitted using narcotics in the past.

The appellant testified in his own behalf, denying the alleged conversations with the police officers and denying

² At the trial the appellant, claiming that he had been the victim of an unconstitutional search and seizure, unsuccessfully objected to the admission of Officer Brown's testimony. That claim is also pressed here, but since we do not reach it there is no need to detail the circumstances which led to Officer Brown's examination of the appellant's person. Suffice it to say, that at the time the police first accosted the appellant, he was not engaging in illegal or irregular conduct of any kind, and the police had no reason to believe he had done so in the past.

that he had ever used narcotics or been addicted to their use. He explained the marks on his arms as resulting from an allergic condition contracted during his military service. His testimony was corroborated by two witnesses.

The trial judge instructed the jury that the statute made it a misdemeanor for a person "either to use narcotics, or to be addicted to the use of narcotics"³ That portion of the statute referring to the 'use' of narcotics is based upon the 'act' of using. That portion of the statute referring to 'addicted to the use' of narcotics is based upon a condition or status. They are not identical. . . . To be addicted to the use of narcotics is said to be a status or condition and not an act. It is a continuing offense and differs from most other offenses in the fact that is chronic rather than acute; that it continues after it is complete and subjects the offender to arrest at any time before he reforms. The existence of such a chronic condition may be ascertained from a single examination, if the characteristic reactions of that condition be found present."

The judge further instructed the jury that the appellant could be convicted under a general verdict if the jury agreed *either* that he was of the "status" *or* had committed the "act" denounced by the statute.⁴ "All that the Peo-

³ The judge did not instruct the jury as to the meaning of the term "under the influence of" narcotics, having previously ruled that there was no evidence of a violation of that provision of the statute. See note 1, *supra*.

⁴ "Where a statute such as that which defines the crime charged in this case denounces an act and a status or condition, either of which separately as well as collectively, constitute the criminal offense charged, an accusatory pleading which accuses the defendant of having committed the act and of being of the status or condition so denounced by the statute, is deemed supported if the proof shows that the defendant is guilty of any one or more of the offenses thus specified. However, it is important for you to keep in mind that,

ple must show is either that the defendant did use a narcotic in Los Angeles County, or that while in the City of Los Angeles he was addicted to the use of narcotics”⁵

Under these instructions the jury returned a verdict finding the appellant “guilty of the offense charged.” An appeal was taken to the Appellate Department of the Los Angeles County Superior Court, “the highest court of a State in which a decision could be had” in this case. 28 U. S. C. § 1257. See *Smith v. California*, 361 U. S. 147, 149; *Edwards v. California*, 314 U. S. 160, 171. Although expressing some doubt as to the constitutionality of “the crime of being a narcotic addict,” the reviewing court in an unreported opinion affirmed the judgment of conviction, citing two of its own previous unreported decisions which had upheld the constitutionality of the statute.⁶ We noted probable jurisdiction of this appeal, 368 U. S. 918, because it squarely presents the issue whether the statute as construed by the California courts in this case is repugnant to the Fourteenth Amendment of the Constitution.

in order, to convict a defendant in such a case, it is necessary that all of you agree as to the same particular act or status or condition found to have been committed or found to exist. It is not necessary that the particular act or status or condition so agreed upon be stated in the verdict.”

⁵ The instructions continued “and it is then up to the defendant to prove that the use, or of being addicted to the use of narcotics was administered by or under the direction of a person licensed by the State of California to prescribe and administer narcotics or at least to raise a reasonable doubt concerning the matter.” No evidence, of course, had been offered in support of this affirmative defense, since the appellant had denied that he had used narcotics or been addicted to their use.

⁶ The appellant tried unsuccessfully to secure habeas corpus relief in the District Court of Appeal and the California Supreme Court.

The broad power of a State to regulate the narcotic drugs traffic within its borders is not here in issue. More than forty years ago, in *Whipple v. Martinson*, 256 U. S. 41, this Court explicitly recognized the validity of that power: "There can be no question of the authority of the State in the exercise of its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs. . . . The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called in question." 256 U. S., at 45.

Such regulation, it can be assumed, could take a variety of valid forms. A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or possession of narcotics within its borders. In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a State might establish a program of compulsory treatment for those addicted to narcotics.⁷ Such a program of treatment might require periods of involuntary confinement. And penal sanctions might be imposed for failure to comply with established compulsory treatment procedures. Cf. *Jacobson v. Massachusetts*, 197 U. S. 11. Or a State might choose to attack the evils of narcotics traffic on broader fronts also—through public health education, for example, or by efforts to ameliorate the economic and social conditions under which those evils might be thought to flourish. In short, the range of valid choice which a State might make in this area is undoubtedly a wide one, and the wisdom

⁷ California appears to have established just such a program in §§ 5350-5361 of its Welfare and Institutions Code. The record contains no explanation of why the civil procedures authorized by this legislation were not utilized in the present case.

of any particular choice within the allowable spectrum is not for us to decide. Upon that premise we turn to the California law in issue here.

It would be possible to construe the statute under which the appellant was convicted as one which is operative only upon proof of the actual use of narcotics within the State's jurisdiction. But the California courts have not so construed this law. Although there was evidence in the present case that the appellant had used narcotics in Los Angeles, the jury were instructed that they could convict him even if they disbelieved that evidence. The appellant could be convicted, they were told, if they found simply that the appellant's "status" or "chronic condition" was that of being "addicted to the use of narcotics." And it is impossible to know from the jury's verdict that the defendant was not convicted upon precisely such a finding.

The instructions of the trial court, implicitly approved on appeal, amounted to "a ruling on a question of state law that is as binding on us as though the precise words had been written" into the statute. *Terminiello v. Chicago*, 337 U. S. 1, 4. "We can only take the statute as the state courts read it." *Id.*, at 6. Indeed, in its brief in this Court counsel for the State has emphasized that it is "the proof of addiction by circumstantial evidence . . . by the tell-tale track of needle marks and scabs over the veins of his arms, that remains the gist of the section."

This statute, therefore, is not one which punishes a person for the use of narcotics, for their purchase, sale or possession, or for antisocial or disorderly behavior resulting from their administration. It is not a law which even purports to provide or require medical treatment. Rather, we deal with a statute which makes the "status" of narcotic addiction a criminal offense, for which the offender may be prosecuted "at any time before he reforms."

California has said that a person can be continuously guilty of this offense, whether or not he has ever used or possessed any narcotics within the State, and whether or not he has been guilty of any antisocial behavior there.

It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare required that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See *Francis v. Resweber*, 329 U. S. 459.

We cannot but consider the statute before us as of the same category. In this Court counsel for the State recognized that narcotic addiction is an illness.⁸ Indeed, it is apparently an illness which may be contracted innocently or involuntarily.⁹ We hold that a state law which

⁸ In its brief the appellee stated: "Of course it is generally conceded that a narcotic addict, particularly one addicted to the use of heroin, is in a state of mental and physical illness. So is an alcoholic." Thirty-seven years ago this Court recognized that persons addicted to narcotics "are diseased and proper subjects for [medical] treatment." *Linder v. United States*, 268 U. S. 5, 18.

⁹ Not only may addiction innocently result from the use of medically prescribed narcotics, but a person may even be a narcotics addict from the moment of his birth. See Schneck, "Narcotic Withdrawal Symptoms in the Newborn Infant Resulting from Maternal Addiction," *The Journal of Pediatrics*, 52: 584, 1958; Roman and Middelkamp, "Narcotic Addiction in a Newborn Infant," *The Journal of Pediatrics*, 53: 231, 1958; Kunstadter, Klein, Lundeen, Witz, and Morrison, "Narcotic Withdrawal Symptoms in Newborn Infants," *The Journal*

imprisons a person thus afflicted as a criminal, even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment. To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be a cruel and unusual punishment for the "crime" of having a common cold.

We are not unmindful that the vicious evils of the narcotics traffic have occasioned the grave concern of government. There are, as we have said, countless fronts on which those evils may be legitimately attacked. We deal in this case only with an individual provision of a particularized local law as it has so far been interpreted by the California courts.

Reversed.

MR. JUSTICE FRANKFURTER took no part in the consideration or decision of this case.

of the American Medical Association, 168: 1008, 1958; Slobody and Cobrinik, "Neonatal Narcotic Addiction," Quarterly Review of Pediatrics, 14: 169, 1959; Vincow and Hackel, "Neonatal Narcotic Addiction," General Practitioner, 22: 90, 1960; Dikshit, "Narcotic Withdrawal Syndrome in Newborns," Indian Journal of Pediatrics, 28: 11, 1961.

SUPREME COURT OF THE UNITED STATES

No. 554.—OCTOBER TERM, 1961.

Lawrence Robinson,	}	On Appeal from the Appellate Department of the Superior Court of California, County of Los Angeles.
Appellant,		
v.		
California.		

[June 25, 1962.]

MR. JUSTICE DOUGLAS, concurring.

While I join the Court's opinion, I wish to make more explicit the reasons why I think it is "cruel and unusual" punishment in the sense of the Eighth Amendment to treat as a criminal a person who is a drug addict.

In Fifteenth Century England one prescription for insanity was to beat the subject "until he had regained his reason." Deutsch, *The Mentally Ill in America* (1937), p. 13. In America "the violently insane went to the whipping post and into prison dungeons or, as sometimes happened, were burned at the stake or hanged"; and "the pauper insane often roamed the countryside as wild men and from time to time were pilloried, whipped, and jailed." *Action for Mental Health* (1961), p. 26.

As stated by Dr. Isaac Ray many years ago:

"Nothing can more strongly illustrate the popular ignorance respecting insanity than the proposition, equally objectionable in its humanity and its logic, that the insane should be punished for criminal acts, in order to deter other insane persons from doing the same thing." *Treatise on the Medical Jurisprudence of Insanity* (5th ed. 1871).

Today we have our differences over the legal definition of insanity. But however insanity is defined, it is in end effect treated as a disease. While afflicted people

may be confined either for treatment or for the protection of society, they are not branded as criminals.

Yet terror and punishment linger on as means of dealing with some diseases. As recently stated:

" . . . the idea of basing treatment for disease on purgatorial acts and ordeals is an ancient one in medicine. It may trace back to the Old Testament belief that disease of any kind, whether mental or physical, represented punishment for sin; and thus relief could take the form of a final heroic act of atonement. This superstition appears to have given support to fallacious medical rationales for such procedures as purging, bleeding, induced vomiting, and blistering, as well as an entire chamber of horrors constituting the early treatment of mental illness. The latter included a wide assortment of shock techniques, such as the 'water cures' (dousing, ducking, and near-drowning), spinning in a chair, centrifugal swinging, and an early form of electric shock. All, it would appear, were planned as means of driving from the body some evil spirit or toxic vapor." Action for Mental Health (1961), pp. 27-28.

That approach continues as respects drug addicts. Drug addiction is more prevalent in this country than in any other nation of the western world.¹ S. Rep. No. 1440, 84th Cong., 2d Sess., p. 2. It is sometimes referred to as "a contagious disease." *Id.*, at p. 3. But those living in a world of black and white put the addict in the cate-

¹ Drug Addiction: Crime or Disease? (1961), p. XIV. ". . . even if one accepts the lowest estimates of the number of addicts in this country there would still be more here than in all the countries of Europe combined. Chicago and New York City, with a combined population of about 11 million or one-fifth that of Britain, are ordinarily estimated to have about 30,000 addicts, which is from thirty to fifty times as many as there are said to be in Britain."

gory of those who could, if they would, forsake their evil ways.

The first step toward addiction may be as innocent as a boy's puff on a cigarette in an alleyway. It may come from medical prescriptions. Addiction may even be present at birth. Earl Ubell recently wrote:

"In Bellevue Hospital's nurseries, Dr. Saul Krugman, head of pediatrics, has been discovering babies minutes old who are heroin addicts.

"More than 100 such infants have turned up in the last two years, and they show all the signs of drug withdrawal: irritability, jitters, loss of appetite, vomiting, diarrhea, sometimes convulsions and death.

"Of course, they get the drug while in the womb from their mothers who are addicts,' Dr. Krugman said yesterday when the situation came to light. 'We control the symptoms with Thorazine, a tranquilizing drug.

"You should see some of these children. They have a high-pitched cry. They appear hungry but they won't eat when offered food. They move around so much in the crib that their noses and toes become red and excoriated.'

"Dr. Lewis Thomas, professor of medicine at New York University-Bellevue, brought up the problem of the babies Monday night at a symposium on narcotics addiction sponsored by the New York County Medical Society. He saw in the way the babies respond to treatment a clue to the low rate of cure of addiction.

"Unlike the adult addict who gets over his symptoms of withdrawal in a matter of days, in most cases,' Dr. Thomas explained later, 'the infant has to be treated for weeks and months. The baby continues to show physical signs of the action of the drugs.

" 'Perhaps in adults the drugs continue to have physical effects for a much longer time after withdrawal than we have been accustomed to recognize. That would mean that these people have a physical need for the drug for a long period, and this may be the clue to recidivism much more than the social or psychological pressures we've been talking about.' "

N. Y. Herald Tribune, Apr. 25, 1962, p. 25.

The addict is under compulsions not capable of management without outside help. As stated by the Council on Mental Health:

"Physical dependence is defined as the development of an altered physiological state which is brought about by the repeated administration of the drug and which necessitates continued administration of the drug to prevent the appearance of the characteristic illness which is termed an abstinence syndrome. When an addict says that he has a habit he means that he is physically dependent on a drug. When he says that one drug is habit-forming and another is not, he means that the first drug is one on which physical dependence can be developed and that the second is a drug on which physical dependence cannot be developed. Physical dependence is a real physiological disturbance. It is associated with the development of hyperexcitability in reflexes mediated through multineurone arcs. It can be induced in animals, it has been shown to occur in the paralyzed hind limbs of addicted chronic spinal dogs, and also has been produced in dogs whose cerebral cortex has been removed." Report on Narcotic Addiction, 165 A. M. A. J. 1707, 1713.

Some say the addict has a disease. See Hesse, *Narcotics and Drug Addiction* (1946), p. 40 *et seq.*

Others say addiction is not a disease but "a symptom of a mental or psychiatric disorder." H. R. Rep. No. 2388, 84th Cong., 2d Sess., p. 8. And see Present Status of Narcotic Addiction, 138 A. M. A. J. 1019, 1026; Narcotic Addiction, Report to Attorney General Brown by Citizens Advisory Committee to the Attorney General on Crime Prevention (1954), p. 12; Finestone, Narcotics and Criminality, 22 Law & Contemp. Prob. 69, 83-85 (1957).

The extreme symptoms of addiction have been described as follows:

"To be a confirmed drug addict is to be one of the walking dead The teeth have rotted out; the appetite is lost and the stomach and intestines don't function properly. The gall bladder becomes inflamed; eyes and skin turn a billious yellow. In some cases membranes of the nose turn a flaming red; the partition separating the nostrils is eaten away—breathing is difficult. Oxygen in the blood decreases; bronchitis and tuberculosis develop. Good traits of character disappear and bad ones emerge. Sex organs become affected. Veins collapse and livid purplish scars remain. Boils and abscesses plague the skin; gnawing pain racks the body. Nerves snap; vicious twitching develops. Imaginary and fantastic fears blight the mind and sometimes complete insanity results. Often times, too, death comes—much too early in life Such is the torment of being a drug addict; such is the plague of being one of the walking dead." N. Y. L. J., June 8, 1960, p. 4.

Some States punish addiction, though most do not. See S. Doc. No. 120, 84th Cong., 2d Sess., pp. 41, 42. Nor does the Uniform Narcotic Drug Act, first approved in 1932 and now in effect in most of the States. Great Britain, beginning in 1920 placed "addiction and the

treatment of addicts squarely and exclusively into the hands of the medical profession." Lindesmith, *The British System of Narcotics Control*, 22 *Law & Contemp. Prob.* 138 (1957). In England the doctor "has almost complete professional autonomy in reaching decisions about the treatment of addicts." Schur, *British Narcotics Policies*, 61 *J. Crim. L., Criminology & P. Sc.* 619, 621 (1961). Under British law "addicts are patients, not criminals." *Ibid.* Addicts have not disappeared in England but they have decreased in number (*id.*, at 622) and there is now little "addict-crime" there. *Id.*, at 623.

The fact that England treats the addict as a sick person, while a few of our States, including California, treat him as a criminal, does not, of course, establish the unconstitutionality of California's penal law. But we do know that there is "a hard core" of "chronic and incurable drug addicts who, in reality, have lost their power of self-control." S. Rep. No. 2033, 84th Cong., 2d Sess., p. 8. There has been a controversy over the type of treatment—whether enforced hospitalization or ambulatory care is better. H. R. Rep. No. 2388, 84th Cong., 2d Sess., pp. 66–68. But there is little disagreement with the statement of Charles Winick: "The hold of drugs on persons addicted to them is so great that it would be almost appropriate to reverse the old adage and say that opium derivatives represent the religion of the people who use them." *Narcotics Addiction and its Treatment*, 22 *Law & Contemp. Prob.* 9 (1957). The abstinence symptoms and their treatment are well known. *Id.*, at 10–11. Cure is difficult because of the complex of forces that make for addiction. *Id.*, at 18–23. "After the withdrawal period, vocational activities, recreation, and some kind of psychotherapy have a major role in the treatment program, which ideally lasts from four to six months." *Id.*, at 23–24. Dr. Marie Nyswander tells us that normally a drug addict

must be hospitalized in order to be cured. The Drug Addict as a Patient (1956), p. 138.

The impact that an addict has on a community causes alarm and often leads to punitive measures. Those measures are justified when they relate to acts of transgression. But I do not see how under our system *being an addict* can be punished as a crime. If addicts can be punished for their addiction, then the insane can also be punished for their insanity. Each has a disease and each must be treated as a sick person.² As Charles Winick has said:

"There can be no single program for the elimination of an illness as complex as drug addiction, which

² "The sick addict must be quarantined until cured, and then carefully watched until fully rehabilitated to a life of normalcy." Narcotics, N. Y. Leg. Doc. No. 27 (1952), p. 116. And see the report of Judge Morris Ploscowe printed as Appendix A, Drug Addiction: Crime or Disease? (1961), pp. 18, 19-20, 21.

"These predilections for stringent law enforcement and severer penalties as answers to the problems of drug addiction reflect the philosophy and the teachings of the Bureau of Narcotics. For years the Bureau has supported the doctrine that if penalties for narcotic drug violations were severe enough and if they could be enforced strictly enough, drug addiction and the drug traffic would largely disappear from the American scene. This approach to problems of narcotics has resulted in spectacular modifications of our narcotic drug laws on both the state and federal level. . . .

"Stringent law enforcement has its place in any system of controlling narcotic drugs. However, it is by no means the complete answer to American problems of drug addiction. In the first place it is doubtful whether drug addicts can be deterred from using drugs by threats of jail or prison sentences. The belief that fear of punishment is a vital factor in deterring an addict from using drugs rests upon a superficial view of the drug addiction process and the nature of drug addiction. . . .

"The very severity of law enforcement tends to increase the price of drugs on the illicit market and the profits to be made therefrom. The lure of profits and the risks of the traffic simply challenge the ingenuity of the underworld peddlers to find new channels of distribu-

carries so much emotional freight in the community.. Cooperative interdisciplinary research and action, more local community participation, training the various healing professions in the techniques of dealing with addicts, regional treatment facilities, demonstration centers, and a thorough and vigorous post-treatment rehabilitation program would certainly appear to be among the minimum requirements for any attempt to come to terms with this problem. The addict should be viewed as a sick person, with a chronic disease which requires almost emergency action." 22 Law & Contemp. Prob. 9, 33 (1957).

The Council on Mental Health reports that criminal sentences for addicts interferes "with the possible treatment and rehabilitation of addicts and therefore should be abolished." 165 A. M. A. J. 1968, 1972.

The command of the Eighth Amendment, banning "cruel and unusual punishments," stems from the Bill of Rights of 1688. See *Francis v. Resweber*, 329 U. S. 459, 463. And it is applicable to the States by reason of the Due Process Clause of the Fourteenth Amendment. *Ibid.*

The historic punishments that were cruel and unusual included "burning at the stake, crucifixion, breaking on the wheel" (*In re Kemmler*, 136 U. S. 436, 446), quartering, the rack and thumb screw (see *Chambers v. Florida*, 309 U. S. 227, 237), and in some circumstances even solitary confinement (see *Medley*, 134 U. S. 160, 167-168).

tion and new customers, so that profits can be maintained despite the risks involved. So long as a non-addict peddler is willing to take the risk of serving as a wholesaler of drugs, he can always find addict pushers or peddlers to handle the retail aspects of the business in return for a supply of the drugs for themselves. Thus, it is the belief of the author of this report that no matter how severe law enforcement may be, the drug traffic cannot be eliminated under present prohibitory repressive statutes."

The question presented in the earlier cases concerned the degree of severity with which a particular offense was punished or the element of cruelty present.³ A punishment out of all proportion to the offense may bring it within the ban against "cruel and unusual punishments." See *O'Neil v. Vermont*, 144 U. S. 323, 331. So may the cruelty of the method of punishment, as, for example, the emboweling a person alive. See *Wilkerson v. Utah*, 99 U. S. 130, 135. But the principle that would deny power to exact capital punishment for a petty crime would also deny power to punish a person by fine or imprisonment for being sick.

The Eighth Amendment expresses the revulsion of civilized man against barbarous acts—the "cry of horror" against man's inhumanity to his fellow man. See *O'Neil v. Vermont*, *supra*, at 340 (dissenting opinion); *Francis v. Resweber*, *supra*, at 473 (dissenting opinion).

By the time of Coke, enlightenment was coming as respects the insane. Coke said that the execution of a madman "should be a miserable spectacle, both against law, and of extreme inhumanity and cruelty, and can be no example to others." 6 Coke's Third Inst. (4th ed. 1797), p. 6. Blackstone endorsed this view of Coke. 4 Commentaries (Lewis ed. 1897), p. 25.

We should show the same discernment respecting drug addiction. The addict is a sick person. He may, of course, be confined for treatment or for the protection of society.⁴ Cruel and unusual punishment results not from confinement, but from convicting the addict of a crime.

³ See 3 Catholic L. Rev. 117 (1953); 31 Marq. L. Rev. 108 (1947); 22 St. John's L. Rev. 270 (1948); 2 Stan. L. Rev. 174 (1949); 33 Va. L. Rev. 348 (1947); 21 Tul. L. Rev. 480 (1947); 1960 Wash. U. L. Q., p. 160.

⁴ As to the insane, see *Lynch v. Oversolser*, 369 U. S. —; note, 1 L. Rep. Ann. (N. S.), pp. 540 *et seq.*

The purpose of § 11721 is not to cure, but to penalize. Were the purpose to cure, there would be no need for a mandatory jail term of not less than 90 days. Contrary to my Brother CLARK, I think the means must stand constitutional scrutiny, as well as the end to be achieved. A prosecution for addiction, with its resulting stigma and irreparable damage to the good name of the accused, cannot be justified as a means of protecting society, where a civil commitment would do as well. Indeed, in § 5350 of the Welfare and Institutions Code California has expressly provided for civil proceedings for the commitment of habitual addicts. Section 11721 is, in reality, a direct attempt to punish those the State cannot commit civilly.⁵

⁵ The difference between § 5350 and § 11721 is that the former aims at treatment of the addiction, whereas § 11721 does not. The latter cannot be construed to provide treatment, unless jail sentences, without more, are suddenly to become medicinal. A comparison of the lengths of confinement under the two sections is irrelevant, for it is the purpose of the confinement that must be measured against the constitutional prohibition of cruel and unusual punishments.

Health and Safety Code § 11391, to be sure, indicates that perhaps some form of treatment may be given an addict convicted under § 11721. Section 11391, so far as here relevant, provides:

"No person shall treat an addict for addiction except in one of the following:

"(a) An institution approved by the Board of Medical Examiners, and where the patient is at all times kept under restraint and control.

"(b) A *city or county jail*.

"(c) A state prison.

"(d) A state narcotic hospital.

"(e) A state hospital.

"(f) A county hospital.

"This section does not apply during emergency treatment or where the patient's addiction is complicated by the presence of incurable disease, serious accident, or injury, or the infirmities of old age."

Section 11391 does not state that any treatment is required for either part or the whole of the mandatory 90-day prison term imposed by § 11721. Should the necessity for treatment end before the 90-day

This prosecution has no relationship to the curing of an illness. Indeed, it cannot, for the prosecution is aimed at penalizing an illness, rather than with providing medical care for it. We would forget the teachings of the Eighth Amendment if we allowed sickness to be made a crime and permitted sick people to be punished for being sick. This age of enlightenment cannot tolerate such barbarous action.

term is concluded, or should no treatment be given, the addict clearly would be undergoing punishment for an illness. Therefore, reference to § 11391 will not solve or alleviate the problem of cruel and unusual punishment presented by this case.

SUPREME COURT OF THE UNITED STATES

No. 554.—OCTOBER TERM, 1961.

Lawrence Robinson,	}	On Appeal from the Appellate Department of the Superior Court of California, County of Los Angeles.
Appellant,		
v. California.		

[June 25, 1962.]

MR. JUSTICE HARLAN, concurring.

I am not prepared to hold that on the present state of medical knowledge it is completely irrational and hence unconstitutional for a State to conclude that narcotics addiction is something other than an illness nor that it amounts to cruel and unusual punishment for the State to subject narcotics addicts to its criminal law. Insofar as addiction may be identified with the use or possession of narcotics within the State (or, I would suppose, without the State), in violation of local statutes prohibiting such acts, it may surely be reached by the State's criminal law. But in this case the trial court's instructions permitted the jury to find the appellant guilty on no more proof than that he was present in California while he was addicted to narcotics.* Since addiction alone cannot

*The jury was instructed that "it is not incumbent upon the People to prove the unlawfulness of defendant's use of narcotics. All that the People must show is *either* that the defendant did use a narcotic in Los Angeles County, *or* that while in the City of Los Angeles he was addicted to the use of narcotics." (Emphasis added.) Although the jury was told that it should acquit if the appellant proved that his "being addicted to the use of narcotics was administered [*sic*] by or under the direction of a person licensed by the State of California to prescribe and administer narcotics," this part of the instruction did not cover other possible lawful uses which could have produced the appellant's addiction.

reasonably be thought to amount to more than a compelling propensity to use narcotics, the effect of this instruction was to authorize criminal punishment for a bare desire to commit a criminal act.

If the California statute reaches this type of conduct, and for present purposes we must accept the trial court's construction as binding, *Terminiello v. Chicago*, 337 U. S. 1, 4, it is an arbitrary imposition which exceeds the power that a State may exercise in enacting its criminal law. Accordingly, I agree that the application of the California statute was unconstitutional in this case and join the judgment of reversal.

SUPREME COURT OF THE UNITED STATES

No. 554.—OCTOBER TERM, 1961.

Lawrence Robinson,	}	On Appeal from the Appellate De-
Appellant,		partment of the Superior Court
v.		of California, County of Los
California.		Angeles.

[June 25, 1962.]

MR. JUSTICE CLARK, dissenting.

The Court finds § 11721 of California's Health and Safety Code, making it an offense to "be addicted to the use of narcotics," violative of due process "as a cruel and unusual infliction of criminal punishment." I cannot agree.

The statute must first be placed in perspective. California has a comprehensive and enlightened program for the control of narcotism based on the overriding policy of prevention and cure. It is the product of an extensive investigation made in the mid-Fifties by a committee of distinguished scientists, doctors, law enforcement officers and laymen appointed by the then Attorney General, now Governor, of California. The committee filed a detailed study entitled "Report on Narcotic Addiction" which was given considerable attention. No recommendation was made therein for the repeal of § 11721, and the State Legislature in its discretion continued the policy of that section.

Apart from prohibiting specific acts such as the purchase, possession and sale of narcotics, California has taken certain legislative steps in regard to the status of being a narcotic addict—a condition commonly recognized as a threat to the State and to the individual. The Code deals with this problem in realistic stages. At its incipency narcotic addiction is handled under § 11721 of the Health and Safety Code which is at issue here. It

provides that a person found to be addicted to the use of narcotics shall serve a term in the county jail of not less than 90 days nor more than one year, with the minimum 90-day confinement applying in all cases without exception. Provision is made for parole with periodic tests to detect readdiction.

The trial court defined "addicted to narcotics" as used in § 11721 in the following charge to the jury:

"The word 'addicted' means strongly disposed to some taste or practice or habituated, especially to drugs. In order to inquire as to whether a person is addicted to the use of narcotics is in effect an inquiry as to his habit in that regard. Does he use them habitually. To use them often or daily is, according to the ordinary acceptance of those words, to use them habitually."

There was no suggestion that the term "narcotic addict" as here used included a person who acted without volition or who had lost the power of self-control. Although the section is penal in appearance—perhaps a carry-over from a less sophisticated approach—its present provisions are quite similar to those for civil commitment and treatment of addicts who have lost the power of self-control, and its present purpose is reflected in a statement which closely follows § 11721: "The rehabilitation of narcotic addicts and the prevention of continued addiction to narcotics is a matter of statewide concern." California Health and Safety Code § 11728.

Where narcotic addiction has progressed beyond the incipient, volitional stage, California provides for commitment of three months to two years in a state hospital. California Welfare and Institutions Code § 5355. For the purposes of this provision, a narcotic addict is defined as

"any person who habitually takes or otherwise uses
to the extent of having lost the power of self-control

any opium, morphine, cocaine, or other narcotic drug as defined in Article 1 of Chapter 1 of Division 10 of the Health and Safety Code." California Welfare and Institutions Code § 5350. (Emphasis supplied.)

This proceeding is clearly civil in nature with a purpose of rehabilitation and cure. Significantly, if it is found that a person committed under § 5355 will not receive substantial benefit from further hospital treatment and is not dangerous to society, he may be discharged—but only after a minimum confinement of three months. § 5355.1.

Thus, the "criminal" provision applies to the incipient narcotic addict who retains self-control, requiring confinement of three months to one year and parole with frequent tests to detect renewed use of drugs. Its overriding purpose is to cure the less-seriously addicted person by preventing further use. On the other hand, the "civil" commitment provision deals with addicts who have lost the power of self-control, requiring hospitalization up to two years. Each deals with a different type of addict but with a common purpose. This is most apparent when the sections overlap: if after civil commitment of an addict it is found that hospital treatment will not be helpful, the addict is confined for a minimum period of three months in the same manner as is the volitional addict under the "criminal" provision.

In the instant case the proceedings against the petitioner were brought under the volitional-addict section. There was testimony that he had been using drugs only four months with three to four relatively mild doses a week. At arrest and trial he appeared normal. His testimony was clear and concise, being simply that he had never used drugs. The scabs and pocks on his arms and body were caused, he said, by "overseas shots" administered during army service preparatory to foreign assignment. He was very articulate in his testimony but the

jury did not believe him, apparently because he had told the clinical expert while being examined after arrest that he had been using drugs, as I have stated above. The officer who arrested him also testified to like statements and to scabs—some 10 or 15 days old—showing narcotic injections. There was no evidence in the record of withdrawal symptoms. Obviously he could not have been committed under § 5355 as one who had completely “lost the power of self-control.” The jury was instructed that narcotic “addiction” as used in § 11721 meant strongly disposed to a taste or practice or habit of its use, indicated by the use of narcotics often or daily. A general verdict was returned against petitioner, and he was ordered confined for 90 days to be followed by a two-year parole during which he was required to take periodic Nalline tests.

The majority strikes down the conviction primarily on the grounds that petitioner was denied due process by the imposition of criminal penalties for nothing more than being in an involuntary status. This viewpoint is premised upon the theme that § 11721 is a “criminal” provision authorizing a punishment, for the majority admits that “a State might establish a program of compulsory treatment for those addicted to narcotics” which “might require periods of involuntary confinement.” I submit that California has done exactly that. The majority’s error is in instructing the California Legislature that hospitalization is the *only treatment* for narcotics addiction—that anything less is a punishment denying due process. California has found otherwise after a study which I suggest was more extensive than that conducted by the Court. Even in California’s program for hospital commitment of nonvolitional narcotic addicts—which the majority approves—it is recognized that some addicts will not respond to or do not need hospital treatment. As to these persons its provisions are identical to

those of § 11721—confinement for a period of not less than 90 days. Section 11721 provides this confinement as treatment for the volitional addicts to whom its provisions apply, in addition to parole with frequent tests to detect and prevent further use of drugs. The fact that § 11721 might be labeled “criminal” seems irrelevant,* not only to the majority’s own “treatment” test but to the “concept of ordered liberty” to which the States must attain under the Fourteenth Amendment. The test is the overall purpose and effect of a State’s act, and I submit that California’s program relative to narcotic addicts—including both the “criminal” and “civil” provisions—is inherently one of treatment and lies well within the power of a State.

However, the case in support of the judgment below need not rest solely on this reading of California law. For even if the overall statutory scheme is ignored and a purpose and effect of punishment is attached to § 11721, that provision still does not violate the Fourteenth Amendment. The majority acknowledges, as it must, that a State can punish persons who purchase, possess or use narcotics. Although none of these acts are harmful to society *in themselves*, the State constitutionally may attempt to deter and prevent them through punishment because of the grave threat of future harmful conduct which they pose. Narcotics addiction—including the incipient, volitional addiction to which this provision speaks—is no different. California courts have taken judicial notice that “the inordinate use of a narcotic drug tends to create an irresistible craving and forms a habit for its continued use until one becomes an addict, and he respects no convention or obligation and will lie, steal, or use any

*Any reliance upon the “stigma” of a misdemeanor conviction in this context is misplaced, as it would hardly be different from the stigma of a civil commitment for narcotics addiction.

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other base means to gratify his passion for the drug, being lost to all considerations of duty or social position." *People v. Jaurequi*, 142 Cal. App. 2d 555, 298 P. 2d 896 (1956). Can this Court deny the legislative and judicial judgment of California that incipient, volitional narcotic addiction poses a threat of serious crime similar to the threat inherent in the purchase or possession of narcotics? And if such a threat is inherent in addiction, can this Court say that California is powerless to deter it by punishment?

It is no answer to suggest that penal sanctions will be ineffective and unfair because we are dealing here with an involuntary status. The section at issue applies only to persons who use narcotics often or even daily but not to the point of losing self-control. When dealing with involuntary addicts California moves only through § 5355 of its Welfare Institutions Code which clearly is not penal. Even if it could be argued that § 11721 may not be limited to volitional addicts, the petitioner in the instant case undeniably retained the power of self-control and thus to him the statute would be constitutional. Moreover, "status" offenses have long been known and recognized in the criminal law. 4 Blackstone, Commentaries (Jones ed. 1916), 170. A ready example is drunkenness, which plainly is as involuntary after addiction to alcohol as is the taking of drugs.

Nor is the conjecture relevant that petitioner may have acquired his habit under lawful circumstances. There was no suggestion by him to this effect at trial, and surely the State need not rebut all possible lawful sources of addiction as part of its *prima facie* case.

The argument that the statute constitutes a cruel and unusual punishment is governed by the discussion above. Properly construed, the statute provides a treatment rather than a punishment. But even if interpreted as

penal, the sanction of incarceration for three to 12 months is not unreasonable when applied to a person who has voluntarily placed himself in a condition posing a serious threat to the State. Under either theory, its provisions for three to 12 months' confinement can hardly be deemed unreasonable when compared to the provisions for three to 24 months' confinement under § 5355 which the majority approves.

I would affirm the judgment.

SUPREME COURT OF THE UNITED STATES

No. 554.—OCTOBER TERM, 1961.

Lawrence Robinson,	} On Appeal from the Appellate Department of the Superior Court of California, County of Los Angeles.
Appellant,	
v.	
California.	

[June 25, 1962.]

MR. JUSTICE WHITE, dissenting.

If appellant's conviction rested upon sheer status, condition or illness or if he was convicted for being an addict who had lost his power of self-control, I would have other thoughts about this case. But this record presents neither situation. And I believe the Court has departed from its wise rule of not deciding constitutional questions except where necessary and from its equally sound practice of construing state statutes, where possible, in a manner saving their constitutionality.¹

¹ It has repeatedly been held in this Court that its practice will not be "to decide any constitutional question in advance of the necessity for its decision . . . or . . . except with reference to the particular facts to which it is to be applied," *Alabama State Federation v. McAdory*, 325 U. S. 450, 461, and that state statutes will always be construed, if possible, to save their constitutionality despite the plausibility of different but unconstitutional interpretation of the language. Thus, the Court recently reaffirmed the principle in *Oil Workers Unions v. Missouri*, 361 U. S. 363, 370: "When that claim is litigated it will be subject to review, but it is not for us now to anticipate its outcome. "Constitutional questions are not to be dealt with abstractly" They will not be anticipated but will be dealt with only as they are appropriately raised upon a record before us. . . . Nor will we assume in advance that a State will so construe its law as to bring it into conflict with the federal Constitution or an act of Congress." *Allen-Bradley Local v. Wisconsin Board*, 315 U. S. 740, at 746."

I am not at all ready to place the use of narcotics beyond the reach of the States' criminal laws. I do not consider appellant's conviction to be a punishment for having an illness or for simply being in some status or condition, but rather a conviction for the regular, repeated or habitual use of narcotics immediately prior to his arrest and in violation of the California law. As defined by the trial court,² addiction is the regular use of narcotics and can be proved only by evidence of such use. To find addiction in this case the jury had to believe that appellant had frequently used narcotics in the recent past.³ California is entitled to have its statute and the record so read, particularly where the State's only purpose in allowing prosecutions for addiction was to supersede its own venue requirements applicable to prosecutions for the use of narcotics and in effect to allow convictions for use

² The court instructed the jury that, "The word 'addicted' means strongly disposed to some taste or practice or habituated, especially to drugs. In order to inquire as to whether a person is addicted to the use of narcotics is in effect an inquiry as to his habit in that regard. To use them often or daily is, according to the ordinary acceptance of those words, to use them habitually."

³ This is not a case where a defendant is convicted "even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there." The evidence was that appellant lived and worked in Los Angeles. He admitted before trial that he had used narcotics for three or four months, three or four times a week, usually at his place with his friends. He stated to the police that he had last used narcotics at 54th and Central in the City of Los Angeles on January 27, 8 days before his arrest. According to the State's expert no needle mark or scab found on appellant's arms was newer than 3 days old and the most recent mark might have been as old as 10 days, which was consistent with appellant's own pretrial admissions. The State's evidence was that appellant had used narcotics at least 7 times in the 15 days immediately preceding his arrest.

where there is no precise evidence of the county where the use took place.⁴

Nor do I find any indications in this record that California would apply § 11721 to the case of the helpless addict. I agree with my Brother CLARK that there was no evidence at all that appellant had lost the power to control his acts. There was no evidence of any use within 3 days prior to appellant's arrest. The most recent marks

⁴ The typical case under the narcotics statute, as the State made clear in its brief and argument, is the one where the defendant makes no admissions, as he did in this case, and the only evidence of use or addiction is presented by an expert who, on the basis of needle marks and scabs or other physical evidence revealed by the body of the defendant, testifies that the defendant has regularly taken narcotics in the recent past. See, e. g., *People v. Williams*, 164 Cal. App. 2d 858, 331 P. 2d 251; *People v. Garcia*, 122 Cal. App. 2d 962, 266 P. 2d 233; *People v. Ackles*, 147 Cal. App. 2d 40, 304 P. 2d 1032. Under the local venue requirements, a conviction for simple use of narcotics may be had only in the county where the use took place, *People v. Garcia, supra*, and in the usual case evidence of the precise location of the use is lacking. Where the charge is addiction, venue under § 11721 of the Health and Safety Code may be laid in any county where the defendant is found. *People v. Ackles, supra*, at 1033, distinguishing *People v. Thompson*, 144 Cal. App. 2d 854, 301 P. 2d 313. Under California law a defendant has no constitutional right to be tried in any particular county but under statutory law, with certain exceptions, "an accused person is answerable only in the jurisdiction where the crime, or some part or effect of it, was committed or occurred." *People v. Megladdery*, 40 Cal. App. 2d 748, 762, 106 P. 2d 84, 92. A charge of narcotics addiction is one of the exceptions and there are others. See, e. g., §§ 781, 784, 785, 786, 788, Cal. Penal Code. Venue is to be determined from the evidence and is for the jury, but it need not be proved beyond a reasonable doubt. *People v. Megladdery, supra*, 40 Cal. App. 2d, at 764, 106 P. 2d, at 93. See *People v. Bastio*, 55 Cal. App. 2d 615, 131 P. 2d 614; *People v. Garcia, supra*. In reviewing convictions in narcotics cases, appellate courts view the evidence of venue "in the light most favorable to the judgment." *People v. Garcia, supra*.

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might have been 3 days old or they might have been 10 days old. The appellant admitted before trial that he had last used narcotics 8 days before his arrest. At the trial he denied having taken narcotics at all. The uncontroverted evidence was that appellant was not under the influence of narcotics at the time of his arrest nor did he have withdrawal symptoms. He was an incipient addict, a redeemable user, and the State chose to send him to jail for 90 days rather than to attempt to confine him by civil proceedings under another statute which requires a finding that the addict has lost the power of self-control. In my opinion, on this record, it was within the power of the State of California to confine him by criminal proceedings for the use of narcotics or for regular use amounting to habitual use.⁵

The Court clearly does not rest its decision upon the narrow ground that the jury was not expressly instructed not to convict if it believed appellant's use of narcotics was beyond his control. The Court recognizes no degrees of addiction. The Fourteenth Amendment is today held to bar any prosecution for addiction regardless of the degree or frequency of use, and the Court's opinion bristles with indications of further consequences. If it is "cruel and unusual punishment" to convict appellant for addiction, it is difficult to understand why it would be any less offensive to the Fourteenth Amendment to convict him for use on the same evidence of use which proved he was an addict. It is significant that in purporting to reaffirm the power of the States to deal with the narcotics traffic, the Court does not include among the obvious powers of the State the power to punish for the use of narcotics. I cannot think that the omission was inadvertent.

⁵ Health and Safety Code § 11391 expressly permits and contemplates the medical treatment of narcotics addicts confined to jail.

The Court has not merely tidied up California's law by removing some irritating vestige of an outmoded approach to the control of narcotics. At the very least, it has effectively removed California's power to deal effectively with the recurring case under the statute where there is ample evidence of use but no evidence of the precise location of use. Beyond this it has cast serious doubt upon the power of any State to forbid the use of narcotics under threat of criminal punishment. I cannot believe that the Court would forbid the application of the criminal laws to the use of narcotics under any circumstances. But the States, as well as the Federal Government, are now on notice. They will have to await a final answer in another case.

Finally, I deem this application of "cruel and unusual punishment" so novel that I suspect the Court was hard put to find a way to ascribe to the Framers of the Constitution the result reached today rather than to its own notions of ordered liberty. If this case involved economic regulation, the present Court's allergy to substantive due process would surely save the statute and prevent the Court from imposing its own philosophical predilections upon state legislatures or Congress. I fail to see why the Court deems it more appropriate to write into the Constitution its own abstract notions of how best to handle the narcotics problem, for it obviously cannot match either the States or Congress in expert understanding.

I respectfully dissent.

Senator HUGHES. What if it did change the law? Is it not your job to enforce the law whatever it is?

Mr. INGERSOLL. That is correct, sir, whatever it is. And I will enforce the law whatever it is. At the same time it is my job to make recommendations to the Congress and on what the—at least give our viewpoint as to what effective law would be.

Senator HUGHES. I appreciate that.

You state such a congressional finding is not in keeping with current medical knowledge. Are you in a position to back this up?

Mr. INGERSOLL. Yes, sir.

I don't think that medical—that the medical community would acknowledge, for example, that the use of the milder, the exempt narcotics as I mentioned in my statement—

Senator HUGHES. We are talking about drug dependence.

Mr. INGERSOLL. One can go drug dependent on these mild substances.

Senator HUGHES. Then it might be helpful to you to review some of the testimony that was taken as late as yesterday from a medical researcher, who testified that it is a disease, in his opinion, and he gave, in response to questions by Senator Dominick, the specific reasons why they considered it to be a disease.

Would you be willing to review that testimony in addition to the opinions you already hold?

Mr. INGERSOLL. I would be willing to. I would be happy to.

Senator HUGHES. Do you consider alcoholism a disease?

Mr. INGERSOLL. I think alcoholism has been defined as a disease legally; yes, sir.

Senator HUGHES. Excuse me. I did not hear your answer.

Mr. INGERSOLL. I think alcoholism has been defined by the courts as a disease; yes, sir.

Senator HUGHES. Who do you think should define a disease, the courts, then, or the medical profession?

Mr. INGERSOLL. Well, I think that depends upon what area we are talking about. If we are talking about treatment, then the medical profession. If we are talking about legal responsibility, then the courts.

Senator HUGHES. How are the two different?

Mr. INGERSOLL. The legal profession and the medical profession have differed on many things.

Senator HUGHES. That is why attorneys have a field day, isn't it, because of differences of opinion on the same laws?

Isn't that why we have multiple courts?

Mr. INGERSOLL. To resolve these differences? Yes, sir, I might add that the review through the court process is advancing toward resolution of many of the differences that have afflicted us.

Senator HUGHES. Hopefully we will get there some day, and we will probably have a whole field of new ones to start with at that point. But at least that is the system and the way it works, and I am sure you would agree with that.

Mr. INGERSOLL. Yes, sir.

Senator HUGHES. I would like to know specifically what medical references you could give me. Which say that drug dependence, addiction and drug dependence is not a disease?

Mr. INGERSOLL. Mr. Chairman, I will ask Mr. Sonnenreich to expand on what we mean in this statement. May I say that my statement did not extend to medical definitions.

The statement restricted itself to legal definitions of drug dependence as a disease.

Now in the *Robinson* case which is the leading case, the issue was narcotic addiction, not drug dependence or drug abuse, and these are very different things legally and medically.

Can Mr. Sonnenreich expand on that?

Senator HUGHES. Surely.

Mr. SONNENREICH. Senator, the reason we have a real problem with this is unlike certain phrases that have been used, like "narcotic addiction," the definition your bill has—and I might add it is the same definition as in the uniform State Controlled Dangerous Substances Act—is a new definition.

It is not found in any existing Federal law.

The problem is that it covers the entire scope of every drug that would be controlled under the Controlled Dangerous Substances Act. Many of these drugs have no addictive liability as such.

We have a real problem in trying to say what would constitute an affirmative defense, if an affirmative defense were raised as a result of that kind of finding.

So we are not arguing that narcotic addiction is a disease or not. We are arguing it from the point of view that the scope is far too broad and you are raising the specter of an affirmative defense that the courts have never allowed.

In the *Robinson* case, all that the court really said is that we cannot prosecute somebody for being a narcotic addict if we make that a criminal act, being a narcotic addict.

Then they said the reason for it was that it is a mental illness or disease. But they were not talking as to an affirmative defense.

The definition in your bill is completely different from existing definitions.

Senator HUGHES. How often does that happen to you in legislation the Congress passes?

Mr. SONNENREICH. Quite a bit, Senator.

Senator HUGHES. With almost every bill that is passed. There are a few that do not alter the definitions.

Mr. SONNENREICH. In this definition where you have so much conflict as to what drug dependence among the medical profession means, we would have a very, very difficult problem, especially when you are also talking about all the drugs that would be controlled.

Senator HUGHES. That is what makes both our jobs so difficult and why are we here. We are laboring in these fields trying to bring clarity and sense into it. I think that there is a good case to be made for the terminology used in this legislation.

So it would be helpful to me if you could clarify your own position for the subcommittee in writing. I think it might help to arrive at a more logical conclusion. I appreciate your concerns, and I want to give your concerns weight.

I really do. That is why I am asking for it.

(The information subsequently supplied follows:)

IS DRUG DEPENDENCE AN ILLNESS OR DISEASE?

There is no objection to the definition of "drug dependent person" contained in S. 3562, especially since that definition is identical to the definition of "drug dependent person" found in the proposed Uniform Controlled Dangerous Substances Act. The problem arises in a statement that drug dependence is an illness or disease, which is found in S. 3562's statement of Findings. Such a statement raises the possibility that a defendant in a criminal prosecution could assert as a defense that he is drug dependent and that his crime was a drug-related offense.

By definition, drug dependence is much broader in scope than the World Health Organization definition of "addiction." It encompasses a much wider variety of drugs and thus a greater number of persons. As a result of this, and due to the fact that there is little unanimity among the scientific and medical communities over the precise meaning of "drug dependence," it would be very difficult to prove or disprove at trial whether a particular defendant is, in fact, drug dependent, should the defense be raised.

This is not to say that a drug dependent person may not be the proper subject for medical treatment. However, the language of S. 3562 should be couched in such terms to preclude drug dependence from being raised in all criminal prosecutions. Merely deleting the statement that drug dependence is an illness or disease would be sufficient.

Senator HUGHES. Section 302(b) gives the administration the authority to administer the program.

You say this would overlap with the law enforcement and administration, referring to the Bureau of Prisons, and so forth. Could you expand on this?

Authority is given to HEW to carry out this function, isn't there?

Mr. SONNENREICH. We are talking about 303(b) are we not?

Senator HUGHES. I have 302(b) on this sheet, but maybe I am wrong.

Mr. SONNENREICH. 302(b) does allow the NIMH, through its community health centers, to administer the program. The overlap that we were talking about with this is the fact that you do have some grants coming out from LEAA with respect to some of these programs.

I am sure you are aware of the fact, Senator, that there have been some problems at the State level with this, and LEAA through its institute has looked at some pilot projects.

I could not give you the figures as to what they have done, but there was a potential problem of an overlap, and that is why we raised it.

Senator HUGHES. You raise it as a possible problem, rather than a statement of fact. Is that right?

Mr. SONNENREICH. That is correct, sir.

Senator HUGHES. Do I understand that you have legislation which you will propose to replace the present Narcotics Addiction Rehabilitation Act?

Is that legislation being reviewed at HEW? When will it be introduced?

Mr. SONNENREICH. Senator, with respect to changes in the Narcotic Addict Rehabilitation Act, both Department of HEW and the Department of Justice are studying it. We have not gone into any stage yet where we are actually rewriting the Narcotic Addict Rehabilitation Act.

I think there was some confusion because we are working on the District of Columbia bill that would deal with some aspects of rehabilitation for drug offenders within the District of Columbia, as Director Ingersoll had testified on March 3 before Senator Tydings committee.

Senator HUGHES. Can you tell me if anything is being done in any prison to rehabilitate a drug abuser or a narcotic addict?

Can you cite me records of anyone who has been rehabilitated there?

Mr. INGERSOLL. I don't think, Senator, that any one is completely rehabilitated from narcotics addiction in any institutional setting by itself.

I think the beginning can be made, at least the physiological dependence can be eliminated.

Senator HUGHES. Simply locking a man in cell will eventually do that, will it not?

Mr. INGERSOLL. Yes, sir. The Bureau of Prisons, I am sure, can specify the programs it has in its several institutions such as Terminal Isle and in California.

I can't recite them with any degree of specificity. But the Bureau of Prisons, as well as NIMH, and myself, recognize that institutional treatment is not going to achieve the result by itself.

There is equal need, probably more need, for extended and community based treatment following institutionalization that has been part of the program.

Senator HUGHES. Do you think it would be helpful to this committee to get Dr. Alexander to come over and testify?

Mr. INGERSOLL. Mr. Alexander has retired as director.

Senator HUGHES. Maybe that would be all the more reason to have him.

Mr. INGERSOLL. I think that he could inform you very well on these prison programs.

Senator HUGHES. I have known Dr. Alexander. I had him go through the Iowa prisons when I was governor to make recommendations on reform, and he is a capable and efficient man.

Mr. INGERSOLL. Yes, he is.

Senator HUGHES. Who is currently in there?

Mr. INGERSOLL. I don't know that the new director has been named, sir.

Senator HUGHES. I have got some extensive questioning, and I don't want to use up another hour.

Being a freshman Senator down here, I frequently come in a hearing room, sit for 4 hours, and never get to ask a question, so I don't want to leave one of my colleagues sitting over here while I take up all the time.

Senator SCHWEIKER. I thank the distinguished chairman for the sympathy, and I want to ask a few questions.

I wonder if you would give me sort of a brief idea of your understanding of the scope of the problem. I have read your testimony and heard part of it. In a few words, would you define for this committee the scope of the drug problem in the United States today as you see it from your vantage point?

In other words, how do you define the problem?

Mr. INGERSOLL. Senator, if you will permit more than just a few words, I will make an effort.

The problem has increased on a variety of fronts and it has increased in terms of the number of people who are drug addicts and drug abusers as compared with 10 or 15 years ago.

It has increased as to the variety of drugs that are presently abused as compared to just a few years ago. It has increased in terms of the amount of drugs of various kinds that are available for abuse.

The present estimates of such things as marihuana abuse, for example, running to 12 million people and as high as 20 million according to some sources.

I think our estimates are rough as to the number of people who are using drugs from marihuana through heroin addiction.

The number of addicts, for example, that are known to our Bureau who have been identified, and on whom we have sufficient information to eliminate duplication and to identify a specific person, have increased at least 40 percent in the last 8 years, probably much more than that.

Senator SCHWEIKER. Forty percent in what time frame?

Mr. INGERSOLL. Between 1960 and 1968. I am sure that the actual number of addicts has increased much more than that because we have—

Senator SCHWEIKER. I realize we are all estimating when I asked that question.

Do you have any ideas about where the thrust of the problem is now? Obviously this started in some of our urban areas, and it obviously has moved to the suburbs. Where do you see the main thrust and the main battleline on the problem now?

Mr. INGERSOLL. I think that depends, Senator, on what drug you are talking about to some degree, and what level of government—

Senator SCHWEIKER. Let's speak of marihuana.

Mr. INGERSOLL. Marihuana is consumed throughout all of our society at this time, particularly in the college area, schools, among the intelligentsia and so on.

Senator SCHWEIKER. In other words, a fairly extensive, widespread scope is what you are answering as far as marihuana is concerned?

Mr. INGERSOLL. Very widespread, yes.

Senator SCHWEIKER. How about the hard drugs? Where are the battlelines there?

Mr. INGERSOLL. I think the primary problem, still with the hard drugs, is most conspicuous within the so-called inner city or among the lower socioeconomic groups.

However, this problem also is spreading into the schools, into the suburbs. The average age of addiction drops each year, for example.

The number of young people under the age of 21, or under the age of 18 who become involved with hard drugs increases each year.

Senator SCHWEIKER. With that general frame of reference, how do you think we should effectively solve the problem?

In other words, having a definition of the problem, what is your philosophy or thinking or approach to attacking the problem?

Mr. INGERSOLL. Speaking from the law enforcement viewpoint, our present objective is to attack the source of these substances, to attempt

to dry up sources of drugs, whether they come from other countries or whether they are produced in this country, legally or illegally.

This alone is not enough. The control of the supply has to be complemented by reduction of the market, and reduction of the market in my judgment will best be carried out if we can reach the minds of the people on a broad base to create a climate of intolerance among the people of this country for the destructive mechanism, escape mechanism, and provide reasonable constructive alternatives.

Now there is nothing wrong with pleasure seeking, which is given as one of the reasons for youthful drug abuse, but I think we can all agree that drug abuse is not constructive pleasure seeking.

It is destructive in the extreme.

I think that if boredom and if the need to escape from the pressures of life are indeed valid motives for extensive drug abuse, then perhaps we ought to look around and find something that is more constructive as an alternative to this.

In the meantime, these are long-range goals, and in the meantime we have to be concerned with today's problems. It is my personal feeling that good, sound, valid educational techniques, if we can find them and if we can discover what their elements are and how they ought to be transmitted, will have some effect particularly on those who have not yet made a decision and who have not yet become confirmed drug abusers.

At the same time the law enforcement effort directed at shutting off or controlling the supplies of drugs should have a salutary overall effect as well.

Senator HUGHES. Would the Senator yield for just a moment? Here again I want to inject something you may not want to answer in an open hearing.

But I had information come to me in the last 2 months that there was a decided effort in opium growing in Thailand, and that actually some of this may be encouraged by American enterprises there. Have you had any information in relation to that in international control?

Mr. INGERSOLL. U.S. enterprises?

Senator HUGHES. Yes.

Mr. INGERSOLL. I know of no governmental encouragement of opium production in Thailand or anyplace else in the world. Quite the contrary, we have been speaking out in the United Nations and bilaterally to discourage production, and encourage governments to do everything they can do to eliminate illicit production.

Senator HUGHES. I did not mean to be misunderstood that our Government is encouraging it.

If I conveyed that, I retract it. When I used the term "enterprises," I was not talking about governmental enterprises but rather a concern for the economy. I understand this is a cash crop there.

It might be well to look into it, John, the only reason I mentioned it.

Mr. INGERSOLL. There is no question that opium is grown in Thailand, and it is grown in some of the areas in which the Thai Government has minimal or no control.

Thailand is not permitted under the convention, is not one of those countries that can cultivate and harvest opium legally for medicinal purposes.

Senator SCHWEIKER. Mr. Ingersoll, let's say that the solution to the problem envisions enforcement as well as rehabilitation, education, and treatment. What do you see from your point of view as your primary emphasis? Where does your work lie in terms of these aspects of the problem?

Mr. INGERSOLL. Obviously enforcement, Senator, but I think I have indicated on a number of occasions that we have a contribution to make to the educational programs.

We also have a contribution to make in our total effort to develop more knowledge about the problem through channels and activities that we engage in as enforcement officers.

Senator SCHWEIKER. Is there any other part of the development of the Department of Justice, where you, in essence combine enforcement and education in solving the problem?

In other words, are there any departments where you work jointly on the enforcement and the educational aspects of the problem?

Mr. INGERSOLL. Of the drug abuse problem, sir?

Senator SCHWEIKER. No, I am trying to ascertain the guidelines or definitions in other areas in the Department of Justice where you use education as a primary tool to solve your problem.

Mr. INGERSOLL. The Law Enforcement Assistance Administration is the first one that comes to mind. All of the agencies of the Department are involved in educational programs within their own sphere of activity. The Immigration and Naturalization Service is an example.

Senator SCHWEIKER. Isn't that education limited to the enforcement aspects? If I understand what you said earlier, you are basically talking about education of users or addicts as opposed to education of trained enforcement personnel.

Mr. INGERSOLL. Under our terminology, training enforcement personnel comes under the category of training. We have extensive training programs in the enforcement community, but I think—

Senator SCHWEIKER. I don't think anybody would argue with that.

Mr. INGERSOLL. The Department extends to educational efforts in a variety of areas.

The Bureau of Prisons, for example, is involved in education not only within the prison system, but outside as well. The Law Enforcement Assistance Administration, particularly through the national institute, as this program develops, will become more and more influential in crime prevention programs I am sure.

This is one of its missions.

The various litigation divisions of the Department are involved in educational programs. For example, the antitrust division is so involved to prevent violation of antitrust laws, and so I think we have a broad educational program.

I would agree that the educational activities of the Bureau of Narcotics and Dangerous Drugs have recently become more conspicuous because I think of the extent of the problem and I might say, quite frankly, that I think this has had a favorable effect on stimulating the other agencies of Government to get involved in the educational process in this area that were not formerly involved.

We have served as a catalyst and I take great pride in this. We are

not attempting to assume total responsibility. I have responsibilities that keep my time completely occupied and keep my staff completely occupied and I would much prefer that all agencies of Government lend their experience and expertise and their knowledge to these preventive efforts.

Senator SCHWEIKER. In your work have you had much experience in the field of returning veterans who have been released from the service and had a drug problem in the services?

What would be your reaction to this problem and any aspects of it that you have encountered?

Mr. INGERSOLL. We have contact with these people as they might be traffickers, primarily.

Our efforts are not directed at detecting abuse, per se, but we are more concerned with controlling traffic.

I can't identify by statistical data the veteran status of the people who come within our purview.

Senator SCHWEIKER. Is there any liaison in this field between your Department and the veterans programs?

Mr. INGERSOLL. Yes, sir. A member of our Scientific Advisory Committee is in charge of the veterans hospital at Stanford, Calif.

Mr. SCHWEIKER. How about any direct line relationship on liaison?

Mr. INGERSOLL. I have liaison people who serve in a liaison function with a variety of departments in the Government. The Veterans' Administration would be one of these.

Senator SCHWEIKER. We were discussing the aspects of how to define narcotics and drug addiction, as a disease, or a crime. I heard your earlier answer. However, I would like to point out that historically our society has not always recognized an illness for what it is. In the early days of the mentally ill they were called witches, additionally, we only recently adjusted our definitions of alcoholism.

In view of this trend, wouldn't the same historical logic dictate that narcotics could well fall into this same category? I don't think that we should be unmindful of our past experience in similar fields.

Mr. INGERSOLL. I think narcotic addiction has already been defined legally as a form of illness.

Senator SCHWEIKER. I understood you to differ with this.

Mr. INGERSOLL. No, sir; not so far as narcotic addiction is concerned. My statement was to drug dependence and/or drug abuse.

Senator SCHWEIKER. What do you think these terms are then?

Mr. INGERSOLL. The World Health Organization and the American Medical Community have made distinctions. They have defined narcotic addiction as physical as well as psychological dependence upon narcotic substances.

Drug dependence is generally a psychological type of affliction, without the physiological characteristics.

Senator HUGHES. Excuse me. Are you saying, then, that a psychological deficiency is not an illness?

Mr. INGERSOLL. No, sir; I am not saying that from a medical viewpoint. I am saying that the courts have not—

Senator HUGHES. We are again at the legal and medical point.

Mr. INGERSOLL. Yes. We are also discussing substantive criminal dependence for which a defense can be raised that was caused by influence or because of drug dependence.

Senator SCHWEIKER. From your experience what percentage of our street crimes are drug related?

Mr. INGERSOLL. This is a piece of information which is not yet available in any reliable form. We hear estimates—as a matter of fact, this is one of our planned research programs for fiscal 1971—we hear estimates in the District of Columbia for example, that as much as perhaps 50 percent. A recent survey of prisoners who had been admitted to District jails I think indicated that somewhere in that general range were drug abusers.

Senator SCHWEIKER. You don't have any preliminary figures from any of your projects yet?

Mr. INGERSOLL. No, sir; that project is not yet underway.

Senator SCHWEIKER. When will you have some of those figures?

Mr. INGERSOLL. I would suggest maybe 8 months or a year after the project begins.

Senator HUGHES. Would you yield for a moment on that, Senator? I was wondering, if your crime reporting statistics from all over the country include that information.

Mr. INGERSOLL. No, they don't. Mr. Chairman, the Uniform Crime Reports refer to drug-related offenses, but these are generally offenses in which the substantive offense involves the drug, rather than another criminal act.

Senator SCHWEIKER. Who is responsible for that not happening? In other words what department is responsible? I realize it probably does not fall under your responsibility, but it would be helpful to have this information.

Mr. INGERSOLL. I am sure that it is something that should have been developed a number of years ago.

I think that one of the reasons we are fighting the scope of a problem in drug abuse that we are now is because not enough was done on a variety of fronts when the problem was just beginning, and this is one of the reasons why the Controlled Dangerous Substances Act provides for a unit in the Bureau of Narcotics and Dangerous Drugs which will gather this information.

