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Part 3

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

ON

H.R. 9264

A BILL TO ESTABLISH A SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION TO CONCENTRATE THE RESOURCES OF THE NATION IN A CRUSADE AGAINST DRUG ABUSE

H.R. 9059

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(and all other identical or similar bills)

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Addicts Rehabilitation Center, New York City, Rev. James Allen, director.
American Legion:
Lyngh, Robert E., deputy director, Veterans' Affairs and Rehabilitation Commission.
Wertz, Terrell M., assistant director, legislative division.
American Medical Association:
Palmer, Dr. Richard E., member, board of directors.
Peterson, Harry N., director, legislative department.
Seevers, Dr. Maurice H., member, committee on alcoholism and drug dependence.
Committee for Effective Drug Abuse Legislation, Neil L. Chayet, counsel.
Defense Department:
Carney, Brig. Gen. Robert B., Jr., Deputy Assistant Chief of Staff G–1, Headquarters, USMC.
Hayes, Brig. Gen. George J., Principal Deputy Assistant Secretary of Defense for Health and Environment.
Kester, John G., Deputy Assistant Secretary of the Army, Manpower and Reserve Affairs.
Rauch, Rear Adm. Charles F., Jr., Executive Director, Drug Abuse Advisory Council, Department of the Navy.
Roberts, Brig. Gen. John W., Deputy Director, Personnel Planning, DSC/Personnel Headquarters, USAF.
Taber, Lt. Gen. Robert C., Principal Deputy Assistant Secretary of Defense for Manpower and Reserve Affairs, Office of the Secretary.
Williams, Maj. Cecil W., USAF, legislative attorney, Office of Legislative Liaison.
Executive Office of the President:
Carlucci, Hon. Frank, Director, Office of Economic Opportunity.
Cooper, Dr. Leon, Director, Comprehensive Health Program, Office of Economic Opportunity.
Jaffe, Dr. Jerome H., Special Consultant to the President for Narcotics and Dangerous Drugs.

ORGANIZATIONS REPRESENTED AT THE HEARINGS—Continued

Executive Office of the President—Continued
- Konopka, Arthur F., Acting General Counsel to the Special Consultant to the President for Narcotics and Dangerous Drugs.
- Perito, Paul L., General Counsel and Assistant Director, Special Action Office for Drug Abuse Prevention, Office of Special Consultant to the President for Narcotics and Dangerous Drugs.
- Smith, Dr. Carl, Acting Director, Office of Health Affairs, Office of Economic Opportunity.
- Weber, Arnold R., Associate Director, Office of Management and Budget.

Health, Education, and Welfare Department:
- Besteman, Karst J., Deputy Director, Division of Narcotic Addiction and Drug Abuse, National Institute of Mental Health, National Institutes of Health.
- Brown, Dr. Bertram S., Director, National Institute of Mental Health.
- Duncan, Dr. Tommy, Clinical Research Center, Fort Worth, Tex., U.S. Public Health Service.
- Edwards, Dr. Charles C., Administrator, Food and Drug Administration.
- Gardner, Dr. Elmer H., Division of Neuropharmacological Drugs, Food and Drug Administration.
- Hutt, Peter, General Counsel, Food and Drug Administration.
- Kurzman, Stephen, Assistant Secretary for Legislation.
- Lacovara, Dr. Dominick, Director, Clinical Research Center, Fort Worth, Tex., U.S. Public Health Service.
- Lawrence, James, Executive Officer, National Institute of Mental Health, National Institutes of Health, Public Health Service.
- Richardson, Hon. Elliot L., Secretary.
- Wilson, Dr. Vernon E., Administrator, Health Services and Mental Health Administration.
- Zapp, Dr. John S., Deputy Assistant Secretary for Legislation (Health).

Justice Department:
- Burrows, Carl, Assistant Commissioner for Investigation, Immigration and Naturalization Service.
- Carlson, Norman A., Director, Bureau of Prisons.
- Coppock, Donald R., Deputy Associate Commissioner for Domestic Control, Immigration and Naturalization Service.
- Farkas, Gerald M., Executive Assistant to Director, Bureau of Prisons.
- Garfield, Frederick, Assistant Director for Scientific Support, Bureau of Narcotics, and Dangerous Drugs.
- Greene, James F., Associate Commissioner for Operations, Immigration and Naturalization Service.
- Heaney, Richard, Deputy Director, Bureau of Prisons.
- Ingersoll, John E., Director, Bureau of Narcotics and Dangerous Drugs.
- Levinson, Dr. Robert B., Mental Health Coordinator, Bureau of Prisons.
- Maloney, Andrew J., Chief, Narcotics and Racketeering Unit, Southern District of New York.
- Miller, Donald, Chief Counsel, Bureau of Narcotics and Dangerous Drugs.
- Seymour, Whitney North, Jr., U.S. Attorney, Southern District of New York.

Kemper Insurance Group, Lewis F. Presnall, director of rehabilitation; and manager, Corporate Alcoholism and Other Behavioral Problems Department, National Loss Control Service Corp. (NATLSCO).

Louisiana Narcotics Rehabilitation Commission:
- Alderette, Edward, executive director.
- Scrignar, Dr. Chester, chairman.
- Swanson, Dr. William C., member.

Malcolm Bliss Community Mental Health Center:
- Buis, Jon, NARA aftercare counselor.
- Davis, Mike.

Missouri Division of Mental Health:
- Knowles, Dr. Raymond R., program director, narcotic addiction treatment program, and chief, alcoholic and drug abuse program.
- Muse, Alvin.

ORGANIZATIONS REPRESENTED AT THE HEARINGS—Continued

Narcotic addict rehabilitation agency program, Tulane University:
Clark, June, drug addiction research team.
Cohen, Dr. Gary, head.
Goldsmith, Bernard, systems analyst, drug abuse team.
Heath, Dr. Robert G., head, department of social psychiatry.
Narcotic Service Council (NASCO)—St. Louis:
Harvey, William M., Ph. D., director of psychological services.
Mitchell, Don, director.
National Council of Community Mental Health Centers:
Levin, Gilbert, Ph. D.
Morris, Jonas V., executive director.
National Loss Control Service Corp. (NATLSCO), Lewis F. Presnall, manager, corporate alcoholism and other behavioral problems department; and director of rehabilitation, Kemper Insurance Group.
New Orleans, La.:
Landrieu, Hon. Moon, mayor.
Thompson, Dr. Doris, director, city health department.
New York City:
Finney, Graham S., commissioner, addiction services agency.
Lacey, Miss Diane, mayor's office.
Lindsay, Hon. John V., mayor.
New York State Narcotic Addiction Control Commission:
Chambers, Dr. Carl.
Hesse, Ray.
Jones, Howard, chairman.
Parents Foundation Against Drug Abuse:
Rembish, Mrs. Helen.
Tarantino, Mrs. Mary.
Pharmaceutical Manufacturers Association:
Adams, Dr. John G., vice president for scientific and professional relations.
Brennan, Bruce J., vice president and general counsel.
Cavallito, Dr. Chester J., executive vice president, Ayerst Laboratories.
Gadsden, Henry W., chairman, board of directors.
Stetler, C. Joseph, president.
Richmond Regional Planning District Commission, M. Miles Matthews, director, council on drug abuse control (CODAC).
Rubicon, Inc., Richmond, Va., Edmund Menken, project director.
Smith Kline & French Laboratories, Thomas M. Rauch, chairman of the board and president.
State Department, Nelson Gross, Senior Adviser to the Secretary of State and Coordinator for International Narcotics Matters.
Treasury Department, Eugene T. Rossides, Assistant Secretary (Enforcement, Tariff and Trade Affairs, and Operations.
Veterans' Administration:
Bronaugh, A. T., Associate General Counsel.
Johnson, Donald E., Administrator of Veterans' Affairs.
Kaim, Dr. Samuel, Director, Alcohol and Drug Dependence Service.
Lee, Dr. Lyndon, Assistant Chief Medical Director for Professional Services.
Musser, Dr. Marc J., Chief Medical Director.
Peckarsky, J. C., Deputy Chief Benefits Director.
Virginia Commonwealth University, Richmond, Va.:
Brandt, Dr. Warren W., president.
Bright, Dr. George M., director, Adolescent Medicine Medical College of Virginia.
Harrison, Willard I., M. Sc., director, department of pharmacy services, and project director, methadone treatment program, Medical College of Virginia.
Mathis, Dr. James, professor of psychiatry, Medical College of Virginia.
Virginia Council on Narcotics and Drug Abuse Control, F. John Kelly, executive director.

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SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

FRIDAY, JULY 30, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order.

We are continuing hearings on bills to establish a special action office of drug abuse prevention, as well as on congressional proposals to help meet the drug abuse problem of our Nation.

We are honored today to have the distinguished Secretary of Health, Education, and Welfare, Hon. Elliot Richardson, to testify, along with his associates, Mr. Stephen Kurzman, Assistant Secretary, Dr. Charles C. Edwards, Food and Drug Administration, Dr. Vernon E. Wilson, Head of Health Services and Mental Health Administration, and Dr. Bertram S. Brown, Director of the National Institute of Mental Health and other associates I see in the room.

We are pleased to have you before the committee again, Mr. Secretary. We welcome you and will be pleased to receive your testimony.

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; DR. CHARLES C. EDWARDS, ADMINISTRATOR, FOOD AND DRUG ADMINISTRATION; DR. VERNON E. WILSON, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

Secretary RICHARDSON. Thank you very much, Mr. Chairman and members of the subcommittee. My colleagues and I are delighted to have the opportunity to appear before you today to testify in support of H.R. 9264, the bill proposed by President Nixon in his message on June 17, 1971, to establish the Special Action Office for Drug Abuse Prevention within the Executive Office of the President. In accordance with the Chairman's invitation, my testimony will also cover related bills pending before the subcommittee.

NATURE OF THE DRUG ABUSE PROBLEM

As the President stated in his message on drug abuse, "the problem has assumed the dimensions of a national emergency." In keeping with that assessment, it is most appropriate that this subcommittee has so promptly taken up this legislation.

In the past decade, this Nation has experienced an alarming increase in the use of drugs. The precise dimensions of drug use and its effect are still not fully known. But we do know, for example, that in New York City, the number of deaths caused each year by narcotics use has risen from 200 to 1,000. More people between the ages of 15 and 35 die as a result of narcotics in New York City than from any other cause. Our best estimate is that there are now approximately 250,000 persons addicted to heroin in the United States.

To deal with this emergency, the administration has sought an amendment to the fiscal year 1972 budget requesting an additional $155 million to mount a comprehensive attack on drug abuse. Of this $155 million, $105 million will be earmarked for rehabilitation of drug addicts and $10 million for drug abuse education. Another $14 million has been requested to support expanded treatment programs in Veterans' Administration facilities. These additional funds will raise the total available for fiscal year 1972 for such activities to $271 million. Much more is necessary to meet the drug abuse problem, however, than financial resources alone. A coordinated Federal response is also essential in order to maximize the impact of the substantial resources we are investing in the solution of this problem. Much progress in this regard has already been made in the field of law enforcement by the transfer of the Bureau of Narcotics to the Department of Justice. But much more needs to be done to coordinate the non-law-enforcement activities of the Federal Government.

At present, nine Federal departments and agencies are involved in the various non-law-enforcement aspects of drug abuse such as research, treatment, rehabilitation, and drug education. Treatment programs alone are supported by at least three domestic agencies. One result is that State and local officials and private groups have often found it difficult, if not impossible, to obtain adequate information about Federal antinarcotics programs. Another result is that duplicative and overlapping projects are mounted in some localities while other areas with similar needs are underserved.

Effective coordination at the Federal level involves, first, ordering the relationships between Federal departments and, second, ordering the relationships of agencies within each department, such as HEW, which has a number of agencies working on these problems.

INTERDEPARTMENTAL COORDINATION

Effective interdepartmental coordination involves at least four major elements:

(1) Rational allocation of funds among various Federal departments and agencies and among various State and local, public and private grantees, and contractors;

(2) Uniform and accurate information to the public and to non-Federal officials regarding the dangers of drug abuse and the availability of Federal resources;

(3) Rapid application of research findings to operating preventive and treatment programs;

(4) Development and utilization of comprehensive social indicators for more precise identification of nature and extent of drug abuse.

To achieve coordination of the Federal effort, the President has proposed in H.R. 9264, to establish a Special Action Office of Drug Abuse Prevention located within the Executive Office of the President and headed by a director accountable directly to the President. This proposal reflects the President's personal commitment to combat the national drug emergency effectively. Since this proposal is a response to an emergency, the Office will be established, not permanently, but for 3 years from the date of enactment of the bill. Provision is made for a 2-year extension if the President determines that an extension would be appropriate.

The Special Action Office will assume overall responsibility for all major nonenforcement drug abuse programs, including those for prevention, education, treatment, training and research. It will develop a comprehensive Federal strategy to deal with these critical aspects of the drug abuse efforts and will set goals for the individual programs in accordance with that overall strategy.

The Director of the Special Action Office will prepare budget requests for all programs over which he has authority and will determine funding priorities. He will maintain general supervisory authority over the operations of such programs. He will also coordinate research, evaluation, and information activities. In short, H.R. 9264 will provide the Director with all the tools necessary for effective coordination of the Federal drug abuse effort.

In his appearance before this subcommittee on June 28, Dr. Jerome Jaffe, Special Consultant to the President for Narcotic and Dangerous Drugs, outlines in considerable detail how the Special Action Office will function. I will, therefore, not go into greater detail about the functions of that Office at this point. However, it might be noted that, before the President's proposal was made, alternative means of achieving much needed Federal interdepartmental coordination were carefully considered and were judged less effective than the Special Action Office now proposed. It would be at least theoretically possible for example, to achieve a similar result by placing all Federal activities relating to drug abuse within a single existing department. This alternative was rejected on the ground that many of the programs to be coordinated are integrally related to other activities of the agencies now managing those programs. For example, drug education is so clearly an important school function that it would be unwise to remove it from the Office of Education, the Federal agency with the closest ties to school systems throughout the Nation.

Similarly, the drug prevention and treatment programs funded by the Office of Economic Opportunity are an important aspect of the antipoverty functions of community action agencies at the neighborhood level. Similar nonenforcement examples can be found in the Departments of Labor, Justice, Transportation, Defense, and in the Veterans' Administration.

Another alternative would have been to assign to one department the leadership role in coordinating the drug abuse activities of all other Federal departments and agencies. This alternative was rejected

because past experience has tended to demonstrate that one department cannot most effecitvely coordinate the programs of so many other departments and agencies. Only through an office situated within the Executive Office of the President is it possible to take advantage of the strengths of so many exising programs while at the same time achieving the necessary interdepartmental coordination. I believe it is significant that some 51 House Members came to the same conclusion and have sponsored H.R. 6732, and six identical bills which would also create an Offiec of Drug Abuse Control within the Executive Office of the President.

From my own experience, both as a State official in Massachusetts and as a Federal official in Washington, I am deeply convinced that extraordinary steps are required to pull together Federal and other resources at the State, local, and neighborhood levels where people actually receive services. This is particularly true in the complex area of drug abuse, where so many interrelated factors are involved in the difficult process of reaching an addicted person, treating him, and getting him back into work and family life. Only if Federal agenies are in a position to work together to achieve a coordinated response will it be possible to achieve more substantial results at the level where services are made available to people.

INTRADEPARTMENTAL COORDINATION

As I have noted, the Special Action Office proposed under H.R. 9264 is a key factor in pulling together Federal departments and agencies, but to be effective there must be a parallel coordinative effort within the individual Federal departments. Intradepartmental coordination is particularly critical for the Department of Health, Education, and Welfare, in which we presently operate programs in four agencies dealing with treatment and rehabilitation, training, research, and education, and the related problems of the labeling and control of prescription drugs.

TREATMENT AND REHABILITATION

Two agencies within the Department have responsibilities in the area of treatment and rehabilitation of drug abusers. The primary responsibility in this area has been assigned to the National Institute of Mental Health (NIMH), a component of the Health Services and Mental Health Administration (HSMHA), which supports a wide variety of treatment and rehabilitation programs in all parts of the country, primarily through grants to public and private nonprofit organizations. The Social and Rehabilitation Service supports vocational rehabilitation services, which are often an essential aspect of treatment programs for drug abusers, principally through programs run by State vocational rehabilitation agencies.

TRAINING

NIMH also supports specialized training programs for the development of a corps of personnel, both professional and nonprofessional, with skills in drug abuse treatment and rehabilitation. Most of the training is conducted on university campuses and is geared toward

community and other local agency personnel for whom the needs are greatest.

RESEARCH

NIMH has the primary responsibility for research to provide knowledge as to the causes, prevention, and treatment of narcotic addiction and other forms of drug abuse. Approximately 10 percent of research funds are spent in NIMH laboratories and the remainder through grants and contracts to universities and other public and private investigators. The Food and Drug Administration (FDA) supports research on the effects of drugs on the human system, particularly the effects of combinations of various drugs. This activity is conducted both intramurally and extramurally. In addition, FDA has important responsibilities for a continuing evaluation of the safety and efficacy of methadone and other drugs used for investigational purposes.

EDUCATION

NIMH funds a wide range of drug abuse information and education activities, and it also has the statutory responsibility for coordinating the health calculation aspects of all Federal drug education projects. NIMH and the Office of Education are jointly engaged in the development and evaluation of new drug abuse curriculum materials. The Office of Education also makes grants to universities and school systems for the training of school personnel, particularly teachers, in the fundamentals of drug abuse education.

LABELING AND CONTROL OF PRESCRIPTION DRUGS

FDA is responsible for assuring that the labeling of all drugs and the advertising of prescription drugs accurately reflect their drug dependence potential. In addition, FDA has authority to reclassify drugs from over-the-counter status to prescription-only status because of drug abuse potential. For example, both folic acid (vitamin B) and potassium permanganate (used in some skin preparations) have been so reclassified.

ROLE OF THE DEPARTMENT "LEAD AGENCY"

To insure coordination of these programs within HEW, I have designated the National Institute of Mental Health as the "lead agency" for all the Department's drug abuse activities. I have also designated the Director of the National Institute of Mental Health as special assistant to the secretary for drug abuse.

In its role as the lead agency NIMH assists each relevant unit of the Department to (1) identify its appropriate role, subject to statutory limitations, in the drug abuse area and (2) coordinate and plan its activities with those of other components of the Department. NIMH is a cntral source of information for the secretary on all departmental drug abuse programs and also as a clearinghouse for all legislative developments in the drug abuse field.

NIMH may be a good link between our Department and the new Special Action Office in the Executive Office of the President once H.R. 9264 becomes law.

Finally, I would like to discuss briefly H.R. 9059, relating to community mental health centers and drug abuse, which is also pending before this subcommittee. We believe that community mental health centers can be important vehicles for the delivery of drug abuse services.

Many community mental health centers play a role in integrating treatment and rehabilitation services for the addict with other related health and human services. The centers have been structured so that their staffs are aware of and responsive to the needs of their respective communities, the milieu in which the addict lives and to which he will return after the initial phase of treatment. The consultation and education arm of the center can reach out to police, courts, schools, and other agencies to assist in developing prevention, early detection, and treatment projects tailored to the characteristics of the community. And the network of mental health and social services established around a center permits treatment to be modified to fit each patient's needs and allows for a progression from inpatient treatment of the acute withdrawal stage, through gradual return to the community through partial care systems, to longer term followup services. This multidimensional approach may be a significant means of reducing recidivism among drug addicts. The increased rate of recidivism is one of the most disturbing aspects of the current drug emergency.

Historically, as this subcommittee is well aware, mental health agencies, like most social services and health agencies, have been reluctant to provide care and treatment for narcotic addicts and other drug abusers. Fortunately, this situation has changed considerably in recent years, and the community mental health centers have played an important role in that change. At present, 25 community mental health centers have treatment programs that have been funded specifically by NIMH to provide comprehensive drug abuse services. Equally important is the fact that at least 55 additional mental health centers which have not received earmarked funds for drug addiction services are providing significant services to narcotic addicts and other drug abusers out of their unearmarked funds.

There has been gratifying progress, but much remains to be done. Clearly, we cannot rely exclusively on community mental health centers to provide coverage of all areas in need of community-based drug abuse treatment and preventive programs. Other agencies must also be mobilized to provide the type of coverage that is urgently required.

Despite the appropriateness of some of the bill's objectives, for reasons discussed below, we must oppose its enactment.

Section 1(a) would require that all applicants for community mental health center grants after June 30, 1972, provide treatment and rehabilitation programs for drug abusers. This provision would force new community mental health centers in areas which already have such programs to duplicate existing services. New community mental health center applicants should be encouraged to provide drug abuse treatment service unless there are existing programs in the area or the center is unable to provide such services. We plan to encourage mental health centers to provide drug services which relate to treatment and preventive services provided by other agencies. The aim

should be to provide, either through the center or through other agencies associated with the center, a comprehensive and integrated system of services designed to meet the needs of the drug patient.

Section 2(a) of H.R. 9059 would require the establishment of drug treatment and rehabilitation programs in all public health service hospitals or facilities except where the need is insufficient to justify establishing such a program. Based on our experience, it is not at all clear that a centralized hospital or clinic is best situated to provide treatment for drug abusers. Our experience has demonstrated instead that community-based treatment programs are more successful. In addition, as the subcommittee knows, our Department has launched an intensive study reviewing in depth the alternative uses of the PHS hospitals for participating in serving the total health needs of the communities in which they are located. Pending the completion of that study and consideration of alternative community facilities for drug abuse programs, we oppose enactment of section 2(a) or H.R. 9059.

CONCLUSION

In conclusion, Mr. Chairman, for these reasons and because Dr. Jerome Jaffe, the special consultant to the President for narcotic and dangerous drugs, is undertaking a review of all current laws pertaining to drug treatment, we oppose enactment of H.R. 9059. We believe that, pending completion of Dr. Jaffe's review, no amendments to drug treatment laws should be enacted other than H.R. 9264, to establish the Special Action Office for Drug Abuse Prevention. This important step is very clearly needed and I urge the subcommittee to act on it promptly.

Mr. ROGERS. Thank you very much, Mr. Secretary, for your statement.

Mr. KYROS. Thank you, Mr. Chairman.

Mr. Secretary, one of the questions arising before the committee in relation to the Special Drug Abuse Prevention Office is that in addition to the coordination of the functions that are labeled in the bill, perhaps the law enforcement aspect also should come within the control of the coordinator. Some of the testimony has indicated that we have situations in Southeast Asia where young civilians and soldiers are coming in contact with heroin and becoming predisposed toward heroin or heavy drugs when they return to the United States, they come back to many States, not just to urban areas or large cities. Suddenly then we have a heroin problem throughout the United States which is like a communicable disease. If the coordinator was able to understand from the law enforcement aspect what is happening he could then prepare to put money in, as you said, where the immediate need is, where the priorities are. Is there some particular reason why enforcement could not come within his control, too?

Secretary RICHARDSON. Mr. Kyros, let me respond to your question, first, by dealing with the illustrative example you gave. In all candor, I don't really think that the example points to the conclusion you reach with respect to the relationship between the special action office and law enforcement.

Clearly, I think you are right in the thrust of the question insofar as it will be essential to assure that there are community based facilities that can follow on with the treatment and rehabilitation of a

discharged veteran. There is contemplated a clear responsibility for the interface between inservice treatment rehabilitation; followup through a Veterans' Administration facility; and, then a program for continuing treatment and rehabilitation within whatever community the discharge veteran may live.

Now, Dr. Jaffe will have to be concerned with the process whereby there can be assurance that there is an available facility or service for the veteran in the community where he returns to live. And we, in HEW, through NIMH, as we visualize our role, have been very much concerned with bringing such resources into being. In the case of the larger communities, the community mental health center or drug abuse center or rehabilitation center may be the facility to which the discharged veteran is encouraged to follow up his treatment.

It may be that in smaller communities, we will need to assure that there are physicians, who have received supplementary training and education in the treatment and rehabilitation of drug abuse, who could assume such responsibility.

In any event, returning now to the first part of your question, and it is not apparent to me that the necessity for these steps in itself requires that the Special Assistant to the President for Drug Abuse should have direct responsibility or authority over the law enforcement side. He will clearly need to work in the closest possible cooperation with the law enforcement people; but I think it is fair to say that the conclusion that he should not be given the same degree of responsibility for that side of the problem as he would be given over treatment, research, and rehabilitation, rests on the conclusion that there is a kind of command responsibility for law enforcement that is of essentially different character than his area of competence would embrace. And it is better, therefore, to continue to rely primarily on John Ingersoll and cement his relations with customs, for example, in order to assure that the law enforcement aspect of the situation is also effectively coordinated and directed.

Mr. KYROS. Mr. Secretary, everything you said is well stated, but I want to return to my point that law enforcement and prevention, treatment, and rehabilitation are all wedded together. What I was trying to say is that the consumption which is happening now in in many cities and rural areas, is geared to the production and enforcement.

We only have x dollars to go around, and the controller should be able to make decisions as to where the money should go. He should know how that side is shaped so that he can put his treatment centers or put his emphasis on detoxification in certain ways.

Secretary RICHARDSON. Well, I am sure he should and certainly there does need to be close coordination. I think the only real issue is whether he should have the same relative degree of authority and responsibility over the law enforcement side. But I am sure there is no difference between us on the need for the closest possible interrelationship.

Mr. KYROS. Thank you, Mr. Secretary.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for your usual logical and lucid presentation. You have uncovered a lot of basic points here. I would like to just ask of Dr. Edwards, apart

from the main subject of what you have testified to, about the question of methadone, which is a highly controversial one right now. I understand a new drug application for methadone is pending before your department.

Dr. EDWARDS. That is correct.

Mr. PREYER. Would you have anything to say about the status of that at this time or could we look forward to any date on which there might be some ruling on it?

Dr. EDWARDS. Yes, Mr. Congressman. We do have a new drug application for methadone that has been submitted by Eli Lilly & Co., and this is being considered by the Division of Neuropharmacological Drug Products. Information relating to the new drug application is being sent to a special advisory committee we have on the particular subject.

This committee will be meeting on September 14, and they will be providing us with their recommendations as to whether or not methadone should be approved for this new use.

Mr. PREYER. We have been reading in the local papers recently of some of the dangers of methadone when prescribed without proper safeguards by physicians and I am sure your group will be considering that. Dr. Roy, I am sure, would know far more about that than I would.

Now, the only other question I wanted to raise at this time, concerns the community mental health facilities. You indicated, Mr. Secretary, that you object to the bill because it would force community health centers to duplicate existing services in areas where such services already exist. I have thought about the bill, and if it is carried out in the language of the bill properly, I think it would not force any duplication of existing programs, but that it would be a method of complementing these programs. The testimony we have heard is that the approach on drug abuse must be a multifaceted program, and that there is a place for the store front treatment centers, the therapeutic communities, the methadone programs—the whole bit.

In the bill, H.R. 9059, in subsection 1 of section (c), it says:

> The center will provide in such fiscal year a treatment and rehabilitation program for drug addicts and other persons with drug abuse and other drug dependency problems, who are in the area served by the center, for the need for such a program in the area served by the center is not of such magnitude to warrant the provision of such a program by the center.

Don't you believe that the "savings" clause would draw your objection?

Secretary RICHARDSON. If it were clarified just a little to make clear that the determination of need is not a determination of the total need for treatment facilities and service in the area, but rather the residual need, taking into account the degree to which some other facility or center is already dealing with the problem.

If that clarification were made or understood, then I think the requirement would be unobjectionable.

Mr. PREYER. I think we do seek to reach the same end, and I don't believe it is our intention at all; that is, the sponsors of this bill, to duplicate any service.

Mr. Chairman, I had one other question I wanted to ask Dr. Edwards which I failed to ask him.

On page 7 of the Secretary's statement, he states:

In addition, FDA has authority to reclassify drugs from over-the-counter status to prescription-only status, because of drug abuse potential.

Dr. Edwards, have you had occasion to use that authority or do you anticipate that there are some drugs which will be changed to "prescription only" status because of the drug abuse potential?

Dr. EDWARDS. Mr. Preyer, we have not used that authority since I have been Commissioner. We are, as you may know, developing a plan to look at the over-the-counter drug market and one of the first classes of drugs we will look at are "mood" drugs, psychotropic drugs, over-the-counter drugs. I would suspect, either using outside expertise or our own, there might be some drugs now classified as "mood" drugs that may go from over-the-counter status to prescription status. But I can't give specific examples at this particular point in time.

Mr. PREYER. I am glad to see you are moving in that direction, and I certainly would like to encourage you in it. We will be interested in the results.

Thank you very much.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. Secretary, on page 3, you indicated that the Office will be established for 3 years and not permanently, with the provision for an extension. Is it your thought that coordination will have reached the takeoff point then, and we no longer will need a coordinator, or that the problem will be sufficiently under control not to require coordination?

Secretary RICHARDSON. I think the judgment to seek legislation to create this office on an emergency basis rests on a combination of two hopes.

One is, as you just mentioned, the hope that a concerted attack will have reduced significantly the dimension of the emergency itself.

The second is that the development of a total strategy will have brought into being a comprehensive network of service and facilities that can carry forward from there without the same kind of governmentwide powers. First of all, to develop the strategy and then get it into action.

Mr. SYMINGTON. Secondly, you stated that you believe that the first order of business is coordination between the relevant departments, and the second order of business is to coordinate within each department.

I would think that is the reverse of what would be necessary to have effective coordination between the departments. That you would want intragency relationships to be worked out first so the coordinator would know what he was coordinating. That is on page 2, of your statement on the bottom.

Secretary RICHARDSON. I don't think that the thrust of this was intended to imply that action under the second heading would wait for action on the first, but rather that there are two different kinds of things that need to be done. As it says here:

". . . First, ordering the relationships between Federal departments and the relationships within each department.

In HEW, NIMH is the lead agency in problems of drug abuse. A year or almost a year after I came into HEW, and well before the pro-

posal to establish the Special Action Office had emerged, we have been seeking to make the lead agency function more effectively. I think this subcommittee is well aware that nothing is more difficult in Government than to weld the rows of separate agencies into a cohesive whole. To assure, in other words, that the whole is greater than the sum of the parts. I think the Government needs to learn how to do this. We have felt that the development of the lead agency role on the part of NIMH in the drug abuse field had important implications for the way in which HEW performs in a great many other areas that cannot be confined within any single operating agency.

Mr. SYMINGTON. I think you are charting, really, a new bureaucratic course in attempting to achieve this kind of coordination between agencies which have many departments within themselves. I have asked previous witnesses if they could give me an example of the success of such an effort previously, and the only, I think, suggestion was the moon race which I think was probably a simpler problem.

Secretary RICHARDSON. Well, I appreciate your use of the phrase "charting a new bureaucratic course." I don't think there is a serious problem confronting HEW today—whether it is drug abuse, alcoholism, or mental retardation, or the many manifestations of the problem of poverty itself—that can be considered the exclusive province or concern of any single one of our line agencies. It follows, therefore, that if we are to make effective use of available resources in attacking these problems, we have to learn how to integrate our resources and deploy them in a way that makes optimum use of them.

Mr. SYMINGTON. Thank you, and thank you, Mr. Chairman.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman.

Mr. Secretary, I personally strongly support the President's proposal. I have some questions that go beyond this proposal and the main one that is of special concern to me is a question of involuntary rehabilitation and civil commitment. When I speak of involuntary commitment I speak of it in the terminology that says:

> We are not just obligated to identify addicts, and then, under some form of civil commitment, get them off the street, but get them off the street into rehabiliation facilities offering every program that may be available, both under the proposal before us and others that may be forthcoming.

Do you have any comment or feeling on civil commitment and involuntary rehabilitation?

Secretary RICHARDSON. My only concern, Congressman Hastings, has to do with the effectiveness of it. I think it is probably axiomatic that the potential success of any program in treatment and rehabilitation of an addict depends upon the motivation of the addict himself. It tends to follow, therefore, that when commitment is involuntary, that you have on your hands an individual who does not have the requisite motivation to make the rehabilitation program likely to be successful. We should at least be using the limited resource of skilled manpower for treatment and rehabilitation of addicts who are preferably motivated to seek recovery. This seems to suggest, therefore, that we ought to emphasize programs that are directed toward those who voluntarily commit themselves.

Mr. HASTINGS. The only objection I have to it is, every place this subcommittee has gone and every State and city that has spent huge

sums of money, and New York is one having spent some several hundred million dollars over the past years, we find we are not reaching the addicts and they are not walking off the street into the voluntary rehabilitation facilities.

In New Orleans, they identified 6,000 addicts and treated 400. I believe that heroin addiction is in fact, an infectious disease in our society.

I am not talking about incarceration in a penal institution, but I think we have a difficult problem, with no solution in the short-range future that I see. And we are going to have to take some difficult steps if in fact, we are going to make correction of the problem at all or we are going to wind up with just a great number more of heroin addicts over the next 5 or 10 years.

Most of the proposals I see on education, rehabilitation and research are in terms of a time span of 5, 10, or 15 years. Frankly, I don't think this country can afford to wait that long. I don't know that civil commitment is the answer, but I am most anxious to take a look at it and see if it might be helpful in a shorter range solution to this horrible problem.

Secretary RICHARDSON. I certainly don't think we should close any doors.

The prospect you project is a horrible prospect, and I think I would be less than honest to try to convince this subcommittee that the sum total of all of the recommendations that we, or anybody else have developed, do not offer any assurance of success.

Mr. HASTINGS. Well, I share that feeling with you. Frankly, I think it is time that both Members of Congress and the administrative agencies of the Government tell the American people that with the passage of any piece of legislation pending here, we are not going to solve the problem of drug addiction. I think the easier answer concept that so many people offer is something that we should stop right at this moment and let the public know we are dealing with a horrible problem that has no easy solution. Too many people have suggested it, and that is why I go to these extreme measures perhaps.

Secretary RICHARDSON. I would only say that I would wholly concur. We have to tell the American people that the aggregate impact of these proposals, or any proposals and programs that I have seen or heard of, do not offer the assurance of success, but I wouldn't go so far as to say they don't contain the potential of success.

One of the more hopeful areas certainly is that of research and the prospect of discovering a heroin antagonist that is truly effective.

Going back for a moment to just the problem of involuntary commitment. New York State has had, of course, a program of involuntary commitment which they are in the process of deemphasizing because of the considerations I touched on earlier.

Mr. HASTINGS. Mostly because of lack of dollars, Mr. Secretary?

Secretary RICHARDSON. It may be. Let me ask Dr. Brown if he would like to add or subtract from what I have said.

Dr. BROWN. The addition I would make is twofold.

One is, we have not fully explored how far one can go with the reaching-out process. For example, right here in the District, Dr. DuPont, whose program I am familiar with, has been knocking on the door and the real issue is shortage of funds and manpower with ability

to have the system grow to take on those who will volunteer and you have a sort of rolling momentum that is good and does help. And even in the most hard-core addict a mixed-up person, there is some element of wanting to save his life and health. If the program is available, and there is momentum, we will reach out, but we have not fully explored in any place yet how far we can go with good outreach programs.

This is analogous to the history of dealing with other problems of mental health, where the only answer was involuntary commitment for centuries. We now find hardly any patients, even those who are grossly psychotic, who will not respond to this type of a sensitive program.

Mr. HASTINGS. The only statement I want to make is mental illness is not addictive to other people.

Dr. BROWN. Yes, but let me say the outreach program has not reached out.

Secondly, we have not yet had the knowledge of how yet to fully treat those who ask for help and are fully addicted, and here I make a plea you are probably familiar with, that perhaps research on the biology and personality of such people would pay handsome dividends.

Mr. HASTINGS. I have many, many more questions, but with the limitation of time, I thank you very much and thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy.

Mr. ROY. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for an excellent statement.

I have been impressed with the fact that the legislation does not reach into the Department of Defense, as well as to the Department of Justice. We had the VA folks before us yesterday, and they tell us that since July 7 three individuals have been referred to them from the Department of Defense for further treatment of drug addiction. As an experienced and excellent administrator, can you tell me how, under the present proposed legislation, Dr. Jaffe could correct this whereby he could be sure that the Department of Defense does not discharge drug addicts into our society without definite arrangements for them to go either to the VA hospitals or community facilities?

Secretary RICHARDSON. I would insist that there be developed a plan for doing this. In fact, to the best of my knowledge and belief, a considerable amount of time and thought has been devoted to the development of just such a plan. I think that an effective way of dealing with the problem could and should be evolved without necessarily vesting in Dr. Jaffe the same kind of authority over the military, for example, that he would have over treatment, research, and rehabilitation programs. But there is certainly no question this has to be done.

As I said earlier in response to Mr. Kyros, there needs to be such a clearly defined interface between the responsibility of the military, responsibility of the VA, and responsibility of community-based facilities, so that no addicted individual is lost in the process of transfer from one to the next. At some point along the line, it may be that there is nothing that can be done to force addicts to maintain treatment. This takes us back to the problem that Mr. Hastings was touching on a moment ago. But in any event, a failure to continue his treatment should, under no circumstances, result from the fact that the VA facility in a given area does not know that a discharged veteran, who is addicted, has come into their area.

VA should pick him up at the point of discharge, and maintain him in one of their facilities for a while on an inpatient basis. In any event, no individual who has been undergoing treatment in a VA facility, and then returned to a communiity where there is no such facility should be permitted to do this without an appropriate transfer of information about him, and about his presence in the area to any community-based facility in the area.

Indeed, ideally there should be somebody in the VA, who takes him to the community-based facility, at least the first time.

We found, for example, when I was in Massachusetts, and concerned there with the coordination of State and local programs in the field of alcoholism, that we achieved a much higher success rate in the treatment and rehabilitation of alcoholic women committed to the State institution in Framingham, Mass., where a person in the correctional system took the inmate at the point of discharge to the nearest State-supported alcoholism clinic. And we found that there was a considerably higher rate of retention of such individuals in the system, and therefore, a higher rate of recovery where this was done than if they were treated in the Framingham Women's Reformatory, then, upon the point of expiration of their sentence, just turned out the door.

I think, clearly what you are talking about has to be done. It is not so clear to me that in order to get it done that Dr. Jaffe has to have, in effect, the same kind of statutory responsibility with relationship to the Defense Department and the VA that he would have over these other areas.

Mr. Roy. There are two other things I want to touch upon and one is the total amount of money to be devoted to the drug addiction problem in the fiscal year 1972, which you state is $271 million. We were told that in the past fiscal year, the State of New York spent $136 million, and as I recall, their budget has been cut back to $96 million at the present time. Do you feel that $271 million is a proper amount of money to devote to the drug addiction problem at this time?

Secretary Richardson. Yes; I do, Dr. Roy. We, in HEW, of course, are constantly confronted with situations in which we are acutely aware of how much more could be done with more money. This is not one of them.

Here, the amount of money requested has been a function of what it was believed could effectively be used over a period of a given fiscal year, recognizing that what can be done in such a year is limted by numbers of trained people and so on, and the process involved in creating a new facility.

I think it is quite clear that the President intends to seek whatever funds are needed in this area, and that this has been the only test of how much to ask for.

Mr. Roy. In the Office of Education, with $10 million, will it have adequate funds to carry out a total educational program with regard to drug addiction?

Secretary Richardson. Yes; recognizing of course, that the Office of Education does not directly provide education. We would not expect, for example, to take over the salaries of the teachers, who, as part of their classroom responsibilities, will include some education in the problems of drug abuse.

I think it is fair to say that, generally speaking, the Federal initiatives that can be carried out with the requested funds are expected to have a multiplier effect in terms of evoking State, local, and voluntary resources over and above what these other governments and organizations would otherwise do.

Mr. Roy. I would like to direct one question perhaps to Dr. Brown or one of the others that are with you, or you, Mr. Secretary, with regard to the epidemiology of drug addiction. We have heard estimates, for example, that perhaps each addict over the lifetime of his addiction will infect, in a sense, 20 other addicts.

I agree with you, we don't know how far Outreach will carry it, as to the number of people that we will bring in. I would like to know, though, first of all, what you feel, or what would you anticipate. Will it be 50 or 80 percent or do you have any idea in this regard. If we have good voluntary treatment programs, how many addicts will come forth.

Second, what are the consequences then of the balance circulating within our susceptible pool, so to speak, of people who might then become drug addicts?

Dr. Brown. I have nothing, but I would say this would be an almost self-derogatory, uninformed guess as to these specific questions. I have spoken with several "on-the-line" administrators who run these programs, such as Dr. DuPont and others, who feel that Outreach may get somewhere between 40 and 80 percent. That is the range. Then there is your question as to what is the addict's infectious potential as far as infecting other persons into becoming possible addicts. We just don't know. It is possible that these people may be the hard-core ones, those who are not only addicts, but are pushers; to put it in straight English, and they are busy at this infectious process, using the word "infectious" in quotes all of the time. But it may also well be that they are the burnt-out cases, who are no longer other than surviving in a way that no longer brings them into contact with possible cases that they can affect or infect. I just don't know where the answer lies there. So, I am giving you, somewhat unhappily, nothing. But as I say in quotes "an uninformed guess" as to answers to your questions.

Mr. Roy. Then, I guess the last thing I want to say comes, perhaps as a statement.

Mr. Secretary, you referred to motivation being very important, and I agree. It is important with regard to whether or not an addict responds to treatment and rehabilitation. I would like to suggest that motivation sometimes is internal and sometimes is external, and at the present time, I don't believe we can conclude, and anyone may correct me if they like, that involuntary programs are less effective than voluntary programs. We have had some figures, for example, which show that involuntary programs are more effective because they are able to keep the people over those first few days when the voluntary, or those who have submitted themselves voluntarily are likely to leave the program. The dropout rate is really high in many areas initially, and after they have been in a program thirty or sixty days, they may then follow through.

Secretary Richardson. It is an important point, and it suggest an intermediate approach between an indefinite period of involuntary commitment and an initial period beyond which an individual drug

addict or abuser has the right to leave. I was very much concerned in Massachusetts with the drafting, when I was attorney general, of legislation which dealt with this very issue.

We did provide, incidentally, Mr. Hastings, for involuntary commitment in certain circumstances. The most obvious and easily justified use of this, of course, is an alternative to commitment to a penal institution for any offender under a law involving drug offense. And there, of course, the individual is going to be involuntarily confined somewhere. One of the things that concerned me most when we were working on this was the question of how most effectively can you structure the content of daily existence in an in-patient facility, holding the people on an involuntary basis or, for that matter, voluntary one, so as to keep them adequately occupied in periods when they are not undergoing some sort of active treatment. This means, of course, considerable problems in staffing and so on. This is an added reason why, in terms of funds and resources, we must rely on community-based facilities and at the same time encourage the individual to engage in some sort of gainful and useful activity, as a much more economical approach.

Mr. ROY. We visited the Arthur Killen Institute in New York, and it cost $1,000 per resident per month. As a final disclaim, though, when I speak of involuntary treatment or civil commitment, I am not thinking of these people necessarily being incarcerated.

I thank you for your statement, and thank you, Mr. Chairman.

Mr. ROGERS. Mr. Schmitz.

Mr. SCHMITZ. Yes, Mr. Secretary, in view of the fact that Dr. Jaffe's office is going to be known as the Special Action Office for Drug Abuse Prevention, I would like to throw out an idea in the form of somewhat of a rhetorical question. But I would like your comments. I would like to talk about prevention rather than treatment. When I was in the State Legislature of California, I was a member of the California Delinquency Prevention Commission which held hearings on many facets of what at that time was called delinquency. And one of these facets was narcotics abuse, marihuana usage, and so forth. One of the witnesses, a law enforcement official, brought out an interesting statistic with regard to marihuana usage by Mexican-American males, and he said there was a high usage prior to a certain point, at which time there is almost a complete drop off, and the certain point was when the young man got married and started a family. And the conclusion that he gave was that, it seems obvious that marihuana was a facet of immaturity, that as soon as he accepted family responsibilities and realized he had to cut his own path, and had a family to take care of, the usage dropped considerably.

Now, if, and let's confine it to marihuana users, if it is a facet of immaturity, and immaturity is fostered by a type of paternalism, is it not possible that the paternalistic nature and trend of government today, which is not abated by your own department, is it not possible that our Government policies themselves are hindering a natural solution? Not to treatment, but to prevention? That may be an unfair question, but I wonder if that facet has ever been pursued?

That while we try to take care of more and more poeple, we are actually preventing their maturation which prevents a natural solution to at least one facet of the narcotics problem?

Secretary RICHARDSON. I don't regard it as an unfair question, Mr. Schmitz. But I regard it as an extremely ingenious exercise in the ideology of the subject matter of this hearing.

I would only say that it may well be that there is a correlation between immaturity in the broad sense and drug dependency in all forms. I have no doubt there is. It may well be, also, that various forces in our society, which tend to perpetuate the length of the period in which a young person is held back from full participation in a responsible role in society is a contributing factor. That the length of education, for example, has the consequence of preventing a lot of young people from feeling that they are being adequately used.

Mr. SCHMITZ. That is an argument I have often used in pointing out that they mature later now that they are in school longer.

Secretary RICHARDSON. Well, they mature faster than their intellects mature, faster than their emotions, but at any length, the feeling of being inadequately challenged and used, I am sure would contribute, in turn, to a feeling of inadequacy and therefore, the need to supplement one's personality by some device. And I expect this is a factor, and I think it would be hard, however, to take the further step or at least establish empirically the relationship of big government to all of this. Speaking as an amateur psychiatrist, would, I expect——

Mr. SCHMITZ. We all are.

Secretary RICHARDSON. I am sure it is an impulse hard to resist wherever that feeling exists.

Mr. SCHMITZ. All right, you won't, but I will. That is all, Mr. Chairman.

Mr. ROGERS. Mr. Secretary, how many addicts are being treated in programs under the jurisdiction of HEW? Have we an estimate of that?

Secretary RICHARDSON. Let me ask Dr. Brown to respond.

Dr. BROWN. Approximately 11,000, Mr. Rogers.

Mr. ROGERS. Eleven thousand?

Dr. BROWN. Yes.

Mr. ROGERS. Is this a recurring population, that figure, is some of it recurring?

Dr. BROWN. Those are the ones that have received treatment in the past year. Some of them will have been for the first time, and some have been on the rolls for as long as 3 years in our program. This is a number that has been increasing as the actual number of facilities and resources increase, as you know.

Mr. ROGERS. So that is the number of treatments? In other words, it may be on some of the same people?

Dr. BROWN. No, I think it is the number of people. Some of those people will be in treatment for as long as 3 years, and some of them having been seen for the first time in a mental health center.

Mr. ROGERS. Is this the primary problem of mental health or primary problem of addiction?

Dr. BROWN. The figures I have given are those who have a major problem in the drug-abuse area.

Mr. ROGERS. I understand that, but did they come in for treatment of mental disease or of addiction?

Dr. BROWN. For one or both. The way they present themselves to the treatment facilities, I would say perhaps two-thirds of that num-

ber came in primarily because they had a drug problem and one-third came in because of some emotional or psychological problems of which drug abuse was a component.

Mr. ROGERS. How many drug centers have you funded?

Dr. BROWN. There are two answers to the question or rather, two ways of getting at the answer—from the standpoint of drug specialized centers and from that of the community mental health centers which have major drug components.

Mr. ROGERS. Yes.

Dr. BROWN. With respect to specialized drug treatment programs we funded a total of 45 such programs by the end of fiscal year 1971, of which 13 are based in or affiliated with a community mental health center. Of the 45 funded programs, 23 were in operation at the close of the fiscal year. To look at it from another point of view we have funded 425 community mental health centers of which approximately 300 programs are operational and treating patients.

Of the 300 centers, we have 25 which have a comprehensive set of drug abuse services that have been specifically supplemented and funded.

These 25 centers, in addition to providing basic mental health programs, have received earmarked funds for dealing with drug abuse.

Mr. ROGERS. For treatment for drug abuse?

Dr. BROWN. Yes.

Mr. ROGERS. When were they funded—the 25?

Dr. BROWN. Within the last 5 years; I don't know if I can answer more specifically.

Mr. ROGERS. I understood you had four funded and eight were approved; so you must have funded some within the fiscal year?

Dr. BROWN. Yes; nine have been funded in the past fiscal year.

Mr. ROGERS. So I presume that most have been funded since July?

Dr. BROWN. No; at the end of the latter part of the fiscal year just completed.

Mr. ROGERS. Just before July?

Dr. BROWN. Yes.

Mr. ROGERS. Will you let us have the breakdown of the types of funding?

Dr. BROWN. Yes.

(The following information was received for the record:)

Distribution of community narcotic addiction treatment programs by specialized drug facilities and community mental health centers—National Institute of Mental Health

Specialized drug treatment facilities:	
Funded under part D of the CMHC Act as amended:	
Staffing of comprehensive programs	29
Drug-abuse service projects	16
Total	[1]45
Community mental health centers drug programs:	
Funded as part of basic CMHC program (part A or B—CMHC Act, as amended)	13

[1] Of the 45 specialized drug treatment facilities, 13 are located within community mental health centers.

Dr. BROWN. There were 55 centers in addition to these 25 which have significant programs in treating drug abusers which they do out of their general funds, staffing funds, and other funds.

Mr. ROGERS. But they are not funded for this specifically?

Dr. BROWN. Not funded, but treat significant addict patients and pay for programs out of general funds or other funds from the community or State.

Mr. ROGERS. So you have a total number of some degree?

Dr. BROWN. Eighty out of 300.

Mr. ROGERS. Eighty out of 300?

Dr. BROWN. That is correct.

Mr. ROGERS. That could provide such services?

Dr. BROWN. Yes, out of the 300, in theory, all could and in practice as many as two-thirds might be willing and able.

Mr. ROGERS. Do you know of any other facilities, nationwide, where you have manpower already assembled in a more expertise fashion that we have in these centers for moving quickly into the drug-abuse program?

Dr. BROWN. Well, Mr. Rogers, that is like asking the man who started the concept of a junior high school of seventh grade to ninth grade "Does he know of any other system that is capable of taking care of the seventh, eighth, or ninth grades." I don't know of any system that would be more ready, able, and willing. And I am familiar with that system, and you have to take that into account.

Mr. ROGERS. Well, maybe you could detach yourself and just give us a professional view.

Do you thing you could do that?

Dr. BROWN. It is identical with my advocacy.

Mr. ROGERS. Well, that is encouraging.

Do you know Dr. Jaffe?

Dr. BROWN. Yes; I do.

Mr. ROGERS. Do you know of his program in Illinois?

Dr. BROWN. Yes; I do.

Mr. ROGERS. What is the extent of his program? If you could sum it up for us?

Dr. BROWN. He has, in the last year, 2,000 patients under treatment, predominantly with methadone. He believes clearly in a comprehensive multimodality approach. A sound one that provides the patient the type of treatment he needs—psychological and educational and so on.

Mr. ROGERS. As I recall, there is a large dependency on methadone?

Dr. BROWN. Yes; the bulk of them receive it.