Presently we do not have legislative authority.

Senator SCHWEIKER. Are you saying you will be gathering this information?

Mr. INGERSOLL. Under the Controlled Dangerous Substances Act, yes, sir.

Senator SCHWEIKER. So crime statistics will be related to drugs.

Mr. INGERSOLL. We will be responsible for maintaining information and statistics of a variety of information which may be received from Federal, State, and local agencies.

In addition to that, as I have indicated, under our own initiative we will be undertaking the research projects which will gather the data.

Senator SCHWEIKER. It seems to me we should have an ongoing, 100-percent operation as to whether a crime is drug related or not. My question is, will the new authority given you permit you to do that, and are you going to do it?

Mr. INGERSOLL. Yes, sir.

Senator HUGHES. If the bill passes. You do not presently have authority.

Mr. INGERSOLL. No, sir.

Senator SCHWEICKER. In terms of law enforcement what is your approach? I heard your earlier statement about pushers and the source of enforcement. What is your approach on the enforcement practices at the Federal level in terms of the mass of users today? Are you talking about the white suburban student or the hard core in our ghetto areas? And, what is your approach to the actual user in terms of enforcement?

Mr. INGERSOLL. Within the enforcement community, we are presently attempting to establish divisions of labor, and the Federal Government is the only level of government that has responsibility and jurisdiction in interstate matters, and the only level of government which can operate in the international area.

Therefore, we are restricting our activities. We feel that it is appropriate for us to concentrate our activities at those levels at which nobody else has jurisdiction.

In turn we are encouraging State and local and particularly municipalities to attend to the strictly local problems, and in this respect we are providing them assistance in the form of information concerning local personalities or localized activities.

We are encouraging local agencies in metropolitan areas to join their resources and manpower within the metropolitan area.

We are providing training assistance on a broad scale, we intend to provide financial assistance and consultative assistance in pursuing their investigations.

I might point out at this time, just Tuesday and Wednesday of this week, we began a series of 14 meetings with the chief enforcement officers of States and municipalities which will extend across the Nation, and in which we will be defining and projecting these programs.

Senator SCHWEICKER. In your House of Representatives statement you said that your enforcement practices at the Federal level were not directed to the mass of people who may be involved in this kind of abuse.

Your forecast related only to illicit traffic and criminal conspiracy on the interstate and international levels.

Mr. INGERSOLL. That is correct.

Senator HUGHES. Could you supply for the record the number of arrests last year for trafficking, as opposed to drug possession.

Mr. INGERSOLL. Yes, sir.

(The information subsequently supplied follows:)

BUREAU OF NARCOTICS AND DANGEROUS DRUGS

A breakdown of the 3,978 arrests made in 1969 by the Bureau between drug trafficking offenses and possession offenses is unavailable at this time. However, between January 1, 1969 and June 30, 1969, the number of trafficking violations reported was 1,398. The number of violations reported for possession was 636.

Senator SCHWEICKER. That is all I have, Mr. Chairman.

Senator HUGHES. Thank you, Senator Schweiker.

In reporting the statistics might it not be important to the country to include alcohol along with other drugs in relationship to crime.

Mr. INGERSOLL. I think that would be beyond our purview, sir. I think as a matter of public information it would be helpful.

Senator HUGHES. You are the only department I know of that would have the capability of producing it.

Mr. INGERSOLL. If we were instructed to do so, we would.

Senator HUGHES. I think the alcohol relationship to crime is evident, also, particularly with regard to violence.

Mr. INGERSOLL. Yes. The Law Enforcement Assistance Administration is interested in the relationship of alcohol.

Senator HUGHES. I think it would be helpful to us as we try to educate in the field of alcoholism, which we will be endeavoring to do at a later point.

Now do you need specific authority to do this?

Mr. INGERSOLL. No, but I think—for what? For the——

Senator HUGHES. For reporting statistics in relation to alcohol?

Mr. INGERSOLL. Oh, yes, I think we would. Alcohol does not come within our control.

Senator HUGHES. It is a legalized drug, so it is not—you smile as I say that. It is a drug, is it not?

Mr. GARFIELD. Not under the Food and Drug Act. It is considered as a food, for the most part.

Senator HUGHES. Pardon?

Mr. GARFIELD. Under the Food and Drug Act it is considered a food, for the most part.

Senator HUGHES. That was a brilliant piece of legislation.

Mr. INGERSOLL. Mr. Chairman, under the definition of controlled dangerous substances in S. 3246, section 102(f) it specifically states that the term shall not include distilled spirits, wine, malt beverages or tobacco as those terms are used in the United States Code.

Senator HUGHES. We will review that.

Thank you for bringing it to our attention. I think reporting statistics in relation to alcohol and crime are important in the total drug scene today.

I realize it is not legally within your purview at the present time so I am not pursuing it for that reason.

We will look at the statutes concerning it. Section 304(h) states in part, a practitioner, and here we mean a medical doctor, may prescribe, administer, or dispense a controlled dangerous substance in the course of his professional practice (1) in good faith within the scope of the patient relationship, and (2) in accordance with the principles of medical care and treatment accepted by a responsible segment of the medical profession.

Are you saying on page 7 of your remarks that you disagree with these principles?

Mr. INGERSOLL. Yes. I think that the basis of the disagreement is twofold. One, we feel that the present procedure which involves the Bureau of Narcotics and Dangerous Drugs and the Food and Drug Administration is a satisfactory system. Secondly, the term "responsible segment of the medical profession" is in our opinion a vague reference. We don't know how this is to be determined, who would decide on which segment, which opinion might be advised.

Senator HUGHES. How would you like it determined, if that is stated in the law?

Mr. INGERSOLL. I don't know that I have an opinion on that, Senator, because as you point out, there are vast differences between the medical and legal profession. When you get inside the medical profession, you really run into controversial issues, particularly in this area.

Senator HUGHES. Do you think it is a proper role for justice to say this patient-doctor relationship does not exist?

Mr. INGERSOLL. We are not concerned about patient-doctor relationships. Our concern is to prevent the diversion of dangerous substances.

Senator HUGHES. How many doctors in the past year have you found diverting dangerous substances?

Mr. INGERSOLL. I think it was 30 or 40. I don't have the data with me.

(The information subsequently supplied follows:)

DIVERSION ANALYSIS—BUREAU OF NARCOTIC AND DANGEROUS DRUGS

A summary of the Compliance Investigations reviewed for the purpose of preparing this report on the diversion of controlled and narcotic drugs is shown below. It reflects diversion at the different levels of distribution by showing some of the seizures and prosecutions that have occurred between 2/1/66, and the present time. These statistics, however, are a cross-section of seizures and prosecutions derived from readily available data. These statistics are representative in that they reflect the majority of the seizures and prosecutions that have been made.

This statistical table sheds some light on the points of diversion. Recordkeeping violations are included as they reflect actual or suspected diversion. The table also segregates violations involving controlled drugs from narcotic drugs. These statistics should be considered in light of the fact that more stringent controls regulate the flow of narcotic drugs along with the fact that the statistics on controlled drugs cover the time period since 2/1/66, while the statistics on narcotic drugs cover the time period since April, 1968.

	Illegal sales		Record violations		Number of seizures	Number of prosecutions
	Control drugs	Narcotic drugs	Control drugs	Narcotic drugs		
Pharmacies.....	25	5	97	14	87	25
Physicians.....	18	3	54	3	53	21
Wholesalers.....	5	-----	34	-----	34	6
Manufacturers.....	4	-----	22	-----	21	4
Researchers.....	5	1	-----	-----	-----	5
Subtotal.....	57	9	207	17	195	61
Total.....	66		224			

Senator HUGHES. I recall one here in the District recently. There has been no trial in the case, so we should not mention it, I guess.

Mr. INGERSOLL. One recent arrest we made involved tens of thousands of dosages that the doctor was handing out from his office. You may also have read of some other harmful effects that have occurred by individual prescriptions of methadone, for example.

We have at least two recent deaths for the record.

Senator HUGHES. Are you saying on page 7 of your remarks that you disagree with these principles in totality?

Mr. INGERSOLL. Well, we also have another problem that I will let Mr. Sonnenreich explain to you, which affects the investigation of new drug procedures.

Senator HUGHES. All right.

Mr. SONNENREICH. Senator, the determination is not just made by the individual practitioner as to what constitutes good medical practice.

The Food and Drug Administration also makes a determination as to whether it is good medical practice or whether it is experimental, and there would be a requirement for an IND filed with the Food and Drug Administration.

This apparently would be in conflict with the existing food, drug, and cosmetic law as to what constitutes research and what constitutes treatment.

The Bureau gets involved in such things as a methadone maintenance program, where we are to insure against diversion.

We are, in conjunction with the Food and Drug Administration, directly involved in these experimental programs in terms of monitoring.

The question that would be raised under your statement here would be that a doctor could say, most of the people in my community say this is legitimate, so we are going to use it as a treatment modality rather than a research modality.

Senator HUGHES. Well, when do you determine the change?

Mr. SONNENREICH. They have to go through the IND procedure, and then they apply for a new drug application under the food and drug law, and then it would be allowed to be in the course of treatment.

Senator HUGHES. Who makes that determination?

Mr. SONNENREICH. The Food and Drug Administration.

Senator HUGHES. You mentioned methadone. I understand guidelines have been developed by your department.

Mr. INGERSOLL. The guidelines are being developed in conjunction with the Food and Drug Administration.

Senator HUGHES. Have they been distributed?

Mr. INGERSOLL. They are not yet published.

Senator HUGHES. When do you contemplate having them published?

Mr. INGERSOLL. In the very near future, we hope.

Senator HUGHES. Have you asked for anything like the American Medical Association opinions on those guidelines?

Mr. INGERSOLL. Yes; we have.

We reviewed the guidelines with the American Medical Association Committee on Drug Dependence, with the National Academy of Sciences Committee. The guidelines are based on an extensive study of 10 methadone programs plus literature, research, and more cursory studies of other practices in methadone.

We have consulted with FDA and NIMH on methadone maintenance programs, and with all those engaged in the research at this time.

And also the principal manufacturer of methadone, Eli Lilly.

Senator HUGHES. Are doctors being arrested even though the final guidelines haven't been published?

Mr. INGERSOLL. No, sir. I am not aware of any arrests of doctors.

Senator HUGHES. In relationship to the use of methadone?

Mr. INGERSOLL. If they are violating the provisions of the law; yes. If they are trafficking in methadone, or writing illicit prescriptions,

but I might say that we have been extremely anxious to work out with doctors who appear to be digressing from what are adequate controls over the substance, and so far we have been very successful in this regard.

We do have at least one investigation that I am personally familiar with, in the case of a doctor who appears to be distributing methadone indiscriminately.

Senator HUGHES. I would like to have a copy of those proposed guidelines for our files if you will furnish them to us.

Mr. INGERSOLL. Yes, sir.

(The information subsequently supplied follows:)

METHADONE MAINTENANCE GUIDELINES

The proposed guidelines for methadone maintenance programs had not been completed and thus were not available for publication at the time of this printing. They will be forwarded to the subcommittee when they are available for publication.

Mr. INGERSOLL. I should point out that the guidelines themselves, the regulations, will be very short and comprehensive. They are based on a research protocol which was developed by the Food and Drug Administration, and which will be published in conjunction with the issuance of regulations.

Senator HUGHES. I would like to have those guidelines along with whatever explanation you can give us on implementing them.

Mr. INGERSOLL. And the guidelines, once published, will be subject to review by administrative hearings.

Senator HUGHES. You object on page 8 to sections 306(b), (c), (d) of the bill on the basis that it conflicts with or overlaps the provisions of the administration bill that recently passed the Senate.

As you indicate in your statement, under that bill the Attorney General has complete authority to register or not register researchers. HEW can only advise him.

It is my own belief that the decision as to whether or not research can be carried out should not be made in the Justice Department, as you well know.

We have had repeated testimony by respected researchers, one Nobel Prize winner, that they have been harassed by the Justice Department.

If you can explain the harassment, or what they interpret as harassment, it would be perhaps helpful to us.

Mr. INGERSOLL. I can't explain those allegations, Mr. Chairman, because we are not in fact harassing researchers. To the contrary, the policy of our Bureau is to encourage research, and I might point out that the number of researchers that have been registered in the area of marihuana research has increased four times since the Bureau of Narcotics and Dangerous Drugs has been housed in the Justice Department.

Senator HUGHES. How long does it take an application to be approved for research in your Department, the investigation, the procedures, the entire program?

Mr. INGERSOLL. If it involves—

Senator HUGHES. Let's take marihuana. You mentioned that.

Mr. INGERSOLL. All right. This has to be reviewed by the NIMH, by the Psychotomimetic Committee. Mr. Garfield can explain in detail

the operations of that committee if you would like, and the process.

Senator HUGHES. I am not so interested in the details of the committee as the time involved, because we have had many protests about the length of time needed for clearance for research projects.

Mr. INGERSOLL. That is not a complaint that should be levied against the Department of Justice, sir.

Mr. GARFIELD. Actually, a request for either funds or the drug itself must be made through the NIMH-FDA Psychotomimetic Committee. They have a group of experts who review the protocol as to its completeness and validity. This particular committee meets at probably 3-month intervals.

At any time a presentation is made, it must await the assembly of a particular committee, and then if the committee finds that the protocol is inadequate, it may return the protocol to the investigator and ask for more information.

Our Department has been furnishing marihuana to this particular committee to supply researchers. We do not review the protocols in any way. We do have a member of our staff, a pharmacologist, who sits with the committee in an advisory capacity.

Senator HUGHES. How many pharmacologists do you have in your Bureau?

Mr. GARFIELD. We have three.

Senator HUGHES. How large a staff do you have overall?

Mr. GARFIELD. The total research staff is about 18.

Senator HUGHES. For the entire Nation?

Mr. GARFIELD. Yes, and it is at headquarters except for two clinical psychologists at the Holoman Air Force Base.

Senator HUGHES. I would like you, John, if you would, to tell me what the substantive objections to the sections we spoke of are. I would like you to provide piece by piece your objections to the provisions, not just as they may overlap or supplant provisions in the earlier bill, either, because that bill isn't yet law.

Mr. INGERSOLL. Yes, I understand that.

(The information subsequently supplied follows:)

OBJECTIONS TO SUBSECTIONS 306(b) AND (c)

The objections to these provisions stem from the fact that they will in part duplicate and conflict with functions which will be vested in the Department of Justice by virtue of enactment of the Controlled Dangerous Substances Act, S. 3246.

Registration of persons handling controlled dangerous substances and the attendant recordkeeping and inventory requirements are a primary means of preventing diversion of these substances into illicit channels. Diversion is essentially a law enforcement matter and as such is a proper function of a law enforcement agency, not the Department of Health, Education, and Welfare.

Subsection 306 (b) and (c) of S. 3592 divide this function by vesting the Secretary of Health, Education, and Welfare with the authority to register researchers and leaving intact the authority of the Attorney General, under S. 3246, to register all other manufacturers, distributors, and dispensers of controlled substances. Logic would dictate that the entire registration function should be vested within a single agency, preferably in the Department of Justice since registration is a diversion-preventing mechanism and diversion is essentially a law enforcement matter.

Senator HUGHES. Classification functions. You state that the classification functions set out in section 309 conflict with the administration's earlier bill.

Now, I would like to know why, because these classifications relate to carrying out this legislation.

Mr. INGERSOLL. First of all, I don't understand the purpose of setting up another classification system. We have proposed one that was very carefully worked out, again in consultation with people in and out of Government who are responsible and have activity in this field.

I think that we should think in terms of using uniform terminology, if nothing else, for the sake of legislative clarity.

Senator HUGHES. The classification of drugs will be established in accordance with the health and social impact that abuse of these drugs might have, and not in relationship to enforcement of law.

Why would the Justice Department object to this kind of classification for internal use by HEW?

Mr. SONNENREICH. Senator, these schedules apply directly to your title IV that we are not commenting on today. The only applicability these titles have, we have seen these similar titles come up for penalty purposes in the District of Columbia bill before Senator Tydings, in voluntary and involuntary civil commitment proceedings in your act, that is the only tie-in that the particular titles have, and of course they do have criminal applicability, because these titles will then have to be tested before the judge in terms of whether or not certain civil commitment procedures will be triggered under the existing law.

That is your title IV. It goes in, for example, when you are talking about availability of criminal records, when you are talking about—I refer you to section 408—and when you are talking about other provisions in your title IV.

Senator HUGHES. We are not even talking about that section of the bill today. What about the rest of the bill in relationship to that.

Mr. SONNENREICH. That is the problem, though, Senator. The problem is that by having that scheduling there, we don't see where it has applicability elsewhere in the bill except of title IV, and when that kind of scheduling, which we considered somewhat vague, ties in to title IV, which deals with civil commitment, voluntary and involuntary, we have some serious problems.

Senator HUGHES. That section may need some clarification, I will agree. We will clarify that, and we will give serious consideration to your views in relationship to it.

But we do want to clarify our position to you so you know why we feel the necessity of it.

In your prepared statement you say that some paragraphs overlap with the Bureau of Narcotics and Dangerous Drugs.

Are you objecting to that and, if so, is there a way we could remove the language causing the overlap? I am just raising these questions, and if it would be easier to do it in writing to us, I would be willing to say to you, "Give it to us in writing."

Mr. INGERSOLL. We will be glad to give it to you in writing. I think we are objecting here on the fundamental ground that it would create duplication and overlapping of functions.

(The information subsequently supplied follows:)

BUREAU OBJECTIONS TO SUBSECTION 704(a) (7)

Insofar as this provision authorizes programs and services for the instruction of law enforcement officers in the causes, effects, and prevention of drug abuse,

there is an over overlapping of functions with the Bureau of Narcotics and Dangerous Drugs. The Bureau presently offers training programs to State and local law enforcement officers, forensic chemists, foreign nationals, college deans, campus security officers, and members of industry engaged in the distribution of drugs.

In fiscal year 1969, some 11,000 State and local police officers received specialized training covering the entire spectrum of drug abuse from causes and effects to the intricacies of effective narcotic and dangerous drug law enforcement. Some 22,000 persons are expected to receive this training in fiscal year 1970.

The Bureau feels that the training of law enforcement personnel should be the function of a law enforcement agency. Subsection 704(a)(7) will duplicate this function by vesting the newly created Administration with authority to conduct training programs for law enforcement personnel. It is this unnecessary duplication which forms the basis for this Bureau's objections to the subsection.

Senator HUGHES. Is there a way, in your opinion, that the overlap could be eliminated?

Mr. INGERSOLL. May we examine that in more depth?

Senator HUGHES. Yes. About the Advisory Committee on Drug Abuse and Drug Dependence, you object to the creation of advisory committee in title VII of the bill.

Why does the Justice Department object to HEW having an advisory committee in this area?

Mr. INGERSOLL. Mr. Chairman, we really have deferred this issue to the Department of HEW. Just as a matter of information, we are questioning the need for the appointment of another committee in view of the fact that a number of committees presently exist that can perform the same functions. This would appear to be a creation of just another level of committee activity.

Senator HUGHES. I went into detail with Roger Egeberg on it and our reasons for disagreeing, so I don't see any reason to belabor the record here again, because it is already in the record.

Senator Dominick, I yield to you.

Senator DOMINICK. Thank you, Mr. Chairman. I had the opportunity of reading Mr. Ingersoll's statement before I came up, so I am acquainted with it. I apologize for being late.

Mr. Ingersoll, on pages 4 and 5 of your statement, you talk about drug-related offenses and the need for modification of the definition of drug-related offense in section 202g. You refer to over-the-counter cough sirups saying that if someone commits a crime after using cough sirup with codeine in it, he might be able to assert successfully an affirmative defense.

Our subcommittee received evidence in Colorado of a tremendous abuse of cough sirups containing codeine. Colorado law for years has permitted sale of this over the counter, but limits codeine content to 1 grain to the ounce, and the sale to 4 ounces of cough sirup in 48 hours. As I understand it, the abuser drinks the 4 ounces at one time, waits 20 minutes for the codeine to enter the blood stream, then induces vomiting to rid himself of the cough sirup.

Attempted regulation of over-the-counter sales has proved ineffective. According to testimony received in Colorado, one store in Denver sold 345 units in June of 1967 and 2,355 units in June of 1969. Another store went from 243 units in September of 1966 to 4,164 units in the same month of 1969.

The Colorado Legislature is attempting to deal with this problem but I want to read to you an excerpt from the statement filed by the Colorado Pharmacal Association at our Denver hearing:

Both the Colorado State Board of Pharmacy and the Colorado Pharmacal Association feel that the regulations adopted by Department of Justice, effective November 1, 1969, were not adequate . . . The Colorado State Board of Pharmacy, in fact, went on record in October of 1969, in a letter directed to John Ingersoll, Director of the U.S. Department of Justice, Bureau of Narcotics, urging the federal government to place all exempt narcotics on prescription.

Mr. Ingersoll, what is the existing Federal law with respect to codeine cough sirups, and what is the Bureau doing about the situation? Do you have any figures on national incidence, or is this a localized problem?

Mr. INGERSOLL. We did a survey of the problem on a spot basis before we issued the regulations late last year, and the extent of the abuse of cough preparations does vary greatly in various parts of the country. In Texas it is a very serious problem, and it is a very serious problem around Washington, D.C.

In some other areas, it is not quite as bad.

The results of this study, however, prompted us to issue regulations which would impose more stringent requirements on those who sold or dispensed these preparations based on—which law is that? It is under the Harrison Narcotics Act.

Senator DOMINICK. Under which act?

Mr. INGERSOLL. Harrison, which was legislated in 1914.

The new regulations require that the purchaser must be at least 18 years of age. Now, we debated extensively in-house whether it should be 18 or 21, and we decided in favor of 18. They also require that only a pharmacist can sell. That is, the pharmacist himself must sell the cough preparation. He can't rely upon a clerk to do this, and also a limited quantity is permitted to be sold to the same person by the same pharmacist in a 48-hour period. Finally, identification is required in addition to the need to sign a book.

Now, we opted in favor of going this far this time to see whether or not this would cure the problem. I might point out that many States have more restrictive regulations than the Federal Government, and I think this is appropriate, because as I mentioned, our information is that the problem varies greatly from State to State.

If the regulations as written are not adequate, then we intend to revise and modify them and perhaps we will recommend to the Food and Drug Administration that these drugs be placed on prescription, but this is an act or regulation that only the Drug Administration can do.

Senator DOMINICK. I think the problem our people face on this is their concern that they will find themselves in violation of the Federal law. Moreover, the burden and risk have been placed on each pharmacist's shoulders and not on an involuntary act.

In other words, the pharmacist has to make the decision in each case as to whether or not the buyer looks okay, whether he is 21, et cetera.

Mr. INGERSOLL. This is why identification is required to establish age.

Senator DOMINICK. With the traffic in I.D. cards, I don't place much faith in that.

Mr. INGERSOLL. I don't think there is anything in the regulations which would cause a criminal prosecution in the event that false identification was provided. Please let me repeat that we intended that these be minimum regulatory controls, leaving to the States to impose tighter restrictions if they saw fit, and leaving, also, the opportunity open for us to tighten up the restrictions if that was necessary.

Senator DOMINICK. I certainly don't want to put you in a bad spot, but I gather what you are saying is that if a pharmacist uses reasonable efforts to abide by your regulations, you would hold that certainly there was no intent to violate this.

Mr. INGERSOLL. I think this would be a judgment that would be made at the enforcement level and it would be made on a reasonable basis.

I should point out, too, sir, that both the American Pharmaceutical Association and the National Association of Retail Druggists favor the responsibility being placed upon professional pharmacists to make these judgments. They regard this, indeed, as a professional responsibility of the pharmacist.

Senator DOMINICK. I will relay your comments to our Colorado association.

(The letter subsequently received for the record follows:)

COLORADO PHARMACAL ASSOCIATION,
Denver, Colo, April 27, 1970.

HON. PETER H. DOMINICK,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR DOMINICK: I am writing in response to your letter dated April 20, with regard to the testimony of Mr. John Ingersoll, Director, Bureau of Narcotics and Dangerous Drugs, Department of Justice. It appears that Mr. Ingersoll definitely understood and expected that there would be problems within the various states concerning the use and abuse of codeine containing cough syrups, as he states in his testimony.

In his reference to the survey of the exempt narcotic problem that his office conducted to various states on a spot basis, my immediate response to his answer referring to this matter is that this type of limited survey cannot possibly provide them with sufficient data on a national basis. Their regulations that are issued effect the entire nation and are not meant to be effective in certain states or certain cities in the United States; therefore, on a problem as serious as this one, it appears to the undersigned and the officers of this Association that such surveys must automatically be conducted through proper sources from every state.

As Mr. Ingersoll indicates, the codeine cough syrup problem was certainly more extremely in one area than another. As a matter of fact, if a rue survey were conducted, you would find a variance in the severity of this problem from state to state—city to city—and area to area within the city.

The pharmacists of Colorado certainly are cognizant of the Department of Justice attempt at more stringent regulations; however, after a period of operating under these regulations, the majority felt the need for a stronger state law for the very reasons stated in my previous testimony. His testimony further indicated that if Department of Justice regulations are not adequate it is their intention to revise and modify them, but that this would be an act or regulation that only the Drug Administration can do. I wish to make reference to Section 4702 (3) of the Federal Narcotic Regulations which, in our opinion, authorizes their office to reclassify or revoke such exempt narcotics, merely on the determination to effect this action. Prior to the signing of the law requiring exempt narcotics by prescription only, by the Governor of Colorado on March 6, 1970,

the very fact that the pharmacist was forced to make decisions in each case as to whether or not the buyer looked o.k., was 21, was sick or well—even to the extent of determining whether or not he was actually purchasing the item for himself, was a real problem to the pharmacists and constantly placed them in the position of diagnosticians.

Identification presented by various purchasers could be, and has been, stolen, forged, and altered, and certainly could not be depended upon to determine a legal or illegal sale. Also, in the event that false identification was used to purchase this type cough syrup which was not detected by the pharmacist, and your question in regard to his position as to violation of the law, it is my opinion that Mr. Ingersoll indicated that regardless of a pharmacist's reasonable efforts to abide by regulations, there is really no provision that affords any protection since he stated that he *thought* a judgment in the pharmacist's favor would be made at the enforcement level. Pharmacists have no assurance that such inadvertent circumstances would allow them any protection.

In reference to the American Pharmaceutical Association and the National Association of Retail Druggists favoring the professional pharmacists responsibility to make these judgments, it is certainly one that is exercised by them in many facets of their operation and one that is generally acceptable to most pharmacist members. However, although we are in close contact with the national associations through communication and personal contact, and a majority of efforts normally are agreed upon and supported by state associations, this does not mean that we agree 100 percent on all issues nor, for that matter, do they, in turn, agree with everything that a state association may do. I think the codeine containing cough syrups are definitely an example of the Colorado Pharmacal Association taking a stand that may differ from the viewpoint of the national associations, but for very good reasons which are substantially supported. Testimony of the hearing conducted before the Senate Health & Welfare Committee, State of Colorado, during the 1970 Legislative Session would bear this out.

I believe that an inquiry with officers of the national associations would produce the opinion by them that they may recommend adherence to the present Bureau of Narcotics and Dangerous Drugs regulations, but that if certain states find reason to strengthen the law, this would be their prerogative. It is our belief that Colorado's present law requiring exempt narcotics be dispensed by prescription only could very well be a pattern for national consideration.

Sincerely,

CHARLES L. CUMMINGS, R. PH.,
Executive Secretary.

Senator DOMINICK. On a couple of other points: I have been interested in the work that has been done in rehabilitation by the Synanon group and the Cenikor group in Colorado. Cenikor is just starting, of course.

We found in our hearings in Denver that these groups, which in many cases are comprised of ex-addicts, are prohibited from treating parolees from any State prison, because parolees are forbidden to associate with former convicts or people on parole.

Consequently, any parolee who comes out and has a narcotics problem, and might be treated by Cenikor or Synanon, is prohibited by law from going to see them.

What is the Federal situation on this? Suppose you are in a Federal prison. Do you have a problem in the same way? If you get out on parole, can you go to one of the ex-addicts without being in violation of the parole?

Mr. INGERSOLL. I can't answer the question, Senator. I will be happy to try to obtain the information and furnish it to you if you would like.

Senator DOMINICK. I think I would, because obviously it seems to me at least that this would be a great injustice if they couldn't use these facilities.

(The information subsequently supplied follows:)

PAROLEES RESTRICTED IN PROGRAM PARTICIPATION

The Federal Parole Board has advised the Bureau that parolees must obtain prior approval from the Board if they wish to participate in programs with ex-addicts and convicted felons. As to whether or not such approval is routinely granted, this Bureau has no information since it is not within its jurisdiction.

Senator DOMINICK. Mr. Ingersoll, Dr. Daniel Freedman, in a February 1970 medical publication had an article entitled, "The Cost of Silence Now," which is devoted to the problems he sees in the Controlled Dangerous Substances bill.

I have a series of questions concerning his article which I will submit to you in writing and would ask that you supply the answers for the record. I may include a question or two on other items as well.

Mr. INGERSOLL. We will be glad to.

(The information subsequently supplied follows:)

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C., April 2, 1970.

Mr. JOHN INGERSOLL,
Director, Bureau of Narcotics and Dangerous Drugs,
Department of Justice, Washington, D.C.

DEAR MR. INGERSOLL: When you testified before the Senate Special Subcommittee on Alcoholism and Narcotics on March 26th, I indicated I would submit a series of questions to you and asked that you supply answers for the hearing record. My questions are as follows:

I. A witness who has appeared twice before our Subcommittee is Dr. Daniel Freedman, Chairman of the Department of Psychiatry at the University of Chicago Medical School. He also serves as Chairman of the Task Force on Drug Abuse and Youth of the American Psychiatric Association. In a February, 1970 medical publication Dr. Freedman has an article entitled "The Cost of Silence Now" devoted to problems he sees in S. 3246, the Senate-passed bill. In an effort to develop our hearing record, I would like to offer you the opportunity to comment on several issues he raises.

(A) Dr. Freedman writes: "(The new powers in the bill) are not simply the authority to prosecute drug abusers and traffickers. Rather, there is *new* power to initially and finally decide—to judge—with respect to a wide range of commonly used and therapeutically valuable drugs' (1) acceptable medical practice; (2) acceptable medical research; (3) who is competent to conduct this. The essential new power is to adjudicate the abuse potential and medical usefulness not only of old, but of newly discovered substances and the conditions under which they may be used—not only in everyday medical practice, but for any conceivable kind of scientific investigation. Precisely why such powers are required for the task of enforcement has never been clearly stated."

Question: How would you respond to each of these points?

(B) Dr. Freedman writes: "The fact that 35% or more of legal prescriptions are for the drugs covered in this bill indicates the extent to which legitimate medical practice is covered. . . . The fact that a patient's confidential records can be available for inspection, even though his pill may be a mild tranquilizer or sedative, should alert all patients and physicians."

Question: I am not sure how the Hughes amendment which was accepted on the floor affects this, but I would like to have your comment.

(C) Dr. Freedman writes: "The fact is that health care costs will increase, since new record keeping is required for commonly used drugs. . . . This bill is addressed to the bulk of law-abiding patients and physicians. Why?"

Question: I would also be interested in your reaction to that statement. In addition, however, would you advise us of whether the Bureau has any evidence that lack of registration of physicians or laboratory scientists regarding psychotropic drugs has led to illicit diversions of these drugs, and if so, provide data on the incidence of such diversions.

II. We have received a number of complaints about the difficulties of conducting research on narcotics and dangerous drugs under existing law. Aside from your discussion of this during your testimony, will you provide for the record a digest of and citation to each Federal statute and Federal regulation which affects research under existing law as well as a brief narrative of the procedure the applicant is to follow.

I appreciate your cooperation in testifying before the Subcommittee, and am confident your answers to these questions will be of assistance to us

Sincerely,

PETER H. DOMINICK,
U.S. Senator.

U.S. DEPARTMENT OF JUSTICE,
BUREAU OF NARCOTICS AND DANGEROUS DRUGS,
Washington, D.C.

HON. PETER H. DOMINICK,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DOMINICK: This is in response to your letter of April 2, 1970, requesting my views on certain statements made by Dr. Daniel Freedman, Chairman of the Department of Psychiatry at the University of Chicago Medical School, regarding the proposed Controlled Dangerous Substances Act, S. 3246.

Addressing myself to Part I, paragraph (A), of your letter, I think it is important at the outset to outline, within the context of the Controlled Dangerous Substances Act, what is meant by bringing a drug under control and the implications flowing from a control determination.

Under S. 3246, if the Attorney General finds that control of a substance is required by United States obligations under treaties, conventions, or protocols, or that a substance has a potential for abuse, as defined in Senate Report No. 91-613, 91st Congress, First Session, page 14 (1969) and House Report No. 130, 89th Congress, First Session, page 7 (1965), he shall issue an order controlling the drug. "Control," in this context, means that all persons manufacturing, distributing, or dispensing the substance must register with the Attorney General, keep records, and make biennial inventories of all controlled substances on hand. Restrictions on the importation and exportation of the substance are imposed. Quotas may be set for manufacturers and order forms required for transactions involving the substance, although these two restrictions depend on the schedule in which the drug is placed. In addition, criminal sanctions are imposed for unauthorized manufacturer, distribution, dispensing, or possession of controlled substances.

This, in effect, is what is meant by "control" within the context of S. 3246. The proposed bill in no way effects the functions of the Food and Drug Administration in terms of determining whether a drug has safety and efficacy for medical use or imposing prescription and labelling requirements.

The authority vested in the Attorney General, by virtue of S. 3246, to bring drugs under control is by no means novel. Under the Narcotic Manufacturing Act of 1960, the Attorney General is authorized to control those opiates found to have an addiction-forming or addiction-sustaining liability similar to that of morphine. The authority to determine that a particular drug has a potential for abuse, and thus warrants being controlled under the Drug Abuse Control Amendments of 1965, was transferred from the Department of Health, Education, and Welfare to the Department of Justice in April of 1968, pursuant to a Presidential Reorganization Plan. This authority to designate drugs as controlled drugs has remained in the Department of Justice ever since. Thus, the Controlled Dangerous Substances Act does not confer any new authority on the Attorney General in this respect, since he already has the authority to bring drugs under control.

The Controlled Dangerous Substances Act is in no way intended to authorize the Attorney General to regulate the practice of medicine, nor will it have this effect. However, this is not to say that physicians are to be given a free rein over dispensing controlled drugs. When a physician dispenses controlled drugs, as opposed to prescribing or administering them, he is acting in the capacity of a quasi-pharmacy. As such, he should be required to register, keep the same records, and make the same inventories required of the pharmacy which dispenses controlled drugs. I see no reason why the two should be treated differently when they are both performing identical functions.

Under S. 3246, researchers using controlled dangerous substances are included within the definition of "practitioners," and as such, they will be required to register, keep records, and maintain inventories. However, under subsection 303(f), they will automatically be registered to dispense or use substances in schedules II through IV, which are all those substances with a medical use, if they are licensed to do so in the State in which they practice.

Under subsection 303(f), persons wishing to engage in research utilizing schedule I substances, which are those drugs having the highest potential for abuse and no medical use, must obtain a special registration from the Attorney General. The necessity for imposing this requirement can be traced to past experience under the existing Drug Abuse Control Amendments of 1965, which do not require registration of researchers using dangerous drugs. This exemption has permitted a number of unqualified persons to obtain drugs under the guise of research and then either abuse them or illicitly distribute them. There have also been a number of instances where persons conducting research in controlled drugs have abused their privileges by either diverting or illicitly manufacturing these drugs for personal profit.

When a researcher in schedule I drugs submits his application for registration under subsection 303(f), the Attorney General must forward it to the Secretary of Health, Education, and Welfare for advice concerning the qualifications of the researcher, since this is an area within his expertise. If the Secretary of Health, Education, and Welfare approves the applicant's qualifications, the Attorney General cannot deny registration except on a finding that the applicant materially falsified his application, was convicted of a felony involving controlled dangerous substances, has had his State license revoked, or his past practices or proposed procedures furnish grounds to believe that the applicant will either abuse the drugs or fail to adequately safeguard his supply against diversion. In the event a registration is denied, the Attorney General must afford the applicant an opportunity to be heard on the matter.

Dr. Freedman and other members of the scientific and medical communities have strenuously objected to this provision, primarily on the basis that they do not wish to have the Attorney General reviewing their research protocols. Rather, they feel this is a function of the Department of Health, Education, and Welfare. On this point, I think my testimony before the Subcommittee on Public Health and Welfare of the House Committee on Interstate and Foreign Commerce on March 3, 1970, would be appropriate. On the issue of protocol review, I stated:

"However, I want to make it clear that the Attorney General's only interest in reviewing these protocols is to ascertain if there are adequate safeguards against diversion and that the physical security of these drugs is insured. He is neither interested in nor qualified to judge what is good or bad research protocol from a scientific point of view and will not do so."

As the statement indicates, the primary controversy has centered around the Attorney General reviewing research protocols, not on the Attorney General having the ability to insure the physical security of the drugs. I do not feel that any responsible researcher would argue the need to prevent diversion of these drugs or that diversion is essentially a law enforcement matter. To this end, we are presently reviewing the language of section 303(f) to see if it can be modified to make our intent more clear and specific.

However, I do not feel that the criteria under which the Attorney General can deny a special registration are unreasonable in light of past experience, nor do I feel that they permit the Attorney General to judge what is acceptable research from a medical or scientific viewpoint. This is a function of the Psychotomietic Committee housed in the Department of Health, Education, and Welfare.

Turning now to the other two statements made by Dr. Freedman, for purposes of clarity, I would like to address them in reverse order.

Existing Federal narcotic and dangerous drug laws require physicians to keep records of all amounts of narcotics and stimulant and depressant drugs dispensed since they are acting in the capacity of a quasi-pharmacy. However, these record-keeping requirements are not imposed on the physician who only prescribes or administers these drugs.

This recordkeeping requirement is carried over into the Controlled Dangerous Substances Act and, with the exception of certain tranquilizers, will apply only to drugs controlled under existing law. Therefore, I cannot see how health care costs will increase by virtue of passage of the Controlled Dangerous Substances Act since it requires no more of physicians than is required under present law.

Turning now to paragraph (B), I see little relevance in Dr. Freedman's statement that 35 percent of all legitimate prescriptions involve drugs listed in S. 3246.

As I already indicated, only dispensing physicians are required to keep records. Practitioners who only administer or prescribe controlled drugs are required to register, but they are exempt from the recordkeeping requirements. Since the prescribing physician is not required to record the amounts of a controlled drug prescribed, the volume of legitimate prescriptions involving controlled drugs has little or no significance insofar as medical practice is concerned.

I find little basis in fact for Dr. Freedman's statement that the recordkeeping and inspection provisions of S. 3246 will infringe on the physician-patient confidential relationship. As I indicated earlier, existing Federal law dictates that physicians dispensing narcotics and dangerous drugs keep records and make them available for inspection. Past experience has shown that the great majority of dispensing physicians maintain a chart, separate and apart from the patient's other records, listing the amounts of controlled drugs dispensed. In conducting a record inspection, this is the only chart which must be looked at. In these situations, there is no need, nor the authorization, to inspect those records containing a patient's background or medical history.

Since substantially similar recordkeeping and inspection provisions are carried over into the Controlled Dangerous Substances Act, I see no possibility, from the standpoint of common medical practice, that the physician-patient confidential relationship will be disturbed.

In response to Part II of your letter, I have enclosed in a separate attachment a listing of certain Federal statutes and regulations bearing on research in controlled drugs. This list is by no means comprehensive due to the large numbers of statutes and regulations which have some effect, directly or indirectly, on persons conducting research in narcotics, marihuana, and dangerous drugs. Many of these statutes and regulations not listed are applied by agencies other than the Bureau of Narcotics and Dangerous Drugs, and therefore I do not feel it would be appropriate for me to comment on them.

Thank you for this opportunity to be of assistance.

Sincerely,

JOHN E. INGERSOLL, *Director*.

FEDERAL STATUTES AND REGULATIONS RELATING TO RESEARCH IN NARCOTIC DRUGS

26 U.S.C. 4721(4), (5): These provisions require practitioners lawfully entitled to administer or dispense narcotic drugs and persons authorized by law to obtain and use narcotic drugs in a laboratory for analysis or research to pay an annual tax of one dollar.

26 U.S.C. 4722: This provision requires annual registration of all persons required by 26 U.S.C. 4721 to pay the special tax.

26 CFR 151.41, 151.47, and 151.48: These regulations set out the taxing rates and the registrant classes. Persons using narcotic drugs in laboratories are registered in Class VI. Physicians or other practitioners administering or dispensing narcotic drugs are registered in Class IV. This latter Class may include practitioners who are administering or dispensing narcotic drugs for the purposes of research.

26 CFR 151.441—151.443: These regulations govern the handling of narcotics by Class VI registrants, who are those persons using narcotic drugs in laboratories for analysis or research. Records of receipts, disposals, and stocks of narcotic drugs on hand must be maintained; and special records must be kept of the dates, kinds, and quantities of narcotics used and the purposes for which they were used. Researchers registered as practitioners in Class IV are not governed by these regulations. They are governed by the recordkeeping requirements set out in 26 CFR 151.412.

FEDERAL STATUTES AND REGULATIONS RELATING TO RESEARCH IN MARIHUANA

26 U.S.C. 4751(3), (4): These provisions require practitioners who distribute, dispense, or administer marihuana to patients in the course of treatment and persons who obtain or use marihuana in a laboratory for analysis or research to pay an annual tax of one dollar.

26 U.S.C. 4753: This provision requires annual registration of all persons required by 26 U.S.C. 4751 to pay the special tax.

26 CFR 152.29, 152.34, and 152.35: These regulations set out the taxing rates and the registrant classes. Persons using marihuana in laboratories are registered in Class V. Physicians and other practitioners distributing, dispensing, or administering marihuana in the course of treatment are registered in Class IV. This latter Class may also include persons conducting research in marihuana.

26 CFR 152.100: This regulation sets out the recordkeeping requirements for Class V registrants, who are those persons obtaining and using marihuana in a laboratory for analysis or research. Records of receipts, disposals, and stocks of marihuana on hand must be maintained; and special records must be kept of the dates, kinds, and quantities of marihuana used and the purposes for which they were used. Researchers registered as practitioners in Class IV are not governed by this regulation. They are governed by the recordkeeping requirements set out in 26 CFR 152.73.

Senator DOMINICK. Going back to the classification problems that you bring up in the process of your statement, and which Senator Hughes asked you about, let me ask you about a problem I see in the so-called Controlled Dangerous Substances Act which passed the Senate earlier this year.

As I understand it, that bill reduced the penalty for use of marihuana to a simple misdemeanor. Yet marihuana is classified in classification I with heroin. How do you put these two things together?

Mr. INGERSOLL. The reason for that, Senator, is that marihuana has no recognized medical use. All the drugs classified in schedule I, irrespective of the degree of danger or hazards they represent are those which are available and used only for research purposes. They have no recognized therapeutic use at all.

Investigation of new drug applications are required to perform any work on these substances at all.

Senator DOMINICK. The Army research which was conducted on marihuana—which I put into the Congressional Record—indicates that there might be some medical use for it.

Let me ask you this. Suppose doctors determine, or HEW does, that there is a medical use for marihuana. What, then, happens to the classification under the Controlled Dangerous Substances Act?

Mr. INGERSOLL. The drug would leave schedule I, either with congressional action or by administrative action on the part of the Attorney General.

If it is through administrative action, it could be removed only to schedule II by him. At a later time it could be removed completely or reduced to a lower schedule. This would apply to any of the drugs which are in schedule I.

Senator DOMINICK. The classifications in that bill, as I understand it, are for purposes of enforcement and control.

Is there any reason to feel that the same classifications must be maintained when we are dealing with rehabilitation and health aspects?

Mr. INGERSOLL. I think it would be desirable and probably necessary to have tighter definitions of the classifications. It would certainly be desirable from the legal viewpoint that standard classification and standard terminology be used in all Federal legislation. There is a probability that some of the terminology relating to these classifications would be found to be too vague to be supported constitutionally, and they do affect, as Mr. Sonnenreich has pointed out, some

provisions of this bill, the bill before us, that we are not testifying on at this time.

These mainly involve the criminal and legal fields.

Senator DOMINICK. I am not trying to argue with you, but just to point out some problems, let's take marihuana. It is in classification I at the present time, saying that it has no known medical value. It is not, however, yet thought of, and I put it in that way, as any kind of hard drug or an addictive type drug, something which for health purposes you may have to have some treatment psychiatrically or motivationally.

It would seem to me, therefore, that it would be very difficult for the Hughes bill to classify marihuana in the same manner.

Do you see the point I am raising here?

Mr. INGERSOLL. I am not sure that I understand it, but let me reply on what I think I understand. I don't see the need for classifying various kinds of drugs for—just for treatment purposes—or, indeed, for a different classification system. I can't understand how the fact that marihuana is in schedule I in the Controlled Dangerous Substances Act would have any effect at all upon treating a person who was a marihuana user.

Senator DOMINICK. Well, it is my understanding, and perhaps I am wrong, that by being classified in No. 1 you are talking about a drug which has no known medical use, but which is also, in the mind of the public, therefore considered as one of the more dangerous drugs, and subject of course, to prosecution if you use it, sell it, possess it, and so on.

Mr. INGERSOLL. What I am saying, Senator, is that the classification scheme will not affect the way in which a doctor or a mental health worker or social worker or a therapist would treat somebody who is involved with abuse of marihuana.

Therefore, we fail to see the need for this classification system for this purpose.

Senator DOMINICK. In other words, it is your feeling that we could leave the schedules the way they are in the Controlled Dangerous Substances Act and still carry out whatever treatment may be needed for rehabilitation or health purposes?

Mr. INGERSOLL. Yes, sir, exactly.

Senator HUGHES. Would the Senator yield on that for a moment?

Senator DOMINICK. Yes.

Senator HUGHES. We have had absolutely contradictory testimony on that from most of the doctors who have testified before us. I wonder if we can reconcile that in some way. We are left with two sets of testimony, yours saying it doesn't make any difference, and theirs saying it does. So it is a matter of flipping a coin and taking one or the other.

Mr. INGERSOLL. Logically, Mr. Chairman, I can't see where the point at which marihuana fits is classified for legal purposes, would have any bearing on the treatment of a marihuana user.

A marihuana user is not treated by giving him more marihuana.

Senator HUGHES. Are you an expert in the treatment of a marihuana user?

Mr. INGERSOLL. No, sir; but I doubt that anybody is, really, and I think that just commonsense would indicate the—

Senator HUGHES. I am not so sure. In the case of alcoholism, you know, there are many treatments which use alcohol.

Mr. INGERSOLL. They can do this, but marihuana, today, is not available for therapeutic purposes.

Senator HUGHES. I understand that. That is what we are talking about.

Mr. INGERSOLL. Your classification schedule will not make it available for treatment purposes, as I see it, in view of other legislation.

Senator HUGHES. Psychologically, it will have an effect; will it not?

Mr. INGERSOLL. I am not sure what kind of effect you are looking for.

Senator HUGHES. Well—excuse me, Senator Dominick.

Marihuana in this country is classified with heroin, and the kids in this country know there is no relationship between marihuana and heroin. I think, for that reason, that we place a great psychological barrier when we try to do anything to eliminate the broad, general use of marihuana. I am talking about that psychological barrier.

Mr. INGERSOLL. Both the Senate and the administration have recognized this in terms of the penalty sanctions which were recommended in the Controlled Dangerous Substances Act, and which was passed by the Senate. This is where the great problem arises in the minds of young people, as I understand it.

Now, in the scheduling scheme that was used in the Controlled Dangerous Substances Act, all of those drugs which had no medical utility, no recognized medical use at this time were put in that schedule I. There are other laws, also, that affect their use for research purposes, and one of these is that the FDA procedures have to be followed if research or investigation of that drug is contemplated.

Mr. GARFIELD. I might point out, Senator, that even though you have schedule I drugs applicable to those drugs for which there is no recognized medical use, there is a distinct breakdown with the schedule. There are three separate breakdowns.

One concerns the derivatives of opium, the other concerns the opiates and the third the hallucinogens.

Senator HUGHES. I debated the issue on the floor 2 days, so I know what the breakdowns are. I failed to change it, and I still feel the way I did, and you feel the way you do.

So we will go back to Senator Dominick and let him pursue his questions.

Senator DOMINICK. I just wanted to ask one more question on the same point—the marihuana inclusion in category I.

What purpose does the classification have other than law enforcement control?

Mr. INGERSOLL. Well, they are also used for regulation of the pharmaceutical manufacturing and distribution and retail sales. This schedule one has very comprehensive recordkeeping requirements imposed on the flow of these drugs permitted to be manufactured in this country, throughout their distribution network or system.

In addition to enforcement and criminal sanctions, there are also regulatory matters.

Senator DOMINICK. I will move on to another subject for a minute, because we may not agree on this one.

Let me ask you about title V of this bill. It makes certain requirements with regard to drug abuse and dependency of Federal employees. Do you have any figures on incidence among Federal employees?

Mr. INGERSOLL. No, sir; I don't, aside from those who are in the Defense Department in the military who are in uniform.

Senator DOMINICK. What do you do with Federal employees who are determined to be involved with either drug abuse or dependence under existing law?

Mr. INGERSOLL. I don't—I am not aware of administrative action that is used in other agencies in this case, and I have no experience within my own staff of drug abusers. If they are arrested and convicted of a violation of any law, why, of course, they are subject to disciplinary action through the standard civil service procedures.

Senator DOMINICK. Under this bill, we provide that Federal employees shall not lose their pension, retirement, medical or other rights because of drug abuse or dependency.

Do they lose any of them now?

Mr. INGERSOLL. I am sure they will if they suffer a criminal conviction, and it is possible that an adverse action would be contemplated against the employee, but I think these are questions that the Civil Service Commission could answer better than I can.

Senator DOMINICK. This is a difference in approach between a regulatory method and a method of rehabilitation and help, as far as drugs are concerned. It is pretty fundamental.

If a person has any other kind of disease, he doesn't lose these rights. If you don't consider this as a disease, then he would. This is where we come into a classification problem or definition problem. It creates quite a stir.

In trying to reconcile the matter, we have the Hughes bill. This issue will probably be the big one. I would think, on the floor. My guess is that it will continue to be one for quite a while.

Senator HUGHES. We are fighting the same battle with relationship to alcoholism, I might add, among Federal employees and military personnel and the entire gamut. This is a similar approach to what we are taking in that.

For example, we just had a man, an officer, in one of the services, 17 years' service, who was asked to submit a resignation under sedation in a military hospital because he was an alcoholic. He did submit it, later withdrew it. Finally, he did resign, rather than face a court-martial for the disease of alcoholism.

What we are talking about is the concept.

Senator DOMINICK. This may also be more applicable to the civil service representatives than you, Mr. Ingersoll, but I would like to ask the question.

The bill provides that "no person may be denied or deprived of Federal employment or a Federal professional or other license or right solely on the ground of prior drug abuse, or dependence, except with regard to extremely sensitive positions specified in regulations promulgated by the Secretary."

This is section 501-C, page 55 of the bill.

Do you know whether or not denials of Federal employment are made on that basis now?

Mr. INGERSOLL. No, sir. I have no information on that.

Senator DOMINICK. Do you know what types of professional or other licenses we might be excluding or making available by the language?

Mr. INGERSOLL. No, sir.

Senator DOMINICK. I think we can ask that question of later witnesses, then.

That is all I have for the moment.

Senator HUGHES. Thank you, Senator Dominick.

I realize you men have been here for a long time and I still have a list of questions to go through with you. Would you like to take a 5-minute break?

Mr. INGERSOLL. As you wish, sir.

Senator HUGHES. We will recess for 5 minutes.

(A brief recess was taken.)

Senator HUGHES. Gentlemen, if we could come to order again, we will get underway.

I have a series of questions that I want to get into the record, and I don't want to belabor them, and if it is easier for you to submit the answers in writing, that is fine with me.

You support a narcotics registry for law enforcement purposes in your prior testimony. Would you agree the registry would be most important to health officials?

Mr. INGERSOLL. I believe that information produced from that registry would be of use to health officials, yes, sir.

Senator HUGHES. Why should the Attorney General have primary authority for drug classifications? Do you have the scientific know-how to overrule the Department of HEW?

Mr. INGERSOLL. I think that the primary reason that we favor the Attorney General having this authority is that after the scientific determinations are made, there are a number of legal ramifications that have to be brought into play. The ruling has to be enforceable, it has to be legally sustainable. It will undoubtedly be subjected to hearings both of the administrative and the judicial type, and if it is going to be implemented, then it has to have legal sufficiency.

The Department of HEW will render advice, as will a scientific advisory committee, as is the present practice. That is under the aegis of the Department of Justice, appointed from a list submitted by the National Academy of Sciences.

In addition to that, much of the work that is done to determine whether or not the drug is being in fact abused is done through our personnel throughout the country.

Senator HUGHES. Would you object to that procedure being reversed, where you are in an advisory capacity to HEW?

Mr. INGERSOLL. Yes, sir.

Senator HUGHES. Do you feel law should have the primary and last judgment over medicine in this area?

Mr. INGERSOLL. I don't think that is the issue, Mr. Chairman. The issue is not how the drug is going to be used for medicinal purposes. The issue is how to control and prevent the drug from being misused and abused in a nonmedical and modality.

Senator HUGHES. Is enforcement or danger to public health the most critical factor in arriving at a determination of whether a drug should be controlled?

Mr. INGERSOLL. I think both are important, Mr. Chairman.

Senator HUGHES. Of equal importance?

Mr. INGERSOLL. In the abstract, yes, sir. As far as the practical administration of the law, then I am afraid you have to look to legal authority for administration.

Senator HUGHES. You indicate generally that there is authority, as called for in S. 3562. This is your implication in the testimony.

I would like you to supply for the record the precise statutory authority on which you rely for the programs contained in S. 3562.

Mr. INGERSOLL. Yes, sir.

(The information subsequently supplied follows:)

EXISTING STATUTORY AUTHORITY FOR DEPARTMENT OF JUSTICE PROGRAMS SIMILAR
TO THOSE PROPOSED IN S. 3562

1. 18 U.S.C. 4251 et seq. (Title II of the Narcotic Addict Rehabilitation Act of 1966, administered by the Bureau of Prisons for convicted addict offenders sentenced to commitment for treatment.)

2. 42 U.S.C. 3701 et seq. (Title I of the Omnibus Crime Control and Safe Streets Act of 1968 establishing the Law Enforcement Assistance Administration within the Department of Justice to assist States in improving and strengthening law enforcement. Training, education, and research for law enforcement improvement are specifically provided for.)

Senator HUGHES. Where they have spelled out for you that they can do the things we are attempting to do.

Would you compare for the record the number of physicians and scientists involved in the drug problem in HEW versus the number in the Department of Justice.

(The information, subsequently supplied, follows:)

MEDICAL AND SCIENTIFIC PERSONNEL EMPLOYED BY THE BUREAU OF NARCOTICS
AND DANGEROUS DRUGS *

Physicians	2
Pharmacologists	3
Sociologists	2
Clinical psychologists	1
Medical statisticians	1

*The Bureau is not in a position to designate the number of scientific and medical personnel in the Department of Health, Education, and Welfare who are involved in the drug abuse problem.

Mr. INGERSOLL. I will have to submit that, also, Mr. Chairman.

Senator HUGHES. All right. Is HEW best qualified to make scientific determinations on drugs subject to abuse or made available for acceptable medical use?

Mr. INGERSOLL. We have recognized in our testimony, and also in the Controlled Dangerous Substances Act that HEW must participate in the scientific side of the determination.

I might point out, Mr. Chairman, that the Secretary of HEW has also indicated his agreement before the committee in the House that has been holding hearings on this matter to the pattern and to the division of labor that is suggested in the Controlled Dangerous Substances Act.

Senator HUGHES. That is what frustrates us. You are all under one head, and there is not much I can do about it. You all take orders from the same horse. You are compelled to follow those orders.

Senator DOMINICK. In this case the horse is a thoroughbred.

Senator HUGHES. I am not debating the merits of the horse. There

is little I can do with relationship to it. I would find it strange if he disagreed with you, I will tell you that.

In Dr. Egeberg's testimony before the House Public Health and Welfare Subcommittee on Drug Abuse Legislation, he said, "I had discussions with Mr. Ingersoll, and we expect to work out the relationships between the kinds of research they are going to do and the kinds of research for which we will be responsible."

Would you tell us, if you can, what relationships have been worked out in such research activities? If you haven't developed those yet, will you supply them to us after you develop them?

Mr. INGERSOLL. Yes, we will; and I think I can say for your information and for the record that I find Dr. Egeberg to be a very cooperative and very helpful person in this regard. I would guess that our activities have not yet proceeded beyond the discussion stage, although I have indicated to Dr. Yolles, head of the National Institute of Mental Health what our intentions are in research and have requested that we—or renewed a request—that we meet very soon so that we can establish the proper means of exchanging information.

Senator HUGHES. I found him to be very cooperative with you, too, in my questioning of him.

Would you indicate specific cases of where serious and substantial diversion of narcotics and dangerous drugs has occurred in research with narcotics, marihuana, and other dangerous drugs?

Mr. INGERSOLL. I can submit that, sir.

(The information, subsequently supplied, follows:)

DIVERSION BY RESEARCHERS AND PERSONS POSING AS RESEARCHERS

Researcher diversions have also taken place on occasion. Various devices have been utilized by employees such as doubling orders and taking the excess and using legitimate letterheads or purchase order forms for personal orders. Some illustrative cases are shown below.

1. In the summer, 1969, BNDD investigated a graduate student at a large midwestern state university. The student was working on a university research project. On the side he was using the university laboratory to make dangerous drugs. This researcher went so far as to use funds provided by a Federal Grant to purchase his dangerous drug precursor material. Our agents arrested him in his lab for illegal possession of dangerous drugs.

2. A diversion of methamphetamine powder involved a major westcoast university professor's research project. Students employed on the research project simply doubled orders directed to a drug wholesaler in Chicago. The amounts involved were one pound quantities, enough to make about 50,000 normal 5 milligram dosage units.

3. In late 1968, Bureau Agents conducted an investigation of the head of the chemistry department at a community college in the Pacific Northwest. Investigation disclosed that the professor was using his position to obtain precursor chemicals and was using the college laboratory on weekends in an attempt to manufacture methamphetamine. This operation was stopped before sufficient evidence was obtained for prosecution and the professor left the college. In the spring of 1968, this former professor informed one of our undercover agents that he could manufacture large quantities of methamphetamine. He was subsequently arrested by local authorities for possession of heroin and marihuana.

4. A cooperating chemical supply firm furnished BNDD with information regarding suspicious orders for methamphetamine from a customer. Investigation by Bureau Agents determined that the customer, who had given a fictitious firm name and represented himself as a researcher, was in fact a young college chemistry student in the Metropolitan New York City area. Sizeable quantities of controlled drugs and chemical precursors were taken from the boy's home along with invoices reflecting that this youth had successfully obtained methamphetamine from three major chemical supply firms on several occasions.

5. In mid 1968, our Agents developed information that a chemist at a nationally known research foundation in Southern California was using his position to obtain lysergic acid which he used to manufacture LSD. He made the LSD and supplied it to illicit traffickers who actually made sales to our undercover agents. He used foundation funds to purchase his materials.

Senator HUGHES. In evaluating drug research, do you deem more important quality research conducted or controls on the drugs being researched?

Mr. INGERSOLL. I think that the quality of research would certainly be impaired and the public safety would be affected if the controls were not adequate.

Senator HUGHES. You came up with a good answer.

Mr. INGERSOLL. Thank you, sir.

Senator HUGHES. Would you care to respond to the criticism we received from witnesses that it serves no useful purpose for law enforcement personnel to talk to teenagers? We have had evidence brought to us that in the case of law enforcement officers in New York City conducting programs in schools, that the incidence of drug abuse after the classes were conducted rose higher than it had ever been before.

Mr. INGERSOLL. You are certainly not placing a cause and effect relationship between the officers presence and increased drug abuse. That is nothing more than a continuation of a pattern we have been experiencing for the last decade.

Now, I think not any police officer, or not just any law enforcement officer can go into a classroom of students to talk. It has to be a properly trained, properly motivated one—

Senator HUGHES. Would you expand on that?

Mr. INGERSOLL. I think you can use as a classic illustration of this the long-term and very effective contributions that police officers have made to child traffic safety in the classroom. Virtually every police department has at least one officer who goes around to classrooms, particularly at the elementary level, lecturing on traffic safety. He is usually selected for his ability to communicate with young children, and he is well trained and well versed in fundamentals of traffic safety. We see juvenile officers working effectively with children in a variety of programs.

One of the reasons for the breakdown, or the so-called communications gap, or other gap between young people and police officers today is because of statements like this, that the police officer has no role in working with children, and I object strenuously to that. I think traditionally and historically the police of this country have done a very effective job working against great odds in preventing and curbing juvenile delinquency.

Senator HUGHES. I agree with that wholeheartedly.

Senator DOMINICK. Just on that same point, I just want to make a distinction, perhaps in the question and certainly in the answer.

A police officer talking about traffic safety is dealing with a group of kids that you know are going to be driving. I don't suppose there are more than an infinitesimal portion of the kids who don't get their licenses to drive. So you are dealing with something that is part of the human equation, but our question is whether or not going into the schools, whether or not they be police officers or otherwise and lectur-

ing on drugs doesn't in fact induce more publicity about it and induce more kids to try it.

Mr. INGERSOLL. Senator, I would agree that none of us be he a doctor, a psychologist, a psychiatrist, a scientist, a police officer, a lawyer, whoever has worked in this field, has found the right educational process. I have seen movies which purport to be drug abuse prevention in nature or purpose, and they do nothing but glamorize drug abuse by the use of hallucinogenic colors and sound and so on.

When I was referring to the police officer's contribution to traffic safety, I didn't have in mind just driver training. I had in mind teaching young children how to cross streets safely, how to avoid accidents, how to take care of themselves on their way home and avoid the kinds of places and locations where they might be hurt, and I think the police officers have a great effect.

I might add that irrespective of what generalized allegations against the effectiveness of law enforcement officers in the drug field, nevertheless we have thousands and thousands and thousands of requests every month for our agents to speak to groups ranging from young people through concerned citizens on the problems of drug abuse.

If we accepted half of the invitations that we receive, or the requests that we receive, many of which emanate from the halls of Congress, I might add, we wouldn't be able to do our other work.

I think we do have——

Senator DOMINICK. I am not trying to run down the officers. I am just bringing up the psychological problems.

Mr. INGERSOLL. I don't think the presence of a police officer can be attributed to the increase in drug abuse.

Senator HUGHES. We have heard testimony that some of these programs conducted in schools, for example by a panel of nonuniformed police officers and ex-addicts, have had an adverse effect.

I have seen films and programs and spots, and packets of material that I think were badly conceived and poorly put together and hastily rushed out that have a potential of increasing rather than decreasing the usage or experimentation in some areas.

I cited an instance in New York City which was brought to my attention by representatives in New York City where this happened.