Mr. ROGERS. Do you know what his rehabilitation rate is? Have you looked into it? Surely your institute is the lead agency that would have given some evaluation to that?

Dr. BROWN. Yes; the program is in the process of, by Dr. Jaffee and others, assessing such basic things as those who have continued in care, those who are recidivists and those who stayed free of crime and those who continue to work. There are no complete studies, and the general picture is favorable.

Mr. ROGERS. How long has this evaluation been going on? How long has he been operating?

Dr. BROWN. Three or four years, I think.

Mr. ROGERS. We don't have any available evaluation?

Dr. BROWN. I would be glad to ask him. Perhaps he can discuss this with you when he appears before the committee.

Mr. ROGERS. I think it would be helpful for the record.

Could you tell me if you know of his rehabilitation rate? Does he claim 20 percent, 10 percent, 30, 40, 50, 60, 70, 80?

Dr. BROWN. I don't know the specific answer, and I would rather not guess since he is so easily available to give a sharper answer than I could guess at it.

Mr. ROGERS. Mr. Secretary, you say in your statement that he has run the program, and I am not sure of our evaluation yet of how he has done. Although I know him to be a very capable man, he is going to have to prepare all of the budget requests for all the programs and also determine funding priorities. Is that correct?

Secretary RICHARDSON. That is correct.

Mr. ROGERS. In other words, he comes in and tells HEW and your lead agency what the funding should be?

Secretary RICHARDSON. Yes.

Mr. ROGERS. And you don't think you have the competence within the Department to determine that?

Secretary RICHARDSON. Well, of course, he wouldn't do it without full consultation with us.

Mr. ROGERS. I assume he would consult.

Secretary RICHARDSON. In fact, he could become a very valuable ally indeed in terms of relations between the drug abuse responsibility of HEW, for example, and OMB.

Mr. ROGERS. Then, what you are telling me is "OMB" will decide and not Dr. Jaffe?

Secretary RICHARDSON. Well, you are aware, Mr. Chairman, HEW does not submit a budget. The only executive branch budget is the President's budget and what comes to the Congress is the result of, of course, initial recommendations that come from the constituencies of HEW that go from my office to OMB and to the President's staff. And then, from the President to the Hill. So what is really involved here, is the creation of a position, for a person whose sole responsibility is mobilization of executive branch resources in an attack on drug abuse.

His function, therefore, his responsibility, is in the development of a total plan to assure that the subelements of that plan properly interrelate to each other and have the proper relative weight and support. And so it follows, therefore, that if anybody is going to have that kind of strategic role, we should be the last point before "OMB" for the development of the total budget for this interrelated effort.

Mr. ROGERS. Well, it is my understanding that Dr. Jaffe can make these decisions himself. As I recall there is no council for him to advise with although I am sure he would consult with them. But there is no mechanism where he must have approval of an interagency council or council of experts. He makes decisions himself.

Is this your understanding?

Secretary RICHARDSON. Yes; I think this is also considered to be, and I see great merit in it, the virtue of the recommendations.

Mr. ROGERS. Well, I suppose he decides to go all-methadone? Some of us might not agree with that and then what do we do? We could pass a law, but they might not fund what we pass.

Secretary RICHARDSON. This is simply another illustration of the problems between the Congress and the executive branch and on the matter of disagreement, on that particular point, though, I think it is inconceivable that a man of Dr. Jaffe's experience and known views would make such a proposal.

As Dr. Brown has just pointed out, he has developed a program in Illinois. You can ask him this yourself, of course.

Mr. ROGERS. He will be here Monday and we will go into it.

Secretary RICHARDSON. But I think there is this to be said just for the record on this point, that is, given the corrosion of the social fabric in some parts of this country, notably New York, consequent upon drug abuse; given the impact on total communities of enormous increase in the rates of crime; to be able to do something that assures that the addict can be freed of dependency on feeding his habit through having to steal in order to buy heroin every day, this can well be the only effective emergency response to this problem. I think it would be inconscionable for us to transfer thousands of heroin addicts from their dependency on heroin to a dependency on methadone, without pledging to them a followthrough in the form of rehabilitation and treatment aimed, so far as humanly possible, to free them from dependency on any chemical.

Mr. ROGERS. I agree with you.

Secretary RICHARDSON. This is especially true of our veterans.

Mr. ROGERS. Yes; I agree.

Secretary RICHARDSON. Who will in many instances have been put on methadone treatment. I think that we must, therefore, and this bears on earlier points made both by Mr. Kyros and Dr. Roy, bear the responsibility we have as a society to make certain we do have available to these veterans the resources that can, if they are willing to take advantage of them, transfer them to a life of independence from any drug.

Mr. ROGERS. Yes; and this is what concerns me about the Department position of not using community mental health centers.

Secretary RICHARDSON. Excuse me, Congressman Rogers, we believe that community mental health centers should be used to the maximum practical extent. We simply say, take the south Bronx, for example, where the addict's rehabilitation center is, and where there are other facilities, the question of whether to use the community mental health center or not is related to the question of the adequacy of other resources. The question of whether if some facilities or services are to be expanded, whether to build on these rather than to incorporate a drug abuse capability in a community mental health center in the same area. And in cases where, for example, the incidence of his drug abuse is relatively low proportionately and it would make no sense to create a freestanding facility aimed at treatment and rehabilitation of drug abuse as such; then, by all means the community mental health center should be used.

Mr. ROGERS. This is basically what the bill says and yet you oppose it.

Secretary RICHARDSON. No; we oppose, or my testimony says we oppose what we read as a requirement that every new community mental health center must provide treatment and rehabilitation for a drug addict or addicts. We say: "Whether or not it does is a determination that ought to depend upon, in the first instance, what other facilities are already there" and there may be some areas where there should be developed specialized facilities in circumstances in which the drug addict population of the area is pretty high.

Mr. ROGERS. Well, I think lines 7 to 9 on page 2 say, "The need for such programs in the area served by the center, if it is not of such magnitude to warrant provision."

Secretary RICHARDSON. Excuse me for this interruption, but I already said, in answer to Congressman Preyer, if that language were clarified to make clear that the "need for such program" phrase means "need

taking into account not the total magnitude of the problem in the area but the residual magnitude of the problem not already met by the existing facilities," then the language would be unobjectionable.

Mr. ROGERS. Let me ask you, why shouldn't every community center be capable of giving drug addicts treatment?

Secretary RICHARDSON. I think the only answer to that is that there is required a degree of specialized training and understanding on the part of the staff dealing with this problem and there ought to be reliance, too, on paraprofessionals, subprofessionals and nonprofessionals, including ex-addicts associated with such a program, and whether to incorporate these into a community mental health center when there are alternative facilities is simply a question of judgment on the effective use of manpower.

Mr. ROGERS. Well, an addict comes in and wants treatment, like in a hospital, don't you think they ought to be able to give the services? The Congress has provided that. We did it in 1968, gave you authority to set up these programs in the community mental health centers and it has not been done.

Secretary RICHARDSON. May I step back a moment, and I would like to invite Dr. Brown to have in mind the possible need to supplement or qualify what I have said, but my notion of the appropriate role of a community mental health center derives really in the first instance from teaching that I got from him when we were in the process of developing community mental health center programs for Massachusetts.

I think it is a mistake to think of a community mental health center as a building. I think you know one ought to add a word "program," because to use the phrase I learned from Bert Brown about 6 years ago:

> What is needed in order to achieve the requirements of comprehensiveness in the 1963 act is a coalition of resources including whatever resources are already there.

Now, if you have therefore an inpatient psychiatric service in a general hospital within the catchment area served by the community mental health program or already within the area of a child guidance clinic, let us say, then these resources should, if adequate to the purpose, be incorporated into the community mental health center program in order to constitute part of its array of comprehensive services.

When you come to drug abuse, it has been noted that drug addicts on the whole do not easily get drawn into service at what looked like an official government-operated kind of facility. If, therefore, in an area with a relatively high incidence of heroin addicts the community mental health center were responsible for the program it might still be appropriate that it operate out of a store front facility for example.

Mr. ROGERS. I understand that. But what I am saying is we have not made any attempt at reaching out with community mental health centers—we have not put out the store front center and have them associated with the community mental health centers. I don't know of anywhere we have the expertise, psychiatrists, and so forth, that can completely adjust to treatment of drugs.

Secretary RICHARDSON. I doubt there is really any disagreement between us. I would oppose personally the creation of a freestanding drug abuse treatment or rehabilitation facility in any area where the existing personnel of a mental health center could absorb this function. I would want to see the psychiatrist of a community mental health

center used certain hours of the day, certain days of the week, in a store front facility, moving out of the office wherever they treated other people rather than to set up this store front facility as an independently operated institution except where, for example, in the parts of New York, the load is such that you can have an independent freestanding facility.

Mr. ROGERS. I think this is what the committee is thinking.

Secretary RICHARDSON. This is very clear to me. I talked to Dr. Jaffe and Dr. Brown and I discussed with Dr. Jaffe this understanding of the role of the community mental health centers.

Mr. ROGERS. But not to use them I think would be tragic.

Secretary RICHARDSON. I think clearly this is true. I don't want to repeat everything I have said, but with only the qualifications we have already stated.

Mr. ROGERS. Let me ask you this, what moneys are going into research, Mr. Secretary, as far as drug research—getting a cure or a new drug that is better than methadone?

Secretary RICHARDSON. The total amount of funds for research in the revised fiscal 1972 budget would be $31,153,000.

Mr. ROGERS. Excuse me. I didn't get it.

Secretary RICHARDSON. $31,153,000. This is an increase of $12 million over the original 1972 budget. The subtotal included $26 million-plus for grants, $1,766,000 for an Addiction Research Center at Lexington, $1,495,000 for marihuana contracts, and $1,515,000 for other direct operations.

Mr. ROGERS. These grants will be generally to whom and for what type of work?

Secretary RICHARDSON. I think rather than have me answer the question and then have Dr. Brown supplement, why don't we go directly to him to give you a better answer.

Mr. ROGERS. Sure.

Dr. BROWN. The research is carried out in a wide range of facilities, universities, clinics, and nonprofit operations. The same general range of research activities is true of other biomedical areas. This includes activities from epidemiology and sociology down to basic biology of the nature of the addictive process and clnical evaluation.

It is a broad program.

Mr. ROGERS. How much directly goes to the drug abuse research would you say?

Dr. BROWN. There are two areas supported in the program—those research efforts that are clearly targeted at say cocaine or heroin or amphetamines. There the focus is on the actual drugs of abuse and their relationships. Approximately one-third of the money is spent in this area and two-thirds of the money is in the general areas of tranquilizers and other drugs—the whole relationship of the psychology of people to drug use or psychopharmacology research efforts. So it is a one-third to two-third cut.

Mr. ROGERS. Is that of the $31 million?

Dr. BROWN. No, sir; I was referring to the grant and contract research program.

Mr. ROGERS. Would you let us have, for the record, the specifics of it, how much is for heroin and the various drugs?

Dr. BROWN. We will be glad to do it by drug and other features.

Mr. ROGERS. That, would, I think, be very helpful.

(The following table was received for the record:)

NIMH RESEARCH GRANTS RELEVANT TO DRUG ABUSE AWARDED OUT OF FISCAL YEAR 1971 FUNDS

	Opiates, other narcotics and their antagonists		Marihuana and THC		LSD and similar hallucinogens		Amphetamines and other stimulants		Barbiturates and other depressants		Drugs not specified		Addiction proneness		Total	
	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards	Number of grants	Amount of awards
Drug abuse funded by DNADA:																
Single drug categories	39	$1,677,210	27	$1,071,633	5	$75,898	8	$326,262	1	$6,721	11	$640,736	1	$78,325	2	$3,876,785
Multiple drug categories	16	365,046	13	291,418	12	215,878	20	430,704	19	465,122					28	1,768,168
Total	55	2,042,256	40	1,363,051	17	291,776	28	756,966	20	471,843	11	640,736	1	78,325	120	5,644,953
Drug abuse funded by other NIMH divisions:																
Single drug categories	5	547,135	1	6,825					1	105,410	2	111,765	1	92,369	10	863,504
Multiple drug categories	4	55,387	2	32,870	4	167,428	9	350,131	11	381,753					12	987,569
Total	9	602,522	3	39,695	4	167,428	9	350,131	12	487,163	2	111,765	1	92,369	22	1,851,073
Drugs which could be abused, funded by other NIMH divisions:																
Single drug categories	2	93,199	1	30,889	13	721,240	22	1,080,179	24	1,560,491	3	216,745	1	24,288	66	3,727,031
Multiple drug categories	12	262,813	5	164,965	29	756,994	65	1,528,612	65	1,733,497					74	4,446,881
Total	14	356,012	6	195,854	42	1,478,234	87	2,608,791	89	3,293,988	3	216,745	1	24,288	140	8,173,912
Total:																
Single	46	2,317,544	29	1,109,347	18	797,138	30	1,406,441	26	1,672,622	16	969,246	3	194,982	168	8,467,320
Multiple	32	683,246	20	489,253	45	1,140,300	94	2,309,447	95	2,580,372					114	7,202,618
Total	78	3,000,790	49	1,598,600	63	1,937,438	124	3,715,888	121	4,252,994	16	969,246	3	194,982	282	15,669,938

Note: The above figures for multiple drug categories are prorated by drug groups.

Mr. ROGERS. Mr. Secretary, we have had what, two Federal facilities over the years for addicts and clinical research?

Secretary RICHARDSON. Yes.

Mr. ROGERS. And they are what?

Secretary RICHARDSON. Lexington and Fort Worth.

Mr. ROGERS. Fort Worth?

Secretary RICHARDSON. Yes.

Mr. ROGERS. It is my understanding that you plan to transfer Fort Worth from its present functions and turn it over to the prisons?

Secretary RICHARDSON. Yes.

Mr. ROGERS. Are you aware that the Senate has passed a resolution saying that the public health hospitals and clinics should be kept open and that the House committee has already passed such a resolution saying that it is the intent of Congress that also Fort Worth and Lexington be kept open. We hope to have this before the floor on Monday and in concurrence with the Senate, if this is passed along with the $14 million additional that the House has put into keep open public health facilities including Fort Worth, to be run by the Public Health Service as a drug treatment center, will this intent of the Congress be carried out?

Secretary RICHARDSON. Well, I can assure you that it will. I do think, though, it might be useful at this point to restate for the record the administration's case for the proposed action.

The Fort Worth institution was originally designed and constructed as a medical facility suitable for prisoners. Over the life of the hospital it has been used extensively for treatment and confinement of Federal prisoners. So it seemed both to us in HEW and to the Department of Justice that it would be a suitable facility for conversion to a medium security institution under the Bureau of Prisons.

There is a medical facility there essentially.

Now, the principal objection that has been raised to this is not that the Bureau of Prisons cannot make effective use of it, including effective use of it for prisoners who are addicts and thus draw effectively upon personnel who have been treating addicts there right along, but it would reduce the capacity to treat addicts on an in-patient basis in the Southwest generally.

Now, we have two answers to that. One is that treatment on an in-patient basis in a facility closer to the community from which the patient comes is substantially more effective in achieving success than treatment at an institution too far away for families and others close to the patient to be able to get there.

Second, the community based facility is more effective because it does not withdraw the individual so far from the environment in which he originally became addicted. Part of the reason we believe the recidivism rates for Fort Worth and Lexington have been so relatively high is that we think that you detoxify the patient and then give him treatment in a very artificial situation. Then when you turn him loose, he goes back into the circumstances out of which he became addicted in the first place and he is unprepared for this. You could have a halfway house, perhaps, but a community based in-patient facility can already serve the functions of a halfway house at the point where the individual can come back at night and so on. So the success rate is better.

The second answer is the net capacity of the in-patient community-based facilities that we do plan to bring into being in Texas will total substantially a larger number than the number served in the Fort Worth hospital.

The number of Texas addicts specifically who were committed for treatment at Fort Worth in fiscal year 1971 was about 400. Under contract with NIMH operational in-patient facilities in Texas now are 175 addicts, and these facilities have a potential for an additional 185.

Early in fiscal 1972, as many as 70 additional in-patient contracts may be negotiated, depending upon the need to do so, and this will create the capability to treat another 260 in-patient addicts. This would bring, therefore, the total in-patient capacity, in Texas alone, in 1972, up to an estimated 618.

Mr. ROGERS. Well, may I say this, Mr. Secretary, you just told us how the VA hospitals are going to bring them in, detoxify them and send them back to their community with followup service we hope to be able to establish. They do this right now in New York. They take them out of their environment just like the VA is going to do and then send them back to communities but they have to have followups and the reason for the rate of recidivism from Fort Worth and Lexington is because we have not given them followup service in the home community.

This is changing we hope and also as far as the facilities you are going to provide in Texas these are not going to take care of enough. For instance, we were in St. Louis and they used a hospital also at Fort Worth and they have an estimated 6,000 addicts. Do you know how many in-patient beds they have in St. Louis?

About 11, and we went to New Orleans and they used Fort Worth and do you know how many detoxification beds they have there?

About 10.

So until we get these facilities, I don't know how we can close and not use them, yet I understand a request has already gone out not to accept any more patients and not use them.

Don't you agree with me it would be better to keep these open until we get all of these facilities to take care of them and with 6,000 addicts in New Orleans and 6,000 in St. Louis, just as two examples right off and with 20 beds to take care of them.

So the old argument that I have heard used about "OK, we are taking them out of the community and detoxifying them" simply does not stand up, but if you send them back to a community with after-care service, which I understand is the thrust of the program you want to establish, I think you could.

Secretary RICHARDSON. Clearly, we would have the responsibility to assure the availability of in-patient beds for any individuals who were transferred from Fort Worth or for those who would have come to Fort Worth if it continued to be operated by HEW.

But, in fact, we have made plans to do this ,effective August 1, 1971. Let me ask Dr. Brown to pick up at this point and tell you how this stands.

Mr. ROGERS. Yes; but it is my understanding that with the intent of the Congress, which I am sure will be expressed by a concurrent resolution which has already passed the Senate and passed the House committee, and with the additional funds, and clear intent in the debate on the floor providing additional funds, I presume you would

not make any change there, but begin to use the facilities? However, I think your letter told me that the transfer was planned for October 1.

Secretary RICHARDSON. I had better reserve an answer to the question. In my response earlier as to carrying out the intent of Congress, that was predicated upon the assumption that the intent of Congress was expressed in a way other than with respect to the appropriation of $14 million for that purpose.

Mr. ROGERS. We express it in a direct resolution, which we will do. This will be done Monday in the House.

Secretary RICHARDSON. Well, this could, of course, override plans that we had already began to carry out. I do think, however, that we owe it to ourselves as well as to the Congress to try to convince you that we proposed to do makes sense.

Let me ask Dr. Brown to pick up on the alternative arrangements that would be made.

Dr. BROWN. Mr. Rogers, the plan to transfer Fort Worth to the Bureau of Prisons I think, taking into consideration all of your points arbout the lack of beds in St. Louis and other places, is a thoughtful and wise one, that would enhance the narcotic treatments capacity of this country.

On the budgetary side, funds were allowed in the NIMH budget to develop the alternative community in-patient, out-patient, and follow-up services and we were developing capabilities that would be equal to those we had in the way of in-patient capacity at Fort Worth.

Second, the facility and its expertise, an issue not quite addressed, but I know is important to you, would have been maintained. I have heard the Director of the Bureau of Prisons state right here, through his deputy, that over 50 percent of the patients that will be treated in Fort Worth in the Bureau of Prisons would be narcotics addicts, so the bulk of the personnel would have continued to do that for which they have been trained and we would not have lost that and I think the Federal prisoners who have narcotics problems are part of a citizenry which we at public health have responsibility for. On the issue of carrying out the intent of Congress I defer to Secretary Richardson, we have been proceeding with an orderly sequence of transfer.

For example, there were neuropsychiatric patients at Fort Worth that have been already transferred to Lexington hospital, and we asked the courts to stop sending us new in-patients and are proceeding as effectively as we can with developing the in-patient and "after-care" service in communities from whence the patients came to Fort Worth in the past.

I think it was a wise and thoughtful plan. Of course, if Congress advises us otherwise, I think the executive branch will take that into account, to say the least.

Mr. ROGERS. I would hope so. As I say, the Senate has acted and the House will act Monday and I am sure the Senate will concur in that feeling and the funds have already been provided. So I would hope that you would suspend any further action in disassembling that hospital.

Now, let me ask you this. What about education, Mr. Secretary? I saw one group denounce about three-fourths of the educational matter in the files on drug abuse because they said they were unfounded and had no basis in fact. Have these materials been reviewed and what is your comment on that, sir?

Secretary RICHARDSON. It is, I think, highly important to try to assess the effectiveness and impact of educational materials. As a matter of fact, when I was in Massachusetts several years ago, we developed a grant application to NIMH for money to try to assess the effectiveness of materials believed by adults to be effective, but which often have tended to be regarded as ridiculous, naive, even amusing to the more sophisticated children to whom they were supposedly addressed.

In fact, in the meanwhile NIMH has sponsored substantial research to assess the impact of various educational materials. The results of this research are only beginning to be analyzed, but should be of great importance in the design of educational materials in the future.

Dr. BROWN. Just a brief point, this is one of those places where I think the critical flaws and faults that were found are a bit of an asset, that we finally have organizations such as the National Coordinating Council looking at these films and materials and giving us a scientific assessment as to their accuracy and impact. And the fact that we found a significant number that were less than effective, often inaccurate, is the indicator we were getting down to the task.

One other point, if I can piggyback, is an example of agency integration. We have worked closely with the Office of Education so that in developing materials for teachers, schools, curricular materials, you have the benefits of the agency of the Office of Education which has the contacts with the school system and also the benefits of the scientific establishment. And, thirdly, to evaluate for both whether it is effective or not.

Mr. ROGERS. You had that coordination?

Dr. BROWN. Yes; we have it going now under the lead agency concept that the Secretary has supported very effectively.

Mr. ROGERS. Would you let us have, for the record, a listing of the basic educational materials you have prepared and the evaluations of them?

Dr. BROWN. Yes; we would be glad to for the record.

(The following information was received for the record:)

EDUCATIONAL MATERIALS—NATIONAL INSTITUTE OF MENTAL HEALTH—OFFICE OF EDUCATION

The National Institute of Mental Health, in cooperation with the U.S. Office of Education, has developed a set of drug education materials (*The Social Seminar*), filmed and printed, to be used in training teachers and in educating adults. It is possible to use either the entire series of separate components to provide information and modify attitudes toward the drug abuser. The two basic components are a 12-part film series of half-hour and full-hour segments and a multi-media package containing a programmed text, three six-minute films and a role-playing simulation game. A series of field trials have been conducted by the contractors who developed the materials, the U.S. Office of Education at a meeting for state coordinators of drug education, and NIMH at selected settings. A summary of findings from the evaluation is attached.

The series is available from state educational film libraries and from the NIMH Drug Abuse Film Collection, National Audiovisual Center, GSA.

12-PART FILM SERIES

Changing—An examination of contemporary culture; in particular the quality of life as its impact is felt by a young family trying to re-orient themselves in a society of conflicting standards and values. (½ hour, color)

What is a Teacher—A diverse group discuss why they are teachers. The discussion covers contrasting attitudes and ideas about teaching and the role of the school in our society. The teachers are also shown in actual classroom settings to contrast and compare their conversation. (½ hour, color)

Brian at Seventeen—This film presents an adolescent's view of his educational needs and how school is and isn't fulfilling them. Brian gives his perspective of the education experience, his parents, and life in general. (½ hour, black and white)

Drug Talk—Many organizations, private and public, bring drug education programs into schools. The segment compares and contrasts several programs for the secondary level, and shows their effectiveness, or lack of it. (½ hour, color)

Bonnie, Tom, Guy, and Teddy—The experiences and life style of American youth typical and atypical. It is an honest view of the world, the pressures of the peer group, the values and the life-style of each person. (1 hour, four 15 minute segments, color)

Jordon Paul: One teacher's approach—Many teachers throughout this country have mastered a successful means of communicating with their students. One of these teachers who is getting through to his students feels he must try any method he can in order to communicate about drug abuse. This is a personal film about a teacher's life and his students. (½ hour, black and white)

Mr. Edler's Class—What elementary schools can do to prevent drug misuse are shown along with action being taken to detect, diagnose, and treat the problem through the use of experimental and innovative approaches to learning in general. (½ hour, color)

The Community in Quest—In the midst of social upheaval, one of the issues confronting the community in drug abuse. In one community a young psychologist was asked to design a program to help. This segment analyzes a community trying to solve its problems through the confrontation techniques of role-playing to illustrate fears and resistance to change on the part of all participants. (½ hour, color)

The Family: You can begin here—A great deal of what a teacher should know and feel about his students can be gained through deeper understanding of how a family group functions. This family, like all families, has numerous identifiable traits, needs, tactics, and reactions. (½ hour, black and white)

Meeting—Activities of the police in the area of drug abuse are presented to the teacher, to show the ramifications of reporting a drug user to the police and the alternative courses open to law enforcement agencies. It is important for the teacher to know how police are treating young people and how, in turn, students feel about the police. (½ hour, color)

News Item: Urban Commune—How a story makes its way to the television screen—problems of research filming, editing, and presentation—affects the objectivity and credibility of the final story. This process is shown for discussion to aid the teacher in developing powers of discrimination in dealing with the flood of information about drug use and the drug culture. (½ hour, color)

Drugs and Beyond—In the not-so-distant future, decisions concerning the use and/or abuse of drugs for "positive" purposes—such as increased learning power, memory stimulation, accelerated maturing processes, tension control—will become major responsibilities amongst educators and administrators. A look into this future offers a perspective on the entire question of drug education. (½ hour, color)

THE MULTI-MEDIA PROGRAM

The multi-media program is entitled, "Drugs: Knowledge, Understanding, Action" and is divided into the following phases:

	Topic	Media
Phase I: Knowledge	Facts about drugs	Programed instruction.
Phase II: Understanding	Psychosocial, legal, and treatment issues.	3 films and discussion guides.
Phase III: Action	Planning of community programs	Role playing simulation game.

Although the program is integrated and sequential in nature, each part has been designed so that it can be used alone. The expected length of the program for teacher training is 15–18 hours, 8 of which would be in-service.

The first part of the program concentrates on the factual issues, the pharmacology and physiology of drugs. A programmed instruction text entitled, "What

Will Happen If", covers the various kinds of drugs, their derivations, their effects on the body and the central nervous system, and other information about how drugs are used and abused.

16mm black and white documentary films—each six minutes long—act as catalysts for small group discussions. Each film is accompanied by a discussion guide which will focus the discussion on specific issues.

The final Phase of the program deals with the problem of a community realizing the extent of its drug problem, and then mobilizing community resources for planning education, prevention, and treatment programs. A role-playing simulation entitled, *"Drugs—A Community at the Crossroads"*, is used for this purpose. The participants assume the roles of teachers, parents, students, and community leaders.

EVALUATION OF THE OE-NIMH EDUCATIONAL MATERIALS

The multi-media drug education program was designed essentially for in-service teacher training. Because drug abuse is not just a school problem, but also community, the Social Seminar should be useful as an adult education program within a community.

Each component part was pre-tested at local and national meetings in Massachusetts, California, Maryland, Illinois, and the District of Columbia during the past year.

The most important evaluation took place in Minneapolis, Minnesota. Thirty-two participants (teachers, counselors, a lawyer, university professors, students, housewives, law enforcement officials, ministers, and a school board member), who volunteered to be part of the pilot evaluation, were favorably impressed with the film materials, discussions, and overall approach employed by the Social Seminar. Another pre-test and evaluation of the program was conducted in the Washington, D.C. area with twenty-five teachers and five students participating from the Baltimore-Washington metro area. These educators, like the community participants in Minnesota, were impressed with the content and approach of the Social Seminar.

Of the total of 62, 58 rated the Social Seminar as "highly recommended" in the area of drug education. The following are summaries of participant responses:

The use of drugs in society was placed in proper perspective without employing a judgmental theme

The pharmacology of drugs was not emphasized but rather placed drug use in total context of society

The Social Seminar should not be used in the classroom just with students but rather for educators and adult members of a community at which time student participation is encouraged

The Social Seminar made it possible for each participant to re-evaluate his own attitude toward drugs and drug abuse

The most important aspect of the Social Seminar were the discussions following each of the films, therefore, requiring that well-qualified leaders conduct the Social Seminar.

Mr. ROGERS. Dr. Edwards, what are the most promising drugs that now are appearing in the treatment of drug abuse. And what is their status?

Dr. EDWARDS. Mr. Chairman, in addition, of course, to methadone, there are several drugs that are under investigational status. One is naloxone, and it is my understanding this does have some promise, but according to the experts we have consulted, it is not likely to replace methadone as a method of treatment.

Another drug that is currently being used, again as an investigational drug is, acetylmethadol, but again, it shows promise, but the degree of the extent of the promise is as yet undertermined.

Mr. ROGERS. Is this for heroin?

Dr. EDWARDS. Right.

Mr. ROGERS. These drugs are for heroin? Did you mention purez?

Dr. EDWARDS. That is a third drug that is being used as an investigational drug.

Mr. ROGERS. What is FDA doing to accelerate research or procedures to try to find an answer to this? Are we taking any actions or are any of our funds being expended in this area?

Dr. EDWARDS. Again, our funds are not designated in this direction. As you well know, our main function is to ultimately pass on the safety and effectiveness of these various drugs and in addition of course, we have the responsibility of monitoring these programs. But the main financial stimulation has to come from elsewhere.

Mr. ROGERS. Is Dr. Brown financing any of these?

Dr. BROWN. Yes, we are financing specifically targeted efforts toward blocking agents or anatgonists. I think we are fortunate with the additional resources made available in the President's supplement, so that now we will be able to take a further step in this critical area. We are working with FDA which is an example of collaborative endeavor. Where we have clear help with procedures and financial resources, we have an effective team going.

Mr. ROGERS. Will you let us know, and could you give us a rundown on what you are doing there, on the various research items. I think it will be well if you can give us the estimated time on these drugs, if possible, as to when we will have some answer.

I presume it will take a certain amount of time, but maybe you should estimate it. And we should know one way or the other.

(The following information was received for the record:)

NIMH RESEARCH GRANTS RELEVANT TO METHADONE AND OTHER NARCOTIC ANTAGONISTS INCLUDING CYCLAZOCINE, NALORPHINE, NALOXONE, AND LEVALLORPHAN (AWARDED FROM 1971 FUNDS)

	Number of grants	Amount of prorated award [1]	Amount of award if not prorated
Grants re methadone	12	$513,047	$566,080
Grants re methadone and other narcotic antagonists	7	282,230	452,590
Grants re other narcotic antagonists	16	544,035	567,267
Total	35	1,339,312	1,585,937

[1] These amounts are figured as that portion prorated to narcotic drugs where grants are relevant to multiple drug categories.

Note: Because of the nature of the research process, it is impossible to give an estimate of the number of years that it will take to develop effective and practical narcotic antagonists. There are promising research leads, but it is not realistic to give a time table for the success of these research efforts.

Mr. ROGERS. What about methadone, Dr. Edwards, can anybody use methadone?

Dr. EDWARDS. No, Mr. Chairman, we have some 280 sponsors of methadone investigational programs, and these 280 sponsors have some 330 program units under their jurisdiction.

Mr. ROGERS. How many people are receiving methadone?

Dr. EDWARDS. To the best of my knowledge, we have no exact figure on it. This is, of course, one of the reasons we recently, along with NIMH and the Bureau of Narcotics and Dangerous Drugs, laid down the requirements for these methadone programs. We were not getting the kind of statistical support we felt absolutely necessary with any investigational, new drug program.

Mr. ROGERS. Will you have those?

Dr. EDWARDS. Maybe Dr. Brown has a more specific number.

Dr. BROWN. We don't know the exact number. At different times,

we have offered estimates of between 20,000 and 30,000 people. On the average I will say 25,000.

Secretary RICHARDSON. Mr. Chairman, may I ask, lest the record seem unclear, either Dr. Brown or Dr. Edwards to expand a little bit on what has been recently required by way of furnishing further information, because this was, as Dr. Edwards said, recognized to be a serious problem. That we didn't know enough. Would it be useful to supplement it a little?

Dr. EDWARDS. In general, Mr. Chairman, the new regulations for our methadone programs were directed in two directions. One to provide the kind of supervision that would prevent the diversion of the drug.

Second, to provide the kind of supervision that would insure the addicts who are receiving the treatment the kind of medical care that all of us feel they have to have. In other words, the kind of comprehensive program that Dr. Brown was speaking of.

Part of this supervision, both as relates to the diversion of the drug and correct medical care of the patient, has to be related to adequate record keeping and the like. And this has not been done to the degree we felt it had to be in order to provide us with the kind of information we needed to determine the safety and efficacy of methodone for this use.

Mr. ROGERS. Are individual practitioners being given the right to use methadone?

Dr. EDWARDS. They have in the past. However, at this point in time before any investigational new drug applications are approved, an individual would have to demonstrate to us that he did in fact have the resources that were necessary to provide the kinds of supervision I have indicated we would want.

Mr. ROGERS. How does the VA qualify with you to use methadone? That is the Veterans' Administration.

Dr. EDWARDS. They have, I think, some 20 programs, alone with NIMH, with the Food and Drug Administration.

Mr. ROGERS. Do you require that methadone be taken at the clinic or office of the doctor or permit it to be taken home or what?

Dr. EDWARDS. In the initial stages of the program, or in the initial stages of the treatment program for an individual, it is required that he take the methadone under supervision. As he moves into the rehabilitation program, he is given more and more leeway as to whether he takes it at home or at the treatment center.

Mr. ROGERS. Is there a black market going on methadone as well as heroin?

Are you aware of that?

Dr. EDWARDS. There is some of this going on. There is no question about that. Of course, this is one of the reasons that we have been terminating some of these programs in recent months.

Mr. ROGERS. I presume taking it home is an invitation to that sort of activity. A week's supply, say, as the VA is doing after so many weeks of treatment. They testified yesterday, they gave a man a whole week's supply. Is this a very good practice?

Dr. EDWARDS. Well, again, this does offer a potential for diversion, but I think this is done because of the need of the particular individual patient. It is only done after, I think, the patient has dem-

onstrated a certain reliability; at least this is part of the program as we visualize it. Once a patient has shown a degree of reliability, he is given more leeway in terms of what he can do with it.

Secretary RICHARDSON. If he does not have it, if he sells it, he does not have it, and he is by definition dependent on it.

Mr. ROGERS. Of course, he may have more than he needs.

Secretary RICHARDSON. That, again, is the kind of thing that does need protection against. In that event, the doctor prescribing it would have violated his responsibility in letting him have too much. I expect that permitting a patient to take it home with him is done only after a period of time, after his doctor determines how much he needs.

Mr. ROGERS. And how many methadone clinics are coordinated with others to make sure that there is not a double use or triple, or quadruple use?

Secretary RICHARDSON. This is a key element in the regulatory process.

Mr. ROGERS. Are we doing anything about that?

Dr. EDWARDS. Again, we are reviewing, Mr. Chairman, all of our methadone programs. As I indicated, we have closed at this point some six programs. We have required that certain specific changes be made in the way between 40 and 50 other programs are doing business. Probably within the next several months, we will completely review all 280 programs.

Dr. BROWN. Let me supplement this: Specifically, in this area, registers are being sponsored by a citywide or metropolitan basis to avoid double prescriptions and overlap.

Mr. ROGERS. Is this required?

Dr. BROWN. I don't know if it is required.

Dr. EDWARDS. It is not required at this point.

Dr. BROWN. Well, let me say, Dr. Jaffee is terribly knowledgeable on this point. One of the program plans he has shared with me is his intention to really get on top of this. This will be an example of how he may be able to be very helpful to all of us within the agencies.

Mr. ROGERS. I presume on investigation of drugs, you could require a register to be kept?

Dr. EDWARDS. Yes.

Mr. ROGERS. And check it with others in the same city?

Dr. EDWARDS. In that case, we could require anything that is necessary.

Mr. ROGERS. Wouldn't it be a good idea?

Dr. EDWARDS. It makes sense, yes.

Mr. ROGERS. How many deaths have we had from methadone? Have we any estimates?

Dr. EDWARDS. I don't have the figure on that.

Dr. BROWN. I don't have a hard figure. I would estimate that in the past year somewhere between 100 and 150 methadone deaths occurred across the country in the past year.

Mr. ROGERS. How many drug treatment centers are in our public health hospitals and clinics, Dr. Wilson?

Dr. WILSON. None as such.

Mr. ROGERS. None?

Dr. WILSON. None as such, no. Not at drug treatment centers. They

address themselves to the general care of the seamen and we have not established any.

Mr. ROGERS. Well, military personnel, too?

Dr. WILSON. Only by contract, sir, with the military.

Mr. ROGERS. I understand you can do it, but you treat about 1½ million people, don't you?

Dr. WILSON. No, we have roughly a million and a half visits, but not a million and a half people.

Mr. ROGERS. Well, a million and a half people are treated, they come in there on a million and a half visits, rather. You mean there are no addicts in this group?

Dr. WILSON. The specific question you asked is, whether we had centers for drug addiction treatment, and the answer to that is "No." If you asked, "Do we apply ourselves to the problem of drug addiction, when it appears," the answer to that is "Yes".

Mr. ROGERS. So you can treat drug addiction in public health hospitals and clinics?

Dr. WILSON. Yes.

Mr. ROGERS. You have the capability?

Dr. WILSON. We have the capacity to do it. We have not organized it in a center type treatment, because that particular population has not, up to this point, presented a problem that would merit a development of centers.

Mr. ROGERS. But in communities where they exist, there may be a severe addiction problem?

Dr. WILSON. But the hospitals have been addressed to a particular target, the beneficiaries of the Public Health Service.

Mr. ROGERS. But the authority there would allow you to establish those for whatever population existed in the community, I presume?

Dr. WILSON. As a part of our study of the use of Public Health Service hospitals as a community resources, this is obviously one of the issues that will be studied extremely carefully, as you and I discussed on a number of occasions.

Mr. ROGERS. Well, we perhaps will put this authority in the legislation.

Mr. Kyros.

Mr. KYROS. No questions.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. No questions.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I want to go back to Dr. Brown's statement with regard to what I suppose one might call Dr. Jaffe's traffic bearing. He has apparently treated about 2,000 patients in Illinois. I think a very conservative estimate of the number of addicts in Illinois would probably be about 10,000?

Dr. BROWN. I would think that is about right.

Mr. ROY. So, apparently he reached about 20 percent of the addicts in the State of Illinois. So, I suppose that he has not reached more, either because he has not had enough authority or enough money, or perhaps, even because he has not had a civil commitment law.

Now, the thing that troubles me is that he is going to bring to us the same persuasion, persuasive ability to achieve a budget from

the Federal legislature, that he had to achieve a budget from the State legislature, the same abilities to coordinate, the same access to ongoing and past research, but do you think we can anticipate any greater achievement nationwide than that which he achieved in Illinois?

Dr. BROWN. Yes.

Mr. ROY. Why?

Dr. BROWN. I think because of two reasons.

One is, I think the justifiable anxiety within the country on the narcotics and drug abuse problem.

Mr. ROY. Reflected by $271 million when last year the State of New York spent $136 million and Governor Rockefeller's man and Mayor Lindsay's man, who have been handling these programs, said they didn't have enough money last year. Isn't it possible he is going to run into a situation here, or is in fact, running into a situation here of not enough money? At least the Secretary does not think so. He thinks he has all of the money he can handle; isn't that correct?

Secretary RICHARDSON. I think in fairness to Dr. Brown, that these are questions which you can much more directly get answers from Dr. Jaffe next week. I would only add that the President has undertaken to respond to what he defined as an emergency and in which I would think all would agree genuinely is an emergency. He has proposed to equip Dr. Jaffe with both the funds, and the authority, to do whatever is required, whatever can practically be done to cope with that emergency. And so the question then would be, "Did the State of Illinois give him that same degree of authority and that same degree of funding?", and I don't think Dr. Brown or I would know that. We do know, whatever may be his situation there, that it is the purpose of the administration to do what has to be done from here on, insofar as the Federal role is concerned.

Mr. ROY. I stand ready to be persuaded, and I am not persuaded at the present time, because of the amount of money being budgeted, because of what appears to me to be some lack of authority and because we have no indication from past performance anywhere in the Nation that voluntary treatment programs alone are going to be enough.

With that statement, I won't pursue it any further.

Mr. ROGERS. Now, the committee may have more questions that we would like to go into.

We do have a call to the floor, and we have our distinguished colleague, John Murphy from New York, who has made a very specialized study of this whole problem. And he was anxious to hear the testimony of HEW before he testified and deferred to the Secretary.

What we would like to do, if it is convenient with you, Mr. Murphy, is go answer and come right back, or if you prefer, a different arrangement, we would make it.

Mr. MURPHY. Whatever the committee would like to do.

Mr. ROGERS. This is the second bell, if we can answer and come right back, because I know your statement will be very important because you made some visits just now to military bases and so forth. And I know the committee wants to hear it.

Mr. MURPHY. I would like to say, though, I think the Fort Worth tragedy with a demoralized staff, demoralized patients, certainly is

something we have to face immediately. We have in this legislation the exclusion of law enforcement agencies and yet we are going to transfer a Federal treatment facility over to the Bureau of Prisons. I want to address myself to that when we get back.

Mr. ROGERS. I think the committee would be very anxious to hear it, because I am sure the Congress is going to act on this matter this coming week.

Mr. Secretary, thank you for being here with your very able associates, and we are grateful to you for your appearance here today.

Secretary RICHARDSON. We appreciated the opportunity, Mr. Chairman, and members of the subcommittee.

Mr. ROGERS. The committee will stand in recess for 10 minutes.

(A brief recess was taken.)

Mr. ROGERS. The subcommittee will come to order.

We have as our next witness our distinguished colleague, my good friend John Murphy of New York, who is also a member of the full committee. The committee knows of your great interest in this problem and the personal effort that you have taken and gone to, assemble some facts and information on what the problem is and what we ought to do about it. So, we are particularly interested to hear your testimony today, knowing of your very recent trip to some of the facilities and the extent of the problem. So, the committee welcomes you, and we are pleased that we can hear your testimony.

STATEMENT OF HON. JOHN M. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. MURPHY. I want to thank the chairman for those kind words. I congratulate him on the recent floor action whereby the House adopted his amendment to the HEW appropriations bill, adding $14 million to bring funding of the Public Health Service hospital system up to last year's level.

We know that the Public Health Service is staffing and budgeting its hospitals at way below capacity, incldding the hospital on Staten Island that the committee visited and for which the chairman made an outstanding presentation earlier this year. I think one of the great tragedies is the Forth Worth addict treatment facility, which I visited just a week ago, about a week after this subcommittee made an on the spot visit. I saw a staff that was demoralized, a staff that had been so cutback that it could not perform its basic mission.

There is a certain manning level that is necessary, whether you have one addict or 500 addicts. The staff had been phased down to the point where they couldn't properly oversee or supervise the number of addicts that were there at the time. And I think that to transfer that facility to the Bureau of Prisons, seems to apply in the case of one of the intents of H.R. 9264 which seeks to separate any type of function in the bill from the Department of Justice. We know the Bureau of Prisons, of course, has a direct relationship to them. At the outset, I will refer to two questions that Dr. Roy addressed to the Secretary of Health, Education, and Welfare.

The first question is, what triggering mechanisms are there as far as an addicted military man is concerned, to get him into either a public health program or a veterans program or a community mental health

program, or one of the many other treatment programs that are available. The Secretary had no language or idea on the matter, but I had communicated to this committee and to all Members of the House on March 16, 1971, H.R. 6172, which I reintroduced yesterday on the 29th of July, and which is now H.R. 10223, with slightly revised language.

The second page of that bill contains the triggering mechanism that I recommend should be part and parcel of any approach to the military drug problem. Of course, when we talk about H.R. 9264, I think we have to understand there is an interrelationship between NARA, between H.R. 9264 and our military drug problems. We may not be able to reach it with amendments to this bill, but we will have to amend NARA and also enact this military drug bill to legally be able to do the following:

My military drug bill provides that not less than 30 days prior to the date on which any member is to be retired, discharged, or separated from active military service pursuant to subsection (a) of this section, the Secretary concerned, shall file a petition with the U.S. attorney for the district in which such member will be separated from active military service or with the U.S. attorney for the district within which the permanent home of record of such member is located, requesting that such member be admitted to a hospital of the Public Health Service for treatment of his drug dependency.

The Secretary shall not file a petition with respect to any member if the Secretary determines that such member has voluntarily filed or will file within the 30-day period prior to his expected date of separation from active military service a petition with appropriate U.S. attorney requesting that such member be admitted to a hospital of the Public Health Service for treatment of his drug dependency.

Any petition filed by the Secretary concerned or member under this section shall set forth the name and address of the member, and so forth, and his military base. The Secretary bases the separation of such member from active military service by reason of drug dependency, which is a physical disability separation. And then, we trigger NARA.

He then comes under the civil commitment provisions of NARA, which, I think, is an answer the Secretary might well look to. And, I think the committee could probably forward it to him for his consideration.

Second, Dr. Roy asked the effects of voluntary movement into this program. This triggering mechanism I just mentioned has voluntary and involuntary movement, because you must have both voluntary and involuntary commitment if we are going to control the drug abuse problem.

There is some experience as far as involuntary input into the program is concerned. It came in my testimony before the House Judiciary Committee on June 23, on the NARA amendments that I proposed. I will go through this, because it is very interesting and gets to what Dr. Roy was referring to.

Figures were made available to me that indicate that under title 2 of NARA, which involves involuntary commitment, even though the number of inmates is comparatively small, the plan does seem to work. As of December 30, 1970, 414 inmates had been released to aftercare following an average institutionalization of slightly over 15 months;

297 or 72 percent were still active, and 28 percent had violated and absconded.

I feel that the fact that 72 percent were relatively law abiding is a tremendous improvement over the 2-percent cure rate of addicts in Federal institutions of which we used to hear. Seventy percent of all inmates in Federal institutions have a drug problem. I feel the provisions in my bill, H.R. 5612, to expand those eligible under NARA is a critical one.

The question that the chairman addressed to the Secretary on how much methadone was being used, and what other drugs were being used, was one that I have current information on. Here are statistics I will submit to the committee for the record, statistical reports as of June 2, 1971, from the Narcotic Addict Rehabilitation Branch.

These are community-based grant programs, the number of patients remaining in treatment programs as of April 30, 1970. And it goes through 23 centers, including Hartford, Conn., New Haven, Conn., Baltimore, Md., Chicago, Ill., Boston, Mass., Kansas City, Mo., St. Louis, Mo., Marlboro, N.J., Jersey City, N.J., Albuquerque, N. Mex., and Brooklyn, N.Y.

The total patients are 816 that receive drug-free therapy. We have appropriated $30 million for research, and these are all the addicts we have on drug-free therapy. The number on chemotheraphy maintenance totaled 5,638. Those on methadone 5,624 on naloxone 14. That is the extent of the experience of this agency with that number of people. They are not trying any other type of chemical. They are strictly a methadone maintenance operation, and I just don't think that the Department has gotten into research or properly put emphasis on research for other types of drugs in spite of what they said this morning. I would like to submit this report for the record.

Mr. ROGERS. Without objection, it will be received as part of the record, and I agree with you in your conclusions there, that presently, they are just depending on methadone and there is no real effort to try to change it.

(See "Statistical Report—1971, Narcotic Addict Rehabilitation Branch," p. 1027, this hearing.)

Mr. MURPHY. Dr. Edwards of the Food and Drug Administration testified that Eli Lilly is their supplier of methadone. When we talk about methadone deaths I point out that we had five in my county, five teenage methadone deaths in 2 weeks. We have had children who go into a parent's icebox and take out methadone that has been placed in orange juice. We have many deaths in the city of New York when children or teenagers buy or accidentally take the methadone that was given to an addict by one of these many Federal treatment programs.

The Secretary said there were 260,000 addicts in America and yet at Lexington, we are treating 500. So the Federal Government involvement in the direct treatment of addicts, including Fort Worth, where they gain their expertise, happened to be 760 addicts out of 260,000 addicts in the United States. In the face of this, the Department of Health, Education, and Welfare wants to close Fort Worth, and phase back Lexington. They want to get rid of an entire Public Health Service system as well as the 5,000 Public Health Service doctors with their medical expertise, and contract out their patients to other agencies, a policy with which I don't agree. And, I am going to support your amendment or your resolution on Monday on the floor. I would like to

get into the military problems and interaction that I think is necessary, legislatively, and relate to you experiences that I have recently had in this area.

It is ironic that these hearings are being held on the anniversary of the advent of the massive heroin problem in Vietnam. Suddenly last summer in late July, a newly packaged, widely distributed, deadly potent form of heroin was being practically given away to our troops.

By September, a majority of all servicemen hospitalized in Vietnam were drug abuse cases. By October, we were losing two men a day to heroin overdoses. By the end of 1970, the situation had gotten so bad an intelligence analyst at the American Embassy in Saigon said, "The Pot-Head Army of 1969 is rapidly turning into 1971's Army of heroin addicts."

One of the marines in the Navy's so-called voluntary amnesty program in Miramar told me he was assigned as guard at the American Embassy. That is an example of the extent of heroin usage. It is used by the guards at the American Embassy in Saigon.

The American Government was well aware of this development right from the beginning. I have obtained a copy of an Army memorandum designated as a fact sheet designed to demonstrate the increased incidence of drug abuse deaths of Army personnel in the Republic of Vietnam during the period from January 1, 1969 to September 30, 1970. This alarming report was prepared at the request of Gen. Creighton W. Abrams and is dated October 23, 1970. The report shows that for the first 7 months of 1970, there was an average of two soldiers a month dying from drug overdoses. This was an increase of 50 percent over the monthly average for 1969. However, once the new supply of heroin reached our troops in late summer, known drug overdose deaths increased 175 percent in August and September according to the Abrams memo.

As ominous as the report to General Abrams was, reports by American military hospitals in Vietnam indicated that many O.D.'s went undetected or unconfirmed and that our drug casualty figures were actually much higher.

U.S. medical personnel reported that when the known O.D.'s were combined with suspected overdose deaths, the increase for August and September was 1,000 percent, or 46 deaths.

During the first 18 days in October 1970, there were 35 known overdose deaths among our troops.

At that rate, instead of the two deaths a month, we were experiencing from January through July, we were experiencing two deaths a day.

That percentage of increase was an astronomical 2900 percent. Such alarming statistics should have led the Government to massive remedial action immediately—not 9 months later. Now that action appropriate to the problem has begun, I urge this committee which has such an excellent record in this area to use its power and prestige to properly implement those aspects of the domestic drug program which have relevance to our addicted servicemen.

As a Congressman and as a former member of the Military Establishment, I was greatly disturbed over this growing shadow of drug addiction that has now overtaken large numbers of our soldiers, sailors, and airmen.

Although I have spent many years talking to experts on drug addiction and our growing drug culture, I have recently intensified my work in this area, because of my concern for our Armed Forces.

I have spent time at all-night drug clinics just off the streets of New York, where addicted ex-GI's seek help for their problems.

During the past months, I have studied many aspects of our military drug situation throughout the United States. I will briefly tell you about some of my findings and submit for your consideration lengthier reports on the various attempts by the military to cope with the drug problem—at Fort Bragg, the Miramar Naval Air Base, and Lackland Air Force Base.

(See "Report of Hon. John M. Murphy to the House Committee on Interstate and Foreign Commerce on Military Drug Programs," p. 1032; and "Report of Hon. John M. Murphy to the House Committee on Interstate and Foreign Commerce on Fort Bragg Drug Program," p. 1035.)

Mr. MURPHY. Initially, I would urge the committee to consider not only the short-range needs of our services to meet the challenge of addicted troops, but the long-range needs which must be inherent in any new Federal program this committee may ultimately put into operation.

While the legislation before this committee concerns itself primarily with civilian programs for the treatment of drug abuse, it cannot separate the civilian drug problem from the military drug problem. The bulk of the hard core drug abusing GI's will eventually turn up in one of the programs covered by H.R. 9264.

Basically, the best thing about H.R. 9264 is contained on pages 5 and 6, where it draws together and coordinates those drug programs in the Federal Government. But it still does not mention in there any Defense Department program.

For example, 30 percent of the male addicts currently in the Federal programs at Fort Worth, Tex., and Lexington, Ky., are former servicemen, the bulk of whom became addicted or had their habits worsen during their tours in the military. Yet these facilities have not begun to receive GI's addicted during the surge of heroin use which began a year ago in Vietnam.

Mr. Chairman, the basic assumption of the military approach to addiction seems to be that if a draftee has gotten through the trauma of being drafted, basic training, and other shocks that military flesh is heir to, he has at one time had the self-discipline and "character" to refrain from drug abuse. The services overlook the psychological fact that a youngster can be pretty disturbed and still get through the preliminaries. But once the main event comes up, Vietnam and its com-

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bination of fear, boredom, drugs, his personality can be severely altered—sometimes irrevocably. In short, it takes an addict a long time to get to be changed and restored to a configuration compatible with military or civilian life. And the limits on programs set up by the administration and the services will not suffice to do the job necessary—for the services, for the addict, and least of all for society.

What the programs I have visited will eventually accomplish will be to simply cull out those GI's who are least in need of treatment and whose major hangup may have been being in Vietnam, and return

them to stateside duty or to civilian life with a good chance for remaining drug free. But the psychologically disturbed drug abuser—and they are a substantial number—will be given a "window dressing" period of several weeks of treatment and then dumped back into society.

Mr. ROGERS. Pardon me. I hate to interrupt right in the middle of your presentation. That is the second bell, and it is a vote. Shall we take time to go answer and come right back?

Mr. MURPHY. I have in the statement here, Mr. Chairman, I think all of the details. The breakdown of categories and types and the conclusion that you can't treat drug addiction as one block of people. It has to be broken down into categories and types. The service programs will only help a fraction of those who are addicted.

I say the others should be physically separated from the service and put into NARA under civil commitment provisions. I think this statement, carefully analyzed, and I hope the staff will go into it in detail, would benefit the committee. I have spoken at great length with the chairman and other members of the subcommittee on this problem. I appreciate the opportunity to be here and will terminate my testimony now and follow up with submission for the record of the reports that I mentioned earlier.

Mr. ROGERS. That would be very helpful. I think the testimony you set forth here, and I have looked through your statement, is excellent and will be very helpful to the committee. And, we will see if we can't follow some of your suggestions.

Mr. KYROS. I want to add that the chairman is planning a visit to Southeast Asia with this committee. I think the gentleman from New York has a concise and penetrating analysis of the military problem in heroin, and I think he has done a real service to the committee.

Mr. MURPHY. Here is a copy of the General Abrams report for the record.

Mr. ROGERS. That will be excellent. We would like, in fact, I would like to get a personal copy of that so I can have it when Mr. Jaffe comes up Monday. That will be very helpful.

(Mr. Murphy's prepared statement and attachments referred to follow:)

STATEMENT OF HON. JOHN M. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman: It is ironic that these hearings are being held on the anniversary of the advent of the massive heroin problem in Vietnam. Suddenly last summer in late July, a newly-packaged, widely-distributed, deadly, potent form of heroin was being practically given away to our troops.

By September, a majority of all servicemen hospitalized in Vietnam were drug abuse cases. By October we were losing 2 men a day to heroni overdoses. By the end of 1970 the situation had gotten so bad an intelligence analyst at the American Embassy in Saigon said, "The pot-head army of 1969 is rapidly turning into 1971's army of heroin addicts."

The American Government was well aware of this development right from the beginning. I have obtained a copy of an Army memorandum designated as a fact sheet designed to demonstrate the increased incidence of drug abuse deaths of Army personnel in the Republic of Vietnam during the period from January 1, 1969 to September 30, 1970. This alarming report was prepared at the request of General Cheighton W. Abrams and is dated October 23, 1970. The report shows that for the first seven months of 1970 there was an average of two soldiers a month dying from drug overdoses. This was an increase of 50 percent over the monthly average for 1969. However, once the new supply of

heroin reached our troops in late summer, known drug overdose deaths increased 175 percent in August and September according to the Abrams memo.

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U.S. medical personnel reported that when the known O.D.'s were combined with suspected overdose deaths, the increase for August and September was 1000 percent, or 46 deaths.

During the first 18 days in October 1970 there were 35 *known* overdose deaths among our troops.

At that rate, instead of the two deaths a month, we were experiencing from January through July, we were experiencing *two deaths a day.*

That percentage of increase was an astronomical 2,900 percent. Such alarming statistics should have led the government to massive remedial action immediately—not nine months later. Now that action appropriate to the problem has begun, I urge this committee which has such an excellent record in this area to use its power and prestige to properly implement those aspects of the domestic drug program which have relevance to our addicted servicemen.

As a Congressman and as a former member of the Military Establishment, I was greatly disturbed over this growing shadow of drug addiction that has now overtaken large numbers of our soldiers, sailors and airmen.

Although I have spent many years talking to experts on drug addiction and our growing drug culture, I have recently intensified my work in this area because of my concern for our Armed Forces.

I have spent time at all-night drug clinics just off the streets of New York, where addicted ex-G.I.'s seek help for their problems.

During the past months I have studied many aspects of our military drug situation throughout the United States. I will briefly tell you about some of my findings and submit for your consideration lengthier reports on the various attempts by the military to cope with the drug problem—at Fort Bragg, the Miramar Naval Air Base, and Lackland Air Force Base. Initially I would urge the committee to consider not only the short range needs of our services to meet the challenge of addicted troops, but the long range needs which must be inherent in any new federal program this committee may ultimately put into operation.

While the legislation before this committee concerns itself primarily with civilian programs for the treatment of drug abuse, it cannot separate the civilian drug problem from the military drug problem. The bulk of the hard core drug abusing G.I.'s will eventually turn up in one of the programs covered by H.R. 9264.

For example, 30% of the male addicts currently in the federal programs at Fort Worth, Texas and Lexington, Kentucky, are former servicemen, the bulk of whom became addicted or had their habits worsen during their tours in the military.

Mr. Chairman, the basic assumption of the military approach to addiction seems to be that if a draftee has gotten through the trauma of being drafted, basic training and other shocks that military flesh is heir to, he has at one time *had* the self discipline and "character" to refrain from drug abuse. The services overlook the psychological fact that a youngster can be pretty disturbed and still get through the preliminaries. But once the main event comes up, Vietnam and its combinaion of fear, boredom and drugs, his personality can be severely altered—sometimes irrevocably. In short, it takes an addict a long time to get in the condition he is in and it will take a long time for his life style to be changed and restored to a configuration compatible with military *or* civilian life. And the limits on programs set up by the administration and the services will not suffice to do the job necessary—for the services, for the addict, and least of all for society.

What the programs I have visited will eventually accomplish will be to simply cull out those GI's who are least in need of treatment and whose major hangup may have been being in Vietnam and return them to Stateside duty or to civilian life with a good chance for remaining drug free. But the psychologically disturbed drug abuser—and they are a substantial number—will be given a "window dressing" period of several weeks of treatment and then dumped back into society.

Mr. Chairman, that is precisely what many of us in Congress have been fighting for 5 years—the unconditional release of military addicts back into our city streets with the potential to spread the drug habit even more. The idea of treating the kinds of addict-servicemen I have spent the past 6 months with, within 30 days is ludicrous. Even the Air Force treatment time span of up to 2½ months will not allow that service to retrieve the bulk of its addicts. And the sad fact is that the hardcore users are the ones who will be released and simply "referred" to a treatment center.

I spoke to Vietnam veterans who were addicted in the early years of our Vietnam involvement and even Korean addict veterans at our Federal facilities at Forth Worth, Tex. and Lexington, Ky. I asked them what they thought the prognosis was for a GI coming off an 11-month heroin habit being "cured" in 30, 60, or even 90 days. Their response was resigned laughter. And these were veterans—Army, Navy, and Air Force—who had been unable to shake their habits in time spans ranging from 2 to 12 years—a few even longer. The behavioral scientists whom I have consulted—the physicians, psychiatrists and counselors—agree that the treatment time alloted by the new White House and Pentagon directives are incongruous with the treatment time span needed for the rehabilitation of a truly addicted person.

I urge the committee to consider and provide for the peculiar needs of the military addict in any legislation it reports to the House.

The types of addicts I have seen in the services this far fall generally into four categories. They include:

Type one: The user whose basic problem was his inability to cope with being in Southeast Asia.

Type two: The conformist type of user who succumbed to group pressures of one kind or another to "go along" with drug use. And in Vietnam where drugs are everywhere and where drug use is a way of life, it was easy for many GI's to "fall into" the habit.

Type three: The weak personality who "caved in" under the normal pressures of service life. It wasn't the war or Southeast Asia—it was the everyday discipline of military life that made him seek relief through drugs. Remember, 60 percent of the addicts at Fort Bragg have never been to Vietnam. A common statement of this type of addict was that he took drugs because he was "hassled" by his NCO's and officers. One burly paratrooper told me his sergeant made him "stand down four times a day and was always hassling me." Hassling in this case refers to the simple routine of soldiering—which reminds me of the many college students who have told me they took drugs because they didn't like the "hassle" of studying.

Type four: The true addict personality with psychopathic overtones. These were the real troublemakers. They stole, sold drugs for profit and to supply their own habits. They were multiple drug users or in constant trouble—or both—long before their service in the Armed Forces.

They were—above all—the "con" artists of the groups I interviewed, attempting to dominate the conversations and give plausible explanations of why they were in the spot they were in. They said they were in the program by mistake; the urinalysis machine made a mistake or the service made a mistake. They really didn't belong at Miramar or Lackland or Fort Bragg—even if *they* volunteered.

Their rationalization for all of these "mistakes" was that they were just "drug users"—they weren't really addicts—they could stop using heroin at any time. And some did stop using—many times—but usually when they were in trouble or facing long prison sentences.

Mr. Chairman, the first and second categories of users are the easiest to handle. For some of them, the geographical "cure" will come into play. Just getting out of Vietnam and away from its environment and group pressures will make them likely candidates as abstainers from hard drugs.

However, even some of the users in these not-so-serious categories have been taking drugs for such long periods of time there is a danger of severe psychological damage which will require intensive treatment and re-education.

Category three is a more difficult group to treat. Any excuse—no matter how minute—is reason enough to shoot up a plastic container or heroin. These people need long term treatment. They need the "family" type addict self-help approach—which means a long term one or two year situation. The Navy has recognized the

need for this type of approach and has in its program at Miramar ex-addicts who handle part of the treatment phase of the program.

The fourth category is certainly out of the sphere of any kind of service oriented treatment program.

These addicts are recalcitrant, testing, troublemakers.

They are arrogant, autocratic and self-perpetuating.

And they are a threat to service discipline.

They are the self-elected leaders of the drug culture.

To spend defense dollars and expend valuable service treatment personnel at this level is unsound practice, medically and psychologically. They should be diligently weeded out for the good of the armed services and for their own good. But I do not advocate that we give up on them just because they are difficult. I *do* recommend we bind them over to the kind of treatment program that does have some hope of changing their attitudes and behavior.

That is why I recommend that the Congress consider my bill, H.R. 6172, which would help the armed services by taking the addict population off of their hands—especially those addicts I have identified in categories three and four. By distributing the service addicts into our Federal facilities on the basis of the causes of their addiction, the Congress can best help our Federal agencies—NIMH, NIH, Public Health Service, and others—to deal with them effectively.

In brief, my bill provides for:

* The physical disability separation from service of drug addicted and drug dependent military personnel. This provision has been made retroactive to cover those addicted servicemen already given less than honorable discharges.

* The civil commitment of drug users to treatment under the narcotic addict rehabilitation act of 1966.

* Penalties for drug offenses that are commensurate with those provided for in the comprehensive drug abuse prevention and control act of 1970.

The heart of the bill will make all of title III of the Narcotic Addict Rehabilitation Act's civil procedures applicable in the case of petitions filed by persons separated from the service. This means that it provides for the same hearing and examination that NARA provides. Once the soldier is studied by the Department of Health, Education, and Welfare and found to be an addict, he is discharged to a hospital of the Public Health Service or any hospital or other facility of the Public Health Service especially equipped to handle drug dependent persons, or any other appropriate public or private hospital or facility available to health, education, and welfare for the care and treatment of drug dependent persons including V.A. hospitals.

My bill is based on the assumption that the crisis of drug abuse facing the military is beyond the capacity of the individual services to cope with. My recent tour of our facilities for military drug users confirmed that assumption. The mission of the Armed Forces of America is the defense of this country. They should not be forced into the business of rehabilitating thousands of drug addicts and multiple drug users. My bill would help solve the problem of weeding out those truly addicted and drug-dependent servicemen and commit them to our already existing Federal program for the treatment and rehabilitation of addicts.

I recommend that this committee expand the appropriate programs under section 5(c) of H.R. 9264 to include not only the thousands of heroin users who will be funneled into these programs by way of the armed services, but the multiple drug users who exhibit all of the psychological symptoms of the opiate addict and who are in just as great a need for treatment.

Finally, I recommend that the Director of the Special Action Office for Drug Abuse Prevention be given specific duties concerning his responsibilities to addicted servicemen and that the problem be given more specific attention or greater visibility in the language of the bill.

NARCOTIC ADDICT REHABILITATION BRANCH—STATISTICAL REPORT, APRIL 1971

PATIENTS IN BRANCH TREATMENT PROGRAMS

Civil Commitment Program (NARA I and III); Community Based Grant Program

TABLE I—SUMMARY OF PATIENT STATUS IN NARB TREATMENT PROGRAMS

Number remaining as of April 30, 1971

	Total
A. Civil commitment program (NARA I & III):	
Program phase:	
Examination and evaluation [1]	135
Inpatient treatment [2]	556
Aftercare	1,374
In methadone maintenance	104
In drug-free therapy*	1,270
Total patients	2,065
B. Community-based grant program:	
Treatment modality:	
Chemotherapy maintenance	5,638
Methadone	5,624
Naloxone	14
Drug-free therapy*	2,778
Total patients	8,416

[1] Includes 13 NARA I.
[2] Includes 42 NARA I.
*The "Drug Free Therapy" category includes some patients who are receiving supportive chemotherapy, other than methadone maintenance or naloxone.

TABLE II.—CIVIL COMMITMENT PROGRAM (NARA I AND III) EXAMINATION AND EVALUATION PROVIDED DURING APRIL 1971

	Totals	Fort Worth	Lexington	Community-based facilities
Number in examination and evaluation at beginning of month	178	51	70	57
Additions during month	195	40	96	59
1st commitment	181	39	85	57
Recommitment	14	1	11	2
Removals during month	238	65	104	69
Not suitable for treatment	93	22	59	12
AWOL	21		15	6
Transfers out:				
Other inpatient facility	48			48
Within same facility	76	43	30	3
Number remaining in examination and evaluation at end of month	135	26	62	47

TABLE III.—CIVIL COMMITMENT PROGRAM (NARA I AND III) INPATIENT TREATMENT PROVIDED DURING APRIL 1971

	Total	Fort Worth	Lexington	Community-based facilities
Number in inpatient treatment at beginning of month	547	202	298	47
Additions during month	138	69	63	6
1st commitment	76	43	30	3
Recommitment	9	5	4	
Transfer in from:				
E&E, other facility	49	21	28	
E&E, this facility	3			3
Treatment, other facility	1		1	
Removals during month	129	25	99	5
Transfer out to aftercare	75	14	57	4
Transfer—recommitment to aftercare	13	5	8	
Transfer to treatment, other facility	1	1		
Not suitable for aftercare	34	4	29	1
AWOL	6	1	5	
Number remaining in inpatient treatment at end of month	556	246	262	48

TABLE IV—CIVIL COMMITMENT PROGRAM (NARA I AND III) AFTERCARE/POST-HOSPITALIZATION TREATMENT PROVIDED DURING APRIL 1971

	Total
Number in aftercare at beginning of month	1,349
Additions during month	89
First commitment to aftercare	*75
Recommitment to aftercare	13
By court order	1
Removals during month	64
Recommitment to treatment	9
Discharges from aftercare:	
By NARB request	50
Rehabilitated	2
By court order	1
Deaths	2
Number remaining in aftercare at end of month	1,374

*Includes 4 persons transferred from community-based in-patient facilities.

TABLE V.—COMMUNITY-BASED GRANT PROGRAMS, NUMBER OF PATIENTS REMAINING IN TREATMENT PROGRAMS AS OF APR. 30, 1971

Centers	Total patients	Treatment modality: Drug free therapy	Number on chemotherapy maintenance: Total	Methadone	Naloxone
1. Alcohol and Drug Dependence Division, Hartford, Conn	305	233	72	72	
2. Connecticut Mental Health Center, New Haven, Conn	297	105	192	178	14
3. University of Chicago, Chicago, Ill	1,246	279	967	967	
4. Johns Hopkins Hospital, Baltimore, Md	193	20	173	173	
5. Boston University, Boston, Mass	289	274	15	15	
6. Missouri Division of Mental Diseases, Kansas City, Mo	24	4	20	20	
7. University of Missouri, St. Louis, Mo	406	51	355	355	
8. Marlboro State Hospital, Marlboro, N.J	170	170			
9. New Jersey College of Medicine and Dentistry, Jersey City, N.J	742	601	141	141	
10. University of New Mexico, Albuquerque, N. Mex	412	17	395	395	
11. Addiction Research and Treatment Corp., Brooklyn, N.Y	778	30	748	748	
12. Addiction Services Agency,[1] New York, N.Y	251	251			
13. Eagleville Hospital and Rehabilitation Center, Eagleville, Pa	340	340			
14. West Philadelphia Community Mental Health Consortium, Philadelphia, Pa	877	43	834	834	
15. Department of Social Services, Santurce, P.R	524	43	481	481	
16. Bexar County Board of Mental Health and Mental Retardation, San Antonio, Tex	316	12	304	304	
17. Health Council—Detroit Model Neighborhood, Detroit, Mich	248	9	239	239	
18. Community Organization for Drug Abuse Control, Phoenix, Ariz	225	225			
19. District of Columbia Narcotic Treatment Administration, Washington, D.C	123	4	119	119	
20. Committee on Alcoholism and Drug Abuse for Greater New Orleans, Inc., New Orleans, La	34		34	34	
21. Diagnostic and Rehabilitation Center, Philadelphia, Pa	67	67			
22. Metropolitan Dade County Department of Hospitals, Division of Mental Health, Miami, Fla	131		131	131	
23. Craig House Technoma Workshop, Pittsburgh, Pa	418		418	418	
Total	8,416	2,778	5,638	5,624	14

[1] Revision received from center.

NARCOTIC ADDICT REHABILITATION BRANCH—PATIENT DATA

	Number of patients remaining in branch treatment programs as of: NARA I	III	Total
Apr. 30, 1971	205	1,860	2,065
June 30, 1970	159	1,497	1,656
June 30, 1969	80	991	[1] 1,071
June 30, 1968	35	272	307

[1] Previous figure was incomplete.

DRUG ABUSE FACT SHEET

SURGEON

23 October 1970.

The attached fact sheet on Drug Abuse is submitted to the request of BG James J. Urbano, DGS P&A, USARV, on 22 October 1970.
FOR THE SURGEON:
Tab A—Fact Sheet

C. S. _____,
Colonel, NSC, Executive Officer.

Incl.
1. Vietnam Drug Abuse Statistics
2. Vietnam Drug Abuse Statistics/Graphs

Subject: Drug abuse fact sheet

Purpose:

The purpose of this fact sheet is to demonstrate the increased incidence of drug abuse deaths of Army personnel in the Republic of Vietnam during the period from 1 January 1969 to 30 September 1970. This fact sheet is in response to a query from General Creighton W. Abrams, Commanding General, United States Army, Vietnam.

Facts:

The following information is provided in reference to drug abuse by Army personnel in Vietnam:

1. During the period 1 January 1969 through 31 December 1969, there were nineteen deaths proven by autopsy to have resulted from drug abuse. There was an average of 1.33 drug abuse deaths per month from Army personnel in 1969.

2. During the period 1 January 1970 through 31 July 1970, there were fourteen deaths proven by autopsy to have resulted from drug abuse. There was an average of 2 drug abuse deaths per month for Army personnel in the first 7 months of 1970, an increase of 50% over the monthly average in 1969.

3. During the period 1 August 1970 through 30 September 1970, there were eleven deaths proven by autopsy to have resulted from drug abuse. This is an average of 5.5 drug abuse deaths per month for Army personnel in August and September 1970, an increase of 175% over the period 1 January–31 July 1970 monthly average. Two of the autopsy proven deaths included in this period were finalized 22 October 1970.

4. During the period 1 August 1970 to 30 September 1970, there were 40 deaths clinically diagnosed or determined by initial medical interpretations as resulting from possible drug abuse. In these cases, physicians suspected the cause of death to be drug abuse, but they were not autopsy proven at that time. Subsequently, eleven of the aforementioned were proven by autopsy (par 3 above).

5. It should be added that the number of cases in paragraph 4 (above) may never be proven by autopsy. The number of deaths from suspected drug abuse determined by clinical diagnosis or medical interpretation is significant in that it reflects a trend toward greater drug usage in Vietnam. However, trends determined from death by drug abuse figures which are autopsy proven must be considered more accurate, and therefore more meaningful.

6. Drug abuse admissions to USAMEDCOM V (P) medical treatment facilities during the period 1 January 1969 to 31 December 1969 totalled 527, or an average of 44 per month. Drug abuse admission figures for the period 1 January 1970 to 31 July 1970 were 486, or 69 per month. Figures for the period 1 August 1970 to 30 September 1970 were 190 drug abuse admissions, or an average of 95 per month. The above figures must be interpreted as representing a trend of increased drug usage by Army personnel as indicated by the increased incidences of hospitalization.

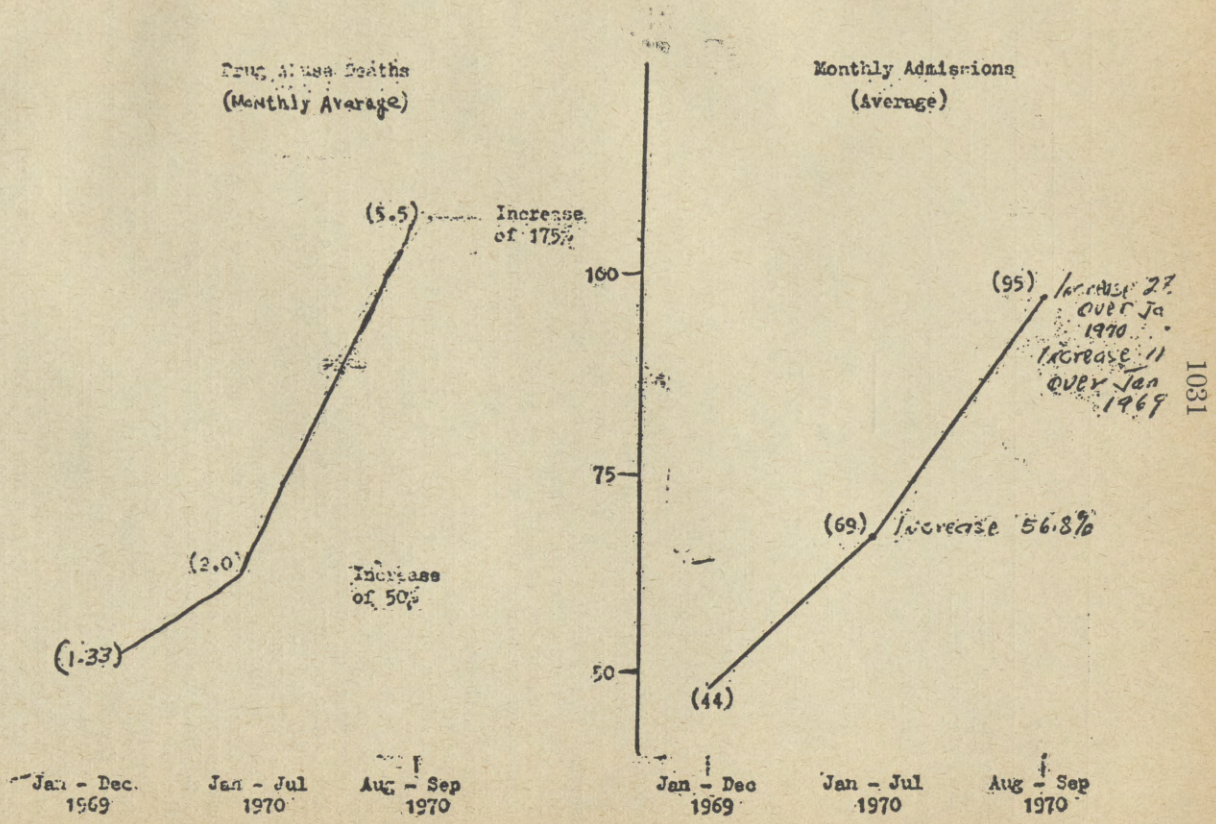
SUBMITTED BY:

BRIGADIER GENERAL THOMAS.

Project Officer:

MAJ HARRIS.

VIETNAM DRUG ABUSE STATISTICAL GRAPHS



VIETNAM DRUG ABUSE STATISTICS

Jan. 1, 1969, through Sept. 30, 1970

Period	Drug admissions for period	Average admissions per month	Deaths		Average deaths per month
			Autopsy	Clinical[1]	
January to December 1969	527	44	16		1.33
January to July 1970	486	69	14		2.00
August to September 1970	190	95	11	29	5.50

[1] Death due to drug overdose through initial medical interpretation.

REPORT OF HON. JOHN M. MURPHY TO THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON MILITARY DRUG PROGRAMS

Mr. Chairman, on July 24, 1970, the Department of Defense issued a task group report on the problem of drug abuse in our military forces. The task group, comprised of experts in the various services who studied the problem world wide recommended appropriate revisions in Department of Defense policy on drug abuse. The following statement appears in the "rehabilitation" section of that report: . . . "Treatment programs require such prolonged absence from productive service, and long-term success rates with such individuals are so low that creation of a treatment and rehabilitation program within the services is not feasible."

After my own study in recent months of various programs in the armed services I am convinced of the wisdom of that particular conclusion. That task force report was, however, superceded by the White House directive of June 17, 1971 calling on the individual services to set up a system of amnesty, detoxification, treatment and return to duty or discharge for addicted servicemen.

I have studied some of the major programs—some rather hastily established—set up by the various services to comply with the President's directives. These include the Navy/Marine program at Miramar Naval Air Base in California, the Air Force program at Lackland Air Force Base in Texas, and the Army programs at Fort Bragg, North Carolina and Fort Dix, New Jersey. I have also visited the Public Health Service programs at Fort Worth, Texas and Lexington, Kentucky to see what happened to addicted servicemen from the earlier years of ou rinvolvement in Vietnam. On my recent trip to Southeast Asia I also conferred with military medical personnel, agents of the Bureau of Narcotics and Dangerous Drugs and Individual Drug Addicted Troops. The results of my meetings and observations have led me to some firm conclusions which I summarize briefly as follows:

1. Drug abusing troops at many stateside and overseas bases are having a disastrous effect on military discipline and morale.

2. While we have not reached the point where drug use has severely hampered the over-all ability of the military to carry out its mission, i.e., the war in Vietnam and the defense of the United States, if the proper steps are not taken we will eventually reach that stage based on current trends.

4. Despite the furor in the Congress and the press over the recent exposures of our service connected drug problem, the military is not aware of nor responding to the nature and depth of the drug menace facing the men in the service. This is especially true in Southeast Asia.

For example, the Navy program at Miramar was set up and administered by professional treatment types. Two weeks after my visit there these personnel were relegated to advisory roles and line officers were placed in charge of the programs.

Top Army Officials told me that the Army has set up 32 different programs in as many Army installations and hospitals to carry out the new Department of Defense drug policy because "we don't know exactly what to do so we are trying 32 different approaches."

5. An already bad drug abuse control program is being made worse by the inflexibility of the administration; it refuses to change in the face of the obvious failures in the program. The problems of the urinalysis phase of the administration's approach are a case in point. On July 22, 1971, I spoke to three Marine "addicts" at Miramar, who were "assigned" to the program by the Marine command as a token compliance with the President's directives. They insisted that they were not addicts even though they had shown up as such on the urinalysis machine.

The Department of Defense has now admitted that almost one third of the troops "failing" the urinalysis test in Vietnam were found to be drug free. On the other hand, there were numerous reports to me during my studies of successful attempts to "beat" the machine in addition to many users who were actually not detected.

6. Many amnesty programs do not attract servicemen who are members of minority groups because of the lack of trust on the part of these addicts for the "white man's" program, nor do the contradicting and fluctuating rules regarding these programs instill in the addict the confidence that if he turns himself in he will receive anything more than disciplinary action or a prison sentence.

The head of the Navy program at Miramar said in reference to the fact that there was not one black addict in his program that the Navy had "10,000 beaters and not one elephant in the trap."

Mr. Chairman, the more I study the drug problem in the Armed Forces, the more I am convinced there is no room for addicts in a military setting.

In my testimony before the subcommittee on health, I described the type of psychopathic addict that will continue to be beyond the reach of treatment personnel despite every effort to prevent him from using drugs. This was brought home to me again when I visited the Miramar treatment facility where the addict patients got me aside and complained that there had been a "sweep" of their barracks the day before my arrival. They were told they were going outside to have a fire drill. The "drill" lasted four hours while naval personnel went through the barracks with marihuana sniffing dogs. I questioned the head of the program and he confirmed the inspection which turned up a drawer full of narcotics—*right in the treatment center.*

The Department of Defense Task Group Report I referred to at the beginning of my statement endorses such a procedure. In their conclusions the group states: "The well-established program conducted by the U.S. Public Health Service and expansion of Veterans' Administration facilities should provide adequate treatment and rehabilitation for service members separated because of true addiction. It is essential that these follow-up programs be established and become operational for those drug abusers who cannot be salvaged for military service and subsequently must be discharged."

WHAT THE TROOPS ARE SAYING

A flavor for the nature and extent of the drug problem in the services can be derived from the G.I. users themselves. In my studies I have found them to be brutally frank in discussing their own drug abuse and that of others. For this reason I have noted some of the anecdotes and comments made by soldiers, sailors, Marines and airmen. Indicative of the pervasiveness of the military drug culture, the disorder and confusion addition has caused in the services, and the conflict between the young addicts and the regular Army officers.

Miramar Naval Air Station

"I got out of NAM just in time. I owed $125 to Vietnamese pushers for heroin. They (the Navy) found 60 pounds of heroin in quarters where I lived in Nha Be one week after I left. This is near one of the hottest combat areas for the Navy, 'Ambush Bend' where the Long Tau and Nha Be Rivers intersect."

"My habit in Vietnam was $20 a day. Here (in the U.S.) it is two Sony Hi-Fi sets and a half dozen watches."

"When heroin users are detected they apply for amnesty—and why not—they may beat a five year rap."

One Navy addict when asked if his effectiveness was curtailed at all by the use of drugs answered, "I worked in an air terminal unit. No one knew I was using drugs. While I was writing tickets a guy would be sitting under the counter rolling heroin dipped cigarettes, light it for me and give it to me. The officer getting the ticket didn't know how my cigarette got lit. I knew a lot of guys who got up to using 10 glacine vials of heroin a day—all they cared about was getting heroin." The addict then repeated over and over, "Get some money to get some heroin, get some money to get some heroin, get some money to get some heroin . . ."

"The attitude of officers in the Marine Corps is that the addict is the lowest creature on earth."

"I got a court martial for possession of marihuana and heroin. They wrote letters to my parents, 55 and 65 years old, telling them this."

Travis Air Force Base

Customs agents: "Dogs are used to inspect the planes after the men leave. Heroin vials are found on the aircraft and also in the customs restrooms and garbage cans."

Army nurse: "The marihuana smoke on some of the flights home is so thick the air turns blue."

A G.I. addict in the Travis Air Force Base Hospital: "My habit got up to $40 a day in Okinawa. So I became a pusher. I turned myself in because I got completely out of wack and was losing control. I was shooting up to 8 times a day. There were 200 in my company and 40 used heroin. One of the users was my hero. He would try to shoot it closer to his brain and so he would shoot it in his jugular vein."

At Travis Air Force Base Hospital I talked to a much decorated G.I. who had been booby trapped and severely wounded. He was deeply disturbed over the drug problem in Vietnam. He told me, "It seems the Army is on one continual 'high.' When I was hurt I was taken to the hospital at Cam Ranh Bay. There were only ten G.I.'s in there for wounds, the rest were for drugs. I caught two patients shooting each other up and on this one day they searched and found 2,000 plastic heroin tubes on hospital property."

I also visited the psychiatric ward at Travis where two G.I.s were going through heroin detoxification. They had abstained from heroin use in Vietnam for five days to "beat the machine"—which they did. When they found that they had beat the machine they decided to celebrate on their last night before departing Vietnam by having a heroin party, in their own words, "one last blast." Fortunately their commanding officer suspected they were drug users and made them take another urinalysis test just prior to their takeoff for the States. When the test results returned "positive" for heroin the plane was already above the Pacific. The C.O. radioed Travis Air Force Base and the two troopers were apprehended when they disembarked from the plane. They were going through withdrawal and put in the base hospital.

A base psychiatrist and I woke up the addicts, a black, 21 year old who will be in the Air Force until 1975; and a white 23 year old Air Force sergeant who will be in until 1973. They were both from the same unit at Ben Hoa in Air Force supply on a restricted air base. In the words of the sergeant, "a guy on the base would buy heroin from Vietnamese military police who would bring in 200 heroin vials a week (which kept getting smaller.) The Vietnamese M.P.s had access to the base and the Air Force pusher would meet them and make the exchange. 200 bottles for $6 a bottle." They described their heroin party as "their last fix. Never touch it again." But when I asked, "How could you smoke this stuff—heroin?" One trooper blurted out, "It's easy, it's great, when you finish you chew the filter."

Lackland Air Force Base

"The Air Force started to give us massive doses of thorazine (a tranquilizer) in Vietnam because some of us were litter cases going through withdrawal. The doses were just too much. I passed out on the floor of the lavatory and on the flight back to the States there were two addicts who went into cardiac arrest and we had to make an emergency landing in the Philippines to save them."

"I tried the Air Force amnesty program in Vietnam three times. I would get detoxed, released, and told to return to my unit. But the first thing I did was go downtown and get a fix. Then I returned to my unit. The amnesty program was a joke."

Vietnamese troops in Laos would come up to our vehicles and press a thumb to their nose in a "snorting" fashion indicating to the American G.I., "Do you want some heroin?"

"Man, like my unit was in a less accessible area than these other dudes and I would take a helicopter trip twice a week to pick up 200 vials of heroin and bring it back to base. But like it was a friendship thing. Everyone was using and I did it because we were all in it together."

When I asked this Air Force corporal how much he paid for the heroin he replied, "$2.00 a tube." When I asked what he sold it for he said, "$5.00 a tube."

"Where are the rest of the addicts (at Lackland)? I know 400 users who went through before me and with me and I don't see but a few of them here. Where are the other 400?"

"On heroin you can do your job real good, man. On pot you get all messed up and can't function, but on heroin you can function."

"I was a heroin user for five years before I got into the Air Force. I was in some of the best treatment centers in New York and New Jersey. I was off drugs for a year before I joined the Air Force, but got hooked again in Vietnam. These doctors here don't know what they're doing. They don't understand drug addicts."

"We want to get home. We miss our parents and friends and the treatment people won't even let us call home with our own money."

An admitted heroin pusher-addict: "When I got grabbed into this program in Vietnam I didn't even have time to take care of my personal business. I had, you know, personal property, electronic equipment, bank accounts. I was forced to leave it all behind."

"Man, why do they always pick on pot smokers and heroin users. I worked at an Air Force Base in Vietnam, used heroin and did my job good. But some of those pilots were juicers man, and sometimes we had to carry them to the plane and dump them in the cockpit and practically point the plane down the runway."

REPORT OF HON. JOHN M. MURPHY TO THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON FORT BRAGG DRUG PROGRAM

Mr. Chairman, I have recently returned from an inspection of "operation awareness," the drug rehabilitation program at Ft. Bragg (the home of the 82nd Airborne Division and the United States Government's strategic reserve) and it is obvious to me that the army is no place for the rehabilitation of this country's addicted servicemen. Although this small operation consisting of only 8 personnel assigned to rehabilitation, counseling, education, treatment and narcotic enforcement, is handling the explosion of addicted troops including those stationed stateside and hooked Vietnam veterans estimated by the Pentagon to number over 30,000. Base officers told me that there are a minimum of 2,500 heroin addicts at Fort Bragg alone.

There was a consensus among command officials and treatment personnel that though this program has filled a temporary, stop-gap need, until a substantial program can be developed using all of the facilities the Federal Government has at hand, the problem of handling massive numbers of addicted G.I.'s will not be solved. I am convinced, however, that Ft. Bragg and other military bases should not have to divert their limited defense dollars and manpower resources which were earmarked to sustain our strategic reserve forces, for the treatment of drug abusers. Ft. Bragg's program, for example, is financed out of monies appropriated for defense functions. I was told that the educational materials used to wean G.I.s away from drug use were literally 'stolen' by army personnel.

In desperation, the managers of "operation awareness" finally asked the Nixon Administration for a minimum of $100,000 to operate the program—they got $31,000. This means that the doctors and therapists have still had to beg, borrow, and steal resources and supplies from other sources.

I am convinced that drug rehabilitation is totally incompatible with the role and mission of the United States army. The only people who enter the program at Ft. Bragg are those who are motivated by impending disciplinary action or who come into the program to taper off from an expensive drug habit. If the addict does not decide to get involved in treatment or has his habit tapered off he simply leaves the program—71 had already done this in the group of 558 that I studied.

The inability of the armed services to cope with the heroin problem and the devastating impact it has on our defense preparedness was emphasized when narcotic enforcement officers at Ft. Bragg told me that half a million dollars worth of military equipment was stolen from Ft. Bragg last year, much of which was exchanged for money in local pawn shops in Fayetteville, North Carolina.

With the cooperation of the state of North Carolina, the military police set up a monthly program to compare pawn tickets with lists of stolen government property. Although some of the property is retrieved by this, the money has already been spent to purchase dope.

Another major method of supporting high cost drug habits is the practice of many G.I.'s who go to Atlanta, Georgia, to purchase "three spoons" of high grade heroin which they cut with dilutants. They shoot up half of the drug themselves and sell the other half to addicts on the base.

The critical increase in the Bragg area drug traffic was pointed out to me by military police who told me that in 1968 in one six block area of Fayetteville, the military narcotic squad purchased three bindles (small containers) of heroin. In 1971, in the same area, they were offered a total of 10 pounds of the drug by pushers which ran as high as 7% pure. Drugs are sold right on the base. Enforcement officials claimed it is too profitable to stop the trade and frankly admitted it was beyond their control.

The problem cannot be entirely blamed on the Vietnam war. 60% of the patients have never been to Vietnam. 80% of the patients are enlistees, not draftees. Many of the records of these addicts indictae that they joined the Army to get away from problems they faced in civilian life. Their medical records indicate that the reasons for volunteering for the Army ranged from a desire to get away from a bad home situation to making a choice between a prison sentence or going into the service. I am convinced that we cannot let Army discipline and morale—and perhaps the Army itself—be destroyed by thousands of drug using dissidents.

Those that *did* get to Vietnam told me some harrowing stories of the drug abuser in combat. Five addicts told me of widespread Nam and Stateside drug use. One trooper (Lee Oswald) claimed he was "smashed on heroin for 365 days" in Nam in a combat unit (rifleman). He said he did not seek to engage the enemy, on the contrary, he avoided contact with the Viet Cong. One shakedown by officers in his unit turned up 16 kilos of pot, two satchel charge bags full of "jays" (marihuana cigarettes), obesitol, and maxitone forte, (speed) BTs (G.I. slang for bionctal, a barbiturate) and opium and heroin.

Two Puerto Rican addicts talked freely of "fragging officers who cracked down—or "hassled"—them over drug use. A trooper named "Speedy" Gonzales told me that he and his buddy fragged *two* captains in a grass hut—and a second Puerto Rican trooper told me his best friend fragged and killed his N.C.O. with a grenade over drugs. Speedy died once from an overdose and was brought back to life. All five agreed if you don't want to get off drugs "in your head" no one can make you—they laughed at the Nixon program of urinalysis and 7 days of withdrawal followed by 21 days of stateside treatment.

I was told by the medical officer in charge of the program of one combat rifleman—an addict—who described how his entire unit in Nam was hooked on heroin. When the dope "supply wagon" failed to show up at one period of time, the entire unit went into withdrawal.

I have described some of the effects of drugs on Ft. Bragg—stolen property, reduced efficiency, lowered morale, etc. One of the problems I am certain is that there has been no effort to crack down on the users for two years. The men know they have nothing to fear from military or civilian law. One E–5 told me he could stand on "Skag" Street in Fayetteville and buy all sorts of drugs in three minutes. Drugs are frequently used in off base "pads" where EMs live, and because there is no extra pay for off-base living, Bragg officers assume the money comes from dope. But it isn't too much different on the base. One jag officer (Captain H. A. Beale) told a member of my staff he could take him into any barracks and in one hour buy heroin, pot, LSD, pills, etc. This situation was confirmed by Counselor Wingblade from the addict intake house.

Mr. Chairman, the more I study the drug problem in the Armed Forces, the more I am convinced there is no room for addicts in a military setting.

Drug abusers at home and abroad should be tested over a thirty day period by qualified medical personnel and if they are determined to be heroin addicts or seriously habituated to other drugs, they should be immediately removed from the Armed Services via a physical disability discharge and turned over to the existing Federal programs for the treatment and rehabilitation of drug dependent persons under programs already established by the Department of HEW.

These ex-servicemen should be in a civil commitment rehabilitation program run by the Department of HEW, strictly controlled by the Attorney General so that they would remain under treatment for up to 42 months. This is the only reasonable approach to the G.I. drug addict. After a thorough briefing and study of the program at Ft. Bragg, I am convinced that the Army is not equipped organizationally or psychologically to handle the problem—nor do I think it is even desirable that it should be.

Mr. ROY. I want to thank the distinguished gentleman from New York, and I am pleased to find out that even if HEW has not been thinking about some of these problems that appear to be of great importance to me, that you have. And, that you have brought forth some answers for us. I have been greatly disturbed about what I felt was the military dumping addicts into our society without any provisions or any adequate provisions for treatment and continuing observations. Thank you very much.

Mr. MURPHY. You can ask Dr. Jaffe about the new figures which are considerably higher than the original figures on the urinanalysis machines.

My experiences with the men already in the Air Force, Army, and Navy facilities raised questions like: "Where are the others who were positive on the machine like we were and did not go into the program?" and, "How about the ones that abstained for 5 days from drugs, beat the machine, and went right back on drugs afterwards?" Those are some interesting questions for Dr. Jaffe.

Mr. ROGERS. Thank you so much.

The committee stands adjourned subject to the call of the Chair.

(Whereupon, at 1:32 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.)

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

MONDAY, AUGUST 2, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2318, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing our hearings on legislation to establish a Special Action Office of Drug Abuse Prevention and other measures proposed to handle the drug problem in our Nation.

We are very pleased today to have as our witness this morning Dr. Jerome H. Jaffe, who has returned to the committee after a trip to South Vietnam. Dr. Jaffe is the Special Consultant to the President for Narcotics and Dangerous Drugs. He is accompanied by Arthur F. Konopka, acting general counsel of the Office.

STATEMENT OF DR. JEROME H. JAFFE, SPECIAL CONSULTANT TO THE PRESIDENT FOR NARCOTICS AND DANGEROUS DRUGS, EXECUTIVE OFFICE OF THE PRESIDENT; ACCOMPANIED BY ARTHUR F. KONOPKA, ACTING GENERAL COUNSEL

Dr. JAFFE. Mr. Chairman and members of the subcommittee:

I am pleased to appear before the subcommittee again to testify on the Special Action Office which has been proposed by the President. It has been nearly 5 weeks since I came before you to testify on the administration's proposed bill, H.R. 9264. During this time I have been engaged in the development of a number of programs and objectives pursuant to the Executive order establishing the Special Action Office on an interim basis pending statutory authorization. This is a time for assessment and intensive planning. We are engaged in an in-depth study of existing resources and relationships, both within and among the concerned Federal agencies. Our concern is that programmatic and policy decisions be made on the basis of complete knowledge of the possibilities.

Since I last appeared there, I have also visited South Vietnam to look into the situation there with respect to the problem of drug dependence within the military. While in Vietnam, and following my return, I have been working directly with representatives of the Department of Defense and the component services to make necessary

adjustment to the screening, detoxification, and treatment system established there and now being implemented for the military in Europe and the United States. I will speak to you of those developments in more detail in a few moments.

In our last meeting questions were raised as to how the new office might operate. Perhaps I can be more elaborate in response to that question now. The Special Action Officer, under section 5(a) of S. 2097, will have policy control over all agencies operating research, education, training, treatment and rehabilitation programs. This policy control includes some programs in such agencies as the Departments of Defense, Agriculture, and Labor, though under sections 5(b) and 5(c), those programs will not be funded directly by the SAO. My office has already been in contact with all the appropriate agencies and is developing working relationships with them to insure a uniform coherent national policy on the programs for research, prevention, treatment, and rehabilitation. My office is developing close working relationships with the Departments of State, Treasury, and Justice. We have already talked extensively with officials of the Department of Justice and have the feeling with all of these Departments that we are gaining a mutual understanding of our problems and policies.

In addition to acquiring the policy control discussed immediately above, the Director, pursuant to section 5(b), would acquire the authority for budgetary and management control over 10 statutorily specified Federal activities. These activities are, generally speaking, the most important in the Federal drug abuse prevention program. They, therefore, represent the priority efforts over which the Special Action Offiice must exert its authority for direct management control. An interesting aspect of this style of management is that there will be many smaller and more specific drug abuse programs which will remain under the budgetary and management control of their agencies. SAO will not have the resources to attempt to control these activities, and in fact it may not be desirable to do so. These programs will represent a valuable potential for testing new concepts which may develop into important new ventures for the future.

The major programs over which SAO will assume management responsibility represent our largest and most important current drug abuse effort. The SAO authority is specifically intended to face up to the need for continuous evaluation of success or failure, and to make the difficult recommendations to the President on the best means of deploying our resources to achieve success. Unless we are willing to face this kind of hard choice, we will never be able to say we are fully meeting our responsibilities.

Thet Special Action Office is still in the earliest stages of its development and, thus, has not formulated the precise mechanisms by which budget and management control could be exercised. We can, however, discuss generally the ways in which the legislation authorizes the Director to do business.

1. POLICY DIRECTION

The Office of the Director will formulate and communicate policy for the drug abuse prevention programs of the Federal Government. I intend to formulate these policies in each separate sphere—treat-

ment, research, prevention, and education; in collaboration with the most knowledgeable consultation from inside and outside the Government that we can obtain. I intend to communicate policy by personal contacts with agency heads and program directors, through conferences where ideas can be freely exchanged as well as more formal policy directives. Some policies enunciated in this fashion will treat the entire drug abuse area, others will be directed toward specific activities.

2. BUDGETARY AND FISCAL MANAGEMENT

The fiscal authorities provide a necessary tool for integrating programs and implementing decisions. These mechanisms can be seen as operating in the following fashion:

The presentation of substantive program authorization requests to Congress: The agencies requesting such authorizations would be required to submit these through the Special Action Office. This would allow the Director both to establish priorities and insure coordination within the overall Federal drug abuse prevention program. It would also permit the Director to present the committees of Congress substantive authorization requests in the context of the overall Federal drug abuse prevention program.

The presentation of appropriation requests: The Director would present a request for appropriations to the programs identified by statute in this bill. This again would afford the opportunity for a greater overview of the Government's efforts in the drug abuse prevention area.

The allocation of appropriated funds during the fiscal year: The Director would allocate to the agencies their funds and assure through sound fiscal management practices that these funds are used as intended. This control of funds, coupled with the Director's authority to modify and transfer programs, would allow him to insure the coordination and efficiency for which he is responsible.

3. REGULAR PROGRAM FEEDBACK SYSTEMS FOR REVIEW BY THE SPECIAL ACTION OFFICE

Through the establishment of reporting mechanisms, the Special Action Office would be kept currently informed of the status of actions being taken under various programs. The requirement to report is itself often a useful management tool for accomplishing compliance. In addition, with accurate performance data, it will be possible for the Director to offer guidance and exercise control at the points where they are most needed.

4. CONTRACTS AND AGREEMENTS WITH FEDERAL AGENCIES

The Special Action Office would have the authority to contract with the Federal agencies for particular tasks and programs to be performed according to such specific performance criteria as agreed upon in the contract. This would allow the Director to clearly establish the desired results of a program, and it would give agencies clear objectives against which to operate their programs.

5. CONTRACTS AND GRANTS

The Special Action Office will have full authority to award contracts and grants for drug abuse programs. While I do not envision operating programs out of the Special Action Office, the authority to do so exists, and that will be done should evaluation of existing programs and performance warrant such actions.

At present, the Special Action Office is operating without the benefit of the full range of authorities provided in the bill, and thus without the full range of management mechanisms delineated above. Nevertheless, I can report to you on the progress we are making.