I don't know what the incident was. I don't know whether it was the result of poor training on the part of the officers, or bad presentation. Perhaps the research you were talking about in relationship to this type of program would be beneficial in these areas.

I think that is a legitimate part of what you are doing. I object to some of the rest of it. I think it is too broad, but we are trying to identify what is the best type of approach.

I think you responded as ably as you can. I don't know anything we could add to the record. If you have anything further to say about it, go ahead.

Mr. INGERSOLL. No; I think I have said enough, Mr. Chairman.

Senator HUGHES. If you would like to submit corrections or additions that would eliminate or pose the least hazard to your department and agency that you feel are necessary, it would be helpful to us in considering the legislation and we would appreciate your willingness to submit that to us for our consideration.

Mr. INGERSOLL. I think it is appropriate to repeat what I said at the outset. I think we are all interested in the same objectives. I think some of us emphasize one avenue more than the other, because these are the things that we are responsible for at the time, but we certainly share the concern of this subcommittee and desire of this subcommittee for the necessary kinds of legislation that will bring this problem of drug abuse under better control.

Senator HUGHES. I think we are all agreed on that. All of us realize that the best way to make your job easier is to stop the input into the drug scene by prevention and education. That would make your job much easier, as you try to get at the traffickers and suppliers and the international controls, where you testified repeatedly your main thrusts and main concerns have to be.

Our differences are in the approach to the problem. So, in spite of our differences, we have no differences in what our common goals are.

I want to thank you very much for your willingness to come over and your patience. I don't apologize for the length of time we took. I feel it is necessary to develop the record and get your positions into it which can be helpful to us.

Senator DOMINICK. Mr. Chairman, just before Mr. Ingersoll leaves, there is one thing that interests me. They have objected, Mr. Ingersoll has, in his statement, to the definition in section 101(a) of whether drug dependence is an illness or a disease. He objected on the ground that the potentials might be affirmative defenses in criminal prosecutions.

My comment is only this, that I am not sure we ought to go that far, either, to say flatout that drug dependence is an illness or disease as such and that it should be so treated in all respects for that reason.

We want to have the ability to treat it to overcome it. The question is, Do we want to treat it as such for other reasons?

So, my comment here is only designed to do this. I wish Mr. Ingersoll, when he has time, will think over this problem. If you have an input as to how that definition should be worded, would you give it to the subcommittee, and obviously send the chairman and myself a copy? This is really perhaps, the key issue in the whole bill, it seems to me, keeping in mind that what we are dealing with is the need for rehabilitation and education, training, et cetera.

As the chairman said, we don't want to cut down on the enforcement or control level, but we do want to have a basis whereby we can get positive programs going in the treatment area. Perhaps you might be able to give us something here out of your experience in the field which wouldn't create the conflict that we presently have.

Mr. INGERSOLL. We will be happy to try to do that.

(The information subsequently supplied follows:)

ALTERNATIVE LANGUAGE TO SUBSECTION 101(a)

As indicated by testimony of representatives from the Department of Justice, the Department feels that a Congressional Finding that drug dependence is an illness or disease will raise the distinct possibility of drug dependence being asserted as a defense in a criminal prosecution.

The Department feels that such conclusionary language is not necessary to carry out the intent of S. 3562, which, in part, is to establish procedures and broad treatment modalities for the rehabilitation and treatment of drug abusers and drug dependent persons. Therefore, the Department recommends that the

Subcommittee should weigh heavily the implications for law enforcement that such a Congressional Finding would have.

Suggested alternate language to Subcommittee 101(a) reads as follows:

"On page 2, line 3, immediately after the word 'dependence,' delete the words 'is an illness or disease that,' so as to make a sentence beginning on line 2 read: 'During dependence requires treatment through health and rehabilitation services.'"

Senator HUGHES. Thank you very much, Mr. Ingersoll, Mr. Sonnenreich, and Mr. Garfield.

Mr. INGERSOLL. Thank you, Mr. Chairman.

Senator HUGHES. The Chair calls Wesley Pomeroy, former Associate Administrator, Law Enforcement Assistance Administration, and former Special Assistant for Law Enforcement Coordination to the Attorney General, U.S. Department of Justice; planner and organizer of security, fire protection, communications, and social-legal-medical services at "Woodstock Festival" in August 1969.

I would like to introduce for the record your biographical information.

(The information follows:)

BIOGRAPHICAL INFORMATION: WESLEY A. POMEROY

Professional Experience

A. June 1969—*Current*: Founder and President, Pomeroy Associates, Inc., 1700 Pennsylvania Avenue, N.W., Washington, D.C. 20006. Telephone: (202) 659-2443.

Applying advanced, innovative, interdisciplinary approaches to help clients meet the challenge of curbing crime in the United States and improving our police, court and corrections systems at all jurisdictional levels.

Combining practical experience, through research and conference techniques to help solve client problems.

Coordinating the work of a small D.C. staff and of many highly qualified consultants—drawn from universities and all types of criminal justice agencies—police, courts, and corrections—located throughout the United States.

Helping State Planning Agencies to interact more effectively with the Law Enforcement Assistance Administration, U.S. Department of Justice, under provisions of the Omnibus Crime Control and Safe Streets Act of 1968.

Evaluating ongoing programs, preparing feasibility studies, and making recommendations for step-by-step modernization of existing facilities and methods for clients in police, courts, and corrections work, at all jurisdictional levels.

Undertaking projects for private corporations and civic organizations who want to apply progressive approaches to avoid violence, promote peaceful expressions of opinion by all citizens, and assist police, court, and correction authorities. Work by Pomeroy Associates, Inc. in this area has included:

January 1970: Designed and implemented a total security plan for the Association of American Colleges to ensure that its annual meeting at Houston, Texas, would avoid violence and reduce the probability of confrontation.

January 1970: Participated with the University Research Corporation in a feasibility study on "Junction Micro City" for the White House Conference on Children and Youth.

November 1969: Provided consultant services to University Research Corporation on "new careers in law enforcement".

October 1969: Designed and implemented a total security plan for the annual meeting of the American Council on Education based on the strategy of avoiding violence and reducing the possibilities of confrontation while the group was convened at Washington, D.C.

Sept.—Nov. 1969: Participated, under subcontract to Arthur D. Little, Inc., in a nationwide project on riot control tactics and equipment involving National Guard units.

August 1969: Planned, organized and coordinated security, fire protection, communications, and social—legal—medical services for the so-called "Wood-

stock Festival" (Aquarian Exposition) which attracted an estimated 400,000 young people to the tiny town of Bethel, New York.

B. *October 1968-June 1969*: Associate Administrator, Law Enforcement Assistance Administration, U.S. Department of Justice, Washington, D.C. Activities included:

Built and administered with two other Presidential appointees the organization created by Congress to implement the provisions of the Omnibus Crime Control and Safe Streets Act of 1968.

Worked with appropriate officials in all states to establish, as provided under Federal legislation, State Planning Agencies charged with developing ways to improve all aspects of the administration of criminal justice—including gradual modernization of court, corrections, and police methods and facilities at the city, county, and state levels.

Helped set up state-Federal cooperative arrangements at 500 colleges and universities for training programs and academic assistance to qualified personnel aspiring to careers in the criminal justice field.

Helped create the Institute of Law Enforcement and Criminal Justice, a research entity within the Law Enforcement Assistance Administration.

C. *March 1968-October 1968*: Special Assistant for Law Enforcement Coordination to the Attorney General, U.S. Department of Justice, Washington, D.C. Duties included:

Coordinating activities of all Federal law enforcement agencies and of all Federal courts and their support systems.

Coordinating all Federal aid programs useful to state, county, and local court and correctional agencies.

Carrying out numerous special assignments:

Developed and implemented procedures and plans for protecting all government buildings in Washington, D.C., during demonstrations and civil disorders. Recommended and set up "after action" studies in cities where riots occurred (in conjunction with the International Association of Chiefs of Police).

Coordinated Federal presence at both 1968 national political conventions.

Served as liaison for the Federal Riot Task Force sent to Chicago in April, 1968 following the assassination of Dr. Martin Luther King in Memphis.

Participated regularly in Steering Committee planning meetings of the "Civil Disturbance Directorate", Pentagon, Washington, D.C.

Served as member, Task Force Committee for Establishment of Coordinated Federal Training Center.

D. *1960-Sept. 1968*: Undersheriff, Sheriff's Dept., San Mateo County, California. Projects conceived and implemented included:

A model county correctional program involving work release, therapeutic community action, and the most advanced individual and group counseling concepts.

A pioneering, innovative ghetto store-front community-police participation program.

A program utilizing beat patrolmen as physical education instructors in inner city public schools.

An ongoing personnel selection research program, involving comparisons between psychological testing, oral interviews, and other cross-matching procedures.

Initiation of planning for developing an area-wide information storage and retrieval system.

Functioning regularly as police field commander at times of threatened or actual civic disorder.

E. *1951-1960*: Sheriff's Dept., San Mateo County, California—various ranks and duties commensurate with regularly received promotions.

F. *1942-1951*: State Traffic Officer, California Highway Patrol (military leave, 1943-1945).

II. Other Professional Activities

A. Consultantships:

Co-directed fourteen conferences on prevention and control of civil disorders co-sponsored by the U.S. Dept. of Justice and the International Association of Chiefs of Police, 1968.

Served as consultant to the President's Crime Commission, 1966-67.

Organized and commanded police and other security and social service forces during the 1964 Republican National Convention at the Cow Palace, San Fran-

cisco. (Peace-keeping innovations applied here served as models for those used at the 1968 Republican National Convention.)

B. Teaching:

Instructor in "Criminal Law" and "Criminal Evidence" at Foothill College and the College of San Mateo, California, 1964-66.

Regular lecturer at National Police Academy, Office of Public Safety, Agency for International Development, Department of State, Washington, D.C.

C. Publications:

Co-author, *Police Selection*, Charles Thomas Publishing Co., 1964.

Various papers, including "Rehabilitation at the County Level" advocating use of therapeutic community action as the basic principle of a county correctional program. (This plan is now in effect in San Mateo County, Calif.)

Pamphlet on how to cope with civil rights demonstrations, emphasizing riot prevention during periods of racial tension, (*Procedures for Racial Demonstrations*).

Pamphlet discussing use of police dogs, police reserves, cadet programs, etc. (*Supplementing Sworn Police Personnel*).

III. Community Service Activities

A. Past President, Board of Trustees, Ravenswood City School District, Calif.

B. Member, Planning Committee for the Annual Police-Community Relations Institute; sponsored jointly by the National Conference of Christians and Jews and the University of San Francisco.

C. Past President and Member, Board of Directors, Peninsula Halfway House, Calif.

D. Board Member, Peninsula Suicide Prevention, Inc., Calif.

E. Past President and Member, Board of Directors, Friends Outside (to aid families of San Mateo County jail prisoners, Calif.).

IV. Education

A. LL.B., 1959; D.J., 1968. San Francisco Law School, San Francisco, California.

Admitted to practice law:

U.S. Supreme Court, 1969.

Circuit Court of Appeals, Ninth Circuit, 1961.

Federal District Court, Northern California, 1961.

State of California, 1961.

B. San Francisco Junior College, San Francisco, California: 1937-38.

C. Pacific Union College, Angwin, California: 1936-37.

V. Membership in Professional Organizations

A. State Bar of California.

B. American Bar Association.

C. California State Sheriffs' Association.

D. International Association of Chiefs of Police.

E. California School Boards Association (past member).

F. California Peace Officers' Association (past member).

VI. Personal Data

A. Born January 1, 1920, Burbank, California.

B. Married; 4 children.

C. Residence: 7529 Friar Tuck Court, Falls Church, Virginia 22042. telephone:

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D. World War II service: U.S. Marine Corps, 1943-45.

E. Recipient, Brotherhood Award, National Conference of Christians and Jews, 1965.

Senator HUGHES. You may proceed with your statement as you desire. I am sorry we delayed you so long this morning.

STATEMENT OF WESLEY A. POMEROY, FORMER ASSOCIATION ADMINISTRATOR, LAW ENFORCEMENT ASSISTANCE ADMINISTRATION, AND FORMER SPECIAL ASSISTANT FOR LAW ENFORCEMENT COORDINATION TO THE ATTORNEY GENERAL, U.S. DEPARTMENT OF JUSTICE

Mr. POMEROY. Mr. Chairman, Senator Dominick, it is an honor to appear before you this morning.

My remarks will be brief, and will be limited to discussion of two basic principles, one related to the prevention of illicit drug use, the other to rehabilitation of drug users.

When one considers drug use, it is necessary to deal with a number of factors. Representative, but certainly not all inclusive, are these: The many different kinds of substances which fall under the inexact title of "drugs"; who produces said substances; community attitudes toward illicit drug use, and toward legal drugs such as tobacco and alcohol; and a host of others.

Because the subject is complex, involving nearly all segments of society, any attempt to devise a program for prevention of drug use must be broad based and involve a large number of people.

It is perfectly proper for the American people to expect and demand hard-hitting, effective, professional law enforcement efforts against importers, bigtime suppliers, and lesser merchandisers of illicit drugs. They have a right to expect results, and such are now being achieved, with Director John Ingersoll of the Bureau of Narcotics and Dangerous Drugs showing the way, along with many fine efforts being made at State and local levels.

I put that in there without knowing John would be here this morning, incidentally.

Senator HUGHES. Very timely.

Mr. POMEROY. It is reasonable and appropriate to expect that those who are arrested for engaging in the criminal drug traffic will be speedily tried in the courts. There are a few court systems which have begun to clear up case backlogs and in other ways make their operations more efficient, but a great deal more needs to be done.

After an offender has been sentenced, we ought to be able to rely upon the expectation that correctional systems—probation, parole, and institutional programs—will significantly modify behavior patterns, and actually correct and rehabilitate. The fact is that they do not, despite the dedication of well qualified and idealistic professionals in the field.

The organizations and services which make up what is called the criminal justice system—a designation which is more a prayer for the future than a reflection of present reality—must be made to work well. This will require continued concern, substantial changes in basic philosophy and goal setting, as well as massive action.

If that system worked better, it would undoubtedly have some effect in preventing illicit drug use. There is no doubt that effective enforcement makes it more difficult for traffickers to operate, reducing the number of options open to them. Some potential offenders may even be deterred by increased enforcement pressure.

The certainty of swift justice in the courts should tend to deter a number of potential offenders, and thereby contribute to prevention. If correctional programs can be made to rehabilitate those who are sentenced for drug offenses, so that they will not reengage in criminal activity upon release, in that sense they will have been prevented from breaking the law again.

But even if law enforcement agencies, the courts and correctional systems became perfect, meshed in a smooth-running continuum, they could do little to prevent drug use to any substantial degree. For their purpose is not to prevent, but to deal with offenders who are only symptoms of the flaws and imperfections in our society.

It is a grave mistake to try to prevent and cure a social aberration as complex as illicit drug use simply by imposing harsher criminal sanctions and reinforcing rehabilitative efforts as they exist today. And it is patently unfair to ask the police to do something, in attempts to shifts responsibility away from where it rightfully belongs.

This is a problem which affects and involves all segments of our society, and the solution to that problem should be worked out at its source. The role of government should be to help groups of private citizens to address themselves to the drug problems within their communities, not to do it for them.

Let me cite an example of what I believe to be a good approach, that now underway in Fremont, Calif. That city on San Francisco Bay has a population of about 107,000, with an average age of 22.9 years (33,000 are still in school. Around the first of this year Chief of Police John Fabbri launched a program designed to involve the total community in dealing with its drug problem. He caused a community drug council to be formed, drawing its membership from a cross section of the entire city.

After the first 10 weeks of activity, 426 young people and adults had been recruited for various task forces, and a 24-hour-a-day hot line had been established, to refer troubled children, parents, teachers, or other individuals to resources able to give assistance when it is most vitally needed—at the time the crisis actually exists. In addition, a youth crisis center had been set up, to be in operation from noon until midnight, 7 days a week.

I believe this to be an excellent program, illustrating the right kind of approach, because it keeps the problem and its solutions where they properly belong, within the community. Variations of this theme are infinite, depending upon the needs of particular communities and the ingenuity of the people who live within them.

Rehabilitation of any group of people whom society has categorized as sufficiently different and nonconformist to require involuntary corrective action is difficult at best. It is difficult because each individual within such a group behaves according to his own unique set of personal needs and motivations, and official programs simply cannot provide sufficient human and monetary resources to afford the personal attention which is an absolute necessity.

There are psychiatrists, psychologists, and social workers who have both the skill and the desire to deal effectively with drug users by helping them to develop inner strengths and compensating mechanisms which give them a better chance to get away and stay away

from drugs. The sad fact is that there just aren't enough such professionals available. Even if there were, the cost of providing individual treatment for drug users, both in and out of custody, would be prohibitive.

Realistically, then, it would appear that programs must be built around the development of an entirely new class of nonprofessionals, who can be trained to deal in relatively simple ways with drug users, at firsthand and where most of the clients are to be found—on the streets. Further, it might be most effective if those selected for training in treatment processes are those who know the problem best, either because they have actually experienced it or because they have lived close to someone who has.

There should be a massive effort to match the dimensions of the problem and it should be action oriented. There are strong suggestions and guideposts in programs already underway: Synanon, Odyssey House in New York, the methadone program in the District of Columbia, to name only a few.

There is a wealth of knowledge about how group interaction can be used in a number of ways to assist people in helping themselves. The field of mental health is rich in techniques and processes. There is no reason why many of them cannot be translated into methods that can be used to train large numbers of persons to work in community-based drug treatment programs.

The American community-at-large has within it a vast resource of men and women who can and should be trained to work earnestly and effectively at the task of reclaiming the lives of those who have been disabled by the use of drugs. We should begin to tap this resource.

Senator HUGHES. Thank you very much, Mr. Pomeroy, I am tremendously impressed with your background and your expertise in this particular field. You have heard a lot of the previous discussion that has been carried on here this morning, the last one being the problem of the disease concept in relationship to drug dependence. This is a new concept which is included in this bill by way of definition.

What is your professional opinion in relationship to the concept of drug dependence as a disease, as opposed to other opinions we have had?

Mr. POMEROY. I think drug dependence can be classified as a disease. The use of drugs seems to be symptomatic only of a deeper, psychological problem, among those who use it, and, since we have decided that mental health is a problem—a disease problem, I think it is consistent to say that drug abuse is too.

Senator HUGHES. You think there is a similarity between the concept of alcoholism as a disease and drug dependence as a disease?

Mr. POMEROY. I think they are almost the same.

Senator HUGHES. Do you feel this is a difficult problem in relationship to enforcement of the law?

Mr. POMEROY. It certainly is. Enforcement officers must enforce laws against the use of drugs and the sale of drugs. I think, on balance, that laws against the sale and use of drugs are needed, but a large group of people whom we serve and who are in the communities

in which the police must enforce these laws don't seem to regard the use of drugs quite as badly as the laws would indicate. There seems to be a growing and fairly widespread acceptance of the use of certain kinds of drugs. This puts the police officer in a bad position, since he is, again, enforcing an unpopular type of law.

Senator HUGHES. What in the way of techniques, for example, handling something like the Woodstock Festival, do you think we are faced with in this country today? I have seen estimates of from 300,000 to 500,000 people at Woodstock, a high percentage of whom were taking drugs, and I don't recall reading that anyone was arrested for the use of drugs out there.

Mr. POMEROY. There were arrests the first night preceding the festival itself, but the law enforcement officials, of which I was not one—I was a private consultant—were faced with the kind of decision that arises in crises situations where they have to balance the peace keeping role against the law enforcement role.

There comes a time when one knows that if he enforces the law, and there are a number of people there who don't want to be enforced, then the peace might be disrupted pretty drastically.

The culture at Woodstock approve of and permitted the easy availability of mind-altering substances, and I think the law enforcement officials made a very wise decision not to emphasize law enforcement. They made the decision that keeping the peace was more important.

That is an example of one of the painful decisions that a law enforcement commander must make, and he can't win. He is going to run into criticism no matter what he does.

Senator HUGHES. Yes. In another instance, a youngster with marihuana on a campus may well be picked up and be subject to the court, and here we had several hundred thousand who may have been smoking marihuana who were not.

Mr. POMEROY. That is true, but that is the kind of judgment that must be made in demonstrations and civil disorders where arrests cannot be made individually or in small numbers.

Senator HUGHES. Incidentally, I would have made the same judgment if I had been responsible for keeping order and peace there. I am not critical of the judgment that was made at all.

Do you think the country is faced now with this type of social outgo quite frequently? There have been a number of others since the Woodstock Festival.

Mr. POMEROY. I think they are, although I don't think that Woodstock will ever be reproduced or duplicated.

Senator HUGHES. What percentage of the people there would you estimate were smoking pot? Is there any way you could give us an estimate of it?

Mr. POMEROY. No; not accurately, but I discussed it with staff members and others, and all I can say is that there was far less than what was reported. There was one newspaper report that 95 percent of the kids were smoking pot. That simply wasn't true.

It would be more accurate to reverse that percentage. There were drugs of various kinds freely available, and those who wanted to could have them, but not all of the kids up there were potheads.

Senator HUGHES. Did you see any relationship of marihuana smoking to violence in that incident?

Mr. POMEROY. It was our feeling that—well, let me demonstrate by a short story.

Prior to the Woodstock Festival, everyone who was concerned with it, those internally and townspeople, farmers and local police, thought that probably there would be quite a bit of drug use, and although they weren't too happy about it, they were not doing a great deal to try to stop it.

About a week before the festival was to begin, a number of people started applying for licenses to sell beer around the periphery of the festival grounds, and unilaterally, the owner of the property, the town council, the State police and a group of citizens went to the Alcoholic Beverage Control Board office and registered complaints, saying, "You can't allow beer to be served, because if you do that the kids won't be able to be handled, and we are liable to have disorder."

What I am getting at, it seems that a great many people think the use of marihuana is less harmful and less threatening in terms of disorder than the use of alcohol.

Senator HUGHES. In your exposure to marihuana, is usually the reaction one of being passive rather than being violent?

Mr. POMEROY. Generally passive.

Senator HUGHES. Have you ever observed anyone violent that was using marihuana alone?

Mr. POMEROY. No; I have not.

Senator HUGHES. You have not.

What do you think law enforcement can learn from such an experience as Woodstock? That is a broad question, but I am sure you learned a great deal in the process.

Mr. POMEROY. I think one of the most important things I learned was that they, the officials who have the responsibility to issue or deny permits, should be encouraged to make a decision quickly, so that they can either be denied or approved early enough so that everyone can settle down and plan intelligently.

Senator HUGHES. In other words, they were crushed by it.

Mr. POMEROY. Yes; and that is what happens time and again. Local boards that have the permit granting power equivocate until the last minute.

Senator HUGHES. If the estimates of Dr. Miller the day before yesterday are correct, there are somewhere between 12 and 20 million users or experimenters with marihuana in this country, most of them young people. Do you think that we could say that the group at Woodstock was representative of the people experimenting with marihuana across the country? Do you know?

Mr. POMEROY. I think you could say it was representative of people who go to rock music festivals. I think that drug use is a very strong part of the culture of the rock music festival.

Senator HUGHES. You have emphasized the parallel in needs for education, prevention, treatment, rehabilitation, and ultimately moving back into the social structure those people who are addicted.

Do you feel that the country today needs the emphasis and force that we are trying to give under legislation of the type we are considering today as well as the law enforcement factor?

Mr. POMEROY. Yes; I certainly do. I think it should be done in ways that involve just as many people in the communities where the

drugs are used as possible. It is a broad social problem, and some of the real basic decisions haven't been made yet. There has to be a real thinking out about what kind of a total culture we are in, and understand some of the forces that are operating within it, because none of us are aware enough of it yet.

We are in a culture where advertising encourages the use of legal kinds of drugs, if you have a headache, you take the strongest aspirin. If you can't stand the thought of getting married, you take a couple of Cope pills. If you want to be thought of as virile, you smoke a particular type of cigarette.

This entire emphasis, and acceptability, of the idea of legal drug use I think probably has a great deal to do with the trouble we are in.

Senator HUGHES. We have been finding this running through the hearings.

I again defer to Senator Dominick for some questions.

Senator DOMINICK. I don't have many, Mr. Chairman.

What you are saying, in effect, was that at Woodstock they made a decision that it was best to leave the drug thing alone and not enforce the laws for prospective drug use?

Mr. POMEROY. Yes, sir.

Senator DOMINICK. It makes it kind of hard when that happens to then go out and say to others that because they weren't in a mass drug deal they are subject to a penalty.

Mr. POMEROY. That is true.

Senator DOMINICK. How many people were killed in that particular so-called festival?

Mr. POMEROY. There were two who died. One died of a heroin overdose, a marine on leave. Another died because he was run over by a tractor at night, sleeping in a ditch.

Senator DOMINICK. How many were injured, do you know?

Mr. POMEROY. I can't answer. There were hundreds injured, but they were minor injuries caused mostly by city kids being out in the country and getting cut by rocks and this kind of thing.

We had one instance of a young man who jumped off a tower from about 15 feet up and injured his back.

Senator DOMINICK. In addition to marihuana, which has been given emphasis from the news media as being used, I gather there were also hard drugs and speed, barbiturates and others.

Mr. POMEROY. That is right. The emphasis was apparently on marihuana and LSD.

Senator DOMINICK. I am informed—I don't know whether it is going to carry through on any kind of a scale like Woodstock, but they have another one of these things planned for Florida during the Easter vacation. Do you know anything about that?

Mr. POMEROY. I have heard they have one down there.

Senator DOMINICK. You are not acting as a consultant?

Mr. POMEROY. No; I am not. My policy is not to act in a consultive capacity in a rock music festival until a permit has been issued and it is under way. Then my role will be to point out things that should be covered.

Senator DOMINICK. In your comments on marihuana, would you agree with what we have heard from other witnesses, that there are

all different kinds of marihuana and that the effect may be different on different people according to the type of personality and the type of marihuana?

Mr. POMEROY. Yes.

Senator DOMINICK. That is all I have, Mr. Chairman.

Senator HUGHES. We have had testimony before a Senate subcommittee in the last 2 days indicating that a rare type of marihuana grown somewhere in Vietnam produces violent reactions when smoked by some of our military personnel over there.

Have you ever come across any of this in any of your experiments?

Mr. POMEROY. No. I have heard that hashish may have that kind of reaction, but I don't know that myself.

Senator HUGHES. Do you think they might be talking about hashish rather than marihuana? Of course, that is an unfair question.

Mr. POMEROY. I have no way of knowing.

Senator HUGHES. Thank you, Dr. Pomeroy. I would appreciate it if you would submit to us your recommendations concerning S. 3562.

Mr. POMEROY. It is my pleasure. I would like to say one short thing if I might and that is, we too often get involved in talking about particular drugs and what they do and while that is somewhat important, the overriding, important problem we have is to find out why people use drugs and to do something about that. The number of mind altering substances could be almost infinite and it doesn't seem to me that acting against them instead of the reasons for using them is going to be productive, in the long run.

Thank you.

Senator HUGHES. Thank you, sir, for being with us.

The Chair calls Kenneth C. Olson. Mr. Olson, welcome to the subcommittee hearing. We appreciate your being willing to wait so long for your appearance here this morning. You may proceed with your testimony as you desire.

STATEMENT OF KENNETH C. OLSON, STATE PLANNING COORDINATOR, OFFICE OF THE GOVERNOR, STATE OF UTAH, CHAIRMAN, NATIONAL GOVERNORS CONFERENCE ADVISORY TASK FORCE ON LAW ENFORCEMENT, JUSTICE, AND PUBLIC SAFETY, 1969; ACCOMPANIED BY ALLEN JENSEN, SPECIAL ASSISTANT, NATIONAL GOVERNORS CONFERENCE

Mr. OLSON. Mr. Chairman, it is a pleasure to be here. If it is agreeable, rather than reading my statement, partly in the interests of time, and partly because of the direction of the discussion this morning, I would like to just refer to it in summary form at certain stages and then make additional comments.

Senator HUGHES. All right. We will incorporate your statement in the record as if given and you may comment on it as you desire.

(The prepared statement of Mr. Olson follows:)

PREPARED STATEMENT OF KENNETH C. OLSON, STATE PLANNING COORDINATOR,
STATE OF UTAH

I appreciate the opportunity to appear before you today to present suggestions and general commentary related to S. 3562, the Drug Abuse and Drug Depend-

ence Prevention, Treatment and Rehabilitation Act of 1970. May I urge at the outset that your committee consider gathering extensive information and direct testimony from state officials relative to this legislation, particularly in considering Title VII, upon which I will base most of my comments and suggestions today.

I serve as state planning coordinator to Governor Rampton of Utah. In that capacity I have responsibility for comprehensive statewide planning and federal-state liaison. It is from that background that I want to make direct comments concerning this act. However, I additionally have had opportunity to serve as director of the Task Force assisting the National Governors' Conference Committee on Law Enforcement, Justice and Public Safety during the past year. It is experience which permits me to present the viewpoint of the National Governors' Conference.

It is my intention to deal briefly with the following items:

1. The current policy statement on drug abuse adopted by the National Governors' Conference in their 1969 Annual Meeting.
2. A few summary statements concerning emerging drug abuse programs in the States.
3. The specific drug abuse program in Utah, and its relationship to S. 3562.

1. *Policy Statement of National Governors' Conference*

Let me call your attention to a policy statement developed by the Committee on Law Enforcement, Justice and Public Safety and adopted by the National Governors' Conference in 1969 relating to the problem of narcotics and drug abuse. The policy statement is appended for your information and I ask that it be inserted in the Record.

As you can see from the statement, the National Governors' Conference is interested in a comprehensive approach to the problems of narcotics addiction and drug abuse. It is for these reasons that the Task Force is very favorable to the concept embodied in and the major thrust of S. 3562, expressed in Title VII.

2. *Experience in Other States*

A critical problem observed in state after state is the inability to mount a comprehensive drug abuse prevention, control and rehabilitation program supported by federal assistance since the delivery system for funding, technical assistance and information services is so highly fragmented at the federal level. Title VII, with its strong emphasis on providing grants to state and local agencies for comprehensive packaging of drug related activities, would make it possible for a state or local jurisdiction to develop a comprehensive approach to the problem. This is in sharp contrast to the current situation which forces state and local agencies to engage in extensive grantsmanship by shopping among various and often diverse concepts of treatment, education and rehabilitation offered by the various federal agencies which now provide assistance. Additionally, most current federal programs in this field tend to relate to preconceived notions of how a state should organize to deal with narcotics addiction and drug abuse. However, initial examination of a sampling of state methods of drug abuse coordination from 13 states—Alaska, Colorado, Illinois, Kentucky, Louisiana, Maine, Maryland, Montana, New York, Ohio, Oklahoma, Pennsylvania and Vermont indicates the variety of approaches being used nationwide. Of these states, five have independent coordinating commissions (Louisiana, Maine, New York, Oklahoma and Vermont), two have commissions established within an already existing department (Maryland and Montana), four have an individual or unit within a department who exercises the coordinating function (Alaska, Colorado, Kentucky, Pennsylvania) and two place their coordination under law oriented agencies (Illinois and Ohio). Clearly, there is no "standard" model.

3. *Utah's Experience and Reaction to S. 3562*

In my own state of Utah we have recently created a division of drugs which has major responsibility for coordinating and providing services to narcotics addicts and drug abusers under a comprehensive framework of drug abuse education, information dissemination, emergency intake, diagnosis and referral, and community based treatment and rehabilitation. The Utah division of drugs is located within our Department of Social Services, giving it a broad human resource orientation.

Our examination of the drug abuse problem and the resources available to combat it led us to the conclusion that a successful program would have the following characteristics:

1. Major responsibility for new program planning, program development, and coordination of existing services must be vested in a new state agency which was not tied to any vested interest in drug abuse control.

2. Recognizing that many state agencies have significant resources to assist, the Utah drug division should not duplicate any existing agency capability.

3. The wide divergence of administrative responsibility for existing program capability required the establishment of an interagency coordinating mechanism.

I have appended a copy of legislation establishing Utah's division of drugs to this statement hoping it may be of interest. In spite of this unitary concept, it will be necessary to us to seek assistance from at least five separate federal agencies.

I would like to urge the committee to maintain its very flexible and comprehensive approach to the provision of grants to state and local agencies. In addition, we strongly endorse and support the concept of permitting state review and approval of applications from local entities and a certification by the state that the local application is consistent with state planning.

We hope that the mechanism in Section 705(d) which permits local agencies to forward disapproved applications to the Secretary need not be invoked often. This hope could be enhanced by requiring close consultation between local and state agencies prior to preparation of a formal application.

Now Mr. Chairman if I could, I would like to deal with one minor problem which appears in Title VII. Section 701 proposes to amend Section 246 (a) (2) of Title 42 of the United States Code, providing requirements that state plans be prepared covering comprehensive drug abuse and drug dependence programs. This is a worthwhile objective; however, the section proposed to be amended really relates to what is called a state plan for planning or an application for a planning grant. This section of P.L. 89-749 is primarily a set of administrative requirements which the state agency must certify and agree to prior to receiving a grant for comprehensive health planning. I would encourage the committee instead to consider amending sub-section (D) of the same section to insure that cooperative efforts are developed among the organizations and groups concerned with the problems of drug abuse. I should point out that this is not entirely satisfactory since it will only provide an emphasis and must be followed up by the Department of Health, Education, and Welfare in insisting upon a truly comprehensive approach to health planning. By definition, however, comprehensive health planning should include such considerations since it represents the major planning effort of the States in the broad functional area of the provision of medical care and related services.

In conclusion, let me again express my appreciation for this opportunity to address your committee and express my willingness to answer any questions which you may have. Thank you very much.

Mr. OLSON. I appreciate that. May I point out my point of view in speaking here today is shaped by two experiences, one being a member of the Governor's staff with a responsibility for program development, and recently being involved in the development of a drug abuse and narcotics control program within the State of Utah, and secondly, as indicated, as chairman of the task force that provided input to a committee of the National Governors Conference.

The National Governors Conference committee on law enforcement criminal justice and public safety, dealt with the problem of drug abuse, and in their report of last year there is a section dealing with these matters.

That is appended to my statement, beginning with about page 5 or 6.

Senator HUGHES. That will be incorporated in the record also.

(The report referred to follows:)

POLICY STATEMENT ON DRUG ABUSE ADOPTED AT THE 61ST ANNUAL MEETING OF THE NATIONAL GOVERNORS' CONFERENCE, COLORADO SPRINGS, COLO., AUGUST 31-SEPTEMBER 3, 1969

DRUG ABUSE

The National Governors' Conference is concerned with the extensive proliferation of the narcotics and drug abuse problem. The Governors of the States recommend the following urgent efforts to combat these pervasive problems:

1. Enactment of state drug control legislation which:
 - a. Grants courts and correctional authorities sufficient flexibility with user to permit individualized sentencing and treatment.
 - b. Requires prompt disposition of the offender's case.
2. An increase in state and local efforts to educate the public, particularly younger persons, by:
 - a. Design of a statewide program for dissemination of factual drug education information.
 - b. Provision of drug education programs in the schools to reach levels from kindergarten through grade twelve.
 - c. Organization of in-service training programs which deal with drug abuse for directors of pupil services, school principals, counselors, and other involved school staff members.
3. Development of state programs for the rehabilitation and treatment of offenders requiring close supervision and control while correcting problems of drug abuse by providing alternative methods for disposition of drug users by the establishment of adequate facilities for both voluntary and involuntary admissions.
4. Initiation of national and statewide research to determine the causal processes which promote initiation, continuance, termination and relapse in drug abuse.

BACKGROUND INFORMATION

The possession, use, or being in the presence of drugs is punishable in most states by a mandatory minimum sentence of confinement. Yet, there are several unaddressed questions as to exactly what is being punished and whether or not such punishment has the sought-for salutary effect on the drug-abuser. Is the use of drugs punished because it is intrinsically criminal? Is the crime-rate associated with drug-abuse sufficiently high to warrant across-the-board imprisonment of drug-users, and what is the cause-effect relationship between drugs and crime? May the use of drugs be considered a voluntary act or does addiction remove the volition in the act and make drug-use a qualitatively different problem than a crime whose punishment is based upon the fact of its having been committed by a rational man? What of the use of non-addictive narcotics? What is the relationship between the arguments sustaining punishment of those who only possess or who are merely in the presence of drugs to those arguments mustered specifically against drug-users?

No answers of ultimate certainty can be given to these questions, for so little is understood about drugs. Little is known about the relationship between crime commission and the use of drugs and about the distinguishing characteristics of the addicted, irrational criminal as opposed to the rational, plotting criminal. Little is understood about the cyclical use of drugs, the psychological or physiological conditions which promote first use of, then addiction to, narcotics and hallucinogens. Nor, is the connectedness of cessation from and read-diction to drugs at all clear.

Because the problem of drug-users lends itself so poorly to a black or white definition of criminal responsibility and because the types of offenders and offenses vary so radically from that of a college freshman trying a new experience, to the psychologically and physically ill, to the criminal whose acts may or may not be related to drug-use, the operation of the law enforcement system must become capable of handling drug-abuse with a more flexible response. While general consensus exists as to the severity with which those who "push" drugs should be dealt, there is serious ambiguity relative to the sentencing and rehabilitation of the individual offender. This necessitates a re-examination of the criminal code as applied to drug offenders in those states

where a minimum sentence is mandatory. With a loosening of the severe sentencing minimums now proscribed by law, the courts would be able to distinguish among various types of drug-users and addicts according to the nature of the drug, the purpose of its being on the person, its association with other crimes, and the degree of addiction, if any. Accompanying the need for a more flexible judicial response to the drug-abuser is the need for a wider variety of facilities and programs for rehabilitative services for the consigned, convicted and the accepted voluntary addict.

Furthermore, research of drug-use questions must be begun. Such research will improve programs of treatment, rehabilitation, and punishment by basing them upon a satisfactorily, factual framework, and will improve educational programs that prevent the further use of dangerous drugs by instructing authorities and the potential drug users in those locations where the development of drug experimentors is most likely.

Mr. OLSON. This is comprehensive. It is not limited to a narrow, law enforcement or criminal justice point of view, but rather concerns itself with a major social issue in broad context. It deals with issues relative to education with measures that would provide input relative to correction, rehabilitation, and also of course is concerned with notions that relate to disposition of offenders who are apprehended and who are referred to the criminal justice system for some type of action.

It is generally, I think, felt by the Governors' Conference that the major problem that exists right now is the fact that the system is terribly fragmented, and extremely difficult to deal with.

In my testimony, I go on and talk about the situation as it now exists in many of the States. The council of State governments is conducting fairly comprehensive surveys of State activity relative to drug abuse, and I understand that information will be made available to your committee staff when it is completed.

Mr. OLSON. I have given an example of the fact that there are many ways of approaching this problem at the State level, that they do not fit any prescribed pattern, and this is primarily because of the structure of State governments, and the point I want to make here is the fact that in a large measure, the way State governments are organized in many cases relates to the Federal legislation which has been passed.

The vertical relationships between Federal agencies on the one hand and counter part State agencies on the other hand, this makes it at times almost impossible for a governor to develop a comprehensive approach to a particular problem, and drug abuse is a case in point.

In Utah, we have been spending the last year or so dealing with the problem of drug abuse. Before you asked the question, several people have indicated to me while I have been in Washington this trip that if Utah has a drug abuse problem, then the rest of the country must be in significant trouble.

The fact is that research that we have conducted indicates that we are probably not much different than any other State, which is primarily small in population, but with a relatively small measure of urbanization in the central cities.

As we have gone about developing our program, and finally adopting legislation we came to the conclusion that because of the fragmentation of the system and our inability at the State level to change the relationship between Federal and State agencies, we would adopt what we referred to as a lead agency approach.

In that concept we created a division of drugs in the State of Utah which has basic responsibility for acting as the point to control drug abuse and narcotic addiction.

However, because of programs administered by the State Office of Education that community mental health service centers which are established within the State by a Department of the Department of State and Criminal Justice we have had to seek to avoid duplicating other efforts.

An alternative to that could have been a repeal of other authorities given to the other parts of the State government in the hopes we could have a better approach.

Our unilateral action would not have helped much, just in one State, so we have taken the approach I outlined to you.

Our coordinating council pulls into one body all the relevant agency people who have something to do with problems of drug abuse and narcotics addiction.

I have been spending the last couple of days in Washington visiting with various Federal agencies attempting to put together the final design of our State control program.

Based on that experience I am willing to say that first of all, the situation is terribly fragmented and is not improving.

It puts us in the States into the role of having to engage in grantsmanship, tailoring our programs to the agencies, which have their own notions as to how the programs ought to be set up.

Secondly, we find ourselves in a position where there are no resources available for a comprehensive program aimed at trying to control drug abuse.

This is due in part to the fact that because resources were limited, most of them are being allocated toward hard narcotic addiction control.

There is very little being done in the broader area of concern that I talked about.

For these reasons, it is my view that both the National Governors' Conference and the State of Utah, for that matter, would strongly support here the notion contained in title VII of the bill before us, frankly, because they provide the States with a hope of a comprehensive approach to dealing with the problems of drug abuse.

It permits us to structure a program of research, education, and other activities aimed at prevention of abuse, and to structure also programs of training and education for educators, for law enforcement officials and for others, and prepare rehabilitation programs which have the capability of touching all aspects of the problem.

As I indicated in my testimony, there is probably only one minor problem that I perceive in the bill, and that is in section 701, which proposes to amend a portion of title XLII of the United States Code relating to comprehensive health planning.

It really proposes to amend a portion of that code which is largely administrative in scope, and I am not sure it is going to have the effect of getting a mandate for planning for drug abuse control in the States.

What might be more appropriate would even be to consider either a change of amendment which I suggested, or the possibility of

requiring the preparation on the part of the States of a fairly comprehensive drug abuse control plan as a separate requirement related to this activity.

I think you may want to give that some consideration. In conclusion, I think what I would really like to stress is that we view the bill as providing a comprehensive approach, something that has been overlooked, I think, sir, in some of the discussion today.

Allocation as between agencies is helpful, if you could ever get the lines sufficiently cleared up, but it has been our experience at the State level that those lines can be cleared up either by legislation, or by the repeal of conflicting authority given to agencies where there is a continual argument about who has the major responsibility to carry out program activities.

That really summarizes what I have attempted to say in there in the testimony, Mr. Chairman. I have provided, also a copy of the legislation passed in Utah as established our division of drugs in hopes that it might be of some value to you.

(The document referred to follows:)

ENROLLED COPY, S.B. No. 18, 1970, UTAH DIVISION OF DRUGS

(By C. Earl Alsop, Orren J. Greenwood, Wilmer L. Barnett, and Ernest H. Dean)

An act amending section 63-35-3, Utah code annotated 1953, as enacted by chapter 174, laws of Utah 1967, as amended by chapter 197, laws of Utah 1969, relating to drug abuse; providing for the creation of a board and a division of drugs within the Department of Social Services; and providing for the powers and duties of the board and the division of drugs and for their composition.

Be it enacted by the Legislature of the State of Utah:

Section 1. Section 63-35-3, Utah Code Annotated 1953, as enacted by Chapter 174, Laws of Utah 1967, as amended by Chapter 197, Laws of Utah 1969, is amended to read:

63-35-3. There is created within the government of the State of Utah a department of social services. There is created within the department of social services the following boards:

- (1) Board of health.
- (2) Board of family services.
- (3) Board of corrections.
- (4) Board of pardons.
- (5) Board of mental health.
- (6) Board of Indian affairs.
- (7) Board of aging.
- (8) Board of drugs.

And the following divisions:

- (1) Division of health.
- (2) Division of family services.
- (3) Division of corrections.
- (4) Division of mental health.
- (5) Division of Indian affairs.
- (6) Division of aging.
- (7) Division of drugs.

Section 2. There is created within the department of social services a board of drugs which shall be comprised of five members appointed by the governor, with the advice and consent of the senate. One member of the board of drugs shall be duly licensed to practice medicine in the State of Utah; another member of the board of drugs shall be a registered pharmacist who is duly licensed to practice in the State of Utah. Of the first appointments to the board of drugs, the terms of office of three members shall expire on March 1, 1971, and the terms of office of the remaining two members shall expire on March 1, 1973. All subsequent appointments shall be for terms of four years each. Not more than three members shall be from the same political party. Vacancies occurring by reason of death, resignation, or any other cause, shall be filled by the appointment of another

person by the governor, with the advice and consent of the senate, for the unexpired term of the person whose office has been thus vacated.

The board shall elect its chairman from its membership and shall meet at least once every three months, and upon such other occasions as the chairman may deem necessary or upon the request of any three members of the board or the governor. Three members of the board shall constitute a quorum for the transaction of its business.

Members of the board shall receive a per diem allowance as approved by the board of examiners plus all actual and necessary expenses incurred in the performance of their official duties.

Section 3. The board of drugs shall be the policy making body for the division of drugs. The board shall establish programs and policies for discharging the responsibilities of the division of drugs.

Section 4. There is created the division of drugs, which shall be within the department of social services under the administration and general supervision of the executive director of social services and under the policy direction of the board of drugs. The division of drugs shall have the following duties and responsibilities:

(1) To educate the public regarding the nature and consequences of drug abuse.

(2) To establish programs for the prevention of drug abuse.

(3) To disseminate information relating to public and private services and facilities in the state which are available for the assistance of drug abusers and potential drug abusers, for the purpose of rehabilitation.

(4) To establish and administer programs and projects for rehabilitation of drug abusers, including, but not limited to, centers for diagnosis, evaluation and treatment.

(5) To make a continuing study of drug abuse in the State of Utah and, from time to time, to submit to the governor and to the legislature recommendations for changes in policy and/or legislation.

In carrying out its duties and responsibilities, the division of drugs shall not duplicate treatment or educational facilities presently existing in other divisions or departments of the government of the State of Utah, but shall work in conjunction with such other divisions and departments in rendering the treatment or educational services which such other divisions and departments are competent and able to provide. To assist in drug abuse control the division of drugs shall cooperate with law enforcement agencies and provide such information of law violations of drug abuse which may come to the attention of the division during its continuing study of drug use and abuse.

Section 5. The director of the division of drugs shall be appointed by the board of drugs, with the concurrence of the executive director of social services. The director shall receive compensation as approved by the board of examiners. The director shall be the executive and administrative head of the division of drugs. He shall be experienced in administration and shall be knowledgeable in matters concerning drug abuse. The director may be removed from office at the will of the board of drugs or by the executive director of social services after consultation with the board. The division of drugs may employ such other employees as may be necessary to implement the provisions of this act.

Section 6. There is hereby created the interdepartmental coordinating council on drug programs. The council shall consist of:

- (1) The state planning coordinator.
- (2) The executive director of the department of social services.
- (3) The director of the division of drugs.
- (4) The director of the division of health.
- (5) The director of the division of mental health.
- (6) The director of the division of family services.
- (7) The director of the division of corrections.
- (8) The director of the division of alcoholism.
- (9) The commissioner of public safety, or his designee.
- (10) A district judge, to be designated by the governor.
- (11) A juvenile court judge, to be designated by the governor.
- (12) A city judge, to be designated by the governor.
- (13) The superintendent of public instruction, or his designee.
- (14) The commissioner of higher education, or his designee.

(15) The director of business regulation, or his designee.

(16) Such other persons as the governor may deem advisable to have serve on such council to properly fulfill the functions thereof.

Persons designated by the governor to serve on such council shall serve at the pleasure of the governor. The state planning coordinator shall serve as chairman of the council. The council shall meet once every three months, and at such other times as requested by the governor or the chairman of the council.

It shall be the duty of the council to carry on a continuous review of the programs within the government of the State of Utah concerned with and related to drug abuse and drug problems to assure that such programs are not overlapping, duplicating or conflicting, and such council shall submit to the board of drugs for presentation to the governor and to the legislature recommended changes in legislation, policy, or implementation of legislation or policy in connection with such drug problems and programs.

Section 7. If any provision of this act, or the application of any provision to any person or circumstance, is held invalid, the remainder of this act shall not be affected thereby.

Mr. OLSON. I should point out that I am accompanied by Alen Jensen who is a special assistant to the Governor here in Washington, and he may also be able to provide some assistance.

We would be happy to respond to any questions you have.

Senator HUGHES. Thank you very much, Mr. Olson.

I might point out to Senator Dominick that Allen Jensen was a member of my staff when I was Governor of Iowa. They are now both very familiar with the States' activities and States' problems such as this, and in coordinating the functions of the Governors, and how to tie into the Federal system.

Making this system work is always important.

Allen, do you have anything to add to Mr. Olson's testimony?

Mr. JENSEN. I don't believe so, except that we have also had conversations with the Association of State Mental Health Program Directors, whom I believe testified for you on Monday.

We reviewed that testimony, and Mr. Olson and I feel that this is certainly a good statement representing the States also, and as they have been made suggestions of willingness to assist in giving information on what is going on in the States, and on the legislation itself, we would like to work with that organization, the mental health program directors, with you and with your staff.

Senator HUGHES. Mr. Olson, do you think the States would object to this system of going down to the communities and also to private associations or individuals, which is included in this legislation?

Mr. OLSON. I don't think so. One of the things I point out in the written statement is the fact that I think it is important at the State level there be a responsibility, as you outlined in your legislation, to review applications of local agencies or private, nonprofit agencies to determine that they are in reasonable consistency and harmony with what else is going on in the State.

I have also pointed out that if consultation can be effective prior to the submission of formal applications I think the entire jurisdictional problem that now crops up can be resolved.

And under a procedure called A-95 relating to the Inter-Governmental Cooperation Act of 1968, this type of prior consultation required on certain grant-in-aid programs. It may very well be that this is the type of program that should be included within that prior review procedure.

Senator HUGHES. I notice you say you incorporated in your state-

ment information on a coordinating council at the State level. We have established that for the Federal agencies.

I notice you describe some of the difficulties you have here in Washington this trip and others, trying to run down information in the various departments.

Mr. OLSON. Yes; I think it is necessary, particularly if tactical or strategic decisions are reached, that maybe you really rationalize the system and eliminate the conflict of authority wherever it exists.

It would be neither if support to the States in education could be vested in a single Federal agency. I am not sure that will happen. In the event then it does not, the interagency coordinating committee becomes even more necessary, to make sure people know about what is going on.

To give you an example, during the past day or so I have been dealing with the question of drug abuse education trying to determine what kind of assistance might be available to the States in this regard.

I have talked to not only the National Institute of Mental Health and to the Office of Economic Opportunity, but also had occasion to review some of the problems with the Department of Justice.

None of them were really aware of the fact that as of yesterday a letter went out from the Office of Education to the chief State school officers of the 50 States offering a grant in aid program for drug abuse education.

It apparently was relatively unilateral on the Office of Education's part, based upon the White House announcement that there would be additional funds made available for this.

On the one hand, I was negotiating and they were not aware of what was going on in other agencies. This makes it very difficult.

Senator HUGHES. You speak for the State of Utah. Do you have a problem of heroin addiction in Utah?

Mr. OLSON. Yes.

It is relatively small, I would think, in terms of that which occurs in other States, but it seems to us to be a product of urbanization and population concentration as well as certain categories of people in socioeconomic classes where need appears to be greater.

We can even tell that our heroin addiction problem is growing, at least in so far as our statistics relate this. To what extent it is going to grow, we are not precisely sure.

We are getting more commitments to the institutions of the State for heroin addiction. We think the problem is of growing concern.

Our primary difficulty is with soft drug use.

Senator HUGHES. Do you have any methadone maintenance program in Utah?

Mr. OLSON. No; we do not.

Senator HUGHES. What is your main drug problem?

Mr. OLSON. Probably at this point, it is in the hallucinogens and in marihuana, and also some related to speed and use of amphetamines and barbiturates, generally.

We believe that most of our problem relates to experimentation but there is a large volume of continuing use. We are not sure of the total amount.

It is again primarily in the hallucinogens and marihuana.

Senator HUGHES. Senator Dominick?

Senator DOMINICK. Mr. Olson, in title VII, the bill refers to project grants to the States. Do you feel there is any need to change this to a formula grant, or adding on formula grants, saying that each State is entitled to a certain amount, based on a formula?

Mr. OLSON. The notion of a formula grant with authority by the State to allocate between various categories of needs would be helpful.

I frankly could live with either provision. I believe that the position of the Government and the governors generally has been that where categorical grants are developed, they should be as broad as possible.

Senator DOMINICK. As you well know our Governor is chairman of your National Governors Conference so it is a pleasure to have you here.

I did want to get your input on that question, and I gather that your answer is that formula grants would be helpful.

If so, do you have any suggestions for the record on how that formula might be developed?

Mr. OLSON. Because of the inadequacy of data as to the volume of drug abuse, that usually puts you back into relating to a distribution of population. I think that is the only acceptable basis that could be developed in this kind of situation.

You might want to consider a floor or a minimum payment to any given State, with the balance of distribution based on population above that.

The reason I don't particularly object at this point to the project grant approach is that the States vary considerably as to what their interests are in the drug field. It may be competition among the States for certain funds would be helpful. We don't feel it in Utah. I think the Governors conference program would be more adaptable to a formula grant application.

Senator DOMINICK. Colorado has people who come in, most of them from California, where the problem is acute. They keep coming into Colorado really substantially increasing the problems that are already there from our own local situation. The population level varies so some kind of a formula grant based only on a level of population isn't going to suit us as far as that is concerned, and I doubt if it would as far as Utah is concerned, either.

If we were going to do specific authorizations in this bill, what authorization level—in other words, how much money are we talking about what the States could actually put to use for these programs?

Mr. OLSON. I could only make a guess, and I prefer not to do that. What I would suggest is that the national Governors' conference could probably provide to you some type of estimate, and we would be happy to work that out.

Senator DOMINICK. I think this would be helpful if you could supply that for the record.

Mr. JENSEN. I might add on that that there is a great deal of difference between the States on that. I believe it is \$80 million in New York State that the State has allocated for drug and narcotics problems, and another State, \$35,000, just getting started in the program.

I think we should add, as Mr. Olson indicated, the survey being done by the Government, on what States are doing in this area in-

dicates a great deal of new legislation at the State level and a great deal of activity in the last 6 months. I did a survey on the legislation passed in the House, H.R. 9312, and it indicated very little activity as of now.

Trying to keep up with the States are doing in a survey is a problem now. In fact, we are being surveyed to death.

Senator DOMINICK. Either one of you gentlemen may be able to give me your comments on this.

In section 701, the bill adds to the requirements for State plans for State comprehensive health planning a detailed requirement that the plan provide services for the prevention and treatment of drug abuse and drug dependence.

What problem is this going to create amongst the various States in that, in the Partnership for Health Act and a variety of others, we try to get away from categorical grants so that the State can use the money wherever their need is greatest?

Mr. OLSON. That particular section of the act is generally a list of administrative requirements that the health planning agency must agree to and abide by before receiving the actual grant for health planning.

It relates to an application requiring them to put into that particular section of the act requirement for a fairly detailed drug abuse program. I think it is probably not the right place. I think the requirement, however, must be made at some point.

Senator DOMINICK. You mean the provision is misplaced?

Mr. OLSON. That is correct. But I think the requirement must be made in order to qualify for and receive funds relative to a drug abuse program that evidence must be submitted of a reasonable comprehensiveness of approach. It would do little good to continue to fragment the delivery system.

Senator DOMINICK. In other words, instead of putting it into an overall planning program, we could restrict this to the project plan specifically with regard to drug abuse and drug dependence?

Mr. OLSON. Provided you continue to maintain a broad comprehensive definition of drug abuse.

Senator DOMINICK. Section 702(a) of the present bill amends section 603(a) of the Public Health Service Act, requiring the HEW regulations under the Hill-Burton program to give special consideration for construction and modernization of facilities for prevention and treatment of drug abuse and drug dependency.

Now, section 603(a) presently doesn't try to dictate where special emphasis should be put. Section 207 of the Community Mental Health Centers Act in fact forbids construction grants for facilities under Hill-Burton unless funds are not available under the Community Mental Health Center Act.

So, we would seem to be going against the tenor of that and putting it into the other bill.

Do you feel we should modify this provision?

Mr. OLSON. I can give a personal opinion. My feeling is that the emphasis on construction should relate generally to the community mental health center program, and that is where the funding assistance really, I think, is needed at this point.

However, it should be pointed out that there are also needs for other facilities. In Utah, for example, we intend the construction or acquisition of several neighborhood-oriented crises intervention centers. They will not provide extensive treatment. They will not attempt to provide continuing community-based treatment.

I can only say that my own view is that the focus ought to be on construction authorization by the community mental health centers which are being established throughout the country.

Senator DOMINICK. Should we, in this bill, require that under the Hill-Burton program special emphasis be given to this particular problem, drug abuse and drug dependence?

Mr. OLSON. I think it is not necessary, Senator.

Senator DOMINICK. Thank you.

That is all I have, Mr. Chairman.

Senator HUGHES. I want to say, Mr. Olson, that in the Hill-Burton Act, we had a clause that stated they could not refuse treatment to an alcoholic patient. Wouldn't you agree that the same thing should be true of the drug abusers?

Mr. OLSON. Yes. I think the primary focus of treatment for individuals who are either alcoholics or drug abusers should be based on a community-based type of activity, but where they require institutional care, I think that a Hill-Burton facility should treat those persons.

Senator HUGHES. If there is anything additional you think might be helpful to us, or if you do get the additional information you mentioned from the Governors Council, please supply it to the subcommittee at as early a date as possible. It will be helpful as we consider this legislation.

I want to thank you both for your patience. It has been a long morning, and your contribution will be beneficial to us.

Thank you both very much.

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

FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

MONDAY, APRIL 13, 1970

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

The subcommittee met at 9:45 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes (presiding) and Dominick.

Staff members present: Wade Clarke, majority counsel; Richard J. Spelts, minority counsel; and Jay Cutler, minority counsel.

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

Dr. Robert L. Dupont has withdrawn as a witness this morning, so the Chair calls Colonel Hassan. If any of your aides are necessary to your testimony, feel free to bring them to the table with you.

Colonel HASSAN. That is all right, sir; thank you.

Senator HUGHES. Colonel Hassan, you may proceed with your statement as you desire.

STATEMENT OF COL. HASSAN JERU-AHMED, DIRECTOR, BLACKMAN'S DEVELOPMENT CENTER, WASHINGTON, D.C.

Colonel HASSAN. Thank you very much, Mr. Chairman.

Mr. Chairman, my name is Col. Hassan Jeru-Ahmed. I am the commanding officer of Blackman's Volunteer Army of Liberation. I am also the director of Blackman's Development Center. Blackman's Development Center has created a drug cure program. Since May 15, 1969, the Blackman's Development Center community-based drug cure program has been having a highly significant impact on the drug problem in the District of Columbia, and has registered approximately 13,000 drug users since inception. Our headquarters is located at 6406 Georgia Avenue NW. And it provides spacious quarters for many phases of the comprehensive services extended to the drug users involved in the program.

Blackman's Development Center did not start out as a drug-related or oriented activity. In our attempt to reach out into the community and provide opportunity for individuals who were underemployed, overutilized, unemployed, and who had fallen between the cracks of existing welfare, health, education, employment, and other existing

"resources," and had become infested with a sense of despair and hopelessness, and who were generally abandoned by society, the concept of the drug cure center was implemented. The aim is to provide the basis for a new, meaningful, and productive life through developing the varying potentials of individuals so motivated to avail themselves of the opportunities to be found at the centers.

Significantly, the influx of users of various kinds of drugs, and in varying degrees of entrapment appeared, spontaneously as it were, to pose a major challenge to Blackman's Development Center's staff. The question of whether to turn our backs on these individuals and, in so doing, renege on our promises to help anyone who came for assistance, or to face forthwith the challenge, was the issue. The decision is now history. The full resource structure of Blackman's Volunteer Army of Liberation was mobilized; the issue was enjoined.

Despite the overwhelming odds of such an operation succeeding, and in many instances deliberate attempts to sabotage the efforts by various segments of the establishment, and outright physical attacks, arson included, drug users rallied to the program in unbelievable numbers. The down and out, the suburbanite, and many others from walks of life one finds almost incredible. No one was, or is, turned away. Socio-economic, cultural, ethnic, and other artificial barriers were never considered as deterrents to service. Drug addiction knows none of these barriers. The drug program which is oriented toward cure as opposed to maintenance (methadone is used in limited strengths so as to alleviate the pain of withdrawal only) subsequently became a primary activity of the center.

To support the curative aspects of the program, users were given the opportunity to become involved in rehabilitation services geared to develop skills in one or more areas of endeavor. Intensive counseling, remedial education, training in all of the building trades, music, arts, employment services, et cetera, are among services provided to the drug users, and others, during withdrawal, and for sustained periods of time once involvement occurs. Additionally, withdrawal supervision, medication supervision, recordskeeping, and general administrative services are provided. Such services come from approximately 75 male and 25 female volunteers, along with the staff officers of Blackman's Volunteer Army of Liberation. These services form the core, the heart of the program. The intensity of the services, the vast amount of the time spent with each individual drug user during withdrawal and until such time as he can stand alone, the depth of support on an individual basis can only be provided through this type of organizational structure, use of paraprofessionals and volunteers as assembled and utilized in Blackman's Development Center's drug cure program.

The apparent success of the program is perhaps best manifested in terms of traditional criteria, by the utilization of the center by the court of general sessions as a third-party custody release agency, approximately 300 such releases have been effected within the past 4 months. Of the 300, not more than six persons have failed to appear on date specified.

Staff of the Center have been engaged in consultation and education services to the community at large, but particularly to the public schools, church, and civic groups. There are many other volunteers

who work in their spare time at the centers. These volunteers represent professions such as medicine, social work, education, religion. Intense training is provided in such areas as human services, paramedical techniques (assisting nurses and doctors in administering drugs, etc.) on a scheduled basis for specified periods of time. A training sequence is implemented that embodies basic training in human growth and development as an undergird to the more specialized activities that come to characterize individual involvements—a self-determined individual involvement—in specific program components. A 3-months period is projected as the initial training period for this latter activity, accompanied simultaneously with actual work involvement. In-depth counseling precedes actual placements in a program component.

There is little question that the approach and the methodology employed by Blackman's Development Center reaches the largest number of drug users and potential users, including the experimenters, the very young of any program existing in the metropolitan area.

Blackman's Volunteer Army of Liberation also serves as an investigative organization in the District of Columbia, with the expressed purpose of finding and exposing those people who are the dealers of heroin and other drugs to children in elementary and high schools. We have reported more than 100 names of men and women who are dealers, meaning the men who have dozens of pushers selling death for them, to the Bureau of Narcotics and Dangerous Drugs, and to the District of Columbia Police Department Narcotics Bureau. Blackman's Volunteer Army of Liberation has also turned large quantities of confiscated heroin and other drugs to the District of Columbia Police Department Narcotics Bureau.

In addition to drug cure, drug prevention and investigative activities, Blackman's Development Center also provides food, clothing and housing for as many as we can afford and who are in need of such services. Blackman's Development Center also produces literature; leaflets, flyers, posters, photographs, bumper stickers, decals and other materials to educate the citizenry on the full extent and nature of the drug problem. Members of Blackman's Volunteer Army of Liberation and Blackman's Development Center carry our message to "Stop Illegal Drug Traffic" all over the United States.

Mr. Chairman, although our activities are extensive, they are not enough to reach the problem at its roots—the mafia, the Cosa Nostra, and the Black Syndicate. Preventative legislation, curative legislation, rehabilitative legislation, and education coordinated to reach the majority of the U.S. population, clearly spelled-out so as to eliminate misunderstanding by all citizens, is required. Bill number S. 3562 in the Senate of the United States, provides the most comprehensive and applicable legislation we have studied to date; legislation that does not negate the humanity involved and also provides for ample punishment for the violators of black and white American future leadership; that is, our children.

Let us hope, Mr. Chairman, that the support of this legislation by Blackman's Volunteer Army of Liberation, whose philosophy and ideas have yet to be voiced or understood, will not be a kiss of death in the minds of our citizens, and if it were possible to register a vote in

the District of Columbia for the passage of bill number S. 3562, I would vote in the affirmative and recommend that all citizens support it.

Mr. Chairman, it has been difficult for black people to be citizens of the United States. This difficulty is based upon the facts of history. The responsibility of white America is to recognize the mistakes of its past and correct them, and the responsibility of black America is to understand the obligations of citizenship and to earn consciously the benefits. Mafia and other types of conspiratorial governments saw the mistakes of America's past and has used them to exploit and kill, economically enslaved and educationally deprived black America. A living black gold mine, through which millions of dollars are drained from the economy. Millions for heroin, cocaine, marihuana and other illicit narcotics.

Today, April 13, 1970, Mr. Chairman, American astronauts are preparing to land, for the third time, on the moon, and black Americans are literally still picking cotton. We wonder about the future of our children, Mr. Chairman. We also recognize, Mr. Chairman, that if American children are turned into drug addicts by underworld people, our future is truly one of oblivion.

The pending legislation in bill number S. 3562, if passed, will be the responsibility of Government to put into effect and enforce. It will also be the duty of every citizen to understand and abide by this law. When this mutual understanding between Government and citizenry occurs, the law enforcement agencies will then be able to complete their part in the war against illegal drug traffic. Black and white Americans will then unite and stop the selling of narcotics in our schools, our neighborhoods and throughout the Nation.

The eyes of the world are upon the United States, Mr. Chairman, particularly upon the District of Columbia, its Capital, that has a black majority of citizens. If we cannot solve the problem of illegal drugs, that was created by men, then it is almost a surety that we will fail in solving the race problem, the pollution problem, the Vietnam problem and all other problems that man has created for other men to solve.

It would be a dreary eulogy to read in the future's history that America solved all problems except the drug problem and allowed enemies to poison her to death through her youth.

I would like to offer for the record copies of our information that we published for the Education Journal.

Senator HUGHES. Thank you, Colonel Hassan. They will be incorporated as part of the record at this point.

(The information referred to follows:)

GENERAL DESCRIPTION

Blackman's Development Center is a private non-profit organization that operates as the community organization of the Black Man's Volunteer Army of Liberation which is the Military arm of the provisional government of the United Moorish Republic. Its basic thrust is that of a militarily operated, self-help organization operation in all areas of concern to the urban community.

DRUG PROGRAM

Blackman's Development Center, Inc., operates four centers: (1) 1333 "T" Street NW; (2) 1407 "H" Street NE; (3) 1642 Newton Street NW; and (4) 6406 Georgia Avenue NW.

Drug treatment is not a primary maintenance program at these centers but they recognize the need for a maintenance aspect for these men and women who have reached the stage of no return. Methadone is given over a 60-day maximum period to enable the addict to slowly and painlessly withdraw from heroin. The drug program also includes crime prevention, drug prevention, drug cure and rehabilitation of the addict.

POPULATION SERVED

Blackman's Development Center, Inc., has registered and treated over 13,000 voluntary registrants since May, 1969. The large majority of whom are Black Ghetto residents. The centers also serve White Suburban addicts.

STAFF

Col. Hassan, his immediate administrative staff, and approximately 75 male and 25 female non-salaried volunteers, many of whom are ex-addicts, form the core or heart of the program with assistance from volunteer professionals, such as doctors, nurses and volunteer citizens.

FUNDING

Blackman's Development Center, Inc., currently operates on a \$125,000 a year. Money for operation comes from Blackman's Development Center's enterprises and contributions by citizens and private foundations.

PLANS FOR EXPANSION

Equipment for urinalysis has been purchased; additional funds are necessary to support urine surveillance. Blackman's Development Center will also open five (5) additional centers, both in the center city and in the suburbs.

BLACKMAN'S DEVELOPMENT CENTER'S DRUG CURE PROGRAM

REGISTRATION QUESTIONNAIRE

The following questionnaire will be used by all drug cure personnel when registering volunteers for the drug cure program.

INSTRUCTIONS:-- After you have obtained the required information, as listed below, and prepared a white 5 x 8 file card as well as an I. D. Card, the completed questionnaire must be immediately hand-delivered to the Chancery in order to complete a 8 x 11 pink "Time-Dose-Withdrawl Complex Chart" for each volunteer. ALL RECORDS PERTAINING TO NEW VOLUNTEERS OR RE-ADMISSION MUST BE IMMEDIATELY PROCESSED. IN ADDITION, THE RECORDS MUST BE LEGIBLE AND WITHOUT ERRORS.

(Please use a ballpoint pen when completing items listed below.)

1. NAME: _____
2. ADDRESS: _____
3. DATE OF BIRTH: _____ 4. MARITAL STATUS: _____
5. NO. OF CHILDREN _____ 6. TELEPHONE NO. _____
7. DATE OF REGISTRATION: _____

New-Admission
Re-admission
8. DATE WHEN IDENTIFICATION CARD WAS ISSUED: _____
9. LENGTH OF TIME USING DRUGS: _____

(List the following information under "remarks" on each index card)

10. TYPE OF DRUGS USED: _____
11. HOW WAS DRUGS ADMINISTERED: _____
12. INDICATE STATUS OF EMPLOYMENT: _____
13. INDICATE JOB PROFESSION, I. E., COOK, PRESSER, ETC. _____
14. Indicate if volunteer was previously enrolled in a methadone maintenance program; its location ; period of enrollment; and type of medication received.
15. Height _____ ; Weight _____
16. HAS VOL. EVER BEEN EXCEPTED FOR 3rd. PARTY CUSTODY TO B. D. C. OR OTHER ORGANIZATIONS BY THE DISTRICT COURTS
 (if answer is yes give Mo. & yrs. _____)

Interviewer-PLEASE PRINT _____

ATTENTION!!**ATTENTION!!****DRUG ADDICTS****DON'T BE A SUCKER**BLACK BROTHERS AND SISTERS

WHEN YOU SPEND \$100.00 ON HEROIN ..\$75.00 GOES TO WHITE-FACED
CRIMINALS WHO LAUGH AT YOU FOR BEING A D-O-P-E ADDICT... \$25.00
IS SPENT BY BLACK-FACED TRAITORS WHO RIDE ELDORADOS AND MAKE YOUR
DAUGHTERS AND SISTERS INTO WHORES FOR THE WHITE DRUG SUPPLIERS...

**WHY NOT BREAK THE HABIT AND
STAY OUT OF PRISON??**

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*ARE YOU TIRED OF BEING A THIEF? *ARE YOU TIRED OF STEALING FROM YOUR
*ARE YOU TIRED OF BEING A PIMP? MOTHER, FATHER, SISTER AND BROTHER?

ARE YOU TIRED OF BEING A **DOPE ADDICT**

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* WHEN YOU HEAR YOUR CHILDREN SAY THESE WORDS - THIS IS WHAT THEY MEAN *

GLOSSARY:

Amphetamine - Speed, Black Beauties, Bennies, Dexies, Ups

Capsule of Drugs(any type) - Egg, Cap

Cocain - Girl, Ice, Coke, "C", Miss Carry, Petro, Freda

Drugs(any type) - Dope

Heroin - Horse, Boy, Snow, Stuff, Dugie, "H", Scagg, Harry Whitey, Poison

Heroin & Cocain - Speedball

Envelope of Heroin - Bag, Sack

Hypodermic Syringe - Needle, Spike, Hyp, Hypo

Scars formed from Repeated Injections - Tracks

To Buy Drugs(any type) - To Cop, To Re-Up

To Have Drugs - In Shape, 'Holding'

A State Inwhich Blood-vessles are Deflated
from Repeated Injections - To Be Burned Out

To Inject Drugs just under the Skin - To Pop, To Skin-Pop

To Intravenously Inject Drugs - To Fire, To Oil, To Take Off,
To Hit, To Main-line, Get On,
To Get Down

To Be Under the Influence of Drugs - To Be High, Stoned, To
Fly, Space, Picked

WARNING WARNING DRUG DEPENDANTS

BLACK BROTHERS AND SISTERS,

UNITED STATES GOVERNMENT'S MASSIVE CRACK-DOWN ON DOPE DEALERS
PUTS YOU ON THE SPOT!!! D.C. POLICE DEPARTMENT HAS FILE
ON EVERY BLACK DRUG SELLER IN THE CITY!!! MORE ARRESTS AND
GREATER RAIDS WILL BE MADE SOON!!! WHITE DRUG SUPPLIERS GET
RICH YOU GET ABCESES AND PAIN. YOU ARE TOOLS OF
WHITE-FACED MAFIA & COSA-MOSTRA DOGS WHO LAUGH WHILE YOU SUFFER.
WHEN HEROIN IS CUT-OFF - - - - YOU WILL BE SICK AND
ALONE!!!!!!

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" This is **Drug Cure** - not **Methadone Maintenance** "

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ATTENTION!!

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*ARE YOU TIRED OF BEING A THIEF? *ARE YOU TIRED OF STEALING FROM YOUR

*ARE YOU TIRED OF BEING A PIMP? MOTHER, FATHER, SISTER AND BROTHER?

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R-R-E-M-E-M-B-E-R, IF YOU ARE AN ADDICT IT IS BECAUSE YOUR ENEMY IS
USING YOUR LIFE TO MAKE HIMSELF RICH AND THE IMPORTERS / MANUFAC-
TURERS OF HEROIN ARE WHITE-FACED CRIMINALS AGAINST BLACK HUMANITY

**BREAK HIS HOLD ON YOU AND
YOUR PEOPLE... NOW!!**

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WARNING DRUG ADDICTS WARNING

YOUR LIFE IS IN DEADLY DANGER!!!

WHITE RACISTS CONTROL ILLEGAL HEROIN TRAFFIC

BROTHERS AND SISTERS,

White Men Manufacture and Import Heroin into the UNITED STATES. They use it to enslave Black men, women, boys and girls. Millions of dollars are robbed from us daily and every dime goes to make them rich while Black People die, in Prisons, Hospitals, in alleys and all of them in MISERY. Why are you a Black slave to white-faced dogs who pretend they love you and Pump Pure Poison into your veins??? Because you don't understand that heroin for negroes is a conscious plan to make thousands of addicts and use our money to take control of U.S. Government....

THE U.S. GOV'T CAN STOP DOPE TRAFFIC
AND WE DEMAND THAT ILLEGAL HEROIN
TRAFFIC FROM ABROAD BE STOPPED!!!

BLACK MEN CAN STOP THE SALES AND USE OF HEROIN AMONG OURSELVES IF
U.S. GOV'T WILL DO IT'S PART. LETS UNITE - DRUG DEPENDANT, WORK-
ING MEN, HOUSEWIFE AND RID OUR LIVES OF HEROIN ADDICTION THAT MAKES
G-R-E-E-D-Y BLACKMEN AND E-V-I-L WHITEMEN FAT AND RICH

PEOPLE THAT WILL NOT FIGHT TO SAVE T-H-E-M-S-E-L-V-E-S

DESERVES TO D-I-E

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WARNING: TO HEROIN SUPPLIERS And DOPE DEALERS
DO NOT SELL HEROIN TO OUR
BROTHERS And SISTERS And CHILDREN

AMERICANS, (Black & White) WE MUST UNITE

THE ONLY PEOPLE THAT CAN BREAK WHITE-FACE DOG MAFIA, MAFIOSI AND COSTRA-NOSTRA SELLING ILLEGAL HEROIN AND OTHER DOPE TO OUR SCHOOL CHILDREN, OUR FAMILIES IS OURSELVES. MOTHERS, FATHERS, SISTERS AND BROTHERS, ALL TEACHERS IN OUR ELEMENTARY SCHOOLS, HIGH SCHOOLS, OUR COLLEGES AND UNIVERSITIES - HOUSEWIVES AND WORKING PEOPLE, WE MUST UNITE TO END DRUG DEPENDANCY AND DRUG TRAFFIC. WE MUST DEAL WITH THE BLACK-FACE TRAITORS OF OUR PEOPLE WHO SELL DOPE TO OUR YOUNG BOYS AND GIRLS AND MAKE WHORES AND THEIVES OF THEM FOR WHITE-FACE DOG DEALERS IN ILLEGAL DRUGS. WHEN BLACK MEN TAKE CARE OF THE BLACK-FACE TRAITORS OF OUR PEOPLE, REST ASSURED WHITE AMERICA AND THE UNITED STATES GOVERNMENT WILL SEE THAT THE WHITE-FACE DEALERS IN DEATH ARE UPROOTED FROM THIS SOCIETY.

DOPE DEALERS SELL DRUGS TO ALL. LIVES & MONEY THEY WANT.

IF YOU KNOW OR SUSPECT ANYONE OF SELLING DRUGS AT OUR SCHOOLS, MAN OR WOMAN THAT LIVES IN YOUR BLOCK OR APARTMENT BUILDING ANYWHERE THAT YOU SEE THEM LET US KNOW WE WILL DEAL WITH THEM OURSELVES. THEY WILL BE PERSONALLY WARNED JUST ONCE. IF THEY DO NOT STOP IMMEDIATELY WE WILL STOP THEM !!!

CALL 291-5900 or MAIL INFORMATION IN A PLAIN ENVELOPE (YOUR NAME ISN'T NECESSARY) TO

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AND ACTION
WILL BREAK THE DEADLY HABIT**









BLACKMAN'S VOLUNTEER ARMY OF LIBERATION

6405 GEORGIA AVENUE, NORTHWEST
WASHINGTON, D.C. 20012

TEL. 291-5900

THIS DECLARATION IS ADDRESSED TO ALL BLACK-MEN AND BLACKWOMEN, DESCENDANTS OF UNITED STATES OF AMERICA AFRICAN SLAVES, ALL BLACK-MEN AND BLACKWOMEN WHEREVER THEY MAY NOW RESIDE ON EARTH.

The passage of time, chain of events, and created circumstances have brought us, Brothers and Sisters, to the most crucial period of our existence. A time when, not simply the lives of black adults but the lives of the entire black population of America, men, women, and children, can end with complete death and annihilation for all time to come. A period of life more precious than all of the wealth of the earth, that is being threatened with a promise of total extinction through the licensed use of brute force, spawned by a hatred based solely upon greed and fear. An era wherein the chains of slavery have become, not a burden to the slave, but a defensive weapon that can fend off the clammy hand of a dead life and a lifeless hereafter, and because of this, the striving for freedom by Blackmen, is no longer suppressed by tolerant power, but unleashed maniacal murder presages of future calculated genocide.

This portended doom of a captive people clearly indicates that Blackmen must wrest their destiny from the control of whitemen and secure by their own efforts, the cherished station of equality enjoyed by all nations of people of the earth.

To continue to accept the physical and mental abuses heaped upon us is an admission of shameful cowardice. To grovel in filth and squalor,

licking the feet of whitemen who viciously enforce a fabricated superiority upon us, 'from the cradle to the grave', is craven self-denunciation of Blackmen's right to freedom.

To permit strange men to violate and defile our life giving mothers, and sisters, and daughters, assists the ravishers in their acts of lustful avarice and hate.

For Blackmen to labor, as slaves, for not even enough compensation to feed our infant black sons, illuminates for all of the world to see, the horrible lot of Blackmen who blindly love, and submit to, a sadistic white master, while at the same time, praying to our master's cruelty for brighter and greener pastures as we are being castrated to death.

Blackmen, fear has sapped your courage! Fear has diminished your strength! Fear has befuddled your mind and your eyes are blinded by fear to the simplicity of understanding. Worlds of precedents have predated you, and you are unable to face the reality of your tragic history written by whitemen with your murdered blood.

Time has evolved into a do now, or die later situation. You wish to flee, yet there is no place to run. You want to hide, but there is no hiding place. You pray, and there is no one to answer your prayers, nothing but the fear that is keeping you a slave. Blackmen, you deny that you are a slave and submit to the lowest forms of servitude. You ask your Black brothers to help you free yourselves; then you push your helpers into the yawning jaws of death for just one more minute of misery as your white master's slave factory, creating unlimited wealth for him, and abject poverty for yourself. What kind of man did your God intend for you to be? A slave or a free Blackman?

We have begged whitemen to accept us as citizens of America, full-fledged, equal sharing, United States of America citizens, for over 100 years after the laws of this country supposedly declared us free. We have fought and died in whitemen's wars, or have broken our backs labor-

ing as he basked himself under a free sun. Blackmen are being killed today after 100 years of begging and defending whitemen and the killing is not confined to a distant land, but we are also being murdered in every state in this so-called Republic which pretends to be a democracy.

It is apparent to good sense, sound reason, and the minds of civilized people, that the methods previously used in our crawl to freedom, justice, equality, and peace, have not proven themselves to be the course of sane men. The hour is now, for the final battle to begin, to win freedom complete and unequivocal freedom!

In order to achieve this end, "a complete and unequivocal freedom," there has now been established throughout America, and within the continent of Africa, BLACKMAN'S VOLUNTEER ARMY of LIBERATION, headquarters, BLACKMAN'S DEVELOPMENT CENTER, Washington, D. C., a united Revolutionary association of Blackmen who have agreed to associate themselves together to lawfully pursue and capture, the centuries denied freedom that is enjoyed by true citizens of the United States of America.

The purpose or purposes for which the Association is organized, as stated in the Third Article of Association, is to EDUCATE, DIRECT, and bring about, within Blackmen and Blackwomen, descendants of United States of America African slaves, through UNDERSTANDING, the firm knowledge and capability to obtain the true station of all free people of the earth, to whom the laws of God, nature, and conscience entitle them: FREEDOM, JUSTICE, EQUALITY, PEACE, and the unfettered, lawful PURSUIT of HAPPINESS.

It has become evident that it is not the intention of white America to deal equitably with the millions of Blackmen and Blackwomen that reside within the continental limits of the United States. It is further evident that there is no reality existent in the many legislative bills that are daily

being introduced to the lawmakers of the United States by whitemen, controllers of this nation, who are playing the final trickery upon Blackmen before opening the gates of all-out genocidal slaughter. That it is clearly seen by the manner in which white America has evidenced its hatred of Blackmen, in their vicious attack upon the brave, but defenseless, Blackmen and Blackwomen, who have formerly followed leaders that are passively and foolishly leading them to entrapment and death. White America has finally turned upon her religious flunkies with gun and rock, because the selected Uncle Toms can no longer control the Black millions for them, with resounding prayers and empty promises of Utopia.

Throughout this vast and ample land, the frightening ugly yell of 'riot' sears its shocking vibrations into the brains of all men, stimulating reaction that heralds the collapse of restraint. An America so weakened by internal conflict, that is unerringly speeding towards totality, cannot withstand also the uncountable masses of Asia who are bent upon the complete defeat of the white world, and America, white America, is aware of this. Poised at the ready stands the entire continental forces of the United States of America, along with the various law enforcement agencies throughout the country. An army of white citizens that is comprised of every element of this violence prone society, capable of suffering defeat, and fully evil enough to slaughter every Black person in this country, as they go down in defeat, rather than release the selfish hangman's rope that they hold around our necks.

Then we, Blackmen, shall use well the bonds of slavery that have been forged with malice aforethought, enslaving not only our bodies, but our minds as well, and promise to return a like coin for the one rendered. For life, liberty, and happiness, Blackmen are too, prepared to sacrifice our 'nothingness in America' for the honor of fighting, united and determined, for a freedom we have yet to taste. Organized, nationwide, world-connected, calculated plans of self-defense will never be initiated into action in an aggressive move, but in the hands of Blackmen

who are hell bent for revenge, united determination means great reward at knowing our enemy will rise no more from the bloody mire where they have been thrown, by brave and courageous, insignificant bits of black life.

Black America will not respond to the insane call of those who declare that violence is the course that must be followed to acquire freedom. The frustrated cry of the negro leaders who have not evaluated the circumstances and formulated a workable solution to the miserable conditions under which they live. Using slogans that are ambiguous in their interpretation, that tend to create violence. Useless demonstrations and treats, of forcing open doors that are privately and personally owned, under the guise that it is good for the country. Ideas, plans, and action that leads to an understandable goal, understandable by all men, is the only workable and acceptable solution to the chaotic methods and severe problems facing America.

DO NOT BE MISLED BY WORDS THAT APPEAR TO NEGATE VIOLENCE. THERE IS NO VIOLENCE GREATER THAN THAT DISPLAYED BY BLACKMEN WHO FIGHT IN SELF-DEFENSE WHEN ATTACKED BY VICIOUSNESS OF RACIAL HATRED.

Millions of American dollars have been spent in the past ten years, supposedly to better the Blackman's condition, both by the federal government, certain state governments, and also numerous organizations and associations or societies. Thousands of dollars have been raised in soliciting campaigns to: build a playground, buy a lamp, teach black children how to play sports, build more schools, conduct various surveys, take this consensus or another, register negro voters, protect civil rights marchers, prosecute civil rights violations in court, transport volunteer men and women who have the bravery of martyrs, hire more policemen to handle riot situations, mobilize the national guards of many states, congressional inquiries into civil rights, and even costly speech making tours by the President of the United States, and the Vice President

of the United States.

Uncountable millions of dollars wasted in futile effort to cover up wrongs done to Blackmen and Blackwomen. It is no longer possible to buy the minds of Blackmen and Blackwomen with bloody paper, who have realized that the only solution to their slave conditions does not lie among the stars, but in positive revolutionary plans and actions, with the sole responsibility for the acquisition of freedom in the hands of Blackmen.

Someday, negroes who have taken high thousands of dollars of this money for their selfish needs, will be recognized as traitors because they have covetously led their people to more years of poverty and confusion. Perhaps the federal government will realize, too late, that the solution to its dilemma is as simple as recognizing the events that brought (it) into being, and admit by honest assistance, that the minds of Blackmen and Blackwomen have nourished the seed of liberty into a strong young tree of life and freedom. It has taken nearly five hundred years for the understanding of nationhood to germinate in the minds of Blackmen, and as with all men, there will be no rest until complete liberation is won, on an honorable battlefield.

The 'Negro Revolution', from the beginning, has remained within the confines of the plans of white America. It will die there, crushed and strangled with its own weight and blood, sinking hopelessly into a quagmire of ignorance. The 'Negro Revolution', empty words falling upon deafened ears, is the laughing stock joke of all free people of the earth. A revolution that has as its goal the return of chains. Integration, lambs laying down to sleep in the den of the wolf. Complacent resignation to conditions and circumstances that will prove its value only when it is understood that the route traveled leads to genocide. Identify 'The Negro Race' and begin by counting yourself, the people earmarked for extermination. The 'Negro Revolution' is not even an honorable connection of words, least of all a battle, because there is no honor in being a negro, a created mis-nomer of degradation and shame.

All things considered, BLACKMAN'S DEVELOPMENT CENTER has un-animously agreed that now is the time to declare, to all men and mankind, that we shall no longer follow incompetent, and white controlled leaders who are blocking the minds of our people from understanding by the use of religious bunk sponsored by a white God. Nor will we respond to the insane, hysterical threats of negro leaders to unleash an army of passive black sacrifices into areas of white society that have not respected, and never will respect, even our existence. Leaders who ask this same enemy that is killing their followers, to join them as they march unarmed and blindly into the enemy's backyard. A theory of passive resistance that was introduced to the recent world by a people who were assured of overcoming their enemy, because they outnumbered the enemy that had invaded their Mother Land, not a land belonging to another, as is the case in America.

BLACKMAN'S DEVELOPMENT CENTER will not compromise its principles nor its goals, which is complete liberation from white domination. There does not appear even the slightest degree of compromise in the Declaration of Independence of the United States of America, and upon this understanding, we declare our course to be one of non-compromise to our head-long freedom.

BLACKMAN'S DEVELOPMENT CENTER will not affiliate, associate or participate in any of the political activities carried on in any city, town, county, state or political party of the United States of America, because it is clearly understood that the political activity prevailing, cannot and will not, in any way assist Blackmen and Blackwomen in the acquiring of the complete freedom sought after. However, BLACKMAN'S DEVELOPMENT CENTER will oppose all internal organizations, groups, political parties, or otherwise identified persons who desire to violently overthrow the United States Government, especially if these persons have declared themselves to be, in word or deed, enemies of Blackmen and Blackwomen, descendants of United States of America African slaves.

Neither shall we demonstrate, sit-in, riot, demand or otherwise compel any person or persons of, or compromising, the Government of the United States of America to give Blackmen and Blackwomen the things or privileges enjoyed and owned by themselves that are held to be their personal prerogatives. BLACKMAN'S DEVELOPMENT CENTER seeks only to be not detained in its drive to freedom.

Brothers and Sisters, now is the hour that freedom, nationhood and the methods required to achieve these things, are to be clearly stated and clearly understood. The time when workable and understandable plans must be initiated into action that will successfully carry Blackmen and Blackwomen to safety and freedom.

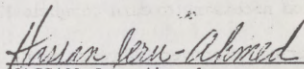
No longer will it be possible for white America to deceive Blackmen with false promises of enjoying the benefits of citizenship that in itself is a lie. A lie perpetrated to keep slaves under control in order to maintain the position of the richest country on earth. Free labor, or labor paid for with table scraps, has built the foundation of America's wealth.

BLACKMAN'S DEVELOPMENT CENTER, with years of groundwork, has prepared the revolutionary foundation and has initiated the positive action necessary to earn complete liberation for Black residents of America. For over 190 years, white America has denied Blackmen the right to even think as a people with a rightful inheritance to liberty. Murdering and imprisoning any Blackman or Blackwoman who dared even to voice protest the barbarous and unhuman existence they are forced to live. White America wishes to keep her servants and prevent them from obtaining the knowledge that will rid us forever of the diverse shackles of slavery. Clouding Black minds with dreams that slaves can be equal to the master and remain a resident within the master's household.

Let it be known and understood, by all people of the earth, that the centuries of slavery and abuses suffered by the Blackmen and Blackwomen under the land of whitemen who have cruelly murdered and enslaved us,

have proven to the world that only degradation and death are forthcoming as long as we remain dependant upon white America for even the food we eat to sustain our lives. Herein lies the cause or causes that make it clearly understood that we, Blackmen and Blackwomen, must fully control the course of our lives and our destiny. That we, Blackmen and Blackwomen, descendants of United States of America African slaves, must recognize the physical danger under which we live, and join fully together in the World Wide Black Revolution in order to save our lives.

Therefore; we, the officers and men of BLACKMAN'S VOLUNTEER ARMY of LIBERATION, in secret session, asking God for understanding necessary to release completely from our lives the chains of slavery so long worn upon our bodies and minds, with firm knowledge of the task ahead and the dangers involved, pledge to one another, to all Black people of the earth, that we will not desist in our efforts to acquire complete Liberation, Freedom, and Self-Determination entitled to all people of the earth. UPON THESE PREMISES WE PLEDGE OUR LIVES AND OUR HONOR.



HASSAN, Jeru-Ahmed
Colonel, Commanding Officer
Blackman's Volunteer Army of Liberation

Colonel HASSAN. Thank you, Mr. Chairman. That is the end of my statement.

Senator HUGHES. Colonel, you state in your testimony that you have registered approximately 13,000 drug users since inception.

Colonel HASSAN. Yes, sir.

Senator HUGHES. Do you have any breakdown of that 13,000 as to male, female, age categories, and so on?

Colonel HASSAN. We are presently involved in an evaluation of our program. We cannot at this time say how many male or female.

The age categories range from, Mr. Chairman, 13 to 68. We approximate 3,000 women in our program at the present time—registrants, that is.

Senator HUGHES. This includes the broad strata of all drugs and narcotics, it is not a particular type of user?

Colonel HASSAN. No, sir. From marijuana all the way through to heroin.

Senator HUGHES. You said the "establishment" has deliberately tried to sabotage your efforts in this field. Would you care to elaborate on that?

Colonel HASSAN. I believe, Mr. Chairman, that there are men within the establishment that have other ideas for drug programs et cetera. I recognize that throughout the country drug cure program or drug treatment programs have become one of the new ways to get a large sum of money into the hands of a few people and it appalls me.

The efforts of sabotage have been very, very subtle. It has been the leading promises and various other things that have never been lived up to. As we as private citizens attempt to do a job that we cannot do alone it appears that we will drown while the others come to the surface.

Senator HUGHES. How successful has been your withdrawal program by methadone, Colonel Hassan?

Colonel HASSAN. If I might explain our use of methadone, I am extremely afraid of dealing with methadone on a maintenance level. I recognize and, of course, scientifically know, that it is an addictive narcotic, a synthetic narcotic. We have seen the effects of methadone addiction in any number of people at our centers. We have had at one time every room of our offices and every room of our homes filled with people who were attempting to break their methadone habit. So we decided that we would use the medication as it was intended to be used, as an analgesic, and we ask our doctors the best way to use it and we use it like aspirin. The maximum dosage we give per day is 20 milligrams and that takes care of the pain of withdrawal from heroin. It does not eliminate the sickness or the upset stomach, but we simply tell them that a man who can't stand a little upset stomach when he does not have any pain is not trying very hard. And, Mr. Chairman, it works. We are able to reach the minds of the men and women who come into our program and at least educate them whether we can accept them into the program or not.

There are many other reasons why we cannot accept them into the program—sufficient quarters, sufficient educational facilities, something interesting for them to do. My men and women have to really

hustle every day to make sure we meet expenses. So we have to be out of the office and we cannot really counsel the people as we would desire.

Methadone can be a boon for the drug dependent. I think in the areas of a man who is classified as a junkie it is a necessity, it will add at least 10 years to his life. But as far as a man just experimenting, using narcotics, methadone maintenance can kill him the same as heroin.

Senator HUGHES. Would you describe methadone to me? There seems to be conflicting testimony before this subcommittee. My understanding of methadone is that it blocks the euphoria of heroin if a person is a heroin addict. There has been some, but not much testimony that indicated that methadone itself could produce a high or euphoria if taken alone.

Colonel HASSAN. Taken alone it would have to be taken in high milligram doses to perform euphoria. It does block the desire for heroin if it has a very high milligram count. Recognizing that if they take a large quantity of methadone, drink beer, use amphetamines or inject it, that there can be a euphoria produced, we decided to keep it very low. The milligram count we have is very low and they could drink if they wanted to and it would not give them euphoria. It would nine times out of 10 make them ill.

Senator HUGHES. You have high multiple drug usage?

Colonel HASSAN. Yes, ranging from marihuana to heroin, LSD included.

Senator HUGHES. Do you have any estimate how many of your patients are multiple users?

Colonel HASSAN. At the present time with a daily treatment rate of 1,611 people, I would say a good two-thirds of them are multiple drug users.

Senator HUGHES. If you get them off heroin do they stay on another drug?

Colonel HASSAN. When we get them off heroin, we have a problem trying to get them off of the methadone. As to the others, we try to make it comprehensive so that we get them off of the drugs. There is a great level of fear in the mind of the drug addict and that is another level entirely. The pain that is accompanied with withdrawal makes them desire always to take a pill. Many men and women desire to break their habits but they are afraid of the pain and afraid to take a change so we have to educate them.

Senator HUGHES. It is more difficult to treat women than it is men?

Colonel HASSAN. I would say so; yes, sir; it is a little more difficult to treat women than to treat men. It is hard to hold the women close in with us or anyone for that matter. They tend to leave a program very quickly after getting over the initial stages of sickness.

Senator HUGHES. I notice you mentioned beer and alcohol, in addition to all the drugs usually mentioned. Is that part of the problem in the drug scene?

Colonel HASSAN. No, sir; I was merely pointing out this is one of the ways with methadone a person may reach a high, a different kind of a high, from what I have been told. They drink beer and inject amphetamines along with the methadone and there is a terrible high.

Senator HUGHES. There has been some testimony before the sub-

committee, Colonel, that people who use methadone for maintenance—many of them—turn out to be alcoholics.

Colonel HASSAN. I have seen that, also, Senator. I have seen that with men who were on very low dosages of methadone. They must have something and that is right before we are able to perhaps put something else into their minds, so that they won't need an alcoholic beverage at the same time.

Senator HUGHES. This would indicate a pretty serious emotional disturbance or some sort of emotional disorder that perhaps we are not getting to at all; is that right?

Colonel HASSAN. Yes, sir; and as I am trying to convey with everything that we do it relates to the inequities, the frustrations, the confusions that exist in our society so we decided to try to change it and we decided to attack one of the most deadly scourges that exist in the country.

Senator HUGHES. It has been reported that some heroin addicts want to get hold of methadone so they can reduce their addiction costs and then operate at a lower level. Do you find that in your treatment of patients?

Colonel HASSAN. That is correct, sir. Many heroin addicts, and especially those with habits that we still classify as users, would like to spend less money for the heroin during the week and be able to spend more on the weekend. Inadvertently, in the beginning of our program, we kind of made quite a few weekend drug users, so we decided to cut the dosage down very, very low after experimenting with it to find out that 10 or 20 milligrams can block the pain and the pain is the thing that drives them to want more heroin.

Senator HUGHES. In your job placement efforts for cured narcotic users, are you running into difficulty?

Colonel HASSAN. Difficulties only in being able to operate it, Mr. Chairman. That is the problem that we have. We do not have sufficient personnel in-house to be able to handle it as we would like to handle it. Of course the thing that we seldom mention, we don't have sufficient money to do it as it should be done. It takes a little money to find a job for a man these days.

Senator HUGHES. You mention that you had some 300 people referred to you by the courts. Were these people referred before trial?

Colonel HASSAN. Yes, sir; they were men and women who had been arrested and subsequently released to our organization on third party custody. We have had some released on probation to our organization, also.

Senator HUGHES. Are these all people who are addicted or users of drugs?

Colonel HASSAN. Perhaps not officially in the courts, Mr. Chairman. All of them were addicted to drugs but after careful investigation out of that 300 we would estimate 245 or 250 to be users of drugs.

Senator HUGHES. Were you able to keep them clean?

Colonel HASSAN. As best we can. The biggest problem is being able to get that person to come in to the center. We cannot house them all. To get that person to come in to the center, sometimes it is a simple matter of being able to afford bus fare for them to get them to come. Sometimes it is a matter that the man has to work or the woman

has to work and cannot come to the center, so we stay in touch via telephone and visits.

Senator HUGHES. How many Outreach workers do you have to do this right now?

Colonel HASSAN. All of them are Outreach.

Senator HUGHES. All of them?

Colonel HASSAN. Yes, sir.

Senator HUGHES. What happened to the 100 suppliers you reported to the police intelligence?

Colonel HASSAN. As yet I do not know, Mr. Chairman, but we have the names and we have doublechecked and verified each one of them.

Senator HUGHES. Do you ever read in the paper that they have been apprehended?

Colonel HASSAN. I saw three names about 2 weeks ago.

Senator HUGHES. Out of the 100 you saw three names?

Colonel HASSAN. Yes. Perhaps there were more, but those were the ones that I noticed.

Senator HUGHES. Have you sought any Federal funding to support your program?

Colonel HASSAN. We have recently submitted a proposal through the Spring Road Mental Health Center to be part of their mental health program to the National Institute of Mental Health and that is the only application or request for funds that we have submitted.

Senator HUGHES. Do you feel there is a need for Federal funding for a private program such as yours?

Colonel HASSAN. Yes, sir; I do.

Senator HUGHES. Are you getting any estimate of the cost to the city of heroin addiction and drug abuse?

Colonel HASSAN. Every time I think of that, Mr. Chairman, it almost looks like I need a computer to count the amount of money. The average habit of the 13,000 people registered with us today is about \$70 per day. Right there my mind stops in being able to figure very quickly the millions of dollars that is stolen by drug users and addicts in a month's time and in a year's time in Washington, D.C. It is staggering and if we calculate throughout the United States it is something almost unbelievable, but we see it every day.

Mr. Chairman, I remember when I was a very young man and suddenly I noticed that my school friends were disappearing, I didn't know where they were. Then I was unfortunately arrested and sent to the District of Columbia jail. I saw such a glamorization of the use of heroin at that early stage by these men who desired to go to Lexington, Ky., because that was an easy way out. Today I see some of those men who are on the brink of death from the use of heroin and other narcotics throughout the last 25 to 30 years. Those men are about to die but today they are moving on the very, very young.

In the information that we gave to be inserted in the record are copies of some of the investigations conducted by some of the young men with our organization. They are written in their language without editing and when you read them, Mr. Chairman, I think you will see the problem in the elementary, junior high, and high schools in Washington, D.C. It makes me think, Mr. Chairman, that it might be a pretty good plan to destroy the United States. Most of us in

this room, in a very few years, comparatively, we will be gone and those youngsters in elementary school, my children included, will be the future leaders of the United States of America. As I said in my statement, if those future leaders are destroyed now or will destroy themselves over the years by drugs, then I can see a very, very near defeat of the United States of America unless we do something about it.

You, and I am sure everyone else loves and desires to protect their children, and so do I Mr. Chairman, and mine are very young.

Senator HUGHES. Colonel, you have a great deal of experience in working at the community level here in the District of Columbia. Have you formulated any percentage, or any estimates of the number of kids in the District of Columbia who go through the school system and experiment with drugs or use drugs?

Colonel HASSAN. Those figures I could not reach in my mind, but every day young men come to join our organization or to join Black Man's Development Center. Each one of them gives us stories about their friends, all of them interested in experimenting with drugs, because there has been a glamorization to it and because the parents are at least at this time ignorant of the problems of drug addiction. Most of them have to work every day, they don't have time to be home with their children. So the children are left free, and around every school there are what we call shooting galleries. The shooting galleries are not houses deliberately set up in the neighborhoods for the youngsters to use narcotics, the shooting galleries are the homes of the children where the parents are at work, both parents, and that is what we call a shooting gallery. The selling of the narcotics is done by the youngsters in the schools, not by a man who pulls up in an automobile at lunchtime and sells narcotics out of the window. Those men now select the youngster that has been addicted to drugs, and for his shot for the day and money he becomes a pusher for the dealers.

Senator HUGHES. You mention in your testimony that you conduct educational programs, Colonel Hassan. As you know, a part of this legislation is focused on education. One of the great problems in the country right now is that of using authentic, believable, and honest education in the field of drug abuse and narcotics addiction.

Could you describe for me what you are talking of when you mention education programs?

Colonel HASSAN. We try to begin, Mr. Chairman, with educating the person, male or female, black or white, to the history that brought us all together in the United States of America. From there, we are able to eliminate some of the confusion as to, No. 1, how my name used to be Albert Roy Osborne and, No. 2, how I got on this continent and, No. 3, why a man who looks like me has English as a native tongue, confusing in the black man's population and also in the white man's population because it has never been clearly defined. We can define it without rancor. We can definite it without creating a hatred between the two because we want to solve the problems that result from this confusion.

Remedial education is a necessity and this is one of the first things we try to have.

Senator HUGHES. Are you talking primarily about the self-identity of the child?

Colonel HASSAN. Self-identity of the human being, of the person; yes. This is what we try to give to the person so he might identify himself and then if he leaves our program and he goes back in to his same environment—we have seen cases where those men have been better able to handle themselves there. On Sunday we have family day at our center on Georgia Avenue, and the way I estimate the rate of cure at the present time without really being able to follow through is by the numbers of men and women who bring their children there to just be together with us. And Mr. Chairman, they come from all walks of life.

Senator HUGHES. Do you conduct any educational programs dealing with drugs and narcotics?

Colonel HASSAN. Yes, sir. Also, with the information, the photographs of the debilitation of heroin and other drugs on the human system, with the knowledge of where the drugs come from, how they get into the United States, who benefits from the sale of illegal narcotics, and what it does to the citizen, the Negro.

Senator HUGHES. You do this in the public school system?

Colonel HASSAN. Yes, sir. We have gone to practically every high school in Washington, D.C., and many of the elementary schools. I believe at the present time Colonel Rafig, my assistant commanding officer, is negotiating to acquire classrooms at District of Columbia Teachers and McKinley Tech., so that we may have permanent classes.

Senator HUGHES. At what age do you think children must be reached?

Colonel HASSAN. I would say approximately 7 years old, Mr. Chairman.

Senator HUGHES. 7 years old?

Colonel HASSAN. Yes, sir.

Senator HUGHES. How about their parents? Do you conduct classes for adult education?

Colonel HASSAN. Yes, sir, and we are heavily trying to restimulate into the minds of the parents to attend. The only place we think where we can get everybody together are the PTA meetings, et cetera.

We have checked out PTA meetings where there may have been 1,200 students in the school and there have been 10 parents at PTA meetings. This is where we are trying to put it back into effect.

Senator HUGHES. You are trying to build them back up that way?

Colonel HASSAN. We are trying and we have a small degree of success at the present time.

Senator HUGHES. You were talking earlier about the size of the abuse and heroin problem here in the District of Columbia. Are drugs and heroin and narcotics available readily in the jails as well as in the prisons in this area?

Colonel HASSAN. I have not been in jail in a long, long time, Mr. Senator.

Senator HUGHES. You talk to a lot of men who have been.

Colonel HASSAN. Yes, sir, but from the reports that come out of the jails the problem is not as great according to these men as it has been reported to be. Of course there are illegal drugs and narcotics

being smuggled into the jails but there is no money in the jails, Mr. Senator—very little money. You cannot buy narcotics with cigarettes. A very privileged few are the ones who get hold of heroin, et cetera, but there are other amphetamines and barbiturates that are available within the premises.

Senator HUGHES. Have you an opinion as to how many of the children who go through the District of Columbia schools have experimented with and use marihuana by the time they graduate?

Colonel HASSAN. Because of not having sufficient knowledge of all of the numbers of children, I cannot estimate actually how many children have experimented with it, but it is a frightening thing when you go to a school and the youngsters say, "Let everybody do their own thing," and these youngsters are 13, 14, and 15. They are literally saying, "If we want to use drugs, it is our business." Someone is putting that into their minds.

Senator HUGHES. That is not only in the District of Columbia schools; I find it that way all over America.

Colonel HASSAN. It is, sir.

Senator HUGHES. Not only with ghetto children, but with some of the wealthiest children in America.

Colonel HASSAN. It certainly is.

Senator HUGHES. They say that if they want to do their own thing it does not make any difference with what they are doing it, they ought to be allowed to go ahead and do it.

Colonel HASSAN. Sort of like a breakdown of the family structure, Mr. Senator.

Senator HUGHES. Yes; it is. You have made a lot of other observations of the use of marihuana, have you not?

Colonel HASSAN. Yes.

Senator HUGHES. In your experience and contacts with people who come to you for assistance and help?

Colonel HASSAN. Yes, sir.

Senator HUGHES. I don't know whether you have a technical or scientific ability to determine or not, but I am continually confronted with this question that keeps arising about violence in relation to marihuana. What effect does marihuana have upon the person who has used it?

Colonel HASSAN. I have seen very little indication of marihuana producing violence. But what I have seen, Mr. Senator, is something that causes that very young mind to be susceptible to another suggestion, and this is the greatest danger. The euphoria, the high, the time when they believe that their mind is expanding greatly, that they can do anything, but they cannot really do it when they are high and then right after they get high they go to sleep.

I have seen young people induced to take heroin because they have been told to "try this pill; it will get you high faster and keep you there longer." This is what causes the youngster in many instances to weaken and begin to use heroin rather than smoke marihuana.

I also know that there is a danger for a young mind or any mind for that matter in smoking marihuana. I have read scientific reports that are very reputable that indicate brain syndromes and many other things as a result of using marihuana. I know that the respiratory

system is alternately slowed down too slow and raised up too high and the blood pressure can also be reduced very greatly by smoking marihuana and it is dangerous, particularly to a young body and a young mind.

I do not advocate the legalization of marihuana. I advocate that it should be investigated, definitely and positively, to find the answers.

Senator HUGHES. Where do you place alcohol in this entire range of mind-expanding drugs and intoxicants that we have in this country?

Colonel HASSAN. Mr. Senator, if I had my way I would do away with it. I believe that alcohol was one of the things used and is one of the things used to confuse. It may be legitimate and legalized, but it also is a dangerous narcotic and that is exactly what it is. We teach our people not to drink. We teach them not to drink because of economy maybe more than anything else, because they cannot afford to drink, but we know the effects of alcohol on the system and on the human body and on the brain.

We have seen many of our fathers die from acute alcoholism; I, for one, have seen that.

Senator HUGHES. As I understand it from reading the papers, Colonel Hassan—and anything I say is not meaning to invade your privacy in any way—but you have shown an extreme willingness to discuss anything anywhere—

Colonel HASSAN. Yes, sir.

Senator HUGHES. You have had some difficulties with the Justice Department. Is that true and, if so, could you tell us about it?

Colonel HASSAN. I believe it relates to our use of methadone, Mr. Senator. It was reported that we were illegally purchasing and dispensing methadone. However, at the time we were using legitimate prescriptions written by Mr. Claude G. Walker, our resident physician, for the drug dependent. When they said we were illegally dispensing it, also, that was before anyone bothered to come up and see what we were doing, to see if we were able to control the medication, to see if we were able to have quantities of medication on the premises without being stolen and go out to the black market as it was about to begin.

Our medication was kept in a locked safe and under guard. We issue one tablet at a time, two at the most, and that is usually during the first 3 days of a person's withdrawal from heroin. This is the only area that I could see where we might have been on the borderline regarding the Justice Department's activities. The U.S. attorney's office told us to stop purchasing and administering methadone. We were forced to and when we did our program was slowed down quite a bit. It was also said that we did not have urinalysis equipment. Unfortunately for us, the urinalysis equipment that we were in the process of purchasing was destroyed in a fire that happened at our building on Georgia Avenue. The fire was created by an arsonist. We are recreating that urinalysis equipment.

Our biggest problem is that the Bureau of Narcotics and Dangerous Drugs has not told us what they want us to conform to, what they want us to do. We want to do it and we have been wanting to do it since January 8, but we don't know what to do so we have to keep

right on like we are going. We are still purchasing the medication on prescription form and we are still administering it in a 10- or 5-milli-gram tablet at a time.

Senator HUGHES. And this is withdrawal?

Colonel HASSAN. Yes, sir.

Senator HUGHES. How long does it take you to withdraw a patient?

Colonel HASSAN. We have withdrawn people in 7 days. We have had some people in the program 6 months. Because we must—well, the medication takes care of the pain but we must psychologically withdraw them. We cannot quite credit ourselves with being psychiatrists, et cetera, so we call it educational therapy and it takes just a little longer. There is no set time period, Mr. Chairman, but 90 days, if we can hold that person in-house is sufficient time.

Senator HUGHES. If you can hold them in now about 90 days you say you can successfully withdraw most of them?

Colonel HASSAN. Yes, sir.

When I say in-house I don't mean keep him living with us or in one of our centers, keep him returning, visiting. Most of our registration, most of our daily treatment is outpatient. These are men and women who go to work every day to support their families who are trying to break that scourge of heroin addiction that is trapping them when they were just having fun at parties, et cetera. These are men and women who have not been arrested for a crime, who have not been arrested for narcotics. These are men and women who are part of the secret society in the drug world and they don't really want anyone to know. So we are trying to help them as they need to be helped.

Senator HUGHES. Have you asked Justice for written guidelines for methadone distribution?

Colonel HASSAN. Yes, sir.

Senator HUGHES. What has been their answer?

Colonel HASSAN. I have heard nothing from them, sir.

Senator HUGHES. You never even got a reply to your request?

Colonel HASSAN. No, sir. The reply was a request to Dr. Lewis who visited our center.

Senator DOMINICK. Who?

Colonel HASSAN. Dr. Lewis—I believe his first name is Edward—visited our center and appeared to be very pleased with what he saw, at least the potential that was at our centers, but we have received no correspondence or anything else from him. He did not even give us an idea of what we must comply with.

Senator HUGHES. Colonel Hassan, I happened to catch Mr. Dupont on television yesterday, I don't know whether you saw the show or not. Apparently you have some disagreement in the negotiating process, and I don't want to inject myself into that at the present time, but it appeared as though you may have been denied aid because of your political views or political activities. Would you care to comment on that?

Colonel HASSAN. Well, I had to smile. I didn't see the program, myself, Mr. Senator, but many people called me and told me about it and they had perhaps a misconception of a lot of it, also.

But Dr. Dupont is political, why can't I be political? What would deny me as a man, as an American, as a citizen of Washington, D.C.,

the right to be political if my political activities are not to destroy, if my political activities are to build? I have the right to be a political man and to do things for my people. I think I would have to.

Senator HUGHES. Senator Dominick asked me to yield. I would be happy to yield.

Senator DOMINICK. Is there anyone in Washington who is not political?

Colonel HASSAN. Not yet, sir.

Senator HUGHES. What is the goal of the Blackman's Army that you are building, Colonel Hassan? That is not connected with the bill we are taking testimony on, but since political views came up maybe it would help me better to understand the objection.

Colonel HASSAN. Full-fledged 100 percent constitutionally amended citizenship in the United States of America. That is what we are working for. Understanding of all of the citizens in the United States, recognizing that we have overcome the dark spots of history as far as a certain level of education, understanding that we really understand the obligations of being a citizen of this Nation or any other nation. This is all we ask of any man, that we are economically and educationally integrated into the main streams of the United States of America.

If we get that, then we can live as free and equal people on the face of the earth.

At the same time, Mr. Senator, there are a great number of us in the United States that desire to migrate. I might desire to migrate for the adventure alone, to be able to enter into a nation in Africa, with, of course, the sanction of that nation, to be able to assist in the development of that nation, to be able to cement the relations between the black people in Africa, the black people in the United States, and also the United States of America in whatever African nations we enter. We are trying to say that in 1957 if a larger number of people that went to Africa in the Peace Corps had been us, then perhaps even China would not be there as she is now. Perhaps we could have dealt a little differently. These are things that happened in the past that teach us what to do now, so that we can take care of the future.

This is our political activity, Mr. Senator.

Senator HUGHES. I have read some stories and heard rumors, of course, Colonel Hassan, about the nature of your activities. This is a friendly question, allow me to take it off the top of my head—it is somewhat difficult for me to state—about the actions you have taken to suppress drug distribution. Would you care to discuss that?

Colonel HASSAN. In reading the history of the United States, Mr. Senator, I read about the vigilantes. I recognize that if it had not been for the vigilantes of the past there would not be much of a United States right now maybe. That problem is the same thing in the areas where we live. We look around us and there is a man down the block selling narcotics and he sells it to schoolchildren. We ask the police and because of the technicalities, the red tape to take care of it, they cannot do it.

We feel that if we cannot stimulate action on the part of government to move as the citizenry moves that we are not going to get the job done. We have not killed anyone, Mr. Senator, we have closed a

few houses. We have not beaten anyone, Mr. Senator, we have told them we would. But we know that if we expose the men who are dealing in narcotics to the eyes of the public that that can stop them. We know that if we turn this information over to the law enforcement agencies and we will assist in apprehending them, that that can clean up the neighborhoods from something that will keep it from constantly falling down.

Senator HUGHES. If you turned in 100 distributors' names and only had action on three, I would say that is a pretty poor record.

Colonel HASSAN. I would say that is all I have seen, Mr. Senator. There may be more. I have not really kept track of it. All I want to do is get the information and give it to the Bureau of Narcotics and Dangerous Drugs and see if there are some changes made in the community.

If there are not, then we will be forced to ask the people who are selling drugs to stop doing it, and we have no fear of that.

Senator HUGHES. Colonel, I am going to defer to Senator Dominick here, rather than pursue this. I will be back with you.

Senator Dominick has been working with me all over the country on these hearings, and the two of us have conducted most of them along with Senator Javits. I am going to allow Senator Dominick the opportunity to ask some questions.

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Thank you, Mr. Chairman.

Colonel, I am glad that you are here.

I have had a chance to scan your statement. There are a number of things that I am extremely interested in, but I think perhaps we ought to lay some groundwork here. If these questions become in any way difficult or embarrassing for you, why, just say so, and I will go off on another tack. I am not trying to do that.

Colonel HASSAN. All right, sir.

Senator DOMINICK. I am trying to lay some groundwork.

First of all, how did you get your title?

Colonel HASSAN. In 1966, 40 men and myself came together in Washington, D.C., and they elected me a colonel in an organization that had a military structure.

Senator DOMINICK. So you created your own group of people, and you are the head of it. Is that right?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. And you put this in terms of army titles or military titles, I will put it that way, in order to designate leadership within your group?

Colonel HASSAN. Yes, sir, and because, Mr. Senator, we recognize at this level a military form of organization is the most effective to reach an objective.

Senator DOMINICK. Now, Colonel, using your title, could you give me some idea of your educational background? You obviously speak very well and have a good command of English and the subject matter at hand. What is your educational background?

Colonel HASSAN. No. 1, Mr. Senator, I am 46 years old. Completed high school and had 9 years of prison and 3½ years of the military. I received my education by experience because I had a desire to be

able to communicate some of the things that were a little cloudy in my mind.

Senator DOMINICK. In terms of formal education, you completed high school?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. And 3 years in the military?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Where were you in the military?

Colonel HASSAN. I was in the Pacific, sir.

Senator DOMINICK. With the Army?

Colonel HASSAN. With the Air Force.

Senator DOMINICK. And this was during World War II, or Korea?

Colonel HASSAN. World War II.

Senator DOMINICK. World War II?

Colonel HASSAN. Yes, sir.

Prior to that, Mr. Senator, I was in Petersburg Federal Reformatory at 17 years old, and when I was in the Petersburg Federal Reformatory, that is when my education really began, because there, with Nazi prisoners of war, Fascist prisoners of war, members of the Ku Klux Klan, both as prisoners and guards, there were Black Muslims that were arrested refusing to go into the draft, and Indians from Virginia who refused to go into the military.

Senator DOMINICK. When?

Colonel HASSAN. Right before and during World War II.

So my education began in a very strange way, it was a political education, and I imagine that is why I say that I am political. But that does not mean I am a Democrat or a Republican or Communist or anything else. I am a man who wants to be able to live in a Nation.

Senator DOMINICK. I didn't realize that there were any Black Muslims at that time.

Colonel HASSAN. Yes, they have been around a long time.

Senator DOMINICK. When was that organization started? Do you know?

Colonel HASSAN. Well, I don't exactly know, but the Honorable Eliza Muhammad has been teaching the religion to people for 37 years, that I know of. I am glad he is around.

Senator DOMINICK. Your group is separate and apart from that?

Colonel HASSAN. They are not our leadership, no, sir.

Senator DOMINICK. Do you cooperate or coordinate with them?

Colonel HASSAN. No, sir, but we are on friendly terms.

Senator DOMINICK. How many people do you have in your army?

Colonel HASSAN. Throughout the country, we have registered 7,000, Mr. Senator.

Senator DOMINICK. Within your own group?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Of which you are the commander?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Does anyone in the Black Development Center have either scientific or medical background?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. How many?

Colonel HASSAN. I do not know, Mr. Senator. I have never given it that much thought.

Senator DOMINICK. Do you have doctors there?

Colonel HASSAN. Yes, sir, we do. Volunteer doctors, and doctors that have become members of our organization.

Senator DOMINICK. Both?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Is your membership restricted to black people?

Colonel HASSAN. No, sir, not Black Man's Development Center. Black Man's Development Center is open to all people.

Senator DOMINICK. Yes, but your group that is actually doing the work, are they all black?

Colonel HASSAN. Yes, sir; In the army, we are all black, but in Black Man's Development Center, we are not all black.

Senator DOMINICK. Are you treating blacks only, or blacks and whites?

Colonel HASSAN. Blacks and whites, sir.

Senator DOMINICK. What is your breakdown? Do you have any idea?

Colonel HASSAN. Out of the 13,000 registrants, approximately 3,000 whites.

Senator DOMINICK. Out of the number of people who are conducting this treatment, how many blacks and whites in proportion to each other?

Colonel HASSAN. I would say it is about 30 to 70, 30 percent white and 70 percent black. Most of the whites that are with us now are the professional, medical people, et cetera.

Senator DOMINICK. Who is actually in charge of the work of the development center?

Colonel HASSAN. I am, sir.

Senator DOMINICK. Who is your deputy, Colonel?

Colonel HASSAN. Colonel Rafiq is my deputy, sir.

Senator DOMINICK. These are names that you have taken since you went into this army. Is that right?

Colonel HASSAN. I had mine quite a few years prior to that, but most of them have taken those names since becoming part of the organization.

Senator DOMINICK. When you become a member of this organization, do you have initiations, or things of this kind that you have to go through?

Colonel HASSAN. An education, sir.

Senator DOMINICK. It is an education?

Colonel HASSAN. Yes, sir; and that is an initiation in itself, to take the cobwebs of many years of confusion from the minds of some of the men and women who come.

Senator DOMINICK. Do you have to swear to an oath.

Colonel HASSAN. A very strange kind of an oath; yes, sir. If I might, I would like to tell you what it is.

Senator DOMINICK. If it would not be embarrassing to you, I would like to hear it.

Colonel HASSAN. It is not embarrassing.

"Be it known to all people that I, a black man, from this day forward absolutely and completely renounce and abjure all former habits in their entirety that have retarded the advancement of black men

toward the equal station of all men of the earth, that I will respect the Constitution of the United States of America, and will, when required by law, defend the Government from physical attack, and that I will labor in any capacity to bring about the fulfillment of the principles and aims of Black Man's Development Center."

That is the simplicity of our oath, sir.

Senator DOMINICK. Well, I certainly don't see how anybody could find fault with that, sir.

Colonel HASSAN. We intended it to be that way, sir.

Senator DOMINICK. You say that you have 13,000 drug users who have registered with you since inception, which is a little less than a year ago. These obviously must come not only from the District, I would think, but also the surrounding area. Is that correct?

Colonel HASSAN. That is correct, sir.

Senator DOMINICK. How far away are we talking about in terms of registration? Just in this area, or around the country?

Colonel HASSAN. Gaithersburg, Md., is about the farthest out that we have registered so far.

Senator DOMINICK. Amongst those who have registered, there are about 3,000 whites?

Colonel HASSAN. Approximately, sir. Approximately 3,000 whites.

Senator DOMINICK. Now, when they register as a drug user, do they register for the purpose of treatment, asking for help to cure themselves?

Colonel HASSAN. Yes, sir; they do.

Senator DOMINICK. Are we talking about heroin users, or are we talking about people who were taking barbiturates, or speed, or amphetamines?

Colonel HASSAN. Heroin, barbiturates, amphetamines, cocaines, methadone, and drugs that are addictive.

We have had a little problem in attempting to reach some of the young people who have taken LSD. We have found very little problem, but I believe I understand some of the dangers and the usage of marihuana.

Senator DOMINICK. You have not had many people, I gather, come in and register because they are using marihuana.

Colonel HASSAN. No, sir. Very, very few. In fact, none.

Senator DOMINICK. Now, LSD or speed or some of the other stimulant type drugs are not necessarily addictive, as I understand it.

Colonel HASSAN. They are extremely debilitating, particularly to the nervous system.

Senator DOMINICK. Do people come in with, in the vernacular, this type of hangup to you?

Colonel HASSAN. Yes, sir; an extreme nervous disorder that results from the use of amphetamines and barbiturates, the ups and downs.

Senator DOMINICK. And your program on this, as I understand it, is largely educational?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. You are not giving any drugs to these people to tranquilize them, or do anything of that kind?

Colonel HASSAN. Yes, sir; the doctors authorize us at certain times to give them antidepressants, or a drug, mild antidepressant, to overcome that moment of almost panic. We feel that that is also necessary.

Senator DOMINICK. Do you have any working relationship with other voluntary organizations that are working in this field, such as Synanon or Cenikor?

Colonel HASSAN. Not Synanon in Washington, D.C., but we pattern much of what is called our Halfway House activity after the Phoenix program in New York City.

We investigated that rather deeply, and we saw that a lot of it was beneficial, so we decided to put that into effect with the ideas that we have.

Senator DOMINICK. In the process of registering with your group, do these people also become members of your army?

Colonel HASSAN. No, sir; it is not required.

Senator DOMINICK. But they can if they want to?

Colonel HASSAN. If they qualify.

Senator DOMINICK. In your statement, you say that your drug program is oriented toward cure as opposed to maintenance, and therefore methadone is used in limited strengths so as to alleviate the pain of withdrawal only.

Now, how long do you usually find that you are using methadone in your successful efforts?

Colonel HASSAN. We have used it as far as 6 months before men and women have come in and said, "We don't want any more." We have used it for as short a time as 7 days, and they have said that we have got it together.

It is something that I do not believe, Mr. Senator, can be stabilized. The low cost of the methadone that we are using, I think it is worth going 90 days or even 6 months, or maybe even a year, if it were necessary, that the milligram content were extremely low.

You see, Mr. Senator, even though we may start at 20 milligrams, we have a gradual diminishing of the amount of medication to zero. We try to bring it down every 10 days.

We have recently devised a method for those who would come in to live with us a 10-day period of physical withdrawal, and then we, of course, at the same time entered into the education affairs to assist in psychologically withdrawing them from drug addiction.

Senator DOMINICK. In some of the testimony that we have received from some of the voluntary organizations, they have taken the position that you should not give an addict any type of withdrawal drug at all, nothing. They just let him sit there and sweat it out.

Have you tried that type of method?

Colonel HASSAN. Yes, sir; we tried that type of method. We tried that method before we discovered and decided to use methadone.

It worked in some cases, but it took a deeper understanding on the part of the person that was withdrawing for him to stick it out and overcome it.

I have seen, Mr. Senator, men who have gone to prison, maybe they went to prison at that moment when they were attempting to get money to get heroin. I have seen these men stay in prison for 10 years, and just as soon as they come out, even though they kicked, as it is called, cold turkey in prison, they go right to get that shot that they were trying to get when they went to prison.

So the cold turkey is not necessarily a defense. In my opinion, again, it is the education.

Senator DOMINICK. What reports or forms do you have to turn in to the Public Health people or to doctors or anyone else, when you get methadone and distribute it?

Colonel HASSAN. We have, of course, the prescription blank that is filled out by the doctor and signed by the doctor, Dr. Walker or whatever doctor that is authorized to sign them.

We have requisition forms that we keep for the dispensation of the delivery of medication to each of our centers.

We have the daily worksheet that records the name of every person we issue medication to, and the milligram dosage.

We have the workcard for the person that has the same information about the medication entered on it.

That is about it, sir, as far as the medication control is concerned.

Senator DOMINICK. How, do you have to turn those in, or are they just available in case anyone wants to inspect them?

Colonel HASSAN. I am a little afraid of the availability of records, Mr. Senator, only because the drug society again is a secret society.