We are engaged in the planning of a national treatment strategy for drug abuse. Its goal is to increase the capacity of health care systems to treat those addicted to dangerous drugs. Subsumed under this objective are several priorities, including the prevention of antisocial behavior and of the morbidity so often associated with drug abuse. Also included is emphasis on improving family relations, job skills, and education among the patient population. Rapid increases in the number of trained personnel available to staff and administer treatment programs are essential if we are to succeed. Training has, therefore, become one of our highest priorities. We are already at work on the planning for a national training center for drug abuse prevention, where individuals from diverse disciplines can come for intensive study in the treatment, education, management, and community organization aspects of the drug problem. It is conceived as a center of excellence to which eminent authorities will come as visiting faculty. Courses of study—variable in length from several days to several months—will include exposure to various ongoing therapeutic programs to assure experiential as well as intellectual learning.

We are also exploring research on new and better therapeutic agents, long-acting narcotic antagonists, alternatives to methadone. At the same time we are aware of the need to refine the safeguards to diminish the potential for abuse of these substances.

We are exploring the possibility of introducing several new concepts in prevention in order to make inroads into the contagion of addiction and drug abuse. New to drug abuse, that is, for many of these concepts have a long tradition in public health primary prevention. The use of information and educational materials is a fertile field for serious research into the efficacy of different techniques. The value of each film or flyer as a preventive device must be weighed against the possibility that repeated exposure to inappropriate materials may produce the opposite of the desired effect. The answer, thus far, is that we don't know what works best, but we are considering several possibilities for rapid empirical research on this question. We are also considering the viability of secondary prevention—intervention in the contagion of drug abuse by skilled teams based on sensitive epidemiologic indicators. Here, for example, a first reportage by a physician of intravenous amphetamine use in a school or community would bring immediate action by trained teams before the phenomenon can spread or become firmly established. Perhaps some day in the not too distant future this possibility will exist for the communities of America.

These are but some of the lines along which we have been working. Simultaneously, we have been facing the rigorous tasks of any new office in organizing management systems, finding staff with unique qualifications, and, in general, orienting ourselves to the job ahead.

I would like to turn my attention now to the situation with our troops, as I observed it, during my trip to Southeast Asia. Much of what I saw was quite impressive. Due to the excellent working relationship established with DOD prior to and during this trip, significant progress has been made. Facilities have been built, screening procedures implemented, laboratories established all in a very short time. Specifically, on June 18 we launched a urinalysis screening procedure which as of July 30 had tested somewhat over 41,800 Department servicemen. Of these, 2,275, or 5.44 percent, had drug positive urines for opiates on our most sensitive test.

This screening process serves not only as a means of identification and quarantine, but it is also the first key step to treatment and, ultimately, to prevention. All servicemen scheduled to leave Vietnam are now having their urine tested for the presence of heroin at least 2 days prior to departure. If the test is negative there is no delay, and the serviceman returns home. If positive, he remains in Vietnam at a specifically developed detoxification facility for up to 7 days prior to transfer to facilities in the United States for further evaluation and further treatment if needed. In doing this, we are attempting to protect two groups: The citizens and the communities, who would be jeopardized if these men returned untreated, needing large amounts of money to maintain their drug use. And equally important, we are concerned about the young men, who in an exotic environment may have chosen to experiment or become involved with heroin, who upon their return to the United States would come in contact with stringent penalties and a far greater expense to supply their daily drug needs. Screening procedures also serve as a useful preventive measure in letting men know that their drug use can be identified. We are aware that some men who are mild or occasional users have stopped using a few days prior to leaving. But these discretionary users do not have as serious a problem as those who are severely dependent.

We are presently making plans to thicken the detection screen to make it even more effective. Soon to be implemented is a plan to move the testing procedures in Vietnam back to a point further than 2 days prior to departure; the screening process already in effect. That does not mean we are going to drop the 2-day screening, but add an additional step to it. The implication of this is that to depart on time, a serviceman will have remained drug free for 4 weeks prior to his arrival in the United States. This, we feel, will afford them better protection from the consequences of addiction and will also be a more significant barrier to contagion. Urine testing is now being conducted on an anonymous random sample basis in all military commands in Southeast Asia, Europe, and the United States. We feel that as men realize the likelihood of being detected fewer will be inclined to experiment. For those men who do use and who are unable to exercise discretionary control over their use prior to departure, and who are, therefore, identified, detoxification facilities were established at the same time as the screening procedures. The full development of treatment facilities, however, is a far more ambitious task than the establishment of laboratories.

To this end, we are working with the Department of Defense to utilize and coordinate existing trained manpower in both the civilian and military population in a massive training effort so that sufficient manpower will exist on site in Vietnam and that facilities in the United States and Europe will be better able to provide adequate treatment for servicemen with drug dependence problems. I have discussed our plans with Secretary Laird, and my staff has been working with Assistant Secretary Kelley, who has DOD responsibility in this area.

I should like to emphasize again that many caveats must be observed in interpreting the information we are now obtaining from Vietnam. First, these figures continue to change as we test men coming from different units and as the proportions of men in the various services shift. In addition, we have recently increased the sensitivity of the detection system so as to increase the time over which drug use can be detected. Furthermore, we have no way of knowing at this time how many of these men are occasional users and how many are markedly dependent. We are constantly increasing our efforts to motivate men to enter treatment. Enforcement procedures to decrease the availability are also in effect.

There are still other complex factors that we believe may cause variability in our estimates over time, and I would be happy to elaborate on these later. In summary, we feel that the urine tests are providing better estimates of the size of the problem than we had previously, but we believe that it will be several more weeks before we can obtain a fairly reliable estimate.

Our relationship with the Department of Defense has been positive. Since last week one of my colleagues has been in Vietnam providing technical assistance to the laboratory personnel there so that fair and accurate procedures could be maintained. We are receiving on a regular basis from the command in Vietnam through the Department of Defense the data we have requested on treatment, detoxification, and identification facilities. The same information is being developed for other U.S. military commands around the world. In my discussions with the Secretary of Defense he has repeatedly affirmed his support of these efforts and his willingness to take whatever measures are necessary to see that the programs we are developing together move forward as rapidly as possible. We are determined to do more than merely treat the military as an isolated problem. In large measure the present military drug problem is a reflection of the problem in society at large—albeit compounded by the specific circumstances in Vietnam.

I have concentrated on the situation in South Vietnam, Mr. Chairman, because I believe that events there can have serious impact on our domestic scene, and also because I think we can learn much of broader use by studying the somewhat more controlled military drug situation.

One of the great advantages of the Special Action Office will be its ability to transfer knowledge between previously insulated agencies. The President commented to me in San Clemente that there are many previous instances where the knowledge gained from military medicine has been beneficial to society as a whole. He is committed to the proposition that we can gain knowledge from the treatment of the military drug problem which will enable us to better deal with drug

abuse in society as a whole. To this end our systems analysts are working with the systems analysis staff of DOD to develop a scientific analysis of the military drug abuse problem and an evaluation of the effectiveness of DOD drug programs.

Certainly drug abuse in the military and in society as a whole represents a serious danger to this Nation. Yet, by candidly addressing this problem and by using the unique characteristics of the military as a sample population, we have an opportunity to gain valuable insights which will make us better able to deal with the problem in civilian society. Again, the military have been extremely cooperative in this matter and the day may not be too distant when I will be able to recommend to my civilian colleagues that they examine DOD drug programs and learn from them.

In my previous testimony I was asked whether the authority for SAO should include direct budget control over DOD drug abuse activities. I believe that my recent DOD relationships have tended to confirm my judgment that such a move would not be useful. The policy authority I would exercise would permit me to come to grips with the essential problems of the military drug abuse scene and its relationship to the domestic situation. I have seen how the military apparatus to combat drug addiction is an integral part of the regular combat and support establishment, not easily separable from its more purely military role, especially in the combat zone. It is difficult to identify the statutory authority for drug abuse work except the basic authority of the Military Establishment itself. There is no alternative to the use of this military capability. I cannot and would not attempt to assume any operational responsibility for those activities. I believe that the key people in DOD recognize the need for central policy guidance both on how best to develop the drug response systems within DOD, and its crucial relationships to our domestic environment. As of now, Mr. Chairman, I believe that the policy authority which H.R. 9264 would give me and the authority of the President, as Commander in Chief, are fully adequate for the task.

Thus, in our relations with other agencies, we are finding that the concepts of H.R. 9264 are viable and effective.

We do not—at least we hope not—intend to become just another layer of bureaucracy. We are getting involved not only in the setting of policy but also in the budgetary process—the key to effective control. We intend to use our budgetary authority to require performance standards and to motivate the separate agencies to work together in a coherent and efficient manner. And through the agencies we hope to improve the standards of the programs that are delivering services to the citizens. We intend to develop a unified response to a national problem.

Yet at present we are constrained by the lack of the full authority that would be provided by the bill before you. We will soon reach a plateau of effectiveness beyond which we cannot legally proceed. For this reason I urge that you act at the earliest possible date to set up the Special Action Office for Drug Abuse Prevention, as provided in H.R. 9264.

Mr. ROGERS. Thank you very much, Dr. Jaffe. We appreciate your testimony.

Mr. Preyer?

Mr. PREYER. Thank you, Dr. Jaffe. You have given us a lot of testimony on your ideas as to how to manage the problem and how to organize it. I will leave those questions to the gentleman on the subcommittee, Mr. Symington, who has had much more experience on that than I have.

I was interested in your South Vietnam trip. First I commend you on your plan for thickening the testing procedure. When I first read of the 2-day provision, it did seem to me that that wasn't enough where you have a strong incentive—in 2 days you go home if you pass, and if you flunk you stay in Vietnam. That is pretty powerful, and I could see how a lot of people could dry themselves out temporarily. As I see it now, you will test 2 days before you go home and then you would test—what is the earliest date, a month before?

Dr. JAFFE. The logistics of this are rather difficult. Ideally, we would like to test 7 days, 10 days, 30 days. That is the period during which men are shifting rapidly from unit to unit in preparation for returning home, so we have to talk to the command about how we can be certain to get the men who are going to go home 30 days before. The issues have to do with the fact that no matter how much we attempt to persuade men that punitive action will not be taken, they are convinced that it is always better not to come up with a positive urine unless you are absolutely forced to, and that means we have to ascertain at which locations we can obtain a specimen that really belongs to the man.

So we can say that it is going to be thickened, and we can say that it will be perhaps 30 days before, but the precise days, and precisely where, are still trying to be developed.

Mr. PREYER. But do you think you would be able to guarantee in every instance at least two tests?

Dr. JAFFE. Two or more. That doesn't end it. The plan envisions continually testing. So we will be testing 6 months before. Once we get those people into treatment, we will then follow the users every week for almost the next 2 months.

Now, the logistical problems of getting the urine specimens, obtaining them and delivering them, are formidable. These are things that really require a lot. It is almost like a campaign. You have to send out helicopters, literally, to fire bases to get them. You have to have officers involved who supervise them. Enlisted men are reluctant to obtain a urine specimen from a buddy if they think that in any way will be detrimental to him. Problems of communications and trust are involved here.

I say we can lay out the plan ideally and then say what is feasible under the conditions that exist.

Mr. PREYER. You would still continue your random samples obtained?

Dr. JAFFE. Random samples are primarily to give us a handle on what is the size of the problem rather than identifying specific individuals. It is almost a separate statistical operation.

Yes, we would continue those.

Mr. PREYER. You mentioned the logistical problem of trying to identify these people where you have shifting troops. Since we are attempting to bring combat to an end and bring our troops home, that question occurred to me in connection with two other statements

you made. One, when you say you don't want any sort of operational control over DOD, you put it pretty heavily on the basis that we should not meddle in a combat operation, which I would agree with; but if we are rapidly bringing the combat part of it to a close, do you think the same reasoning applies to it?

Dr. JAFFE. To a large extent; yes. Let me give you an example. If there is a unit 200 miles away from where we are collecting urine, at the present time simply by saying, "Get those specimens and get them here 30 days before. We need that," somehow the commanders make it happen.

I would have to review the budget and say I don't know how much a helicopter costs or what it takes to man it and how to get it in there and how to make sure it gets in there safely. Right now that is handled by command and I am not sure it is cost accounted.

It is an issue of transporting specimens that have been adequately supervised back to a laboratory so we can identify people.

These are rather complex issues which get into almost a total understanding of a military operation. I would wonder whether or not we would have our own drug abuse helicopters, or do we borrow them from the command. If we borrow them from command, don't we have to know whether they would be needed for other preparedness?

These are the kinds of things you get into. Somebody could say, "If we leave those go, how do you respond if there is a crisis if they are out collecting urine?" These are command decisions, as I understand them and as I saw them there. I would not want to take the responsibility at this point to do either; to detach military personnel from their assigned duties to get involved in drug abuse.

On the other hand, I think the costs of replicating that system and getting your own staff and your own special vehicles to do this would be absolutely exhorbitant and would deplete the kinds of resources that I would like to see best deployed in the civilian end of things.

Mr. PREYER. To shift just for a moment, you say that your latest screening tests, which were July 30, showed 5.44 percent had drug-positive urines on a most sensitive test. Do you have a benchmark that you could measure that against? For example, what was the percentage figure a year ago? Was it 2 percent or was it 3 percent?

Dr. JAFFE. Unfortunately, there was no benchmark figure. There were no figures on urine tests prior to this initiative on June 18. What we did have were some questionnaires carried out theoretically anonymously. Hopefully, they gave us some honest answers. They were carried out by the Army in April and May on a random sample of men both in replacement battalions and even field units and carried out on men below the rank of E–5, or E–5 or below. That was the group thought to be most susceptible.

Mr. PREYER. Assuming that was not as scientifically valid as this, what sort of percentage figure did that show?

Dr. JAFFE. It indicated with respect to opiates—and again based on this rank group—about 5 percent were estimated to be using opiates on a regular basis.

Now, I might point out that was Army and of a particular rank. To get an estimate of what percentage of the entire command, which

would be comparable to the data we are getting, since we are getting on everybody now, you would have to dilute the Army figures by adding in a percentage of the officer corps, as we know officers use these close to zero. Then you would have to dilute the Army figure by the Air Force and Navy, which are data which are now considerably lower. So one would say in April and May our best estimates would be in the, perhaps, 3 percent mark of regular use.

The estimates of people who have used it one time or higher, 10 or 12 percent, is not surprising. In fact availability in some neighborhoods of the United States, sociological studies have indicated that in many neighborhoods the number of young men who had tried heroin on an occasion was considerably higher than 10 percent.

So, again looking at an occasional user versus somebody who is more of a regular user, these are reasonable figures.

Our figures on urine testing, of course, don't make that distinction. It will only tell whether somebody has opiate in his urine at the point where he is about to leave.

Mr. PREYER. On your urine tests, on July 30, it was 5.44 percent. Do you have the figures as to what it was on June 30 and May 30 and April 30?

Dr. JAFFE. Yes. What happened—and it is an interesting phenomenon we had predicted—is that with the advent of urine testing the first few days we had two factors working simultaneously, and a third factor which is unfortunate, which is that you don't suddenly develop 20 supremely trained lab technicians in the middle of Vietnam. So there was a technological problem with people learning their equipment.

But what we suspected was that the number of people we saw the first day or so—and this could affect those people for 4 or 5 days—went from about 7 percent quickly over a period of 10 days down to 5 percent. This was on June 18, because most people were suspected——

Mr. PREYER. On June 18 it was 3 percent?

Mr. JAFFE. No, closer to 7 or 8 for a day or 2 days and then it slid down.

Mr. PREYER. When did you begin this testing?

Mr. JAFFE. June 18 at Long Binh and June 19 at Camranh Bay.

Mr. PREYER. It begin at 7 percent and quickly went down to what you think was a realistic figure of 3 percent?

Mr. JAFFE. Down to 3.2 percent, and then it flucuated. Then it began to creep back up again as people realized we meant business. We weren't out to cut off any heads and we are going to treat them like human beings. The panic of cold turkey or hiding urines or bribing people perhaps decreased.

We think the figures we have been getting from, say, July 1 are, perhaps, going to be representative of what we can achieve before we institute further treatment, screening, and so forth, until we get the entire range of incentives and options functioning. We do think that what has been happening from about the beginning of July to present is a reasonable estimate of the size of our problem.

Mr. PREYER. We have heard wide-ranging estimates on it, and it seems to me what you are saying is that we really haven't had any solid testing procedures up until June. Only recently are we really beginning to find out. Even from your explanation of those figures

it makes me believe the old statement that while figures don't always lie, they seldom voluntarily tell the truth, because there is no explanation of one of them there.

Mr. JAFFE. I have the opportunity to go for all of the data and see what makes the most reasonable interpretation. We have many bits of information, and it is not just the information from this urine screening. It is the information from what happened when General Cushon closed down four corps and the number of people that came forward. It was the information we got from those two questionnaires carried out by the Army again on only enlisted men. We tried to put all of this together and tried to come up with some estimate of the size of the problem.

The problem is not the man who, out of curiosity uses it once, but the man who looks as though he is not going to stop on his own.

Mr. PREYER. I appreciate your answers on that. We heard some other figures last Friday, I believe, tending to show that this percentage, the 5.44, represents a very rapid increase over what it would have been a year ago. I think we would be interested in following your month-by-month figures from now on to see whether that is going up.

Mr. JAFFE. Without question, Mr. Congressman, everyone believes that heroin was largely a nonproblem about a year ago; that suddenly it appeared; the availability was there, and useful. But this is true of many, many neighborhoods in many parts of the country where suddenly there is no use. You could pick out a suburb in the United States where the same thing was true; that in certain suburbs one could never obtain heroin and it wasn't there. And suddenly it appears and a few people begin to use it and it spreads like an epidemic.

We have have seen these happen repeatedly, not just in Vietnam but here in this country. It does have an epidemic quality.

Again, we also will be interested in following these figures, because these begin to give us some measure against which we can gage the effectiveness of the various procedures we institute to treat, to prevent relapse, to discourage use in the first place.

Mr. PREYER. Thank you. Dr. Jaffe.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

Dr. Jaffe, it is good to see you again, and I think this is a very excellent statement. We have had hopes and aspirations which I hope we can see fulfilled.

I wonder if I am justified to detect a change in emphasis of the thrust of your office from your last statement to us; that is to say, your previous appearance here.

At that time I think we covered some of the ground as to whether you would be a coordinator or you would get into operations, and you said you most certainly will not get into operations.

I seem to recall your feeling that you would get bogged down with limited personnel, and you possibly couldn't get into the operations. Maybe I am having semantic difficulty, but on page 3 of your statement here you distinguish between what you will do with respect to small and specific drug abuse programs. You say SAO will not have the resources to attempt to control these activities, the inference being that you will control activities in the larger programs. In fact, you

subsequently state: "The major programs over which SAO will assume management responsibility represents the largest effort."

How does one assume management responsibility without getting into operations?

Dr. JAFFE. There is a semanic problem. Perhaps I can clarify it. These are programs operated by various agencies for which there is no specific authorization in statute. For example, Agriculture has a 4-H program. The Department of Labor has the Job Corps. All of these have drug programs.

We can in fact talk about general policy, but we will not be directly responsible for them; we will not in fact review their budget; we would not, in the final analysis, assume responsibility. In effect, if you don't have this, you can't assume responsibility.

For those other programs which are authorized by specific statute, we will in fact review the budgets, see if we can get them working together in concert and present a unified budget to Congress which is the way it should be.

Actually, the process is much more elaborate, as you know, before things get to Congress. Butt he fact is that we will have responsibility and authority. The responsibility is to see that that money is well spent, that those programs are developed, and in the final analysis, and only as an absolute desperate resort, we would take one of those programs and begin to operate it ourselves. But that is finally the court of last resort when we have the responsibility for seeing that things get well done to take on that operation, or to make a grant, or to make a direct contract. So that nothing has changed. The procedures and the policies and the style of operation is still as we directed it.

There are agencies and statutory authorities over which we have responsibility both for policy and for the management, meaning how well it is spent, and for those as a court of last resort we might have to write our own grants.

There are others which we would try to make policy over, but which cannot be disentangled from the operations of the departments. I have given you some examples, and we can give you others, such as the model cities program of Housing and Urban Development, and there are probably still others that we would go into.

Mr. SYMINGTON. Do you mean the model cities has a drug——

Dr. JAFFE. But there is no specific statutory way that can be separated out and, therefore, that is budget which we will not review and which we will not try to synthesize and present.

Mr. SYMINGTON. Is that what you would call a smaller and more specific drug program?

Dr. JAFFE. We assume they are smaller. That is not the main thrust of model cities.

Mr. SYMINGTON. You say they will present a valuable potential for testing new concepts. What will bring them to your attention, inasmuch as you are not giving them the overview that you are giving others?

Dr. JAFFE. The fact that we will not review budget does not mean we will be unaware of what things are transpiring. I assume that as we begin the development of review programs, programs will come to our attention that don't take any Federal money at all. These just happen to be Federal programs we will not have budgetary au-

thority for. I think it is no secret that many of the good things that have been developed over the last few years have not necessarily arisen out of federally funded programs. Some of the self-help programs, for example, arose quite independently of Federal support.

Mr. SYMINGTON. I believe we could give an example of that from our trip to New Orleans where we saw, I believe it was, a methadone center, very small, but which dealt with about 90 people in the community who are known on a first-name basis with the people that operated the centers and worked very well because it has a high morale factor among those people.

Dr. JAFFE. We have to look at the full historical context; that medical care has, at least over the first half of this century, been largely a responsibility of communities and States and not the Federal Government. But people do develop programs on their own.

Mr. SYMINGTON. We would hope that the information on such small programs would come to our attention, because there might be some interesting breakthroughs made possible by it.

Dr. JAFFE. I think we would be irresponsible if we did not create a mechanism about everything that is being done, even if we don't put money into it.

Mr. SYMINGTON. I have another question that perhaps counsel can help with. I have really been wrestling with this since the last time we met. In the general context of wanting the law enforcement community to handle its mission with the proper coordination with the highest state of the art of rehabilitation and sensitivity, I look at page 5 of the bill, section 5, subsection C–1, paragraph D, where it refers on the middle of page 5 to the Comprehensive Drug Abuse Prevention and Control Act of 1970, section 502(a)(1). Do you see that there?

Dr. JAFFE. Yes.

Mr. SYMINGTON. Whatever is provided in that section that is covered by your authority escapes me on reading the section, because what our new bill provides is that you will control the authority of 502(a)(1) to the extent that it pertains to public education not involving law enforcement. But if you read 502(a)(1) it states: "educational and training programs on drug abuse and controlled substances—law enforcement for local, State and Federal personnel."

It wouldn't seem that there is any part of that subsection that relates to public education distinct from law enforcement. I am wondering if perhaps there has been an amendment to that section that I don't know about. Does counsel have any comment to make?

Am I failing to see something that is in there?

Mr. KONOPKA. I can't give you an answer on that right now. I haven't that material with me. There may have been an amendment. It has happened with these in a number of instances in these sections enumerated, and there have been statutes and the USCA haven't picked them up yet.

Mr. SYMINGTON. I am sure it is a very meritorious idea to insist on public education that doesn't involve law enforcement, but I would hope that we can get to these local, State, and Federal personnel that are engaged in law enforcement and have some input in their attitude.

I appeared before 500 or so law enforcement officers in St. Louis County some months ago to try to explain the latest changes in the law regarding marihuana and some of the other drugs. I must say they were not very pleased with the changes. They didn't understand them. They

evinced a clear lack of communication with anybody who has anything else to do except law enforcement.

If we are going to make progress here, I think some cross-fertilization is definitely required.

Dr. JAFFE. One probability—and it is only a probability—is that if we create a national excellence center, some of the officers might rotate through there as part of their training. Certainly, we can't train them to make their case or do undercover work; they can learn some aspects of pharmacology and treatment and broaden their own backgrounds.

If that model turns out to be a good one, other training centers in other parts of the country might be able to be linked up with the local law enforcement people who can learn part of their background at those centers so we could begin to share a common heritage, if you will, of what is known about the field.

Others in training would go on later to learn technology in that area as law enforcement went on to learn more about their specific responsibilities. There is the kind of thing that requires negotiation, good will and cooperation, and you can't force them to learn.

Mr. SYMINGTON. I understand. I am now informed that 502(a)(1) has not been amended since its enactment. I would suggest that counsel look over that section of that provision, because it might be they were attempting to provide some authority to the specific action office and missed the section they were looking for. Even subsection 2 would be an interesting one for your authority in it. In it the AG has authorized to fund studies or specific projects designed to compare the deterrent effects of various law enforcement strategies on drug abuse.

That is really getting to the nub of things. I would like to see that in the bill. I am not familiar with all of the AG's authority for public education or any other kind, but we might take a look and see if there isn't something else that it would incorporate into your bill that would give it a little more meat.

Dr. JAFFE. It is my understanding that the intent of this bill is, to the extent that law enforcement in general at the Federal level participates in public education, that public education shall be consonant with the kind of public education presented by the Office of Education.

So the Federal level will speak with a more sensible, rational voice.

Mr. SYMINGTON. I understand that, and I think that is a worthy objective. I don't think it is met by the section that appears to be addressed to it.

Dr. JAFFE. We appreciate you pointing it out, and we will look into it.

Mr. SYMINGTON. I do hope that your expressed intent to work closely with law enforcement personnel and to acquaint them with your policies and your philosophies is carried out.

Dr. JAFFE. We could report some progress in that area that is at least in the early stages. Law enforcement people from the Department of Justice did meet with people from AMA, from our office and other groups around the country, to discuss the sensible regulation of methadone, for example.

Mr. SYMINGTON. That is true, but I think you will have to reach an awful lot of sergeants and patrolmen and detectives on the beat in small enough groups so they can tell you what bothers them in a way

that you can go out in the community with an effective and solid grant.

Dr. JAFFE. I would like to see that happen, but I can say at this point I am optimistic.

Mr. SYMINGTON. Thank you very much.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. I notice your statement on page 12 states you have departed from the fiscal control that was originally included in your bill. Do you feel that in doing this you may have lost some of the muscle you need to do a job of setting policy? Is there a possibility that the agencies might not buy your policy if you have no control on their purse?

Dr. JAFFE. I think that without policy control only, you are rather impotent to get a job done. With fiscal authority you have a better chance, but the realities are that you have to be prepared to get down and really push to get things done.

The only areas we don't have fiscal control over are those areas where there is no specific statutory authority to get the job done. It is very hard to say this is the piece that we now control.

The Department of Defense is one of those areas.

Again, there is both the problem there is no specific statutory authority for them to treat drug abuse and the fact that their operations are such that they are almost inextricably intertwined with heir miliary operations. There we can only hope that we can keep our relationships with the Secretary of Defense sufficiently warm, sufficiently cooperative and congenial that he will use his influence to see that policies that make sense are implemented in a timely fashion.

Mr. NELSEN. There seemed to be quite a storm about your fiscal control from other agencies, and it might be that your position is a wise one. Why do you find the addiction such a problem in the military? I understand it hasn't been as bad as reported, but it is still bad.

Dr. JAFFE. Yes; it is.

Mr. NELSEN. What seems to be the reason for that? Certainly the men in the service are aware of the risk to their own physical makeup by it. How do you figure it out?

Dr. JAFFE. Well, there are three major factors. First, I think we should point out that the group that is in the military at present is the group that in the United States, if there were no military, would be the highest risk. The 18- to 22-year-old male is the group that generally has had the highest addiction rates. Certainly that is the case in New York. It is the case in most places.

Furthermore, the group that is generally in the service at this point tend to be somewhat skewed. So we not only have the highest age groups in terms of sex, but in terms of socioeconomic groups there is a skewing that will increase the possibility.

Now, let us look at several other factors which are equally important. When this first began, the men did not realize in some instances that they could become dependent. They thought it was cocaine they were using. Second, they thought if you snorted or smoked this drug you would not become dependent. Their notion of addiction was something you did with a needle, and only 5 or 6 percent are using needles over there. Ninety-five percent think there is no problem, and we could

talk about the most critical issue which is, perhaps, availability. The other thing is that they thought it couldn't be detected.

So heroin was an opportunity to do something which was secret and which was fun and which was in direct defiance of authority, which they don't tolerate well, and do it with impunity.

Now, the one thing we have done with the urine test is to say that you can't do it with impunity. But there are other factors there.

Mr. NELSEN. What about the claim that high military people in South Vietnam have been involved in heroin distribution? Did you find any evidence of this?

Dr. JAFFE. First of all, I am not an attorney. I wouldn't know what evidence was if I stumbled into it, what is admissible, what is real evidence.

Certainly, I heard only the rumors that everyone else has heard, and I am not really competent to say what is a rumor and what can be substantiated.

Mr. NELSEN. I think you are wise.

One of the members appeared before our committee, and he seemed to be of the opinion that if heroin was made available under proper controls to a known addict, treatment could be continued with the use of heroin and gradually phase him out. Also, there was a feeling that medical advice indicates methadone has its risks and that there have been no known reports that would indicate that its use is totally safe. Have you any view on that?

Dr. JAFFE. Well, I have been to England, and I have been in a long series of correspondence with colleagues there. I think it is important to distinguish between methadone maintenance and heroin maintenance as they now have it in England and begin to be very specific about what we are envisioning. If we are going to talk about giving people heroin intravenously, which is what they have in England, then you have a situation which is not really contrary to most people's use. When you use pure British heroin from various pharmacies, you have people who use it intravenously, and they do die of overdoses and they do give themselves infections.

They range from being on the nod at times, because they take a little too much, to being a little too sick to be productive because they have used it up before the next day's supply comes.

Second, the heroin is such that you have to give them some to take home or they would have to live near the neighborhood clinic, which is not good for the neighborhood clinics.

Now, the only thing you do accomplish in keeping the price low enough is that heroin users do not become a tremendous deterrent to the community. But with respect to the individuals themselves, this is certainly only a sort of a stopgap measure.

In contrast, when you use a drug, a synthetic drug, such as methadone, you do insist that it is given orally. That is No. 1. When it is given orally, people do function. They do hold jobs. Their need for heroin itself, which is then maintained, as an illicit drug goes down. They seem less motivated to seek it out.

Furthermore, there are ways to increase the dose of methadone so that they don't even feel the effects of heroin. Now, they don't inject themselves and don't get hepatitis and don't take overdoses. They are, of course, dependent upon methadone, and this is the disadvantage.

This is quite important, since the drug lasts long enough that you can have people come back every day and ingest it under direct observation, and no drugs need go out into the community. So you begin to have a greater safeguard for the community. This is important.

Now, at the same time there are people—and one must admit it—who are not interested in methadone. They are intent on using heroin. This is a problem to be faced honestly and candidly. What shall we do with that group?

We have heard arguments from people in Congress and people in the communities who say that those people who won't accept treatment with methadone should be civilly committed—treatment whether they want it or not.

There are other arguments which say that people who don't want to be treated with methadone should be treated with heroin. That creates difficulties, of course, because it is difficult to control. Once you give people heroin, what do they do with it? Do they turn on their friends?

If we really had to set higher priorities, how can we reduce the number of new users, or how can we reduce the number of new people dependent?

I think that consideration of that concept of giving people heroin to use as a treatment is far down the line of consideration. We are far from making methadone available to those who want it.

Mr. NELSEN. Thank you very much.

Dr. JAFFE. I am sorry to take so long. It is a complex issue.

Mr. ROGERS. Dr. Roy?

Mr. ROY. Thank you, Mr. Chairman.

Thank you for coming back to see us, Dr. Jaffe, and I appreciate your report. I don't want to take you back into what seems to be the distant past, but I do want to know about the Illinois drug abuse program you supervised. Over what period of time did you supervise the program?

Dr. JAFFE. The program was created by the Narcotics Advisory Council sometime in 1966, and it was submitted to the legislature by the State of Illinois some time in the spring of 1967. It was passed sometime in July, signed by the Governor sometime in the late fall of 1967; and although I was the consultant, I didn't become an official member of the operating team until sometime in February of 1968.

It took some time to build staff. There were some civil service problems, since there had never been any addiction specialists, and they didn't know the status of this. We had some problems in getting tooled up. I might point out that things are much better here at the Federal level.

So, in effect, I supervised the operation of the program from January 1, 1968, which we considered the starting date, the date when we first began to treat patients, until effective as of July 1 of this year. So that is 3½ years. We planned it for a period of time prior to that.

Mr. ROY. How many patients did you treat over that period of time?

Dr. JAFFE. I think the number of patients treated perhaps exceeded 4,000. At this point in time, there are perhaps 2,100 people in treatment. In other words, that is the treatment capacity of the system, with perhaps 28 to 30 functional facilities spread across the State.

Mr. ROY. Of the difference between 2,100 and 4,000, what happened to those individuals; do you know?

Dr. JAFFE. Well, some were called to meet their Maker. There is a problem of treating people. Another group——

Mr. ROY. How many of the 1,900?

Dr. JAFFE. Well, remember that our program made no selections whatsoever. We took in everyone who came to the door. That sometimes meant taking in people who were in the last stages of tuberculosis and grade 4 cardiac failure who, after we got them treated, went into open heart surgery; some of them got well, and some of them did not.

So you do have that kind of attrition rate, taking in, again, all comers, some having left us for sojourn within the barred facilities of prisons, both Federal and State. Some have simply graduated.

A number of people passing through this system have completed treatment and are off following their own life careers in various parts of the United States. We have people living in Florida, people in Boston, people in San Francisco, people in San Diego. I can name more towns. There are people in Detroit and East St. Louis.

Then there are the inevitable failures. When you take in everybody, you don't do so well.

So I would say one-third of those people have simply dropped out of treatment and are doing poorly. The other groups are doing well or not doing anything at all.

Mr. ROY. Of the 4,000, how many were placed on a methadone maintenance program?

Dr. JAFFE. I would suppose perhaps—and I can only give you a very rough idea—that at any given time, perhaps 80 percent of the total had been on methadone. In our program, methadone is not necessarily a permanent treatment; in fact, it is the rare situation that somebody would come onto methadone and stay on it through his full course of treatment. Most people after a year, or sometimes less, are actually withdrawn from methadone, and they try to make it without methadone. Some will relapse and come back on methadone.

I am fortunate enough to have the administrator of our program here visiting us. Perhaps we can get some specific information of what percentage of the current 2,100 are actually on methadone at this point.

Mr. ROGERS. Would you identify yourself for the record.

Mr. DUERK. Mr. William Duerk. As of last Friday, there were 78 percent of the total patient population receiving methadone.

Dr. JAFFE. I might elaborate that over the last 2 months, we have moved from 1,800 to almost 2,200. Is that correct?

Mr. DUERK. It was 2,208.

Dr. JAFFE. In other words, we opened up several facilities. And methadone being the first phase of treatment for most people in the inner city, we have this proportionately high percentage of people on methadone at this point in time. In general, it is usually a much lower level of people on methadone.

Mr. ROY. We get different stories from people about methadone. Is it more or less difficult to withdraw from methadone?

Dr. JAFFE. All of the stories you hear are true. What happens is that it takes longer. It is the equivalent of having a chronically an-

noying, uncomfortable feeling over a period of several weeks as opposed to having an acute illness which gets over in a matter of 4 or 5 days. So some people would prefer to be extremely sick and get it over with and others would like to avoid that and withdraw from methadone.

But without question, when you withdraw from heavy doses of methadone, you feel fairly uncomfortable for several weeks and feel mildly uncomfortable for several weeks after that. You don't sleep well or eat well. It is not a horrible situation, but it certainly keeps one thinking of how well it would feel to be perfectly normal if they weren't on the drug. It is both difficult but mild in terms of intensity of syndrome.

Mr. Roy. How many addicts do you think are present in the State of Illinois? What is your estimate?

Dr. Jaffe. It is very difficult for us to estimate. We think perhaps it is 8,000 or 9,000, in that range. But I wouldn't be surprised if it were somewhat higher than that.

Mr. Roy. What was your budget in Illinois for the last fiscal year as far as the program was concerned?

Dr. Jaffe. Total combined, State and Federal?

Mr. Roy. Yes.

Dr. Jaffe. $2.3 million is State. But the Federal budget was about an additional $500,000. So we had $2.8 million. As to the total between July 1 of last year and July 1 of this year, $2.4 million, to treat that group.

I don't think it would be fair to say we treated 2,000 people for a full year. We had a rather rapid rate of growth of patient care, so the average number of man-years would obviously be somewhat less than 2,100 if someone were making a cost account of what it would cost to treat. You couldn't credit us with the full 2,100 for that entire year.

Mr. Roy. You had 10,000 addicts. I think New York State has perhaps 15 times that many and perhaps as many as 150,000 addicts. So you are apparently doing it much less expensively than the State of New York. I recall they told us they had $136 million in the previous fiscal year, and they are looking forward to $96 million in the coming year.

Now, I am sure, because of the fact of what your mission is here, that you have some thoughts as to why New York spends so much and Illinois spends so little.

Dr. Jaffe. I am not sure that Illinois spends so little. We take great pride in the efficiency with which we spend it. After all, of the total of $2.4 million, only $400,000 was coming from the Federal Government. I think it is simply a matter of feeling that we thought we should spend that money as though it were coming out of our own pockets, to be concerned as to the kinds of services we were getting with it, and maximizing the kinds of voluntary inputs we would get.

We would be happy to have people complete the program and see where we could have attempted to avoid unnecessary expenditures. We could give you many examples where we looked at something and we said we could do it better with one-fifth that. So that at one point we had a psychiatric unit that really did no better than a residential facility with respect to improving people. But the cost in that unit was somewhere from $85 to $90 a day, and the cost of the residential

facility in which people felt more comfortable and in which there was more accomplished was approximately $11 a day. We closed one and expanded the others. This is then model.

I am not sure whether or not programs as large as New York's have that kind of immediate flexibility or immediate feedback.

Again, I am telling you how we were able to do it rather than to criticize New York. For example, we could have all of the people if our unit were opening this and they move into it, where perhaps if New York had to do that it would have to discharge some people and hire others because they wouldn't be within the same system. I don't know what their situation was. I can only tell what our situation was.

Mr. ROY. As I look at the figures—and I am sure in many ways they are not comparable—you spent about one-fourth of what New York spent for a comparable number of addicts. What is the amount of money authorized for fiscal year 1972, as far as the programs that you will be supervising?

Dr. JAFFE. The State of Illinois?

Mr. ROY. No; federal budget.

Dr. JAFFE. Again, if you will define "supervising." In terms of policy or in terms of budgetary control?

Mr. ROY. Budgetary control.

Dr. JAFFE. I would guess the total Federal budget is $381 million. From that we would subtract $48 million. But I believe included in there is part of the law enforcement budget, if I am not mistaken. So, with a quick glance at this I would say there is $150 million, plus $30 million, which is $180 million, and the $42 million, which is $220 million. That is perhaps the best estimate.

Mr. ROY. That is the amount now authorized and appropriated or just authorized?

Mr. JAFFE. That is the request for appropriation, $220 million, over which we will have budgetary control. We will have policy control over a considerably larger size budget.

Mr. ROY. I will try to get through this quickly. As I recall, the people from the Department of Defense told us if they picked up an addict who would not be eligible for treatment, he would perhaps be discharged prematurely. If he was eligible for discharge, he would be treated only if he volunteered to remain in the service. If he did volunteer, however, and if they could find a VA facility or community facility, he would then be discharged to one of these facilities. Now, we received the figure the other day from the VA that between the dates, as I recall, of July 7 to July 29 they had three transferees from the Department of Defense. What happened?

Dr. JAFFE. I think there are two issues here, one of which is the consent of the transferee. The transferee is a very special situation as opposed to a discharged person who is then told of the availability of a facility to which he can volunteer.

Now, we have some further information. These were people on active duty we were turned over to the VA.

Our goal is to hav every person treated adequately prior to discharge, because there has been concern voiced that if you simply transfer somebody, once he is out of the military he can leave a VA hospital the same day.

Mr. ROY. Excuse me, Dr. Jaffe. But if he doesn't volunteer for treatment prior to discharge, there is no choice for him but to be discharged; is this correct?

Dr. JAFFE. We have sought authorization to be able to extend somebody's tour of service by an additional 30 days in order to see he does get adequate treatment. To the best of my knowledge, this legislation has not been passed yet. So all we can do is extend a man's time of service to the statutory period of 2 years. But those people come right up to the edge before we detect them.

Indeed, we will be holding them 7 days and have them physically cleaned up to a degree. Then we have no option to say here are the facilities you could go to. If we transfered these people, they would leave the same day we transferred them, if that is the way they would like to do it.

I believe they ought to point out this does not mean they are necessarily treated. I have a letter from Daytop Village indicating 40 people from Vietnam have received treatment there. Certainly in our program we are treating Vietnam servicemen, and I think this is typical of most programs; that they are not disenfranchised in their status as citizens by virtue of the program.

Mr. ROY. Then you are seeking a voluntary treatment program for servicemen, so we are seeking a voluntary program piecemeal at the present time; is that correct?

Dr. JAFFE. We are seeking the statutory authorization to extend the period of service for an additional 30 days, which would permit us to accomplish at least the beginning of treatment of drug dependent people prior to their discharge.

Mr. ROY. That would be a brief involuntary treatment program?

Dr. JAFFE. To the extent that if they didn't elect to participate in the treatment—yes.

Mr. ROY. Thank you very much.

Mr. ROGERS. Where would you establish a national training center of excellence and when?

Dr. JAFFE. Well, I would hope within a matter of months and I would like to see it somewhere within the Greater Washington area. There are a number of reasons for this.

First of all, we could have some of the best faculty in the world participating. Second, we think we would create some models of cooperation. We do have a metropolitan area; we have people from Virginia, the State of Maryland, the city of Baltimore; we have private agencies; we have governmental agenices that could all contribute.

As I say, we would like to see Federal offices and legislators at all levels participating in that.

Mr. ROGERS. Should we, in effect, form a national institute of drug abuse and let you carry on in that setting?

Dr. JAFFE. The national institute of drug abuse would, in effect, be rather narrow.

Mr. ROGERS. It depends on how we set it up.

Dr. JAFFE. Yes, if in fact one would take all programs from all other departments and all other agencies and incorporate it. It would be the major reorganization. It could represent all of the things that needed representation. But at least the concept as we are trying to develop it is that the VA would train some of their people in such a center.

That would mean they would have a component that would be incorporated in there, which would mean you would have to incorporate the VA into this national institute.

The same thing is true of the Department of Defense. We have some very bright people in military medicine who could cooperate and some of the people getting into education, prevention, and treatment in the military could rotate to a center here and apply their skills and present model programs for prevention and treatment right in facilities here and people could rotate from the seat. The Office of Education could participate.

It would be very difficult to do this within a single agency. It would be almost easier to get people into a nonagency directed national training center.

Mr. ROGERS. Now, do you have an interagency council set up, and did you set up such an interagency council?

Dr. JAFFE. An interagency has been in existence from February and has met monthly.

Mr. ROGERS. Are you using this?

Dr. JAFFE. I attended one of their meetings. I reviewed their minutes. Apparently since then they are still sort of getting organized.

Mr. ROGERS. What I want to know is, do you as coordinator use this technique, the interagency council? Is this going to be your technique of getting to the agencies, or what?

Dr. JAFFE. There are perhaps many techniques of getting to the agencies. Certainly, the interagency council is one way of getting feedback from them.

Mr. ROGERS. But you are not planning, from your testimony, to use them?

Dr. JAFFE. First of all, I am not sure who makes up that interagency council. I have not had adequate time to review the component membership or what its history is or whether or not in fact it has functioned effectively as a coordinating mechanism. If it has, it would certainly be a logical step to simply use that as a form for feedback.

Mr. SYMINGTON. Would the chairman yield?

Mr. ROGERS. Yes, I will yield.

Mr. SYMINGTON. Is the chairman asking if there is a council in effect or if Dr. Jaffe intends to establish one? I take it there is no interagency council. Do you know whether or not there is such interagency council that compares various agencies' drug efforts today?

Dr. JAFFE. There is a council. What it has accomplished to me is not clear at this point.

Mr. SYMINGTON. You say you don't know who serves on the council?

Dr. JAFFE. I know what agencies are represented, but I don't know the specific people, what their role is within the agency, whether or not they are the highest level or fourth echelon.

Mr. SYMINGTON. Are these agencies you intend to supervise?

Dr. JAFFE. Frankly, I don't know that I know every single agency that makes up that council. I met people from a number of agencies, including the Department of Defense and someone from the VA who attended those meetings.

Mr. SYMINGTON. It was interesting to me that in your testimony today you said you have begun very in-depth conversations with all of

the agencies, and you going great guns, but you are not sure what the interagency council is.

It seems to me that would be a logical vehicle for talking to the agencies but perhaps a good one to avoid talking through.

But I would simply suggest that there ought to be some on-going communication between the agencies to carry out our policy, and it ought to consist of people in each agency who have direct line responsibility from their secretary and are not too far down the line.

Dr. JAFFE. That is the issue that I should really look into.

I should point out parenthetically that I had intended fully to go to that meeting. Something came up with Congress that delayed my attending all but the last 15 minutes of the meeting which lasted several hours. Some of my staff were there. They did attend.

Mr. ROGERS. I think it would be helpful if you would let us have for the record a statement of the council, who is on it, and if you continue to plan to operate with it and in what manner. Would you let us have that for the record?

Dr. JAFFE. Yes, I will, sir.

(The following information was received for the record:)

MEMBERSHIP LIST—FEDERAL DRUG ABUSE PREVENTION COORDINATING COMMITTEE

The Federal Drug Abuse Prevention Coordinating Committee was created as a result of a November 20, 1970, request submitted by Egil Krogh, Jr., Deputy Assistant to the President for Domestic Affairs, to Secretary Elliot L. Richardson. The request in essence asked for a plan of action to implement the drug abuse education coordination mandate of Title I of the Comprehensive Drug Abuse Prevention and Control Act of 1970 in order to take over the functions of the White House Ad Hoc Committee on Drug Abuse Information. On February 12, 1971, Secretary Richardson submitted such a plan to Mr. Krogh.

Secretary Richardson designated the National Institute of Mental Health as the agency to coordinate functions of the Committee. Dr. Bertram Brown, Director of NIMH and Special Assistant to the Secretary for Drug Abuse Prevention was appointed Chairman of this interagency committee. The following Federal agencies are represented on the committee:

(1) Bureau of Narcotics and Dangerous Drugs: Dr. John Langer; and Frederick Garfield.

(2) Bureau of Customs: Mr. Art Settel.

(3) Department of Defense: Capt. George Sult.

(4) Office of Education: Dr. Donald Davies.

(5) Social Rehabilitation Service: Dr. James Garrett.

(6) Office of Economic Opportunity: Dr. Carl Smith.

(7) Law Enforcement Assistance Administration: Mr. Richard W. Velde.

(8) National Institute of Mental Health: Dr. Bertram Brown; David Kefauver; Thomas Koehler; and Gerald Kurtz.

(9) White House: Richard Nordahl.

There were essentially six subcommittees:

(1) Subcommittee on Professional and Paraprofessional Training;

(2) Subcommittee on School and College Based Programs;

(3) Subcommittee on Mass Media;

(4) Subcommittee on Materials, Pretesting and Evaluation;

(5) National Clearinghouse on Drug Abuse Information Advisory Committee; and

(6) Subcommittee on Community Programs.

I believe that the Federal Drug Abuse Prevention Coordinating Committee has made a useful beginning toward isolating problem areas and suggesting needed Federal programs in order to curtail the demand for abuseable drugs in America. The Committee has, however, been hampered by the lack of resources and effective administrative mechanisms to bring about decision-making. The legislative authority sought under the Administration's proposed Special Action Office for Drug Abuse Prevention (H.R. 9264) will in my estimation satisfy these

deficiencies. In the meantime we are reassessing all of the multiple aspects of our interrelationship with the coordinating committee. The ultimate decisions in this regard will be dependant upon this reappraisal.

Mr. ROGERS. Now, let me ask you about this. It seems to me in Illinois you are putting your main reliance on methadone. What is going to be the treatment for the armed services?

As I understand it, you detoxify them for a week. Then where do they go? Where are they presently going as soon as they have been detoxified for a week?

Dr. JAFFE. The group that is detoxified for a week is then further subdivided as to those people who are staying in the service. Those people who are staying in the service are moved, as I understand it, to military hospitals at the present time.

Mr. ROGERS. Where?

Dr. JAFFE. I think there are several locations. For example, the Air Force, I believe, is taking people to Lackland.

Mr. ROGERS. Lackland Air Force Base?

Dr. JAFFE. Yes, and to the best of my knowledge, the Navy is sending its people to Miramar.

Mr. ROGERS. How about the Army?

Dr. JAFFE. I do not know where the Army is sending its people, but we can supply that for the record.

Mr. ROGERS. You don't know where they are sending them? Maybe some of your aides would know.

Dr. JAFFE. Some of them have been sent to Fort Sam Houston. We can supply it for the record.

(The following information was received for the record:)

ARMY FACILITIES FOR TREATING MEN WHO REMAIN IN SERVICE FOLLOWING DETOXIFICATION

The Army is presently using the following facilities for treating those men who remain in service after they are detoxified:

Walter Reed General Hospital, Washington, D.C.
U.S. Army Hospital, Fort Devens, Mass.
Walson Army Hospital, Fort Dix, New Jersey.
Patterson Army Hospital, Fort Monmouth, New Jersey.
Kimbrough Army Hospital, Fort Meade, Maryland.
Kenner Army Hospital, Fort Lee, Virginia.
DeWitt Army Hospital, Fort Belvoir, Virginia.
McDonald Army Hospital, Fort Eustis, Virginia.
Ireland Army Hospital, Fort Knox, Kentucky.
Womack Army Hospital, Fort Bragg, North Carolina.
U.S. Army Hospital, Fort Jackson, South Carolina.
Martin Army Hospital, Fort Benning, Georgia.
U.S. Army Hospital, Fort Gordon, Georgia.
U.S. Army Hospital, Fort Steward or Tuttle Army Hospital, Hunter Army Airfield, Georgia.
Nobel Army Hospital, Fort McClellan, Alabama.
Lyster Army Hospital, Fort Rucker, Alabama.
U.S. Army Hospital, Redstone Arsenal, Alabama.
U.S. Army Hospital, Fort Campbell, Kentucky.
Brooke General Hospital, Fort Sam Houston, Texas.
Reynolds Army Hospital, Fort Sill, Oklahoma.
U.S. Army Hospital, Fort Polk, Louisiana.
Darnall Army Hospital, Fort Hood, Texas.
General Leonard Wood Army Hospital, Missouri.
Fitzsimons General Hospital, Denver, Colorado.
Munson Army Hospital, Fort Leavenworth, Kansas.
U.S. Army Hospital, Fort Carson, Colorado.
Irwin Army Hospital, Fort Riley, Kansas.
Raymond W. Bliss Army Hospital, Fort Huachuca, Arizona.

U.S. Army Hospital, Fort Ord, California.
William Beaumont General Hospital, Fort Bliss, Texas.
Letterman General Hospital, California.
Madigan General Hospital, Fort Lewis, Washington.
Valley Forge General Hospital, Pennsylvania.
Sandia Base Hospital, New Mexico.

Mr. ROGERS. Do you know how many have been sent?