If I might try to explain for a moment. The youngster who has experimented with narcotics, the only ones that he tells is his peer group. After experimenting for a period of time, he finds the narcotic, marijuana, heroin, or otherwise, that gives him the euphoria, or that false sense of physical well-being that he is seeking, and then he becomes a user of that particular narcotic. He gets a habit at that level. He is in the habit of using that particular drug.

Senator DOMINICK. It need not be addictive, but it is a habit?

Colonel HASSAN. It is a habit; yes, sir. If it is an addictive drug, and he continues to use it, sooner or later something very, very drastic is going to happen to him.

If you would say to that person, "You have a habit. You are hooked," he will tell you, "No, I am not," simply because he has not tried withdrawal. But one day sooner or later, again, he is going to not be able to acquire his fix, as it is called, and that is when the pain is going to hit him, and at that moment, that is when he becomes an addict. Then he will continue to use that drug, and do everything he can to raise the money to buy it, and he will become totally dependent upon that drug.

The drug dependent has a short period to go before he becomes a junkie, and that is exactly what it means, that they will put anything into their veins, still attempting to reach the euphoria they reached when they were experimenting with drugs, and it is almost impossible.

Senator DOMINICK. Now you, I am sure, are aware of the English system of voluntary shots at a clinic when you are a registered narcotics user. What is your opinion on that?

Colonel HASSAN. Mr. Senator, when a person uses heroin, the tolerance level tends to grow. There is never a time when they can stabilize their desire or need for heroin. It continues to grow on and on.

I know that if a person goes through the stage of experimentation using drugs, he will become addictive to drugs, become dependent on drugs, that he is going to become a junkie. We also know statistically that the maximum life span of a junkie that is free is 2 years.

Somehow, it appears to me that the English system fails to recognize the values. In order to solve the problem of illegal drugs, et cetera, they give away a narcotic that is bound to kill the person that is using it.

In my mind and in my heart, I could not live under such a system, if I saw it existing around.

Senator DOMINICK. I bring that out because a number of people in various publications have said that the only problem with heroin is the crime that induces the addict to indulge in it—the need to get money in order to buy heroin. They reason if you let the addict have heroin when he needs it, you would not have these other problems.

I don't think this is very good logic. I wanted to get your attitude on it.

Colonel HASSAN. No, sir; I don't think that is accurate. I believe also that one of the big problems with heroin is, well, the Mafia and the importers of the narcotics, that is who really benefits from it.

Of course, that person has to continue to steal, but who benefits from the money? That man who gets into the country, that man who distributes it throughout the United States.

These are the people that would not benefit if such a program like is in Britain was put into effect in the United States, but still, again, the user of the heroin is going to die. His system will demand and crave more and more of the heroin.

Senator DOMINICK. Colonel, during one of your answers to a previous question, I believe you referred to your development centers in the plural.

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Do you have more than one?

Colonel HASSAN. Yes, sir, Mr. Senator. We have four centers operating in Washington, D.C., at the present time. We want to open about 15 more, if we can ever get around to it.

Our headquarters are at 6406 Georgia Avenue NW. We have the center that is a neighborhood center in the Mount Pleasant area of Washington at 1642 Newton Street NW. We have another center right in the heart of the drug traffic, right in the heart of the misery, in the 1300 block of T Street NW. The fourth center is located in another drug center and that is in the 1400 block of H Street NE.

We have a strong, urgent desire to go to the Southeast, where there is a problem almost beyond my imagination, according to the reports, but we cannot get there yet.

Senator DOMINICK. When you say you cannot get there, you don't have the necessary funds?

Colonel HASSAN. That is correct.

Senator DOMINICK. Or it would be too dangerous?

Colonel HASSAN. We are not scared of the danger. We have fears, but our problem is, of course, being able to afford to go.

Senator DOMINICK. In your statement, you refer to the fact that the centers have been utilized by the court of general sessions, and approximately 300 releases have been effected, I gather, to the center for treatment. Is this correct?

Colonel HASSAN. Treatment, third party custody to insure the person returning to court on time, working with the bail agency.

Of course, the District of Columbia Court of General Sessions, and several from the U.S. district court, and some from the juvenile court, also.

Senator DOMINICK. What success have you had in your educational program with regard to these?

Colonel HASSAN. With the people released from court, I think we have had the best record, because these people, we have them almost like a captive audience. The first time, they are either in the bull pen or they are in the District of Columbia jail.

So we don't get them out just right away because they say, "Please help us." We might talk with them two or three times, until we determine whether or not this person genuinely desires to stop killing himself, and then we will try our best to help him.

Senator DOMINICK. When you are talking about a good record, are you talking in terms of 40 percent, or 80 percent?

Colonel HASSAN. Of the 300 people released to us through the courts, I would say about 50 percent of them basically have it together, as far as drug usage, the reuniting of their families, employment, or at least a desire to live a better life.

Whether they are going to be successful in maintaining that desire, only the future will tell.

Senator DOMINICK. Do you try and stay in touch with them?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. So that if they have problems, they will call you, or do you call on them at regular intervals?

Colonel HASSAN. Most of the time, after the first stimulation, we ask them to call us at least twice and maybe three times per week, so that we know they are around.

We offer from the beginning any kind of assistance they need, and it has been assistance needed from pain and delinquent rent to putting food in the refrigerator.

Senator DOMINICK. Do you have any records to show how many have been rearrested of those who have been first sent to your group for treatment?

Colonel HASSAN. We can easily determine that, Mr. Senator.

Senator DOMINICK. If you could, and could give us that, I think it would be helpful to the record.

Colonel HASSAN. All right, sir.

(The information subsequently supplied follows:)

BLACKMAN'S DEVELOPMENT CENTER,
Washington, D.C., April 20, 1970.

Senator HAROLD H. HUGHES,
New Senate Office Building,
Washington, D.C.

SIR: In checking our records for the exact number of persons released to us on third party custody through the D.C. Court of General Sessions, U.S. District Court and Juvenile Court, we have to date 270 releases. Our records also show that only 39 releases have been rearrested.

We are also doing a survey on the number of males and females who have served in the Armed Forces of the United States. We will gladly submit our findings when this survey is completed.

Respectfully,

Col. HASSAN JERU-AHMED,
Director, Black Man's Development Center.

Senator DOMINICK. You referred to this before, and I shall not go into it too far in view of the jurisdiction of this particular subcommittee, but I think both the chairman and I are interested in it.

You gave 100 names to the police of pushers, or dealers, whatever we want to call them. My understanding is you said that only about three of them, as far as you know, had been arrested.

Colonel HASSAN. Yes, sir; that is only the extent of my knowledge. There may have been many more, because I know that they were extremely pleased with receiving the names, and they promised to me that they would move to apprehend these people as soon as possible.

Senator DOMINICK. When you talk about these 100, are you talking about the local retail pusher, the fellow who is on the street, or are you talking about the distributor, one step above that?

Colonel HASSAN. May I please make a drug abuse clarification, Mr. Senator? There is a difference between the pusher and the dealer.

The dealer is the man that hires 75 or 100 pushers. The pushers are the people who sell to the young and other people.

At the present time, due to limited funds and various other things, we cannot quite penetrate through to the supplier, the person who supplies narcotics into the District of Columbia.

In 1967, I believe it was, we called the Bureau of Narcotics and Dangerous Drugs, and we said to them, "We can trail a drug dependent or drug user or drug addict very easily to the pusher, and we can trail the pusher to the dealer." Now, that is as far as we can go, but if we could trail the dealer, then we would find the supplier.

That is the man who we really want to stop. That is the man who continues to bring the drugs into the country and into the cities.

Senator DOMINICK. In your statement you refer to the Mafia, the Cosa Nostra, and the Black Syndicate as the three major suppliers, I would think that you would classify them. Is that correct?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Have you been able to penetrate any of those organizations to get accurate information on it to turn it over to the Justice Department or Treasury?

Colonel HASSAN. Some of the names were some of the men that were part of the syndicate that exists in Washington, D.C.

Senator DOMINICK. Now, are most of the drugs that you are dealing with imported from overseas, or are they manufactured within the country?

Colonel HASSAN. Most of the heroin that comes into the United States comes from out of the country. We have been able to determine that narcotics comes from, of course, Turkey through France into the United States, and through other means.

I am aware, Mr. Senator, that narcotics also comes into this country to support the Black Chinese Communist revolution that is going on around.

Senator DOMINICK. And that comes in from overseas?

Colonel HASSAN. Yes, sir.

Senator DOMINICK. Is this also true of the barbiturates and the speed-type drug, or are those locally manufactured and distributed?

Colonel HASSAN. The majority are locally manufactured, to my knowledge. Some of them leave the country and come back in, per-

haps from Mexico and Canada, and come back into the country, but amphetamines and barbiturates are easily available in every city. They can be acquired.

Senator DOMINICK. Now, colonel, and I will be through in just a few minutes here. Where do your funds come from for development of your programs?

Colonel HASSAN. We have created a renovation company, and I think we have a few contracts that we are working on now that earn this money.

Senator DOMINICK. A renovation company?

Colonel HASSAN. Yes, sir; renovation of properties.

We have a printing concern, and extermination business, and I mean vermin.

Senator DOMINICK. A multilegged variety, you mean?

Colonel HASSAN. Yes, sir.

We have a service station. The rest of the money comes from the contributions of the citizenry, and two foundations that have given us small sums of money, that we greatly appreciated, but it is all gone.

Senator DOMINICK. We have had some testimony indicating that methadone is an effective method of approach only for those who are pure heroin users, and I am using the word "pure" as the vital word in this.

Now, what happens where you have people who are using a variety of different type drugs?

Colonel HASSAN. We have seen that with drugs like amphetamines, along with heroin, the results are the same. We have not had to take the person off of the small amounts of medication, simply because of our process of using the medication.

I take it that when you say pure heroin users, that is that person that becomes what I have classified as a junkie, that person who puts anything into his veins.

That person does need maintenance, and I am not opposed to maintenance on that level, but I believe, Mr. Senator, that a greater intelligence must be determined before a person is placed on methadone, a dosage of 60 to 70 milligrams that increases to 135 to 150 milligrams, and then after perhaps a year or two attempt to diminish that person from that medication.

Just thinking about it is something that gives me a little shudder. I don't see how it can be done, when it is even hard psychologically to take them off 20 milligrams per day.

Senator DOMINICK. We have had a fair amount of testimony indicating that the drug educational programs that have been used in the past, where people go around and speak to the kids in the schools and tell them about the evils of drug use, just simply have not worked. In many cases it stimulated curiosity so more people tried them.

Now, what is the difference between that approach and the type of educational program that you are using?

Colonel HASSAN. I believe what I have heard said before, Mr. Senator, that a former drug user, or an addict that got it together, is the best qualified to teach the youngster about the use of narcotics.

Then I have sat in those meetings, many times, and I have seen the man that used to use drugs, and I will say that he used to use them

well. He is well dressed, he is now almost immaculate, he is clean, he has money in his pocket, he has an automobile. He is talking about the scourge of drug use and drug addiction, and the youngsters look at him and say, "You used it, and look at you now." So it does not penetrate into that youngster's mind. He still sees a degree of glamour.

Ours is a little different. We don't try to shock the youngster. We first want to tell him what is happening. We don't believe that it is necessary that a counselor or drug educator has to be an ex-drug dependent, but if he is qualified to convey intelligently to the youngster or the person he is trying to help with the problem, then let him be an ex-drug user, but it is not necessary, because a lot of the people with our organization are not ex-drug users, but a lot are.

The ex-drug dependent that is in most of the programs I have seen is there because it is a good way to make a living, and he can talk about the drugs, but how to cure the person merely is not in most of the programs.

Before we initiated the Black Man's Development Center program, we investigated every one that we could find existing from California, from the west coast to the east coast, and we put together the things that were workable from all of it, along with our ideas, and we came up with something that registered 13,000 people.

Now we have got to create something to keep them all continuing to come back.

Senator DOMINICK. Thank you, Colonel.

I will reserve the rest of my questions and defer to the Chairman.

Colonel HASSAN. Thank you.

Senator HUGHES. How many other drug centers are there around the District?

Colonel HASSAN. At the present time, I think there are four others, Mr. Senator, other than the Narcotics Treatment Agency. There are many attempting to get funding from various agencies, et cetera.

But I think they are all needed.

Senator HUGHES. Are they reaching many people?

Colonel HASSAN. They are reaching a segment of the population, I cannot estimate how many.

Senator HUGHES. Can you identify them for me?

Colonel HASSAN. Of course, the Narcotics Treatment Agency, Bon-A-Bond EFEC, Southwest House, Friendship House, and the other one that has opened recently in the Alexandria area, because we have been treating people from Alexandria, also, that come in to Washington so that they may be able to go back to Alexandria.

Senator HUGHES. Do you have an estimate of the number of drug dependents in the District of Columbia?

Colonel HASSAN. I have been asked that question, Mr. Senator, so many times I hesitate to answer.

We have registered 13,000 and we have not fully reached suburbia, and we have not reached Southeast Washington sufficiently, we have not reached Georgetown and DuPont Circle sufficiently.

So I would be a little hesitant to say how many, but if I gave the figure of 20,000, I would be conservative.

Senator HUGHES. I have had the estimate given to me here that drug dependents in the District of Columbia cost the District a million dollars a day.

Your 13,000 addicts, at a \$70 a day habit, which you gave me earlier, mathematically comes out close to that, without anyone else.

Colonel HASSAN. Yes, sir.

Senator HUGHES. Would you say a million dollars a day cost was probably low?

Colonel HASSAN. Yes, sir, I would say that.

Two months ago when we were before the Senate District Committee, I think the average that we had reached at that day was \$85 per day. As we expanded to more people, of course, the average has come down a little, but it is still at a very high average cost for the drug user in Washington, D.C.

Then he has to acquire through whichever means he can three times the amount of his habit, in order to get the money for his habit. If he steals, if he boosts, as it is called—if his habits are \$100, he has to steal \$300, because the boost is only worth a third, if he gets that, and most of the time he gets heroin in exchange for the goods.

Senator HUGHES. Isn't it also true, and here again this is not within my jurisdiction, but we have had this come up so often about the stealing and the fencing of materials—

Good grief, to turn over this volume of material that is stolen every day in major urban areas would require a syndicate that is massively and delicately organized, would it not?

Colonel HASSAN. The people who buy the goods from the drug addict, Senator, is the ordinary person who lives next door to me, and all over the area.

Senator HUGHES. Is that right? Just buy hot stuff?

Colonel HASSAN. I know that it is quite a temptation when someone walks into the door with a \$500 color television and you can buy it for \$100.

Now, that is where they make their money, not a fence that purchases all of the goods stolen by all of the drug addicts.

Senator HUGHES. It is not organized?

Colonel HASSAN. No, it is the urgency of that drug dependent to get that money together, and he will steal, and he will sell it to his friends. They have a built-in clientele, whatever they get. They even take orders for merchandise.

Senator HUGHES. Some of the friends are as guilty as he is.

Colonel HASSAN. Yes, sir; they certainly are, but they may not understand it.

Senator HUGHES. How about an education program to get them to understand?

Colonel HASSAN. We try to get them to do that, also, Mr. Chairman.

Senator HUGHES. They are contributing to the delinquency.

Colonel HASSAN. I have seen mothers and fathers who really are destitute because their children have drug habits, who purchase stolen goods from drug addicts. So we try to point it out to them what they are doing, they are putting a nail in the child's coffin.

Senator HUGHES. The percentages you give in relation to racial makeup in your programs run almost true with the percentages of the District, don't they? Is that right?

Colonel HASSAN. Very close.

Senator HUGHES. About 70-30?

Colonel HASSAN. 70-30.

Senator HUGHES. Is the black population about 70 percent presently?

Colonel HASSAN. About 70 percent in the District of Columbia, maybe a little more.

Senator HUGHES. In relation to this particular piece of legislation, Colonel Hassan, it has a different approach to the problem of the drug problem U.S.A. Do you believe that drug dependence is an illness?

Colonel HASSAN. Yes, sir; it is an illness. It is a self-induced illness. Heroin is like an acid. It is an acid. It burns, injures the entire person, and the cure for it is very simple. All you have to do is stop using it. But the pain of the cure forces you to need more.

It is also a psychological illness, because it stimulates into that person's mind the belief that he is thinking, but he is sound asleep into the perpetual gnawing of the heroin user.

This is the greatest sickness, Senator, the mental illness that is caused from the use of heroin, and other addictive narcotics.

Senator HUGHES. I don't know whether you are knowledgeable about these particular details or not, but if so, I would like to have it in the record.

Do you have any idea, of the 13,000 registered drug users, how many of them are veterans of the Armed Forces of the United States?

Colonel HASSAN. No, sir, I do not; but thank you. I will make that survey also.

Senator HUGHES. Do you believe any of them to be veterans?

Colonel HASSAN. I know some of them are, many. Yes, sir. Some of them are from the Vietnamese war, some are from the Korean War, and some are from World War II.

Senator HUGHES. If you do make such a survey, I would appreciate having a copy of it filed with the subcommittee.

Colonel HASSAN. I will put it into effect and get you a copy, sir.

Senator HUGHES. Of the few veterans that you could identify, have you had any veterans that come to you that were addicted when they were discharged from the services?

Colonel HASSAN. Mr. Senator, we have military men that come to us.

Senator HUGHES. That are still in the service?

Colonel HASSAN. That are still in the service; yes, sir.

Senator HUGHES. And they are addicted?

Colonel HASSAN. Yes, sir.

Senator HUGHES. How can they get by with this, do you have any idea?

Colonel HASSAN. I think maybe it is because, as it is with most people in the country, they don't understand drug addiction, they don't know what to do about it.

Mr. Senator, even in the medical schools the doctors are not taught about drug addiction. They are taught about the effects of drugs on the human being, but they are not taught about drug addiction, what causes drug addiction.

I would say that perhaps a man like Dr. Dupont, who has had the experience of dealing very closely with drug dependents, and maybe Dr. Besteman, who has had the experience of dealing with drug dependents in Lexington, Ky., have more knowledge than any other phy-

sicians in the country, except one that is working with the drug treatment or drug cure program.

Every one of the doctors that assists our program has admitted to this fact, that they are not trained as far as drug addiction is concerned.

Senator HUGHES. You seem to indicate that you feel that experimenting with and using marihuana—if I followed you correctly—conditions the mind so that it is more susceptible to the usage of other drugs and narcotics. Is that correct?

Colonel HASSAN. Yes, sir; I do say that.

Senator HUGHES. And from your experience, you believe that is a fact, that it does condition the mind?

Colonel HASSAN. Dependent, of course, upon, I would say, the psychic mentality of the person, young or old, that is smoking marihuana, that if there is that opening, that opening of frustration, they can be induced to try heroin or another drug very, very simply. I have seen it done. It is not a physical dependency, Mr. Senator.

Senator HUGHES. Yes; I understand.

Then if I might ask you a couple questions in a different direction, Colonel Hassan. We have had testimony before the subcommittee in relating to public service educational programs on television and radio.

Do you think a public service program aimed into the problem areas of your city is going to have an effect on the children that you are familiar with on the streets the same as it would on the children in the area that I live in, for example—which is out in northern Virginia?

Colonel HASSAN. When we opened in June our center at 14th and V Streets, Northwest, in a burned-out building, we plastered that building with posters and flyers and handbills, "Slavery '69" posters that we got from the National Institute of Mental Health, we distributed those posters and flyers in 16 cities.

The education from the posters alone, along with what we were trying to teach the people, this is what brought the people to our doors.

Senator HUGHES. It did bring them in?

Colonel HASSAN. Yes, sir. We had massive distribution of some of the information that is in the two envelopes that I have given you, the handbills, the flyers, the bumper stickers, the decals that we put out in the streets by the thousands, the hundreds of thousands from our headquarters on Georgia Avenue.

This is what brought the drug user, the drug addict, to our doors. We asked them simply to check it out, that we think we have found a way to help, and they came, and then word of mouth spread what we were attempting to do all the way to northern Virginia, and they came to the tune of 13,000.

Senator HUGHES. Contrary to the public opinion that the drug problem is only prevalent in urban schools, we had a problem erupt in my own State of Iowa in what would be considered a rather mild

small town atmosphere involving dozens of students involved in drug abuse. Only a few weeks earlier, we had heard testimony that basically there was little or no problem.

We find this all over the country—school officials testifying to one thing, and students testifying to another. If we can get the students to testify—and strangely enough, we do get them to testify, they are very courageous in wanting to talk about this—really they want someone to communicate with.

We have been spending most of our time here today discussing getting people out after they are already in.

Now, you are concerned, and you have dedicated a lot of your time to keeping people from getting in?

Colonel HASSAN. Yes, sir.

Senator HUGHES. In other words, stopping the input into this mechanism, while at the same time trying to do everything we can to get the people out of it.

Colonel HASSAN. Yes, sir.

Senator HUGHES. What in this bill relates to what you feel we can do in educational programs in schools? You said we should start at about 7 years old.

Colonel HASSAN. Yes, sir.

Senator HUGHES. Trained teachers?

Colonel HASSAN. Yes. We have been somewhat successful in meetings with teachers and faculty at universities, et cetera in telling them what to look for and once they discover that the person is using a narcotic, how to handle him, how to get him someplace where he can receive help. At the same time, of course, the parent-teachers' association meetings.

Every child in the country is compelled to go to school. It is a captive group, it is a captive gold mine. Many men have recognized this, Mr. Senator.

If we don't stop the drugs going in by educating the parents and the teachers that must sort of like look out for the children in their care in the schools, the teachers are always going to say that there is no drug problem, simply because they will not know what to look for.

I believe that there should be a constant flood or flow of literature and information to the teachers as part of their education about a problem that exists in the country. We have attempted to do it with our meager facilities.

Senator HUGHES. As a black man, you have had a lifetime of dual standards of justice, I would imagine.

Colonel HASSAN. Yes, sir.

Senator HUGHES. Is it the general policy in the District of Columbia—or do you know—if a youngster is apprehended or if a youngster would seek assistance from a teacher in one of the District schools, would they then be expelled from school because they were using drugs?

Colonel HASSAN. Perhaps in the past a lot of them would have been expelled. Most of the schools that we have reached, we have asked

them to send them to us. I know of at least three instances where a youngster has been turned over to our organization for a period of 2 weeks, so that we might educate him and take him off of the addictive drug.

Senator HUGHES. Who did they call first, you, or the police?

Colonel HASSAN. This time I think they called us first because they didn't want to call the police because then it would be a punitive measure instead of a curative measure, punishing the youngster instead of helping the youngster, frightening the younger instead of soothing his fears.

So some of the teachers have called us, and some of the policemen discovering young children using drugs have brought them to us, and we have helped as many as we can.

We have not been successful with all of them, because of parental control, and we certainly will not infringe upon that, but we try to educate the parents, once they know that that youngster is using drugs.

Senator HUGHES. Do you believe that a drug user wants to get out—I am told that practically all of them reach a point where they want out. Is it a question of, when they feel that way, is help available?

In my own State, a young man went into the county hospital, a heroin addict, and asked for treatment—to be withdrawn. The intern called the police, and the police and the doctor told the addict that when he gave them the names of his suppliers, he would be treated, and not until.

Now, I have found this to be a rather common practice around the country.

Colonel HASSAN. That is my greatest fear in revealing the names of this secret drug society that is registered with our organization, because in order to eliminate the problem, perhaps certain members of the law enforcement agencies may extort names of other people, may even put that person in jail to give them a prison record, if they do not give their names.

I don't think this is a tactic that should be used by the police.

Senator HUGHES. This seems to be dividing our society, Colonel, and that is why I was raising all this double standard idea again.

Now, what are we doing? All of us I think want to be friends to the police, trying to get the distributor, the dealer, the supplier, on up that line—the intercontinental shipments.

I know that you can nail a pusher and they will have another one back in 24 hours.

Colonel HASSAN. Unless you stop that supply.

Senator HUGHES. Unless you stop the supply some place, and we have got to do it.

You are doing everything within your capability to cooperate with the police to fulfill this function?

Colonel HASSAN. Yes, sir, I certainly am.

Senator HUGHES. Now, the next point: how do we keep from dividing ourselves so we are not looking antipolice, and we are not looking anti-something else, because that is what is happening to us? We are being divided in our purpose.

Colonel HASSAN. I think it is education again, Senator. We try every time we get the opportunity to tell everyone individually and collectively or otherwise that the man that is selling the narcotics lives in the same block where you live, and you will know if you just keep your eyes open who is selling narcotics in that block.

It is best to know what to look for. Then, if you know that that man is selling drugs to other children, sooner or later he is going to sell it to your child. It does not make any difference to him.

If you refuse to inform the police, as we say in the Black Man's Development Center, that is a cowardly act or an unintelligent act. That is the way we can stop it. Educate the population about what it really means to snitch, as they say in the juvenile fashion, about a person who is selling poison.

We are not like that at Black Man's Development Center, and when we find one, we will let the officials know. If the officials can't stop him, then we are compelled to do whatever we can to keep him from selling narcotics in our neighborhood. He is going to move out of the neighborhood, but when he moves out of the neighborhood, then you have, of course, got to stay right behind him until we can compel law enforcement to deal with him as it should be.

Senator HUGHES. If there were one thing you could say to a group of youngsters around this country who have attempted to experiment with drugs and narcotics, what would you say, Colonel?

Colonel HASSAN. I would tell them first that the pleasure of living is far better than the mystery of dying, and if they don't understand it right now, they had best go a little slower before experimenting with any narcotic.

That is about the only thing that you can really tell, because they are caught up into the glamour of the drug society. They are caught up in the glamour of—well, there is a glamour to poverty, when the man who lives in the same block with you has a shiny new car, and he wears good clothing, and he does not work. You want to be like him, because he seems to have it made.

We ask them to think a little bit about it. The responsibility lies, of course, with Government, it lies with the parents, and it lies with the educators.

I believe, Mr. Chairman, that the educators have to be educated so that they may in turn teach the children how to save their lives. We tell him, "Don't use any of it," but we don't know if it would work in that manner.

Senator HUGHES. Senator Dominick, do you have some more questions?

Senator DOMINICK. Just one more, Mr. Chairman.

Colonel, you have this figure of 13,000 drug users who have been registered since inception. How many of those are still on your list?

Colonel HASSAN. 1,611 treatments as of Saturday, sir, daily.

Senator DOMINICK. Are more people being registered all the time?

Colonel HASSAN. Every day new people, and now returnees to the program.

Senator DOMINICK. So some of the ones who thought they were cured found out they were not, and are now coming back?

Colonel HASSAN. Some of them who came first came for that respite that Senator Hughes mentioned, that come so they could save a little money, some of them became weekend drug users. Some, of course, cured themselves. Some came maybe for the meal, but they came, they stayed a while, they left, they are returning. I hope we can get them all back.

Senator DOMINICK. Your percentage of total cures, then, you would estimate as below 50 percent, but that you are still working on it?

Colonel HASSAN. At the present time we have not been able to really follow through to find the total cure. The people have decided emphatically and are doing everything they can not to use drugs any more.

The way we tell is their revisits to our centers, and they don't need the methadone, but they come back for the educational therapy. That is the cure, for us.

Senator DOMINICK. To try and summarize, then, again, you feel that we need to make an all-out approach, cooperating with the police and the Government as well as voluntary educational groups. Is that correct?

Colonel HASSAN. Yes, sir, Senator.

Senator DOMINICK. Thank you, Colonel.

Colonel HASSAN. Thank you, Senator.

Senator HUGHES. Colonel Hassan, I want to thank you. You have been very patient, and we have kept you here a long time this morning answering questions.

I have, in conclusion, a couple more questions. Do you think the local community centers in the District of Columbia can handle the drug problem in the District?

Colonel HASSAN. I think they can, if a realistic plan is put into effect. I am not saying, Mr. Senator, that we have the only realistic plan, but I think all of the facilities are available. I think it can.

Senator HUGHES. Do you think that facilities such as yours should also be funded?

Colonel HASSAN. Yes, sir. I would say included into that plan of action.

Senator HUGHES. How about hospital facilities? Do you have any hospital facilities available?

Colonel HASSAN. At the present time, we utilize Freedmen's Hospital. There are doctors on the staff at Freedmen's Hospital, Dr. Matori in particular, that at any time of the night or day we have a very acute case, we can call him and send that person to Freedmen's Hospital for treatment. So we make it available to ourselves whenever we need it.

Senator HUGHES. How many people have died that have contacted you, from drug abuse?

Colonel HASSAN. I know of three, sir. They died in the bull pens of the jails, or the Women's Detention Center. I know of three that have died since we met them as drug dependents, and that was, of course, one of the reasons they did not adhere to the program, and went back to using narcotics.

Senator HUGHES. In relation to alcoholism, if a person quits drinking and makes it 6 months or a year after being addicted for 20 years and then falls back I look at that as a positive step, even though they are classified as recidivists, when they come back.

Would that not be the same thing with a drug abuser, who has been using drugs for a decade, and is then clean for 6 months, and then goes on for 4, and comes out again? It is a rather positive thing, even though it is not permanent.

Colonel HASSAN. Yes, sir. That means he came back to something that helped him for a period of time. If we can help him for a period of time, if we intensify the kind of help, we might be able to help him for a great deal longer.

Senator HUGHES. Thank you very much, sir.

Colonel HASSAN. Thank you.

Senator HUGHES. Mr. Andrew E. Ruddock, Director, Bureau of Retirement, Insurance, and Occupational Health, Civil Service Commission.

Welcome to the subcommittee. My compliments for being patient.

You may proceed with your testimony as you desire, sir.

STATEMENT OF ANDREW E. RUDDOCK, DIRECTOR, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, CIVIL SERVICE COMMISSION

Mr. RUDDOCK. Thank you, Senator.

I have a brief statement which I would like to read, if I may.

Mr. Chairman and members of the subcommittee, I thank you for the opportunity to appear here today to present the Civil Service Commission's views on S. 3562, a bill which would provide for a massive Federal attack on the sickness of drug addiction.

By letter of April 10, 1970, the Commission reported its views on this bill to the Honorable Ralph Yarborough, and with your permission, sir, I would like for that letter to be made a part of the record.

Senator DOMINICK (presiding pro tempore). It will be made a part of the record at this point.

Mr. RUDDOCK. Thank you, sir.

(Letter to be furnished follows:)



CHAIRMAN

UNITED STATES CIVIL SERVICE COMMISSION

WASHINGTON, D.C. 20415

April 10, 1970

Honorable Ralph Yarborough
Chairman, Committee on Labor
and Public Welfare
United States Senate

Dear Mr. Chairman:

This is in further reply to your request for the Commission's views on S. 3562, a bill "To provide a comprehensive Federal program for the prevention and treatment of drug abuse and drug dependence."

Except for sections 301(b)(2), 501(a) and (c) and 502, the bill does not directly affect any programs administered by the Civil Service Commission and our report is therefore limited to comments on these sections.

Section 301(b)(2) establishes a Level V position as Commissioner, Drug Abuse Prevention, Treatment, and Rehabilitation Administration in the Department of Health, Education, and Welfare. On the basis of duties described in the bill, Level V appears appropriate for the position of Commissioner.

Section 501(a) first requires that the Commission, in cooperation with the Administration and other Federal agencies, develop and maintain appropriate policies and services for the prevention and treatment of drug abuse and drug dependence among Federal employees.

Federal agencies are authorized to provide health service programs to promote and maintain the physical and mental fitness of their employees (5 U.S.C. 7901). Under this authority, as implemented by the Bureau of the Budget Circular No. A-72, June 18, 1965, the Chairman of the Civil Service Commission is directed to, among other things, assist the agencies in developing adequate occupational health programs and, the Civil Service Commission and other Federal agencies are to consult with the Department of Health, Education, and Welfare which is responsible for providing agencies with occupational health standards, and for evaluating the agencies' programs in relation to these standards.

Pursuant to the cited authority, the Commission has been and continues to be very active in promoting and assisting Federal agencies in establishing and improving occupational health facilities and

programs. In this effort, the Commission has already developed and widely publicized a model agency program to deal with drinking problems of employees and plans to develop one to deal with drug abuse.

Second, section 501(a) requires that Federal employees who are drug abusers or drug dependent shall not lose pension, retirement, medical or other rights. Of these "rights," the only one that, to the Commission's knowledge, may be lost by a Federal employee is the right to retire because of total disability, which under the Civil Service Retirement law, must not be due to vicious habits, intemperance, or willful misconduct on the part of the employee within five years before becoming totally disabled.

As administrators of the Civil Service Retirement law, we can say that in recent years denial of a claim for disability retirement because of vicious habits, intemperance or willful misconduct has been extremely rare. In disability retirement cases involving alcoholism or drug addiction, the Commission observes the well-established policy of not adjudicating the employee's entitlement on the basis of the possible etiology of his illness but on the basis of the deteriorative changes he has suffered and on the degree of his disability. Where there are no deteriorative changes, the Commission nearly always finds by psychiatric examination that the employee is afflicted with a primary psychiatric disorder and that his dependence on alcohol or drugs is a secondary symptom which does not disqualify him for disability retirement.

Third, section 501(a) requires that a good-faith attempt shall be made to find appropriate nonsensitive work within the Government during the employee's rehabilitative treatment, rather than placing him on sick leave, provided the employee accepts appropriate treatment.

The Commission has no objection to the third requirement imposed by section 501(a) but for the reasons indicated is of the opinion that the first and second requirements are unnecessary and should be deleted from the bill.

Section 501(c) provides that no person may be denied or deprived of Federal employment solely on the ground of prior drug abuse or prior drug dependence, except with respect to extremely sensitive positions specified in regulations promulgated by the Secretary of Health, Education, and Welfare.

The Commission agrees emphatically with the principle that Federal employment should not be denied solely on the grounds of former drug abuse, and current Federal practice carries out this principle. The Commission is of the opinion, however, that regulations governing this area of suitability for Federal employment should continue to be the Commission's responsibility. Further, since Federal agencies themselves are in the best position to evaluate the sensitivity of their own positions, there is no apparent reason for the Secretary of Health, Education, and Welfare to assume this responsibility. The Commission therefore strongly objects to covering Federal employment in section 501(c).

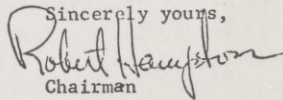
The effect of section 502 is to require the health benefits plans which participate in the Federal Employees Health Benefits Program to cover drug abuse and drug dependence in the same way as other illnesses that are not self-inflicted.

Of the 38 plans that participate in the health benefits Program, the two largest Government-wide plans, in which 80 percent of all employees are enrolled, have no exclusions or limitations on treatment for alcoholism or drug addiction; benefits for treatment of these conditions are the same as for other illnesses, i.e., benefits are payable for necessary hospital confinements and professional medical care, inpatient or outpatient, the same as for other illness. Some of the 36 other smaller plans which participate in the health benefits Program limit benefits for alcoholism or drug addiction or exclude treatment of these conditions from coverage. However, the Commission annually renegotiates contracts for these plans and since 1968 has urged that these exclusions and limitations be removed. In response to this urging, restrictions in many plans were removed in 1969. We believe it likely that all but perhaps a very few will remove their existing restrictions by 1971.

As indicated, the large majority of Federal employees already are in plans that impose no restrictions on benefits. Because the contracts for the various plans are bilateral agreements, the Commission prefers that removal of the pertinent restrictions from the smaller plans that still have them be achieved through negotiation rather than unilaterally through the force of law; we are confident that removal will be so achieved in the reasonable future. For these reasons, the Commission believes that enactment of section 502 of S. 3562 is unnecessary and undesirable.

The Bureau of the Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

 Chairman

Mr. RUDDOCK. The Commission is in complete accord with the broad objectives of this bill—to get at the illness through modern methods of treatment, rehabilitation, education, and prevention.

Only six provisions of the bill are of direct official concern to the Civil Service Commission.

The first, section 301(b) (2) puts in level V of the executive salary schedule the proposed Commissioner of the proposed new administration. Level V appears to be appropriate for the position as it appears in this bill.

The second provision, section 501(a), would require the Commission, in cooperation with the administration and other Federal agencies, to develop and maintain policies and services for the prevention and treatment of drug abuse among Federal employees.

Federal agencies are authorized to provide health service programs to promote and maintain the physical and mental fitness of their employees (5 U.S.C. 7901). Under this authority, as implemented by the Bureau of the Budget Circular No. A-72, dated June 18, 1965, the Chairman of the Civil Service Commission is directed to, among other things, assist the agencies in developing adequate occupational health program, and the Civil Service Commission and other Federal agencies are to consult with the Department of Health, Education, and Welfare, which is responsible for providing agencies with occupational health standards, and for evaluating the agencies' program in relation to these standards.

The Commission has been and continues to be very active in promoting and assisting Federal agencies in establishing and improving occupational health facilities and programs. Under existing authority, the Commission can and intends to develop a program concerning drug abuse in cooperation with and after consultation with appropriate agencies of the Government.

In view of this, it is our opinion that this specific provision in the bill is unnecessary.

Senator DOMINICK. Would you prefer to go through your statement, or would you like to have questions as you go?

Mr. RUDDOCK. I would prefer to go through it, but I leave it at your pleasure.

Senator DOMINICK. All right.

Mr. RUDDOCK. This section would also require that no Federal employee lose any rights, including specifically "retirement rights," because of drug abuse.

This requirement is also unnecessary. The only right that can be lost is the right to a disability retirement annuity, which under the civil service retirement law cannot be based on a disability resulting from vicious habits, intemperance, or willful misconduct on the part of the employee within the preceding 5 years.

However, in disability retirement cases involving alcoholism or drug addiction, the Commission observes the well established policy of not adjudicating the employee's entitlement on the basis of the possible etiology of his illness.

Rather, the determination is made on the basis of the deteriorative changes the employee has suffered, and on the degree of his disability. Where there are no deteriorative changes, the Commission

nearly always finds, by psychiatric examination, that the employee is afflicted with a primary psychiatric disorder, and that his dependence on alcohol or drugs is a secondary symptom which does not disqualify him for disability retirement.

In the last 10 years, only two applications for disability retirement have been received in which drug addiction was a known factor. In each case, the addiction was the result of legally prescribed drugs in the course of treatment of a serious physical impairment. In each case the physical impairment was totally disabling, independent of the drug addiction, and the applications were approved.

This bill also contains a provision that requires that a good faith attempt be made to find appropriate work for an employee during his rehabilitative treatment. The Commission favors and endorses this provision.

Section 501(c) prohibits denial of Federal employment to a person solely on the basis of former drug abuse. The Commission agrees with the principle that Federal employment should not be denied solely on the grounds of former drug abuse.

The standards for suitability for Federal employment currently in use endorse this principle. Applicants for Federal employment who have a history of drug addiction are given the same consideration as is given to other applicants who have a history of some other impairment. If the applicant has recovered from the addiction, he is eligible for Federal employment except in the most demanding positions.

I should mention at this point that instances of drug abuse among applicants for Federal employment have been exceedingly rare. We do not have any statistics, but this is the opinion of those whose jobs make them sensitive to the matter.

Our policy is not to employ known addicts or pushers, but not to disqualify those people who may have been occasional experimenters or users who have been rehabilitated.

As this particular provision is written, it would seriously infringe on the responsibilities of the Civil Service Commission and the heads of Federal departments and agencies.

The Civil Service Commission is authorized by statute to develop suitability standards for entry into the competitive service, and for issuing regulations to be followed by agencies in determining fitness for Federal service.

Heads of agencies are required by the President to identify the positions in their organizations which are of a sensitive nature from the viewpoint of national security, and it appears to us that they are in the best position to do so.

This provision would have the Secretary of Health, Education, and Welfare assume these responsibilities insofar as prior drug abuse or prior drug dependence is concerned. We do not believe this is necessary or desirable.

We cannot perceive any advantage to be gained by isolating the area of suitability as it relates to former drug abusers from the function we now exercise in determining fitness and suitability standards for all Federal employment.

The Commission, therefore, strongly objects to this provision of the bill.

The final provision of direct concern to the Commission is section 502, which would require the health benefits plans which participate in the Federal employees health benefits program to cover drug abuse and drug dependence in the same way as other illnesses that are not self-inflicted.

The two largest Governmentwide plans, in which about 80 percent of all employees are enrolled, have no exclusions or limitations on treatment for alcoholism or drug addiction. Benefits for treatment of these conditions are the same as for other illnesses. In other words, benefits are payable for necessary hospital confinements and professional medical care, inpatient or outpatient, the same as for other illnesses.

Some of the 36 other smaller plans which participate in the health benefits program limit benefits for alcoholism or drug addiction, or exclude treatment of these conditions from coverage. However, the Commission annually renegotiates contracts for these plans and has urged that these exclusions and limitations be removed.

In response to this urging, restrictions in many plans were removed in 1969. We believe it likely that all but perhaps a very few will remove their existing restrictions by 1971.

Because the large majority of Federal employees already are in plans that impose no restrictions on benefits, and because the contracts for the various plans are bilateral agreements, the Commission prefers that removal of the pertinent restrictions from the smaller plans that still have them be achieved through negotiation rather than unilaterally through the force of law.

For these reasons, the Commission does not believe this provision is necessary or desirable.

I thank you for the privilege of appearing this morning. I will be glad to try to answer any questions you may have.

Senator HUGHES (presiding). Senator Dominick, why don't you proceed?

Senator DOMINICK. Mr. Ruddock, title V of the bill makes certain requirements for programs for drug abuse and dependence for Federal employees, as you know.

We would like to know whether you have any figures on the incidence of drug abuse and dependence upon Federal employees.

Now, it does not seem to me that you directly deal with this in your statement, even though you refer to the fact that only a very small number of Federal employees have been deemed to have this problem.

Mr. RUDDOCK. Sir, we do not have any statistics. I would assume that this is one of those problems that is kept pretty well hidden.

There are only two areas in which we were able to put any perspective on this at all, and one is in the area of impression. It is the impression of those people in the Commission who deal with applicants for employment that there are relatively few applicants for employment who are drug addicts or drug dependents.

The only other area was in our adjudication of applications for disability retirement, where over the past few years we are aware of only two cases in which drug addiction was a known factor.

But these are largely impressions, sir, rather than statistics.

Senator DOMINICK. In other words, the problem of drug abuse as it may affect individuals and the numbers of people who may be participating in drug experimentation one way or another has really never been pursued within the Civil Service.

Mr. RUDDOCK. That is right.

Senator DOMINICK. Now, you say in your prepared statement, however, that the Commission can and intends to develop a program. Now, this would indicate to me that they have not developed anything yet.

Mr. RUDDOCK. That is right. We have not developed anything in the area of drug abuse.

Senator DOMINICK. And also you don't have any specific program with regard to rehabilitation or cure?

Mr. RUDDOCK. No, sir. We have a lot to learn in this area.

Senator DOMINICK. Well, I hope that these hearings that the chairman has been so ably pushing will be an eye opener for people, both in the Federal service and outside. I think we have really gone into it in considerable depth.

Now, what do you do with Federal employees who are involved with either drug abuse or dependence? Are they usually fired on some other ground?

The Commission probably doesn't even know about their abuse. Is that right?

Mr. RUDDOCK. We really don't know. We would hope that the supervisor would try to help the employee, or try to steer him to those facilities which can give him treatment. We would hope that he would recognize the illness of the employee and grant sick leave for the purpose of treatment, and that the objective would be one of therapy rather than one of punishment.

Senator HUGHES. How many Federal employees do you have under your jurisdiction?

Mr. RUDDOCK. Almost all of the employees in the executive branch are under the civil service system.

Senator HUGHES. How many is that?

Mr. RUDDOCK. It would be about 2½ million?

Senator HUGHES. About 2½ million?

Mr. RUDDOCK. Yes.

Senator HUGHES. And you only have two drug abusers?

Mr. RUDDOCK. We had two applicants for disability retirement in which drug addiction was a known factor.

Senator HUGHES. Excuse me, Senator.

Senator DOMINICK. I think the chairman has brought up the same point that I was driving at.

Where a person is doing inadequate or sloppy work or just plain does not show up, or has excessive absences on account of alleged illnesses, you don't have any program now to determine to what extent this may have been caused by drug dependence?

Mr. RUDDOCK. No, sir; there is no formal program for that.

Senator DOMINICK. I recommend that you get one in a hurry, because I would strongly suspect that you will find there is a great deal more of it than you have any records of at the present time.

I think your testimony makes clear the lack of data and programs in this area. I withhold the balance of my questions.

Senator HUGHES. I might ask if they can lend us technical assistance in working with this particular piece of legislation.

I wonder if we might seek your assistance at staff level?

Mr. RUDDOCK. Yes, indeed. I think at this point we have much more to learn than we have to contribute, but I would be most happy to cooperate.

Senator HUGHES. I am afraid as I view your testimony, it is an absence of knowledge rather than an awareness of fact that has brought about the testimony.

Mr. RUDDOCK. Yes, sir.

Senator HUGHES. So with that thought in mind, I would hope that the staffs might be able to review it with you.

I am sure in my own mind that of 2½ million employees, that the sheer incidence is not any less or not any greater than with persons of average similar employment.

Mr. RUDDOCK. I am sure that is true.

Senator HUGHES. And that a concealed problem is what we are dealing with.

There is little that we can do today, so I would not have questions myself today, but I would simply say that we will contact you. I have no desire to put into the record things that obviously are not existing at all. There is no reason to pursue it.

Senator, excuse the interruption.

Senator DOMINICK. I am glad the chairman said that, because this is exactly my attitude.

We are not trying to castigate the Civil Service Commission. What we are trying to say is that you have a lot of people that we are sure to some extent, at least, are going to be found to be hung up on drugs in one way or another, just like any other group of 2½ million people would be.

Perhaps we ought to start working together to try to see what we can develop by way of a program to determine to what extent the problem exists.

Senator HUGHES. Thank you very much, Senator Dominick.

I believe on that basis I will just suspend without trying to get in the record any specific questions at this point, and let you cooperate with the staff.

Thank you very kindly, Mr. Ruddock, for your willingness to come and testify.

Mr. RUDDOCK. Thank you, sir.

Senator HUGHES. The hearing is closed.

(Whereupon, at 11:55 a.m., the subcommittee recessed, to reconvene at 9:30 a.m., Tuesday, April 14, 1970.)

FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

TUESDAY, APRIL 14, 1970

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

The subcommittee met at 9:40 a.m., pursuant to recess, in room 4232 New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes (presiding), Kennedy, Javits, and Saxbe.

Staff members present: Robert O. Harris, staff director; Wade Clarke, majority counsel; Richard J. Spelts, minority counsel; and Jay Cutler, minority counsel.

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

The Chair welcomes again Dr. Egeberg, Dr. Miller, and their counsel, Mr. Ellenbogen.

I did have a chance to glance at the analysis you have furnished this morning. I think the staff had a chance to go over it during the night. You know it was delivered last night so we cannot be very familiar with it.

I considered your request for a later hearing date on this subject matter but in the interest of time did want to get as much out of the way as we possibly could this morning. If I determine we still need some more time later on, we will just have to negotiate a time when you can come back again, but if possible I hope we can finish today.

It is my understanding that you did not have an open statement this morning. Is that correct?

STATEMENT OF ROGER O. EGERBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY MORTON G. MILLER, M.D., ASSOCIATE DIRECTOR FOR SPECIAL AND COLLABORATIVE PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH; AND THEODORE ELLENBOGEN, CONSULTANT AND FORMER ASSISTANT GENERAL COUNSEL FOR LEGISLATION, HEW

Dr. EGERBERG. No, no opening statement.

Senator HUGHES. Is there any comment that any of you would like to make before we begin?

Mr. EGEBERG. I apologize for getting our information to you so late but the time element, as you have stated, was a very difficult one to handle. We did have this approved by the Bureau of the Budget and by the White House.

Senator HUGHES. Well, if I might, then, I will begin with what I hope will be useful questions.

Your detailed analysis of S. 3562 and the comparison of your present authorities with the authorities set out in this legislation will be extremely helpful to the subcommittee in their deliberations.

I want to thank you for this assistance, and I am hopeful that we may continue to receive technical assistance as the subcommittee continues its deliberations. I hope we might continue our relationship of the last couple of weeks.

Your testimony before the subcommittee on March 24 made the administration's opposition to the legislation which we are considering sufficiently clear, I think, for all of us to understand. And you already know of my strong irritation about the fact that that position has been taken. I am still not sure why the administration would take that position. But rather than dwell on that today, I would like to begin by asking you several questions based on the assumption that the bill before us, or something quite like it, will be reported out of the subcommittee, because we would like your assistance. We are not trying to hamstring you in any way, we will simply try to work together under the unpleasant circumstances of being on the opposite side of the issue. The first paragraph of this legislation contains the statement: "Drug dependence is an illness or disease that requires treatment through health and rehabilitation services."

Do you disagree with that statement and, if so, would you explain the reasons for your disagreement?

Mr. EGEBERG. No; I agree with that statement.

Senator HUGHES. You do agree with it.

Mr. EGEBERG. Yes, sir.

Senator HUGHES. Could you explain your reasons. Why do you view drug dependence as an illness or disease?

Mr. EGEBERG. Well, I view the underlying problem of the person who becomes drug dependent as one which is essentially psychological in nature. I can tell you of one experience. When I was on the Presidential Commission on Narcotics we visited many prisons and many correctional institutions. Very frequently we found men who said they had started using heroin intravenously in a group of four or five people. They had gone on doing this by themselves on weekends and on vacations of 3 or 4 days, and at the end of 2 years they were the only ones left who were using it. The others had stopped using it because they had felt that it was either too difficult to get the money or that they had other things they would rather do. But this one patient out of five or six seemed to be the one who would get hooked.

I think that there are indications that this is a psychological susceptibility, that not everybody who takes narcotics necessarily becomes a habitual user. I am sure Dr. Miller can give you more scientific answers than that.

Senator HUGHES. I would like you to fill me in, Dr. Miller, because this will be a point of controversy in the legislation itself. That is why I ask the question, because this is a different approach.

Can you give me your professional opinion, Dr. Miller?

Dr. MILLER. I think one of the critical distinctions, Senator Hughes, is between drug abuse and drug dependence. When we are talking about dependence, we are talking about psychological or physical dependence on a drug. When we talk about abuse we talk about any use of an illegal drug or inappropriate use of a drug which may have some medical use. There is no question among mental health professionals that drug dependence is an illness or could be viewed as symptomatic of illness. I don't think the distinction is that critical. But in every case where one finds drug dependence, be it narcotics or on amphetamines, barbiturates, heavy usage of a drug like marihuana, or the continual use of a drug like LSD, almost invariably one will find some very significant underlying emotional disturbance. Additionally, when people are seriously drug dependent they will frequently develop physical symptoms which are related to the drug or the use of the drug. For instance, hepatitis, as we know, is extremely common among people who use intravenous amphetamines. They suffer from malnutrition, and with those who abuse meta-amphetamine, psychosis is frequently seen. So there would be no question in my mind that drug dependence is an illness, primarily emotional in nature, which requires considerable rehabilitation.

Senator HUGHES. The description you have just given me would fit also the difference between a chronic alcoholic and an occasional drunk who becomes overintoxicated. One is dependent and the other may just occasionally go over the line. Is that what you are telling me one of the basic differences is between dependence and basic use?

Dr. MILLER. I would consider the abuse would fit the person who drinks to excess, even on a periodic basis.

Senator HUGHES. He is an abuser?

Dr. MILLER. Yes, sir.

Senator HUGHES. But he is not necessarily an alcoholic?

Dr. MILLER. No, sir.

Senator HUGHES. The same is true with other drugs or narcotics, if a person uses them occasionally he abuses them, but he is not necessarily addicted to them?

Dr. MILLER. That is correct.

Senator HUGHES. Or there is not necessarily an illness involved other than a psychosis?

Dr. MILLER. That, I think by and large, is correct.

Senator HUGHES. I am trying to outline this because this will be a point of contention in debate. You feel that dependence is an illness or disease?

Dr. MILLER. Yes.

Senator HUGHES. Thank you very much.

Now we move for a moment to the location of the authorities placed in the administration established in the bill. I am talking about the administration that is established by the bill itself, and the location of the authorities within it. Now, your analysis of S. 3562 and your earlier comments before the subcommittee indicate that you would prefer that the authorities given to the administration established in the bill be given directly to the Secretary of HEW. Is that correct?

Mr. EGERBERG. That is correct, which would give him more flexibility.

Senator HUGHES. And you know in our private discussions that I personally had no objections to that when we met in my office and discussed it. So I am just trying to clarify the record on what your preferences are.

Mr. EGEBERG. Yes.

Senator HUGHES. Also, my own position is that I was not advised on the placement of the administration, it is just a matter of designation.

Would you agree with that, also, Dr. Miller?

Dr. MILLER. Yes, sir.

Senator HUGHES. Your previous testimony has made reference to the fact that the services of the National Advisory Mental Health Council would not be utilized under the proposed bill. Now, would it be preferable from your point of view for us to place these authorities under the Secretary and require grant review and advisory functions to be carried out by the presently existing National Advisory Mental Health Council?

Mr. EGEBERG. Would that be preferable?

Senator HUGHES. Would that be preferable to you.

Mr. EGEBERG. Yes, I think that would fit the present pattern better.

Senator HUGHES. Technically, would this be the best arrangement administratively?

Mr. EGEBERG. I would think so.

What do think about that?

Dr. MILLER. Yes, sir. The Council currently is the principal review group for grants related to the area of narcotic addiction and drug abuse. It consists of experts from the mental health field and the public. I think this would be an appropriate function for them.

Senator HUGHES. I want to inform you I have no objections to that, either, so we are not debating on those points. It is a matter of trying to clarify where we both stand, if we can. I don't know what other members of the subcommittee think, but I want to at least get straight where we are going.

Now, in the codification of existing authorities, both your analysis of S. 3562 and your comparison of the existing authorities with the authorities contained in this legislation point out the fact that your existing authorities to carry on activities in the drug abuse prevention and rehabilitation area are in many cases very general—as in the Public Health Service Act—and are scattered between that act, the Community Mental Health Centers Act, the Narcotic Addict Rehabilitation Act and other authorities. Do you have objections to the codification of these authorities in a specific way, so far as they might relate to drugs, so that your authority is clearly visible and understandable to those persons working around the country in those areas?

Now I want to point out that you have indicated a vast need for funding in this area, and this kind of spelling out of authorities and delineation of responsibilities should be helpful along this line, I should think.

Mr. EGEBERG. Yes, it very likely could be helpful. I think in this case I would like to ask Mr. Ellenbogen if he has any background on that.

Mr. ELLENBOGEN. Well, it is true, as the comparative analysis furnished to you demonstrates, that, first of all, in some instances the authority is spelled out in very broad terms and not explicitly in terms of drug abuse or drug addiction, and also that it is sort of here and there. So I think it would be useful from the standpoint, not of giving the authority we need, but from the standpoint of better understanding on the part of perhaps the public to put it all together in one place.

In a way, this has been done, let's say, in the case of heart disease and cancer. There are sections in the Public Health Service Act, for example, to the effect that in carrying out section 301, which is the broad research authority section, the Secretary shall or may conduct and suggest research with respect to heart disease or cancer. This kind of approach could be useful, at any rate, in this field.

Senator HUGHES. Well, I think without a doubt to get the national emphasis on a program such as we are talking about here today there is going to have to be an individual identity of that program. That is a personal opinion of mine.

This visible identity, I think, is absolutely essential. Do you not think so?

Mr. ELLENBOGEN. Sir, I would just suggest, though, that you will come across some provisions that you might not consider representing your latest thinking. Then the question is, do you simply want to restate them as they are or do you not? So there are problems in that approach, too.

Senator HUGHES. I would like to ask Dr. Miller about this in his professional opinion. As a psychiatrist and doctor and division director, what is your opinion on this?

Dr. MILLER. I would tend to agree, Senator Hughes, that in terms of visibility there might be some real value in pulling together the various authorities which are currently distributed in a number of different parts of the law into one omnibus type statute.

Senator HUGHES. And you do this without trying to fracture anything or destroy anything but to coordinate the function. We are not interested in creating problems in your agency and I hope we have made that clear.

I don't want any tug-of-war between us here again today about what we are trying to do. Let's just lay it on the table. If you wonder what I am trying to do, ask me. If I don't know, I will ask the guy that is advising me and if he does not know we will get together for another meeting. We will ask Senator Javits, maybe he knows. Dr. Egeberg, I would like your opinion on this for the record, if we can, the clarification of the identity of these programs, drawing them together for the sake of visibility. You know in the problem of mental retardation we were unable to do anything in the country until it had clear visibility. I think the same is true with cancer, the same is true with heart disease and smoking and the same is going to be true probably with drug abuse and narcotics addiction, is it not?

Mr. EGEBERG. I am coming around to that point of view, I think I may have told you before that we felt harassed by the definite project-oriented programs that we were subjected to, or that we have been required to take advantage of.

However, I can certainly see the advantage of having a lighthouse, something that is definite and clear for everybody to see and to look to for understanding and instruction.

Senator HUGHES. In the field of alcoholism, for example, we have been struggling for identity for Lord knows how many years, and all of you are familiar with the work in that field, and all of you have had a special interest in it, and yet the identity, even though you have the National Advisory Council, has not been maintained across the country.

From the information you have given me, the drug problem in the country is still ballooning, is it not? It is still growing, it has not leveled off, has it?

Mr. EGEBERG. Not yet.

Senator HUGHES. Is that right, Dr. Miller?

Dr. MILLER. That is right.

Senator HUGHES. From all the evidence we can get, it is still growing rapidly.

Dr. MILLER. Yes, sir.

Senator HUGHES. Then I would like to move on just for a moment. I don't want to get hung up on any of these, I am just trying to clarify our positions.

Getting to guidelines, in the methadone withdrawal and maintenance area, section 304, subsection (h), of the bill contains provisions meant to preserve the rights of medical practitioners to prescribe controlled dangerous substances, including methadone.

Now how do you suggest that we deal with this problem of preserving these professional rights and responsibilities in such a way as to provide adequate safeguards over the use of methadone for maintenance or withdrawal while at the same time making the private practitioner's legal position clear.

Mr. EGEBERG. I will let Dr. Miller go into a little more detail on this, but thus far we have felt that the use of methadone in narcotic dependent persons is in the exploratory stage, and while there may be criticism that we have been exploring him for too long a time, dealing with the mind does take an awfully long time. I don't know how close we are to recommending that this become a definite form of treatment. I think I would have to ask Dr. Miller about that.

Senator HUGHES. Dr. Miller.

Dr. MILLER. Our current procedure, Senator Hughes, involves first of all clarifying that methadone, used as a long-term maintenance treatment, is an experimental drug which is subject to the IND or Investigational New Drug regulations issued by the Food and Drug Administration. The FDA is in the process now of preparing regulations for the use of methadone under an IND. FDA it is going a little further than they usually do in that they have prepared a draft protocol for distribution to potential prescribers of methadone which will enable them to comply rather readily with the IND requirement.

Senator HUGHES. When you say protocol, is that the guideline? Is this the guideline I have been searching for and have not been able to find?

Dr. MILLER. In part these would be the guidelines, that is correct, sir.

Senator HUGHES. When will they be out? We have not been able to get them yet.

Dr. MILLER. My understanding is that the FDA will be publishing these guidelines fairly soon.

Senator JAVITS. What do you call fairly soon?

Dr. MILLER. This is what I have been told by the Agency, I really can't answer that.

Senator JAVITS. I want to question you rather closely on this.

Mr. EGEBERG. From the way Dr. Edwards works, I would say if he is the one who said "fairly soon", he means in a few weeks.

Dr. MILLER. This will hopefully clarify what we have been stating before this and other committees. Namely, the broad professional view, the view of the Department, and NIMH—that the safety and efficacy of long-term use—has still not been definitively established. This is one of the prerequisites for allowing the drug to be used more widely.

One of our principal concerns which we have reiterated here before also relates to what will happen when, indeed, as I suspect it will, methadone will be accepted; that is, we will have passed the IND test and it will be considered to be a safe and effective medication. At that point other very difficult questions will arise. By and large, if the drug has been accepted for use, it then can be used by any licensed physician. In this instance, as a narcotic drug it would need to have the additional factor of the physician having a narcotic tax stamp. I think from a professional standpoint I would have some concern at this point in time about every practitioner in the country prescribing methadone for maintenance purposes.

Senator HUGHES. Doctor, let me interrupt you. I notice you are making a decided distinction between maintenance and withdrawal.

Dr. MILLER. Yes, sir. Methadone has had an accepted use for withdrawal for some years now.

Senator HUGHES. You are not speaking about just a maintenance program in comparison with a withdrawal program?

Dr. MILLER. No, sir. Methadone is accepted as an agent that can be used safely for the withdrawal of a narcotic addict from his drugs.

Senator HUGHES. And any doctor can prescribe it now?

Dr. MILLER. That is correct, sir.

Senator HUGHES. All right.

Senator JAVITS. For that purpose, withdrawal from narcotic addiction only, or prescribing the drug generally?

Dr. MILLER. He can prescribe it as an analgesic, that is a pain killer, and he can prescribe it for withdrawal, to withdraw someone from another narcotic.

Senator JAVITS. I gather the withdrawal has a time bracket.

Dr. MILLER. Yes, sir.

Senator JAVITS. Would you estimate that?

Dr. MILLER. It would vary with a number of factors: the health of the person involved, the size of his habit—but probably within 2 weeks almost anyone could be withdrawn safely.

Senator JAVITS. Two weeks?

Dr. MILLER. Yes.

Senator JAVITS. The chairman tells me that it could take up to 6 months. Would you say yes or no, that it could take up to 6 months to treat the withdrawal problem.

Dr. MILLER. From the straight physiologic side I would have to stand by just several weeks.

Senator JAVITS. Several weeks?

Dr. MILLER. Yes.

Senator JAVITS. Now after several weeks if the doctor continues to prescribe methadone is the doctor vulnerable to a charge of nonprofessionalism, or improper practice, or some charge similar to that?

Dr. MILLER. This is somewhat in the legal area, Senator Javits. At this point there are a number of physicians who are using methadone for long periods of time and in some ways it becomes a question of good faith. If the physician says that he is treating the patient with a long-term withdrawal procedure, that is, he is going to withdraw him over 6 months, then it becomes a discretionary matter as to whether he is actually doing this or whether he is actually giving the person methadone with the idea of maintaining him, switching him from heroin to methadone as maintenance.

Senator JAVITS. May I go ahead with this, Mr. Chairman?

Senator HUGHES. Yes.

Mr. EGEBERG. In the one case I think Dr. Miller mentioned physiologic changes. On that basis, some people can be withdrawn in as little as 2 days and others in up to 6 or 7 days. As to the psychological aspect, there are still many who feel withdrawal requires longer than 2 weeks, but that is the psychological aspects of it and not the physiological.

Senator JAVITS. Dr. Miller, after the period of time which you have described and Dr. Egeberg has described, is it the doctor then vulnerable to either a charge of violation of Federal law or to a charge of improper practice professionally, or both?

Now before you answer, may I tell you there are thousands of people being treated with methadone in New York and it is labeled an experiment. I think it is very important that these brave doctors, and that is what I call them advisedly because you fellows have not given us any other handle. You offer us nothing but more and more crime to supply the heroin habit while you look into it. I am not blaming you but you have got to remember that when you answer my question.

Now I ask you that question: Is this doctor now vulnerable to either or both of these charges?

Dr. MILLER. At this point the New York programs, for instance are not considered to be violating the law in administering methadone for maintenance purposes. It is my understanding that recently Dr. Dole has applied for an IND for methadone which would bring his program within total compliance, and there has been no problem, or I would see no legal problem with it there or in the other projects which we are supporting and which would be conducted under independent auspices.

Senator JAVITS. But New York doctors have not yet gotten this permit?

Dr. MILLER. They have filed for it.

Senator JAVITS. They have filed for it, but have they gotten their permit?

Dr. MILLER. I could not answer that.

Senator JAVITS. Don't you think they are entitled to have the highest priority? Particularly, when the doctors and scientists have given us nothing and can give us nothing for a considerable time, except treatment that takes 2 years and more and involves tremendous expense in housing, et cetera. This is simply impossible with 100,000 addicts or more in the New York area responsible for a minimum of 50 percent of the crime?

Dr. MILLER. It is an extremely difficult issue.

Senator JAVITS. Don't you think we are entitled to have the Federal Government get on its horse and do something effectively about it? Say it runs a risk and not leave all these doctors and wonderful people exposed?

Mr. EGEBERG. I do.

Senator JAVITS. Well, I do too.

Mr. EGEBERG. I will take him off the hook. I want to very much. I don't know Dr. Dole. I remember on that previous commission he said he would be willing to try methadone maintenance. At that time you could not get a doctor to be interested in narcotics addicts except in the Fort Worth and Lexington institutions.

Senator JAVITS. Well, I am hoping Dr. Egeberg, to have your feeling on that, an absolute public notice to the situation because it is moving in a very affirmative and very broad direction.

We simply have no other way to turn. The crime situation attributable to the narcotics addiction is just simply overwhelming.

Senator HUGHES. May I point out a problem that came up in my capital city, Senator Javits?

We had a very small methadone withdrawal program running there. There had been nothing prior to this at all but apparently the police infiltrated the withdrawal program and put men in the withdrawal room as patients in order to gain confidential information from the addicts. This blew the program clear out of the water, and now there is not a heroin addict that would come for treatment to anyone in the city. The addicts are back on the streets having to steal \$100, \$200, \$300 a day to maintain their heroin habit. We all support the police, and we all support everything we can do to cut back the importation of heroin and opium, getting the suppliers and distributors. We can have a health program trying to get people off the streets but as long as we use them as an infiltrative organism of the vice squad they will be unsuccessful.

Mr. EGEBERG. They had to infiltrate because the doctors felt this was a matter of personal discretion and wanted to protect their patients.

Senator HUGHES. That is correct.

Mr. EGEBERG. Yes, I think I am aware of that situation.

Senator HUGHES. And it is a very bad situation in my opinion.

Senator JAVITS. Doctor, may I impress on you and Dr. Miller and your colleagues in my home city, which is tragically the seat of probably the major narcotics addiction problem in the country in many terms, especially in terms of crime. This is probably the number one anticrime problem and the twilight zone in which this is located, considering the thousands like those we are now talking about, 10,000, maybe 20,000 in connection with methadone.

Certainly we ought to know first as to the professional situation of the people concerned and, secondly, as to methadone itself we are up some blind alley. Certainly, on a very high priority, the United States Government ought to help us to find out all we can. Also, it seems to me that if you placed priorities in this field, consider what you can do quickly to assist in the urgency for utilizing medication.

I am not leveling this at you, you are both eminent men before us, and I have the warmest regard for you, Doctor, and all your associates. But it seems to me that as a legislator that this would be the top priority. I beg you to comment or advise us, or do what you can, without exhortation, just out of the sheer human problem that is involved.

Senator HUGHES. Would the Senator yield a moment?

I would like to ask about these guidelines which we were discussing, the guidelines, or the protocol you talked about, and which the FDA is supposedly providing.

What advice have they had from HEW?

Dr. EGEBERG. FDA has been working very closely with Dr. Miller's colleagues at the National Institute of Mental Health on this.

Senator HUGHES. What have you done then to protect the professional doctor in these guidelines?

Mr. EGEBERG. I think that when the protocol is issued it will be seen that a doctor who was interested in carrying a patient on methadone, that is, carrying along rather than a withdrawal—

Senator HUGHES. As a maintenance program?

Mr. EGEBERG. Yes. Will obtain such permission rather readily. Let me give you an analogy. When streptomycin and other drugs became available for the treatment of tuberculosis, many doctors who had not previously treated a case, assumed they were capable of treating tuberculosis and for a period of probably 10 years there was much mismanagement of patients with tuberculosis.

I think it is for this reason that we want to know who is experimenting with methadone so that we can have some control in getting a proper evaluation of it, so that physicians will be slower to regard this as something that can be used universally. The intention is not to try to keep people from using it. I think it will be easy to get permission.

Dr. MILLER. This would provide significant protection for the doctors filing the IND and fulfilling that requirement.

Senator JAVITS. But again it is the perspective which it will provide... That is what I am urging you to do, provide it. At least given them that much.

Now who is the official whose signature is required for that purpose?

Senator HUGHES. Isn't the FDA responsible to you, Dr. Egeberg?

Mr. EGEBERG. Yes, the agency is responsible to me and it will be through discussions with Dr. Edwards and Dr. Miller and his colleagues and myself that this will be done. We are also having discussions with Mr. Ingersoll at the Justice Department because, while we have straightened out a number of things, we want to be certain that we have resolved this whole issue, including its legal aspects. We know what his attitude is and he knows what ours is.

Senator HUGHES. You informed us at one hearing that you won every battle in those discussions in that last bill.

Mr. EGEBERG. Did I vote?

Senator HUGHES. Excuse me. Fred Black said that. I am sorry, Doctor. I apologize. That stuck in my mind and I cannot get rid of it. It didn't look like you won anything to me, but anyway, I hope this discussion does not turn out like that.

Senator JAVITS. Thank you, Mr. Chairman.

Mr. EGEBERG. I think if you look back to the general attitude in Washington about 8 months ago you will see that I won one or two.

Senator JAVITS. Mr. Chairman, I feel very strongly about this. I really think, to leave these people dangling out there in an uncertain condition, is most appalling. I hope that you and Dr. Miller will with your authority and competence, resolve any interdepartmental differences.

Mr. EGEBERG. I shall talk to Dr. Edwards this afternoon.

Senator JAVITS. Thank you.

If I may be excused, Mr. Chairman—

Senator HUGHES. Before the distinguished Senator from New York leaves, about this protocol or guideline that we have been discussing this morning, I would like to ask the ranking member if he agrees with me that we get a copy of this even though it is confidential. I would like to see what we are doing in these guidelines or protocols, and if it is in order I would like to request them to submit it to us as a matter of confidence so at least we might be informed on what they are doing in this area.

Senator JAVITS. I agree with the chairman provided the committee agrees to be bound by the same restriction on the use of the document that pertains in the executive department.

Senator HUGHES. Until such time as—

Senator JAVITS. Yes.

Mr. EGEBERG. I would be very glad to bring Dr. Edwards around and do that.

Senator HUGHES. Gentlemen, let me ask you just a question or two on the degree to which you want a strictly community mental health centers approach. Some of the most creative and successful programs which the subcommittee has seen have been administered by smaller, private, nonprofit groups around the country. They have been most effective in handling narcotics addiction and drug abuse. They have had, really, no relationship with community mental health centers.

Often they make strong use of former drug users and operate out of street settings, or store front settings in their outreach programs.

Now, what kind of legislative criteria, if any, should we require before such groups may obtain Federal funding?

If this question is too broad for you to answer orally, I would like to get the answer in writing. I realize that you cannot just sit down and dictate orally a funding procedure for a group like this, Dr. Egeberg.

It is a tough question. I think we agree that some of this is necessary, do we not?

Mr. EGEBERG. It certainly is. When I was in my past position we were interested in that problem in the neighborhood around us which

was primarily Spanish-American. Without any physician's help they were taking people off of heroin—I think I made mention of that before—and doing a very good job as far as that part was concerned. They were using ex-addicts. They needed help only when it came to taking them off the barbiturates.

Yes, I feel that if the mechanism can be worked out to help fund some of this it would help a great deal.

Dr. MILLER. Mr. Chairman, if I may comment about that.

Senator HUGHES. Yes, sir.

Dr. MILLER. Under the Community Mental Health Centers Act, part D, which provides for special services for the narcotics addict, and which was recently extended and improved by the Congress, we have authority to support not only projects which are affiliated or related to community mental health centers but, in communities where there are no mental health centers, we have authority to support projects which provide comprehensive services for addicts. One of our largest projects of this kind is in New York City, in the Bedford-Stuyvesant area where the applicant was a foundation with very strong ties to the local community, headed up by Mr. Katzenbach, former Assistant Secretary of State.

Additionally, under the direct grants part we have authority to support new and innovative demonstration programs and having indeed supported projects which are not connected with community mental health centers.

For example, in New York City one of the pioneer residential programs using ex-addicts on the treatment staff was funded for a number of years under NIMH demonstration grants.

Additionally, we have other projects of this nature as well. The authority and the philosophy I think is present within the act and within the administration of the current act to support such a program. Our reliance on the mental health center approach is based on factors like the lack of availability of skilled manpower to participate in these programs and the need, in our opinion, for the comprehensive approach. We feel that whether a program is supported under the base act or is a service program under another part of the act that it have available a full range of services for the addict.

For instance, a treatment service without prevention service, without a 24-hour emergency service, without the backup of a general hospital where a person who has had an overdose or has hepatitis can be readily admitted, I think in the long run will cost us more than guaranteeing that these things be present.

We do not ask that the applicant himself provide all of these services. He may contract, he may affiliate, he may set up a number of kinds of arrangements with community agencies. Many of these will be non-mental health agencies. They may be health, rehabilitation, social service agencies but we feel very strongly from a mental health standpoint that the principle of continuity and availability of care are critical. This is the basis on which we have administered the program.

Senator HUGHES. Apparently you feel you should always be tied to a medical center.

Dr. MILLER. I think there should be some access to a medical setting; yes. For instance, we were talking about methadone a moment ago. This is a prescription drug which can only be prescribed by a physician. I think a program is much stronger if the physician is actively involved than if he is available or involved only to the extent that he writes a number of prescriptions. I think he should be much more involved than that.

Senator HUGHES. We are going to have to go back because of earlier testimony that came in. We have received testimony that S. 3246, the administration bill which earlier passed the Senate, and this bill, S. 3562, are mutually exclusive of each other—that the Congress can't encourage health and scientific professionals with one piece of legislation and slap their hands with another.

Now, as you know, there has been a great deal of concern about the administration's drug bill by the medical and scientific community. I suppose you still support this legislation.

I have a few questions concerning that administration bill. S. 3246 gives the Attorney General the authority to determine whether substances should be added, deleted, or rescheduled as controlled dangerous substances under that act. No absolute criteria are set out that he must meet in making this determination. He must only consider certain factors in making his decision, among which are: the risk of the drug to the public health, the psychic or physiological dependence liability of the drug, the scientific evidence of the drug's pharmacological effect, the state of current scientific knowledge regarding the drug, and whether the drug is an immediate precursor of a substance already controlled. The Secretary only has the authority to advise the Attorney General.

Now how on earth do you justify your support of the placement of this in the Department of Justice rather than in HEW?

Mr. EGEBERG. Certainly this is supposed to be done on the advice of the Secretary of HEW and the Attorney General has on two occasions made very strong statements before either your committee or another committee of Congress that he certainly would not make decisions without listening very, very strongly to the advice of the Secretary of HEW.

Senator HUGHES. Without listening very strongly. That does not mean that he agrees with them, does it?

Mr. EGEBERG. Without being influenced very strongly by what he says.

Senator HUGHES. I won't even pursue that, doctor, but I will say this: Could you tell me why HEW should not make these decisions and then the Secretary ask Justice for advice? Obviously, you are the division that deals with the scientific research, medical history, training, education, the entire field. Now why on earth should this country place this power in the chief law endorsement agency of the country?

Mr. EGEBERG. Well, after a thorough discussion—and they were thorough discussions, involving representatives from the Department of Justice and from our group within HEW—and with the Secretary's concurrence, we felt that this would be a workable system.

Senator HUGHES. Is it one you approve of?

Mr. EGEBERG. Yes, I approve of the system.

Senator HUGHES. Dr. Miller, do you approve of it?

Dr. MILLER. The administration position, as you know, Senator Hughes, as Dr. Egeberg stated—

Senator HUGHES. Let us forget the administration position. I ask you as a physician and a scientist, if you can answer the question. If you can't, tell me you would rather not.

Do you approve of it?

Mr. EGEBERG. Do you want me to look the other way?

Dr. MILLER. Senator Hughes—

Senator HUGHES. I realize I am putting you on the spot, but that is the intention. I really can't conceive of the head of an agency like this approving of this kind of an administrative setup, Dr. Miller. I have got to be convinced that in your own conscience you believe that this is correct.

Dr. MILLER. In all honesty, Senator, speaking as a professional now and as someone who has a long and extensive contact with the research community, I recognize that there are certain major problems which are raised by the proposal and I would sincerely hope that on the basis of the considerable discussion that has taken place before this committee and others, that there is a clear understanding all around about what the needs of the research community are.

I recognize that one of our distinguished psychiatric researchers testified, I believe before this committee that he does not know whether it would have been possible for him to have conducted the research he did with the tranquilizing drugs with a law like S. 3246.

It is always hard to examine that kind of thing retrospectively. But I do know that Dr. Kline has stated this feeling.

Mr. EGEBERG. I think it would be very helpful to have a great deal of discussion on this subject so that in general the legislative intent can be made clear.

Senator HUGHES. I have placed Dr. Miller in a very embarrassing position, working as he does with the administration. He is subject, I suppose, to either being hired or fired on the basis of what he says here. I recognize that fact. I would like to ask you that same question. As a professional physician, ex-dean of a medical school, do you believe as a professional physician that this authority should be granted to the Attorney General of the United States rather than the scientific body of the Department of Health, Education, and Welfare?

Mr. EGEBERG. I won't be begging your question but saying I think this will work.

Senator HUGHES. Well, in my opinion, Doctor, you are begging the question but there is no reason to pursue it any further. I realize the position you are both in here today. I think the answers that you have already given are in fact an answer in themselves.

As legislators we are going to take a different view of it, I hope. From there on we can cooperate with whatever we come up with.

It is almost impossible for me in approaching this subject to be able to ask either one of you a question without placing you in an embarrassing position but I will ask the questions because I feel I must.

How do you account for the fact that the vast majority of the medical and scientific community has banded together to oppose this legislation?

Mr. EGEBERG. Well, I think that the vast majority of the medical community, if I may say so, has turned its back on the question of narcotics addiction and drug abuse for about four or five decades. They are beginning to look at it now. I have not been aware of a stand that they have taken but I am delighted with the fact that they are beginning to be interested in large numbers. We have always had committees that were interested but now individual physicians are beginning again to be interested in large numbers.

Senator HUGHES. Well, I think it is rather obvious I am not going to be able to get answers for some of these questions but I will go ahead asking them anyway, Dr. Egeberg, in order to try to make a record of some sort, whether it is negative or otherwise.

In determining whether a substance comes within schedule "I," the Attorney General must find that there is no accepted medical use in the United States, lack of accepted safety for use under medical supervision, and a high potential for abuse.

Now, who is best qualified to make these determinations, HEW or Justice?

Mr. EGEBERG. I would expect that we would make the findings on a scientific basis and that Justice would accept those findings.

Senator HUGHES. Then should not the authority be within your department so you can then advise Justice on any question about drugs or narcotics that they may have?

Mr. EGEBERG. I think this will work.

Senator HUGHES. Let the record show the chairman smiled at that point.

The criteria for scheduling substances in schedules II, III, and IV follow along similar lines, and I presume your answers would also follow along similar lines.

Mr. EGEBERG. Yes.

Senator HUGHES. No need to pursue those in detail.

Mr. EGEBERG. Yes, sir.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

APR 23 1970

APR 22 1970

Honorable Harold E. Hughes
Chairman, Special Subcommittee on
Alcoholism and Narcotics
Committee on Labor and Public Welfare
Room 1327 New Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

As you will recall, at my appearance at the April 14 hearing of your Subcommittee on S.3562, you asked certain questions concerning another bill, i.e., S.3246, which is the Administration's proposed "Controlled Dangerous Substances Act of 1969" in the version recently passed by the Senate.

In particular, you asked for my personal opinion on the question whether the authority, contained in S.3246, to make changes (after enactment of the bill) in the statutory schedules of controlled dangerous substances should be vested in the Secretary of Health, Education, and Welfare or, as provided in that bill, in the Attorney General after obtaining the advice of the Secretary and the Scientific Advisory Committee specified in the bill. Upon reviewing the transcript of the record, I should like to clarify and amplify my response by reiterating what I said on this question in testifying on the original Administration bill, S.2637, before the Juvenile Delinquency Subcommittee:

"S.2637 would retain with the Attorney General the authority he now has to determine when a dangerous drug should be brought under Federal control. The bill would improve this procedure by establishing four categories, or schedules of controlled substances on the basis of the liability for abuse and legitimate

medical value of each substance. As I have indicated, we believe that this provision represents a major and necessary step toward orderly and effective control of dangerous drugs.

"The decision to place a potentially dangerous substance under Federal control involves both legal and scientific considerations. There are those in the Congress and elsewhere who advocate giving to the Secretary of Health, Education, and Welfare the ultimate responsibility for deciding which substances are to be brought under Federal drug abuse control.

"I would be less than candid if I did not acknowledge that there is merit in this suggestion. The hazard to society and to an individual posed by abuse of a drug must be assessed in the light of scientific information on the nature of a given drug, its physiological and psychological effects, trends in its use among various segments of the population, and other factors that are largely the province of the health sciences.

"But we must recognize that determination as to which drugs are to be brought under Federal control and in what manner are an essential element of the regulatory process and thus should logically be made by the agency responsible for such control.

"We think it is highly appropriate, indeed essential, that the Attorney General, in the exercise of his control authority, be guided by the best available scientific information, and we fully support the provision of S.2637 requiring him to seek in writing the advice of this Department and a committee of scientists.

"I would remind the committee that Attorney General Mitchell, in his testimony before you on September 15 stated that he would exercise his authority to schedule controlled substance only upon advice in writing of a Scientific Advisory Committee and of the Secretary of the Department of Health, Education, and Welfare.

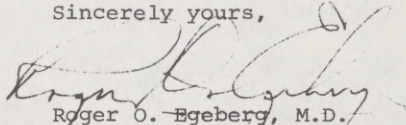
"You have my assurance, Mr. Chairman, that this Department will promptly and fully meet its responsibility in this critically important area of control, so that the Attorney General will be able to base his determinations on the best possible scientific information that can be provided him." (Narcotics Legislation, Hearings before Subcommittee to Investigate Juvenile Delinquency of Senate Committee on Judiciary, 91st Cong., 1st Sess., pp. 686, 687.)

I should like to invite attention to the fact that S.3246 would require the Attorney General to appoint the members of the Scientific Advisory Committee from among nominees of the National Academy of Sciences, and then only after consultation with the Secretary of Health, Education, and Welfare. It should also be noted, again, that not all of the factors that are to be considered in controlling a substance under S.3246 are medical or scientific in character. One of the important elements in making a determination as to control of a substance would be its potential for abuse. This could be shown by, among other things, the extent of actual abuse of the drug as indicated by diversion from legitimate channels. As stated in the Committee report on S.3246, the "normal way in which such diversion is shown is by accountability audits of the legitimate sources of distribution, such as manufacturers, wholesalers, pharmacies, and doctors." (S.Rept. No91-613, p.15) Another factor specified in the bill for consideration is

"controls required based on United States' obligations under international treaties, conventions, or protocols", a factor that involves primarily legal judgment.

I should appreciate it if you would be good enough to cause this letter to be included in the hearing record on S. 3562 at the end of my earlier response to your question.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Roger O. Egeberg", with a stylized flourish at the end.

Roger O. Egeberg, M.D.
Assistant Secretary for
Health and Scientific Affairs

Senator HUGHES. In the area of research, under the administration bill which you support, research applications by medical and scientific professionals who wish to conduct research with schedule I substances must be approved by the Attorney General, and the Attorney General may deny such an application if, among other things, "*the applicant's past practice or proposed procedures furnish ground for the belief that the applicant will abuse or unlawfully transfer such substances or fail to safeguard adequately his supply of such substances against diversion from legitimate medical or scientific use.*"

Now this language, the emphasized portion, "the applicant's proposed procedures furnish ground for the belief that the applicant will abuse such substances," what do you understand that language to mean?

Mr. EGEBERG. They suspect that the researcher is either going to be careless in the distribution of the drugs, or possibly be a user himself. In these instances, they should have a right to deny him the opportunity to have the materials.

Senator HUGHES. How is Justice going to be able to get this information?

Mr. EGEBERG. How are they going to get this information?

Senator HUGHES. I suppose I better ask them that question. It is really a restrictive authority, isn't it, if it applied that way?

Mr. EGEBERG. Well, this is part of the discussion that we are having at the present time and I would like to ask Dr. Miller to corroborate this. Our discussions have been very promising about how this will be handled. We realize that this is not well known outside of Washington and that possibly some people there are working under old misapprehensions.

What do you think about that?

Dr. MILLER. In our recent discussions with the Justice Department we have been told that the Justice Department is going to drop certain areas of research which they had been involved in as a result of projects started while the Bureau of Drug Abuse Control was in FDA prior to its being transferred and we have been invited to pick up any of those projects which we feel are worthy of continuing.

So we understand that the intent of the Justice Department, at least in terms of its own research authorities, is to limit it to the research related to their law enforcement function.

Senator HUGHES. We have been told the same thing by the Justice Department when they were here to testify.

I would ask you the same question regarding President's ad hoc commission and your rather loosely knit arrangements for consulting one another between the two departments. What happens when we get a new President and a new Attorney General and a new Secretary of HEW?

Dr. MILLER. Dr. Egeberg and I met with Mr. Ingersoll just about a week ago. The liaison is not restricted to the President and the White House group, there is considerable contact between the agencies. As I said at that particular meeting among other things we discussed the fact that the Justice Department was going to terminate certain research projects which are much more in the health and mental health field.

Senator HUGHES. What do you construe the Justice Department's authority in educational research to be?

Mr. EGEBERG. I would think that that is a field which might well be open to both the Department of Justice and to HEW, because in their efforts to do research on how they can control the sales and the importation and the distribution of drug products and narcotics, I would think that education might play an important part. That would be my personal interpretation.

Senator HUGHES. You would conceive that they should have this educational authority, then, and that you ought to abandon that?

Mr. EGEBERG. Not that we are going to abandon it; no. We shall carry on with it.

Senator HUGHES. Where are the guidelines that say who does what?

Mr. EGEBERG. Mr. Ellenbogen.

Senator HUGHES. As I read the bill—let me read it. I didn't want to get into that much detail.

On page 64 of S. 3246:

EDUCATION AND RESEARCH

SEC. 602. (a) The Attorney General is authorized and directed to carry out educational and research programs necessary for the effective enforcement of this Act. In connection with such programs he is authorized to—

(1) establish methods to assess accurately the effects of controlled dangerous substances and to identify and characterize controlled dangerous substances with potential for abuse;

(2) enter into contracts with public agencies, institutions of higher education, and private organizations of individuals for the purpose of conducting research, or special projects which bear directly on misuse and abuse of controlled dangerous substances.

I don't see any restrictions on that, Dr. Egeberg, no matter what your counsel says.

Mr. EGEBERG. All right. Let my legal mind speak.

Senator HUGHES. He is not going to reply after that.

Now go ahead, please. I would like your interpretation.

Mr. ELLENBOGEN. Would you like me to reply?

Senator HUGHES. Yes.

Mr. ELLENBOGEN. I would interpret the second sentence of S. 2346 that you read to be within the limits of the preceding sentence, which says that the educational and research programs must be those that are "necessary for the effective enforcement of this act," and it is within that framework that it would have to be conducted. Now necessarily there would be an overlap, I think, between the two departments which would require some coordination in order to avoid duplication, which is being done.

Senator HUGHES. I recall Mr. Ingersoll's testimony here. He said he viewed education within the public school system, you know, as an integral part of prevention of the enforcement act.

Now, how can you reconcile that with the educational department of your own division?

Mr. ELLENBOGEN. This bill refers to enforcement and not prevention.

Senator HUGHES. I know what the bill refers to. I am referring to Mr. Ingersoll's testimony.

Mr. ELLENBOGEN. I think you should ask the Justice Department on that.

Senator HUGHES. I did, and I didn't get any more successful an answer than I am getting right now.

Mr. ELLENBOGEN. Actually though, as I say, there is a gray area.

Senator HUGHES. It is all gray, isn't it?

Mr. ELLENBOGEN. No.

Senator HUGHES. Where is the restriction on this? What can't they do? Tell me what this Attorney General can't do under this authority?

Mr. ELLENBOGEN. Well, what they cannot do?

Senator HUGHES. What they cannot do.

Mr. ELLENBOGEN. In the way of research or education?

Senator HUGHES. Both.

Senator ELLENBOGEN. I think their research would have to be directly related to some function of the Attorney General under this bill, some enforcement function. This would include research necessary to decisionmaking under the classification section of the bill.

Senator HUGHES. How about education?

Mr. ELLENBOGEN. Well, foremost I think in education would be the training of law enforcement personnel.

Senator HUGHES. I am asking what they cannot do, not what they can do.

Mr. ELLENBOGEN. I think it would have to be education—

Senator HUGHES. Can they go into the school system to educate little children 7 years old and 8 years old? Can they enter into research grants for the purpose of determining whether they should or should not?

Mr. ELLENBOGEN. They cannot make any grants under the section at all, they can only make contracts.

Senator HUGHES. They can make contracts.

Mr. ELLENBOGEN. For educating children in the schools? Well, I would defer to them on that, on what is necessary for the enforcement of this act. The question is open to argument.

Senator HUGHES. As I view it there are no restrictions on it but there is no use to pursue it any further because, obviously, you cannot answer the questions for them. When you said what they could do I thought maybe you could tell me what they could not do in the converse, but you apparently can't.

Mr. ELLENBOGEN. I think I know that they would not enter into fields of education and research that were being carried out by HEW. They have already indicated their attitude on that by withdrawing from some biological research, or physiological research, that they inherited from the earlier Bureau of Drug Abuse Control. On the score of research, our understanding with them I believe—and I think it comes out of the bill, too—is that their research will be in the areas of their business, primarily such areas as the prevention of the importation and distribution of these drugs, and the catching of people that violate the act, and ways to prevent diversion into illegal channels.

Senator HUGHES. The declaration of their business. Let me read you one of the declarations under S. 3246.

The Congress, however, finds and declares that the illegal importation, manufacture, distribution, possession, and improper use of controlled dangerous substances have a substantial and detrimental effect on the health and general welfare of the American people.

Now if we go down and say that the Attorney General is authorized and directed to carry out educational research programs necessary for the effective enforcement of this act, you tell me where he is restricted.

Mr. EGERBERG. I think the word enforcement there limits him.

Senator HUGHES. But the findings and declarations state "The substantial and detrimental effect on the health and the general welfare of the American people," which opens the door wide open.

Mr. ELLENBOGEN. Sir, this is simply part of a congressional finding laying a constitutional basis for the regulatory and penal features of this bill and has, in my view, no operative effect in enlarging the specific provision on education and research.

In other words, I don't think that the research section would authorize general research or education on drug abuse or dependence simply to promote the health and welfare of the American people.

Senator KENNEDY. Do you have any objection to spelling it out in the Hughes bill, then, just restricting, if that is just the general finding, to carry forward the point that the chairman has made that in terms of education the Attorney General's position will be more restricted? Do you have any problem with this?

Mr. ELLENBOGEN. I do have a problem in that there is an area where both the Departments would approximately conduct education or research which might overlap and which would require coordination. I think it might be unfortunate to try to be too exclusive or specific in the statute. However, as Congressional committees often do, they illuminate legislation by statements in committee reports, and it might be of some help to do so in this connection, depending on what the report says. However, that bill is not before this committee.

Senator HUGHES. I think it would contribute little, really, to pursue this a great deal further. But the problems as I see them are so many and so broad in this so-called little bit of overlap that you are describing that there is going to be nothing but discord, disagreement and trouble on who has the authority to do what. Now you show very little concern for this and yet within the broad scope of the authorities you already outline for me you show a great deal of concern if we try and define those.

I believe for the time being I will yield to the Senator from Massachusetts.

Senator KENNEDY. I thank the chairman.

I am sorry, Dr. Egerberg, that I didn't have a chance to get here and hear all of the earlier part of your testimony.

First of all, I am interested in the level of funding by the administration of the drug abuse programs. As I understand, in 1971 it is some \$56 million. Is that right?

Mr. EGERBERG. It is close to \$56 million.

Senator KENNEDY. \$56 million. This represents an \$8 million increase over the previous year, as I understand it further.

Mr. EGERBERG. I think about a 33 percent increase over the past 2 years.

Senator KENNEDY. Well, what are those figures? How much does that come to in terms of dollars? What has been the increase that is taking place in the last couple of years in terms of the administration recommendation?

Dr. MILLER. I unfortunately do not have departmental data. The \$63 million figure is correct for 1971 for the Department. The NIMH budget was \$37 million in 1969, so in these past 2 years for our program there has been an appreciable increase in this field.

Senator KENNEDY. As I understand it, it is an \$8 million increase from fiscal year 1970 to fiscal year 1971, isn't that correct?

Dr. MILLER. It is \$8 million for the Institute; it would be in that area for the Department. I suspect the Department would be more in the area of \$9 million or \$10 million, Senator Kennedy.

Senator KENNEDY. In any event, it is somewhere between \$8 million and \$10 million for the total drug abuse program in terms of what the administration has requested for the existing programs.

Am I correct in that?

Dr. MILLER. Yes.

Senator KENNEDY. But at the same time, the Director of NIMH has spelled out quite dramatically to the committee the figures in terms of the growth of addiction, and the growth of the drug problem, and the nature of the problem that we are confronted with today. I think the Chairman of this committee, in the course of his hearings which have taken place in a great many parts of the country, has demonstrated the magnitude of it as well.

All of us are aware of the budgetary restraints which are certainly upon all of the departments. But I do feel, quite frankly, that this low funding you mention does at least reflect some sense of priority in terms of what the Department places on these programs—to get an increase of only between \$8 million and \$10 million. Moreover, as I understand it, the total program available for community services or community facilities is funded at only \$10 million.

In contrast, a State like New York, although it is not typical, has expended over the last few years some \$300 million on the drug program. Are you familiar with that?

Dr. MILLER. I believe it is considerably more than that. Senator Kennedy, if my figures are correct. Since they started their State narcotic addiction control commission they have expended around \$300 million, much for construction and purchasing, and renovation of facilities.

Senator KENNEDY. How does the Federal effort rank in terms of what other States are spending for drug abuse? Do you know?

Dr. MILLER. New York State certainly by far has the largest financial input into the narcotics problem. California has had a State program for some time. I do not have the current budget figures for that program.

However, most of the other States spend relatively little in this area.

Senator KENNEDY. What is the problem in terms of funding? Is this because we have not been able to develop a program in which Federal resources would be or should be made available to local communities to help and assist them? What is your feeling, Dr. Egeberg, on why there is such inadequate funding? Is it because we don't think there is a need at the local level to develop programs to help and assist local communities, or that we don't think that the States need these kinds of resources to help them develop drug programs, or that we don't need it in the fields of education or rehabilitation or research?

Why do you think there is such a limited kind of allocation of resources at present?

Mr. EGEBERG. Well, I certainly agree that the States need help in what has become a nationwide problem. Within the very stringent budget of the last few years one looks at some things proportionately rather than absolutely.

This increase of 33 percent in the amount of money given to this program over a period of 2 years—while we could probably use more in view of the stringent budget—is certainly going to help us in the long run. I think we have made progress.

Senator KENNEDY. What do you have in terms of applications now for those resources—say for the \$10 million you have available for community support or community facilities or contracting for those funds? What do you have in terms of applications?

Mr. EGEBERG. Do you know how many?

Dr. MILLER. I was just handed the information, Senator. I don't have the dollar amount. We have 16 applications in house now pending review.

Senator KENNEDY. Sixteen applications for what kind of facility?

Dr. MILLER. I am talking now about the community assistance program.

Senator KENNEDY. Yes. That is what I am referring to.

And you have 16 applications for these kinds of facilities?

Dr. MILLER. This year.

Senator KENNEDY. What is the amount of those requests in dollar terms?

Dr. MILLER. In the area of \$4 million.

Senator KENNEDY. In the area of \$4 million.

I had an opportunity to chair some hearings on this problem up in Massachusetts in the last few days, and the demands and interest at the local level just amazes me, in terms of what many of these communities are trying to do in finding some kind of help and support. It really amazes me—perhaps it should not but it does amaze me—that there are only 16 communities who have made requests drawing on this fund.

Can you think of any reason why it is such a small number? Is it because of lack of interest or is it because the communities know that resources are not there or is it because they don't know that there is such a program in existence?

Dr. MILLER. It would be hard for me to give a specific answer to that, Senator Kennedy. I do know, however, that before one can apply for a Federal grant in this area there have to be certain conditions met.

For instance this is a matching grant program and one real possibility I guess at this point for the applications coming in so slowly is that this committee recently reported out and the President recently signed new legislation which goes into effect July 1, which increases the Federal matching rate. So I suspect that a fair number of communities are holding back so that they will get the preferential matching rate after July 1.

Senator KENNEDY. What is the rate now?

Dr. MILLER. The rate right now starts at 75 percent Federal share. This is in the staffing support for professional and technical staffing

and extends for 4 years and 3 months with the Federal share declining each year, so that by the last year it is at 30 percent. The new legislation would provide for a total of 8 years of —

Senator KENNEDY. That is staffing?

Dr. MILLER. Staffing.

Senator KENNEDY. OK.

Dr. MILLER. I refer to that because we do have construction authorities under this legislation but up to now we have not received any applications so we have not supported any construction grant.

Senator KENNEDY. What is the formula for that?

Dr. MILLER. The current formula for that is consistent with the formula for the base Mental Health Centers Act, Burton from one-third to two-thirds Federal share.

Senator KENNEDY. And you have not had any requests for those?

Dr. MILLER. Not for construction, no, which is not surprising in that construction is first of all expensive, and takes a long time. Experience in the field has been that in some ways the use of existing facilities to converted houses might even be preferable to construction of new facilities for this purpose.

Senator KENNEDY. It really surprises me. Yesterday we passed in the Senate the Mental Retardation bill, for example, and there is some \$331 million in applications by communities there for funding grants for mental retardation facilities. In comparison, it just amazes me that—as interested as people and communities are in the problems of mental retardation—there are only 16 requests for some kind of help and assistance under your program to help community facilities for drug abuse treatment.

Dr. MILLER. The question of local matching has been a real problem even in grants which we have awarded where we have had certain assurances that other forms of matching would be available. We have found that it has taken longer than anyone would expect to get some of these projects off the ground because of the difficulties in finding local matchings. We would hope that with the new matching formula that this will become less of a problem.

Senator KENNEDY. Are we to assume that we can go back to our communities and say that there are these funds available? You say you have only got a request in there for some four millions of dollars. Can I go back to the communities in Massachusetts and say: Come on down to Washington. You will be considered on your merits, obviously, but there are Federal funds which are available and after July the Federal matching share will be even greater. I would like to know what to tell the people in my State on this problem.

Dr. MILLER. I should point out that we do have a grant in Massachusetts at Boston University. We have one of these community assistance grants which is in operation now. In terms of future applications clearly they will be judged on their merits and to the extent that funds are available they will be paid.

Senator KENNEDY. What kind of a program do you have for local communities that are trying to do the job? We have got a number up in Massachusetts for Winchester, there is project concern which has been locally developed and motivated. In Malden they have this

ACID program which has been very impressive. And a number of different communities have taken local initiative on programs. They take different form, different direction.

One of the real problems is that they have not been able to coordinate themselves, that the State has been slow in developing communication so that there can be a cross-fertilization of programs and ideas.

But what can we tell these communities in terms of what kind of assistance, if any, they can receive from the Federal Government?

Dr. MILLER. Not to be flippant, Senator Kennedy, I guess the first is to start with the new Assistant Commissioner, Dr. Mathew DuPont, who recently left my staff—

Senator KENNEDY. He is superb, absolutely superb. He testified and he is just first-rate. But after they consult with him for awhile, what kind of resources are available? Are there any resources to help communities on these projects?

Dr. MILLER. The resources are two kinds. One, and a very critical one is in the area of technical assistance. We have been impressed by the enthusiasm of a number of communities. I spoke yesterday with the Representative from Massachusetts from New Bedford where the local citizens are starting a very interesting project which will develop a narcotic addiction program intimately related to a community mental health center.

Senator KENNEDY. Completely community. They expect to raise \$110,000 in the next 3 or 4 weeks and there is no Federal aid. This is the problem. I find great interest in the local communities, but the Federal Government is not interested.

Mr. MILLER. As I say, one thing that we do offer which is very critical—is this technical assistance. Enthusiasm is quite critical to the program. However, there is a real shortage nationwide of really skilled consultants, persons who are really knowledgeable on how one sets up such a program.

A major part of our work, both from our own offices here in Washington and from the NIMH staff in the regional office in Boston is involved with site consultation with potential applicants. I would suspect that one of the reasons for the still relatively small number of applications is that there is a lot of spadework going on now. I trust this spadework will be effective and then not only stronger applications but stronger programs will result.

Specifically, directly to answer your question, once the applicant is convinced his application is in good shape and after consulting with the State as well as the regional people, the application is sent to us here in Washington where it is reviewed on a quality basis and then grants are paid to the extent that funds are available.

Senator KENNEDY. Well, what can the community receive?

Dr. MILLER. Well, the law restricts us to the support of construction and the professional and technical staffing of such a program. Talking about staffing, this has been our sole experience up to date with this part of the program. We can support a broad range of staff, including professionals as well as nonprofessionals. Some of our grantees have up to 50 percent of their staff consisting of nonprofessionals.

Senator KENNEDY. Do you get the communities to actually develop facilities as well.

Dr. MILLER. We certainly do, Senator Kennedy.

Senator KENNEDY. What has been your experience on that?

Dr. MILLER. We have been quite active in cities where there is a considerable problem and little or no resources available. In one city for instance we have put a man virtually full time to work with the city in the various agencies within the city to enable them to begin to develop such a program.

We have to choose places carefully because of our own limitations but I believe we can justify this on the basis of some areas which are just in dire straits because of total lack of local facilities. So we do see our role as a stimulant as a significant one.

Senator KENNEDY. But it is going to be very limited if you have got only \$10 million nationwide. As I understand it, the best estimate is that it cost \$2,000 a year to treat a heroin addict. Is that about the figure that you use?

Dr. MILLER. \$1,500 to \$2,000 a year.

Senator KENNEDY. The best estimate from Mr. Callahan, who is regional director of the Bureau of Narcotics and Dangerous Drugs up in Boston, is that we have some 4,000 heroin addicts in Boston alone, which would mean that if you were going to treat these people it would take \$8 million in just Boston alone.

Dr. MILLER. The \$10 million, I should point out, is the total for the program and includes the cost of continuing grants which have already been made. So the actual amount is free money, or new money available to be expanded for new grants, and is somewhat less than that.

Senator KENNEDY. Well, how much is that?

Dr. MILLER. This fiscal year we will have somewhere in the area of \$4 million.

Senator KENNEDY. So you have approximately \$4 million, then, which is available in terms of professional staffing and other assistance under the matching formula—nationwide funds available for new kinds of programs.

Well, now Dr. Egeberg, do you think this shows something about a sense of priority on drugs?

Mr. EGEBERG. I think that the increase in funding of the last few years as compared with the increase in research in other areas is very encouraging. But I think one has to remember that when biological research was being encouraged by Congress, much of the financing depended on the number of grants that had been received in the previous years. If there were many grants that had been left unsupported on the basis of money rather than the quality of the proposal, this seemed to stimulate a greater supply of money for such projects in succeeding years.

So I personally feel that grants should be encouraged to come in, and we are encouraging them.

Senator KENNEDY. We are getting your message. We will go out and try to stimulate some of these. Of course it is unfortunate, as all of us realize, to arouse the interest and hope and expectation in any of these communities and then not have the resources to be able to meet them. I mean I am sure you are convinced as someone who I know has

spent many years involved in this problem, that there is a crying desperate need in these communities and a great willingness to provide local resources and matching funds.

As pointed out, there is such a lack of funding that in a very significant and dramatic way, we unfortunately fail to even start to come close to the problem.

As I understand it, now, in terms of the increase in funding for these community facilities, in 1969 it was \$8 million; in 1970 it was \$8 million; in 1971, fiscal year, it is \$9.9 million.

Dr. MILLER. That is correct.

Senator KENNEDY. So \$8 million in 1969, \$8 million in 1970, and \$9.9 million, or \$10 million in 1971. I suppose you can go on and say from eight to 10 million is a 25-percent increase, but when you look at the dimension of this problem it really is difficult for us to assume that it has much of a priority in terms of the department.

Could I just move into terms of education for a moment? Could you tell the committee what aspects of drug education you feel are especially critical at the present time?

Mr. EGEBERG. I feel that the problem is becoming critical in grammar school.

Go ahead.

Dr. MILLER. NIMH has been developing a program, and the Office of Education has recently received funds to implement their own education program. These programs are based on one principle: Namely, that any education program must be based on scientific evidence because of our experience over the years that scare techniques just do not work as prevention programs. There are numbers of different populations which have to be reached and one needs to develop a number of different mechanisms for reaching them.

Clearly, the heroin addict in the ghetto, be he black or Puerto Rican, responds to different kinds of educational information materials than the adolescent in the suburbs who is experimenting with marihuana.

To this point our past and future program is predicated and based on scientific information. It has consisted of a number of TV and radio spots and various posters, all of which have been distributed nationally.

Senator KENNEDY. What is the thrust of the program? Is it to scare the kids in terms of drugs, or do you try to tell them what they can take without getting into trouble? What is the thrust?

Dr. MILLER. The thrust of our program, Senator Kennedy, is presenting information which is totally based on scientific facts. That is to say, if we don't know something about a drug, we will so indicate. We are very concerned about a form of credibility gap which has developed over the years in this area. We are convinced that the scare techniques which were so prevalent several years ago and until recently do not work, in fact they may work negatively.

If someone is told, for instance, that a drug like marihuana is addictive or can lead to various severe effects any time that he takes it, and then if we also say that heroin is addictive, we may not get that latter message across because people have turned off when they know that the information that we have given out about marihuana is not accurate. I think particularly when we are talking about a drug like

marihuana which is being used so widely, we have to be extremely careful about what we say and be extremely factual about it.

There is no question that the main trust in this regard is scientific accuracy. We have distributed upwards of 20 million pamphlets which describe the effects of the major drugs abuse—marihuana, LSD, the amphetamines, and heroin. These are currently being revised and we expect that many millions more will be distributed.

Clearly, one of the target groups are the young persons in the Nation—grammar school, elementary schoolchildren, as well as high school and college. Different programs need to be developed and tailored for their specific needs. In this regard, we have supported the development of a curriculum which, with modifications depending on local needs, can be applied widely with the next few years. It is aimed at giving the basic facts about drugs in ways which are comprehensible to youngsters.

There is another area of education which we feel is critically important, which is the education of health and other professionals who are involved with drug abusers. This year we will be developing as a result of a recent release of funds a targeted program which is aimed at training large numbers of physicians, psychiatrists and other mental health professionals who will be working in the community facilities which we hope to be supporting over the next few years. Likewise, we will be training ministers and other gate-keeper-type persons to recognize the problems of addiction and to deal with the drug abusers and allow them to appropriately refer persons with drug problems to agencies which can provide treatment and rehabilitation.

Senator KENNEDY. Who do you think should be responsible for the education programs other than those which are related to law enforcement? What department?

Dr. MILLER. Well, within the Department the Secretary has the authority to make these decisions and at this point the principal agencies involved are the Office of Education and the National Institute of Mental Health.

Senator KENNEDY. They should be the ones. Other than programs which are strictly related to law enforcement, they ought to be the ones that are charged with the responsibility?

Dr. MILLER. With the principal responsibility.

Mr. EGEBERG. I have had several talks with the Commissioner of Education, Mr. Allen, on this very subject, and I think he is deeply interested in this and pushing hard to find a handle.

Senator KENNEDY. I am not worried about Commissioner Allen, I am worried about Secretary Mitchell.

How effective have you found these young former addicts are in terms of the education program? Do you try to use these young people? Have you found this to be effective?

Dr. MILLER. We don't use them directly, but many of our grantees who employ ex-addicts do use them for education activities. I think the experience is mixed. Some communities report that this works extremely well, in other places there has been some concern raised. This may depend on the particular technique which is used. I think that there is a clearly established and defined and valuable role for the ex-addict in the treatment rehabilitation and prevention aspects.

Senator HUGHES. Thank you very much, Senator Kennedy. We appreciate your assistance this morning.

The Senator from Ohio.

Senator SAXBE. Dr. Egeberg, do you think some areas are more important than others? Suppose we had unlimited amounts of money. What areas do you think we could best exploit to try to stop this almost galloping growth of the drug problem?

Mr. EGEBERG. I feel that the most important area, sir, is the area of education. When we looked at this problem a number of years ago, we found that the boys who started or the girls who started on pills, or on smoking or on heroin became sort of heroes to their school friends. It would seem to me that if drug abuses can be made to assume a different image—one of being immature, childish, and failing to grow up emotionally—and get some humor into that. I think we could begin to remove one of the factors that stimulates drug abuse. They are following the leader.

Now beyond that, I certainly feel that if we can get a large number of addicts under some kind of control, whether it be with methadone for those that would seem to be most amenable to that treatment, or other forms of treatment, that would also represent an important advance. Trying to prevent the drugs coming into the country is also certainly something that has to be done and done very well. I remember when I was on that former committee they had enough men in the department to examine one ship in one harbor and I don't know how many arrived at one time, let alone planes.

That seems to be rather a difficult means of controlling this problem. I think maybe Dr. Miller would like to add something to that.

Dr. MILLER. I think it is clear that becoming addicted or becoming a severe drug abuser is a process which takes time.

Senator SAXBE. The phenomenon that we are seeing is a psychological thing rather than a physiological one. In other words, it is built on the stress of our times and the popular appeal. Now this especially is true down in the grade schools and the junior high schools where it seems to be prevalent now.

Does this indicate that it will run its course like most fads, or once these people are hooked, is it going to continue to grow?

Mr. EGEBERG. I think the history of other countries indicates that it is hardly a swing of the pendulum. Once you have a large group who use these drugs, you have a large and continuing problem. That is why I think prevention is so utterly important.

It begins with a lot of people before they are particularly aware of social problems and they are just copying. It is at this point we could begin to have a real impact—by letting them know the dangers of what they are copying and by trying to take away some of the supposed heroism of experimenting with drugs.

Senator SAXBE. I have been impressed by the evidence. It seems that rather than turning them away from drugs, it has glamorized it. Prohibition glamorized drinking in this country. It seems that today because of the laws, it has turned young people to it because it is the thing to do. We read about the 12-year-old and even younger who get hooked.

Now I question whether you are ever going to shut off the supply

because we tried that in prohibition. It was somewhat easier to make but nevertheless there are a lot of drug substitutes; even if they are not as effective, they seem to be substitutes. Everything from inhaling gasoline fumes to some that are obviously more effective.

What worries me is that as we get into this educational thing, are we selling the teachers? Now, I notice that there has been a lot of money going into this education area; that is, relative amounts have gone into this area of teaching the teachers, in trying to sell them on the thing. Has that been effective, do you think, or will it be effective as the group grows in 1971?

Mr. EGEBERG. I think it is beginning to show some effect. I think what you said, Senator, about the glamorization of drug use among young people is a very important factor. In addition to the teaching of the harm and of the natural life histories of those who become dependent on dangerous drugs, aside from that I think we have got to change the picture of what a drug user really is. I think we have to use as teachers people of an age which is very close to the age of the people we are trying to reach.

Senator SAXBE. Well, I am one who would vote for an unlimited amount of money that would be effectively spent. I will support a move to change the program from Justice to HEW or any other change which I think would affect this problem. What rather dismays me is the fact that we could very well be approaching another situation where we get the idea that money is going to cure everything, that money is going to put people in the field and have an effect on this. I find nothing that indicates that we have gotten to him yet and I don't know how we are going to get to him.

Now on rehabilitation and cure, certainly it is something we have to look to. I know and you know that in most hospitals they have no facilities and don't want much to do with the addict. I have a son who is a resident, and he says when they come in, they treat him and they get him out of there because there is no place in the hospital for this kind of a man, and beds are too valuable. They just don't have the ability to cope with this problem in our big general receiving hospitals where people come and go.

But I don't want this to become a political football because that is not going to solve it. I will just throw it into a limbo of something else to kick around. We are accused of not spending enough money on it, and then we spend more money on it and we don't get the proper reaction. So we have to blame somebody. I don't think that there is anybody who disagrees. It would be easy to go back and say that the Johnson administration refused to spend any money on this so we have this problem today. I don't think that if they doubled or tripled the money that they had spent then that we could have stopped a psychological phenomenon that was well on its way. We have not been able to head those off in this country.

Now the only good thing about it that I can see is that as the 13-year-olds take it up, the ones that are 18 and 20 will look upon it as a juvenile thing, that they don't want to have anything to do with it. I begin to see this a little bit. So where we have to work, it seems to me, is to help those who were hooked try to kick it.

Now if more money is needed I will certainly go along with it but just to devote money and sit back and say, "Well, we have done it now," I don't think that this is going to solve any problems.

Dr. MILLER. Senator Saxbe, I just might mention one thing.

There is one instance I think which is relevant here. Following the dissemination of scientifically based information that LSD might cause chromosome damage and cause psychotic reactions, might cause damage to unborn children, we did notice a leveling off of LSD use at least among the college population. I think this reinforces our belief that it is possible through the wide dissemination of scientifically based information to make some inroads.

I think we need to develop more and different kinds of vehicles to get to the population but this is one thing that has helped.

Senator SAXBE. That is all, Mr. Chairman.

Senator HUGHES. Thank you very much, Senator Saxbe.

I would like to go on and on but we are running out of time. We have other witnesses.

I would just like a couple of brief comments. Yesterday we had a witness from the Civil Service Commission testify on the bill. Out of two and a half million employees they only had two people that were discharged because of drug abuse. Does this sound reasonable to you?

Mr. EGEBERG. No; I think there must be more than that.

Senator HUGHES. Of course the whole tenor of the testimony was that if there is a problem, you know, that we handle it in-house in this type of program but nothing is being done, frankly. From all the indications about 85 percent of the insurance for Federal employees covers drug abuse and narcotics addiction already. Do you have anyone taking advantage of that coverage, or is there the same subterfuge we have with the alcoholism?

They put down cirrhosis of the liver or ruptured disc.

Dr. EGEBERG. They used to say that if a man was working, he therefore was not an addict because one could not do both. One could not work honestly and support a habit. Now with the other drugs I have a feeling that addicts in the civil service organization would be a very small fraction of the drug-dependent population if you took the country as a whole. But I would still agree with you that charity begins at home and we better start seeing what we can do within our own departments to find out if there are people there who could be helped and to see that they get help.

Senator HUGHES. Do you have a personnel director in your department?

Mr. EGEBERG. Yes.

Senator HUGHES. If an applicant placed on his application that he had been a heroin addict 15 years ago, would you hire him?

Mr. EGEBERG. Would I? Yes. I have in the past.

Senator HUGHES. Would your department hire him today?

Mr. EGEBERG. I don't know. I know that where I worked previously one had to get a waiver from somebody very high up in order to take somebody like that on the job. I don't believe that there would be any objection to hiring such a person but not to put him in an area where he would have excessive temptation such as working in a hospital or something like that.

Senator HUGHES. It is an unwritten law, common in business, that you just don't hire those people if you find on their record that they have been convicted of drug violations, or narcotic violations or rape. They are out.

Mr. EGEBERG. Yes. I had an addict come to me because I met him in prison once and he wondered if I could get him a job. It took me 1 year to get him a job. I used all the resources I had in order to try to help him. There is a very strong prejudice on that score, a very strong prejudice.

Senator HUGHES. This gets to another area of education, which is why I was raising the question, Dr. Egeberg. I know what the common practice is; I have had similar experience in trying to get employment for people addicted to alcohol, drugs and narcotics.

It is a common public attitude. Once the persons are branded, for the rest of their lives they carry the sign, you know, and they have had it.

Now this process of public education requires a great changing of attitudes, historical attitudes, and it is a very difficult job. I think we should focus on that. Don't you agree?

Mr. EGEBERG. I think we should focus on it very, very much.

Senator HUGHES. Otherwise, the millions of young people today who are being branded are more or less doomed.

Mr. EGEBERG. Yes.

Senator HUGHES. In the Armed Forces we come across similar attitudes. I had asked, along with Senator Dominick, for a briefing by the Pentagon on drug abuse and narcotics addiction problems in the military. It was rather disappointing but, nevertheless, we had the briefing.

You have had a great deal of experience in the Armed Forces yourself. The problem is rising and we keep getting information both first-hand, from reading the papers, and through official channels in the Armed Forces. We had a man testify yesterday that he had members of the Armed Forces coming to him for treatment of heroin addiction while they were still in the Armed Forces.

Now is it possible for people who are heroin addicts to be in the Armed Forces and for their people not to know about it?

Mr. EGEBERG. Well I would think that if they were alert to this through some kind of educational program they would be very apt to know, but sometimes they are not.

I was woefully ignorant when I was in New Guinea in World War II. I told you the story just before we came in here, and I won't repeat it, but I didn't finish that story.

I gave them 500 tablets.

Senator HUGHES. You did give it to them?

Mr. EGEBERG. I had not been in combat yet.

Senator HUGHES. You had not been there very long. Well, the medical package came in handy to a lot of people, not for wounds but for a lot of reasons.

I might say in relation to that we also have heard from the Pentagon that their commanding officers could look their men in the eye and determine the state of their health, as to whether they were using drugs or not.

Mr. EGEBERG. They ought to look at their tongue. They talk about the pinpoint pupil of a person who is on drugs—pinpoint pupil while

he is taking a dose, while he is really affected by it, but as soon as that wears off he no longer has a pinpoint pupil.

Senator HUGHES. How many line commanders have you known that have had that capability?

Mr. EGEBERG. How many what?

Senator HUGHES. Line commanders—captains, lieutenants, second lieutenants.

Mr. EGEBERG. Well, I don't think it exists on the basis of looking a man in the eye. That is supposed to be the way you can tell a crook and I never find it works.

Senator HUGHES. This was even in relation to marihuana, which would be more difficult, would it not?

Mr. EGEBERG. Yes. I don't think—

Senator HUGHES. A survey taken on the basis of asking company commanders whether their men used marihuana, what value would that have?

Mr. EGEBERG. Well, I would think if you asked the lieutenants you might get a little more insight than if you asked the platoon leaders who lived closely with them. I think you might get some insight. But a company commander is also beginning to be a distance from his men; yes.

Senator HUGHES. I won't belabor that any more.

I might ask Dr. Miller just a couple more questions.

Do you have any fund grants to Cook County Hospital in Chicago?

Dr. MILLER. In the narcotics program?

Senator HUGHES. In any program.

Dr. MILLER. I would have to check.

Senator HUGHES. We had a person in our office the other day, and I could hardly believe it, but he told me that that hospital, which is the largest hospital in the United States of America, receives not \$1 of Federal funds. Not \$1.

Mr. EGEBERG. That hospital I can tell you has been through more political trouble—with emphasis on that word—in the last 25 years than 15 other hospitals, including all in New York City put together, and they have had difficulty getting medical schools to be consistently interested in them. They have consistently had trouble in getting good physicians to come and stay. I think the reasons why they have not had grants—

Senator HUGHES. Most of the jobs are political patronage, aren't they?

Mr. EGEBERG. That used to be the case and I don't know that it requires political patronage any longer to get a fellow a job at the Cook County Hospital.

Senator HUGHES. It might be political punishment.

My point is that here is one of the largest facilities available, with an 80-percent black population of patients, over 50 percent of them alcoholic patients. If the information given me is correct, it was that they have no funds whatsoever in any field, let alone in the field of alcoholism, drug abuse, and narcotics addiction. It surprises me that a group worked with alcoholic patients that came into the hospital. If I recall correctly, they have through there every year some 70,000

patients. This is not to criticize your Department. I doubt if they ever really filed an application for assistance.

Mr. EGEBERG. There has been a great deal of instability in that institution. I think if you went one block up the street to St. Luke's Hospital you would find they receive many, many grants and they are working with a similar population, but not anywhere near as large a group as they have at the Cook County. I don't know what one can do about it. I suppose one can try to establish a group that one could work with, and I am not sure but what they may not already have been done because they are trying to get the medical schools more actively interested in the hospital. It might be that some of them have grants that work in the hospital.

Don't you think so?

Mr. MILLER. Certainly possible.

Senator HUGHES. I didn't expect you—

Mr. EGEBERG. That is the big open distressing situation.

Senator HUGHES. Here is the situation where they are running tens of thousands of patients pell-mell through a hospital where they have no alternatives and it is a very difficult thing. I think maybe we should hold hearings in conjunction with some of the problems there and see if we can determine what, if anything, can or should be done with large institutions like this, particularly where the problems are exceedingly difficult.

Mr. EGEBERG. They are complex and very difficult in Cook County. I am aware of some of them.

Senator HUGHES. Gentlemen, I want to thank you. I have taken practically the entire morning with you.

Senator Dominick had some questions he wanted to ask you. I would like to make them a part of the record at this point and submit them in writing and have you submit your answers back in writing, if you would, for the record.

Mr. EGEBERG. Thank you, we will do that.

Senator HUGHES. We will appreciate your continuing cooperation, at staff level, with us.

Mr. EGEBERG. We would welcome the opportunity to discuss any arrangement.

Senator HUGHES. Thank you very much.

Mr. EGEBERG. Thank you.

(The information subsequently supplied follows:)

ANSWERS TO QUESTIONS SUBMITTED BY SENATOR DOMINICK TO ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, AND DR. MORTON G. MILLER, ASSOCIATE DIRECTOR FOR SPECIAL AND COLLABORATE PROGRAMS, HEW

I. COMMUNITY MENTAL HEALTH CENTERS APPROACH

Question. When you were here on March 24, you mentioned 16 drug centers are now being funded and 14 more are projected by FY 1972. Are these special facilities, or are they programs incorporated in existing Community Mental Health Centers?

Answer. Of the 16 centers funded six are presently part of a comprehensive community mental health center. The remaining ten are special programs for narcotic addicts located in most cases where there is no comprehensive mental health center.

Question. According to your latest data, how many Community Mental Health Centers are currently being federally funded? How many are now operational?

Answer. Funded Community Mental Health Centers as of 12/31/69:

Construction grants only-----	158
Construction and staffing-----	122
Staffing only-----	103
Total-----	383
Total Community Mental Health Centers operational as of 12/31/69-----	210

Question. How many regular Community Mental Health Centers now include drug programs, and will you provide a list of their location by city?

Answer. Funded Community Mental Health Centers with drug abuse and addiction services by city as of 6/30/69:

Gateways Hospital: Los Angeles, California.

Kedren Community Mental Health Center: Los Angeles, California.

Mission Community Mental Health Center: San Francisco, California.

Central County Mental Health Center: San Mateo, California.

Denver General Hospital: Denver, Colorado.

Area B: District of Columbia.

Area C: District of Columbia.

Garfield Park Service: Chicago, Illinois.

Boston State Hospital: Boston, Massachusetts.

Range Mental Health Center: Virginia, Minnesota.

Bergen Pines Community Mental Health Center: Paramus, New Jersey.

Community Center for Mental Health: Dumont, New Jersey.

Bernalillo County-University of New Mexico Medical School Community Mental Health Center: Albuquerque, New Mexico.

(1) Metropolitan Community Mental Health Center: New York, New York.

(2) Washington Heights—West Harlem Community Mental Health Center: New York, New York.

(3) Convalescent Hospital for Children: Rochester, New York.

(4) Comprehensive Mental Health Center: East Meadow (L.I.) N.Y.

(5) Samaritan Hospital: Troy, New York.

Hahnemann Community Mental Health Center: Philadelphia, Penn.

Mayaguez Mental Health Center, Mayaguez, Puerto Rico.

Cagras Mental Health Center: Cagras, Puerto Rico.

Arecibo Mental Health Center: Arecibo, Puerto Rico.

Aguadilla Mental Health Center: Aguadilla, Puerto Rico.

Ponce Mental Health Center: Ponce, Puerto Rico.

Bayamon Mental Health Center: Bayamon, Puerto Rico.

Carolina Mental Health Center: Carolina, Puerto Rico.

Presbyterian Hospital of Dallas: Dallas, Texas.

Question. Since so much reliance is placed on the Community Mental Health approach, I think it is imperative for the record to show how much was appropriated for these centers, including what portion of the funds were devoted to drug programs, over the past few years. Can you provide that information as well as the budget request for FY 1971?

Answer. Community Mental Health Center Appropriations for the period 1965-1971.

From the inception of the Community Mental Health Centers Program in 1965 through the most recent appropriation for fiscal year 1970 a total of \$230,500,000 has been appropriated for construction of community mental health facilities and \$217,049,000 for initial staffing of new community mental health services. For fiscal year 1971, the Department expects to obligate over \$80 million with respect to this program.

A small minority of centers have constructed specialized facilities and/or received Federal staffing assistance for a separate, specialized drug abuse treatment program under the base Community Mental Health Centers Act. The majority of centers, however, serve limited numbers of drug abusers within a general program of mental health services and cannot readily identify the portion of salary and operating cost actually allocated to the treatment of drug abuse.

II. WHITE HOUSE COORDINATING COUNCIL

Question. The Civil Service Commission was omitted. Do you know why? We had testimony yesterday from the Civil Service Commission that it has jurisdiction over some 2.5 million Federal employees. Do you think it should be brought into the co-ordinating picture?

Answer. I do not know why the Civil Service Commission was omitted from the Co-ordinating Council. In my opinion the Council is designed to assure program and policy coordination among the operating agencies of government. I do not know of any drug related program administered by the Civil Service Commission, but I am certain that the Commission would participate in any Council activities relating to policies toward Federal employees who are drug abusers or drug dependent persons.

III. TRAINING CENTERS

Question. Where are these four special training centers located?

Answer. The exact location of these centers is not yet determined. Requests for proposals are currently in the hands of organizations who expressed an interest in rendering this service. When the proposals are received, a competitive review for technical competence, cost, and other pertinent characteristics will be made prior to selection.

Question. Who is eligible to apply for such training and how do they go about applying?

Answer. A notice appeared in the Commerce Business Daily of March 24, 1970, inviting qualified and interested parties to apply. The requirements and eligibility standards are those that apply to the government contracting mechanism.