Dr. JAFFE. I do not have that material at this time.

Mr. ROGERS. What concerns me is that we are supposed to have had 8,000 turn themselves in for amesty within the first 6 months; 3,500 supposedly have been arrested for heroin possession and use.

Now, I realize we didn't set up your program for detection until June, but I wonder what has happened to these 12,000 when the VA just testified this last week before this committee that they really had only had three people referred to the VA specifically for treatment of drug abuse. I wonder what has happened to all of these 12,000 people. I just wondered if you had any information. I know you can't know everything all at once here.

Dr. JAFFE. I don't know very much of what happened prior to June 18, prior to specifically beginning to make policy. I think it is important again in a historical context to recognize that until there was a clear-cut statement by the President that people would obtain treatment but would not thereby become subject to military action, many of the men that were detected or turned themselves in were not given honorable discharges. However, their records did not justify that.

But the VA was not permitted under its statutes of operation to treat people who had not obtained honorable discharges. So to the extent that people who were arrested were discharged without an honorable discharge, to the extent that people who turned themselves in, at some point through relapse or behavor, were not given honorable discharges, the VA had no mechanism for treating them.

Mr. ROGERS. These were amnesty cases. At that time these 8,000 turned themselves in because they were told they would receive amnesty and, of course, there would be no dishonorable discharge because there was no crime committed.

Dr. JAFFE. I don't know what percent——

Mr. ROGERS. I understand that, but I want to know how many got treatment, because only three had been turned over to the VA.

Dr. JAFFE. If you are speaking about treatment by the service yourself, then I share your curiosity as to what happened. Obviously, the VA has not treated many as direct transfers. How they treated them, the people who volunteered for treatment is at question.

We do have several units functioning. The unit in Washington has treated many people. There are many units treating people. The mechanism of how these people enter is not clear to me at this time.

Our program is treating more than 60 Vietnam veterans at this time.

Mr. ROGERS. That is where they come in and volunteer or unless they are arrested under a crime or sent. That is how they get in presently.

Dr. JAFFE. Right.

Mr. ROGERS. Now, I wish you would check this with the military for us and let us know what happened. I think it is quite important.

Dr. JAFFE. I will try to check it. I cannot give you any assurance that I will be able to obtain that information quickly enough to include it in the record, because it is not at all clear as to what kinds of data have been kept on people who are entering amnesty programs.

Many of them, as I saw them, in Vietnam were informal. They

were operated by commands. They were a group of volunteers. They were set up and people came in.

I am not certain. I am not saying that the data has not been recorded or obtained. I am simply saying I am not certain it has been.

Mr. ROGERS. What I would like to know is what their procedure is. Have they taken them, given them treatment or just let them go home, or have they tried to turn them over to the VA, or what?

Dr. JAFFE. We shall record your question and do all we can to obtain an answer. It is certainly important to us, as I am sure it is to Congress.

(The following information was received for the record:)

PROCEDURES INVOLVING ARMED SERVICES AMNESTY CASES

"Amnesty" is a general term that applies to those individuals voluntarily seeking assistance for problems of drug abuse. Amnesty is a policy whereby an individual's self-admission of drug abuse will not be used for judicial proceedings. Officially this is now known as "exemption" in the Army, Navy and Marine Corps and the Limited Privilege Communication Program (LPCP) in the Air Force. "Amnesty," urine screening and law enforcement are the methods by which drug abusers are identified.

Rehabilitation is a program whereby an individual once identified by any means is treated for drug use. In those posts where a formal rehabilitation program has been established individuals identified as drug abusers who have time left to serve in Vietnam are directed to participate in a program of therapy. Presently these programs operate under different identities, such as "half-way houses", medical facilities and counseling services. On those posts where established rehabilitation programs do not yet exist, identified individuals are generally directed to existing Army medical and social agency channels. At ths time individuals with time left to serve in Vietnam completing a program of therapy are re-integrated into their original unit or a new unit, depending on the circumstances. Now that an Army wide rehabilitation program is being developed it is envisioned that any identified individual will be channeled immediately into a rehabilitation program.

Those servicemen who are identified by DEROS urine screening are detoxified (5–7 days) and returned to the United States. Upon return, they enter into the military treatment and rehabilitation program. If their time of service has expired, they are given the opportunity to extend service for rehabilitation at military faclities. Should they decline this option, they are dscharged and referred to V.A. and civilian facilities near their home.

If the returnng servicemen have more than two weeks of duty left, they can be transferred to V.A. facilities via the Armed Services Medical Regulating Office (ASMRO). They can then be discharged from the service at the V.A. facility. From July 1 to September 10 1970, 23 such transfers were completed. In order to use this system fully, legislation to hold servicemen 30 days beyond ETS is needed.

Mr. ROGERS. Let me ask you, can you, in effect, separate the treatment in the military from the civilian? Can you make a real division in the difference in treatment?

Dr. JAFFE. To the extent that the military treats adequately, the load on the civilian side of things will be reduced.

Mr. ROGERS. That is not what I am asking. I am saying can you really separate treatment programs with the civilian population and the military? Can you separate them and run the military as a little separate operation here and the civilian all separate from that, and so forth?

Dr. JAFFE. Not only can you, but in many cases I am not sure you can afford not to. I wouldn't know how to put a civilian operation, for example, on a military base.

Mr. ROGERS. Now, I thought you told me that you were going to have to take a man who is an addict in the military—you certainly are not going to cure him in 30 days, are you?

Dr. JAFFE. If he is an addict, as we have understood the addict in the inner city for years, the chances of curing him are minimal.

Mr. ROGERS. I would say if he has been using it for 1 or 2 years steady you wouldn't cure him in 30 days. Wouldn't you agree to that?

Dr. JAFFE. I would say 1 year is something you can't do. But what about 1 week?

Mr. ROGERS. That is not what I am asking. I am asking about hard addicts that you have shown up to be 5.44.

Dr. JAFFE. Mr. Chairman, one of the difficulties is the interpretation of that data. All that have shown up are people who come up with positive urine specimens. I wish we could tell which are hard addicts.

Mr. ROGERS. I understood you were telling us that, because you said you show 10 to 12 percent of one-time users or more.

Dr. JAFFE. That is what a survey revealed in April or May, sir.

Mr. ROGERS. What kind of survey was that?

Dr. JAFFE. That was a random sample of men at the rank of E–5 and below in the Army.

Mr. ROGERS. How was it made, by a questionnaire?

Dr. JAFFE. By a questionnaire.

Mr. ROGERS. I think we should have a copy of that for the record.

(The following material was received for the record:)

OAKLAND STUDY—MARCH 1971—1,011 VIETNAM ENLISTED RETURNEES SEPARATING FROM SERVICE (ARMY, K. E. NELSON, M.D.; JACOB PANZARELLA, Ph. D.

	Before		During		Current		
	Percent	Amount	Percent	Amount	Percent	Amount	Ever used
Marihuana (total users)	45.8	461	58.80	592	37.10	374	635 equals 63.10 percent.
Experimental (1 to 4 times)	13.40	135	13.62	137	[1] 7.73	78	
Casual (5 to 19 times)	14.90	150	11.13	112	[2] 7.63	77	
Heavy (20 to 199 times)	12.01	121	16.50	166	[3] 9.84	99	
Habitual (220 or more times)	8.46	85	17.54	177	[4] 11.90	120	
Combined frequent (20-plus)	28.30	285	34.09	343	21.80	219	
Amphetamines (total users)	14.0	141	16.4	165	5.76	58	207 equals 20.6 percent.
Experimental	4.06	41	5.56	56	3.47	35	
Casual	5.85	59	6.96	70	1.29	13	
Heavy	3.67	37	3.36	34	.69	7	
Habitual	.39	4	.49	5	.30	3	
Combined frequent	4.06	41	3.85	39	.99	10	
Barbiturates (total users)	11.32	114	15.46	156	7.04	71	184 equals 18.27 percent.
Experimental	3.67	37	4.95	50	2.77	28	
Casual	4.67	47	5.85	59	2.66	27	
Heavy	2.76	28	2.10	22	.99	10	
Habitual	.60	6	2.48	25	.59	6	
Combined frequent	3.36	34	4.58	47	1.58	16	
Acid (LSD, peyote, etc.) (total)	12.67	127	9.54	96	4.16	42	164 equals 16.20 percent.
Experimental	5.76	58	5.36	54	3.26	33	
Casual	10.39	101	8.95	90	.59	6	
Heavy	2.29	23	.15	3	.10	1	
Habitual	.30	3	.15	3	.19	2	
Combined frequent	2.59	26	.30	6	.29	3	
Heroin or morphine (total users)	6.17	62	22.68	228	16.15	163	235 equals 23.38 percent.
Experimental			5.77	58	4.27	43	
Casual	3.08	31	4.50	46	3.47	35	
Heavy	2.48	25	9.15	92	4.27	43	
Habitual	.59	6	3.18	32	4.17	42	
Combined frequent	3.07	31	11.23	113	8.43	85	
Opium (total users)	7.75	78	19.59	196	9.14	92	206 equals 20.4 percent.
Experimental	2.98	30	5.86	59	5.17	52	
Casual	2.37	24	7.26	73	2.68	27	
Heavy	2.37	24	5.86	59	.89	9	
Habitual	0	0	.49	5	.39	4	
Combined frequent	2.37	24	6.36	64	1.28	13	

[1] 1 to 4 times.
[2] 5 to 10 times.
[3] 11 to 29 times.
[4] 30-plus.

COMPARISON OF DRUG USE PATTERNS OF VIETNAM ENLISTED RETURNEES (AGE 26 OR BELOW, RANK E-6 OR BELOW) PRIOR TO TOUR IN VIETNAM

	1970		1969	1968	1967
	Percent	Number	(percent)	(percent)	(percent)
Marijuana:					
Experimental (1 to 4 times)	13.40	135			
Casual (5-19)	14.90	150			
Heavy (20-199)	12.01	121	9.60	8.00	
Habitual (200+)	8.46	85	7.30	7.50	
Combined light (1-19)	20.47	206	16.90	15.50	
Combined heavy (20+)	28.30	285	17.90	15.90	
Total users	45.80	461	34.80	31.40	12.33
Amphetamines:					
Experimental (1 to 4 times)	4.06	41			
Casual	5.85	59			
Heavy	3.67	37	2.80	2.90	
Habitual	.39	4	.40	1.20	
Combined light	9.91	100	9.20	8.30	
Combined heavy	4.06	41	3.20	4.10	
Total users	14.00	141	12.40	12.40	
Barbiturates:					
Experimental	3.67	37			
Casual	4.67	47			
Heavy	2.76	28	2.50	2.50	
Habitual	.60	6	1.00	1.60	
Combined light	8.34	84	6.50	7.30	
Combined heavy	3.36	34	3.50	4.10	
Total users	11.32	114	10.00	11.40	
Acid:					
Experimental	5.76	58			
Casual	10.39	101			
Heavy	2.29	23	3.20	1.50	
Habitual	.30	3	.30	.40	
Combined light	16.15	159	8.10	6.80	
Combined heavy	2.59	26	3.50	1.90	
Total users	12.67	127	11.60	8.70	
Heroin or morphine:					
Experimental					
Casual					
Heavy	2.48	25	1.00	1.10	
Habitual	.59	6	.30	.30	
Combined light	3.08	31	3.00	1.10	
Combined heavy	3.07	31	1.30	1.30	
Total users	6.17	62	4.30	2.50	
Opium:					
Experimental	2.98	30			
Casual	2.37	24			
Heavy	2.37	24	.90	1.00	
Habitual	0	0	0	.90	
Combined light	5.05	54	4.60	4.40	
Combined heavy	2.37	24	.90	1.90	
Total users	7.75	78	5.50	6.30	
Alcohol (not analyzed)					

PRELIMINARY FINDINGS—NOT TO BE CITED, COMPARISON OF DRUG USE PATTERNS OF VIETNAM ENLISTED RETURNEES (AGE 26 OR BELOW—RANK E-6 OR BELOW) DURING TOUR IN VIETNAM

[In percent]

	1971	1969	1967
Marihuana:			
Experimental (1–4 times)	13.62 (137)		
Casual (5–19)	11.13 (112)		
Heavy (20–199)	16.50 (166)	11.90	
Habitual (200+)	17.54 (177)	17.70	
Combined light (1–19)	24.75 (249)	20.50	21.6
Combined heavy (20+)	34.09 (343)	29.60	7.4
Total users	58.80 (592)	50.10	
Amphetamines:			
Experimental	5.56 (56)		
Casual	6.96 (70)		
Heavy	3.36 (34)	4.00	
Habitual	.49 (5)	1.20	
Combined light	12.52 (126)	11.00	
Combined heavy	3.85 (39)	5.20	
Total users	16.40 (165)	16.20	
Barbiturates:			
Experimental	4.95 (50)		
Casual	5.85 (59)		
Heavy	2.10 (22)	2.70	
Habitual	2.48 (25)	1.10	
Combined light	10.80 (109)	7.80	
Combined heavy	4.58 (47)	3.80	
Total users	15.46 (156)	11.60	
Acid:			
Experimental	5.36 (54)		
Casual	8.95 (90)		
Heavy	.15 (3)	1.60	
Habitual	.15 (3)	.50	
Combined light	14.31 (144)	3.20	
Combined heavy	.30 (6)	2.10	
Total users	9.54 (96)	5.30	
Heroin or morphine:			
Experimental	5.77 (58)		
Casual	4.50 (46)		
Heavy	9.15 (92)	.60	
Habitual	3.18 (32)	.20	
Combined light	10.27 (104)	1.40	
Combined heavy	12.33 (113)	.80	
Total users	22.68 (228)	2.20	
Opium:			
Experimental	5.86 (59)		
Casual	7.26 (73)		
Heavy	5.86 (59)	5.80	
Habitual	.49 (5)	1.80	
Combined light	13.12 (132)	9.80	
Combined heavy	6.36 (64)	7.60	
Total users	19.59 (196)	17.40	

Prevalence of drug use of Vietnam enlisted returnees (age 26 or below, rank E–6 or below)

[Current use—During last 30 days]

	Percent	
Marihuana:		
Experimental (1–4)	7.73	(78)
Casual (5–10)	7.63	(77)
Heavy (11–29)	9.84	(99)
Habitual (30+)	11.90	(120)
Combined frequent (11+)	21.80	(219)
Total users	37.10	(374)
Amphetamines:		
Experimental (1–4)	3.47	(35)
Casual (5–10)	1.29	(13)
Heavy (11–29)	0.69	(7)
Habitual (30+)	0.30	(3)
Combined frequent (11+)	0.99	(10)
Total users	5.76	(58)
Barbituates:		
Experimental (1–4)	2.77	(28)
Casual (5–10)	2.66	(27)
Heavy (11–29)	0.99	(10)
Habitual (30+)	0.59	(6)
Combined frequent (11+)	1.58	(16)
Total users	7.04	(71)
Acid:		
Experimental (1–4)	3.26	(33)
Casual (5–10)	0.59	(6)
Heavy (11–29)	0.10	(1)
Habitual (30+)	0.19	(2)
Combined frequent (11+)	0.29	(3)
Total users	4.16	(42)
Heroin or morphine:		
Experimental (1–4)	4.27	(43)
Casual (5–10)	3.47	(35)
Heavy (11–29)	4.27	(43)
Habitual (30+)	4.17	(42)
Combined frequent (11+)	8.42	(85)
Total users	16.15	(163)
Opium:		
Experimental (1–4)	5.17	(52)
Casual (5–10)	2.68	(27)
Heavy (11–29)	0.89	(9)
Habitual (30+)	0.39	(4)
Combined frequent (11+)	1.28	(13)
Total users	9.14	(92)

Mr. ROGERS. Take a hard addict—I don't care what the percentage is—how are you treating him? Are you going to give him detoxification for a week, and then you are going to send him to some Army hospital for 3 weeks?

Dr. JAFFE. Yes, sir.

Mr. ROGERS. Then what?

Dr. JAFFE. Then I think we will tell him where facilities are available in the event he requires them.

Mr. ROGERS. Are you going to have a definite turnover to the VA? Are you going to ask that someone accompany him to the VA and say, "Here is a man and he needs treatment"?

Mr. JAFFE. I think after 30 days most people are able to find their way to the VA and other facilities. Strangely enough, 30 days is enough time for people to gain a great deal of control over how they will make decisions about their lives.

Mr. ROGERS. Is he going to be on methadone within the time?

Dr. JAFFE. He will not be.

Mr. ROGERS. If he is a hard addict?

Dr. JAFFE. It is awfully hard to be a hard addict in the sense of using continually for a year in the service.

Mr. ROGERS. You are telling me there are no hard addicts in the service?

Dr. JAFFE. I am saying that no hard addict is defined as having used heroin every day for a year, sir. That would be awfully difficult to do.

Mr. ROGERS. That is not our understanding. Why is that difficult to do when it is so available and so cheap?

Dr. JAFFE. That would mean that a man—and again we are talking primarily about Vietnam, I would suppose—has to begin using in large quantity the moment he gets there and not be interrupted for a single day during his entire tour of duty.

I would say that can happen, but it could happen with such infrequency that we have not considered that we should approach the treatment of the Vietnam serviceman as if he could not be treated without methadone.

Methadone generally is viewed as the kind of treatment that one offers to people who have not been treated successfully by means that do not require chronic medication.

Mr. ROGERS. Which is what? What kind of treatment is that that doesn't require medication or any methadone with an addict?

Dr. JAFFE. There are at least three or four separate approaches.

Mr. ROGERS. All right, if you would just explain those for me.

Mr. JAFFE. "A," after a period of withdrawal people can remain in a therapeutic community for varying periods of time.

Mr. ROGERS. How many therapeutic communities has the Army set up?

Dr. JAFFE. The Army, to the best of my knowledge, has set up none at this point.

Mr. ROGERS. I would agree, none. So that treatment is out.

Has the Navy set up any? I know of none.

Dr. JAFFE. All right.

Mr. ROGERS. Do you?

Dr. JAFFE. I know of none at this point.

Mr. ROGERS. That is the Navy. What about the Air Force?

Dr. JAFFE. There is one model therapeutic community in Vietnam.

Mr. ROGERS. Was that the Navy or Army or Air Force?

Dr. JAFFE. The Navy has one model therapeutic community, but it needs a lot of work——

Mr. ROGERS. So it is not effective?

Dr. JAFFE. I would guess it is not effective.

Mr. ROGERS. I would think you are right.

Now, what about the Air Force?

Dr. JAFFE. I really don't know what the Air Force has.

Mr. ROGERS. This is what concerns me now. You say you don't want any real control. You want to have a policy and a little byplay and hope they are going to follow your suggestions, but when we come down to specifics we don't see anything.

All right, what is the second treatment now?

Dr. JAFFE. May I point out now that last week the men who were writing the policy for treatment for the military have visited programs in New York and Chicago. They were, in fact, looking for the first time at treatment programs. I think you have to recognize that until recently the military was not charged with treating the drug dependent individual. They were told if you detect this, this is a court-martial offense and get them out. The treatment up to that time was unofficial.

Within a matter of weeks they have geared up; they have written proposals; they are visiting programs, and I think they are doing so sincerely to try to find out what is best.

Mr. ROGERS. But I am saying these do not exist.

Dr. JAFFE. That is true.

Mr. ROGERS. Now, what is your second treatment?

Dr. JAFFE. There is the possibility that once people would be withdrawn they could be maintained on narcotic antagonists.

Mr. ROGERS. Which are what?

Dr. JAFFE. Pharamacological blockades.

Mr. ROGERS. What are the names?

Dr. JAFFE. Cyclazocine, which is the only one, I think, that has any potential at this point in time.

Mr. ROGERS. How many are using that?

Dr. JAFFE. In the military?

Mr. ROGERS. Yes.

Dr. JAFFE. None. It is an investigational drug and would probably interfere with military efficacy.

Mr. ROGERS. And it is still very investigational, and it is quite questionable as to its overall effect.

Dr. JAFFE. Right.

Mr. ROGERS. All right; that is the second treatment. What is the third?

Dr. JAFFE. Well, there is the possibility that people can be withdrawn, participate in group therapy, they have their urine tested periodically and live partially, at least, in halfway house facilities as they return to duty.

Mr. ROGERS. That is pretty much the first treatment, isn't it, group therapy or therapeutic communities?

Dr. JAFFE. Therapeutic communities as defined more precisely required a more prolonged period of residence, several months at least.

Mr. ROGERS. How many are getting this third treatment in the Army?

Dr. JAFFE. I would say the third treatment is perhaps the modal treatment, a few weeks of detoxification followed by groups followed by support.

Mr. ROGERS. How do they keep them? You are only giving them a week's detoxification.

Dr. JAFFE. We have several populations. One is the population of men detected early in the course of their tour of duty in Vietnam.

Mr. ROGERS. You are now testing——

Dr. JAFFE. No; some people come in and seek treatment on their own. We will be testing in a matter of weeks. If you want to refer only to those people who are being tested as they leave, that is a more specific population. That breaks into those groups that are going to serve longer and those groups that are scheduled for mustering out of service.

Both groups are detoxified for 7 days. The groups that are going to serve longer are sent back to facilities in the United States.

Mr. ROGERS. Where, at these hospitals?

Dr. JAFFE. To the best of my knowledge, in these hospitals; yes, sir.

Mr. ROGERS. Now, we need to be specific, and we need to know. How long are they kept there?

Dr. JAFFE. I can't really say, sir.

Mr. ROGERS. Three weeks?

Dr. JAFFE. We can provide that for the record. It may be longer.

(The following information was received for the record.)

AIR FORCE, ARMY, AND NAVY PROGRAMS AND POLICIES FOR TREATING DRUG USERS AFTER DEPARTURE FROM SOUTHEAST ASIA WITH SERVICE TIME REMAINING

Under the policy guidance of the Department of Defense, each of the three Armed Services has developed different programs and policies for treating individuals who have been identified upon their departure from Southeast Asia as drug users, and who have service time remaining. These programs are as follows:

AIR FORCE

Once an individual has been identified by urinalysis as a drug user, he initially undergoes detoxification after which he is aero-medically evacuated to the Special Treatment Center at Lackland AFB. Here he undergoes psychiatric evaluation from 7–10 days in-patient period. If it is determined by this evaluation that the individual has potential for future military service, he then enters a 46 day in-patient rehabilitation program. Those individuals found not having a potential for future military service are referred to the Veterans Administration rehabilitation programs and discharged from active duty under honorable conditions. After the rehabilitation phase the individual is returned to duty and provided with follow-up support treatment for a period of one year.

ARMY

Individuals identified as drug users by urinalysis screening undergo an initial 5–7 day detoxification after which they are medically evacuated to an Army community based rehabilitation program at any one of 33 posts in the United States. These may be designed as in-patient or out-patient modalities in which an individual participates in the rehabilitation program but also he fulfills many of his daily military duties. Upon completion of the program the individual reintegrated into a unit. Individuals who fail to complete the rehabilitation cycle or who are subsequently identified as recidivist and whose sole problem is that of drug use are eligible for discharge under honorable conditions.

Those individuals identified as drug users initially undergo a one to three week period of detoxification and evaluation at a Naval hospital. They are then transferred to the Naval Drug Rehabilitation Center, either at Miramar NAS or Jacksonville NS where they participate in a two to three month rehabilitation program designed to be responsive to their needs as determined by evaluations. Upon successful completion of this treatment, the individual is returned to normal duty. Those who fail to successfully complete the rehabilitation program are eligible for discharge under honorable conditions provided they face no disci plinary actions for matters other than drug abuse.

Mr. ROGERS. Well, as a matter of fact, I understood you to say that they could be kept 3 weeks in these hospitals.

Dr. JAFFE. What we asked for was the authority to extend treatment for those people who are not scheduled to stay in the military service so that all people could have a minimum of 4 weeks of treatment. Those people that are going to be in the military another year can have their treatment extended at the discretion of the physicians in those military hospitals. There is no limitation on that.

Mr. ROGERS. Well. I didn't think you were testing them until they were ready to get out. What do you mean by another year? Will the Army take them back where they are drug addicts?

Dr. JAFFE. Well, a drug addict is not necessarily any more incureable as an alcoholic. If somebody has been drinking and they cure him, he can return to duty.

Mr. ROGERS. That is not what I am asking. Will the military let them reenlist? As they are ready to go out and they find they are addicted, do they let them come back in?

Dr. JAFFE. I am trying to see if I can fully understand.

Mr. ROGERS. This may not be a fair question to ask to you, because it is military policy, but I wondered if you knew if they allowed them to come back in, once they had been detected about drug addiction.

Dr. JAFFE. That is easier to answer for those people where reenlistment is not an issue.

Mr. ROGERS. We will let that lay. Suppose they are just to get out. What happens?

Dr. JAFFE. Right now, if they have no time after the 2 years and they are right up to the wire, all that can be covered is 7 days. That 7 days is sort of an extension over their time.

Mr. ROGERS. Because you are not testing them early enough to do that prior to that, are you?

Dr. JAFFE. That is correct.

Mr. ROGERS. Why not?

Dr. JAFFE. Well, I spoke to Camranh Bay today, and we talked about laboratory capacities. We talked about the training of laboratory people, and we talked about the difficulty in testing people sometime—let us say we talked about 30 days, 40 days, 60 days prior to the discharge. This was part of the original plan as we laid it down.

Now, I must say that sometimes we feel we are on the horns of a dilemma, if you will. We know that we would like to test people. At the same time, we are told that some people are slipping through that screen; they are handing in grandma's urine, if you will. Only two facilities are built with specific provision to make sure this doesn't happen.

At the facilities where they haven't taken all of these precautions,

we begin to question the meaning of the information. Those procedures have to be developed.

Now, when we see that people who are 30 days prior to leaving Vietnam aren't going two places, we have to have specimen-collecting facilities, perhaps in 30 days. I have said we have to build those so when we start sending in specimens they do not consist of beer, they do not consist of soap suds, or they do not consist of one's best friend's urine specimen, or the entire thing is meaningless.

Now, there are two specialized facilities, and they are manned by 10 men.

Mr. ROGERS. So, as a matter of fact, what is happening now is that the testing really doesn't give any good figures because they are collecting them from all over——

Dr. JAFFE. No, sir. They are testing them at primarily two places.

Mr. ROGERS. Are they having to bring them in, the tests?

Dr. JAFFE. The men themselves pass through in the greater majority of occasions. Except for the Air Force and Navy, all of the enlisted men pass through these facilities, which are arranged with mirrors and men watching. It is a 10-man staff, and we would like to see the same thing for all of the services.

Mr. ROGERS. How long will it take the Air Force and Navy to do that?

Dr. JAFFE. I suspect they are in the process now.

Mr. ROGERS. Could you let us know definitely?

Dr. JAFFE. We could find out what steps they have taken to assure that their procedures are as foolproof as those of the Army.

(The following information was received for the record:)

STEPS TAKEN BY THE AIR FORCE AND NAVY TO INSURE ACCURATE URINALYSIS DATA

AIR FORCE

On July 13, 1971, as a result of a visit by General Ryan, Chief of Staff of the Air Force and General Dixon, Deputy Chief of Staff for Personnel, HQUSAF sent a directive to Southeast Asia outlining the procedures to be followed to ensure accurate urinalysis data. These procedures include:

Frontal observation of the collection process.

Use of the photo on the identification card for positive identification and of the signature if there is any doubt.

A complete body search prior to urine collection.

Periodic attempts to invade the system with false documents and hidden urine.

Emphasis on command responsibility for a foolproof system.

NAVY

In late July 1971 Navy urinalysis testing procedures were improved to make the screening process as foolproof as possible. Basic steps taken essentially entail a "two-man rule" wherein each individual to be screened is observed by two or more persons while the urinalysis sample is being taken and all samples to be tested are handled in the presence of two more persons during delivery to drug testing facilities. Additionally each individual being screened is required to be stripped to the waist while the sample is being taken in order to visually assure that foreign liquids are not substituted for a valid sample.

Mr. ROGERS. Now, you say everyone who is coming back will go through those two centers?

Dr. JAFFE. Everyone except the Air Force and Navy people.

Mr. ROGERS. Will go through it?

Dr. JAFFE. Yes, sir.

Mr. ROGERS. These two centers?

Dr. JAFFE. Yes, sir; they are already doing that.

Mr. ROGERS. Now, how many more laboratories do you need over there?.

Dr. JAFFE. The issue is not laboratories so much as it is collecting facilities and trained men to see that in fact the urine specimen we have obtained and then transshipped to the laboratories belong to the men that are supposed to have given them.

Mr. ROGERS. The laboratories can't process them you feel?

Dr. JAFFE. At this point we think they are gearing up a third laboratory. At this point we will have adequate capacity to do that.

Mr. ROGERS. Where will the third laboratory be?

Dr. JAFFE. I think they are planning to put one at Da Nang.

Mr. ROGERS. Da Nang?

Dr. JAFFE. That is my belief.

Mr. ROGERS. As soon as you detect this you give them 7 days, but you haven't gone back far enough actually give treatment.

Dr. JAFFE. That is correct.

Mr. ROGERS. Why can't you do that?

Dr. JAFFE. We can, but the——

Mr. ROGERS. It is still the collection bit?

Dr. JAFFE. It is the collection bit. I can say that plans are afoot to do this, but there seems to be little point in running specialized tests on beer.

Mr. ROGERS. Has this shown up before?

Dr. JAFFE. It has.

Mr. ROGERS. So we are not really geared up yet to do an effective testing job unless it is only for those men getting out?

Dr. JAFFE. Plans are being developed to do this.

Mr. ROGERS. What is the time on it?

Dr. JAFFE. I would hope that it would be only a matter of several weeks or less before this is done.

Mr. ROGERS. I think it would be well to let us know.

(The following information was received for the record:)

TIME SCHEDULE OF URINALYSIS OF MEN NOT SCHEDULED TO LEAVE VIETNAM

The time schedule for Vietnam for other than DEROS personnel is as follows:

1. Personnel requesting extensions, July 22, 1971.
2. Leave personnel, August 15, 1971.
3. R. & R. personnel, Camp Alfa (Long Binh), September 10, 1971; Da Nang, October 10, 1971.

Dr. JAFFE. I might point out that men going on leave are only going away for a week or two and then coming back and do not pass through these points but pass through the facilities at Than Son Nhut. Men going on R. & R. do not pass through these facilities. These facilities are being developed and will be on line in less than 14 days.

So each time we build a collection site, we have to train people about all of the little nuances of making certain the specimen is delivered intact from its natural point of discharge to its appropriate point of analysis.

Mr. ROGERS. Now, let us follow this. They are getting out. How many have been placed on methadone?

Dr. JAFFE. None, sir.

Mr. ROGERS. None at all?

Dr. JAFFE. None at all, to the best of my knowledge.

Mr. ROGERS. So you are not using methadone for any treatment of addicts separated from the service?

Dr. JAFFE. If you are referring to methadone maintenance, the regularly daily administration as opposed to methadone detoxification simply to ease withdrawal, that is correct. However, if somebody comes back to a civilian facility having relapsed, then he is eligible for methadone. In other words, we don't feel methadone should be the first line. It should be our fallback position. We feel that young men age 18 to 22 who had never had treatment before should not be placed on methadone as the first response.

Mr. ROGERS. Even though his addiction shows up and he has withdrawal symptoms?

Dr. JAFFE. Well, withdrawal symptoms you can see after 3 or 4 weeks of drug use. It is really not an adequate way to measure the intensity of his chance to relapse later.

Mr. ROGERS. Are you making sufficient tests in the service before they are released to determine what the degree of addiction is?

Dr. JAFFE. There virtually is no way to determine whether somebody will require methadone or will respond to some treatment which will not require methadone.

Mr. ROGERS. How do you determine it in your Chicago operation, or Illinois operation?

Dr. JAFFE. Historically, almost all of the people we see have attempted treatment and have failed the treatment on one or more occasions. When they come in we feel they should make the decision as to whether or not they want to go onto methadone first, go into the therapeutic community, or go into a residential center and withdraw. They are all eligible for methadone. In the overall majority where they haven't done well and have relapsed, I feel those people are appropriate candidates for methadone.

Mr. ROGERS. I understand that in some treatments they determine the degree of addiction by what the man has been taking by giving him small doses and then bringing it up to a level where he does not have the withdrawal symptoms.

Dr. JAFFE. That is how, if somebody is to be put onto methadone, you would determine what his dosage should be.

Mr. ROGERS. I understand that. But isn't that generally the way it is done?

Dr. JAFFE. Not necessarily, sir.

Mr. ROGERS. What other way is it done? You don't start with the biggest dose, do you?

Dr. JAFFE. Some people do. Some people start with a huge dose the first day. We happen not to in Illinois.

Mr. ROGERS. Every place that this committee has visited I do not think that they started with the biggest dose. It is inconceivable that you give him more than he would require to maintain his habit. Do you want to get him on more methadone?

Dr. JAFFE. Are you asking me what way I want to do it or other programs want to do it?

Mr. ROGERS. I am saying I don't know anyone who does that.

Dr. JAFFE. There are a number of programs that do believe that blockade requires that you do bring up the dose.

Mr. ROGERS. How do you stabilize, by starting low and coming up to determine what the stabilization will be?

Dr. JAFFE. You start him on a dose you think he can tolerate for the most part.

Mr. ROGERS. How do you determine that until you begin to test him with specific doses?

Dr. JAFFE. Well, we could talk about a number of specific cases. It turns out that when people come in there are many cases in which they could be maintained quite adequately on 10 or 15 milligrams of methadone a day, but most programs start out impirically giving people 40 or 50 milligrams the first day.

Mr. ROGERS. Well, this is not what we have seen. We have seen where they usually start around 20. Then they go up to 30 or 40.

I would just like you, for the record, to give us some examples of people who use that system where they start them out with the largest dose. I am surprised to hear that.

Dr. JAFFE. Well, I will ascertain whether that is still going on. To the best of my knowledge, here in the narcotic treatment agency in Washington the average starting dose is about 40 milligrams.

Mr. ROGERS. Haven't they closed some of those?

Dr. JAFFE. No, sir. They have closed some general practitioners. These were unaffiliated with the Washington, D.C., programs. We could perhaps find you a number of examples of methadone programs where they start people on an average dose of about 50 the first day and then increase the dosage. Now, once you have started——

Mr. ROGERS. Not in a large dose, though, like 120 or 130 the first day.

Dr. JAFFE. Very few people do that.

Mr. ROGERS. That is the point we were trying to make.

Now, let me ask you, as I understand it, you are not recommending any methadone treatment for servicemen who are being separated for maintenance?

Dr. JAFFE. At the present time we are not.

Mr. ROGERS. Do you plan to?

Dr. JAFFE. I would prefer to wait and see how things are working out. If this is successful—you need feedback, sir.

Mr. ROGERS. I understand that. When the men are released from the 3 weeks of hospitalization, what happens? Are they referred to a local community? Are they referred to the VA? How are they referred? What is the policy?

Dr. JAFFE. The men who are now being treated in military hospitals are men who will do more service. They will be returned to their units.

Mr. ROGERS. What are you doing with those who are detoxified? In other words, you are not giving any hospitalization to anyone who will not continue in the service?

Dr. JAFFE. At the present time that is true.

Mr. ROGERS. What happens to them?

Dr. JAFFE. I believe they are sent home.

Mr. ROGERS. Sent home without any followup?

Dr. JAFFE. To the best of my knowledge, that is probably the case.

Mr. ROGERS. Are you going to allow this to continue?

Dr. JAFFE. No, sir.

Mr. ROGERS. What have you done to change it?

Dr. JAFFE. Well, we have done, in terms of policy, all that can be done without further statutory authority. Most of those men cannot be retained further. There is no——

Mr. ROGERS. I don't know if you have to retain them, but you can certainly require the military to immediately establish contact with the VA on the entry into detoxification. You can have a direct referral, a followup, have the VA pick them up. Shouldn't that be done?

Dr. JAFFE. That is part of the policy, sir.

Mr. ROGERS. I don't see it being executed.

Dr. JAFFE. If it is not beting executed we will look into why it is not.

Mr. ROGERS. You just told me nobody is doing it, and the VA has told us they have only had three referred to them. That is a pretty good showing that no policy is being carried out.

Dr. JAFFE. I think they said three transfers.

Mr. ROGERS. Well, three referrals.

Dr. JAFFE. That is probably not accurate.

Mr. ROGERS. Well, Dr. Musser, who is head of the VA program, said that, and I went into specific questioning on that because I was startled. Now, they have treated people who have come in for treatment who are already discharged, some of them, up to maybe 1,500, they think, who are direct addicts, 2,500 with psychological problems where they find addiction.

But there has been no liaison directly from the military to the VA on men coming out of Vietnam, which is what I thought we were establishing in June.

Dr. JAFFE. Well, that was my understanding of what should be done.

Mr. ROGERS. Well, I do think this needs your attention very rapidly, and I question where you say you have policy over the military. I wonder if this is a sufficient authority.

Dr. JAFFE. I am not at this point sure whether the difficulty lies with the VA or military, and I think it would be unfair for me to make the assumption that if either group is responsible for the fact that people are not being transferred upon discharge into the VA. I would appreciate an opportunity to look into it.

Mr. ROGERS. I don't know who is responsible either, but this committee is going to find out, because I think it is absurd to go through a farce of detoxification of 1 week and expect that to cure the addiction problem. I am sure you would say that is not going to do it.

Dr. JAFFE. I never thought that 7 days would be more than a stopgap measure. It is superior to prior to that time when nothing took place, sir. Certainly, we would not have applied for the additional 3 weeks. We would not have sought the additional authorization to retain them if we felt this wouldn't have happened.

I think we should also point out that if a man is scheduled for discharge and if he is transferred to the VA, he can walk out the same day.

Mr. ROGERS. I understand that, but you at least tried with a followup.

Dr. JAFFE. Without effort and some trial that is the minimum we can do and we can't do any more.

Mr. ROGERS. I am sure you do, but to find out this isn't being done is discouraging. Now, let me ask you, What about when he gets out of the VA? Is there any followup to go to a cmmunity facility, a community mental health hospital?

Dr. JAFFE. We are hoping that we will be able to persuade the various agencies that their cooperation should be of a level that there will be followup, because we feel that the VA has really only a limited number of facilities compared to the number of communities there are; that the VA would have to followup in many instances, and they in fact will have to establish their liaison.

On the other hand, there are civilian facilities that are not fully tooled up that exist in close geographic continunity with a well-established VA facility. It may be difficult for us to convince the VA to accept the civilian people in exchange. There is no reason why the people who are not servicemen cannot make use of the existing capacity in the VA.

Mr. ROGERS. I don't think there is any excess capacity. They are just beginning to gear up. They have five facilities, and they are asking for an appropriation for 30.

Dr. JAFFE. That is the present status.

Mr. ROGERS. We hope so, but I am not sure they will be able to do that type of thing, and I think there may be some priority with the veteran or civilian getting in first.

But let me ask you first, in your program in Illinois, do you allow them to take methadone home with them?

Dr. JAFFE. Yes; we do.

Mr. ROGERS. How long? I thought you said it was to be supervised.

Dr. JAFFE. I said one of the possibilities which makes methadone theoretically superior to heroin is that you can keep them coming in every single day. In the beginning of our treatment program people come in 6 days a week, and at one point we considered having them come in 7 days a week.

In time, when people are demonstrating by urine testing they are no longer using heroin and they are working and functioning, we may feel it becomes counterproductive for a man to come in 6 or 7 days a week to a treatment facility that may require him to take two buses. You can't expect a man to work and to come to an existing program to merely pick up medication. This is an intolerable burden for most people, and certainly anybody with a medical illness to go to his doctor just to get a pill every day would find out it is easier to suffer than get the pill.

So we do have people coming in 5 days a week and then 4 and then 3. That is a graduated program, and we feel programs follow that.

Mr. ROGERS. What is the greatest amount of methadone you allow to be taken out for how many days?

Dr. JAFFE. It is appropriate for me to say that the policy when I left was that once a week is a minimum. The minimum number of times a man can come to have medicine for ingestion without supervision in Illinois is once a week. You don't achieve that level until you have been in the program for 2 years, and you have had virtually drug-free urine for the entire period of time and have been working.

Mr. ROGERS. This would be the only time. The VA in their testimony tells us they let them take a week's supply home after a few months.

Dr. JAFFE. I would say as policy becomes more uniform over the Federal services, these discrepancies will, in fact, no longer exist.

Mr. ROGERS. In other words, would you not approve of methadone for a week's supply being given or a few months?

Dr. JAFFE. No; it should take considerably longer before people reach that stage.

Mr. ROGERS. Would you want that change made in the VA program?

Dr. JAFFE. Yes; I would.

Mr. ROGERS. Now, I think I would like to clarify for the record whether you feel there are any hard addicts coming out of the service or not. I got the impression you felt there were not.

Dr. JAFFE. I suppose it is a semantic issue of how you define a hard addict. Without question there are some.

Mr. ROGERS. To what degree and so forth, and what is your definition of a hard addict?

Dr. JAFFE. My definition of a hard addict is a person who has used it over a period of time who, after some treatment, relapses even under adverse conditions where he feels he will get into great difficulty.

Mr. ROGERS. So it requires a relapse period in order to determine whether a man is really a hard addict?

Dr. JAFFE. Either a relapse period or an extensive period of use, at least several months of continuous use, and I think it is more a matter of trying to gage attitude, gage behavior, and look at what the man is doing in the context of his drug use.

If you have a man use because his buddies will hand him a little bit and sit there passively and use it every day, you can't predict when that man will have to go get the drug for himself.

If you have a man who after several months uses enough and he is selling it to his friends, he is in the situation where his involvement with that drug has already reordered his value system, that friends don't mean as much as they should, that man is ready to be viewed as a hard addict.

Furthermore, we don't really know enough about the differences—and they may be significant—between smoking and snorting heroin and using it intravenously. Certainly, anyone who has already begun to use it intravenously should be viewed as the most serious variety of drug users we can have. Because 5 percent or so have already moved to that mode of administration, we can say at least that number should be considered hard core of the total that are there. I don't want to minimize the situation.

On the other hand, I do think we ought to recognize that we will pick up occasionally on these urine testings somebody who may have used it once or twice. To build a procrustean bed and to say no matter when we find them and under what conditions he will have to have at least 6 months of treatment, may be counterproductive. We may throw the occasional users into the category of hard core users. That is one of the limitations of the detection system which says there is only drug in the urine or there is not.

Mr. ROGERS. Is the Army presently capable of making these decisions?

Dr. JAFFE. Frankly, I don't think their men have had sufficient experience with these problems. We plan to send a number of civilian consultants there to see what we can do in the way of crash training.

This has been met with enthusiasm and appreciation by the Department of Defense.

Mr. ROGERS. When is that program to begin?

Dr. JAFFE. It has already begun.

Mr. ROGERS. The start of the training program?

Dr. JAFFE. Plans are already under development to take certain men en route to Vietnam to develop treatment programs and civilian treatment programs. We are beginning to select men who could spend 2 weeks in Vietnam to help develop these programs.

Mr. ROGERS. Are most of these men psychiatrists in the Army?

Dr. JAFFE. We will be training a range of treatment personnel. I think some psychiatric technicians, social workers, perhaps some nurses, some psychiatrists, and some general physicians. Those who will do the training will range from various psychiatrists to ex-addicts and people who are familiar with treatment programs.

Mr. ROGERS. What is your greatest need in the area of this in the area of this whole problem?

Dr. JAFFE. Frankly, a 30-hour day.

Mr. ROGERS. What about personnel? What is the greatest need there?

Dr. JAFFE. To get things started in Vietnam? Perhaps to find some unit of great excellence that had three times as many people as it needed for its own expansion so we could take them for 2 or 3 weeks and meld them within the services.

Mr. ROGERS. What about psychiatrists? Is there a need for psychiatrists?

Dr. JAFFE. The psychiatrist plays a role, if he had had specific training. Most psychiatric training that I am familiar with does not include any specific training in the area of addictions. I have known some programs that are in direct continuity with excellent treatment programs that never once rotated a man through that program for training in his entire 3 years of training. And the man leaves his psychiatric treatment program as ignorant of how the program works as the day he started his training.

So the title of psychiatrist actually means nothing with respect to the knowledge of a man about the specific treatment of drug users.

Mr. ROGERS. I understood you made the statement that what you really needed was 160 psychiatrists and 20 hours a day. You didn't make that?

Dr. JAFFE. Twenty would underestimate, and I probably didn't say "psychiatrists," because the psychiatrists in general, because of their extensive training and because of their income expectatons, can only be used in the most broad coordinating, supervisory, and organizational roles. In fact, most of the treatment is done by people with considerably less extensive training. One couldn't afford to staff for the treatment of 200,000 people with psychiatrists. In fact, we have found that our people who have been trained from diverse backgrounds, such as from nursing, from psychology, from social work, and other disciplines—and ex-addicts themselves—are able to function better in terms of communication, are willing to do things in psychiatry that psychiatrists very often feel unwilling to do and actually are more effective in treatment than psychiatrists.

This does not demean their role. It means that very often he can only be a trainer, a coordinator, a policy developer or a supervisor.

Mr. ROGERS. I presume that is what a psychiatrist must be.

Dr. JAFFE. But he has to learn his skills himself.

Mr. ROGERS. Is is easier for you to teach a psychiatrist or teach someone who is not trained at all?

Dr. JAFFE. If you want an honest statement, a psychiatrist has to unlearn a number of things before he can be taught.

Mr. ROGERS. It is not so much an association then with mental problems or mental hangups or psychological problems. I always thought there was a close association with drug use and, perhaps, some psychological problems. Do you feel this is not true?

Dr. JAFFE. It is not quite as close as our previous views would have us believe. As a matter of fact, to the extent that an individual focuses on an individual's background and his problem, I suppose that with the sociology and peer pressures and other kinds of attitudinal things, he begins to miss the most effective means of reestablishing attitude, reestablishing behavior.

Mr. ROGERS. What concerns me is that we say all of this and, yet, when we look at what is happening—for instance, I guess you are familiar with Dr. Chambers' work and Dr. Taylor in New York?

Dr. JAFFE. I know of Dr. Chambers.

Mr. ROGERS. I just wonder whether in methadone where the incidence of cheating is so high we are not fooling ourselves on this treatment we are giving.

Dr. JAFFE. First of all, they coined the term "cheating." That is obviously a pejorative term and attitudinal view, and it depends on what you are trying to accomplish by treatment. That study, I believe, was actually written at Philadelphia hospital before Dr. Chambers went to New York. They have some views that if somebody uses heroin from time to time after being in methadone treatment, that in point of fact the treatment is a failure.

Mr. ROGERS. Here is what he says during his study. During May of 1969, 82 percent of the patients had used at least one of the drugs. Specifically 77 percent or a little over had abused heroin.

Then 8 months later they checked the same group and among the patients who were the same census group the incidence of cheating had increased from 82 to 97 percent with heroin—I am sorry. Heroin was 92 percent. Overt cheating was up to 97 percent.

Now, maybe you need some more psychiatrists; maybe you need some people more skilled——

Dr. JAFFE. They were evaluating a program run by psychiatrists, sir.

Mr. ROGERS. What I am saying is that maybe you need some more psychiatrists and training and more individual attention. I don't know.

Dr. JAFFE. I am not trying to say we don't need more psychiatrists. There is a desperate need for them. But I don't think we should assume that the entire burden of delivering a health care system can be put on them.

Mr. ROGERS. I understand, and I don't think anybody proposed that. But I think just to set up programs without some pretty well-trained people is going to be a very difficult problem nationwide.

Dr. JAFFE. Our experience in Illinois has been that psychiatrists' need for income is such that it is very hard to even get them to take jobs with the program so we can teach them.

Mr. ROGERS. I understand, and we are going to try to produce more manpower under this bill that the committee has produced.

Now, let me ask you this——

Dr. JAFFE. By the way, sir, I think if one looks across programs such as those evaluated by Drs. Chambers and Taylor, you will find their findings may be somewhat atypical; and depending on how one analyzes the data, you find a different point of view.

It is quite true that once people start treatment, if you look a year later virtually none of them will stop using heroin. So at the end most of them will have tried heroin again.

But if you look at a group of 100 who have used heroin on any given week, the figure quite often is less than 30 percent, and in some places only 10 or 15 percent.

Again, perhaps a more reasonable figure of efficacy of treatment would be how many people in that treatment group will be arrested in that year; how many of those people have been convicted and how many of those are holding legitimate jobs.

These are important points of progress as well.

Mr. ROGERS. I would agree, but I think all these figures of 36.6 percent had dirty urine, 76 to 100 percent of five; 15 percent had 75 percent of the time, it is not a one-time use.

Dr. JAFFE. This particular program was out of a community mental health center and was directed almost entirely by psychiatrists, sir. There are many programs that are less forgiving, more demanding of their patient clientele and, therefore, in effect, get what they demand, with a lot more compliance and conformance with that program expectation, including decreased dirty urine positive.

We had some programs which were not forgiving and were demanding more and got more. The problem we have experienced is that you would get that percentage of positive urines down to 5 percent or less and that many people under that kind of pressure drop out of treatment.

The program in Philadelphia had probably a lower dropout rate than——

Mr. ROGERS. He only had one dropout.

Dr. JAFFE. Well, our programs that demand compliance can get the number of urines up to 95 percent, but at the same time we have a 30-percent dropout rate. These are the balances.

Mr. ROGERS. In fact, he did another study and this shows that in the 2-year period 80 percent continued.

Dr. JAFFE. In that sense they are extremely successful.

Mr. ROGERS. Well, I don't know how successful they are, because I am not sure if they are all taking heroin it is doing much good.

Nevertheless, let me ask you this: How much money is being set aside and programed for section 7 of the bill, which is the Director's authority to make grants to any public nonprofit agency or institution?

Dr. JAFFE. $100,000.

Mr. ROGERS. Do you think that is sufficient?

Dr. JAFFE. It is probably sufficient for the period of time we are thinking about in terms of getting tooled up. It is probably not going to be sufficient if we look at this over a range of several years.

Mr. ROGERS. I wouldn't think you could do very much with $100,000.

Dr. JAFFE. You asked how much money is available totally for direct treatment?

Mr. ROGERS. I am asking what amount of money you will have to make grants to public nonprofit agencies or institutions.

Dr. JAFFE. Directly of this office?

Mr. ROGERS. Yes.

Dr. JAFFE. Only $100,000. We did not intend, as I said, to make direct grants but rather to help coordinate the granting authority of other agencies.

Mr. ROGERS. How much will be from other agencies?

Dr. JAFFE. What is the total from other agencies?

Mr. ROGERS. For grants and contracts.

Dr. JAFFE. In treatment and rehabilitation the amount that is now being asked, including that for the VA, the new total is $147 million.

Mr. ROGERS. Now, that is for service, prevention, treatment, and rehabilitation?

Dr. JAFFE. This is treatment and rehabilitation. Education and training is another $28 million.