(The announcement follows:)

"A—Research and Development Sources Sought. The National Institute of Mental Health is seeking organizations with extensive experience in professional education programs in having capabilities in one or more of the following four major areas of the Professional Education Program in the Prevention and Treatment of Drug Abuse. (Note) No single source will be considered for work in all the areas:

"1. Organizations related to community treatment facility and possessing the capability to develop an implement short course training center for professional and para-professional persons working or planning to work in drug abuse prevention, treatment and rehabilitation programs. The nature of the training will be didactic and clinical intensive in nature and at least four weeks duration capacity is estimated at 720 trainees per year.

"2. Organizations possessing the capability to develop and implement short term training courses for health and related professionals practicing specialties which bring them into contact with drug abuses. Training would focus on recognizing abusers and assisting in obtaining adequate care. Courses would be of short duration approx. two weeks. Didactic in nature and set up in a large number of cities having a significant drug abuse problem. Capacity is estimated at 1,000 trainees per year.

"3. Organizations having teacher training experience and possessing the capability for developing and producing highly sophisticated innovative and factual information material for training teachers about drug abuse. All media material will be developed including printed audio visual film and television programs.

"4. Organizations possessing the capability for the development and production of training materials on drug abuse and models for their dissemination to health and social service professionals.

"Emphasis will be placed on both development of material and design of demonstration vehicle such as supplements to professional journals, stereo tapes for home or car, low cost 16mm films programs for educational radio and TV etc. Anticipated audience is 50,000 health and social service professionals.

"Interested organizations are requested to provide the applicable info cited in this announcement heading and specify which of the above areas they are qualified in to provide brief documentation of a specific capability namely your form of curriculum vita and publication of staff.

"This is not a request for proposal, Respondents will not be notified of the results of the evaluation but sources deemed fully qualified will be considered when and if proposals are solicited. No further info avail and phone inquiries

will not be honored. Closing date for the submission of responses is ten days from day of this publication. Refer to SS-ND-6 and submit to Contracts Management Section AMGC NIMH Barlow Bldg. WT208 5454 Wisconsin Ave., Chevy Chase, MD 20015. (R078)"

Senator HUGHES. The Chair calls Dr. David C. Lewis.

Dr. Lewis, I appreciate your great patience. I know you have been waiting all morning and I am sorry it took so long but we thought it was necessary.

We welcome you before the subcommittee. You may proceed with your statement as you desire

STATEMENT OF DAVID C. LEWIS, M.D., ASSISTANT PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, AND DIRECTOR, MEDICAL OUTPATIENT DEPARTMENT AND EMERGENCY UNIT, BETH ISRAEL HOSPITAL, BOSTON, MASS.

Dr. LEWIS. Mr. Chairman and members of the committee, I first would like to thank you for the opportunity to testify before you today

Though I am a practicing internist, my major interest in the drug abuse field is not in the area of treatment and rehabilitation but in the development of effective programs for the prevention of drug abuse and drug dependence through education.

Senate bill S. 3562 that you are now considering is the most exemplary piece of Federal legislation that has addressed itself to the problem of prevention, and I strongly endorse it.

Of the three methods used historically to attack the problem of drug abuse—enforcement, treatment, and rehabilitation, and education—I feel that the most effective and least costly approach will be prevention through education; and by costly I refer as much to the cost of human suffering as the cost in dollars.

I realize that through the deterrent effect of the law, enforcement also can serve a preventive function. Enforcement, however, has obvious limitations in its effectiveness. The efficacy of the prohibition laws and the widespread use of marihuana today in the face of existing laws illustrate this point. The best we can say is that the number of drug abusers would be even higher if it were not for the laws. These drug abuse laws, then, are at best a partial solution to the problem, and no solution for the personal tragedies of drug abuse and drug dependence. It is imperative to develop alternative programs to the enforcement approach which we have relied upon for the past 56 years.

I have a particular sense of urgency concerning the development of new approaches to the problem of drug abuse. Today there are increasing numbers of young heroin users. Marihuana users now comprise the majority of students in some schools, and many of these students are now seeking to experiment with hashish, mescaline, and LSD. Many young people are trying the new mind-altering substances that are continuously entering the drug scene.

There seems to be little motivation for change among drug abusers, and most of them never enter into a therapeutic setting. While serving as a voluntary physician in a center providing counseling for young people who were using heroin, LSD, mescaline, and intravenous amphetamines, it was painfully obvious that these young people had

made their decision about drug use and few were motivated to seek change. For those who are motivated to seek treatment, our ability to effect meaningful change is limited at the present time and our resources are inadequate. We must provide the desperately needed support for treating those victims of drug abuse and drug dependence who now seek and need it, and we must encourage research in the development of more effective treatment methods. This bill addresses itself very effectively to these problems.

The exact nature of drug treatment and rehabilitation programs will vary from community to community, and appropriately so. It is important that programs supported by this act be closely tied with the existing community programs of public health and mental health, and that treatment for drug abuse and drug dependence be closely linked with comprehensive medical care delivery. Support should also be available to community programs not heavily saturated with health professionals, such as ex-addict-run programs.

I hope that the same kind of communication and coordination that is set forth in titles VIII and IX of this bill can be encouraged in the local communities where the services will be rendered. Although the coordination of applications for local programs required by section 705 would guard against unnecessary duplication of effort, it would not necessarily result in communication among programs once they were in operation. Federal support to facilitate communications among the developing programs I think would be a good investment.

The amount of Federal support for community programs will have to be substantial. As a member of the Coordinating Council on Drug Abuse of the city of Boston, I advised the mayor of the city of Boston in the development of his program which he has already described to you. Our estimate of the cost of beginning a comprehensive program for the city of Boston is close to \$1 million. Our proposed funding includes both private and governmental sources. However, \$1 million will provide us with services to meet the needs of only a percentage of those who require these services.

Because of my interest in prevention and education, I have spent the past year developing and implementing the concepts of a drug education program designed to make kids stop and think. It is based on the premise that the ultimate responsibility for drug-taking rests with the individual. Since the on-the-spot decision to take drugs is made by the individual, education can be effective only if it is directed at the decisionmaking process. It must provide information so that the social, medical, and legal implications of drug-taking can be viewed in personal terms—what can this do for me? What can this do to me?

In discussing drugs, particularly with our young people, we will have to admit that we do not have all the answers, and recognize controversy where controversy exists. Also, a great deal of thought must be given to the issue of credibility. We do not make decisions on the basis of information we cannot believe, and neither will our youth.

Because I think it is pertinent to this issue of credibility, I would like to comment on the role of enforcement officials in drug abuse education.

Through a physician, I am no stranger to the educational efforts of enforcement officials. I now work with the attorney general of

Massachusetts in his efforts to encourage better drug abuse education. For years I have participated in drug education programs with enforcement personnel from local police groups and from the Federal Bureau of Narcotics and Dangerous Drugs. I have seen most of the movies and written materials prepared by the Federal Narcotics Bureau and its successor agency, the Federal Bureau of Narcotics and Dangerous Drugs. It is not an isolated physician's view that brings me to the conclusion that enforcement officials should play a consultative role rather than a primary one in the field of drug abuse education.

Law enforcement officials can communicate with kids, and many of them very effectively. However, when the same person enforcing the drug abuse laws tries to teach about drugs, he is, in my opinion, at a considerable disadvantage. Young people tend to be suspicious of the information he brings to them.

I am not criticizing the educational material that is now being prepared by many law enforcement agencies. While the material is not of uniform quality, some of it is excellent. We have surely come a long way from the disastrous and incredible "scare films" that were once used by the Federal Narcotics Bureau.

But even if the material is good and the enforcement official talented, kids have an emotional reaction of distrust. Emotional reactions really count in education. Emotional reactions of this sort can prevent effective communication and can prevent learning.

Who then should assume the leadership role in drug abuse education? While physicians have so far made the major expert contribution to drug abuse education, those specially skilled in the field of education must also have a prominent leadership role.

In what forum will learning take place? In schools, churches, teenage groups, and families? I think in all of these. While a lot of the learning about drugs will take place outside formal educational structures, schools will play an important role in this effort.

Who will actually do the teaching? There simply aren't enough experts to go around. This is illustrated by the call that I received 2 days ago from a teacher asking for help in setting up a program in her school. She was working with a committee of parents and they decided that the best way to deal with the teenage epidemic of drug abuse was to have a schoolwide program on drugs. They wanted small group discussions where the students could really talk about the way they felt and ask questions that were on their minds. They decided to do it on a classroom level, a sound decision. They wanted a doctor to come into each class four times between now and the end of the year, but there were not enough doctors available for even one-tenth of the program she had planned.

Hopefully, we can soon reach the point where our schools can include drug education in their ongoing classroom programs, taught by teachers, and not have to rely on outside experts. This bill can provide some of the needed support to the schools for this purpose and the much-needed evaluation of drug education programs.

At a time of scarce resources, this Federal education effort should not be diffused among multiple Federal agencies. I see the possibility of our developing a federally supported program where the police come into communities and say, "Kids, these are the illegal drugs

and I am going to tell you about them. When I'm finished, the doctor will tell you about alcohol and cigarettes." In this light, I am discouraged that major educational responsibilities are proposed for the Justice Department in the Controlled Dangerous Substances Act of 1969, and I am encouraged by the educational provisions of this act.

In this bill, the major responsibility for treatment and rehabilitation, for research, and for education related to drug abuse and drug dependence is placed where it must be, in the Department of Health, Education, and Welfare. Drug abuse and drug dependence are primarily public health problems. It is critical that the major responsibilities for developing and supporting research and education in the field of drug abuse and drug dependence be given to the agency whose major activities are already concerned with medical research and with education.

It was my honor and privilege to share the platform with the chairman of your committee at the annual meeting of this Nation's secondary school principals, and it was a particular pleasure for me to hear his views on drug education.

I feel the Nation owes a considerable debt of gratitude to Senator Hughes and to the rest of this committee for your efforts to help us deal with the most difficult problem of alcoholism and other forms of drug abuse and drug dependence.

Thank you.

Senator HUGHES. Thank you very much, Dr. Lewis. I deeply appreciate your being here this morning. I am going to ask that your biographical information be included in the record because you have a long history of experience in this field which lends a great credence to your statement.

(The biographical information follows:)

BIOGRAPHICAL INFORMATION ON DAVID C. LEWIS, M.D.

Education:

Brown University: A.B., Magna Cum Laude (1957).

Harvard Medical School: M.D. (1961).

Current Professional Status:

Assistant Professor of Medicine, Harvard Medical School.

Director of the Medical Outpatient Department and Emergency Unit, Beth Israel Hospital, Boston, Massachusetts.

Diplomat, American Board of Internal Medicine.

Community Activities (related to drug treatment, education and adolescent problems):

Chairman, Drug Treatment and Drug Education Committee, United Community Services of Metropolitan Boston.

Advisor to the Study of the Rehabilitation of Drug Dependent Persons for the New England Governor's Conference.

Member of the Coordinating Council on Drug Abuse of the City of Boston.

Member of the Massachusetts Attorney General's Advisory Committee on Drug Abuse.

Dr. Lewis has been the Medical Director of The Medical Service, a free clinic on Boston's Beacon Hill that has seen over 3,000 young people. This clinic provides medical, psychiatric, and social services.

Publications (related to drugs):

Dr. Lewis is the author of *The Drug Experience: Data for Decision-Making*, a comprehensive drug education program that includes texts for students and teachers, and audiotaped interviews. Published this year by CSCS, Inc., of Boston, it is being used by schools and community groups in the United States.

Dr. Lewis is the author of several articles on the subject of drug abuse and drug education. These articles have appeared in: *The New England Journal of Medicine*; *The Bulletin of the World Health Organization*; *The Bulletin of the National Association of Secondary School Principals* (An article entitled "The Need for Drug Education in Our Schools" will be published in the May, 1970 issue of this journal.)

Senator HUGHES. Since you are from the State of the distinguished Senator from Massachusetts, I will defer to the Senator from Massachusetts for questioning.

Senator KENNEDY. Thank you very much, Mr. Chairman.

Let me likewise extend a warm welcome to Dr. Lewis here this morning and commend him on his testimony, which I think is extremely strong and compelling.

Let me ask you, doctor, from your experience what kind of Federal support is necessary to meet the immediate needs in drug abuse?

Dr. LEWIS. Just from our experience in Boston, to meet immediate needs we would have to enlarge our program several fold and we do not have the available resources to do this. I think there has to be a significant increase in available Federal support, more than has been indicated in earlier testimony today.

Senator KENNEDY. You heard them say this morning that they have approximately \$4 million now which is available to communities and I guess they have only 16 applications for this.

Dr. LEWIS. That \$4 million is, in my view a totally inadequate amount. If the word gets around that available Federal support is inadequate, there is a negative influence on both the number and the kind of applications that are received.

The support that will be needed to generate new programs in this area will have to be considerable. We have to train new personnel, and we will have to support different kinds of community efforts and community structures than we usually support. By this I mean that we will have to support ex-addicts groups and community organized groups in which health professionals and other professionals do not play the prominent role. These are the groups that are really dealing with the problem. These are the groups that are in the very front lines.

Looking at current support for the existing health structures, and then adding the support necessary to encourage the community groups dealing with these problems, I feel that support will have to be increased many fold over what is now available.

I am also very upset that we cannot identify what we are doing now in the field of drug abuse and drug dependence.

We conducted an audit in the State of Massachusetts to try to identify those programs or parts of programs that dealt with drug abuse and drug dependence, and we had a very difficult time. As a matter of fact, most of the information that was needed was not available. From this Massachusetts experience, I expect that it would be very difficult to identify those programs that now exist in this country. I would not even be able to guess the amount of funds that are now going into such programs. I think it is imperative that such programs become visible, so we can identify what we are doing now. Then we can identify future goals.

Senator KENNEDY. You do not feel that the available support recommended by the administration for programs in these local communities really begins to meet the needs in these communities?

Dr. LEWIS. No, I don't. It is very evident that most of the groups that are being formed in communities are voluntary organizations with unpaid personnel. I served as medical director of a voluntary medical clinic with 60 volunteer staff that operates on Boston's Beacon Hill and provides free medical services. We have seen 3,000 to 4,000 young people. We saw those 3,000 to 4,000 patients at a cost of approximately \$2,800. I think it works out to be 80 cents per patient visit which is incredible in terms of current medical care costs. We could do this because of the donated services, donated supplies, and the donated efforts of all of the professionals and the community representatives. That voluntary system of service plays an important role, but it cannot be sustained as a totally voluntary system.

There has to be Federal support for programs or the development of programs like this clinic so that part of the organization of such programs can be supported and the voluntary part can still continue.

Senator KENNEDY. Of course, as we have seen in Massachusetts just very recently, there has really been no place for these communities to turn to for assistance.

Dr. LEWIS. People are not sophisticated about where to go for funds. Everybody needs money, and minute amounts of money can make a considerable difference in some of these community programs. For example, the free clinic could stop functioning because we are today \$200 in debt. These are the kinds of moneys that allow some of the voluntary efforts to continue. The dollar cost of this kind of support per program is minimal but the dollar cost for total national program support is going to be very, very substantial. There is, I think, no escaping the fact the cost will be substantial.

Senator KENNEDY. How do you feel about the administration's education program?

Dr. LEWIS. I am confused by the administration's education program. I know of it mostly through reading in the newspapers. I am concerned that the education program of the administration may be a public advertising program rather than a program that allows kids to learn about drugs in small groups where they can discuss the way they feel and think about drugs.

I am also concerned about where the leadership for such an educational program will come from. This has been expressed in my statement because I think credibility is very important. I don't think we need the Jack Armstrong "Wheaties is good for you" kind of education or "build a good character and you will have no problem with drugs." I don't think we need that kind of education right now for our young people. I think that young people by and large do not listen to that kind of education and do not make decisions on the basis of it.

Senator HUGHES. Would the Senator yield?

Senator KENNEDY. Yes.

Senator HUGHES. Dr. Lewis, I asked Dr. Egeberg to identify their existing authority to conduct all these programs. We have a great deal of difficulty in identifying the authority which they claim they have. This is the same problem we are experiencing in education. We have difficulty in finding it. It is a very broad authority that does not pinpoint this problem, and what we are in fact saying is how are we

nationally going to identify the problem without the special emphasis on it that is necessary by pulling all of this together.

So I can understand your problems. I don't as a Senator know where to send anyone who calls and asks, "How do we make an application for this?"

Senator KENNEDY. As I understand the administration's education program, the President did not ask for any additional funding. I gather that he freed \$3.5 million which had already been appropriated under the Education Profession Development Act. I am wondering if much of a program can be developed with \$3.5 million, generally recognizing what is needed nationwide.

Dr. LEWIS. I doubt it very much. You can put that all into one ad agency contract for television and say you have accomplished education for the Nation. That is what I am afraid of because that is the easiest way to distribute the money so it will be visible.

In my comment about not enough experts to go around, I do not mean that the answer is to train enough experts to go around. I think the answer is to help the existing education structures in our society, and I include the family in this, to be able to deal with this problem. There should be available resources to present the scientific data about drugs to young people. They should have this information available so they can study it on their own, and so they can discuss it.

Now these kinds of efforts are going to require substantial funding; not just for the educational materials but also for training our teachers. The way it is now the teacher gets into an inevitable confrontation, an adult versus a younger person in the classroom and there is the usual debate about marihuana and its legalization and marihuana versus alcohol. What we need to do is to develop sources of credible material from which the kids can learn about drugs. Then the teacher can become a discussion leader and not a confronter of a value system.

For the teacher to become a discussion leader, to become familiar enough with this field to become confident enough not to provoke confrontation is going to require teacher training. I don't think the \$3.5 million would even begin to touch the teacher education in this area. We have not even considered other community educational resources that are very important to learning.

Senator KENNEDY. I think you put your finger on a very helpful point. When we were at these hearings in Winchester, Mass., the president of the senior class and also another senior said that one of the reasons for the taking of drugs was that the kids were just bored with school and they felt the whole education process was irrelevant. I suppose if you started off with a traditional educational program on drugs to be used in these same institutions you really only are feeding the existing institution which many students feel is irrelevant and not useful.

Dr. LEWIS. That is true, but what goes on in the school, perhaps the major kind of learning that goes on in the school now comes from talking to your peers. There are hundreds and hundreds of kids that I have seen and many hundreds that I have not seen that have never talked to any adult about their drug use. Schools are one of the places the kids get together and talk with each other.

Even though the school structures have their limitations, I see drug education in the schools as one of the viable educational alternatives. I believe it is important that in the same physical setting where peer discussions are taking place that an educational process also take place which puts students in contact with an adult in a discussion situation.

I think that there are ways in which this can be worked into the school situation in which it will be exciting. It is a topic the kids are talking about all the time. It is not as if you are bringing some dry esoteric subject to the students.

Kids want to learn about this. There is a lot of information about drugs. There is a misconception among the adult population that kids are particularly knowledgeable about drugs, and that is often a misconception. When you present young people with information and an opportunity to discuss motivations for drug use, I find them very responsive, very interested. Discussions are lively. I think the exchange of views is important.

Senator KENNEDY. Finally, could you tell me what your view of methadone maintenance is?

Dr. LEWIS. This has become a public debate and a political debate. I am a practicing internist. I see patients who are addicted to heroin who request methadone maintenance and I don't know what to do.

I am also a physician who has made a study of the history of our narcotics laws, particularly as they relate to the physician's prerogatives in this area, and I don't know what to do. I look to the Department of Health, Education, and Welfare, particularly the health segment, to give me some kind of leadership or give me some kind of policy statement about what my rights are. Will I be backed up if I decide as a private practicing physician to put somebody on a methadone maintenance program? I don't know the answer to that.

Last week one of the interns at the hospital where I work called me and said, "We are about to discharge a patient who is addicted to heroin and the psychiatry resident who was on the case suggested that we discharge him with enough methadone so that he could get to a methadone maintenance program." The resident decided to make a phone call to the Bureau of Narcotics and Dangerous Drugs to check it out and see if it was legal. He made the phone call and the response was that it was not legal. He was told that the only way you can give methadone is if you tapered it off and you would probably be best off if you did not give the methadone at all.

My reaction to this is that it is likely that policies that should be decided by the courts will be decided by other agencies of the Federal Government and this may be clearly inappropriate. The Federal Narcotics Bureau, particularly while it was under the direction of Mr. Harry Anslinger, had a long history of policies related to the Harrison Act defining what they believed to be the professional practice of medicine in relationship to the Harrison Act. It is a matter of public record, not a matter of opinion, that the Bureau overstepped its legal authority with some of these policies. I fear the same thing is going to happen again. I hope in terms of the urgency of this problem as expressed in today's hearing by Senator Javits that if a decision is to be

made and if it is to be made by the courts that it will be made swiftly so that those of us who have to treat patients will know what our rights are.

Senator KENNEDY. Thank you.

Senator HUGHES. I thank the Senator from Massachusetts very much.

I would like to ask you, when you are talking about education you have discussed very little about education for parents. Do you have any particular ideas on how we can approach that question?

Dr. LEWIS. I think it is probably of second priority but very close in priority to drug education for young people. The issue of credibility is less important for parents. They are more apt to accept whatever sources about drug information they can get their hands on. Parents are also very interested in learning about drugs and they are very frustrated in the terms of the way they can communicate with their kids.

When parents ask me about drugs and drug education I give them a credible reference that they can read about drugs and I talk about whether they can communicate with their kids or not, not just about drugs but about everything else because I think the emphasis in the adult population in terms of drug education consists of much more than just learning about the drugs.

I try to shift the emphasis from drugs to an emphasis on how the family deals with children and how parents communicate with their children. Do they talk about any social issues? What kind of responsibilities do they give their children? Do the kids feel they really belong in the family? I feel this kind of parent education may make more of a difference in the drug problem.

Senator HUGHES. What about TV's role in the educational programs? We have a decided gap in television programs, particularly where this type of thing could be used properly.

Dr. LEWIS. I suppose it is the quality of the programs that come onto the television that make the difference. There are about 20 million ex-cigarette smokers in this country, and the decrease in the percentage of teenagers that are now beginning to smoke can be attributed partly to the national campaign about the health risks of cigarette smoking. A significant part of this campaign has been aired on television. So television certainly can play a role. However, in my estimation, TV will not play the greatest role in drug education.

Senator HUGHES. Section 710 of this bill requires Federal funds to be cut off under all Federal programs, including Hill-Burton hospital funds, for any private or public hospital which refuses to admit or treat drug abusers or drug dependent persons. What is your opinion of that section?

Dr. LEWIS. I think it is sound. In referring young people from the free clinic to the existing hospital resources we saw how insensitive and lacking some of our existing institutions were in terms of their willingness or abilities to provide care to these patients. I find no objection to such a regulation at this time. As Dr. Egeberg said previously, the medical profession is becoming more interested in the treatment and rehabilitation of persons afflicted with problems of drug

abuse and drug dependence. Hopefully, such sanctions won't be necessary over the long term. Right now I have no objection to that kind of wording.

Senator HUGHES. Do you believe the medical community is becoming more interested in treating these patients?

Dr. LEWIS. I think so, partly because of the public recognition that this is a public health problem and not a criminal problem. There is a growing interest among young physicians in the field of community medicine. This is one real community problem, and an inescapable one if you are interested in community medicine today. This is why I feel that the problems of drug abuse and drug dependence will be of significant interest to physicians in the future.

Senator HUGHES. Dr. Lewis, I want to thank you very much for being with us and giving your testimony supporting this legislation and your continuing advice. If we should have any questions, we will be in touch with you.

Dr. LEWIS. Thank you.

Senator HUGHES. The Chair calls Dr. Robert L. Dupont, Director of the Narcotic Treatment Agency, Department of Human Resources, District of Columbia government.

Dr. Dupont, I thank you very much for your patience in waiting this morning. I have to get a complete record on a controversial bill such as this.

You may continue as you desire.

STATEMENT OF ROBERT L. DUPONT, M.D., DIRECTOR, NARCOTIC TREATMENT AGENCY, DEPARTMENT OF HUMAN RESOURCES, DISTRICT OF COLUMBIA GOVERNMENT

Dr. DUPONT. I am sorry I do not have a prepared statement as to the state of narcotics treatment in the District of Columbia, I have found myself running so fast from one job to another from one program to another that it was not possible for me to sit still long enough to get the information into a prepared statement. I do have some ideas that I would like to share with you.

Senator HUGHES. All right.

Dr. DUPONT. First of all I think that in the country, in Washington, D.C., in particular, we are witnessing an epidemic of drug abuse and that this epidemic has overtaken our professionals and our technology and our funding base and leaves our experts, whom we had hoped could cope with that problem, in a very embarrassed position because they are patently unable to cope with the dimensions of the problem at hand.

Now in the District, where this problem is very severe, we have focused our attention on the problem of heroin addiction for a number of reasons. First of all we think the evidence is particularly clear that this abuse is dangerous to society and to the individuals. We are very concerned about the problem of crime in the streets of Washington and the contribution that heroin addiction is making to that crime problem.

We then say that we are going to try to deal with the whole universe of the heroin addiction problem in the District of Columbia.

A number of studies have been carried out in the last 8 or 10 months to suggest what the dimensions of that problem are. The study was carried out at District of Columbia jail, which shows that 43 percent of the men coming into the jail were heroin addicts. That is percentages.

First of all the study had not been done in any previous jail intake using urine tests so that we did more than just interview people. And it supported the idea that there are at least 4,000 chronic heroin addicts involved in crime in the District of Columbia and that the number probably exceeds that by some factor, perhaps two or three.

Now it seems that when we began to think about this in the District we decided that some new approaches were needed. It was not possible to deal with the community's problem by setting up a new ward at a hospital or designating a halfway house and saying that is the District's program in response to what clearly is an epidemic with grave consequences to the community.

When we looked around to find what ideas we could find that would be serviceable in dealing with this epidemic we found four primary ones. First was the use of ex-addicts as the primary treaters. We have done this and we have found them to be our most dedicated and effective staff members. Perhaps our proudest accomplishment in the Narcotics Treatment Agency in its first 60 days of operation is securing Civil Service authority to hire on a permanent basis 30 ex-addicts as counselors. It is extremely important that these people are treated with dignity and respect as counselors. We are now working in cooperation with the Washington Technical Institute to get these men and women AA degrees, associate of arts, and we are hopeful that they will go on to bachelor degrees and open up opportunity skills for them that they can use in their dedication that they possess in large measure.

The second idea that we found that was very helpful to us was methadone, particularly methadone maintenance. I think the evidence, such as it is in the field of drug abuse, supports the assumption that methadone maintenance must be included in the treatment options of the chronic heroin addict and anyone who wants to deal with the problem. We have secured authorization from the NIMH and the Food and Drug Administration, the Federal Bureau of Narcotics and Dangerous Drugs to proceed to use methadone maintenance and we are proceeding.

The third idea that we found that was very helpful was the urinalysis to determine whether an individual is abusing the hard drugs. It is difficult for a person who has not had the experience in the programs to understand how important it is for the counselors and the patients to deal with facts around the question of drug abuse, to get out of the problem of playing games with each other, out of the game of, Do you trust me? You know I am a man and honest to God I didn't take any type of drugs. That undermines many relationships like this.

So we have the patients give us urinalysis samples, in many programs daily. Every week we have a sheet which has the names of all the people who have used drugs on it during the week and the counselor and the patient sit down and talk about the sheet as a

piece of reality they must confront. Nobody is sent back to jail, nobody is thrown out of the program, but that is a reality that must be dealt with. I cannot overemphasize how important it is for that to go on. It is expensive but it is absolutely essential, it seems to me.

The fourth point is that we have developed a research strategy which we think will give us the basic information we need about what kind of programs to continue to support, where to increase our support, and where to hold back our support so that we are continuously dropping our rates from various program components, the rates of dirty urines or continuing drug use, employment statistics and rest the rates with all cooperating programs.

We cast our net broadly to include cooperating nongovernmental programs on the assumption, as Dr. Lewis has said, that many of these community efforts are not only the response to the inadequacy of the Federal and governmental programs but also the expression of very constant concern and should be fostered rather than replaced. We are endeavoring to do this, and in 60 days I can report that we have met with considerable success. We started with about 100 patients in treatment, and when I say in treatment I mean in continuing treatment.

One of the problems we have in this field is the people report statistics for people who sign the registry and I don't think that helps anybody. It is a useful epidemiologic measure perhaps. We define treatment as a person returning four times or at least a 2-week period. That gets us out of a revolving door. We have increased in 60 days from about 100 patients to about 550 patients in the District of Columbia.

Now our programs call for about 5,000 heroin addicts in treatment at the end of a year and also calls for a large increase in the funding. We have heard from HEW about an increase in funding of 30 percent or 33 percent in 2 years. I am anticipating in our program, and I don't know whether we will get the money but we are going to make our case very forcefully that we are going to double the amount of money that is devoted to heroin treatment in the District of Columbia every 3 months for 15 months.

That is my anticipation, that we will go from \$3,000 a year funding money as of September 1, 1969 to a funding rate of \$10.4 million a year in 15 months in the District of Columbia. Whether we will get that money or not, I don't know. I see my job as the Director of the Narcotics Treatment Agency to run the best programs I can, to develop comprehensive plans and to put it to the leaders of our community, in Congress, in the White House, in the District Building that this is the need of the community and this is what the cost is to deal with the problem.

Senator HUGHES. Would you yield at that point. What is the cost of heroin in the District of Columbia today?

Dr. DUPONT. Using some figures that Senator Tydings developed in the Senate District Committee, I calculated \$242 million a year. I think that is not a bid figure.

Senator HUGHES. A \$10 million investment would be pretty small.

Dr. DUPONT. That is my argument. That is the case that I make, and so far I have been increasing the budget very regularly. I think it is very difficult for any public servant to turn down a request for a

program that offers these kinds of tradeoffs. I think one of the demands, and this is something that I didn't learn in medical school, is that you have got to learn how to be a politician a little bit. Part of that has to do with presenting your case in a clear, forceful way so that the alternatives are laid out before the people who are making the decisions. They have the responsibility for making the decisions, that is not my responsibility. My responsibility is to lay out the alternatives. I think in this field we have not seen very much of that.

Part of the problem has to do with the fact that we have not generated the kind of expertise around the country that can manage a budget, that can plan a program and the associated politics. For example, it seems to me that the study we did at the District of Columbia jail last summer was absolutely crucial to the level of support we have already received in the District. Prior to that anybody could say there are really not that many addicts, it is totally an estimate. That is where it was in the District until that study was done.

When we were able to show that 43 percent of the men booked into the jail were heroin addicts, that more than half of the criminal homicides and more than half of the armed robberies were committed by addicts during the month of our study, that was powerful evidence and it went a long way to getting us the support that we have gotten so far.

Senator HUGHES. I do not know whether you said this or not, but did you say that a narcotics registry is not useful?

Dr. DUPONT. No, it is useful. What I say is that we cannot call it treatment just to register someone. See, one of the problems is that you can open up a clinic and start registering addicts. I am saying that should not be confused with treating addicts. Just to have people come to the door is not treatment. They have to be retained in some kind of a treatment program, and the critical variable is retention rates in the program. That is the limiting factor for everybody's program.

How many can you have come back tomorrow and the next day and the next day after that because in this field there is no evidence that there is any short treatment. You cannot treat anybody in a day or two or a week or two for heroin addiction, it is a long-term process.

Senator HUGHES. I know your position is relatively new here in the District but could you supply for the record—maybe you have already done so—your own background and educational experience in this field?

Dr. DUPONT. Well, I am a graduate of Emory College in Atlanta, Ga., and Harvard Medical School in Boston. I did my medical internship at Western Hospital in Cleveland. I did my residency in psychiatry at Harvard in Boston. I worked for 2 years doing research and clinical work at the National Institute of Mental Health in Bethesda. The last 2 years I worked for the District of Columbia's Department of Corrections developing model treatment programs for corrections. It was in the capacity of working with the Department of Corrections that I got swept up in the tide to do something about narcotics addiction. Prior to a year ago I had no experience in this field and I have tried to learn as fast as I can.

Senator HUGHES. Based on your 2 years here would you say that the narcotics problem is growing in Washington?

Dr. DUPONT. I think the only evidence we have is that it is getting worse all the time.

Senator HUGHES. It is an epidemic, running wild.

Dr. DUPONT. Yes.

Senator HUGHES. You made the concrete statement that there were 4,000 chronic heroin addicts involved in crime and the number perhaps doubled or tripled that.

Dr. DUPONT. Yes. That is the floor, the lowest possible level that this study revealed. It could not be below that.

Senator HUGHES. As you know, we had testimony yesterday from Colonel Hassan from the District. He testified that he had 13,000 drug abusers registered. Now that does not necessarily mean they were heroin addicts.

Dr. DUPONT. That is right, or that they were from Washington.

Senator HUGHES. They may have been from outside the District of Columbia. I just want to point out that there is a substantial broad base.

You talk about methadone maintenance. How about methadone withdrawal? Do you use methadone withdrawal?

Dr. DUPONT. Yes; we do. Methadone withdrawal is very useful. What it accomplishes is that the addict can go through the process of getting clean without the physical agonies and physical dangers of cold turkey withdrawal.

Senator HUGHES. What kind of facilities would you have if you geometrically progress in funding to take care of all these people?

Dr. DUPONT. When we started we did not have any hospital beds, for example. We now have 80, and May 1 we are going to go up to 120. My plans call for going up to 500 hospital beds within the next year. We are basing this on the strategy of trying to clean up all the addicts that we can so that an addict has a try-on abstinence before we put him on methadone maintenance. We think this is an important policy position.

We find it is most difficult with most addicts to get them off heroin on the street. The problem is that when the methadone dose gets down they start shooting up heroin again. You need them to have a drug-free environment; that is not 6 months or a year, that requires 2 weeks or a month.

Senator HUGHES. What percentage of your patients are black and white?

Dr. DUPONT. About 90 percent are black, 10 percent are white.

Senator HUGHES. Ninety percent and 10 percent. Where does your support come from financially?

Dr. DUPONT. Well, we are operating now with appropriated funds that were previously directed to the District of Columbia Health Department and the Department of Corrections. Our level of funding from appropriated funds is \$1.3 million a year. That will increase in 1971 to about \$2.5 million. We have hopes of getting some money from NIMH and from OEO and from the Law Enforcement Assistance Administration of an additional \$2.5 million. Where we go from there in terms of our funding, I don't know.

Senator HUGHES. How old is the District of Columbia Narcotics Treatment Agency?

Dr. DUPONT. Sixty days.

Senator HUGHES. Sixty days. And your funding trend, you believe, is going to progress upward as you estimated?

Dr. DUPONT. That is what my projection is. I will go as far as it goes and see how far that is.

Senator HUGHES. What size staff do you have?

Dr. DUPONT. We have about 110 staff members now. I anticipate going to a staff level of around 600 or 700 at the end of the year.

Senator HUGHES. How many of those 110 are paramedical?

Dr. DUPONT. Are ex-addicts, you mean? Medical, we have only three doctors so 107 are nonmedical. Many of them are nurses, however. I would say doctors and nurses would account for about 35 of the 110. Nine physicians are research. We devote a good bit of our energies to continuing study. Thirty of the positions are ex-addicts.

Senator HUGHES. What is the relationship of black and white on the staff?

Dr. DUPONT. I don't know. It is not too far from that 90-10. Maybe it is probably 70-30.

Senator HUGHES. Have you had any difficulty in getting patients?

Dr. DUPONT. No, sir. We have more business than we can handle. We get along fine with Colonel Hassan. I don't know whether he reflected that in his testimony but he and I have a pretty good relationship.

Senator HUGHES. He reflected a very warm relationship. I mentioned it to him because I happened to see you on television the night before in which you mentioned some questions about his political activities which would force you to take a very hard look at some of his activities in this field. I did not clearly understand you so I will ask you to clarify that now. What kind of political activities are you worried about?

Dr. DUPONT. Not really worried about any. As far as I am concerned he can do whatever political activities he wants. He said my organization was political.

Senator HUGHES. It is not political.

Dr. DUPONT. I did not mean to be critical of him. My point, and I did not come out very clearly in that television interview and it gave me considerable concern—I am not sure I can state it any clearer now. That is my problem. Let me try.

I think that there are difficulties of joining together a city government program and the kind of program that Colonel Hassan runs. That does not apply to all community organizations, some are easier to work with than others. I think Colonel Hassan and I may work it out. All I want to do is not be in the position—and that is my only point in that interview—is not to be in the position of saying that I promised him that I was going to save his program if he comes up short on money again. That is the only concern I have, that I want to negotiate in good faith, and I think we are doing that.

I think Colonel Hassan can do some things I can't do. I will give you an example of this. There is a potential Halfway House at 19th and T, NW., that I wanted to have for a program for a year and a half. I could not get it; I had the money but I could not get it. I did not like the redtape the District of Columbia government puts you through. They gave it to Colonel Hassan. That is one example.

I am not sure he would be as effective as he is if he had more Government support and I think he feels that way, too, to some extent. I hope we can work out a mutually cooperative agreement. Certainly our relationship so far has been entirely cordial.

Senator HUGHES. Are most of the addicts that you have working for you black?

Dr. DUPONT. Yes, sir. Not all but most.

Senator HUGHES. Do you find that someone like Colonel Hassan or someone like a black addict has a greater ability to reach the black population?

Dr. DUPONT. They try hard.

Senator HUGHES. What about the professional personnel?

Dr. DUPONT. Well, I think the professional personnel have a role but usually not as the primary treater. The professional person can offer consultation. You know, Colonel Hassan has more medical support than I do. The Medical Committee for Human Rights has provided volunteer doctors at each of his centers every night. He needs doctors, too, but they play a very important role in the program as consultants, not as the managers of the program.

Senator HUGHES. Have you had contact with other major city areas in the country since you have been here as a physician?

Dr. DUPONT. Yes. I have visited programs in New York City and Chicago and also attended some conferences where I talked to people around the country.

Senator HUGHES. Are you patterning your own program after any existing programs or is it an initial effort?

Dr. DUPONT. Well, I think that I am trying to draw what I can from various programs. For example, in Chicago, Dr. Jerry Jaffe, who testified last summer before your committee, has developed a very sophisticated network of treatment services and research strategy that I am borrowing on very heavily.

Senator HUGHES. I am very interested in that because the lack of coordination seems to be one of the problems in the country. A part of the problem is that many persons or government agencies panic into starting something that really should not be started. Their efforts need to be patterned on some sort of a coordinated effort.

Dr. DUPONT. I think one of the crucial points about that has to do with information. I think if you get built into a program a reliable research component that it is kind of a self-writing mechanism if it is honest in evaluating the data that comes in. I think it cannot be overestimated that we are in a situation where we don't know the answer. In other words, no one can say this works and that does not. Jaffe's basic premise is that he says in the program, "Different strokes for different folks." You know, it is the way one thing is not going to be the answer for everybody and that is what we want to build here, too.

Senator HUGHES. Are you familiar with Senate bill 3562, the bill that we are discussing?

Dr. DUPONT. Yes, I am.

Senator HUGHES. Do you support it?

Dr. DUPONT. Yes, I do.

Senator HUGHES. Do you believe, as a professional psychiatrist and M.D., that drug dependence is an illness?

Dr. DUPONT. Yes, sir, I do.

Senator HUGHES. Can you tell me why?

Dr. DUPONT. Well, I don't know. I guess it borders on mental illness. I guess the spirit in which I was responding has to do with whether it is a crime or an illness. Looked at from that point of view it seems to me quite clear that it is a compulsion that a person gets into and feels he needs to continue to maintain his physiological or psychological well-being and it is detrimental to his health.

Now I do feel rather strongly that any assumption that a person who is addicted cannot also be a criminal would be fallacious. A person may very well commit crimes even to support his habit which are not in my view excused by the habit. In other words, I feel very strongly that the habit itself and the feeding of that habit is not a crime. That is the way I look at it and it is a fine line.

Senator HUGHES. There is nothing in the bill saying that a crime is not a crime.

Dr. DUPONT. Right.

Senator HUGHES. Under any circumstances, whether it be in relation to alcoholism or whether there are court cases. The question is one of how to treat drug dependence—as an illness or disease.

Dr. DUPONT. Yes.

Senator HUGHES. I was just trying to get as many professional points as I could.

Dr. DUPONT. I think the point Dr. Lewis made here need to be reemphasized. I think what we are all seeing is a very hard group of young doctors around the country who are really getting involved with the problem of drug abuse and its treatment. I think this is true and it is very exciting.

When you go to a professional convention dealing with drug abuse, it is exciting to see many people like Dr. Jaffe and others around the country who are coming up with very impressive data. In this field where 10 years ago nobody had a new idea, now it seems like you follow along and every 6 months or so you have some new thing to keep up with. It is a very exciting development and very hopeful for our communities.

Senator HUGHES. I suppose that hardly any of your patients are there strictly because they smoke marijuana.

Dr. DUPONT. None at all.

Senator HUGHES. None at all.

Dr. DUPONT. We are targeted to heroin. We would not turn him down for treatment, we would send him to the community mental health courses. I don't think we can tie up our resources with marijuana use.

Senator HUGHES. Why not? Don't you agree marijuana is a problem?

Dr. DUPONT. I don't think it is the problem in Washington, D.C. Heroin is, though.

Senator HUGHES. Have you had much experience with persons who use marijuana?

Dr. DUPONT. Yes. Some of them function well and some of them don't. It is like alcohol in my view.

Senator HUGHES. Have you seen anyone who is a chronic user of marihuana only that was violent?

Dr. DUPONT. No, but that does not mean it does not happen. I have not seen that. My experience with the chronic marihuana user is he does not think very clearly, he does not function very well, he is often a confused person. He is not a violent person although I think that it is perfectly consistent for some people to be violent at some time.

Senator HUGHES. Usually they are passive.

Dr. DUPONT. Yes.

Senator HUGHES. How much of your problem is multiple usage in narcotics?

Dr. DUPONT. Very little. This is something I think our studies have been very helpful in showing. For example, in the receiving home where we identified 17 percent of the intake there were heroin addicts—that is, 17 and under. Seventy-eight percent of those started with heroin so only 22 percent started with any other drug. In our population in the District of Columbia, not suburban areas but the District, it is primarily confined to three drugs, marihuana, cocaine, and heroin. The pattern used of the drugs is very different.

Marihuana is used characteristically once a month, every week at the most. That is the characteristic way of using marihuana. So when you ask the question of your sample, what is the frequency of use, 80 percent of the people will be on it less than once a week, end of the scale, whereas heroin is exactly the opposite. Heroin is characteristically every day or more than three times a week. I think that is a very important point. Cocaine comes in there but usually occasional use. A real cocaine fiend is not easy to find.

Senator HUGHES. It is kind of a fill in?

Dr. DUPONT. Yes; it gives him an up. It does the same things that amphetamine does, makes your heart beat fast and is a scary experience.

Senator HUGHES. Is the pattern the same in Georgetown, the pattern of drug use?

Dr. DUPONT. No, I am sure it is different in Georgetown. Much more marihuana and much more LSD, much more speed. I am sure it is different.

Senator HUGHES. There seems to be a lot of indication that marihuana in the District is being mixed with other drugs. Have you run into that?

Dr. DUPONT. No, I have no evidence of that although I have heard that.

Senator HUGHES. I have no evidence of it either, but I keep hearing and I keep trying to find out.

Dr. DUPONT. I think you know, Senator—at least I feel very strongly about this—that to get involved in other drugs in the District is too difficult. I think what we need to do is go after the heroin. Although I recognize the very serious problems in Georgetown and other segments of our population with amphetamines and marihuana. There are serious problems in marihuana and I acknowledge that. From a

social planning point of view, it seems urgent that we put No. 1 priority on heroin in the District.

Senator HUGHES. Are you going to run any educational program?

Dr. DUPONT. Yes. I think Dr. Lewis had some good ideas about how to do that. I think it is essential though that we begin as a first effort to provide treatment services. I am thinking in terms of summer for an educational program. I think Dr. Lewis planning for small group discussions and using the teachers is a very wise one.

Senator HUGHES. Will the school board be cooperating with you in educational programs?

Dr. DUPONT. I am sure they will. I have not done much with them. It is a problem for me to encourage business at this point because we have more than we need.

Senator HUGHES. I imagine now you are completely overwhelmed. Sixty days in business and most of your time has been spent testifying before someone or another on some program.

Dr. DUPONT. Where I usually say the wrong thing and spend 2 days trying to explain.

Senator HUGHES. I wish you well and I hope these hearings will be beneficial in establishing a pattern of law and funding that can enable all of us, working together, to get at this problem of epidemic proportion in our country. Certainly this great capital city of our great Nation has more than their share of this problem. If we need to concentrate on the heroin addicts, we can pick a half dozen cities in the country and find probably 90 percent of the heroin addiction in the country in those half dozen cities.

Dr. DUPONT. Senator, Dr. Miller raised the point about LSD and, that being sort of a model, we have been stemming the tide, so to speak. Even if in one city we can demonstrate that we can get these figures starting to go down—not pretending but really make the figures go down—I think it is going to make a difference to the whole country. It is going to change a lot of attitudes about things and it will be a very important achievement for us. I think New York City is too big to do that. When you are talking about 100,000 addicts in one city, it is beyond any man's ability to conceptualize in a few years treating 100,000 addicts.

Senator HUGHES. Have you done any research on heroin being distributed here in the District?

Dr. DUPONT. I don't know what it is but I understand it has come up. It has gotten better in the last year. That is true all over the country.

Senator HUGHES. No information of what it is mixed with.

Dr. DUPONT. I try to stay clear of the enforcement areas of things for many reasons. I really think that is Chief Wilson's problem and the U.S. attorney's problem and the Federal Bureau of Narcotics and Dangerous Drugs problem. I have enough problems.

Senator HUGHES. It could be a part of the educational process.

Dr. DUPONT. To learn more about it.

Senator HUGHES. Because the foreign substances may be more harmful.

Dr. DUPONT. The overdose deaths, for example, I think that is very interesting. It suggests we don't know why people are dying of over-

dose, it is totally mysterious. Where the most overdose deaths are, in New York City, it has been shown that it is some impurity in the drugs. The drugs they find in the blood and in the syringes hanging out of their arms are the same drugs they took yesterday and were planning to take tomorrow that are still left on their table. I think that is a mystery. I think these are areas that we need to communicate clearly to the people. It is as if they can take a thousand deaths and the thousand first times they die without any way of predicting that. I think that is a piece of information that needs to be disseminated very widely.

Senator HUGHES. Doctor, thank you very much for coming and testifying this morning. I know it was rapid, and the reason I wrote you yesterday again was we thought it was important to get as much evidence as we could about your work here in the District of Columbia.

Dr. DUPONT. I am honored to be here and happy to be of whatever help I can.

Senator HUGHES. Thank you for your patience.

The hearing is closed.

(Whereupon, at 12:55 p.m., the subcommittee recessed, to reconvene at 9:30 a.m., Wednesday, April 15, 1970.)

FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

WEDNESDAY, APRIL 15, 1970

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

The subcommittee met at 9:45 a.m., pursuant to recess, in room 6202, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senator Hughes.

Staff members present: Robert O. Harris, staff director; Wade Clarke, majority counsel; Richard J. Spelts, minority counsel; and Jay Cutler, minority counsel.

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

The Chair calls Dr. Jonathan O. Cole, superintendent, Boston State Hospital, Boston, Mass.; former Chief, Psychopharmacology Research Branch, National Institute of Mental Health; chairman, Committee for Effective Drug Abuse Legislation.

Dr. Cole, you may proceed with your testimony.

STATEMENT OF JONATHAN O. COLE, M.D., SUPERINTENDENT, BOSTON STATE HOSPITAL, BOSTON, MASS.; FORMER CHIEF, PSYCHOPHARMACOLOGY RESEARCH BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH; CHAIRMAN, COMMITTEE FOR EFFECTIVE DRUG ABUSE LEGISLATION

Dr. COLE. Thank you, Senator Hughes.

I am very pleased to have a chance to testify here and I appreciate what you and your committee have been trying to do in this area over the last few months. I am talking really with three hats on. In addition to being the chairman of the Committee on Drug Abuse Legislation, I am to some extent the legislative representative of the American College of Neuropsychopharmacology, a group of scientists working in research on drug effects on the brain that has been concerned about legislation coming before the Congress this year.

I got involved in the whole business of being interested in legislation as a result of concern over the administration bill, I guess now the Dodd drug abuse bill, S. 4246, and have testified in the House on H.R. 13743 which is a derivative of that bill.

I had three major concerns. One was fear that overdominance of the Justice Department in matters of medical practice and science and scientific knowledge and research might have a very bad effect both on the practice of medicine and on our obtaining further knowledge in what is still the pretty murky area of drug abuse. I was also very concerned about the proposed system for classifying drugs of abuse and in the dominance of the Attorney General in deciding which drugs should be classified in what way. I was worried that that bill did not give adequate protection or assurances to people doing research on drugs of abuse.

My view of the present bill, S. 3562, is colored to some extent by these concerns. I am delighted that the new bill will give a major and very clear role to the Department of Health, Education, and Welfare in nonenforcement aspects of drug abuse, and I think this is proper and excellent. The bill is so comprehensive that I have trouble digesting it all and deciding what all of its impacts would be; but its major thrust is clearly a good one since it emphasizes strongly the need for more education, more treatment, more rehabilitation, and more training of personnel and more research in drug abuse.

I wish it was an appropriation bill since some of the problems that NIMH is now having, are a result of inability to pay research grants which have already been approved in the area of drug abuse, but I am well aware that appropriation bills arise in the House rather than in the Senate. It would be impossible for this bill to contain money as well as powers and principles.

I think that existing Federal programs are inadequate in scope, effectiveness, size, and funding. The bill does a lot to correct everything except the funding part, and with a strong message from the Congress that a major and broad program is needed I assume that funding will come along.

At the State level in Massachusetts it is very clear that we have a lot of drug abuse and very little in the way of State programs to do anything about it. My hospital, for example, has 16 beds for the hospitalization of people for drug abuse so we have been having to run primarily an outpatient program because we don't have beds in which to put patients. There is a moderate sized prison unit at Bridgewater and a couple of other State hospitals are beginning to set up small services, but compared to the total need this all is a drop in the bucket.

We have one small, relatively poorly staffed methadone maintenance clinic and some individual towns and communities have been developing committees on drug abuse and some information centers have been developed. The city of Boston is getting in the act, to some extent, and it is providing us with some treatment space in the community and this is certainly a desirable thing. However, I think a larger availability of Federal support would be a very big help to the States.

The one aspect of the bill I like is the provision of emergency medical services, and I think these are badly needed by drug addicts. I think many emergency rooms are not prepared to handle the person who is in trouble with drugs and in crisis.

I also responded very favorably to the provision in the bill to make the Veterans' Administration facilities available to veterans who got dishonorable discharges for drug addiction in the past. I was in Japan

during the Korean war and discharged five or six soldiers, of who appeared to be addicts. We were stuck with doing this on the basis of such evidence as finding a syringe in the soldier's locker, and this struck me as being really the kind of evidence that would not hold up in a court of law and yet the soldier was on his way out of the service with a dishonorable discharge with rather weak evidence.

I think in retrospect that some of the people we discharged as heroin addicts were actually using "speed" but we were too naive to know the difference as we did not know anything about the intravenous methedrine. I managed to stay in Japan a year without finding out that intravenous methedrine was a problem there, and it shows a major defect in military intelligence and in our awareness of the problems of drug abuse.

I know the VA has done a good deal to try to open its facilities to the problems of alcoholism, and to do the same with regard to drug abuse would be most desirable.

Section 304(h) I believe gives some legal support to physicians who are running methadone maintenance treatment programs, and if in fact it can be read this way, I think it is a good idea since the status of the physicians using this has always been shaky, and an M.D. is currently not quite sure whether he is in the right when he runs a program of this sort.

I think section 305 which makes reporting both mandatory and confidential is also a very good thing since I think we need more data on numbers of people involved in drug abuse, but we also need to keep it confidential so that they don't get in trouble later.

Drug abuse reporting has been cursed with a bloody history. I gather there was once a similar confidential drug reporting system for addicts in the city of Chicago which after 2 years was turned over to the police so the whole file suddenly stopped being confidential and was handed over to the law enforcement end. I don't think this could happen to a Federal register.

Under section 306 I read the part on the conduct of research as indicating that the new unit should have its own in-house research programs, and I think this is a very good idea. The addiction Research Center in Lexington, Ky., at the Public Health Service Hospital there, has had a distinguished history. I think anyone running a Federal program would want some direct contact with his own research facilities as well as supporting activities around the country through grants.

Section 306(c) confused me. It had something to do with the registration of practitioners and researchers. I was not quite sure whether it mitigated some of the evils of the administration bill and got the doctors out of the hands of the Justice Department. The present bill, however, leaves the status of the Ph. D. laboratory scientist still in limbo and I worry about his place in the whole scheme of things since he must use drugs in the carrying out of experiments in animals and in test tubes. My reading of the Administration Drug Abuse bill has been that he needs a State license—which States don't provide—before he can get a Federal license to use the drugs.

I also was very much in favor of having the information service proposed under this bill in the area of drug abuse. In my own experience I think a focused information service on a special problem

like drug abuse can be excellent if staffed by competent people who understand the problem area. I think that larger operations like the National Library of Medicine or the National Clearinghouse for Mental Health Information are fine for general purposes but they generally are not well enough done at the detail level and the people who handle them do not know enough about the detailed area to really give a good responsive answer to an inquiry from the outside. You need somebody familiar with the field to answer inquiries sensibly; otherwise, you tend to get a computer printout overflowing with stuff that is irrelevant to your original question.

I have some concern about the education provisions of the bill and would like to see something added making some kind of evaluation of education programs mandatory, since I sometimes feel that by giving high school students lectures on drug abuse you end up getting into fights with students who feel more knowledgeable than you are and you end up having very little net impact on anything. Sometimes I think a speaker suggests new abuses to the kids who had not heard about them before rather than changing their attitudes toward drugs in the desired direction.

I like the general principle stated in the drug classification section of the bill and wish the section in the Administration Drug Abuse bill was worded in such a way.

I also was very much in favor of title V in its effort to insure that drug dependent people are treated like other citizens with medical illnesses by the Federal Civil Service, health insurance, the Department of Defense and the VA.

And title VI similarly which prevents discrimination against drug dependent individuals under programs administered by the Federal Government or by the States with Federal assistance.

I was particularly intrigued with section 710 which put pressure on hospitals to admit and treat drug dependent patients who turn up on their doorstep. As I have been thinking about it since I wrote my testimony I think a more reasonable position would be to insist that a hospital either admit and treat such patients or have a real working relationship with a more specialized facility that would be directly available to the hospital on short traveltime and short notice to handle such problems if the first hospital is not equipped to do it itself.

I was a little worried about the Advisory Committee section, section 801. I guess having been raised in the National Institute of Mental Health I value the study section review system. It has been developed out there over a number of years and I have been used to using the National Advisory Council for the secondary review of proposals. I was not quite clear whether the Advisory Committee proposed in this bill would function as the National Advisory Mental Health Council does or would be a subcommittee under it. The question of how review and approval of projects would work under this bill was a little unclear to me.

I also was intrigued by the bill's development of an agency of uncertain location within the Department of Health, Education, and Welfare and ended up doing some serious thinking as to whether it should be in the National Institute of Mental Health or whether it should be a separate agency. I finally gave up and decided I had no

coherent opinion on this matter. I think separate status would give it a good bit of visibility and might give it more financial support than having it within NIMH. On the other hand, within the National Institute of Mental Health there are a good many talented people and a good many good support systems which would be useful to a drug abuse program of this sort.

In summary I think the bill as a whole is a good move in a proper direction and I think many of its provisions are both wise and far-reaching and I am happy to endorse almost all of its provisions as presented. I never really understood the old Narcotic Rehabilitation Act provisions and how these differ from them so I also pass on that since I have never managed to unravel that confusion.

(The prepared statement of Dr. Cole follows:)

PREPARED STATEMENT OF JONATHAN O. COLE, M.D., SUPERINTENDENT, BOSTON STATE HOSPITAL, BOSTON, MASS., FORMER CHIEF, PSYCHOPHARMACOLOGY RESEARCH BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH; CHAIRMAN, COMMITTEE FOR EFFECTIVE DRUG ABUSE LEGISLATION

I am testifying as a representative of the American College of Neuropsychopharmacology and as Chairman of the Committee for Effective Drug Abuse Legislation. In both capacities, I became involved in legislative issues this year as a result of the concern of both groups over the Administration's drug abuse bill, S-3246 and H.R. 13743. The major issues relevant to those bills are:

1. The overdominance of the Department of Justice in matters of scientific knowledge, research and medical practice.
2. An unwise basis for classification of drugs of abuse.
3. Inadequate provisions to protect needed research into drug abuse.

My view of S-3562 is colored by these concerns. When passed, this bill will clearly reinforce the necessary predominant role of the Department of Health, Education (DHEW) and Welfare in all non-enforcement issues with respect to drug abuse. S-3562 is truly a comprehensive bill in many, many respects. I only wish it could do more to correct the evils embodied in S-3246.

The other major lack of S-3562 lies in its very nature—it is enabling legislation, not an appropriation bill. With many grants in drug abuse currently unpaid by NIMH, one could make a substantial case that the federal drug abuse program would be enhanced more substantially by a large ear-marked appropriation than by the awarding of a wide range of new responsibilities and powers to DHEW.

On the other side, I feel strongly that drug abuse is a large and growing national problem and respect the clear intent of S-3562. If the administrative structure of this bill gets adequately funded, a new and potentially revolutionary force in drug abuse will have begun.

The major purpose of the bill appears to me to be the creation of a major important and effective federal drug abuse program emphasizing education, treatment, rehabilitation training and research. This I favor. The need for such legislation must lie in a conviction by the bill's sponsors that existing federal programs are inadequate in size, scope and effectiveness. Again, I tend to agree although I am not aware in detail of the scope and nature of current NIMH and related programs in drug abuse.

I know that at the state level, effective programs are small and really very inadequate to meet a very large and growing need for education, treatment or rehabilitation.

The general treatment and rehabilitation emphases of the bill are excellent. The position on "Emergency Medical Services" underlines a real and urgent need. The recognition of the great usefulness of ex-drug abuser staff members in such programs and of the problems involved in hiring them into state or federal positions is also excellent.

As someone who was reluctantly involved in giving dishonorable discharges to drug dependent soldiers during the Korean War, I applaud the opening of Veterans Administration Hospitals and clinics to such ex-soldiers.

If Section 304 (h) gives a legal support to physicians conducting responsible methadone maintenance treatment programs, I welcome this also.

The confidentiality component of the statistical reporting Section (305) also is very desirable.

Under Section 306, the power of the new agency to "conduct" research is very valuable. The provision of research support is good; the obligation on the agency to actively conduct research as well is even better. The present Addiction Research Center in Lexington, Kentucky has a distinguished history. More direct research of this sort into other aspects of drug abuse is necessary.

I don't understand Section 306(c) sufficiently to know whether or not it mitigates the provisions on registration of practitioners under S-3246. This present bill also leaves the Ph.D. laboratory scientist in limbo, since he is not licensed by his state, but needs access to controlled drugs for his basic research.

The creation of a central special information service on drug abuse is also a good provision. In my experience focussed specialized information services staffed by experts in a special field with real content knowledge are far more useful than broad multi-purpose information services like the National Library of Medicine or the National Clearinghouse for Mental Health Information.

The education provisions of the bill are probably as good as present knowledge will permit. I would strongly urge adding a requirement that the impact of education programs be evaluated. I often suspect that a vast proliferation of drug abuse education and prevention programs will give us all the illusion that something useful is being done about a terrible problem. I'm afraid that this may turn out to be placebo treatment for the anxieties of the middle-aged middle class any may have either no impact on the drug abuse epidemic or even a negative one. Without evaluation, such programs may be very expensive and inefficient ways of meeting a public demand.

The drug classification provisions of the bill look reasonable. The effect of such classification is unclear. I wish this section was in S-3246.

With respect to Title IV of this bill, I am incompetent to comment since I am unclear about the provisions of the current Narcotic Addicts Rehabilitation Act and how this older legislation has worked out.

As to Title V, I applaud the intent to insure that drug dependent persons be treated like other people with medical illnesses by Federal Civil Service, health insurance, the Department of Defense and the V.A.

Similarly, Title VI is wise in preventing discrimination against drug dependent individuals under programs administered by the federal government or by the states with federal assistance. I am impressed by Section 710 in particular and hope it will prove workable to insist that public and private hospitals not discriminate against drug dependent patients.

I think that the provision for an Advisory Committee (Section 801) is weak. This council should either have the powers of the National Advisory Councils of the National Institutes of Health or should come under such a council. I would also like to see the project grant review system of the NIMH and the NIH specifically included in this bill, since I feel that the peer-review system is an excellent one.

Lastly, the great issue posed by this bill is the hierarchical location of the new agency. Should it be within NIMH or should it be an independent bureau? On this issue, I pass. I can see many virtues, including economy (saving costs of establishing various support services) for putting it in NIMH and I believe the program could draw strengths from the many other relevant programs and expertise in NIMH. On the other hand, visibility and the chances of obtaining major funding increases might be maximized by separate status. I am glad the bill does not specify a fixed solution to this problem.

Senator HUGHES. Dr. Cole, I thank you very much for your statement, your presentation and your support of this legislation.

Would you see any difficulty with placing this authority in the Secretary without any specific division?

Dr. COLE. This is obviously the easiest thing to do, is place it in the Secretary and give him the option of placing it where he will. I don't know if that is what you mean by that statement.

Senator HUGHES. The authors of the bill did not want to place the administration, they wanted the Secretary to have the authority to

place it where he will. I would have assumed myself that it would be in NIMH.

Dr. COLE. That gives him freedom to do as he wishes, yes.

Senator HUGHES. In section 801 we have no objections, as I stated yesterday to Dr. Egeberg, to placing the grant review system where it presently is. This testimony supports that indication on your part.

Would you feel that the peer system review has worked well and will continue to work well? Again as far as I know, there are no objections to that in the subcommittee.

You mentioned in your written testimony the section which provides that hospitals receiving Federal funds be required to treat the drug abuser or the drug dependent person on an equal basis with other persons.

Do you view the drug dependent person as an ill person?

Dr. COLE. Yes.

Senator HUGHES. Is drug dependence an illness?

Dr. COLE. Yes, I think it is. I think there are degrees. I am not sure that the casual marihuana smoker could be defined as an ill person, but the kind of person who ends up in the emergency room in a panic as a result of taking LSD or the person who turns up with severe withdrawal symptoms from heroin I would define as an ill person.

I think the issue of whether a given patient needs hospitalization is a separate issue, but I think the person who is in severe trouble with drugs and clearly needs hospitalization should be able to get it and should be able to get it rapidly and efficiently without fighting with hospitals about their restrictive admission.

Senator HUGHES. Would you care to give us an estimate of what level of funding you think would be necessary to meet the needs of this country in research and education and rehabilitation?

Dr. COLE. At the research end I would say a budget going up to \$10 million over the next 3 or 4 or 5 years would probably be adequate, but at the service end and in education the needs are overwhelming enough that I would guess something on the order of \$75 million would by no means be excessive although I really have not got a prepared thoughtful estimate. I know it would be an awful lot of money.

Senator HUGHES. The bill that passed the Senate, the administration bill or the Dodd bill, classified drugs by statute for the purposes of legal control and the bill before this subcommittee, 3562, classified drugs in section 309 for purposes of treatment.

Now is there any need to classify drugs in the statute for purposes of treatment and if so, what function does this classification serve?

Dr. COLE. I was not sure that there was. However, if it is tied to the compulsory admission to private hospitals, there might be some need to discriminate between No Doz and heroin, and there might be some purposes secondarily in the regulations growing out of some parts of this bill to classify drugs. Otherwise, other than as an educational statement which might have some impact on public policy or might have some secondary impact on the classification in the other bill, I have not seen a need for it.

Senator HUGHES. The administration bill may or may not pass the

House of Representatives, may or may not wind up somewhere in the conference committee with something like this bill or close to it, which then may or may not be a matter of compromise.

Dr. COLE. I would think in terms of making a statement as to how drugs would be classified, it would be most appropriate in the hope that it would influence enforcement as well as treatment.

Senator HUGHES. If I could talk just for a moment about the education of physicians in medical schools, are you knowledgeable enough to hazard a professional opinion on how adequate that is in America today in relation to drug abuse or dependence?

Dr. COLE. I suspect, knowing Boston University and Tufts fairly well and having medical students from their schools come through our hospital, I think it is probably still fairly weak. I think there is a real need for making sure that good education occurs.

I think it kind of falls somewhere between the Department of Pharmacology and the Department of Psychiatry, and is not necessarily paid attention to by anybody. I know I got out of a class A medical school in 1947 without knowing that methadone was the way you treated heroin withdrawal and didn't hear about it for about 5 more years, so I watched four addicts being withdrawn cold turkey without realizing there was a better way to do it.

There are many other areas over and above that specific thing. The appreciation of the larger problem is one I don't think medical students get.

Senator HUGHES. You have had some experience with methadone withdrawal?

Dr. COLE. A limited amount, yes.

Senator HUGHES. Where would you draw a line between maintenance and withdrawal? Could a patient be withdrawn in a week, 2 weeks, 3 weeks or in some patients could it take up to 6 months?

Dr. COLE. The whole issue gets involved in what is treatment. I think there are patients for whom very gradual methadone withdrawal on an outpatient basis might be a viable system if you had close enough contact with the patient to make sure he was not abusing other drugs and actually was cooperating with the program.

If you hospitalize him, I don't think that more than a week or two would be necessary to accomplish systematic withdrawal. On the other hand, I think there have been programs which appear to be reasonably effective, which have maintained people on methadone for a time limited period of a few months and have then withdrawn them slowly.

I think the real problem of heroin addiction is really not the withdrawal, it is the changing of life style and social adjustment of the addict. I see methadone maintenance as a crutch which can accompany other efforts to get the patient involved in a more active and productive and reasonable life and as such I would like to leave the doctor free to focus on a treatment program for the total addict and use the methadone as it fits into the treatment plan.

Senator HUGHES. Right now that is just about totally unclear to the physician out in the field who withdraws a patient by using methadone. He does not know when he crosses that imaginary line between maintenance and withdrawal?

Dr. COLE. I think he is never quite clear whether maintenance is legal or not even if it is part of a treatment plan. If I understand the old Bureau of Narcotics regulation, it says it is illegal to maintain the habit: however, if you are doing treatment at the same time that you are keeping the guy on methadone, I personally would not consider this supporting his habit.

I think the doctor who came to court on this issue could win if he had a larger treatment plan which would take 2 years and said he was maintaining a patient as part of a larger treatment plan.

I think he might win, but I think a lot of doctors would be reluctant to face a court fight with the Department of Justice.

Senator HUGHES. You are dealing with a psychological problem or emotional disturbance where with one patient it might be acceptable for withdrawal in 2 weeks and another one might take 2 months.

Dr. COLE. I think you have to decide how you are going to treat the whole patient rather than treating all patients by a book of regulations. I was intrigued that one of the common criteria for methadone maintenance is that it should be used only in people who failed on many other programs.

Dr. Jaffe from Chicago talked at my hospital not long ago and someone asked, "Do you only put addicts on methadone if they have failed on other programs?" Dr. Jaffe said, "In Chicago there were no other programs before I got there, so we put them on methadone as the first treatment if they need it."

So you cannot set up a criterion, that might work in New York City, for methadone maintenance in other places that have not had similar programs.

Senator HUGHES. We are dealing with a triple-threat disease where we find emotional instability, problem of life style, the physical addiction, withdrawal problems and symptoms. There could be little doubt that we are dealing with an illness under those circumstances, is there?

Whether it is an emotional imbalance that induces a physical dependence, it becomes a compounded illness.

Dr. COLE. Sometimes when I hear case presentations of addicts, I get the impression that sometimes the problem of the drug is not the central one. I think the real problem may be why they are not doing something else constructive. The person seems to use drugs to fill a vacuum in his life.

In talking at the high school level, I think what we need is education in living as much as education in not using drugs, because I think the two are of opposite sides of the same coin.

Senator HUGHES. You spoke in your testimony on page 3 about dishonorable discharges in the service for narcotics addiction when you were in Japan during the Korean war. Could you elaborate on that a little? How much of a problem was it?

Dr. COLE. I don't think I saw more than four or five or six presumed heroin addicts during my 9 months at the Army hospital over there, so it was not a huge problem. But when it arose, our hands were tied as to what we could do with it.

As I understood things, you had to process the person for a dishonorable discharge and I think they could get 5 years in Leavenworth along with it. But time having gone by, I may be mixing this

with homosexuality which lead to the same handtying when it was clearly present in a soldier.

Drug abuse was not a large problem, but dishonorable discharge seemed to me an inappropriate and oversevere response on the part of the military.

Senator HUGHES. As far as you know, there is no alternative?

Dr. COLE. That is right.

Senator HUGHES. Except a dishonorable separation from the service.

Dr. COLE. I suspect that if the doctor could have stretched himself to diagnose schizophrenia or something, he might have gotten away with giving the patient a medical discharge, but I didn't find anybody whom I could really warrant a medical discharge, for some other psychiatric condition.

Senator HUGHES. Did you use any sort of urinalysis to determine whether the patient was using narcotics or drugs?

Dr. COLE. No; we had nothing to go on except the history and the occurrence of withdrawal symptoms.

Senator HUGHES. It was just accidental if you turned up one?

Dr. COLE. Yes. There were no laboratory facilities to tell you if you were right or wrong.

Senator HUGHES. You did not treat the person as an ill person?

Dr. COLE. We tried to talk with him and understand him a bit, but it was, I think, purely custodial care until the system moved in its inexorable way.

Senator HUGHES. Then we dumped him on the street to steal \$300 a day in civilian life to support the habit.

Dr. COLE. I remember one addict who said he had withdrawn himself three times on his own while in the service before he finally got caught and ended up in my ward. I had a feeling that he was functioning generally adequately and that he could have gone on doing this without getting into too much trouble.

Senator HUGHES. Could you give me the hospital and the position you held there?

Dr. COLE. I was chief of psychiatry at the 141st General Hospital in Fukuoka, Japan. It is on the southern island.

Senator HUGHES. Beautiful city, I have been there.

Dr. COLE. Very nice.

Senator HUGHES. Were these veterans of the Korean conflict or were they perhaps stationed in Japan?

Dr. COLE. The ones I mentioned were stationed in Japan. I think there was more access to drugs in Japan.

Senator HUGHES. I believe you stated earlier you were not sure, because you could not make an analysis of whether they might have been on amphetamines or heroin.

Dr. COLE. That is right. I can remember one case where the major evidence was the possession of the syringe or presence of the syringe in the soldier's locker, which left you with the choice of either—it gets clearer as I think about it. I think the issue was either making a diagnosis and getting out with a dishonorable discharge or having the Army law enforcement people bring charges against him and get him a prison term.

This seemed to be enough evidence at the time to put someone in Leavenworth.

Senator HUGHES. Did you have any trouble with marihuana there at the time?

Dr. COLE. None that I was aware of. I may have been too naive to know about it, but there was one that I was aware of.

Senator HUGHES. Have you had much contact with people using marihuana over the years?

Dr. COLE. In psychiatric hospitals, I know our drug addiction unit has patients who use marihuana along with other things. I have been in contact with students who use marihuana in casual social relations. I have never treated a marihuana user as such and from the few I have had contact with in a professional capacity, it seems as much a problem of bad judgment as marihuana use.

It gets the kid in situations where he will be picked up possessing marihuana, you wonder how he was self-defeating enough to get himself into these situations so regularly. It often seems more like a personality defect rather than major psychological harm due to the drug.

Senator HUGHES. You list on your list here that you represent the committee for effective drug abuse legislation. Are you speaking for them today in this testimony?

Dr. COLE. The group is sufficiently loosely organized that I am speaking as the chairman, but not necessarily for all members of the group. My testimony has not been cleared with the people who have allied themselves with us, so I think I am speaking on behalf of them, but this is not a statement approved by the organization.

Senator HUGHES. What do you think the role of the Justice Department should be in research areas?

Dr. COLE. I think they have a reasonable and respectable need for research relevant to problems of enforcement. I think that they need some technology to help them prove the substance they have got is a certain thing and, for example, be able to trace marihuana to a source by its chemical identity.

I think they have probably a place for research on law enforcement methods and techniques. I think I would prefer to have them focus their research effort principally on things of direct concern to the enforcement agency rather than getting out into broader areas of abuse liability of drugs and surveys and things of that sort.

Senator HUGHES. Who should determine the need for the quantities of drugs and narcotics for medical use?

Dr. COLE. I think this is a medical decision; it should be in HEW rather than in Justice. I am a little worried. One of my wilder fantasies is that the administration bill could, in effect, close down research on drug abuse by not making any drugs available, by having the Justice Department set the quota at zero for the production of certain drugs, which would turn off research automatically.

Senator HUGHES. What do you view to be the role of Justice in the field of education or educational research?

Dr. COLE. I think the education of law enforcement officers is a perfectly reasonable place for them to work. I really don't see them as appropriate people to be working with high schools or physicians or with other than informing people as to their regulations and as to the law and what its implications may be for practitioners or students.

I don't think they should have the total role of drug abuse information.

Senator HUGHES. Classification of drugs on the basis of the public health?

Dr. COLE. I think that is a problem for Health, Education, and Welfare, not for Justice, although the Justice Department does get some information by its enforcement activities, and I think these should be made available to groups. I think the medical community, sociological researchers, often gets faster and more reliable information than enforcement agencies about which drugs are being abused, by whom, and when.

Senator HUGHES. Are you opposed to the administration bill?

Dr. COLE. Those parts of it that get involved with science and medicine, I am; yes. I think there is some reason to recodify the prior legislation, though I must say I recently heard Mr. Ingersoll make a case as to why the administration needed a new bill. As I heard it in the House subcommittee, it did not seem like an awfully strong case that they needed a bill at this time at all other than perhaps to clear up the issue as to whether marihuana possession could be a crime.

Senator HUGHES. I believe that is all for the present, Dr. Cole. I want to thank you very much for being with us this morning and sharing your ideas with us on this particular piece of legislation. It should be helpful to us in our consideration.

Thank you very much.

Dr. COLE. Thank you, Senator.

Senator HUGHES. The Chair calls Dr. Frank E. Iaquinta, chairman, Department of Ambulatory Care, Roosevelt Hospital, New York, N.Y., representing the American Hospital Association.

Doctor, will you identify your associate for the record, please.

Dr. IAQUINTA. Yes. My associate is Mr. Kenneth Williamson who is the deputy director of the American Hospital Association.

Senator HUGHES. You may proceed with your testimony.

Dr. IAQUINTA. Yes, sir.

STATEMENT OF FRANK E. IAQUINTA, M.D., CHAIRMAN, DEPARTMENT OF AMBULATORY CARE, ROOSEVELT HOSPITAL, NEW YORK, N.Y., REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Dr. IAQUINTA. My name is Frank E. Iaquinta. I am a physician and chairman of the Department of Ambulatory Care at Roosevelt Hospital in New York where I have responsibility for handling drug abuse problems. It is a pleasure for me to appear before your subcommittee on behalf of the American Hospital Association in response to your request for the views and comments of the association on section 710 of S. 3562, the Federal drug abuse dependence prevention, treatment, and rehabilitation bill.

Senator Hughes, when you introduced S. 3562 in the Senate, you spoke of the urgent need for a concerted attack on the drug problem from the standpoint of prevention, treatment, and rehabilitation. While recognizing that strict enforcement of stern laws dealing with drug abuse and illegal distribution of narcotics and dangerous drugs

is necessary, you emphasized the fact that drug addicts are sick people and that more needs to be done than has been done in the past to bring about maximum efforts in research, education, prevention, treatment, and rehabilitation in the field of drug abuse. The American Hospital Association agrees with these statements.

In response to your request I shall confine my remarks to section 710 of the bill which deals with admission of drug abusers and drug-dependent persons to private or public hospitals. First, I would point out that the association has long recognized alcoholism and addiction to other drugs as medical problems. The association's most recent statement concerning the admission of patients with alcohol and other drug problems to general hospitals was approved last November and has been distributed to more than 6,600 hospitals and patient-care institutions.

The major thrust of this statement is that general hospitals should develop programs for the care of alcohol and other drug problem patients, and that decisions concerning admission of such patients should be based only on the needs of the individuals. The statement calls on hospitals to accept their community responsibility for the appropriate admission of persons acutely ill as a result of any drug intoxication, and also their responsibility for the subsequent referral of these persons to specialized and aftercare treatment resources. General hospitals, in the association's view, are not expected to provide all rehabilitation services required by such patients, but they do have a responsibility to stimulate the development of such services or the resources to provide them, if they are lacking in the community.

In short, as the policy statement sets forth clearly, the association's position with regard to admission of patients with alcoholism and other drug problems is that such patients should be admitted to and treated in private or public hospitals on the basis of their medical needs, to the maximum extent feasible consistent with the availability of the necessary facilities and personnel resources to provide proper therapy for such patients. We understand this is also the aim of section 710 of S. 3562, but we do not feel enactment of the section would be wise or practical.

The admission of patients to a hospital and the treatment of patients in a hospital are matters that call for medical decisions which should be made by health professionals on the scene. Priority for admission of patients to a hospital should not be dictated by law but rather by the medical requirements of the patients.

Might I digress for a moment at this point?

Senator HUGHES. Surely.

Dr. IAQUINTA. Much has been said, by community groups particularly, that hospital beds are very essential for the treatment of drug addiction. We have had this said in New York City through group confrontations at various institutions. It is very difficult to explain to some individuals that hospital inpatient beds are not always absolutely necessary. For instance, there are groups in Manhattan who are agitating for many more adolescent beds. This is really a frustration at not having other adolescent out-of-hospital facilities available for rehabilitation and day care, rather than any idea of what the medical reason for admitting someone to a hospital should be.

We have no problem with admitting the acute overdose of any

drug. We have no problem admitting a complication of drug abuse, whether it is hepatitis or other things. When the person presents himself merely for help with his drug problem, I take issue with the fact that he should be admitted. It is rare the person that has to be admitted. We have found, from about 18 months of working with adolescents, and having an adolescent unit, that in the year of 1969, only three adolescents had to be in the hospital for withdrawal—because the habit in young people is so small and usually so inconsistent, that withdrawal is almost negligible. Therefore, long periods of therapy and/or methadone are not necessary.

I think there is nothing magical about this hospital bed. In many instances it may even be wasted. We have one institution in New York that conceded that there should be more inpatient beds to satisfy a sit-in of a local community. Twenty-eight beds were given over to adolescents who had drug problems. When I left New York they had only 18 of the beds filled, the other 10 just lie fallow because there are not enough patients to fill them.

At the same time, the same hospital has the problem that there are no adequate rehabilitation facilities to send these kids to once they leave that hospital, after being there a week. This is where the difficult part comes in. They have accomplished nothing in that week.

If I may go back now to my statement.

Senator HUGHES. Let me ask you this. Since you digress from your statement I would like to interrupt and ask you a couple of questions.

You say you have 10 beds constantly lying empty for lack of hospital need?

Dr. IAQUINTA. This is another hospital, but also in New York City. Yes.

Senator HUGHES. With the highest rate of drug addiction in the country in New York City, you have empty beds?

Dr. IAQUINTA. It may be incomprehensible but there are many inconsistencies. I can tell you of a local store front, sponsored by an OEO program, that is there really for community residents to use. But the local community people don't use that store front because they would be recognized. So the people on 50th Street in Manhattan may go up to the Bronx for their treatment and the people from Brooklyn may come to Manhattan. There are inconsistencies like this.

Senator HUGHES. Go ahead with your statement and then I will get back to some of these questions.

Dr. IAQUINTA. It appears to us that section 710 of the bill is contrary to the intent and purpose of community planning for health facilities, which you have recognized in other sections of the bill. We believe that patient needs must be related to communitywide planning and that services and facilities should be provided where planning decisions indicate they will best meet public needs. On the other hand, section 710 seems to require each and every hospital to provide facilities and services for the treatment of drug addicts.

Senator HUGHES. Could I ask, do you need special facilities and special services to treat a drug addict?

Dr. IAQUINTA. I was going to digress again anyhow to tell you about our own program which we are doing very inefficiently and on a small scale (yet considerable for us), and what we might hope it to be. You might perhaps understand that we do not have any money to do it, and I don't know how we are doing it now.

We have a methadone maintenance program, whether it is legal or not, with very strict criteria for accepting patients. The criteria are very strict. We have 45 patients at present and we hope to build it up to 200 very shortly. We think we have 10,000 or 15,000 addicts in our catchment area.

We have methadone ambulatory withdrawal for some adults. We have some inpatient methadone withdrawal. We have an adult drug abuse clinic. We also have an adolescent drug abuse clinic, separate from the clinic primarily because other children do not like to be associated with addicts at times.

We are hoping to form a day care rehabilitation program and we also hope in the near future to have a day center facility available, which we cannot finance and fund now, but we should hope to staff. We have an inpatient consultation service. We have an inpatient staff educational program. We have been talking at public schools, to family groups and so on—a community education program.

We have written up a little methadone newspaper, which is the first of its kind. We hope to have a general store front soon for an outreach program.

Senator HUGHES. To get back to the hospital, are all of these facilities completely separate and independent from the rest of your hospital facilities?

Dr. IAQUINTA. They are mainly within existing areas.

Senator HUGHES. Do you put a recovering addict, if you get one, that needs hospitalization in a ward with other patients?

Dr. IAQUINTA. We do at present but we don't like it.

Senator HUGHES. Why not?

Dr. IAQUINTA. We don't like it because he may wind up in a ward where someone does not realize that he has a real drug problem. That is our in-hospital education lack. He may get a complication because someone does not realize he is an addict and that he may need certain specific therapy.

Senator HUGHES. You mean some of your trained personnel may not realize that?

Dr. IAQUINTA. Right.

Senator HUGHES. That is an educational problem?

Dr. IAQUINTA. Yes.

Senator HUGHES. That is not the fault of the patient.

Dr. IAQUINTA. No.

We have security problems and this probably is the most important.

Senator HUGHES. You mean with drugs?

Dr. IAQUINTA. We know they continue to get them. Every once in

a while we know they addict a person in the next bed, but most usually they get the drug in there.

Senator HUGHES. What do you do with alcoholics?

Dr. IAQUINTA. They are admitted to general wards also.

Senator HUGHES. They are just with the other patients?

Dr. IAQUINTA. Yes.

Senator HUGHES. Do they steal the alcohol?

Dr. IAQUINTA. They used to. We used to have alcohol rubs on the end table years ago, but we had to take them off eventually.

Senator HUGHES. Can't you do the same with the drugs?

Dr. IAQUINTA. Except that you cannot search every visitor that comes into the hospital. It is very difficult. It is harder to conceal a bottle of liquor.

Senator HUGHES. Is the drug patient a nuisance?

Dr. IAQUINTA. No. Some may have some personality quirks but they are not a nuisance.

Senator HUGHES. Do they disrupt the other patients?

Dr. IAQUINTA. Occasionally. My worry is that if you put them into the hospital and you have them either in for a complication or for withdrawal of their drug, you just are not accomplishing your goal because you know that they are getting the drug while you have them there. This to me is one of the few scientific things I apply to drug addiction. Most of it is almost nonscientific.

Senator HUGHES. I won't belabor that. Go ahead.

Dr. IAQUINTA. Just to finish that list, we have established a central reporting, and data collecting area. We have set up more and more for additional laboratory tests, family counseling, group sessions. We support many local facilities, like Phoenix houses and Odyssey houses in our area. You can see what needs to be done by only one hospital that has about 570 beds.

Senator HUGHES. Do you have arrangements with those houses like Phoenix House?

Dr. IAQUINTA. No written things. They are in our area.

Senator HUGHES. Just an understanding?

Dr. IAQUINTA. Yes. If someone needs a physical or gets sick, we will see him.

The reverse is not so true because these houses usually are constantly full. We have the problem of having no "outs" insofar as referring our patients.

I might as well finish the rest of the statement, if I may?

Senator HUGHES. All right.

Dr. IAQUINTA. In fact, section 710 contains both an affirmative requirement that hospitals admit and treat drug abusers and drug dependent persons on the basis of medical need and a prohibition barring discrimination against such persons, because of their drug abuse or drug dependence. It should be recognized that there are a great many hospitals that do not have the facilities (the space) or personnel to provide proper medical management of drug problem patients. To re-

quire all hospitals to develop and maintain such treatment capabilities could lead to a costly and unnecessary duplication of facilities.

One of the questions that comes to mind in considering the provisions of section 710 is, "Would general hospitals lacking the treatment facilities and trained personnel to provide care for drug addicts be required to admit drug problem patients?" If this question is answered negatively, "Who will have the authority and responsibility for making decisions as to the adequacy of a hospital's facilities, and the competency of its personnel, in the area of treatment and rehabilitation of drug addicts?" Also, if section 710 becomes law, "What course should a hospital follow when a drug addict and a critically injured accident victim or other seriously ill person come at the same time seeking admission to the hospital's last vacant bed?"

Senator HUGHES. What do you do now?

Dr. IAQUINTA. I think the "hang-up," sir, is what I think you mean by admission of a drug addict as an acutely ill person. I agree that he may be as acutely ill as any other accident victim, but I disagree as to the person that needs to be admitted—he is really not an emergency, and there is no need for instant admission.

Senator HUGHES. I asked the question, if you had one about to die from drug abuse and one about to die from an accident, what would you do?

Dr. IAQUINTA. I would treat them both.

Senator HUGHES. You say if you only had the capability of taking one.

Dr. IAQUINTA. Yes.

Senator HUGHES. What generally do you think the hospital's responsibility in America is in the face of this growing epidemic of drug abuse?

Dr. IAQUINTA. Unfortunately, I think part of the answer to that is a regional one. New York City is certainly a lot different than a small town somewhere in the midwest, where there may not be as much drug abuse.

Senator HUGHES. Give an example, Doctor. Have you found the same thing in New York City in the last 5 years? We supported experimental demonstrations in alcoholism at detoxification centers. This proved to be quite an expensive development where we developed strictly detoxification centers and moved them on.

Now, many of them are reaching the conclusion that it would be much better if we admitted acute alcoholic patients to general hospitals for detoxification and then move them into a halfway house center after, 4, 5, 6, 7 days which is what the normal detoxification process takes rather than constructing or building adjacent to that some sort of a hospital facility, because it has to be near one.

I am assuming that drug abuse patients other than alcoholics have many other physical and mental disorders. It intrigued me. The fact is that they are there so there has got to be some sort of close relationship with them.

So, what is it best to do, to provide financial aid thereby depriving general hospital construction of part of that aid so we can provide specific housing for patients of this kind? We have millions of Americans suffering from it. Or is it better to try to include it into the financial structure of hospitalization in the country, the Federal aid?

Dr. IAQUINTA. I think it is a combination of the things that you mention. I have spoken to many of the people around New York and I fail to see the need for true hospitalization to a very high cost bed for a noncomplication of drug addiction. I find this difficult to support.

I would say that you need a separate area that is not run like a hospital where you have adjacent day-care activities, rehabilitation programs, vocational and occupational rehabilitation, counseling, places where you can get parents in, a place for the kids to slip away from whatever the social problems that may be adding more than anything else to their using the drugs.

Senator HUGHES. The rest of the bill does deal with this somewhat, 710 does not. But what treatment facilities will the hospital have to develop and maintain other than those they already have to meet the requirements of this bill to admit them on the basis of medical need?

You have just said there is not much medical need.

Dr. IAQUINTA. There is a medical need to admit the many who have hepatitis, that have blood stream infection, that have acute overdoses. Yes, these are medical illnesses. I doubt though that you need a sophisticated hospital section and certain trained personnel, personnel who are very scarce in this area, to take care of the people that need rehabilitation and really a home away from the other influences that let them take drugs.

Senator HUGHES. I cannot see that we are disagreeing. I think we are straining at an end. I think you are concerned about something that I am not concerned about because you are in the business and I am not.

Dr. IAQUINTA. I probably could agree more with a certain amount of pressure on hospitals that are in a high epidemic area for addiction, like New York City, to have more facilities than they have now, if they had the money to do it, and the personnel.

However, I don't necessarily see the pressure that would bear on a hospital in Minnesota that has few local addiction problems but may have to admit—in order to comply with this—a person presenting that hospital with a drug addiction problem. I think they should refer him.

Senator HUGHES. I cannot see there is any place in America that does not have the problem. We have a problem in Clear Lake, Iowa.

Dr. IAQUINTA. I think the small hospital should probably send that person elsewhere. For instance, with our program, that I listed before, if we try to do it all we would need about a million dollars to run that project, the personnel and so on. So expensive. Facilities would be expensive. What we are thinking of doing with a sister hospital is perhaps using that hospital's beds, our outpatient expertise, which

we have more of than they do, and together work out a rehabilitation program.

This makes more sense than each hospital providing the beds, and avoid duplication.

Senator HUGHES. We wrote such a provision in on alcoholism as you know on Hill-Burton funds and it passed. Do you look for any great amount of trouble with that?

Dr. IAQUINTA. Trouble with what?

Senator HUGHES. With that specification on Hill-Burton funds and alcoholism.

Dr. IAQUINTA. I know to what you allude, but I am not too familiar with the whole wording of that.

Mr. WILLIAMS. I think, Senator, that the matter of Hill-Burton construction would boom and not require a patient program. The matter of saying that in those facilities that were built with Hill-Burton funds there must be consideration given to the treatment of alcoholics, that is one thing, but that is quite different than writing a law that every hospital has to admit patients for a given condition.

Senator HUGHES. If they have a medical need to be admitted. Are you denying patients now that have a medical need?

Mr. WILLIAMSON. No.

Senator HUGHES. Then what are you worried about?

Mr. WILLIAMSON. We think, for example, if the Federal Government is going to write into a law saying that every hospital has to admit a certain class of patient, then the Federal Government has an obligation to assure that that hospital will have its costs reimbursed completely for the care of such patients.

If you are saying that as a matter of principle, Senator, I think what we are worried about is Federal law—

Senator HUGHES. Do you agree that a drug addict or a drug dependent is a sick person or not?

Mr. WILLIAMSON. Yes.

Senator HUGHES. Then why should they have to have a guarantee more than anyone with a heart attack because they ate too much fat meat?

Dr. IAQUINTA. Again it is difficult to convey the difference between that patient and the addict who has an addiction, a cellular addiction. This is true chemical fact and it is an illness in that respect. I think that to classify the person, who just has the habit and needs to come off it and be rehabilitated, with a person who has another medical problem is the very fine point that I never seem to make. We always admit a person who has a medical need for a bed, but I disagree that each addict has a medical need for an in-hospital bed as we understand it now.

Senator HUGHES. Your statement says that you have always admitted alcoholic patients too, does it not?

Dr. IAQUINTA. Yes.

Senator HUGHES. But I still have trouble getting patients in the hospital who are suffering from alcoholism all over the country. I get

reports almost daily that they are refused admittance. It is a good statement. I support it and I know you are doing everything you can, but the fact out on the street is that they won't admit them.

Dr. IAQUINTA. In many instances, again, I am sure that some hospitals don't have the facilities to keep the patient.

Senator HUGHES. What type of a special facility does an alcoholic patient need when he is unconscious, maybe dying? What does he need special?

Dr. IAQUINTA. The unconscious person is a different person. The person who is, let's just say, drunk needs a place to wake up in. He may not be unconscious.

Senator HUGHES. How long does it take you to render him unconscious? Usually the first thing you do is give him something to put him to sleep.

Dr. IAQUINTA. We don't usually.

Senator HUGHES. They have changed a little over recent times then.

Dr. IAQUINTA. I think if one is worried about withdrawal in an alcoholic person then one would initiate certain treatment schedules that might sedate him or might try to prevent convulsions and so forth. If he has just had too much to drink, he really needs a place to sleep it off and not be sent out into the street again.

Senator HUGHES. Where would you suggest that be?

Dr. IAQUINTA. Well, I know that in Detroit they had a very smart idea. They had a part of the hospital, a wing that they used, staffed by one or two specially trained nurses so anyone who was inebriated could come and sleep it off. These people just took care of them during this period of insobriety and the resultant symptoms and the next morning they would send them out.

In the meantime, they would use that as a contact for further treatment with AA. They treated the acute episode only.

Senator HUGHES. Is that a proper approach to alcoholism?

Dr. IAQUINTA. That is one to take care of the many people who are picked up by the police, and are not acutely sick.

Senator HUGHES. They substituted that for the tank but it does not give them any help, does it?

Dr. IAQUINTA. No, it does not. On the other hand, you can talk until you are blue in the face to someone who really does not want to stop drinking and they will never accept AA or any other form of therapy. We happen to use a lot of AA support in our alcoholic programs.

Senator HUGHES. Could you furnish me a copy of the AHA statement of policy on the policy of admission for the record if you do not have a copy.

Dr. IAQUINTA. We have one, sir.

Senator HUGHES. If you would, would you supply it to the reporter. (The information referred to follows:)

AMERICAN HOSPITAL ASSOCIATION STATEMENT ON ADMISSION TO THE GENERAL HOSPITAL OF PATIENTS WITH ALCOHOL AND OTHER DRUG PROBLEMS^{1 2}

Alcoholism ranks fourth among causes of illness and disability in the United States today, and other drug problems also are becoming serious medical concerns. Like other medical emergencies, alcohol and other drug emergencies require the best in diagnosis and medical management.

Courts and legislative bodies increasingly recognize that alcoholism per se is an illness and not a criminal activity, but although improved methods of treatment are available for all patients with drug problems, the majority of hospitals still deny admission to such people.

The reluctance of hospitals to admit patients with alcohol and other drug problems is often based on the misconception that, because these patients are uncontrollable and disruptive, special facilities and staff are required for their care. The truth is they are not. Professional knowledge is required, not special units; the successful management of such patients in regular units is well documented.

Further, the health insurance industry is beginning to support the admission of alcohol and other drug patients to the general hospital. The Blue Cross Association, for example, has eliminated from its national contracts discriminatory clauses excluding coverage for mental illness, alcoholism, and drug addiction.

Failure to admit alcoholics and patients with other drug problems denies them the benefits that would be available in cases of poisoning due to other causes; similarly, it denies hospital personnel and house staff the opportunity for education in the management of such cases.

Since 1944, the American Hospital Association has recognized alcoholism and addiction to other drugs as medical problems requiring broad-scale attack. In that year a special committee of the Association recommended that "the primary point of attack (on alcoholism) should be through the general hospital."

The Association urges general hospitals to develop programs for the care of alcohol and other drug problem patients. Decisions concerning admission of these persons should be based only on the needs of the individual. Hospitals should accept their community responsibility for the appropriate admission of persons acutely ill as a result of any drug intoxication, and also their responsibility for the subsequent referral of these persons to specialized and/or after-care treatment resources. The number and availability of such resources are increasing.

Although the hospital is not expected to provide all rehabilitation services required by these patients, it does have the responsibility to stimulate the development of such services and/or the resources to provide them, if they are lacking in the community.

Senator HUGHES. Could you also supply me section 710 for the record. Do you think it is bad language? Let's have you come up with some alternative language that you think is better.

You don't have to do that right at this moment, you can supply that in writing.

Dr. IAQUINTA. All right.

(The information subsequently supplied follows:)

¹ Approved by American Hospital Association, November 19-20, 1969.

² Revision of *Statement on Admission of Alcoholic Patients to the General Hospital*, approved September 1957.

American Hospital Association

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May 4, 1970

Honorable Harold E. Hughes, Chairman
Subcommittee on Alcoholism and Narcotics
United States Senate
Washington, D. C.

Dear Mr. Chairman

This letter is in response to the two requests you made on April 15, when Dr. Frank E. Iaquina and I appeared before your Subcommittee on Alcoholism and Narcotics.

Dr. Iaquina in his testimony on behalf of the American Hospital Association with regard to Section 710 of S. 3562 outlined the Association's position concerning the admission to hospitals of patients with alcohol and other drug problems, which is that decisions concerning the admission of such persons to general hospitals should be based only on the needs of the individual. In recommending that Section 710 be deleted from the bill, Dr. Iaquina emphasized that the admission of patients to hospitals and the treatment of patients in hospitals are matters that call for medical decisions by health professionals on the scene after consideration of the medical requirements of the patient in each case.

Following a discussion of the responsibilities of hospitals in the face of the growing epidemic of drug abuse, you stated that you did not feel we were disagreeing, and you added that you would like to have the Association come up with some alternative language for Section 710. We do agree, Mr. Chairman, that the Association's statement on admission to the general hospital of persons with drug abuse problems and Section 710 of your bill have the same goal -- the admission of drug problem patients to hospitals based solely on consideration of their medical needs and without discrimination because of their drug abuse or drug dependence. We do not believe, however, that the admission of patients to hospitals should be dictated by law, and we cannot, therefore, offer any language to impose on

hospitals a legal requirement that they must admit drug abuse or drug dependent persons.

You may be sure that the Association does intend to continue to urge general hospitals to develop programs for the care of alcohol and other drug problem patients and for the referral of such patients to specialized and/or aftercare treatment resources. For example, the Association is now working on a proposal that is designed to develop programmed instructional materials for hospitals to train their professional staffs, including physicians, nurses, social workers and other hospital personnel, in the treatment of drug addicts. Also the Joint Commission on the Accreditation of Hospitals has accepted at the request of the American Hospital Association modifications of the standards for accreditation which are aimed at improving the care or referral of drug abusers.

The second request you made was that Dr. Iaquina go over Subsection (h) of Section 304 of the bill and supply his personal comments with regard to it. He has done so and his views on Section 304 (h) are as follows:

"Although I agree with the first sentence, re "disseminating guidelines for the use of controlled dangerous substances", I do not agree with the second sentence. My reason follows.

"First: I believe that what is intended by "controlled dangerous substances" is methadone.

"Second: It should be made clear that a "practitioner" means a licensed medical doctor only - and not a chiropractor, etc.

"Third: Methadone should not be prescribed indiscriminately by any "practitioner". I, personally, believe it serves a useful purpose, and that its scope may be broadened in the future. However, it should only be available through a recognized drug addiction agency - hospital, clinic, etc. Too many abuses and misuses could arise from unrestricted (unregulatable) dispensing.

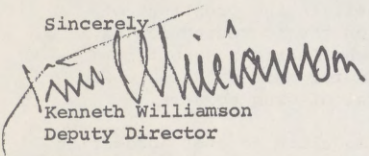
"Fourth: There is no guarantee that patients will take the drug, but sell it, after filling their prescriptions. Also, attempts at rehabilitation would be half-hearted and poorly available to the local "practitioner". That the "practitioner" alone could provide the whole service is untenable.

"I would rather see an easing of the current legal restrictions, and the red-tape, involved in the use of methadone, so that more health facilities would be encouraged to use it. This goal should be avidly fought for.

"My remarks have been brief but they summarize my feelings and those of my colleagues at The Roosevelt Hospital."

Thank you, Mr. Chairman, for your and your Committee's consideration of the Association's views.

Sincerely,


Kenneth Williamson
Deputy Director

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Senator HUGHES. For example, a hospital either must admit a patient or have contractual relationship with other facilities so a patient can be referred or some sort of arrangement where a patient simply is not going to be turned back into the street.

Dr. IAQUINTA. I agree with that.

Senator HUGHES. I think our goals are the same.

How many hospitals are represented by the American Hospital Association?

Mr. WILLIAMSON. About 6,800.

Senator HUGHES. Of these, how many now accept patients for drug abuse and drug dependence?

Mr. WILLIAMSON. I could not tell you, I don't think we know.

Senator HUGHES. You don't have any idea?

Mr. WILLIAMSON. We have no exact count.

Do you know in New York City, for example?

Dr. IAQUINTA. No. I could quickly think of six or 10 hospitals in New York City, because of their location in very high-incidence areas. St. Luke's, Harlem.

Senator HUGHES. You have some very good programs. Whatever I say that may sound critical is not critical of what you are doing.

Dr. IAQUINTA. I know.

Senator HUGHES. I happen to know that America is not represented by the way you are trying to meet problems.

Dr. IAQUINTA. No, but I think even more in New York City would or could do it, they face several very important obstacles. One is the appropriate personnel. They are not that available.

Senator HUGHES. This is another thing we are trying to get added in this bill, some educational approaches that can supply not only the professionals, but the paramedical people that many times can be utilized with patients such as you are describing.

Dr. IAQUINTA. They are just not available. Also, we are in the center of Manhattan. We run a very active ambulance service so we have innumerable emergencies coming in daily. Our hospital has to fulfill so many functions that it is difficult to reorient one's self and to re-deploy people, with the limited funds that are available, to solve the problem. This is why we cannot do very much very fast.

Senator HUGHES. Could you specifically, where you have objection to the language in section 710, offer us some recommended alternatives that you would find less objectionable while still meeting the general goals which I think we understand today?

Dr. IAQUINTA. Yes.

Senator HUGHES. That might be helpful to us in our consideration.

Dr. IAQUINTA. Yes, sir.

Senator HUGHES. Submit them to us as soon as you can. We would be very happy to have them for our consideration. We are not trying to do damage to anyone, we are just trying to see that people can be hospitalized and be treated when it is necessary along with any other medical patient, whether it be accidents or heart disease or whatever.

Did you read section 304, subsection (h) of the bill regarding medical guidelines?

Dr. IAQUINTA. Yes, I did, sir; but I would have to look at it again to recall exactly what you mean.

Senator HUGHES. Would you take a glance at it? Do you have a copy of the bill? Section 304, subsection (h). Bottom of page 12 and top of page 13.

Dr. IAQUINTA. Yes, sir. I am sorry but I don't remember the question.

Senator HUGHES. What do you think of it?

Dr. IAQUINTA. I think this is appropriate as long as I knew who exactly was going to make the decision as to what are certain dangerous substances. It says, "coordinating functions of the administration, shall be the duty of the administration."

Senator HUGHES. I hope we wind up with HEW making our decision, that is our ultimate goal.

Dr. IAQUINTA. I think there should be some definite medical background to deciding which substances are dangerous or not.

Senator HUGHES. Right now I am of the opinion that there may be hundreds or even thousands of physicians in America using methadone who are on the borderline of breaking the law. They are displaying a great deal of courage because it is either use it or turn these people back into the streets to prey on society.

Dr. IAQUINTA. I am sure they are.

Senator HUGHES. Senator Javits I know is concerned because of New York and the high incidence rate there of heroin addiction. It is so terribly high here in the District of Columbia, Los Angeles, Chicago, and a few other major areas of the country.

Do you believe that maybe it is time for the country to take a little risk with methadone? We have proven that we are not getting very far any other way, it is just ballooning.

Dr. IAQUINTA. Yes. I think we have had to overcome a lot of criticism, in our own hospital, of the use of methadone maintenance treatment. It has come from all quarters, all specialties. Again, this is what I referred to before as perhaps not pure science but a feeling that you are accomplishing something that has no true scientific basis. However, if you can—and we have seen it in our program—if you can rehabilitate some people, keep them away from stealing, keep them away from hurting others and to get back with their families, then I think this is very useful.

In our small program we hired a few methadone patients that have been on the program for about a year within our hospital. I cannot give good statistics yet because we have not done it that long, but I know there was only one individual that committed a crime in that period—and that was not drug related—who went to jail.

You must understand, or you do know I am sure, that the criteria that we use is that set up by the Beth Israel group which are very strict rules.

Senator HUGHES. Very strict and very hard.

Dr. IAQUINTA. We try to abide by them thus far. It may be that experience may demonstrate that the criteria might be loosened up just a little bit.

Senator HUGHES. It might be helpful to us if you would go over section 304, subsection (h), and determine what language changes you

could make for the record that would be helpful to us for a guideline for consideration.

Dr. IAQUINTA. I would be happy to.

Senator HUGHES. I understand we are dealing with the total new approach that is very controversial in many ways. Any help you would give us for consideration would be very helpful.

I want to thank you very much for being willing to come and testify this morning. In spite of the fact that some of my questions are aggressive I don't view our position as being different. I think actually we are in 100-percent agreement on what we want to do. It is a question of how we spell it out so that we are not putting a great burden of weight on someone where it is not needed.

I don't think we want to do that either, but at the same time, we want to assure that a patient who is a drug dependent, who needs hospital admission, gets hospital admission at least where hospitals are getting Federal funds for operation.

That is our goal.

Mr. WILLIAMSON. I think the doctor has some very interesting figures on the cost of treating patients which you asked earlier. What was the cost projection? He has a cost projection on 200 patients, I think.

Senator HUGHES. Are these heroin patients?

Dr. IAQUINTA. Yes. This was just trying to estimate what it would cost us to have a bare minimum of personnel to run a 200-patient methadone program exclusive of drugs, laboratory tests, and so on. Personnel alone would cost about \$250,000. If you start adding in urine tests, physical facilities, the drug and additional personnel, it easily would be \$300,000-\$400,000 for 200 methadone patients for a year.

Senator HUGHES. 200 patients hooked on heroin with a \$50 a day habit is \$10,000 a day.

Dr. IAQUINTA. Right.

Senator HUGHES. Thirty days recovered would be \$300,000. It is a pretty good investment for the Government.

Dr. IAQUINTA. Yes.

Senator HUGHES. I understand it costs somewhere between \$1,000 and \$2,000 to care for a patient on a maintenance program.

Dr. IAQUINTA. Yes. I think ours would come close to that.

Senator HUGHES. But I don't know. I am assuming that it might even result in withdrawal for those patients.

Dr. IAQUINTA. This would be our hope.

Senator HUGHES. It would be the goal certainly to withdraw all those patients that could be withdrawn.

I understand many of these patients when they withdraw become alcoholics, they substitute alcohol for drugs because they are not treated for emotional disturbances that go along with the disease.

Thank you very much.

Dr. IAQUINTA. Thank you.

Senator HUGHES. Our next witness is supposed to be here in just a minute. The Chair will recess until his arrival.

(A brief recess was taken.)

Senator HUGHES. The committee will come to order.

The Chair has received information that Senator Harrison Williams is unable to leave another hearing. He was scheduled to testify. We will receive his testimony for the record.

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

Senator WILLIAMS. Mr. Chairman and members of the committee, thank you for this opportunity to testify regarding S. 3562, Senator Hughes' bill of which, as you know, I am a cosponsor. I would like to commend the chairman and all of the members of this committee for the diligence they have shown in pursuing this important subject of drug abuse prevention and rehabilitation. I believe the hearings we have held have given us a good insight into the serious nationwide problem of drug abuse, and I hope the result will be the enactment of a comprehensive program to deal with it.

The dimensions of drug abuse in this country are staggering. Official estimates by the Division of Narcotics and Drug Abuse of the National Institute of Mental Health place the number of heroin addicts in this country between 120,000 and 150,000, but that is just the top of the iceberg. Unofficial estimates are that the number of people addicted to that drug might be closer to half a million. Even that figure is probably low.

The Division says that a minimum of 8 million people, and perhaps as many as 20 million, use marihuana. There are 8 billion doses of amphetamines, commonly called "speed," manufactured legitimately in this country every year. The Division estimates at least half of them get into illicit channels, outside of medical control. There are 12 billion doses of barbiturates—"downers"—manufactured legitimately every year and half of them also disappear into the underground drug market.

There are no sound, scientific figures on the number of people who misuse amphetamines and barbiturates, but a recent survey indicated as many as 20 percent of all Californians may be using speed.

We have all seen the headlines about 12- and 13-year-old children using drugs such as heroin, but I wonder if we realize how great the problem is? Preliminary figures from New York City show that 224 teenagers died there last year as a result of narcotics overdose or acute narcotics poisoning. Since the first of this year a teenager has been found dead every day in New York as a result of narcotics use.

Look at the situation here in the Nation's Capital. An excellent article by Ronald Kessler in the Washington Post of March 20, 1970, told of the use of heroin at a high school just a few minutes walk from this building. Students there said between 150 and 200 of their classmates use heroin every day, while another 100 use it sporadically. That would mean one-fourth of the school's total enrollment uses heroin.

Students interviewed said 10 to 15 outside drug pushers enter the school every day to make sales. Students told how they would sneak

out of school during the day to shoot heroin, or even do it right in the school washrooms, and then return to class in a narcotic daze.

And drugs are by no means limited to inner-city schools. This problem is like a cancer that has spread to every segment of our society. There is virtually no corner of the country that is free from it, and the disease recognizes no bounds of economic class or race.

A recent story in *Time* magazine told of 14- and 15-year-old children, sons and daughters of middle-class, suburban families, who are using heroin.

In March, police in suburban Arlington, Va., went to a high school while classes were in progress. They had 13 students summoned from their classrooms and arrested them on drug charges. Later they arrested three more students who were only in junior high.

One result of the growing number of drug abusers has been a dramatic increase in crime related directly to drug use. Drugs are expensive and the more a person uses them, the more he wants them, thus the more money it takes to support his habit. At the same time, heavy drug users are seldom able to hold down a steady job, and almost never are able to legitimately earn high incomes.

The result is that the heaviest drug users, the ones who need the most money to buy drugs, are the ones who earn the least money. Almost inevitably they turn to crime. It has been calculated that in New York City alone addicts must raise as much as \$700,000 every day to support their habits. To do so, many of them turn to robbery, shoplifting, burglary, forgery, and prostitution.

One of the high school students interviewed in the Washington Post article told how he "learned to steal real good" after he developed a \$22-per-day heroin habit. His favorite device to support his habit is by stealing 10 or 15 steaks from a supermarket and selling them to people in his neighborhood.

Aside from the cost to society at large in terms of crime, lost income, increased welfare rolls, lost human resources and the costs of enforcement, each drug abuser represents an individual tragedy.

Even people whose abuse of drugs is of relatively modest proportions soon find that their lives are no longer their own. They soon lose the power to guide themselves, following instead the pursuit of drugs as their guiding principle.

They lose interest in jobs, families, friends. Their only concern is obtaining drugs for their next high. They give up the power to decide on a course of action and then follow it, the very thing that differentiates man from other animals.

Mr. Chairman, I think the members of this subcommittee would agree with me when I say the problem of drug abuse is one of the most serious problems this Nation faces. And I think they would also agree with me when I say that our response to that problem up to this time has been totally inadequate.

Steps toward stricter enforcement of drug laws will not, by themselves, solve the problem. You cannot dissuade a youngster from try-

ing drugs just by reciting a lawbook to him, nor can you rehabilitate a drug abuser with a police billy club.

What is needed is a comprehensive, nationwide program aimed at educating potential drug abusers and at rehabilitating those we have not been able to head off. I believe S. 3562 would move us a long way in that direction. I am particularly enthusiastic about its specification that drug dependence is a disease which requires treatment and rehabilitative services, and the section establishing a drug abuse prevention, treatment, and rehabilitation administration.

As you know, I introduced a bill last year—S. 1816, the Drug Abuse Prevention and Rehabilitation Act—aimed at accomplishing those goals, and that bill is before this committee. Although in substance it differs somewhat from S. 3562, the thrust and goals of both measures are the same.

I will, of course, give my wholehearted support to whatever effective legislation in this area this committee finally agrees on. While S. 3562 is more comprehensive than my own measure, there are several points in my bill which I would strongly urge be included in any legislation recommended by the committee.

First, my bill specifically provides for grants to medical schools and institutions of higher learning to develop and carry out drug abuse education programs for students of medicine, psychology, psychiatry, sociology, social work, and other related fields. I think it is important we single out medical schools for inclusion here because it is often the family doctor who is called upon to make the first professional contact with a young person who is thinking of trying drugs or who has already done so. We expect these doctors to respond to the problem, but too often we have provided them with little education about it. Under my bill, a 5 year, \$105 million graduated authorization is made for these curriculum programs.

My bill also provides for the establishment of a national council on drug abuse control to be composed of specified officials of the administration. Such a high-level interagency council in the Executive Office of the President is of critical importance in coordinating drug abuse education programs, in determining the effectiveness of Federal and State laws on narcotics and other dangerous drugs, and in encouraging State and local and private organizations to participate in efforts to combat the abuse of narcotics and other dangerous drugs.

Finally, my bill would direct the Secretary of HEW to make grants to assist States and nonprofit organizations in establishing, developing, equipping, and operating drug addict treatment and rehabilitation centers. For this program, \$350 million is authorized on a graduated basis over a 5-year period, beginning at \$50 million in the first year. Up to 30 percent of the money available will be used to make grants to nonprofit organizations which develop a comprehensive program for the prevention and treatment of drug addiction, and research with new techniques and methods for improving this treatment and rehabilitation.

Under the authority of the Narcotic Addict Rehabilitation Act of 1966, the Community Mental Health Centers Amendments of 1970, and certain executive reorganization orders, the National Institute of Mental Health is currently administering a program embracing two clinical research centers (Fort Worth, Tex., and Lexington, Ky.), 16 community narcotic addiction treatment centers, and what are termed community treatment resources in over 100 cities in 40 States. In point of fact, this program is totally inadequate to deal with the extensive problem of narcotic addiction and drug abuse. For example, with respect to the emphasis in my bill upon treatment and rehabilitation centers, the administration budget for the current fiscal year allocates only \$4 million to fund applications for additional community narcotic addiction treatment centers—in addition to \$4 million for continued funding of existing centers. It is perhaps a sufficient commentary on the effectiveness of the administration of this program to note that only 16 applications have been received.

Moreover, recent testimony before this subcommittee by HEW officials indicates a strong preference for limiting drug abuse programs to authorities provided under existing law. Preference is given to the utilization of existing community mental health centers, even though regional hearings have demonstrated the nonutility of these centers for certain forms of drug abuse treatment and rehabilitation where a completely independent community outreach is required. Nor have those officials taken sufficient account of the legislative history of the community mental health centers amendments, wherein Congress purportedly limited the authorization period for narcotic addiction and drug abuse treatment and rehabilitation programs in expectation of the development of legislation on a long-range program by this subcommittee. Finally, a substantial question has been raised in the course of testimony before this subcommittee about the actual intent of the administration in stressing the responsibility of local communities for establishing viable addiction treatment and rehabilitation programs. Senator Yarborough has pointedly asked whether this position amounts to a proposed reduction of Federal involvement in these programs. If so, we shall witness the same profoundly hazardous false economy imposed upon the National Institutes of Health last fall by the Bureau of the Budget in cutbacks on crucial biomedical research.

In concluding these remarks, I would like to emphasize the second part of the section of my bill, dealing with treatment and rehabilitation centers; namely, the requirement that up to 30 percent of the funds appropriated under this title go to private, nonprofit organizations. Here we reach what I have referred to as the need for a com-

munity outreach separate from programs publicly identified with governmental agencies. We meet the need for innovative approaches to treatment, and for centers that "identify" effectively with the subculture and the immediate environment of the narcotic addict or drug abuser. We provide an essential supplement to Government-funded centers with a "professional" and research orientation. And we enable the addict to escape the dead end cycle of arrest and jail through providing immediately available opportunities for "positive" referral.

These private, nonprofit organizations, and I have in mind specifically ones such as Odessey House in New York and DARE in Newark have been doing some of the most innovative and promising work in the field of rehabilitation. By working with small groups and offering a "total environment," these private organizations often meet with substantially greater success than do Government efforts at rehabilitation.

Let me recount for you the comments of a young man named Danny, a resident of a private rehabilitation center, who testified during hearings I conducted in Camden, N.J. earlier this year.

"We know we are only an inch from the gutter," Danny told us. Then he said:

"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 fail."

Mr. Chairman, if we can produce Danny's living examples of the depths of a drug abuser can fall to and of the rehabilitation that is possible, we will be on our way to solving this problem.

These private, rehabilitation programs are showing us the way. They certainly deserve a fair share of any Federal money made available for this purpose.

In closing, Mr. Chairman, let me leave with you the poignant phrases expressed in a prayer for help in solving this problem offered by the Rev. Ace L. Tubbs, former pastor of my own church in Westfield, N.J. Here is part of Reverend Tubbs' prayer:

Give us eyes to see the hidden pain of others. Give us sympathy sharpened by our own suffering. Give us wisdom and strength to lighten the burdens of those who resort to drugs so that they will not need a way of escape. Above all, grant that courage and steadfast faith may sustain all those for whom help does not appear to come in time, lest we have even more tragic deaths among our youth.

Senator HUGHES. At this point I order printed statements of those who could not attend the hearings and all other pertinent material submitted for the record.

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IRWIN TOBIN
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RECD MAR 12 1970

April 29, 1970

Hon. Jacob K. Javits
United States Senate
Committee on Labor and Public Welfare
Washington, D.C. 20510

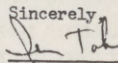
Dear Senator Javits:

I received your letter and a copy of The Federal Drug Abuse and Drug Dependence Prevention, Treatment and Rehabilitation Act of 1970 (S.3562). My reaction to the legislation is most favorable. The direction seems to be one designed for treatment and prevention for which you are to be commended. This indicates a very positive approach. I should like to add a word of caution, however.

It is not enough to state that a person shall be committed for treatment and rehabilitation. There is great need for competent personnel and adequate facilities. Far too often, courts and agencies, faced with a most unsatisfactory alternative to a very frustrating problem, exacerbate an already difficult situation.

I am also very much concerned with the implementation of educational aspects of this bill. Experience has indicated that financial assistance for projects do not always utilize the knowledge, skill and training of the most qualified people. There is no gainsaying the fact that New York City has the dubious distinction of being the drug capital of the world. I sincerely believe that we have been involved in efforts that have implications for the rest of the nation. The lessons we have learned should be shared and made available to all who are concerned. In effect, I am suggesting that this bill make provision for the services of concerned educators with on-the-job experience in the formulation of educational programs.

I wish to thank you for granting me the privilege of reading and reacting to what I deem a most significant bill.

Sincerely,

IRWIN TOBIN
Director

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Statement of

THE NATIONAL LEAGUE OF CITIES

and

U. S. CONFERENCE OF MAYORS

on

S. 3562, THE FEDERAL DRUG ABUSE AND DRUG DEPENDENCE, PREVENTION,
TREATMENT, AND REHABILITATION ACT OF 1970

Presented to

Special Subcommittee on Alcoholism and Narcotics

Senate Labor and Public Welfare Committee

The National League of Cities and U. S. Conference of Mayors are deeply concerned about the growing impact of drugs and its manifestations in rising crime rates, dependency and other adverse social costs. In the past few years, arrests for drug offenses have grown at a more rapid rate than arrests for almost any other crime. The rising drug arrest rate is a matter of grave concern because of the great involvement of the young and resulting permanent staining of records of those implicated in drug offenses. In 1968, 3% of arrested drug violators were under 15 years of age, 26.6% were under 18 and 76.6% were under 25.

There are also indications that drug addiction is responsible for a tremendous volume of street crime which addicts must commit to secure funds to support their habits. In some communities, it is estimated that over 50% of robberies, burglaries, and other such property-related crimes may be directly attributable to addicts in need of money.

Patrick V. Murphy, Policy Commissioner of the City of Detroit and formerly Administrator of the Law Enforcement Assistance Administration, recently told a group of mayors meeting in Detroit:

"The mathematics of this are overwhelming. Supposed that we have 1,000 addicts in Detroit -- and we have many times that number known to authorities -- and that 500 of them support their habits by crime that involves the conversion of stolen property. Let us say that it costs the average addict \$5 per day to purchase the drugs he needs and that he must steal \$4 worth of merchandise to realize \$1 in cash by quick conversion. That means that 500 addicts must steal \$160 per day, or in other words, \$80,000 a day to support 500 habits. Although we have only sketchy proof, it seems likely that our 12 largest cities may experience over 51% of the national total of reported robberies in part because a large proportion of the nation's drug addicts live in most cities."

In light of such facts and figures there is an obvious and urgent need to increase federal, state and local efforts to prevent and control the abuse of drugs. This must be a two-pronged attack.

First, enforcement of drug laws must be made fairer and more effective by employing the latest techniques to control drug traffic and by modernizing the penalty structure for drug law violations. New laws should impose severe penalties on the professional drug merchants. But they must also recognize that addiction and the use of drugs may be as much a sickness as a crime and impose penalties appropriate to the dangerousness of the drug involved which deter use but do not unfairly punish weaknesses and temporary indiscretions. Legislation has already passed the Senate to accomplish many of these objectives, and several states are acting to improve the structure of their drug laws consistent with these goals.

Second, efforts to treat and rehabilitate persons using drugs outside the criminal structure and to deter the use of drugs through education of potential drug users must be increased. S. 3562 and related legislation would accomplish a substantial improvement of the federal effort in this regard.

Drug problems manifest themselves most directly and have their severest impact at the local level. It is at this level which prevention, rehabilitation, and educational programs must be concentrated. These local based programs have four needs to which this legislation can address itself.

There are:

1. Improved coordination of various efforts being made at the local level and a better exchange of information among programs in various cities as to what methods of prevention, treatment, and education are proving most effective.
2. Development of better methods to upgrade educational programs and generally supply the public with information about the dangers of drug abuse. Currently, many believe that educational programs undertaken in the schools do more to stimulate youthful curiosity than to deter use of drugs, and the education available to the general public beyond that in the schools is woefully inadequate. A nationwide program is necessary to develop a realistic and effective curriculum for drug abuse education in high schools, junior highs, and perhaps, even grade schools. Further, the means need to be developed to undertake a nationwide campaign to improve public information and, thus, public recognition of drug dangers.
3. More resources must be provided to support drug abuse prevention and treatment programs at all levels. To assure adequacy of resources, increased federal aid must be provided to local programs. Local governments are currently facing a severe financial crisis as rising, and well justified, demands for services from local citizens are pressing hard against local revenue bases which individual local governments have limited, if any, capacity to expand to meet the rising demands for services. Only a substantial input of federal aid can assure that local drug control programs can be geared up to the level of operations necessary to deal with drug problems in the community.

S. 3562 will provide valuable assistance in solving these problems by improving coordination, developing better information programs, and making available a greatly increased level of assistance for local programs.

The fourth problem which needs addressing is the necessity of giving greater recognition at the federal level to the important role local governments play, and must continue to play, in drug abuse control efforts. It is local officials who must deal every day with drug addiction, crime, social degradation, and other factors related to drug abuse, and it is local officials to whom citizens turn first to seek assistance with their problems. Many of the most effective drug control programs are those which have been developed at the local level to serve individual communities. Yet, too often, federal legislation deals primarily with the states whose experience and interest is sometimes far removed from the hard realities of need at the local level.

S. 3562 clearly recognizes a strong local role in the drug control effort, but in certain specific instances it neglects to consider the involvement of local government, and in its grant approval processes it gives state governments a higher level of authority than may be adequately justified by state experience and interest in this field. It has been the experience of the National League of Cities and U. S. Conference of Mayors that many federal aid programs which cede to the states a large degree of control over dollar distribution do not result in effective use of dollars where they are most needed. Instead, under state control, dollars are often distributed broadly across the state in grants so small to have any real impact in solving critical problems.

The states do have a role in such programs to work with the Federal Government in overseeing local programs¹⁰ to assure that unnecessary duplication is avoided and that programs do not work at cross purposes with each other. However, S. 3562 would appear to go well beyond this in severely limiting the relations between localities and the federal government where states have agencies responsible for administering the statewide plan for treatment and prevention of drug abuse. In these cases, states would have authority to approve local applications, and where the state did not choose to approve local application the only recourse the local government would have would be to file an amended application with the state or send the application to the Secretary of H.E.W. with notation of the state's disapproval and then appeal this disapproval. This, in effect, constitutes a limited governor's veto over local applications.

As this state approval process is presently constituted in S. 3562, the National League of Cities and U. S. Conference of Mayors could not support its adoption. Our experience in other programs such as water pollution control, highway safety, and Law Enforcement Assistance lead us to believe that if the state approval structure remains as presently constituted, the program will be limited in its effectiveness at the local level. To avoid these problems, we urge that the language of Section 705 be amended to allow local governments to file their applications directly with the Secretary of H.E.W. At the same time, local governments should be required to file a copy of their application with the state. The state should then be given 30 days in which to comment to H.E.W. on the local application, indicating whether, in the state's view, the local application is consistent with other efforts being made in this area.

The Secretary of H.E.W. could then consider the state's comments in his review of local application. Such a procedure would assure the state program oversight to aid the Federal government in avoiding unnecessary duplication of effort and programs which work with cross-purposes with each other, but it would not give state's dominance of the dollar distribution structure to the extent that individual local programs might be rendered ineffective.

With this suggested change, S. 3562, will give local government a valuable assist in upgrading their efforts to prevent and control drug abuse, and the National League of Cities and U. S. Conference of Mayors would strongly support its adoption.

THE NEW YORK ACADEMY OF MEDICINE

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STATEMENT

ON

FEDERAL DRUG ABUSE AND DRUG DEPENDENCE PREVENTION, TREATMENT

AND

REHABILITATION ACT OF 1970 (S. 3562)

In March of this year The New York Academy of Medicine approved a statement objecting to the passage of "The Controlled Dangerous Substances Act of 1969" (S. 3246) by the Congress on the basis that the bill was "medically and scientifically unrealistic" and that its passage "would represent an unwarranted intrusion by the Department of Justice into the field of medical care and research" in which field the Department of Justice has no expertise.

On March 9, 1970 a bill entitled the "Federal Drug Abuse and Drug Dependence Prevention, Treatment and Rehabilitation Act of 1970" (S. 3562) was introduced by Senator Harold Hughes from Iowa. Unlike the former bill, S. 3562 approaches treatment, education, and research in drug use from a realistic viewpoint and is in line with responsible medical practice. Moreover, it places the responsibility for organizing and administering the program in the Department of Health, Education, and Welfare rather than in the Department of Justice. This delegation is proper and in line with the views of the Academy as outlined in the March 13th statement.

Accordingly, The New York Academy of Medicine endorses S. 3562 as a progressive and realistic first step toward the solution of a most serious problem.

April 27, 1970

Senator HUGHES. The hearing for today is closed.
(Whereupon, at 11:20 a.m., the subcommittee was adjourned subject to the call of the Chair.)