Mr. ROGERS. What is your research?

Dr. JAFFE. The total research at this point in time is well over $31 million. Some is spread out over the Department of Agriculture.

Mr. ROGERS. Would you give us a breakdown of that and how it is? You can do it for the record.

Dr. JAFFE. All right.

Mr. ROGERS. And in what areas of research it would be used.

(The following information was received for the record:)

Current breakdown of research and evaluation funds

	In millions
NIMH	30.5
OE	.2
OEO	.5
VA	1.0
LEAA	.2
BNDD	1.5
DOL	.2
Total	34.1

Note—Department of Agriculture has $2,100,000 for irradication research.

Mr. ROGERS. Now, are you going to try to encourage research on any particular antagonists?

Dr. JAFFE. There are two new antagonists which look promising.

Mr. ROGERS. What are they, sir?

Dr. JAFFE. There is M–5050, and there was one that was recently developed at Lexington which has another designation, the numbers of which I don't recall.

Mr. ROGERS. Can you let us know for the record?

Dr. JAFFE. We could put that into the record.

(The following information was received for the record:)

ANTAGONISTS BEING TESTED AT LEXINGTON

(At the date of this insert (Nov. 19,) the following antagonists are being tested at Lexington):

EN 1639
Naloxone Pamoate Suspension
1–BC–2605
1–cyclazocine

Mr. ROGERS. Could you tell us a little bit about these two antagonists.

Dr. JAFFE. Well, M–5050 is a derivative of etorphine and endoethene combined. Etorphine is about 1,000 times more potent than morphine on a milligram basis.

The antagonist itself is felt to be extremely potent and probably has minimal side effects, but that has to be determined. We feel it is, therefore, a good candidate to be made into a repository form. That is, this might be a drug you could use in low milligram dosage in some kind of repository injection. If this were so, we could give some of the antagonists that would last 30 days. Obviously, there is a technology problem in that.

The other drug which was developed at the addiction research center at Lexington has, as I understood it, a potency close to that of cyclazocine. It is orally effective and lasts for 24 hours. Its advantage seems to be in its lower side effects, as I understand it, and, therefore, it might be available relatively immediately to test on an oral basis in clinical operations.

The difficulty with cyclazocine is that many people complained about its side effects and were reluctant to take it. This drug may be free of that.

I know it has been available for some time for testing. We would like to see those tests, because these drugs are likely candidates for treating people who are perhaps either unwilling to go into the therapeutic communities or are not seen as ready candidates for methadone.

Mr. ROGERS. How many therapeutic centers are there in the country, do you know?

Dr. JAFFE. Wehave been trying to get that information. There seems to be some 6,000 programs. Whether they should merit the Appalachian program is a question we would have to look into with thoroughness.

Mr. ROGERS. How many programs specifically for drug abuse does the Federal Government have?

Dr. JAFFE. I suppose you mean how many do we give some money to.

Mr. ROGERS. Yes.

Dr. JAFFE. I am not sure we can give some money. We have them. We just give them partial support. I would guess of the identifiable programs we have at least 25 or so are out of NIMH. We have another 18 or so, as I recall, out of OEO.

We can get these things for the record.

Plus there are a number of smaller programs that are functioning and getting smaller support. The VA has some units, and there are a number of programs which, while not officially funded as drug abuse programs, are taking care of some drug users.

(The following information was received for the record:)

DRUG ABUSE PROGRAMS FOR TREATMENT AND REHABILITATION FINANCED BY FEDERAL GOVERNMENT

The number of drug abuse programs for treatment and rehabilitation financed by the Federal Government in whole or in part is 377. This exclusive of LEAA and SRS block grants programs and BNDD and DOD.

Mr. ROGERS. Not a very heavy involvement, though?

Dr. JAFFE. Again, traditionally medical treatment has been a community and State responsibility. The Federal Government has entered into direct funding only recently.

Mr. ROGERS. Let me ask you, today we anticipate that the House will pass a resolution similar to the Senate saying we want the public health hospitals and clinics kept open and also Fort Worth and Lexington to be continued. I presume the Congress will pass this very shortly. The House today, I think. We have also added money to maintain Fort Worth and the public health hospitals at the level of last year.

When this intent of the Congress passes, I presume you will plan to use the Fort Worth facility as the drug addiction center, as it is clearly the intent of Congress that it be done.

Dr. JAFFE. I think we are going to have to review all of the reasoning behind the intent to use it as a facility that would treat prisoner addicts and look at the impact.

Mr. ROGERS. I think there is no intent of the Congress for that. I was saying the intent to use it as it has currently been used.

Dr. JAFFE. Well, if this has legislative authority and it prevents us from doing anything else, we will have no choice.

The issue is that while we are simultaneously advocating the importance of followup in the community, it does not seem appropriate to continue to operate programs that take people several thousand miles from their homes and have no mechanisms for that followup. But certainly where there is no option to do otherwise, then——

Mr. ROGERS. Let us get this clear for the record. I think this is the impression that everyone has been trying to give the committee; that to pull somebody up out of the community and send them to detoxification or hospitalization anywhere from 4 to 6 months, hard addicts, is just out.

It might be that if there were no followup, they then go back to their community. I think that has been the fault of the programs in Lexington and Fort Worth, and there is no proposal to close Lexington. So I think it is conceded, of course, there must be followup.

Now, New York rips them up out of New York City and takes them out to the end of Staten Island, which is about as hard to get to for people as Fort Worth would be, and then they put them back in. But there is a followup.

Now, that is exactly what the VA is going to do; bring them into the hospital for treatment and then the followup in the community.

Now, how does Fort Worth then differ?

Dr. JAFFE. I would hope that the VA would not attempt to treat people miles from their community but would try to treat those people who surround their actual facilities who can make contact.

Mr. ROGERS. Now, look at the VA facilities. They are simply not in every community.

Dr. JAFFE. That is right.

Mr ROGERS. So they have to be uprooted from the community.

Dr. JAFFE. They should not be treated in veterans facilities. If it is better for somebody to get treatment close to his home, then I am not certain that saying, "You are a veteran and you must go to a veteran's facility," is in this best interest.

Mr. ROGERS. Every community is not going to have a drug abuse treatment center either.

Dr. JAFFE. I am not certain in time——

Mr. ROGERS. This is absurd to think about this. Every community in this Nation cannot have a proper, authorized drug control program for some time. It is going to take time. What are we going to do in the meantime?

Dr. JAFFE. We will do whatever we can do in the meantime, sir.

Mr. ROGERS. I hope it won't be closing facilities which we already have which we can use right now, even if it means transporting them a bit, if you can get some following aftercare. I am sure you ought to look at that very carefully, because I am sure you will find the intent of the Congress will be expressed very soon on this.

Mr. Preyer?

Mr. PREYER. No questions.

Mr. ROGERS. Dr. Roy?

Mr. ROY. No questions.

Mr. ROGERS. I am not sure this was brought out for the record in Illinois. Do you have a percentage of rehabilitation or do you speak of it in that term, the percentage of people rehabiliated?

Dr. JAFFE. We talk about the percentage of people who are working and holding legitimate paying jobs, and we talk about——

Mr. ROGERS. But there is still treatment?

Dr. JAFFE. There is treatment, but once people leave treatment they don't necessarily report back to us how well they are doing.

Mr. ROGERS. Any figures you can give us on that would be helpful.

Dr. JAFFE. I can only request the people back there to obtain the information for me. Having come here, I have given up my right to demand.

Mr. ROGERS. I understand that, but I presume in your authority where there is Federal funding they would have no hesitancy in supplying the figures, even though it is only a half million.

Dr. JAFFE. They might be slower to do it than somebody who works directly for the Federal Government. Tihs has been our experience.

Mr. ROGERS. They might be what?

Dr. JAFFE. Slower to provide it than if they were working directly for the Federal Government.

Mr. ROGERS. I am surprised at that, because I thought most cooperated very well, and I assume if you are relying on cooperation you will have to rely on State and local groups as well.

Dr. JAFFE. We will try to get the information.

Mr. ROGERS. If you can't, let us know, and I will make a direct request. I thought your State director was here.

Dr. JAFFE. He is the administrator and not the director.

Mr. ROGERS. Maybe the administrator has them.

Mr. DUERK. I don't have them here.

Mr. ROGERS. I understand you don't have them here, but if you could let us have them for the record, they would be helpful.

(The following information was received for the record.)

REHABILITATION GOALS IN ILLINOIS PROGRAM

It's impossible to speak in terms of the percentage of patients rehabilitated without some reference to the criteria for rehabilitation and the timeframe after entry into treatment. Obviously the situation will be different three months after

entry into treatment and 2½ years after entry into treatment. In addition, some patients who are doing well with respect to heroin use will not be doing well with respect to employment or antisocial behavior. Some patients who are doing well at three months may have dropped out of treatment entirely by one year. However, perhaps a long run view is best suited to gauging the overall effectiveness of a program. In that respect we would refer to a followup study of the first three hundred (300) patients to enter the Illinois multimodality system. The system consisted of at least three different components: an ambulatory methadone program; a therapeutic community; and a hospital unit associated with a halfway house.

Approximately 2½ years after entry into the system, 60 percent of patients can be considered to have achieved some goals of rehabilitation. That is, they are either still in treatment or are no longer in treatment but are known to be doing well. Forty percent can be viewed as not meeting rehabilitation goals in a clearly demonstrable way. This is a conservative estimate. We were unable to obtain followup information on 50% of individuals in the second group, and its entirely possible that they were doing well even though we could not obtain followup information.

Of the 182 individuals in Group I, only 146 are still in active treatment; the others have completed treatment entirely. Of the 146 still in treatment, 23 percent were using on medication whatsoever or were entirely abatement.

Mr. ROGERS. How are you planning to treat the civilian population, the hard-core addicts, who need commitment?

Dr. JAFFE. Who need commitment?

Mr. ROGERS. Yes.

Dr. JAFFE. Would you refine someone who needs commitment?

Mr. ROGERS. Hard-drug addicts who have to go through a period of detoxification. And I presume you feel that they have to be detoxified in some area away from drugs, or do you know? Maybe you don't believe that.

Dr. JAFFE. Treating people in the community in residential facilities after they have been withdrawn from drugs. Very often, one of the problems for people with minimal skills is that jobs are not that easy to obtain. A man sometimes does hold a job. A woman does sometimes have children. If we keep them out of the community more than several weeks so they can't see their children or can't go back to their employer, they lose what little progress they have made in their lives.

So it is important to us to treat people so that, after 3 or 4 weeks, they can go back to work, or where a woman's children can come directly to the facility and see her and maintain contact with her. Children rarely bring heroin to a facility. So these are the kinds of facilities we like to see.

Mr. ROGERS. I understand the Utopia, but where do communities of this kind exist?

Dr. JAFFE. They exist in Bedford-Stuvesant and certainly exist in Chicago, and they exist in many parts of the United States where people have not developed rigid ideas as to how a treatment facility behaves or what it looks like.

Mr. ROGERS. Do you know how many beds they have in New Orleans in the treatment facility? Ten. Do you know how many they have in St. Louis?

Dr. JAFFE. How many?

Mr. ROGERS. About 11.

Dr. JAFFE. Do they say they need more beds or more out-patient facilities?

Mr. ROGERS. Both.

Dr. JAFFE. Well, we are obviously more fortunate. Perhaps we have planned better. But in terms of beds, we have not built our beds within traditional medical facilities. This has permitted us to expand greatly. It is very hard to get beds within medical facilites.

The way we have developed them. It is considerably easier and considerably better for the patients.

Mr. ROGERS. Where do you get your beds?

Dr. JAFFE. Well, for example, the Salvation Army has a facility on the south side of Chicago, which it has intended for use in alcoholics, which they felt was no longer needed for that. We have that facility there.

There is a staff quarters and mental health center south of Chicago. We have the staff quarters there and we have room for 70 people there.

We have a facility that is an old mansion. We have 30 or 40 people there.

Mr. ROGERS. What is the longest period of time you would probably keep someone as an inpatient in the community health center?

Dr. JAFFE. It varies, in some cases from 2 weeks to, in some cases, 2 years. We call it residential. We have, for example, an old retreat, formerly used by a group of nuns, taken over by our facility. That houses 70 people.

So it is a lot easier to find 70 beds that way than build a 70-bed hospital that requires it to be built around a concept of medical illness and infirmity. Our people need a place to live, but they do not need a place that defines them as being sick and unable to provide for themselves. They need a retreat rather than a place that emphasizes invalidism.

Mr. ROGERS. Have you asked the National Institute of Mental Health how many drug programs they can get started immediately in their community mental health centers?

Dr. JAFFE. I haven't asked that question specifically; no.

Mr. ROGERS. Would you let us know?

Dr. JAFFE. I will make inquiry.

Mr. ROGERS. I would think this would be a good place to begin. This would give us some knowledge of capability. I would think that each of those centers would know or could easily find out what is available in their communities. I would think you would have to start somewhere to get an inventory of what the capability is.

Dr. JAFFE. We have already started that and are looking into that.

Mr. ROGERS. What have you found?

Dr. JAFFE. We have found that a study funded by one of the groups required modification to even ask the question of what the capacity was. In enumeration, a census of treatment programs provides little for planning unless it tells you how many patients you treat in resident status, total inpatient status, outpatient status, and the cost.

We finally had to abandon the question of cost because we felt no programs could provide that data in even a primitive way.

Now, that contract has been modified, and we think we will get that census of what the treatment capacity of the United States is, not just around mental health centers but around private groups, around State facilities. We don't know what the census is of the treatment resources. But that has already been undertaken more than 2 weeks ago.

Mr. ROGERS. Who has that?

Dr. JAFFE. I don't know what group has the contract. I think NIMH had let the contract. They tried to help us get the census.

Mr. ROGERS. How much was it, do you know?

Dr. JAFFE. It was a $50,000 contract.

Mr. ROGERS. I think if you would keep us advised on that and let us know the results of it. I would think the American hospitalization and community mental health centers program could quickly give you a census by simply sending out a questionnaire to their constituent people. It might give it very quickly.

Dr. JAFFE. We will ask them to do so.

Mr. ROGERS. I am sure they would cooperate with you, because I think it is essential to know what we can do, and I don't know how you can proceed, as you say, unless you know what is available and you know what needs to be done.

(The following statement was received for the record:)

UTILIZATION OF COMMUNITY MENTAL HEALTH CENTERS AS DRUG ABUSE TREATMENT UNITS

It is not possible without an institution by institution, and community by community investigation to determine which Community Mental Health Centers (CMHC's) could appropriately utilize drug abuse treatment units. In conducting such a census, we would examine the need for a drug treatment center in each applicable community. We have initiated early evaluations of the needs of individual communities and in the future we will be able to determine those CMHC's in which drug treatment programs should be established.

Mr. ROGERS. Thank you for coming back.

This committee is planning a trip to South Vietnam. We will leave Thursday evening in order to try to see for ourselves some of the problems involved. We are very much concerned about the present programs. We are glad you have been out there, and we think your input into the military will be helpful.

I think we have not yet seen sufficient movement in trying to get the military to coordinate with the VA, with communities, and I realize this takes some time.

But the committee is going to look into this very carefully so we will know how to gear the provisions of this bill.

Thank you so much for your presence and for your generosity with your time.

The committee stands adjourned until tomorrow at 10 o'clock.

(Whereupon, the subcommittee adjourned, to reconvene at 10 a.m., Tuesday, August 3, 1971.)

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

THURSDAY, AUGUST 5, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, at 10 a.m., pursuant to notice in room 2318, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The committee will come to order, please.

Our hearing today on the narcotics abuse problem is scheduled to hear from the pharmaceutical industry and its response to this committee's proposal that the major research-oriented pharmaceutical firms pool their scientific resources in the development of long-acting, nonaddicting drugs to block effects of heroin addiction.

It was just this last week that this committee initiated discussions with the industry to determine whether there may be promise in such an approach to narcotic addiction control, and I am gratified to learn that there is a research development opportunity here to which greater attention can and should be given.

This morning, because of the short notice, all of the presidents of the companies could not appear, but we are pleased to have the president and chairman of the board of Smith Kline & French Laboratories here with us, and, of course, speaking for all of the industry, Mr. C. Joseph Stetler, the president of the Pharmaceutical Manufacturers Association.

We will resume hearings in September when Congress reconvenes, and those additional people in the pharmaceutical industry who might want to testify will be welcome to do so at that time.

The development of a nonaddicting narcotic antagonist would give us a major weapon to deal with the heroin epidemic which we are now witnessing in this Nation. What we hope for is a safe and much more effective successor to methadone which will not be as addicting as methadone is.

Now, of course, I do not minimize the research and development challenge that this will pose for the pharmaceutical industry. There are many scientific bridges to cross, but I do hope that the major drug manufacturers will be willing to thoroughly commit themselves to this task, regardless of its difficulty. And if, this morning, we do receive the response which we hope for from the industry, this committee will take all appropriate steps to obtain cooperation from the Federal and State agencies and the scientific and other groups in the

field, and from the medical and scientific communities at large. Assistance, I am sure, will be needed from the National Institute of Mental Health, the Food and Drug Administration, the Addiction Research Centers at Lexington and Fort Worth, and others with scientific know-how.

I also hope that we can have a summit conference this fall of scientific leaders of industry, Federal and State agencies, and universities and medical schools so we could get the project going.

Our first witness this morning is Mr. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, accompanied by Dr. John G. Adams, vice president for scientific and professional relations, and Bruce J. Brennan, vice president and general counsel.

We welcome you, gentlemen, to the committee, and we will be pleased to receive your statement.

STATEMENT OF C. JOSEPH STETLER, PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; ACCOMPANIED BY DR. JOHN G. ADAMS, VICE PRESIDENT FOR SCIENTIFIC AND PROFESSIONAL RELATIONS; AND BRUCE J. BRENNAN, VICE PRESIDENT AND GENERAL COUNSEL

Mr. STETLER. Thank you, Mr. Chairman, and members of the committee. You have identified my associates, and we are here representing the Pharmaceutical Manufacturers Association.

Our association consists of 120 firms whose mission it is to research, develop, and produce and distribute the great majority of the medicines prescribed and dispensed in the United States.

Our association has been following your current series of hearings with interest and approbation. Fortunately, on Tuesday of this week, our board of directors had its regularly scheduled meeting and it was possible for me at that time to discuss with them our previous conversations which tied in with the statement you just made and your release of yesterday. I am glad to be able to say that they have authorized me to appear here today to offer the continued cooperation of the prescription drug industry in developing more effective means of treating narcotic dependence, including heroin which, as you know, has no legitimate medical use, and, also, in meeting the national need for alternatives to the presently abused narcotics.

We share the deep concern of the President, of this committee, and others over the Nation's drug abuse problem. We agree that more can and should be done by industry and Government, individually and jointly, in the search for solutions. We hope to have the opportunity to work with you, and with the governmental agencies operating in this field. I confidently believe that the experience, expertise, and facilities of this industry can, and will, materially increase the potential for the success of any related future research efforts.

In considering this subject we must do so, however, with the realization that the effort is far from new. For over a century, since the introduction of morphine in medical practice the search has been carried on for medications which will safely remove pain and not expose the user to the potential of dependence. Work has been carried out in universities, in Government institutions and, very substantially, in drug research laboratories.

For many years the pharmaceutical industry has worked closely with Government agencies on the development of analgesic drugs having low dependence-producing potential, and on related research problems. During World War II, the predecessor agency to the National Institute of Mental Health supervised a relatively successful research program which involved collaboration with industry scientists in attempting to discover pain-killing drugs. Much basic knowledge was uncovered in this research.

As World War II was ending in Europe, in 1945, the Allied Armed Forces sponsored visits to research laboratories in Germany by teams of scientists who examined the available records to learn about the new developments during the war years by German scientists. The team assigned to the medical and drug field included a group of pharmaceutical industry scientists. This team uncovered, among other things, the drug now called methadone, which became available shortly after World War II.

About the same time the National Academy of Sciences/National Research Council began a research effort in the narcotics field which enlisted the financial and scientific support of the pharmaceutical industry. The Committee on Narcotics and Drug Addiction, now called the Committee on Problems of Drug Dependence, invited the industry to participate in a research program aimed at developing better analgesic agents with less liability, narcotic antagonists and blocking agents, and better methods of testing for potency and addiction potential. The program includes a screening process for new drugs to determine their practical usefulness as analgesics, sedatives, or stimulants.

This collaborative research effort which continues to the present day, has involved contributions from the pharmaceutical industry of several million dollars, plus uncounted hours of effort on the part of industry scientists and executives. With a decreasing availability of Government funds during the past several years, the industry's share of the research budget of the Committee on Problems of Drug Dependence has increased; last year the pharmaceutical industry contributed almost $200,000.

We feel that the research program sponsored by this committee of the National Academy of Sciences/National Research Council is important and has resulted in great benefit to the medical profession and the public. We believe it should be continued with increased financial support.

A major portion of the overall research effort in this area has been devoted to the search, not for antagonists and blocking agents, but substitutes for morphine and other drugs derived from opium. While some genuine progress has been made, the need plainly has not been completely met, and, therefore, the question properly arises: What more can be done? Would an additional Government-industry joint venture help meet the need?

Quite frankly, Mr. Chairman, we do not know. However, many qualified firms are prepared for further exploration of the question. Collaborative efforts of the past have been productive, as the wartime programs such as the research project involving antimalarials attest. And, certainly, the threat we face now is as frightful as the one we faced in the 1940's, if not more so.

In investigating the possibility of a new joint industry-Government research and development effort, several important factors must be assessed. There are administrative, legal, and commercial questions which would require attention. One of these is the application of the U.S. antitrust laws to such a program, which would quite likely require a sharing of research data and facilities. In the light of such possible activities, it could well be expected that there would be some sharing in the production and distribution of resulting substances or products. A clear expression from the Department of Justice and the Federal Trade Commission on the application of antitrust laws to a specific program would seem to be necessary. It may be that an exemption from the antitrust laws, tailored to existing special circumstances, would be required.

When public and private funds and resources are both involved in the development of an invention or process questions of property rights and the licensing of pharmaceutical products and processes invariably arise. We suggest that special attention be given to providing a flexible approach to these matters.

While we have directed most of our remarks to questions concerning drug research and development in resolving the problems of drug abuse and dependence, we feel there are a number of nondrug related questions which the committee could well consider. For example, we feel that programs which would advance the research of the biochemical nature of dependence should be supported and encouraged. Research in areas such as this might well determine a common biochemical characteristic among narcotic users which could provide a basis for reversing or preventing the process of dependence.

At present, all newly developed narcotic analgesics, antagonists and blocking agents are processed through the Federal Addiction Research Center at Lexington, Ky. The current staffing and budget for this facility does not permit the screening of more than half a dozen new compounds a year. We recommend that the subcommittee consider additional support funds which would provide for the safety and abuse evaluation of significantly greater numbers of compounds at the Lexington Center.

The solution to the problem of widespread narcotic addiction in our society should be approached, in our opinion, by coordinating the dedicated efforts of Government, academic science, and industry. Basic research, quite varied in nature, is essential. The PMA supports a greater degree of involvement by the Government in such research programs through the use of Government laboratories and university grants.

In addition to any new collaborative efforts, the pharmaceutical companies will continue to conduct their own research programs for the development of products useful in achieving the objectives we are discussing here today.

We fully recognize that the industry, which has discovered or developed most of the drugs which have alleviated or ended many major diseases in other categories, should have a strong interest in attacking this most destructive new kind of plague. We do have that interest, and we pledge our willingness to explore with you the ways in which our capabilities, joined with others, might help meet the challenge.

Thank you.

Mr. ROGERS. Thank you very much. Mr. Statler, for indicating that the industry will cooperate in this problem. I commend the industry. I think it is a good step forward, and this committee will pursue with the Department of Justice and the Federal Trade Commission the question of antitrust provisions so that the proper action could be taken there, because the committee envisions that drug companies would come together with their top people, their scientific people, in conferences, so that there would be an exchange of viewpoint and knowledge. That would be the point of getting them all together. So, I presume this would be a necessary item to go into.

What is counsel's feeling as to the conference of the Department of Justice and the Federal Trade, say, if we restricted this, first of all, to heroin?

Mr. BRENNAN. I think there are a number of examples both in this industry and others, and Mr. Stetler alluded to one in the 1940's where such a program was undertaken with the concurrence of these agencies and in light of the antitrust laws. I think that we would not find it too difficult to create such an arrangement.

Mr. ROGERS. Good.

Mr. BRENNAN. It is not new to the Department of Justice, and I think it could be facilitated.

Mr. ROGERS. I wonder if you would also pursue that with them as well?

Mr. BRENNAN. Yes.

Mr. ROGERS. And let us know the reaction you get, and we will keep in close touch. I think that would be very helpful, because I think that would be the major, as I see it, the major problem, in getting started.

Mr. STETLER. I just cannot believe that there will be a problem. I am sure they view this just like you do and we do. We are not asking for any long-term, unusual advantages. I just cannot conceive of there being a serious objection to it.

Mr. ROGERS. I would agree, and I think, particularly, if we restrict it, first, to heroin in our discussions, that they would be very willing to cooperate.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

And I join the chairman in commending the industry in being willing to pool resources to emphasize research efforts in this field.

You point out very clearly some of the problems, but I think, when we see this excess of some of the Government and private industry cooperative efforts such as Comsat and the space effort, we can certainly conclude that where there is a will there is a way. It seems to me it ought to be possible here.

You mentioned that in the research area most of the effort to date has been to develop substitutes for morphine and other painkilling drugs rather than in developing block agents or antagonists.

So far, I think most of that effort has resulted in giving us new drugs which can be abused. I understand that heroin, for example, was originally thought to be a nonaddictive substitute for opium, but it turned out to be quite otherwise.

From the point of view of the good of mainkind in the long run, I would assume that developing a better painkilling drug might be

the best thing you could put your efforts into, but, from the short-term point of view of our drug problem today, I hope that you are not indicating that you are not going to put equal emphasis on: (1) trying to develop a substitute for methadone which would be nonaddictive and (2) working on the blocking drugs and antagonists, because it does seem to me that that in where our short-run, quick benefits may lie.

Mr. STETLER. Yes. I think it is obvious why, as a purely commercial pursuit, there has been a major emphasis on the development of substitute analgesics.

But, as we approach this challenge, the one you are identifying, we fully recognize that the major effort would be in the antagonist and blocking area. There has not been enough emphasis put on it, and that is what we are now prepared to do.

Mr. PREYER. On the subject of blocking drugs, perhaps Dr. Adams would be the man I should address this question to.

One thing that bothers me about that is whether it is possible to develop a drug which will block the craving for heroin but which will not block out too many other natural cravings of an individual.

Now, we do not want to turn people into robots, blocking out all of their natural desires and cravings and instincts. Is it possible, scientifically, to develop a drug which will be pinpointed enough to block out the craving for heroin but which does not block out too wide a spectrum of natural desires and emotions in a human?

Dr. ADAMS. I think, certainly, that one of the things that must be researched in much greater detail is the problem of cross dependence. This has been one of our big problems with the blockers and with the antagonists and with the development of morphine substitutes. This is a phenomenon that simply is not well understood, and a considerable amount of research effort must be directed to it. It appears that each time a firm discovers a new, potent analgesic it has addiction liability.

Now, some progress has been made—at least, in the case of antagonists. Naloxone, which has been developed and is in clinical trial, appears to be completely antagonistic without any of the undesirable properties of some of the other narcotic analgesics.

However, much more work will have to be done with Naloxone.

There are other compounds that are now being tested that seem to have this same property. Pharmacologists refer to this as an antagonist with an agonist component, and, if we can find the antagonist without the agonist component, we will have an effective antidote, at least, to heroin and other addictive drugs.

We have to learn more specifically how methadone and other such drugs produce their effects. If we can pinpoint that, it may be possible to produce the drug that will remove the craving for drugs and remove the physical dependence, without interfering with any other life processes which will enable the rehabilitated addict to pursue a normal life and not have the recurrences that are so frequent, in the case of narcotic addiction. These are the research target areas that have to be approached, and I think we have the capability to do it in a program such as the one you are suggesting.

Mr. PREYER. Well, it is a very delicate business. As you say, you are dealing with the life processes and the strains of the human person-

ality, and I am sure you will proceed with great care. There may well be an extremely important need for blocking agents. One school of thought says that the craving for heroin is something actually cranked into your metabolism. Once you become a drug addict, that becomes a part of your chemical system, and that you never get rid of the craving. That is a very pessimistic view, and I certainly hope it is wrong—and I think it is wrong and that willpower can overcome this craving. If that is the case, it looks like the blocking agents will be an absolute necessity as an answer to it, that you have to block that off before you can then proceed to do your other cure.

Do you have any thoughts about that theory?

Dr. ADAMS. I might just offer two comments. One is that if this is, in fact, true—and I doubt it—there may be a way to alter the metabolism of the particular target organ where these drugs are producing their effects. Another possibility would be that there may be a genetic factor involved which, to the moment, has not been very thoroughly explored. If there is this irreversible type phenomena you refer to, it could very will be, some kind of a genetic factor is triggered by the drug that, certainly, will bear very intensive investigation. These and other unknowns in the field simply have not been thoroughly explored. I think we have the technology to do it.

Mr. PREYER. Well, I wish you luck. It is a difficult field, and I am delighted to see that you in the industry are recognizing these problems and are willing to make this effort.

Thank you very much.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

I have no specific question. I would like to comment, however, there seems to be a little bit of a switch here. We are now appealing to the industry to help us with a job, and so many times it has been the other way around where industry has been under attack from political sources for alleged failure to act.

But, one question regarding methadone. Who developed methadone, in the first place?

Dr. ADAMS. Methadone was a German discovery.

Mr. NELSEN. I see.

Dr. ADAMS. And a team of experts that were sent to Germany following World War II discovered it, and it was brought back to the United States and marketed here as an analgesic drug.

Mr. NELSEN. We hope for some developments and the tremendous nationwide research capabilities of the firms you represent are extensive, and, are perhaps, greater even than that of Government, as far as the research in the drug field is concerned.

Dr. ADAMS. Without question, Mr. Nelsen, the drug industry makes the biggest contribution to drug research, an investment of now over $600 million a year involving well over 20,000 scientists.

In looking for the strength in drug research in this country, I think one looks to the drug industry.

Mr. NELSEN. If the various firms join hands in research and worked together, is that a danger of one protecting their ideas from another because of competition? If so can we overcome that so that everybody is working together on this particular endeavor and trying to find an answer?

And if we give you the protection of antitrust, then you would be more free to exchange ideas, would you not?

Dr. ADAMS. I defer to Mr. Stetler on the question of antitrust.

Mr. STETLER. I think any collaborative arrangements that are started would be done obviously with Government cooperation and, to some extent, supervision. We would not attempt to say to you that in this effort, or any other, all of the competitive instincts of this industry are going to be suddenly submerged.

Mr. NELSEN. I understand that.

Mr. STETLER. But I do say, in this instance given the initial limited target and relatively new areas to be explored and the recognition of the common problem that exists, that this would not be a major obstacle to an effective collaborative effort.

Mr. NELSEN. I join with Mr. Preyer in wishing you well in the endeavor and appeal, as a member of the committee to the industry, to give us the help we need.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

Dr. Adams, you mentioned a possibility of genetic vulnerability to heroin. Would it follow that a long-time user is likely to convey such a vulnerability to his children?

Dr. ADAMS. I do not think I can answer your question specifically. I am not a geneticist, but if there is a genetic factor, it would seem to follow that it could be transmitted to successive generations if there is, in fact, a gene of some type involved.

Mr. SYMINGTON. I was wondering, from heroin addiction itself, regardless of whether there was an original genetic vulnerability or at least the relative vulnerability, if it could be created in future generations by the use of the drug by a given person?

Dr. ADAMS. Well, apart from any direct drug ingestion or a genetic abnormality, the mere fact that these people are sick, that their social and—as a mater of fact, their physical—physiological qualities are affected, which, in turn, will affect the lives of their children, this certainly can have an effect. Now, it is not the straightforward genetic type of a problem, but it certainly becomes a sociological problem and may lead successive generations to become victims of the same weakness and the same disease.

Mr. SYMINGTON. As far as you know, you cannot inherit physical dependence?

Dr. ADAMS. As a result of ingestion, I do not think so. But I do not know. It may be something that is worthy of investigation. This is what I meant earlier. And perhaps this is a new avenue that should be pursued.

Mr. SYMINGTON. Another thing—and perhaps this is for Mr. Stetler.

You mentioned that the subcommittee should consider additional funds for the evaluations of the Lexington Center. In your view, based on your knowledge of what they are doing there, are these funds sufficient today for what they are doing? Are you seeking additional funds for this study, or do you feel that they are underfunded as it is?

Mr. STETLER. I think they are underfunded as it is. I was shocked to get the statistics that were new to me, that I mentioned in our testimony,

of their capability to scream only half a dozen or less compounds a year. It just seems obvious, without a lot of exploration, that that is an inadequate capability on the part of the facility. Absent any further mandate or assignment, I think that they do not currently have enough money to do their job.

Mr. SYMINGTON. What would be a fair number of compounds per annum?

Mr. STETLER. I really do not know. I have a feeling that there are a great many more than a half a dozen a year that are available and worked up to the point where they could be processed. It seems to be one of those obvious inadequacies. We are going to be interested in following it up, and I think you probably might be, too.

Mr. SYMINGTON. You mentioned that methadone was a German discovery. We must assume that they did not rest on their oars for a quarter of a century after that. To what extent are we able to communicate and learn from European pharmaceutical firms and scientists in the scientific community there, in a cooperative fashion, so that breakthroughs are hastened?

Mr. STETLER. I will let Dr. Adams answer specifically on what has evolved with respect to methadone. I think that we have made some good progress in the last few years, in terms of a better capability for coordinating research efforts with prescription manufacturers overseas. We have an organization which is now just 3 years old, which is a federation of associations of pharmaceutical manufacturers from all over the world. This provides us with an increased capability.

Our companies are extending their operations, both research and marketing, to many, many countries of the world. This puts us in closer contact with not only the commercial but the scientific communities in these countries, so that the capability exists and is improving.

Now, Dr. Adams might comment on what—if he knows—has happened in the methadone field.

Dr. ADAMS. I can only comment that a number of derivatives of methadone have been synthesized and tested for a number of purposes. One is for an analgesic that would not have addiction properties. Other properties investigated would include their capabilities as blocking agents or as antagonists.

As a matter of fact, one of them is under investigation now, acetylmethadol, which seems to have some promise as a blocking agent, which has not been established yet.

But, as far as other research in Europe is concerned, I cannot comment on that. I simply do not know, because much of that is not reported in the American literature. But it seems reasonable to assume that the same kind of research programs on analgesic drugs are being conducted in Europe as are being conducted here, and it might be worth while to have an exchange of information on this very serious problem, because it is not only serious in the United States. This is a worldwide problem in terms of heroin addiction.

Mr. SYMINGTON. Well, I would think that there would be a way that you would try to establish a structure. And perhaps there is something going on in the U.N. now. I believe I saw a paper from the U.N. the other day that indicated that a worldwide attack was being made on heroin addiction, but certainly we do not want to just rely on the American journalists for things that are not printed there, and I hope

to explore that. I think it is interesting that methadone was developed, I take it, not as an alternative to heroin but as an alternative perhaps to morphine. It was developed as a painkiller by the Germans, and it was only accidentally that they discovered that it was an alternative to heroin, and was addicting but not as severe.

Dr. ADAMS. That is a fairly recent discovery. As I recall, the use of methadone as a blocking agent for withdrawal was introduced as recently as 1965.

Mr. SYMINGTON. Why did they develop the drug?

Dr. ADAMS. As a substitute for opium because of the problems they were having in obtaining opium in World War II.

Mr. BRENNAN. Mr. Symington, I might add one thing, too, on your question concerning what we might do through the U.N. or take advantage of work that is being done in foreign countries.

There is a committee of the World Health Organization specifically designed to look at drug dependence questions, and, as Mr. Stetler mentioned, this international pharmaceutical manufacturers association has, just a few months ago, been given nongovernmental organization status within the WHO, so we now can more closely relate to WHO and its committees as more or less a semiofficial member. So, I think that, too, that exchange will now be facilitated and increased.

Mr. SYMINGTON. I hope so. Thank you very much.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Do you have a great deal of experience, Doctor, with heroin addicts or morphine addicts?

Dr. ADAMS. No; I have none, Dr. Carter. I am a pharmacologist by profession.

Mr. CARTER. Yes, sir. Did you ever ask a heroin addict that if he had all of the heroin that he could ever use would he ever quit the habit?

Dr. ADAMS. No; I have never asked the question, but I can tell you from my reading that the recurrence is very, very great.

Mr. CARTER. Well, I had a rather interesting conversation with Dr. Seivers at the Department of Pharmacology of the University of Michigan not too long ago.

In the course of our conversation we were talking with an addict, and I asked him this question, and he said "No, he would never quit." And Dr. Seivers stated—and he has had very wide experience, I guess as much as any man in the country—Dr. Seivers said he had never heard one say that he would kick the habit if he could get all of the heroin he wanted. So, we do have a great problem with this, because of the characteristics of heroin itself.

You mentioned an analgesic called Naloxone; is that right?

Dr. ADAMS. Yes.

Mr. CARTER. What precisely—or in general, either—does this particular medicine do?

Dr. ADAMS. Well, so far as we know, apparently when it is given in advance of the taking of heroin and some of the other opium derivatives, apparently it fits on whatever receptor is involved and prevents the access of that receptor to the heroin when it is injected subsequently, and, effectively, then, blocks or antagonize the effect of the heroin or other addictive drug.

Mr. CARTER. It does not do anything about the patient's desire for heroin, does it?

Dr. ADAMS. No; on the basis of some of the material I have read, apparently there is a recurrence, there is relapse following the Naloxone. So, it is not the perfect answer to the problem.

Mr. CARTER. They will still have it.

Are you familiar with the use of Nalline?

Dr. ADAMS. Yes, I am.

Mr. CARTER. Could describe that?

Dr. ADAMS. Yes. Nalline is also a narcotic antagonist used generally, however, in the acute episode of morphine poisoning rather than with the trial or maintenance of narcotic addicts. It is a very effective drug.

Mr. CARTER. You are correct. All opiates have a respiratory depressant effect. Of course, one of the great problems, as I see it, is to develop a drug which will relieve pain and yet not be addictive, if that can be done.

If we could take heroin even, or morphine, and keep the pain-relieving properties and knock out that which causes the euphora and, from that, addiction, then we would be accomplishing something. But I wonder about the use of an antagonist. I believe we are going to have to develop a different type of drug. It is a very complicated sort of thing.

According to our estimates, although we have a great problem, it is approximately half that much. We have about 365,000 addicts, I believe, in our country at the present time.

That is the estimate, is it not?

Dr. ADAMS. I am not familiar with that figure, either.

I thought it was closer to 50,000 for heroin.

Mr. CARTER. 360,000, something like that. I believe that is right. 365,000. The Federal Government has records of about 62,000 people who are addicted at the present time.

Dr. ADAMS. Yes; I am familiar with the figure. I was not familiar with the 300,000 figure.

Mr. CARTER. I believe that is correct. It is a great problem, and certainly I want to compliment you, gentlemen, in the work you are doing. It is a tremendous problem, and, on my part, I want to cooperate, and I want to see a partnership between Government and industry, and with the members of the scientific groups throughout the country, to see if we can stop the craving in some of these addicts for heroin or morphine or whatever drug they are addicted to. I thank the chairman.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman.

I would like to join my colleagues in commending your industry and especially your willingness to cooperate and trying to come up with some solution to this serious problem.

When this subcommittee was in New York City holding hearings, Mayor Lindsay made a statement, and I am going to quote it, and then I am going to ask you for a comment.

He stated:

> In the absence of the significant Federal research effort, New York City has acted to sponsor a nationwide program for development of new antagonist drugs—long-lasting, non-addictive compounds which will block the effect of heroin for weeks or months at a time.
>
> With intensive research we believe it should be feasible to develop an innoculation against heroin which would be administered to youngsters in the same way as that seen against such infectious diseases as small pox, polio, and measles. New York City has had to start this research effort on its own.

Are you familiar at all with what he might be referring to?

Dr. ADAMS. Yes; it has been suggested if one were to conjugate heroin, for example, with a protein, that when injected this would act as an antigen and produce antibodies so any subsequent injection of heroin would produce antibody and antigen reaction that would be so frightening to the patient that chances are they would discontinue the use of heroin.

Mr. HASTINGS. Is this research that your industry has been involved in or individual companies?

Dr. ADAMS. I am not aware of any of our companies having been engaged in that kind of research, but I would certainly think they are familiar with the concept.

Mr. CARTER. If the distinguished gentleman would yield on that, a drug which is very effective in alcoholism, of course, is antabuse which is causing such reaction as he mentions. I am sure you are familiar with that.

Dr. ADAMS. Yes.

Mr. CARTER. With that particular drug.

But if we could develop something like that in heroin users, they would not want to take heroin if they were on such a drug. I think, and I think the gentlemen in this group might be interested to know that when a person, an alcoholic, has been taking antabuse and he takes alcohol, he has such a tremendous reaction that it is very frightening. By means of this drug, we have been able to actually cure alcoholics.

I thank you.

Dr. ADAMS. The other element there, Mr. Hastings, would be that the presence of antibodies would prevent the effect of the heroin, too, so that effectively the patient would be vaccinated against it.

Now, whether that would prove to be the solution to his problem remains to be seen.

Unfortunately, the record is that most of these people revert—or possibly he might look for some other sort of stimulation to produce the same kind of euphoria that he previously had obtained with something like heroin.

Mr. HASTINGS. I take it that you do not think this avenue offers really too much hope for solving the problem?

Dr. ADAMS. I would not be that pessimistic about it.

Mr. HASTINGS. Why has there not been more research on the part of industry or individual companies if it does, in fact, offer some hope?

Dr. ADAMS. I cannot give you an answer to that, Mr. Hastings, but it seems to me it is an avenue that deserves further exploration.

Mr. HASTINGS. It is surprising that it is the city of New York, not the Federal Government or industry, that has bothered to take a further look at this, if it offers any hope at all.

Mr. STETLER. I think it is one of the answers that obviously will be looked at carefully with the new emphasis or capability at the Federal Government level. I think that anybody would be hard pressed to say, really, why it has not been done before.

Mr. HASTINGS. You mentioned that you had a total research budget of how much, over $600 million?

Dr. ADAMS. Over $600 million for the year 1970.

Mr. HASTINGS. And your testimony was you made a contribution to the Drug Dependence Committee of NAS of about $200,000?

Mr. STETLER. That is in one area; yes.

Mr. HASTINGS. And would you anticipate that that, under a spirit of cooperation, might be increased?

Mr. STETLER. Oh, I am sure of it. That has been an effort that has been going on within this committee for over 25 years, and the annual extent of funding has varied over the years.

The Federal Government has participated in the funding, too. However, as I mentioned in the last 2 or 3 years their participation has gone down, and I do not know why. When we talk about $600 million to $700 million in research effort, of course, that is the aggregate, the total, of our cost involvement in all sorts of research for all sorts of drugs. This has no specific relationship to the particular problems we are talking about now.

Mr. HASTINGS. I understand that.

Mr. STETLER. But, in answer to your specific question, I think, yes; our companies are aware of the fact that by virtue of this offer of cooperation it involves additional expenditures of funds in this particular area and probably an additional expenditure of Federal funds, both being more involved in the effort and in the financing.

Mr. HASTINGS. Well, I am somewhat disturbed—and I am sure the entire subcommittee is—that with the knowledge, after 25 years of these organizations doing extensive research and the type of problem, or the type of antagonist or blockage drug which would be hoped to be successful, and, yet, apparently, there has been very little, if any, success; and it does not seem that we are within striking distance right now in the time frame of coming up with such a drug.

Mr. STETLER. I should say, again, as we mentioned in our statement that the majority of the effort in these years and in this area has not been directed to an antagonist or a blocking agent, but more in terms of substitute products. There has been some work in that field, and there has been some success, but you are correct, in feeling that we still have a good way to go. We do not see the answer in sight right now.

Dr. ADAMS. I think one of the possible answers to that, Mr. Hastings, is the fact that 25 years ago our society was able to assimilate, I think, most of those addicts. They were adequately treated at Lexington and at Fort Worth, but with the increase——

Mr. HASTINGS. Or either we did not pay any attention to them.

Dr. ADAMS. The problem is now acute, and it requires a different kind of solution.

Mr. HASTINGS. On the subject of methadone, I am somewhat interested in it, because I do not see any short-range, easy answers to this problem we are talking about. Methadone seems to offer—and I say "seems to offer" advisedly, because I do not know what it does offer and I do not know if anyone else really knows, but I am aware that there is an NDA at the FDA right now on methadone, and I thought that it would not be too long before that became a legalized prescription drug. Is that your general analysis of the situation?

Dr. ADAMS. As I listened to Dr. Edwards' testimony the other day, I think he mentioned that there were 238 IND's on file at the present

time, and, obviously, the purpose of that is ultimately to submit an NDA for approval.

Mr. HASTINGS. Has that NDA already been started to be proceeded?

Dr. ADAMS. I do not know that.

Mr. HASTINGS. I believe it has. The question that arises in relation to that, with the lack of knowledge we have on methadone, the results of it—and there has gotten to be a very serious diversion factor from many clinics throughout this country, many diversions to the street where methadone is now being illicitly sold, and, now, of course, on the street, that we would anticipate that there would have to be some stronger controls than exist in the present law in relation to methadone.

Does your industry generally feel that would be the case?

Mr. STETLER. That appears to be so, and I think everything that has happened in the last few weeks and months indicates a pretty general agreement with that concept in the Federal agencies. I do not know if you have listened over this last weekend, but I heard commercials on the radio and television to the extent that the District of Columbia Medical Society had urged their doctors not to prescribe and pharmacists not to dispense methadone. So the scientific and professional community, as well as the Government agencies, are realizing some of the problems that that particular drug has caused.

Mr. HASTINGS. Well, I do not want to put you on the spot at the moment, but you feel generally that should methadone become a legal prescription drug that you support additional controls?

Mr. STETLER. It will have to be a well controlled item. No question about it.

Mr. HASTINGS. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much, Mr. Stetler, and your associates. I do hope we can proceed rapidly with this.

Since we will have a little more time, the committee would like to hear from drug company executive officers, perhaps the week that we come back, and we will try to be in touch, and if you could get some word to them, so that we can get into some very specific details on what we can do to move things quickly.

We, in the meantime, will contact the Attorney General and the Federal Trade Commission to see if we can get clearance for work in this area.

Thank you, and I commend the industry for you attitude in trying to help the Nation solve this problem.

Mr. STETLER. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is Mr. Thomas Rauch, president of Smith Kline & French Laboratories, Philadelphia, Pa.

Mr. Rauch, if you will come forward?

We are pleased to have you here as a chief executive officer of Smith Kline & French, one of the great drug companies of the country.

And I might say that it was with Mr. Rauch that we first initiated discussions, and we were pleased at the response he gave and, of course, at the industry's.

The committee welcomes you, and we will be pleased to receive your statement.

STATEMENT OF THOMAS M. RAUCH, CHAIRMAN OF THE BOARD AND PRESIDENT, SMITH KLINE & FRENCH LABORATORIES

Mr. RAUCH. Mr. Chairman and members of the subcommittee. My name is Thomas M. Rauch. I am chairman of the board and president of Smith Kline & French Laboratories, Philadelphia, Pa.

I appreciate the opportunity to appear before this subcommittee today.

Mr. Chairman, I have a brief statement that I would like to read.

Mr. ROGERS. Certainly. That will be fine.

Mr. RAUCH. My statement supports what has already been said.

You have called on the American pharmaceutical industry to bring its research and development talent to bear on a truly challenging task, but one which, if carried to completion, can be of vast potential benefit to mankind.

You have challenged our industry to pool its scientific and development resources in a major cooperative effort to perfect long-acting, effective, and nonaddicting narcotic blocking agents. The development of such agents, as all will recognize, can be a major first step in the conquest of heroin addiction.

We at Smith Kline & French Laboratories are ready, Mr. Chairman, to join in such a common effort. We commit ourselves today to this task. We do so out of the concern we in industry share with you and all responsible Americans over the national scourge of narcotic addiction.

At first—and I think Mr. Nelsen was touching on this—we may be a little ill at ease when we find ourselves working together instead of competing in the quest for new therapies. But the public need is so great we must set aside private interest for a time, until this job is done.

From a scientific viewpoint, it must be realized technical limitations exist. At this moment in time, certain technical barriers, certain shortcomings in our knowledge of the fundamental biochemical and/or psychological events involved in drug dependence, largely prevent the crash development of a medical solution for the serious problem of addiction.

However, assessing the present state of the art does suggest approaches to the problem which can be divided into three major thrusts, our scientists tell me. The first of these is the technically feasible and most timely approach of pursuing the clinical development of certain drugs which are known to block the effects of heroin, and those narcotic antagonists which are thought to have potential in the treatment of the narcotic dependent individual. It is imperative that we fully investigate the utility of these agents as quickly as possible to determine their safety and efficacy for use in the treatment of drug dependence.

The second major thrust, whose success is somewhat further removed in time than the first project, would involve study of the many narcotic antagonists which have been the subject of preclinical research, but which have not yet been prepared for clinical trials.

The third thrust, which is the most remote in time of all these possibilities, would involve basic research into the understanding of the biological mechanisms involved in addiction. Such research can be

expected to be difficult, timeconsuming and costly, but it will probably be necessary, if we are ever to arrive at an understanding of what drug addiction really is and what we can medically do about it.

It is now necessary to sound a note of caution. Judge Preyer and others of the subcommittee have already pointed out the difficulty of this task. Behind every bit of research, by its very nature, lies the specter of failure. In the wake of every successful drug development program is a collection of half successes and outright failures. It should not be expected that such a program as we are considering here would be exempt from this historical pattern. It seems important, if we proceed as suggested here, that we do so with the great hope of success but at the same time not raise false hopes of any immediate breakthrough, either in the mind of the public or among those unfortunates who are addicted to narcotics. We do not see the miracle drug to cure addiction as a near term possibility.

Mr. Chairman, I hope, as this program goes forward, that it can become a pooling of the resources of the whole medical-scientific community, in industry, in Government, and in the universities and medical schools.

The jobs can't be done as fast, or as well, without enthusiastic participation, for example, of the National Academy of Sciences/National Research Council, the National Institute of Mental Health, and the Federal Addiction Research Center at Lexington, Ky. If I may suggest a starting point, it might be a meeting of research leaders of participating industry, biochemical and medical scientists in university and other research centers, NIMH, and Lexington officials.

Such a meeting, we believe, could be held under the auspices of the National Academy of Sciences/National Research Council. Perhaps the new Special Action Office for Drug Abuse Prevention at the White House could join in the initiative of convening this meeting of scientific leaders.

Parenthetically, we are much impressed by the vigorous new programs being proposed both by the administration and in Congress to control drug abuse and to rehabilitate the users.

As Mr. Stetler pointed out, there are two complicating factors for the pharmaceutical industry in the kind of pooled, targeted research program we are discussing today.

First, because the search for heroin blocking agents is closely related to ongoing research for nonaddicting analgesics—products that have broad market potential, it is not inconceivable that R. & D. success in finding a heroin antagonist would also be a significant advance in analgesic therapy.

Administrative safeguards therefore should be developed to protect each participating firm's rights in any new analgesic product. On the other hand, it should be clearly understood that no rights would accrue to a firm for a compound's use in the public service aspects of heroin addiction control.

Second, the kind of R. & D. pooling we are discussing carries with it the possibility of violation of Federal antitrust laws. I think this point has been covered in enough detail. I just wanted to be on record with it, that it is important for Congress to include in drug abuse legislation appropriate language sanctioning this pooled industry research effort.

In conclusion, Mr. Chairman, S.K. & F. is ready to make a contribution of its scientific expertise and resources on a pooled basis with the rest of industry and the scientific community in general in this crucial area of research.

It is my hope that we can quickly get on with the job as a result of the leadership provided by this subcommittee.

Mr. ROGERS. Thank you very much for an excellent statement and one that goes right to the point, I think, and puts it in proper perspective.

This committee will contact the National Academy of Sciences to see if they will participate; we will also contact Mr. Jaffe as well as the Attorney General, and the Federal Trade Commission and see if we can begin to move to set up some meetings as you have suggested. I think this is what we need: to pool the resources and target in the drugs necessary to defeat this heroin problem.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

And I join with him in commending you. I like your flat statement, "We commit ourselves today to this task." I hope all of the other presidents of our leading drug companies will also be that flat in their commitment. The tides, as you put it, are working together instead of competing in quest for new therapies. I think your statement that your hope is, as this program goes forward, that it can become a pooling of resources of the whole medical, industrial, and scientific community as well as Government, universities, and medical schools, certainly points up what an exciting thing this could be.

You have mentioned, for example, that one of the thrusts of your research would be involving basic research into the understanding of the biological mechanisms involved in addition, so that you are on frontiers of new knowledge here.

And, I think that this is very exciting as a prospect, and we look forward to the results of it. Thank you very much.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

May I express appreciation for your statement, and I want to compliment the chairman of the committee on the record for his idea of asking industry to cooperate with Government in this endeavor. As Mr. Preyer has pointed out, this can be a very exciting effort, and, certainly, one in the public interest. I also want to thank you and your firm for your pledge of cooperation. We can go far with this kind of a program. It will be quite an enterprise and one that we can all be working in for the good of solving a real problem that we have. Thank you very much.

No questions.

Mr. ROGERS. Thank you, Mr. Nelsen.

Dr. Carter?

Mr. CARTER. Certainly, I want to compliment the distinguished president and chairman of the board of this great company for his efforts, as I complimented Mr. Stetler and his group for their work. And, again, I think that our chairman is due great credit for bringing you people here today.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

Mr. Hastings?

Mr. HASTINGS. I have no questions, Mr. Chairman.

Mr. ROGERS. Thank you so much.

We do appreciate the response, and we are grateful for the very fine appearance on short notice of the company and Mr. Stetler of the Pharmaceutical Manufacturing Association. We are grateful for your response, and we are going to follow through, and I think that this will get us on the track and, perhaps, really bring about a breakthrough more rapidly than any other method that I can think of to begin to cure the heroin problem in America.

We appreciate your being here.

The committee will stand adjourned, subject to the call of the Chair.

(Whereupon, at 11:12 a.m., the subcommittee adjourned, subject to the call of the Chair.)

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

THURSDAY, SEPTEMBER 9, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman), presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning, the Subcommittee on Public Health and Environment is continuing hearings on various legislative proposals to combat the mounting drug abuse problem experienced in this country. Shortly before the August recess, this committee proposed that the various pharmaceutical manufacturing firms in this country pool their research efforts to devise a blocking agent or another kind of agent, to combat heroin.

We were gratified by the response of the representatives of the Pharmaceutical Manufacturers Association as well as the president of one of the drug companies, Smith Kline & French, who indicated that our Nation's pharmaceutical industry would cooperate in this effort. This morning our committee is pleased to receive the testimony of the association and the president's and chief executive officer's representatives of some 26 of our major pharmaceutical companies. It is my understanding that these member firms produce about 95 percent of the Nation's prescription medicines and have at their command some 20,000 scientists.

Shortly after receiving the first assurances of cooperation of the Pharmaceutical Manufacturers Association, this committee contacted the Attorney General, representatives of the Federal Trade Commission and Dr. Jerome Jaffe who is the President's Special Consultant for Narcotics and Drug Abuse. All gave assurances to this committee that they would cooperate fully in trying to work out whatever problems might be involved of an antitrust nature, or any other legal problems that might be involved in trying to bring about a total industry-Government effort to assist in the development of this blocking agent.

This morning we are pleased to have this excellent representation of the pharmaceutical industry. I think the American people should be greatly impressed with the cooperative attitude that is so vividly expressed here by the presence of so many chief executive officers and the distinguished president of the association and other officers of the association.

66-841—72—pt. 3——10

Our first witness this morning will be the chairman of the board of directors of the Pharmaceutical Manufacturers Association, Mr. Henry W. Gadsden. He is also chairman of the board of Merck and Co., Inc. He has with him Mr. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, and Mr. Chester J. Cavallito, executive vice president of Ayerst Laboratories. Of course, I understand you will introduce the other representatives.

We are pleased to welcome you to the committee, and commend the industry for this cooperative effort.

STATEMENT OF HENRY W. GADSDEN, CHAIRMAN, BOARD OF DIRECTORS, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; ACCOMPANIED BY C. JOSEPH STETLER, PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; AND DR. CHESTER J. CAVALLITO, EXECUTIVE VICE PRESIDENT, AYERST LABORATORIES; AND INDUSTRY OFFICERS AND REPRESENTATIVES

Mr. GADSDEN. Thank you, sir.

Today, I am speaking primarily in my capacity as chairman of the board of PMA. As you know, PMA represents 120 pharmaceutical firms whose research and production capabilities account for most of the medicines that have been developed and provided around the world in the past 30 years.

Our purpose today is to affirm our support of an activity that is clearly in the national interset, and also to report on the steps we have taken in the last 4 weeks to begin converting that support into meaningful action. A national effort is required, on a scale commensurate with the need, if the problem of narcotic addiction in our society is to be brought under control. Within such a context, we believe the actions we propose to take or have already initiated will enable the prescription drug industry to make a valuable contribution to solving the problem.

With me today, as you have mentioned, are Mr. C. Joseph Stetler, president of the PMA, who appeared before your committee on August 5, and Dr. Chester J. Cavalitto, executive vice president of Ayerst Laboratories and cochairman of a newly appointed PMA Scientific Task Force. Also present are senior executives from 26 PMA member firms. We are here, Mr. Chairman, out of a desire to demonstrate our genuine commitment to try to make useful contributions to an accelerated program of industry research in narcotic addiction.

This level of attendance at a congressional hearing by key officials is quite unprecedented in our industry.

If I may, Mr. Chairman, I shall now introduce the pharmaceutical executives present. I shall ask each of them to stand as I give his name, position, and company affiliation.

LIST OF 26 SENIOR EXECUTIVES OF PMA MEMBER FIRMS PRESENT AT HEARING

Mr. Charles R. Adams, vice president and general manager, Riker Laboratories.

Mr. ROGERS. Mr. Adams, the committee welcomes you.

Mr. GADSDEN. Mr. H. W. Blades, chairman of the board, Wyeth Laboratories.

Mr. ROGERS. The commitee welcomes you, Mr. Blades.

Mr. GADSDEN. Mr. Lewis F. Bonham, vice chairman, the Norwich Pharmacal Co.

Mr. ROGERS. Mr. Bonham, the committee is delighted to see you.

Mr. GADSDEN. Mr. Joel R. Brown, Jr., president, Wallace Pharmaceuticals Division, Carter-Wallace, Inc.

Mr. ROGERS. Welcome, Mr. Brown.

Mr. GADSDEN. Mr. George R. Cain, chairman of the board, Abbott Laboratories.

Mr. ROGERS. Mr. Cain, we welcome you.

Mr. GADSDEN. Mr. Robert B. Clark, president, Hoffmann-La Roche, Inc.

Mr. ROGERS. Mr. Clark, the committee welcomes you.

Mr. GADSDEN. Mr. Fred A. Coe, Jr., chairman of the board and president, Burroughs Wellcome Co.

Mr. ROGERS. Mr. Coe, the committee welcomes you.

Mr. GADSDEN. Mr. Joseph P. Conlon, director of pharmaceuticals, E. I. Du Pont de Nemours & Co., Endo Laboratories, Inc.

Mr. ROGERS. We are delighted to see you, Mr. Conlon.

Mr. GADSDEN. Mr. William C. Connor, chairman of the board and president, Alcon Laboratories, Inc.

Mr. ROGERS. Mr. Connor, we welcome you.

Mr. GADSDEN. Mr. W. H. Conzen, president, Schering-Plough Corp.

Mr. ROGERS. We are delighted to see you.

Mr. GADSDEN. Mr. Henry F. DeBoest, vice president, Eli Lilly & Co.

Mr. ROGERS. Mr. DeBoest, the committee welcomes you.

Mr. GADSDEN. Mr. Albert J. Frey, president, Sandoz Pharmaceuticals.

Mr. ROGERS. Mr. Frey, we welcome you.

Mr. GADSDEN. Mr. Richard M. Furlaud, president, Squibb Corp.

Mr. ROGERS. We welcome you.

Mr. GADSDEN. Mr. Raymond D. Hetterick, president, Lakeside Laboratories, Inc.

Mr. ROGERS. Mr. Hetterick, the committee welcomes you.

Mr. GADSDEN. Mr. C. B. William Howell, president, Geigy Pharmaceuticals.

Mr. ROGERS. Mr. Howell, the committee welcomes you.

Mr. GADSDEN. Mr. John T. Kimball, president, Baxter Laboratories, Inc.

Mr. ROGERS. Mr. Kimball, the committee welcomes you.

Mr. GADSDEN. Mr. H. Robert Marschalk, president, Richardson-Merrell, Inc.

Mr. ROGERS. Mr. Marschalk, the committee welcomes you.

Mr. GADSDEN. Mr. George W. Orr, Jr., executive vice president, Miles Laboratories.

Mr. ROGERS. Mr. Orr, we welcome you.

Mr. GADSDEN. Mr. Ray T. Parfet, Jr., chairman of the board, the Upjohn Co.

Mr. ROGERS. Mr. Parfet, we are delighted to have you.

Mr. GADSDEN. Mr. John J. Powers, Jr., chairman of the board and president, Pfizer, Inc.

Mr. ROGERS. Mr. Powers, the committee welcomes you.

Mr. GADSDEN. Mr. Austin Smith, chairman of the board, Parke-Davis & Co.

Mr. ROGERS. Mr. Smith, we are delighted to see you.

Mr. GADSDEN. Mr. Donald Van Roden, president, Smith Kline & French Pharmaceuticals.

Mr. ROGERS. Mr. Van Roden, we are delighted to see you.

Mr. GADSDEN. Mr. Morris S. Weeden, president, Bristol Laboratories.

Mr. ROGERS. Mr. Weeden, we are delighted to have you.

Mr. GADSDEN. Mr. W. Clarke Wescoe, president, Winthrop Laboratories.

Mr. ROGERS. Mr. Wescoe, it is good to see you.

Mr. GADSDEN. Mr. Foster B. Whitlock, vice chairman and executive committee, Johnson & Johnson.

Mr. ROGERS. Mr. Whitlock, we are delighted to see you.

Mr. GADSDEN. Mr. William L. Zimmer III, president, A. H. Robins Co., Inc.

Mr. ROGERS. Mr. Zimmer, the committee welcomes you.

Mr. GADSDEN. The three of us at the witness table and these gentlemen will be happy to answer any questions the committee may have or to participate in any discussion that will help advance the committee's interest.

Mr. Chairman, the response throughout the industry to the committee's inquiries has been completely positive. Rarely have we had such unanimity. Many firms have pledged involvement of their talents and facilities. Others, not having the needed personnel and laboratories, have offered to be helpful in other ways. I believe that the response—while reflecting our awareness of the magnitude of the problem under attack—is attributable to the responsible and affirmative approach this committee has taken to stimulate new initiatives bearing on finding solutions to the problem of narcotic addiction in our society.

In making this commitment to participation in a broadened national effort, we recognize—as I am sure the committee does—that there will be no quick answer, no easy solution. Unfortunately, no one has the basic information, or the chemical and biological sophistication, to predict with certainty the successful outcome of a search for new ways to bring narcotic addiction under control. It is precisely for this reason, of course, that the search must be accelerated and that a national commitment of will and resources must be made.

The pharmaceutical industry agrees with the committee that since narcotic addiction is a societal disease with multiple manifestations, the Nation must work toward its control by pursuing all avenues that can lead to its prevention, diagnosis, treatment, and cure. This in turn suggests the very breadth of the effort that will be required—a truly national effort. We are keenly aware that the sheer complexity and social consequence of the problem makes it mandatory for our activities to be linked with what others are doing in university and government laboratories, in private and public programs of all kinds and at all levels, and insofar as possible with what other nations are doing. Fortunately, what we represent and what we can contribute is a highly specialized resources for research and development to chemistry and biology related to the evolution of compounds for use in man. And we

welcome this opportunity to bring that resource increasingly to bear on a problem of critical importance, just as we have in the past. We hope and believe our resources can hasten the availability of better ways to control narcotic addiction.

We cannot commit ourselves, and certainly I cannot commit the industry, as to the precise patterns to be followed by each company as it plays its part in strengthening the industry's program and blending it with the national effort. We are an extremely heterogeneous group of companies, in all ways. Some among us may elect to commit their own funds and resources to strengthen research effort in this field. Some may have a special capacity to carry out a part of the task that the Government particularly wants to do, in which case a grant or contract might be appropriate. Some may elect to participate by joining with others in a multicompany contractual arrangement of some sort to explore various parameters of a given problem. Whatever the mechanism, Mr. Chairman, we will respond to the best of our ability in helping meet this challenge.

It may be almost self-evident, but it should be said that in this as in all fields of research endeavor, a variety of research approaches to the same problem or problems may have positive values. Having several companies work in the same field but apply their own perspectives and techniques is more likely to yield results than fostering a rigidly organized, closely coordinated spectrum of research projects in which one project is assigned to one laboratory under the assumption that a centrally conceived approach is right.

Mr. Chairman, in this as in all matters adversely affecting human health, maintenance treatment—although worthwhile—is a poor alternative to cure, which in turn is a poor alternative to prevention. But if prevention and cure are out of reach at the moment, and if the consensus among informed authorities is that better methods of treatmen are almost within reach and are badly needed now, the prescription drug industry is glad to take part in an augmented national effort to achieve that goal.

We shall need a broad strategic assessment to make sure all potentially productive approaches are being explored—an assessment that must, again, take into account the problems posed by over centralization, the opportunities missed if diverse approaches are not encouraged, and the potential contributions to be made from research ideas that are out of the main stream of medical and scienific thought.

A more specific need to develop expanded facilities for the testing of candidate drugs, together with agreement on protocols for the testing of such drugs. The clinical investigations will require facilities and patient populations beyond the capacities of a company to acquire, and the protocols for measuring the safety and effectiveness of narcotic antagonists will probably have to differ greatly from those for most medical compounds. Here is an area where prompt governmental leadership is called for. It would be bitter irony if a number of promising candidate compounds were to present themselves, only to remain unevaluated because of lack of testing facilities or lack of agreement on testing protocols. I am sure, however, that appropriate governmental agencies are anticipating these needs and will take effective steps to meet them.

Since the hearings on August 5, we have taken a number of actions in which you will be interested.

Almost immediately afterwards, we wrote to Attorney General Mitchell and to FTC Chairman Kirkpatrick to explain our objectives. We suggested a joint meeting to discuss any antitrust questions that might arise.

We have received responses to our letters and a meeting with representatives of the department of Justice was held last Friday, September 3. While it is certainly too early to make any categorical statement about the positions that the two agencies will take, their representatives have evidenced a clear appreciation of the public interest goals that are involved. It would appear that responsible means of pursuing them in consonance with the law will be found.

Also, immediately following our August 5 testimony PMA wrote to all of its members firms seeking their support of the project. The number of companies represented here today is indicative of the response to that communication.

At the same time, we asked the research directors of 30 of our member firms to serve on a special scientific task force to examine the overall problems and opportunities which this project will present.

That group, which is chaired jointly by Dr. Cavallito and Dr. John Adams of the PMA staff, held its organization meeting on August 31.

Among the task force's objectives are the exploration of long-term and short-term tasks to which the industry can apply itself, and the investigation of ways in which we can work with other groups, to learn their goals and to help reach them. Representatives of outside organizations attending the August 31st task force meeting included officials of the National Institute for Law Enforcement and Criminal Justice, the National Academy of Sciences, National Research Council Committee on Problems of Drug Dependence, the Food and Drug Administration, the Drug Research Board, and the newly created Special Action Office for Drug Abuse Prevention.

The steps Government agencies are taking to deal with this problem are reassuring. We are prepared to work with them. Industry representatives have been active in assisting Dr. Jaffe in his new assignment. As you probably know, there was a joint meeting held yesterday, under the auspices of the Special Action Office for Drug Abuse Prevention, in which concerned scientists from industry joined with those from Government and academia to begin mapping out a coordinated effort for research and treatment of narcotic addiction. Dr. Cavallito attended the meeting as one of many industry participants.

In conclusion, for myself and all of the industry representatives here today, I would like to congratulate you, Mr. Chairman, and the members of the committee for your level of interest and your approach to this broad national problem. We are pleased to have this opportunity to appear before you and to present our views. We will be glad to try to answer any questions which you may have.

Mr. ROGERS. Thank you very much, Mr. Gadsden, for an excellent statement, and for the steps that have already been taken that you have outlined for us today.

I wonder if we could have some indication of how many of the companies present—maybe they could indicate to us—are currently working on antagonist in the narcotic field, or some type of blocking agent.

Mr. GADSDEN. May I suggest then if it suits you, sir, that Dr. Cavallito speak to that, because this was one of the subjects of exploration

by our scientific group, and there may be additional companies working on it which are not represented here.

Mr. ROGERS. Fine.

Dr. CAVALLITO. Mr. Chairman and members of the subcommittee, the number of companies or organizations that are currently engaged in research in this area can range from a hard core, if you will, of perhaps some half dozen companies that can be clearly identified with a history of involvement in this field to a much larger number of participants if one broadens the scope to include research programs that may lead to novel modes of treatment of such cases.

Some of the companies have been engaged for many years in research directed to the search for better drugs, influencing human behavior, and out of this, as well as the more clearly identifiable research related to the narcotic antagonists, may come useful drugs of the future.

Our position today with regard to agents such as methadone, for example has resulted as a fallout from research carried out for a number of years in attempts to discover and develop strong analgesics devoid of narcotic propensities.

In the course of such programs, drugs and compounds potentially useful in the treatment of addicts have appeared as a result of this kind of research.

In the past, the rincipal thrust has been toward the discovery of such analgesics, but in the last year or so, and particularly with the attention your committee has drawn to the problem, there indeed may be a shift in attention.

Part of this, of course, is related to the change in attitude that has evolved relative to the drug addict, that he is looked on as a subject perhaps meriting medical attention rather than as a social-legal problem.

There have been changes in attitude which may result in changes in research direction.

Mr. ROGERS. Well, I think you have pointed up what I wanted to know.

Now I presume that we have your agreement to devote the resources of the drug industry, with the committee that you have formed to begin to set forth steps. We would anticipate that the governmental agencies will cooperate, and I am sure they will, and if they don't this committee wants to be informed of it right away.

Dr. CAVALLITO. Well, as followup to the activities that Mr. Gadsden and Mr. Stetler have alluded to, the research managers of many of the companies represented here and others met last week and assessed the steps might be taken to implement the charge that we have.

Among the approaches are shorter term projects directed to the exploitation of leads currently available, coupled with simultaneous programs that may have longer term yields, and, of course, higher risk of success.

These would involve studies of the basic biochemistry of addiction, which we understand virtually nothing about. A coupling of basic long-term research together with a shorter term effort directed to the exploitation of current leads would appear to be a balanced program.

In seeking this, we are certainly most needful of and willing to cooperate with such agencies as Dr. Jaffe's group, with the VA group, with

the National Institutes of Mental Health, with the Committee on Problems and Drug Addiction, the FDA, and others that have been underway for some time.

Mr. ROGERS. Thank you.

Mr. GADSDEN. I think I might explain, Mr. Chairman, that many of the men who attended the first meetings were really the heads of research who might or might not be personally scientifically knowledgeable about these particular problems.

It is the intention now that a smaller group of people who are experts in this particular field be appointed to lay out a program of all the various approaches to the problem that might be considered.

As I told you, some firms may prefer to become not involved with property rights and spend their own money. Some may want to be in on a multicompany contract. This is something we have to report to you as we go along.

Mr. ROGERS. Yes; it will have to be worked out. I think it would be well if all the presidents and representatives would stand now. I want these people to get a feeling of how many people have come here to commit themselves, and I think there is a photographer here.

I would live to have him take a picture of this group standing, because I think it is a significant step in the fight against drug abuse in this country.

If all of you would just stand one moment, I think it is excellent.

Thank you very much.

Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman. I don't know that I have a specific question to ask, but I want to say thank you to the group assembled here.

It seems to me, looking back on a little history, that many, many times it has been sort of a different kind of meeting before congressional committees, one of kind of giving the drug people a little bit of a bad time. But here we are, a committee of the Congress, asking the firms that are expert in their field to help us solve a drug problem. I think those of us who are practical and honest about it must admit that the total research facility available to the firms that are represented here exceed anything that we have in Government or any other place. If we are to get moving in the direction of a constructive approach to combat the problem that exists your cooperation is most important. I would say, also, that our chairman came up with this idea, and I must say that he should be complimented for thinking it out and thinking it up, as the fellow says. I want to say to all of you that we welcome you here, and we think your opportunity is extensive, and we will cooperate with you in every way we can find some answers.

Thank you.

Mr. GADSDEN. Thank you very much, Mr. Nelsen, on behalf of my cohorts and associates here. Some of us had been down here before, and not always very pleasantly. But I want to reiterate what I think we have said before, that this effort can't be the exclusive province of the pharmaceutical industry.

Academic medicine, government, and everybody has to get involved, because there are so many sociological questions involved. Someone has suggested that an existing drug will aid in the with-

drawal symptoms, and one group will argue that maybe this is good, the person won't feel he is condemned to taking drugs forever after, but there is still an argument going as to whether a hangover cure is a good thing or not.

So these are decisions that I don't think we as an industry can make even if we have the agents.

Mr. NELSEN. I am sure we all agree that the whole field of medicine and research will have to be tied together to do the job. Thank you so much.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman. I wish to welcome all of the members of the industry here today. As the chairman has stated, the subcommittee just returned from a trip to Southeast Asia.

I think one thing that stood out in our minds was that cutting off the sources of heroin and other hard drugs is going to be a very difficult problem. I think that what you and the chairman have started here today is going to be quite valuable and quite necessary.

I would like to ask specifically, from your testimony, what particular drugs right now seem to offer any avenue of approaching this problem?

What particular drug could you name right now?

Mr. GADSDEN. Before I defer to Dr. Cavallito, they seem to fall into two discrete groups at least, and I am not sure I understand the differences. One is the longer acting methadone-like products, and the other is narcotic antagonistics.

Dr. CAVALLITO. In terms of identifiable leads at this time, the only drug in actual practice, of course, is methadone. A near term objective that many experts in this field identify is to attempt to develop a methadone-like agent which has a much longer duration of action.

Methadone must be given each day. Just from the nature of the patient being treated, he cannot be given a week's or a month's supply of drugs and told to go home and take it. This provide logistic problems and other problems of control.

There are others who feel, however, that this may not be a bad approach in that the reinforcement the patient gets on a daily appearance is important. Nevertheless, one of the goals is to find a longer acting methadone-like agent.

The nature of the agent should be what the pharmacologists refer to as a pure blocker. A pure blocker is one that does not have any analgesic properties, pain-relieving properties per se but has purely antagonistic property. For example, the drug maloxcine would be in this category.

Mr. KYROS. You mean this kind of drug doesn't produce any euphoria, but blocks the use of heroin?

Dr. CAVALLITO. One does not get a pain-relieving effect. The euphoria alluded to may be manifest, or the effects on the mind, may be manifest by hallucinations. One of the current leads in this area, cyclasocine, an investigational drug of Winthrop's, presents some question as to whether or not it produces hallucinations. If it does not and if it does have pure blocking properties, this, again, is a useful and valuable lead.

The limitations to date has been that we know so little about the

controlled evaluation of new investigational agents of this kind in a properly controlled clinical setting.

The availability of competent, well trained medical scientist in appropriate settings with the patient population to carry out these is a limiting factor, and is one which I think agencies of the Federal Government may be concerned with.

I know Dr. Jaffe's group is certainly concerned with this matter. There are further leads further down the line that other companies have. These are identifiable in terms of current approaches to blockers of the heroin type drug.

Mr. KYROS. Are you saying, then, in trying to develop the best drug that we might use that you might have several; that is, one might be just a pure blocking drug, and antagonistic to other hard narcotics, and others might be combinations of those kinds?

Dr. CAVALLITO. This could happen. Among the possibilities thrown out is the evaluation of maloxcine in combination with cyclasocine.

We know so little about the controlled patient responses to some of these investigational drugs that our guidelines from the clinic back to the laboratory are rather diffuse. The chemists for example in the industrial laboratories at some of the meetings we have had ask, "What do you want of us, what kind of molecules do you want of us?"

The answers to these kinds of questions must come from the clinic. We need this kind of coordination and feedback and the increased attention currently being directed to the problem may bring it about.

Mr. KYROS. Have you thought about how to undergo testing in a clinical evaluation? Where would you do this?

Dr. CAVALLITO. First, I am not a physician, sir, so my answer will be rather general.

Mr. GADSDEN. I understood that one of the next meetings which was going to be convened by Dr. Jaffe was on this very subject, as to how you did do the testing and what the protocol should be. I am told that if, in testing, you throw the patient into withdrawal symptoms he very obviously gives an adverse reaction. But this is relatively new territory for a good many of our companies.

Mr. KYROS. Do you think that because of the laws we have already enacted, namely, the Drug Abuse Control Act, which went through this committee in the past 2 years, research in this area would be hampered, and we would probably need new legislation to authorize you to do all these things?

Mr. GADSDEN. I plead ignorance. Joe, perhaps you know more about this than I do.

Mr. STETLER. I think at the moment there is no need for new legislation. There is a need for a more effective coordination among industry, a little change in emphasis, and more attention in general to the problem.

You asked about the availability of facilities to do the clinical research work. Although there is a great increase in the number of addicts, that doesn't mean that they are situated in places where you can do good control tests.

I was impressed the other day when our scientific group met, personally thinking that the population in Lexington must be vastly increased.

They tell us that actually the population in Lexington is lower, because in the past, when a man was convicted of a crime and he happened to be a narcotic addict, he was sent to Lexington. Now there are so many people convicted who are addicts, why pick one and send him there?

So the people in Lexington are apparently those who got there voluntarily. They can also leave voluntarily. So if you are conducting a controlled test, it could be disrupted quickly by the departure of the people being used in the testing.

So there has to be some assistance in locating the places where the addicts are and can be used and are willing to be used in some of this testing. I think it is in that area that we detect a need to work effectively with government.

Mr. KYROS. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Hastings?

Mr. HASTINGS. Thank you, Mr. Chairman. I would like to join my colleagues in welcoming you here before this committee and to express my appreciation to you for your active interest in this most serious problem. I might take this opportunity too, to express our thanks to our chairman who had the foresight to suggest that this great national effort be made.

I have a couple of questions. Dr. Cavallito, perhaps you can answer this, with reference to methadone.

Do you look at methadone more as a possibility of detoxification, or as a maintenance drug?

Dr. CAVALLITO. I think that is more of a clinical question than I would feel really competent to answer.

Mr. HASTINGS. Who is a clinical expert here, then?

Mr. GADSDEN. Since I have no expertise, I will answer it.

As you know, there is a great dispute about the merits of this drug, as to whether it takes a person from one addictive drug to another, and whether it is good or bad. I think the proponents, with respect to maintenance therapy, say the individual is returned to being a useful member of society and society itself is benefiting just because he is no longer stealing.

I am sure there are others who feel it should be done through other forms of psychotherapy or something of this kind, but I believe, from what knowledge I have, that there are more people who are on maintenance therapy than there are who are going through withdrawal.

Dr. CAVALLITO. One of the problems, Mr. Hastings, is apparently the high percentage of individuals who have been on methadone therapy that do not remain clean later. I think the percentage that I heard was something like 60 to 70 percent of those having been treated with methadone do not remain clean.

So it is obviously not a complete solution to the current problem.

Mr. HASTINGS. The pharmaceutical industry apparently does not have a position on methadone. Am I correct?

Mr. GADSDEN. The three of us up here, I don't think, should take a position, because this is something that various companies supply, and I don't think the medical profession has a position.

Mr. HASTINGS. I understand that. I am not being critical. I express this concern because I view methadone as a maintenance drug, primarily. Throughout the country, in talking to addicts and talking to people who run the so-called methadone maintenance centers, all agree that we are legal pushers of methadone, an addictive drug, which is more valuable than heroin, and when an addict uses it he is in a much better position than when he used heroin.

But I think we have to recognize that, that it is primarily a maintenance drug.

Perhaps I should talk to Eli Lilly, because I think they have a new drug application in on methadone to the FDA. Could a representative of Lilly tell me where we stand?

Mr. DEBOEST. Yes, Mr. Hastings. We do have a new drug application which was submitted as a result of collecting data from a number of the clinics around the country, organizing the data and evaluating it, submitting it to FDA. The status of the NDA at the present time is essentially that of approval, although this is not official until administrative determinations can be made how you handle the drug, which is, of course, outside our scope.

Mr. HASTINGS. Thank you. I have a followup to that. I would hope that methadone would receive the approval of the FDA. I think it is valuable in the overall problem. At the same time, I would hope your company and the industry would support much stricter regulation and control by the Justice Department, than we utilize from the normal prescription drug.

I don't see methadone as being made readily available to every doctor in this country to freely prescribe, and I have had conversations with the Justice Department already, and I think that we discussed this with Mr. Stetler, as a matter of fact, when he was here and I would certainly hope that Eli Lilly would be in agreement with the Justice Department and this committee when we start talking about stronger controls after the approval of methadone by the FDA.

Once again, I appreciate the presence and the interest of each and every one of you gentlemen.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

I join the rest of the committee in congratulating the industry on what must be an unprecedented joint effort, in which an entire industry joins together, rather than competing, to search for new therapies. As Mr. Gadsden has pointed out so well, this isn't just a case of industry itself working together, but a case of working with Government and the academic communities also.

Your special contribution from the research side should be considerable. Did I understand the chairman to say in his opening statement that there were 20,000 scientists employed in the pharmaceutical industry?

Mr. GADSDEN. I think his statement probably alludes to the membership of the pharmaceutical manufacturers associations, which, however, does represent, we believe, the vast majority of the pharmaceutical research that is performed in this country.

Mr. PREYER. That is a tremendous resource that can be brought to bear on the problem.

I was interested in your statement, Mr. Gadsden, on the top of page 4, where you say that "Maintenance treatment, although worthwhile, is a poor alternative to cure, which in turn is a poor alternative to prevention."

I take it the procedure you envision here is that perhaps a maintenance treatment might be the easiest, or the first, answer to come by—some form of better methadone—for example, that Dr. Cavallito spoke about.

But you would be pushing beyond that for the cure, and even beyond that for prevention, which would go into the question of basic biological mechanisms that lead to drug addiction.

Mr. GADSDEN. That was the guarded intent of the sentence, sir. References have been quoted in the newspaper about immunization, vaccines and things of this kind. I don't think any of us would deny that it would be very desirable in high risk areas to be able to do something so that you could assure that 11- and 12-year olds never become addicts.

When I talk to the people of our scientific staff, they don't even know how to start to do this. I asked them whether in connection with an older problem, such as alcoholism, anybody has ever had any success, and they haven't.

But obviously, this is the thing you would like to do. The intermediate one is to be able to administer something to the person once and for all over some period of time so that he never again will take heroin because it will have very unpleasant side effects.

What we are talking about, and I think what the scientists are talking about is something that will be effective more than 24 hours.

Mr. PREYER. I think that the progression of research on this is where the excitement and the whole challenge lies, and I hope that neither the drug industry nor our country would stop if we find a pill that is a better methadone, for example, which is really nothing but maintenance, so that we decide that we have an easy, miracle answer that will solve the drug problem and will push it out of our consideration, when we haven't gone on to a cure and prevention.

I am delighted that the industry is intending to attack the whole spectrum of this problem, and I hope we can get some light on it, because this committee is certainly convinced that this is a tremendous and growing problem and threat to this country.

I would like to ask one question. You just used the blocking drugs, Dr. Cavallito. One thing that concerns me is that in developing a blocking drug you develop one that is sufficiently discriminating, where it can block the craving for heroin, but that doesn't block out all the other natural cravings and instincts so that you turn a person into a zombie.

On page 4 you make the statement that the protocols on measuring the safety and effectiveness of narcotics and antagonists are going to have to differ from most medical compounds.

I hope you are not saying that because we need an answer in a hurry that we are going to let down the standards on how we test those drugs just to get something out.

How do you mean that the protocols for measuring the safety and effectiveness will have to differ?

Dr. GADSDEN. There is a regulation promulgated by the Food and Drug Administration in May of 1970 as to what was considered proof of efficacy. Safety, I think, has been better established over a period of time.

Now, a well-controlled study recently has gotten fairly narrowly interpreted as a double-blind crossover study. I as a layman am not sure how you run a double-blind crossover study with somebody who is a narcotic addict and where I wouldn't think—this is truly a layman talking—I think he can tell the difference between a placebo and an active ingredient pretty quickly, because I expect he would get withdrawal symptoms.

Mr. PREYER. I think our committee is familiar with some of the problems you mention there. What you are saying I take it, is not that you think the standards for antagonist drugs ought to be lowered, but that the testing procedures for it must be reasonably based on commonsense and not so elaborate that you stop the whole program in its tracks.

Dr. GADSDEN. I think it has to be tailored to the special situation with which you are confronted, and that is the reason I think the industry would prefer, with some participation by us, that these be promulgated and approved by governmental authorities so that there is no suggestion that we are taking any shortcuts.

Mr. PREYER. As the chairman mentioned in another connection, I think on the question of protocols if you run into difficulty, the committee would also like to hear from you on that. We perhaps could be of aid in reaching agreement on it.

Thank you very much for your statement and your contributions.

Mr. ROGERS. Mr. Schmitz?

Mr. SCHMITZ. Thank you, Mr. Chairman. I, too, would like to welcome this high-powered entourage here. I was expecting one of my constituents. Is Mr. Gavin Herbert here?

Mr. STETLER. He was supposed to be here, but he had some reason that he couldn't possibly make it, and he asked me to extend his apologies.

He did intend to come, and he is fully behind the program.

Mr. SCHMITZ. Thank you.

Mr. Chairman, not having any constituents here, I have no further questions.

Mr. ROGERS. I am sure the gentleman does not mean his interest in the drug problem is limited to his district. I am sure he would not want that projected.

Mr. Symington?

Mr. SYMINGTON. Thank you very much. I like to join you, Mr. Chairman, and other members of the committee in welcoming these distinguished gentlemen today, and one who is absent from my district, but who also himself is concerned with the problem nationwide is Mr. Harold Thayer, chairman of the board of Mallinckrodt Chemical Works, and with your permission, Mr. Chairman, I would offer for insertion into the record his letter to Mr. Joseph Stetler, president of PMA, fully endorsing this effort and explaining his absence.

Mr. ROGERS. Without objection, it will be made a part of the record at this point.

(The document referred to follows:)

MALLINCKRODT CHEMICAL WORKS,
St. Louis, Mo., August 23, 1971.

Mr. C. JOSEPH STETLER,
President, Pharmaceutical Manufacturers Association,
Washington, D.C.

DEAR JOE: Thank you for your letter of August 11 bringing me up-to-date on your appearance before the Rogers Subcommittee. You deserve an "A" for your presentation and getting the industry such favorable comments from the press.

Mallinckrodt Chemical Works would certainly be willing to explore the feasibility of a joint research effort with other members of the industry in the area you suggested. As you will note from our response to Congressman Pepper (copy enclosed), we already have expressed our interest in antagonists and blocking agents. I know that our Dr. Floyd P. Hallett has already agreed to participate as a member of the PMA Scientific Force on drug dependence.

I shall be in Europe September 9 on a long-planned vacation and regretfully will not be able to attend the hearings scheduled for that day. I do appreciate having been asked to participate in such an important event and am sure that it will be a tremendous success.

Good luck and let me know if I can be of any help in the future.

Sincerely,

HAROLD E. THAYER,
Chairman of the Board and President.

Mr. SYMINGTON. I would like to ask, Mr. Gadsden, this question. It is really, as you yourself said, a unique and historic moment that we experience today with the gathering of the clan you might say, of your industry.

One problem that has been on our minds here from time to time during our hearings on various aspects of the drug problem is related to prevention and psychology, or perhaps—well, certainly social psychology—and therefore to the marketing of all drugs.

You, sir, said that among you were no clinical experts, and I take it there are no psychology experts, although some digress may be there.

Young people today will observe the televised advertisements for various approved and undoubtedly safe and useful anxiety relievers, and mood changing drugs, and it is difficult for them and perhaps for some of their elders, to know where to draw the line and to understand where safety is behind you and danger is ahead.

As drug manufacturers, I take it that your primary interest is to come up with useful and clinically acceptable drugs to help people alleviate pain. Once you have manufactured such a drug and it has gone through certain testing and the Government accepts it, you turn it over to the marketing part of your business, and undoubtedly people get together and brainstorm how best to move this out into the market.

Perhaps you gentlemen here don't participate in those discussions, but someone does, and eventually some of the 2,000 detailmen who work for the industry who visit doctors offices will have these and attempt to sell them.

Others, with respect to over-the-counter drugs, will be figuring on how to sell them on TV and so forth.

When you say on page 4 that there is no real alternative to prevention, I put it to you that one form of prevention is to get people to see things in perspective, and I would like to ask you to what extent you and those with you today sit back and discuss whether or not the

kind of advertising for drugs today does place in precisely the right perspective the utility of drugs which are proved useful as distinguished from those that are dangerous so that the laymen who watch can understand.

Mr. GADSDEN. This is a subject which was discussed very briefly last evening when we were preparing for this meeting. There are, as I think you recognize, two major segments within the industry. Many of the companies represented here today are active both in the so-called proprietary segment and the so-called ethical segment.

We have been accused over the years of a lot of things, and I think the idea that somehow we are responsible for heroin addiction is repugnant to us. But having had that suggested, I can assure you that it is going to be a subject of scrutiny by the individual companies and by other trade associations, both of whom have in existence an advertising code.

Speaking only for my own company—but I suspect it is not different from the others—it is not true that new products are introduced without my personal knowledge of what is being said about them.

In other words, there is a new product committee which lives with the research project from the time it emerges from the test tube, goes into the clinic, and goes into safety assessment.

The initial advertising and promotion has to be submitted and the representations by the marketing people. We recognize a responsibility, and this is a collective "we" because although I can tell you how we do it, I am sure the same mechanisms exist in the other companies.

There have been some pretty bad articles written recently, and these will not go ignored. We will do whatever is necessary to make sure that our skirts are even cleaner than we would have hoped they have been in the past.

Mr. SYMINGTON. I think that is a very good statement. I think that the scope of the problem and of the effort to meet it would incite the same kind of cooperation industrywide, as the effort to find a blocking agent for heroin. Not simply a purely competitive posture but how close to get to the line before it is crossed.

Since your industry is so competitive and strongly so, it would seem that an industrywide conference should be held—perhaps one has—I am not familiar with all your activities—on the marketing aspects of the useful drugs, and held on a continuing basis, perhaps inhibiting some of the more competitively minded people, but never the less useful to the society as a whole.

I am glad to hear your explanation of how these matters are at least considered within your own business and undoubtedly the others that are here represented today. But we are all mindful in one way or another of Mr. Huxley's happiness pill of the future without which it will be difficult to get out of bed, and we know we don't want that kind of future for people.

We want people, perhaps, to suffer the pain necessary sometimes to realize their humanity. I am not sure I put that very well, but I thing that this is a difficult problem for a civilized society to handle, and we need your help.

Thank you.

Mr. ROGERS. Thank you very much.

I am impressed with the fact that you have already had organizational meetings. It is my understanding that you had representatives meet with Dr. Jaffe yesterday, too.

Do you see that leadership should be assumed by the Government as such, though, in directing this, or should it rest within the pharmaceutical industry?

Mr. GADSDEN. I think I attempted to say, Mr. Chairman, that the nature of the problem is so broad that it goes beyond our particular expertise, and therefore there has to be a coordinated national effort in which we assume some degree of responsibility for those things which we know how to do, which is the biological-chemical research, and somebody else has got to tell us what else ought to be done.

Therefore, we welcome the leadership and the coordination of the Federal Government.

Mr. ROGERS. I understand Food and Drug has already formed a special committee to devote attention to this problem, and will try to be cooperative.

Mr. GADSDEN. Yes, sir.

Mr. ROGERS. I wonder if any of the company representatives have any particular statement they might like to make that would be helpful to the committee?

Would anyone care to make a statement?

For instance, the priority that must be given, the resources that are needed—yes, would you identify yourself?

Mr. MARSCHALK. Robert Marschalk of Richardson-Merrill. I might give an example of how a Government-industry project worked with our company in the past.

Around the early 1960's the Army was interested in developing some rather exotic vaccines that had no commercial significance. We obtained a contract from the Army and under this contract they paid us on some sort of a cost-plus basis. We got a modest fee, and in doing the work on these vaccines, we added something to our body of knowledge.

They asked us to develop at least three vaccines, which we did. They provided us with the viruses, and from the viruses, we went through all the complicated steps to develop the vaccine. These three were Riff Valley fever, tularemia, and Venezuelan equine encephalitis. That is one that is being used on horses today, although we happened to have developed it for use on humans.

This was an example where, in effect, an arm of the Government took the leadership, went to certain people whom they felt had some expertise, let out reasonable contracts, and we performed under the contract.

I would suggest that there is some room for some of this type of activity here if somebody can say, "Here is something that you seem to have some expertise on."

Mr. ROGERS. Yes; I presume the conferences with Dr. Jaffe and the National Institutes of Mental Health and the National Academies of Science will develop the areas that need specific research.

I presume this will be what you anticipate.

Mr. GADSDEN. We would envision that when Dr. Cavallito's and Dr. Adams' committee comes up with a program that this will be presented and joined in with Dr. Jaffe.

Mr. STETLER. Dr. Rees of Winthrop is working part time with Dr. Jaffe's office. As a matter of fact, he was sent as Dr. Jaffe's representative to our meeting last week.

In his particular assignment, given to him by Dr. Jaffe, he will work on developing a blocking agent for heroin. Obviously, as a member of our task force, this provides a very effective tie-in. I would envision no real difficulties in our relationship with that body. It is a new body, as you know. The legislative authority is still pending. We are prepared to move as fast or faster than they, and maybe we can give them some impetus or a push from time to time.

Mr. ROGERS. I hope you could and I hope that will be done. What has been the experience with maloxone? I believe Mr. Conlon is here. Could you give us just a quick statement on that?

Mr. CONLON. Well, maloxone was developed by Endo Laboratories as an antagonist in normal hospital use for this type of drug. It was noticed by some investigators who were interested in the addiction field, and the concept of using it to block the use of blocking heroin was conceived.

It was conceived by several investigators who had noticed it being tested for this other use. Maloxone may or may not work in the long run. We are not sure.

But our posture on maloxone at the present time is, since it was one of the candidates that can be looked at quickly, our position is that we are prepared to sit down with Dr. Jaffe and work out the mechanism of evaluation that he would propose, the timetable, the method of operation, and exactly how he would want to go about doing it.

We would be moving into an area where we really are not truly expert, and therefore feel the need to have some guidance from an organization such as Dr. Jaffe's.

Mr. ROGERS. What does the drug do as far as the heroin addict is concerned?

Mr. CONLON. The concept is that if you can keep maloxone in the system, while it is there the addict will not get a high from heroin.

Mr. ROGERS. It would block the euphoria. Is it addictive, as far as you know?

Mr. CONLON. It is not addictive, and has been approved by the Justice Department as a nonnarcotic drug.

Mr. ROGERS. Thank you very much. Mr. Wescoe, I think, from Winthrop is here.

Mr. WESCOE. Yes.

Mr. ROGERS. Would you tell us about your drug?

Mr. WESCOE. The history of cyclazicine, Mr. Chairman, relates to the analgesic program of Winthrop Laboratories.

As one of the laboratory screens for the development of a compound like that, it is tested for narcotic antagonism. Cyclazicine was found to be very potent as a narcotic antagonist. It was so good in the laboratory that it was taken almost immediately to Lexington and there examined by Mr. Martin, and was confirmed in the human that it was an antagonist to heroin, and a very good one.

It has some disadvantages. First of all, unless one watches the individual doses when the treatment of the addict begins, one may find hallucinations in sensitive subjects. If, however, one starts with a very small dose and works up over a period of time to a larger one,

this is largely overcome, and that large dose is only 4 milligrams of the substance.

There are those who have criticized the compounds for long-term usefulness because actually its effects last only between 18 and 24 hours. It can be taken and is effective by mouth. What we are trying to do now, and we have been on this project now for a period of a little bit more than 12 months, is to find a form of the substance that would have a long depot possibility, where one injection might last a week or 2 weeks.

May I point out to Mr. Preyer, Mr. Rogers, that this is an absolute definite and specific antagonism, and it does not make one a robot. All it blocks is the action of the substance taken in. It does not block any of our emotional responses, and a person who uses cyclazicine, or for that matter maloxone, is really a normal individual.

Mr. PREYER. Thank you very much.

Mr. CONLON. There are many opportunities, sir, if I may add one other, that perhaps serves as a useful analog of what also might be done. There is the magnificent effort which went on with all these companies in the last world war in the search for an antimalaria compound, and there came out of that effort not only one but at least two very specific and very good antimalaria compounds, both of which are still marketed.

Mr. ROGERS. Thank you very much.

Mr. SYMINGTON. May I ask a question?

Mr. ROGERS. Yes, Mr. Symington.

Mr. SYMINGTON. I think both of you advised this, a blocking agent for heroin, would that necessarily block the craving for another addicting drug, such as methadone?

Mr. CONLON. It would block anything that is related to the morphine-type molecule, Mr. Symington. It would block morphine, cocaine, and heroin. I cannot specifically answer relative to beyond that.

Mr. SYMINGTON. I think that is the kind of thing we need, because methadone addiction is as serious.

Mr. ROGERS. Is this addictive in any manner?

Mr. CONLON. No; as far as we know, it is not. It produces no euphoria. As a matter of fact, the initial response to it, if there are psychological effects, are unpleasant, which is why it may have its serious disadvantages. If it is too unpleasant, people won't take it under any circumstances.

Are there any other comments or suggestions that you might have for the committee?

Mr. Powers, how about you? Do you think there is enough impetus now to really do something, or are we just talking into the sky here?

Mr. POWERS. No; I think it is really underway, and I want to congratulate you on getting it started. I recall earlier discussions of the subject. I am sure it is underway in this industry.

Frankly, I had some doubts about it getting underway, because as you look at it, and this must be the implication of your question, it is a pretty big, amorphous kind of a subject to tackle, and to have a whole industry attempt to tackle it with all the obvious problems is a pretty hard thing to contemplate. However, I am convinced that we are on the track and that we are really going to do something.

The real question remaining in my mind is the extent to which we are going to be able, all of us, to get a good, cooperative effort with the various Government agencies and this industry, and I say that without intending at all to malign anybody, but it is just again the difficulty of getting so many thinking people. On this subject I can tell you, everybody has his own idea.

There will be people who will tell you the whole notion of using drugs is for the birds. These are the psychiatrists and psychologists who think that is the only approach. I would suggest that it is probably a combined approach, but there is going to be a lot of argument, a lot of debate, and we are all going to have to hold together on this. I think the industry can.

Mr. ROGERS. Thank you. I think that is reassuring, because I know the committee does not want to go through an exercise in futility if we are really not going to produce something. I believe we will. I think the response of the industry has been so overwhelming that I think we will, and I am sure there will be some problems, as you point out, but if we set up a drug office with proper authority, then we would expect to be kept advised where there are blockage agents in the Government, and there may be some there that we may have to find a cure for. But this committee will devote itself to finding an antagonist to the blocking agents of government.

I have asked Dr. Jaffe to send a representative. I was hopeful he could be here this morning. We didn't give him much notice. But I am sure he wants to cooperate. He has sent his chief counsel here, and I am going to call on him in just a minute, to signify that they are behind this effort. We are going to see if we can't be helpful in coordinating some Government efforts to solve this problem. This committee has just taken a trip, some of the members, to the area where they are producing drugs, in the Golden Triangle in Southeast Asia.

I think the President has done a magnificent job in getting Turkey to agree to cut off their production. But I am afraid it is going to shift to some other parts of the world and I am afraid one of those areas is going to be this area in Southeast Asia.

So I am told we can stop the drug, and I think that is a very formidable task when there is so much money involved, to stop the drug from coming into the country. Then I think the emphasis in the drug problem is going to be to try to find a cure or some blocking agent or some prevention or a vaccine of some type, and I think you have a great challenge, which I am delighted to see you responding to.

Mr. Conzen, how about a comment from you? Do you think we are just backing up a tree, or do you share Mr. Power's feeling?

Mr. CONZEN. I share, Mr. Chairman, the views of Mr. Powers. As a member of the PMA board of directors, I participated in the decision of that board which authorized Mr. Stetler to appear before your subcommittee on August 5 to offer the continued cooperation of the prescription drug industry in developing more effective means of treating narcotic dependence and of meeting the Nation's need for alternatives to the presently abused narcotics.

I have read Mr. Stetler's statement to the subcommittee and heartily concur in his pledge on behalf of the industry to explore with you the ways in which our capabilities, joined with others, might help to meet this challenge.

Mr. Chairman, let me add that not only in my capacity as a businessman, particularly my lifelong involvement in the pharmaceutical industry, but as a human being and a family man, I am deeply concerned about this most serious problem and impatiently desirous of finding a solution for it as rapidly as possible.

Let me say, Mr. Chairman, that on behalf of the Schering Corp., we are prepared to commit ourselves to the task you have outlined in the sense of applying whatever skills we may have to the objective. Our company is not, either by scientific disciplines in our research or in facilities by way of equipment in our production and manufacture, skilled in the field of narcotics or addictive drugs.

As you know several member companies of the PMA, are highly skilled and significantly equipped in that field. Nevertheless, we will cooperate in whatever way we can, and we pledge utilization of our facilities and our personnel to the extent they can be useful in this mission.

For the further information of the subcommittee, I am furnishing you a copy of a letter addressed by our vice president for corporate research to the Honorable Claude Pepper, chairman of the House Select Committee on Crime, dated June 25, and concerned with this very same problem.

Thank you very much, Mr. Chairman, for giving us the opportunity to appear before your committee.

(The letter referred to follows:)

SCHERING CORP.,
Bloomfield, N.J., June 25, 1971.

HON. CLAUDE PEPPER,
Chairman, Select Committee on Crime, House of Representatives,
Washington, D.C.

DEAR MR. PEPPER: Thank you for writing us concerning the very important problem of drug abuse and the possibility that the pharmaceutical industry in general and Schering Corporation in particular might work cooperatively with the Federal Government in developing better narcotic blocking or antagonistic drugs. As far as this specific aspect of the attack on narcotic addiction is concerned, there are several firms in the industry better qualified than Schering by previous experience and expertise to contribute substantially.

Schering, in the past, has neither marketed nor done research on narcotic drugs, nor have its chemists concerned themselves with modifications of narcotic drug structures. It is most probable that chemists with a background in narcotic drug chemistry would be best qualified to develop longer lasting and more effective narcotic blocking agents; I would, therefore, suggest that the most meaningful cooperation might be obtained from those companies which now and in the past have marketed drugs or agents allied to narcotics chemically or biologically.

I am not answering your specific questions on our facilities, personnel, and previous research since, in general, our answers to these questions would be noncontributory. Further, I do not believe it would be desirable for the government to provide funds to a firm such as ours which has not been active in this general field.

I should, however, point out that Schering has done and continues to do research on non-narcotic analgesic agents. None of those that we have examined so far would be blocking or antagonistic drugs but their substitution for narcotic analgesics in medical practice would reduce the quantity of narcotics which would need to be produced for prescription by the medical profession and thereby decrease the opportunity for their diversion into illicit channels. The non-narcotic analgesics would have no appeal to the addict. However, our research on non-narcotic analgesic agents does not require Federal funding since such products are sufficiently attractive from a purely commercial point of view to insure that Schering and other companies will continue their development without benefit of Federal aid.

I regret that I have not been able to assist you with answers to the specific aspect of attack on the addiction problem with which your letter is primarily

concerned. I expect that you will obtain more useful information from other sources. However, should my reply suggest any other assistance which we might render to your Committee, we will be pleased to discuss the matter further with you.

Sincerely,

AUGUSTUS GIBSON, M.D.,
Vice President, Corporate Research.

Mr. ROGERS. Thank you, and we appreciate the statement you have made.

If we could hear maybe from one more president, Mr. Furlaud.

Mr. FURLAUD. Mr. Chairman, I would simply like to say on behalf of the Squibb Corp. that we certainly support the position taken by Mr. Gadsden on behalf of the association, and I personally would like to congratulate you, sir, and the members of your committee, for the leadership you have provided to mobilize all the resources in government and industry and in the academic field.

I am convinced with Mr. Powers that this industry is deeply committed to making the effort that it can, and I think it can make a successful effort in trying to resolve this problem.

Mr. ROGERS. Thank you very much.

I am delighted, too, to see Mr. van Roden, whose president testified before our committee previously.

The committee is grateful to all of you. We appreciate the time we have taken in showing the interests of your companies in trying to solve this national problem.

Your industry is to be commended. We are grateful to you, and we hope you will keep in close liaison with this committee. We intend to see that the cooperative efforts of the industry are put to good use and that the Government does not stand as a blocking agent to you in this effort to solve this problem that really has gotten completely out of hand in this Nation.

Thank you, we appreciate your presence.

Our next witness will be Mr. Paul Perito, who is the General Counsel and Assistant Director of the Special Action Office. Mr. Perito, the committee welcomes you. We know of the good work you did with Congressman Pepper in his committee, and we think Dr. Jaffe is fortunate to have you working with him.

If you would take back the message to Dr. Jaffe and the President to hope he will be able to cut through the OMB and be able to speak for him on drugs whenever an industry is willing to cooperate, and I am sure he will, I know he has already taken steps.

We welcome you here.

STATEMENT OF PAUL L. PERITO, GENERAL COUNSEL AND ASSISTANT DIRECTOR, SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION, OFFICE OF SPECIAL CONSULTANT TO THE PRESIDENT FOR NARCOTICS AND DANGEROUS DRUGS, EXECUTIVE OFFICE OF THE PRESIDENT

Mr. PERITO. Thank you, Mr. Chairman. I would like to say, before I refer to my prepared testimony, which is very brief, that I know Dr. Jaffe conceives of the mission of the Special Action Office to be, as you put it, an antagonist against any blockage that may occur in our attempts to get at the heart of the drug problem. I know that you,

Mr. Chairman, and your committee, are giving serious consideration to the legislation before you, which is absolutely crucial if we are to effect our mission.

Mr. Chairman, and members of the subcommittee, on behalf of Dr. Jaffe and the Special Action Office for Drug Abuse Prevention, I want to thank you for this opportunity to brief the subcommittee on what transpired yesterday at a meeting called to explore ways of accelerating the research and development of new drugs for the treatment of opiate dependence. Dr. Jaffe has asked me to extend his regrets that he could not accept your kind invitation to appear in person this morning, Mr. Chairman, because he has an engagement at the White House.

Our meeting yesterday was called by Dr. Jaffe and our Special Action Office to review the state of the art concerning narcotic antagonists, drugs which optimally preclude the euphoric effects of opiates but which themselves would not be addicting. Several of these antagonists are currently being tested, but appear to have some undesirable side effects and are not sufficiently long lasting. To determine if and how the scientific genius of America could produce a long lasting and safe narcotic antagonist with minimal or no side effects, Dr. Jaffe called together leading researchers from the pharmaceutical industry, representatives from NIMH, the Food and Drug Administration, and the National Academy of Sciences—National Research Council, and the Federal Trade Commission and the Department of Justice.

Also present were staff members from your committee, Mr. Chairman, and staff members from the Select Committee on Crime. Dr. Jaffe is exceedingly appreciative for your leadership, Mr. Chairman, in helping us to reach our common goal.

The general consensus of that meeting was that the narcotic antagonists have a real and potentially major role to play in the treatment of narcotic addiction, but there have been, as you well know, several stumbling blocks to their perfection.

Perhaps the major problem areas have been the limited ability of government and industry to rapidly evaluate the efficacy of these compounds and test them on animals and huamns, and the availability of sufficient amounts of these compounds for such testing.

Dr. Jaffe feels confident that yesterday's meeting will result in, among other things, an accelerated approach and research program to produce, test and evaluate antagonists and other compounds which may be helpful in the treatment of drug dependent persons. All of the participants at the meeting have agreed to work with the Special Action Office to effect this common goal. In our capacity as the coordinating and policy-directing agency for drug abuse activity, we have taken it upon ourselves to coordinate all Government action in this field and serve as a conduit to private industry and the university community in the development of clinically useful antagonists.

To follow up on the fruitful start made yesterday, we are convening small working groups to tackle specific problems. As a result of these working groups and the problems they will explore and the ideas they will propose, we will then make specific recommendaitons for action. Furthermore, we hope these working groups will surface any roadblocks or, to use your term, Mr. Chairman, blockages that stand in the way of the successful pursuit of our common goal. You may be

sure that the Special Action Office will act swiftly to remove any of these roadblocks as they surface.

The staff of the Special Action Office was extremely impressed with the spirit of cooperation evidenced by all the participants at yesterday's meeting and we believe that a fruitful government-industry-university effort will be the result. The exact form that this effort will take has not yet been determined, and will, to a large degree, depend on the findings and recommendations of the working groups.

Mr. Chairman, all of us, I believe, share a sense of excitement at the prospects of this accelerated research program to find the best narcotic antagonists. Mr. Chairman, on behalf of Dr. Jaffe and the Special Action Office, we look forward to working with you and the members of your committee and staff in your considerations and deliberations concerning the legislation which is pending before you.

We know that you feel, as we do, that a coordinated effort is absolutely necessary if we are going to move this thing forward and move it forward now.

Thank you, Mr. Chairman, and members of the subcommittee, for your consideration.

Mr. ROGERS. Thank you, Mr. Perito, for your statement. I am delighted to hear it. I knew the meeting was successful yesterday, and the industry was ready to pool their resources.

Mr. PERITO. Yes, sir.

Mr. ROGERS. It is my understanding, too, that you have had cooperation from the Department of Justice and Federal Trade.

Mr. PERITO. That is correct. Both FTC and Justice representatives attended the meeting yesterday, and at the present time, given the present patterns that have been discussed, their attitude was one of complete cooperation.

Obviously, as new approaches evolve, the position of those agencies is that they will explore those problem areas and get to them rapidly. I am sure, based upon what has transpired in the past few weeks, that their posture will continue to be one of complete cooperation.

Mr. ROGERS. Yes. This is good to see develop now, because John Mitchell, as you know we talked to John Mitchell, has assured cooperation of that Department, and you see this is being exhibited?

Mr. PERITO. It is, and it was manifested by representatives of the Department of Justice and FTC yesterday.

The Food and Drug Administration and National Institute of Mental Health have been cooperative participants in this venture all along.

Mr. ROGERS. I think we are at the beginning of trying to find some answer to the heroin problem. This committee will follow it closely. We expect to be kept advised by Dr. Jaffe of what is happening, and of blockage that does occur.

Mr. PERITO. Yes, Mr. Chairman. We will look to you for your cooperation and help if and when problems arise.

Mr. ROGERS You will get it. We are grateful to all of you for being here today. Are there any questions?

Thank you.

We appreciate the presence of all here today. I think this is really a historic step for the betterment of this Nation.

Thank you.

The committee stands adjourned.

(Whereupon, at 11:50 a.m., the Subcommittee on Public Health and Environment adjourned subject to call of the Chair.)

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

FRIDAY, OCTOBER 22, 1971

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
INTERSTATE AND FOREIGN COMMERCE COMMITTEE,
Richmond, Va.

The subcommittee met at 9:30 a.m., pursuant to notice, in the auditorium of Virginia Commonwealth University's Medical College of Virginia campus, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The Subcommittee on Public Health and Environment of the U.S. House of Representatives will come to order, please.

First of all, I want to say how pleased and delighted we are to be here in Richmond and at the university to have the benefit of the advice of witnesses that we will hear this morning.

We are conducting hearings over the country and in Washington on what I think it is one of the Nation's most serious problems, drug abuse.

We have 35 pieces of legislation that the committee must consider, including the President's proposal to set up a Special Action Office for Drug Abuse headed by Dr. Jaffe, and this committee hopes to write this legislation within the next few weeks.

These hearings will be most helpful to us in doing that.

We have come to Richmond at the invitation of your distinguished Congressman, and our good colleague who is the ranking member on this subcommittee, the Honorable David E. Satterfield.

It is a real pleasure to be here in his district, and the contribution he has made to this committee's work has been outstanding, so we are honored to be here today in your district.

We are pleased that the members of our subcommittee, not all of them could come, but I think we have a good representation in addition to Congressman Satterfield, Congressman Kyros of Maine to my left, Congressman Preyer of North Carolina, and Congressman Symington of Missouri.

Mr. Steve Lawton is the counsel to the subcommittee.

I think we will proceed, if you would like to say anything first.

Mr. President, we are honored to be here on your campus, and we would be pleased to have any statement by you that you wish.

STATEMENT OF DR. WARREN W. BRANDT, PRESIDENT, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA.

Dr. BRANDT. Thank you, Congressman Rogers, it is my privilege to welcome you and the members of the subcommittee this morning, particularly to Richmond.

If I may digress for a moment, I think you will find that Richmond is in a warm enthusiastic glow this morning from the appointment of one of their most respected and favorite sons, Mr. Lewis Powell to the Supreme Court.

I think you will find the city is quite excited about this particular development.

We are also delighted to have you at Virginia Commonwealth University.

The university was formed by the legislature in 1968 by combining two existing State institutions in Richmond, the Medical College of Virginia, on which campus you find yourself, and the Richmond Professional Institute with a campus about 2 miles west of here.

We are the largest institution of higher education in Virginia in terms of head count enrollment, primarily due to a very large evening college program which currently enrolls 4,800 out of our total of 14,800 head count enrollment.

We are the second largest in the State in terms of full-time equivalent enrollment.

On this campus we have a broad range health sciences center, which includes the school of medicine, with an entering class of 136.

We also have dentistry, nursing, pharmacy, a whole range of allied health professions, and some 11 Ph. D. programs in the health related sciences.

On the other campus, we cover the usual arts and sciences. We have the largest university-based school of the arts in the country, with a broad range of programs in the arts.

We have very active programs in business, community services, and education, plus a graduate school of social work. We were early into the drug problem as it developed around the country.

I think you will find that people on both campuses were very significantly involved in many of the early efforts to bring recognition to the drug problem as it developed, and to start educational efforts to begin to make headway toward counteracting that problem.

We have a number of short courses that are offered in the drug area to all types of groups.

We have some formal courses that are dealing with this problem.

We have degree programs in occupational therapy rehabilitation counseling, and many others which are very actively interested in working with those that have this particular problem.

We have three speakers we would like to present to you this morning on behalf of the university. These three gentlemen come from this campus.

They have all been for some time now closely involved with drug problems, and we think the experiences they have had will be particularly beneficial to the committee.

The first one I would like to introduce will be Dr. George Bright, who comes to us educationally from Texas. Dr. Bright is head of our program of adolescent medicine, in our department of pediatrics in the school of medicine.

He has developed a very interesting and we think, outstanding program in working with problems in adolescent medicine, and in this day and age one of the key problems of course is the drug problem.

He has been most effective in identifying with the teenage group,

particularly the middle class and upper middle class teenage group in the city of Richmond. They have come to him in the programs that he has developed. Some of the experimental programs he has been carrying out we think are quite distinctive, and we are pleased to have you hear him.

In addition to Dr. Bright, we have Dr. James Mathis, who is chairman of our department of psychiatry, for Congressman Symington's information, educated at the University of Missouri, and has his M.D. from St. Louis University.

Dr. Matthews came to us a year ago. He has an extensive experience in the psychiatric field, and a great deal of experience working with young people and working with the drug problem in particular.

Following him will be Mr. Harrison, who is director of the pharmacy services in the Virginia Commonwealth University Hospital. Educated at the University of Michigan and the University of Florida, he has been working very closely in a leadership role with the methadone program. I think he will have many significant comments to add to the other two gentlemen. Let me again welcome all of you, and we hope you have a delightful visit to Richmond and to the Virginia Commonwealth University. We are honored and pleased to have you here.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much, Dr. Brandt, for your very generous remarks, and the background of your university.

I think it might be well just to mention this committee has just completed legislation in a conference with the Senate, which is not always easy, to try to work things out, but we have been successful in completing the health manpower legislation and the Nurse Training Act, which probably will be, I think, the most significant supporting legislation for medical education in the history of this Nation, and I am sure that this university can benefit from it.

We hope we can fund it properly.

Dr. BRANDT. Mr. Chairman, we are certainly very cognizant of your efforts in that area, as well as the cancer area, and because of the close relevancy these have for the total programs as well as the specific programs in cancer, we are watching developments practically daily, and at any time we can be of assistance, please do not hesitate to call on us.

Mr. ROGERS. Thank you.

Our first witness is Dr. George M. Bright, director of adolescent medicine at the Medical College of Virginia.

STATEMENT OF DR. GEORGE M. BRIGHT, DIRECTOR, ADOLESCENT MEDICINE, MEDICAL COLLEGE OF VIRGINIA, RICHMOND, VA.

Dr. BRIGHT. Thank you very much.

The Adolescent Clinic at the Medical College of Virginia is, at present, an outpatient facility, offering comprehensive medical-social services to young people between the ages of 12 and 21. The usual problems frequently encountered in the adolescent years are those of growth and development, drug abuse, school achievement, and interpersonal relations.

Since the Adolescent Clinic became an established teaching and service area 1½ years ago, approximately 1,000 families have been seen for a variety of chief complaints. Recent statistics of this total number reveal 51 percent have drug or drug-related problems. Of this total number, 135 are adolescent opiate (heroin) addicts under the age of 21. With this basis, it became mandatory to develop a comprehensive program not previously available to this age group.

The permanent staff consists of a medical director and associate, a registered nurse and a nurse aide, a medical-psychiatric social worker, an occupational therapist and job developer, a medical librarian, a psychiatric consultant, a receptionist, four secretaries, and five resident physicians in pediatrics. Two fourth-year medical students serve a 1-month or 2-month elective on a rotational basis. Students from the departments of social work, pharmacy, and occupational therapy within the Virginia Commonwealth University complex, attend teaching sessions held on Monday, Wednesday, and Friday mornings.

A large percentage of the patients population came from referrals through agencies, physicians, schools, or by word of mouth. Although 51 percent of these young people have drug or drug-related problems, the majority have significant medical chief complaints warranting consultation with a group of pediatric subspecialties within the Department of Pediatrics at the Medical College of Virginia, including cardiology, hematology, neurology, endocrinology, nephrology, allergy and infectious disease, gastroenterology, and obstetrics and gynecology. A more detailed description of the clinic function is included in this adolescent medicine manual (see attachment—Adolescent Outpatient).

An equally important part of any medical program is an inpatient section for medical and social problems. At the present time, construction is underway to develop a 10-bed section which will be available for referrals throughout the State. This unit is being designed to care for adolescents with the comprehensive approach to those medical or social problems requiring hospitalization. The most frequent medical problems are local and systemic infections, secondary to the communal use of nonsterile needles and syringes. The more complicated medical problems are those of growth failure, psychosomatic symptoms, and diagnostic problems referred from outlying communities where laboratory facilities and our subspecialties are not available. This area is to be used for adolescents who need medical services to withdraw from opiates and/or a controlled environment from adverse effects of hallucinogens (see attachment—Adolescent Inpatient Service). This is the only adolesent diagnostic and treatment center for drug abuse in the State of Virginia.

An important aspect of the drug treatment program is in methadone maintenance and detoxification programs whose objectives are outlined under the methadone maintenance and substitution program (see attachment).

The rules and regulations followed in establishing this program are in compliance with Federal and State regulations regarding methadone hydrochloride.

The enclosed protocol will give you an in-depth interpretation of the entire adolescent program. It includes copies of the social history, physical examinations, social intake form, consent forms, samples of

laboratory urine screening sheets used in maintaining up-to-date accurate records, and followup data. Of the 13 area hospitals in the city of Richmond, the Department of Pediatrics of the Medical College of Virginia has the only training-treatment program for drug abuse with special services for heroin addicts.

Guidelines have been developed for methadone use in the emergency room setting that would give the physician a moderate amount of background and accurate information for an acute detoxification schedule. Recommendations for referral and consultation with the adolescent or adult programs are mandatory (see attachment—Methadone Emergency Room Gudelines.

Richmond is very fortunate to have a multimodality approach to drug abuse. Methadone maintenance and detoxification is only one part of the medical support.

Psychological support services are also available as outlined in the protocol. The adult methadone service and pharmacy dispensing area works very closely with the adolescent program, as well as the therapeutic community, Rubicon, in providing job counseling, social guidance, therapy sessions, and educational programs—(see attachment—Methadone Adult Services and Methadone Pharmacy).

Since drug abuse is a community affair, proposals were presented to civil clubs in an effort to assist with an educational program, as well as to involve them in rehabilitation for young people who have already been evaluated and were ready for reentry into an entirely different life style than they had been accustomed to. Proposals were presented to an inner-club council with a positive response in terms of a commitment for sponsorship programs, donations, and assistance with a job bank. The adolescent clinic is very fortunate to have a job developer who serves as the director of the hotline, or the Richmond Crisis Intervention Center, and serves as coordinator for the adolescent medical ward with young people who have physical handicaps and problems with their self-image. As a result of this service, hotline and the clinic receive approximately 100 phone calls per day for drug or drug-related information.

In 1970, it became obvious that many of the parents did not understand the terminology used by young people involved in experimentation, use, and abuse of drugs. A training manual was developed to include a vocabulary and medical information concerning a variety of prescribed and illicit drugs. This manual is now used throughout the State by teachers, law-enforcement agencies, and the medical profession (see attachment—Hotline Manual).

Another important service of the adolescent service is a medical librarian who collects the educational materials with complete reprint files on drug abuse and an up-to-date collection of journals, periodicals, books, and films relating to the medical-social problems of adolescents (see attachment—Bibliography).

The city of Richmond is indeed fortunate to have a Council on Drug Abuse Control—CODAC—serving as an umbrella for a variety of other agencies available to young people and adults. Brief descriptions of the services provided by our therapeutic community, the Rubicon, the Fan Free Clinic, included (see attachments). All of these agencies communicate and cooperate in helping expand programs for our adolescents.

These young people want to know and demand to know where we as parents, teachers, and administrators stand on a variety of issues that they consider quite important. If we can continue to provide settings and services where they can see consistency in their elders and a relevant educational program, perhaps we can work together to better find and clarify our value systems more honestly.

Mr. Chairman, I wish to submit this information outlined in my statement for the record.

Mr. ROGERS. The material will be made a part of the record.

(The attachments referred to follow:)

ADOLESCENT CLINIC

CLINIC FOR ADOLESCENTS

The Medical College of Virginia offers an outpatient facility for persons between the ages of 12 and 21 to meet the needs of an age group generally poorly understood and frequently inadequately dealt with. It offers a comprehensive service to patients with all types of complaints from all socio-economic levels. A series of research projects is being conducted to help clarify some of the problems encountered in this age group.

The clinic operates a full time outpatient division with a permanent staff of a medical director, nurse interns, trainees in Pediatrics, medical students, pharmacy students, and college students from the departments of social work, vocational rehabilitation, and psychology from the Virginia Commonwealth University. A group of sub-specialists is available for consultation. A Vocational Rehabilitation counselor is assigned to the Adolescent Clinic to work with referred adolescents and their families. A social worker, nutritionist and psychologist are also available for consultation. The aim of the clinic is to provide for the adolescent a physician who is interested in him as an individual—a person. This is a physician who sees his patient in an informal, relaxed atmosphere, in pleasant and comfortable surroundings.

At present there are no longer separate facilities in the clinics for staff and private patients. We are developing a clinic that does away with separation of care and offers surroundings that are appealing to all, regardless of income and race.

Visits are by appointment, and are long enough to avoid the haste and preoccupation often found in busy clinics. At least an hour is allowed for each patient and his or her parents. During the first visit the patient is seen alone. His own history is taken and complete physical examination is carried out. In subsequent visits the patient is encouraged to take responsibility for his own treatment and appointments, and to respond to the physician as an individual in his own right . . . probably the most important aspect of the doctor-patient relationship.

The patient is seen by the same doctor at each visit. The fact that one doctor is responsible for the patient provides continuity of care. If special advice is indicated, physician and patient see the consultant together, but further management remains in the hands of the adolescent's own physician. Careful examination of treatment, tests, and the details of his complaint help to elicit the patient's interest and cooperation. Effective communications with the family, the referring physician, the school, and other sources of information help to insure a thorough understanding of each individual's case.

The usual problems seen in the outpatient setting are those of growth and development, school, physical exertion, drug abuse, personal relationships, and body image which are so important in each adolescent's life. Also seen are those patients with psychomatic symptoms, behavior disturbances, and other conditions.

Patients being seen at the Adolescent Clinic are from the metropolitan area, neighboring towns, and rural districts throughout the state. They are drawn from all social classes. Clinic fees are reasonable and graduated to meet families' ability to pay. Patients are referred by family doctors, schools, social agencies or other facilities in the community. Hospital beds, special laboratories, and clinics at the Medical College of Virginia are available when required.

In order to meet the needs of an expanding program, the first floor of McFarland Hall at the Medical College of Virginia serves as the outpatient section.

This area has been renovated to offer practical and efficient space. This includes: 1 waiting room, 1 reception area, 1 clinic nurse's office, 2 examining rooms, 1 consultation room, 6 physicians' offices, 1 library and conference room, and the director's office.

The area operates by appointment only. An emergency walk-in service will be developed through the pediatric outpatient department after sufficient staff has been added to meet this vital need.

The adolescent has been thought of as a public nuisance too long. If our attitudes prevail, more subcultures, such as the hippie movement and the drug scene will continue to evolve. We are not faced with a new problem, but we are faced with a problem of surviving the period called adolescence because of the numbers involved. We are challenged to help them become involved with the essential issues of the day. This involves applying principals that speak for themselves and these principals are:

1. LISTEN TO THEM: Recently a very intelligent youth expressed himself in this way: "Many young people would be more eager to assume an active societal role if only the older members of society would *speak with them* and *not simply to them*."
2. GIVE THEM THE FACTS: No matter what the issues are, no matter how controversial they may be, there is no excuse for withholding the truth.
3. TRUST THEM: They may not always deserve it, but they will become more responsible much faster if trusted rather than being watched or mistrusted.
4. BE CONSISTENT: It is important at any age, but particularly so at adolescence, for the young person to know what he can get away with and what he cannot get away with and certainly the reasons why.
5. MAINTAIN FIRM AND FRIENDLY DISCIPLINE:
6. TRAIN STUDENTS FOR INDEPENDENCE IN EVERY WAY POSSIBLE:
7. REMEMBER YOUR OWN FEELINGS DURING ADOLESCENCE:
8. SET LIMITS: Set limits and enforce them, but never make a promise you cannot keep or a threat you cannot enforce. Standards should be enforced firmly and flexibly, not rigidly and without reference to the issue at hand.
9. AVOID SETTING GROUP AGAINST GROUP: It is of no consequence if this be one racial group against another, teacher against students, or one ethnic group against another ethnic group. The conflict should be between good ideas and inferior ones. The question is not *who* is right, but *what* is right.
10. EXHIBIT STANDARDS OF GOOD TASTE AND BEHAVIOR: It is of the utmost importance that these standards are those you would like adolescents to emulate, but don't demand agreement from them.

In summary, then, the problems we face in developing programs for our adolescents are not new, but there are new challenges, and that is that they are our problems today. If we want and hope for a better tomorrow, then we must begin to solve these problems now. Our adolescents want to know where we, as parents and teachers, stand on the issues. If we can offer them a setting where they can be worked with, where they see strength, where they can see consistency in their elders and not hypocrisy and bigotry, hopefully we will be able to better define and clarify our faulty value systems honestly.

Care of Adolescents in Out-Patient Clinics

MARTIN G. WOLFISH, M.D., CHIEF, ADOLESCENT SERVICES, THE HOSPITAL FOR SICK CHILDREN, TORONTO, ONTARIO, CANADA

This Report has been prepared for the Society for Adolescent Medicine.

The following members of the Committee on Out-Patient Care have generously contributed to this Report and are thanked warmly for their help.

Harry W. Bain, Toronto, Ontario; Michael I. Cohen, Bronx, N.Y.; W. A. Daniel, Birmingham, Alabama; R. C. Eddy, Mercer Island, Washington; N. M. Ewell, Charlottesville, Virginia; S. F. Friedman, Rochester, N.Y.; Roswell Gallagher, New Haven, Conn.; D. Garrell, Los Angeles, California; Nydia Gomes-Ferrarotti, Buenos Aires, Argentina; Adele Hoffman, New York, N.Y.; H. Hortling, Helsinki, Finland; Doris A. Howell, Philadelphia, Pa.; Mrs. William Hull, R.N., Cleveland, Ohio; P. J. La Ruffa, Dallas, Texas, Iris F. Litt, Bronx, N.Y.; G. H. Lowrey, Davis, California; H. R. Miller, Chicago, Ill.; Joan E. Morgenthau, New York, N.Y.; L. N. Pearlman, Ottawa, Ontario; C. K. Pitt,

Decatur, Alabama; I. R. Shenker, New Hyde Park, N.Y.; S. H. Sklar, Cliffside Park, N.J.; Donald A. Stewart, Toronto, Ontario; I. C. Williams, Jamaica Plain, Mass.

The Adolescent Clinic

Total patient care has certain goals, requirements and limitations which will be the text of this report. In this age of systems teaching of medical students and system-oriented specialty clinics within the paediatric hospital, an age-oriented clinic may appear an anachronism. In a teenage clinic the emphasis is on the whole patient rather than on his affected or afflicted parts. The emphasis is on his phenomenal growth and his physical, emotional, intellectual and social development. Children of this age need and want a physician to doctor them, not their systems. An adolescent clinic staffed by both generalists and specialists will create this setting for health care to the teenager.

Requirements

STAFF REQUIREMENTS

A paediatrician, well-trained in growth and development and preferably with training and experience in adolescent medicine should be the primary medical contact at the clinic. He should be interested in the physical, emotional, intellectual and social facets of the teenager's health and well-being.

An internist or family physician may fill the paediatrician's role in the clinic if he has similar training and experience.

A fellow in a training program for care of adolescents may help staff the clinic under the direction of a staff physician. This will provide the fellow with clinical experience, provide material for his teaching and may also be the basis of a research project related to this age group.

Paediatric and other residents interested in the care of adolescents may be attached to the clinic under the supervision of a staff physician. Thus the adolescent clinic may be incorporated profitably into the teaching program of the hospital or university.

Medical students also find the adolescent clinic useful to their studies in paediatrics, psychiatry, developmental medicine or behavioural sciences or as an elective course. Student interviews, examinations and supervision should always be directed by a staff physician-teacher.

In addition to the staff physicians, medical specialists are needed in the clinic. Many problems presented by patients at the adolescent clinic require the services of a psychiatrist for their solution. He should, like the clinic physician, be especially aware of, experienced in and sympathetic to the problems of the teenager. He will direct those caring for the emotional health of the patient, consult with the medical staff and teach students and residents.

The services of a consulting endocrinologist, an allergist, neurologist, surgeon, plastic surgeon, orthopaedist, gynaecologist, dermatologist and other specialists are invaluable. Whether these specialists visit the clinic or the patient visits the specialty clinic in question depends upon local conditions.

The psychologist is invaluable for psychometric evaluation, projective examinations, school progress and vocational aptitude testing. He may also give psychotherapy in consultation with the psychiatrist where applicable.

Nurses to be employed in an adolescent clinic should be chosen with particular reference to their expertise and feelings in dealing with the adolescent. Their duties are many and varied and include: primary patient contact and intake-interviewing; counselling re acne, personal hygiene, menstrual problems, weight reduction, interpersonal and social problems; follow-up visits when contact with the physician is unnecessary; school visits and home visits where desirable; telephone advice. The nurse with these special qualities should be used to the best advantage. Other jobs such as reception, making appointments and so forth should be handled by clerical staff.

Close liaison with the local public health services through the public health nurse is advisable and valuable providing a two-way flow of information: information to the clinic regarding home environment, school progress, school behaviour, contact with juvenile court authorities; information from the clinic to the school, the guidance counsellor, probation officer, or other person responsible for the child's welfare; the public health nurse may also help in the home giving nutritional help or advice, home-making advice and so forth. She may also trace

the reason for missed appointments and encourage the recalcitrant to return to the clinic.

A well-trained case worker can assist in diagnosis of emotional disorders, in patient interviewing, in psychotherapy and in the management of emotional overlay or underlay or organic disorders. The scope of the social worker's endeavors depends upon a definition of the parts played by the psychiatrist, the psychologist and the other members of the clinic staff. She may also act as a referring person and liaison between the clinic and outside social service agencies.

The services of a trained dietician or nutritionist are most useful to advise patients about the food they should eat, to help the physician and to collaborate with the public health nurse in any nutritional aspects of the patient's diagnosis or management.

Paramedical trained persons such as "health education technicians", "social health advocates", and so forth can be usefully employed in the clinic.

Primary contact people, such as "detached street workers" are providing an innovative service on the street level and should be encouraged to work closely with the clinic. These persons trusted by the young can be an important source of referrals to the clinic and will benefit from the clinic's back-up facilities to the services that they are able to offer.

SPACE REQUIREMENTS

The space requirements of the clinic will depend upon the number of patients expected, the use to be made of other hospital facilities such as x-ray and laboratories and how much can be shared with other clinics. The waiting-room should be separate and free from the noise and tumult of infants and toddlers; the decor stimulating or restful, rather than depressing.

Examining rooms should ensure privacy from accidental intrusion and be sound-proof. A conference room should be provided.

Staff attitudes supersede physical amenities. Many small hospitals, even with limited space and limited budgets, convey by their attitudes rather than their opulent surroundings, a feeling of acceptance, warmth, and a desire to be helpful.

Clinical Laboratory Facilities

The clinical should have available the usual hospital laboratory services including roentgenography, haemotology, chemistry, bacteriology, pathology.

All patients seen in an adolescent clinic should have the accepted basic laboratory screening, including: urinalysis and urine culture if indicated; haemoglobin and other haematological tests as indicated; tuberculin test; serology and vaginal cultures in sexually active patients; cervical cytology in patients on contraceptive hormone therapy. In certain centers other testing such as screening, in Negro patients, for Sickle cell anaemia by haemoglobin electrophoresis and serum glutamic oxaloacetic transaminase (SGOT) and serum glutamic pyruvic transaminase (SGPT) in drug-users. Chromosome studies in delinquents may be indicated.

Pharmacy

The pharmaceutical service of the adolescent clinic should stock the types of medications of particular use to this age group. Tablets, rather than liquid medicines are preferred by the teenager. Specialized medication such as dermatological preparations and hormonal products should be available.

Recording

PROTOCOL

A standardized history form is useful for compilation of data in an acceptable form to serve as a guide for the less-experienced resident or student and to facilitate retrieval of information. In centres where computerized information storage is used or anticipated, the clinic history form should be adaptible to data processing.

Forms used in the adolescent clinic differ from the usual pediatric history forms in several ways: they emphasize the patient's own history including school grade and performance information; pubertal and menstrual information; they inlcude other pertinent information such as sexual activity, drug-taking and so forth; they include an estimate of pubertal level (Tanner classification).

Health and functional enquiry questionnaires filled out prior to the visit will bring out information which may be missed because the examiner fails to ask or the patient hesitates to answer. Several useful questionnaires are available, such as the California Medical Survey and the Scan Cards. A questionnaire specially suitable to a clinic's needs may be designed.

Patient and parent should be given the opportunity of being interviewed separately, or together, or both.

Where applicable, the physical examination should include pelvic and rectal examination. If the parent is not present when a female patient is being examined a nurse should be. Adequate protection of privacy and facilities for dressing and undressing should be provided.

Limitations

Age of Patients

The age limits for attendance at an adolescent clinic should be flexible. Generally the ages of 13 to 19 years are appropriate. An earlier age intake is allowable for pubertal girls, or other patients who feel more comfortable in surroundings suitable to their age. The upper age limit may be extended to include college students, migrant or alienated youth and retarded youth.

Intake and Appointment Procedure

Appointments to the adolescent clinic may be anticipated from a number of sources which vary somewhat with the locale. The patient may come to the clinic for many reasons. He may come himself or be sent by his parents. He may be referred to the clinic by other hospital clinics, by school physicians, nurses and guidance counsellors, by social service agencies dealing with adolescents or street services such as free youth clinics and drop-in centres. He may also be sent by the juvenile court authorities.

Appointment scheduling should include provision for the initial appointment, requiring a minimum of one hour and including parent and patient interviews, history-taking, physical examination and reporting; the follow-up appointment varying from a relatively short visit such as for acne, to a longer visit, say 2–3 hours, for counseling and re-interviewing; the drop-in appointment needed for emergency care, preliminary screening for children brought in by street workers.

Follow-up appointments may be with the physician or with other appropriate staff members such as social worker, psychiatrist, nutritionist and nurse.

Some appointments will not be kept. The number of missed appointments can be reduced by the nurse or social service worker contacting the child or parent and impressing on him the importance of keeping his appointments.

Clinic Hours

The hours the clinic is open vary from locale to locale, and depend upon hospital space and time commitments. In general, clinics scheduled during regular hospital hours make access to laboratory and x-ray facilities and adequate nursing, medical and ancillary staffing easier.

Evening or Saturday clinics do not interfere with school, but do interfere with student after-school working hours. Unfortunately, in many inner-city areas, for children to travel to and from hospital after dark is inadviseable because of street dangers.

Consent and Confidentiality

The resolution of the Society for Adolescent Medicine concerning patient consent and confidentiality tempered by the hospital's legal position and locale statute or custom should be the standard for adolescent clinic out-patient care.

"Although the Society for Adolescent Medicine believes that the parents should be informed, and their consent obtained whenever possible, nevertheless we stand in favor of legislation which would allow the self-consent for preventative and therapeutic health care of minors when, in the judgment of the treating physician or hospital, there exists significant hazard to the health of said minor or others, and the treatment for such health hazard could not be administered effectively if the right to self-consent were denied."

This will of necessity be statute or custom.

In general, problems of consent and confidentiality are related to pregnancy—diagnosis, care, or termination; venereal disease—diagnosis, treatment, source of infection; drug-abuse, addiction and education; contraception—treatment, supply of contraceptives and education; psychiatric diagnosis and treatment.

To what legal and ethical extent is information about a child privileged? From whom should it be withheld, to whom should it be given? Answers to these questions must be sought within the context of local jurisprudence.

Special Problems of the Adolescent

DRUG-TAKING

The clinic's facilities must be available to the adolescent drug-user without fear of punitive or police action. In hospital emergency departments medical and nursing staff must be informed about what "street drugs" are currently being used in the locality served by the hospital, what are the toxic reactions and how to treat them.

Facilities should include a quiet place for isolating the patient, enough trained staff for talking him down, necessary drugs for treating him and facilities for admitting patients requiring hospitalization for psychosis, malnutrition, hepatitis, pneumonia and so forth.

Frequent, skillful non-medical street workers can help by case finding, bringing patients to the clinic, reassuring them and talking down the patient on a bad trip or freak out.

Providing facilities for ongoing treatment, such as methadone maintenance, is a valid function of an adolescent clinic.

CONTRACEPTIVE INFORMATION AND SERVICE

Information and supplying of contraceptives for sexually active patients may be handled by the clinic or by an affiliated gynaecology or birth control clinic. Supplying the means of contraception involves the question of legal consent and confidentiality. Expert legal advice should be sought. This service is preferable to an unwanted pregnancy.

Supplying contraceptives should never be a mechanical, impersonal function of the clinic. The younger adolescent requires thorough interviewing regarding sex knowledge and sexuality in addition to pregnancy prevention.

PREGNANCY

Facilities for diagnosis of pregnancy should be available to the patient. Although pregnancy diagnosis should not require parental consent whether to allow a young girl to proceed with a pregnancy or to terminate the pregnancy without parental knowledge and support is an ethical as well as a medical decision.

Where the adolescent clinic is not in a hospital with obstetric facilities, close cooperation with a prenatal clinic is required for referral and continuing care.

PREGNANCY TERMINATION

Where termination of the adolescent's pregnancy is permitted by law, the clinic must decide which patients are suitable for abortion and arrange for such termination.

VENEREAL DISEASE

Facilities for diagnosis and treatment of venereal disease are an integral part of the teenage clinic. Cooperation with local public health authorities is essential for contact-finding and follow-up.

THE "STREET CLINIC"

Many teenagers, some with the above problems, some not, plus the ever-growing numbers of migrant youth are unwilling to use the establishment-recognized hospital-based clinic. To meet the needs of these young people the clinic may have to move out of the confines of the hospital walls into street clinics, after-hour clinics, or out-reach centres involved in bringing health into the streets and patients into the clinic.

Health Education

Health education is a vital role of the clinic in preventing disease among those it serves and maintaining their good physical, mental, and social health. Health education should include such topics as drug-taking and addiction, alcohol abuse, tobacco smoking, nutrition and obesity, skin care and grooming, veneral disease, sex and sexuality, physical fitness, local after-school employment opportunities, educational and career opportunities, any other subject of value to the adolescent.

Professional Teaching

An adolescent clinic provides an excellent teaching facility for students. These include medical students, paediatric or medical residents, psychiatry trainees and psychology students, student nurses, student physiotherapists, dietitians, student teachers, social work trainees, dental students, divinity students, recreation-work students and paraprofessional trainees in health-care. A clinic used as a teaching laboratory will always be nurtured by young people and new ideas.

Research

Such a clinic provides a fertile field for research, the scope of which should be as wide as the imagination of the research scientist. Both cilnical and laboratory research are pertinent to the adolescent and may vary from psychosocial to biological, always within the constraints of ethical care of adolescents. Research outside the clinic itself is also proper; research into community problems, athletics, motor vehicle accidents and secondary school health problems.

A Multi-Disciplinary Approach

Because the cilnic is served by both medical and allied professionals, the patient benefits. Conferences and the informal and free exchange of information among members of the clinic and the sharing of ideas, make better care possible.

In Conclusion

The adolescent clinic exists for the benefit of the teenager. Service, teaching, and research must all be directed toward this goal. In this age of rapid change, instant communication, and technological and social transition, the needs of the teenager are exaggerated and at the same time ignored. "The adolescent of today becomes the adult of tomorrow" is more than a time-worn cliche. Let us ensure the health of that tomorrow!

ADVANCE REGISTRATION

Adolescent Clinic, Box 151, MCV

PLEASE PRINT INFORMATION

PATIENT'S NAME SEEN IN: THE ADOLESCENTS' UNIT

SERVICE _____ CLINIC

ON _____ AT _____ ☐ AM ☐ PM

HAS CHILD EVER BEEN A PATIENT AT THIS HOSPITAL ☐ YES ☐ NO

IF YES, WHEN _____ MONTH _____ YEAR

☐ STAYED OVERNIGHT

☐ TREATED AT CLINIC OR X-RAY

HOSP. REC. NO IF KNOWN _____

PATIENT'S LAST NAME | FIRST | MIDDLE INITIAL | DATE OF BIRTH | AGE | SEX

RELIGION | ☐ BAPTIZED ☐ YES ☐ NO | BIRTHPLACE | SOC. SEC. NO.

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED | SPOUSE'S FIRST AND MAIDEN NAME

ADDRESS STREET AND NUMBER | APT. NO. | CITY | STATE | ZIP CODE | AREA CODE | HOME PHONE

FATHER'S FIRST NAME | SOC. SEC. NO. | BIRTHPLACE | DATE OF BIRTH

MOTHER'S FIRST AND MAIDEN NAME | SOC. SEC. NO. | BIRTHPLACE | DATE OF BIRTH

FATHER'S OCCUPATION | EMPLOYED BY

ADDRESS OF EMPLOYER | AREA CODE | PHONE NO.

MOTHER'S OCCUPATION | EMPLOYED BY

ADDRESS OF EMPLOYER | AREA CODE | PHONE NO.

NEAREST RELATIVE OR FRIEND WITH PHONE (NOT LIVING WITH PATIENT) | ADDRESS | AREA CODE | PHONE NO.

FAMILY DOCTOR | ADDRESS | AREA CODE | PHONE NO.

REFERRING DOCTOR OR AGENCY | ADDRESS | AREA CODE | PHONE NO.

PRIVATE MCV STAFF DOCTOR | ADDRESS | AREA CODE | PHONE NO.

INCOME

NET FAMILY INCOME – TOTAL FAMILY INCOME (FATHER AND MOTHER) AFTER ALL DEDUCTIONS EXCEPT SAVINGS PLANS, CREDIT UNION PAYMENTS, ETC.

FAMILY MEMBERS LIVING ON STATED INCOME: ☐ MOTHER ☐ FATHER; NUMBER OF DEPENDENT CHILDREN _____; NUMBER OF OTHER DEPENDENTS _____

TOTAL NET PER WEEK: ☐ UP TO AND INCLUDING $57 ☐ $58-68 ☐ 69-81 ☐ 82-94 ☐ 95-107 ☐ $108-120 ☐ $121-133 ☐ $134-146 ☐ $147-159 ☐ $160-172 ☐ $173-185 ☐ $185-198 ☐ $199 AND OVER

INSURANCE

BLUE CROSS ☐ YES ☐ NO | STATE | CITY | B.C. CARD ☐ BLUE ☐ WHITE

BLUE SHIELD* ☐ YES ☐ NO | NAME OF SUBSCRIBER | ☐ INDIVIDUAL ☐ GROUP | CERTIFICATE NUMBER

OTHER HOSPITAL INSURANCE ☐ YES ☐ NO | NAME OF INSURANCE COMPANY | ADDRESS

NAME OF SUBSCRIBER | ☐ INDIVIDUAL ☐ GROUP

NAME OF PERSON OR AGENCY RESPONSIBLE FOR PATIENT'S BILL | MEDICAID NO.

IF DCG, NAME OF SOCIAL WORKER | OFFICE ADDRESS

OR THE COMPARABLE PHYSICIANS' SERVICE COVERAGE OF YOUR STATE (OTHER THAN Va.)

DATE _____ SIGNATURE OF PERSON RESPONSIBLE FOR BILL _____

Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Preliminary Medical Information

We will be able to plan and to carry out our patient's care more efficiently if we can have the following information in advance of the first visit. To help us, will you please fill in as much of this form as possible and then mail it to us at your earliest convenience.

Name and address of the doctor to whom you would like us to send a report:

Patient's name:

present age: birthday: year born: Race:

Would you please state in two or three sentences

1) what this patient's problem is:

2) what it is you wish us to try to do:

3) Has this patient been seen by another physician or agency for this or related problems. Please give name, address and dates.

Patient's weight at birth:

Age (in months) when he (or she)

walked: sat up: said single words:

said sentences:

When urine training was completed:

When bowel training was completed:

What illness was there in the first year?

At what ages did he (or she) have:

Measles: Chicken Pox: Whooping Cough:

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Please list any illnesses or operations which required a hospital stay (with causes and dates):

At what age were "shots" or vaccinations for the following given: If "booster" shots or re-vaccinations have been given, please give the date of each of these.

Diphtheria: Polio:

Tetanus: Smallpox:

Give name and address of school currently attending:

Grade: Guidance Counselor:

When was the last dentist's examination:

When was the last eye specialist's examination?

Has patient had tuberculosis____

Has anyone in the family had tuberculosis _____

FAMILY HISTORY

Name:	Height:	Weight:	Age:
Father:			
Mother			
Sisters:			
Brothers:			

Please print your name and address and telephone number here: _____

_____

Telephone:_____ _____

If you are unable to keep this appointment, please call us a day or more in advance.

Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Clinic Sheet

Referred by:

History as Given by Adult Informant (state whom) Date of Birth

Chief Complaint

Present Illness or Problem:

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Delivery (easy, complicated)

Health First Two Weeks (uneventful, difficulties)

Feeding Problem? Mother's Attitude:
Any Illness in First Year?
Convulsions Temper Tantrums
Walked at Talked at Toilet Trained at
Mother's attitude toward training (easy, strict)
Coordination (shoe-tying, dressing, throwing balls)

PREVIOUS HEALTH GENERAL HEALTH

Communicable Disease (severity)
Any Severe Febrile Illnes?
Cerebral Palsy Epilepsy Tuberculosis
Rheumatic Fever Allergy (or contact with)
Emotional Disorders
Other
Accidents (concussions)
(fractures)
Operations or Hospitalizations - type and date

Present or Past Medications

Bowel Eating Sleep

Menarche (previous explanation)
Dysmenorrhea Pre-menstrual tension

Behavior - Adjustment:
at home
at school
with friends
with siblings

School Achievement:

How Does He Get Along with People in General?
Adjustment away from Home: at camp
Jobs
What are Chief Assets and Skills?

Immunization: Diphtheria Tetanus Smallpox
Typhoid Needs
Family History: (age; general health; any significant illness; occupation; schooling; own apparent adjustment and relationship to others; age and cause of death)

F

M

Siblings

Any familial disease (mental, epilepsy, cancer, etc.)

Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Clinic Sheet

Patient's Statement: Chief complaint and present problem.

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SYSTEMIC REVIEW 4.

Headache Syncope

Hearing Vision

Epistaxis Colds
Hay Fever Asthma

Toothache Last Dental Examination

Chest Pain Palpitation Tachycardia
Cough Wheezing Dyspnea

Appetite Indigestion Polydypsia
Abdominal Pain Nausea Weight: Gain or Loss:

Dysuria Frequency

Menarche: Age at Onset Explained Beforehand
Regular Duration Dysmenorrhea
Pre-menstrual Tension Date Last Period

Joint Pain Atheletic Injuries Backache

Thumbsucking Bedwetting
Sleep Dreams

Exercise Fatigue Easily

GENERAL ADJUSTMENT:

Home Neighborhood

School: Present Grade School

School Success Best Subject

Reading Spelling Arithmetic

Attitude toward School Toward Teachers

Summers
Jobs
College Plans
Career Plans

Interests: Music Art
Nature Sports
Mechanical Business

Day Off

Friends

Family Relationships

Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Clinic Sheet

PHYSICAL EXAMINATION: 5.

General Appearance

Height (without shoes) Weight (without shoes, jacket, skirt)

Vision - without glasses: OD OS OU
with glasses OD OS OU
1.50 test OD OS OU

Phoriae: Distant Hor. Vert. Near Hor.

Color Vision

Date of Last Thorough Vision Examination (by whom)

Skin: Color Pigmentation Dry or Oily

Eruptions, acne

Icterus Pallor Palms (dry or moist)

Vaccination Scar Other Scars or Marks

Hair (dry or oily)

Ears: Hearing Canals Drums

Eyes: Pupils: Equal React to Light Accommodation

Extraocular Movements Conjunctivae Exophthalmus

Fundi

Nose: Obstruction Sinus Tenderness

Mouth and Throat: Oral Hygiene Gums Caries

Fillings Occlusion

Tonsils Thyroid

Lymph Glands: Cervical Supraclavicular Axillary Inguinal

Thorax: Deformity Gynecomastia (m) Breast Development (f)

Lungs:

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B. P. (recumbent)

Heart

Abdomen

Genitalia: Stage of Development

Hernia — Pilonidal Sinus

Neurological: Gait — Coordination

Strength — Reflexes

Balance

Extremeities: Paralysis, atrophy, etc.

Feet

Posture: Neck — Shoulders

Spine (curvature) — Tenderness

Motion Limited or Painful

Habits: Nail Biting — Tic

Speech (stutter or lisp)

Masculinity or Femininity:

Personality Traits: Confident — Tense — Dependent

Stable — Antagonistic — Restless

AUDIOMETER SCREENING TEST
FAILED_____
PASSED_____

Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Clinic Sheet

Positive Findings (include patient's needs) 7.

Laboratory Procedures Ordered

Tentative Diagnosis

Brief Description of the Patient and His Problems

Disposition, Present Recommendations and What to Do at Next Visit.

(signed) M. D.

Supervisor

A-625.5 - MR 191

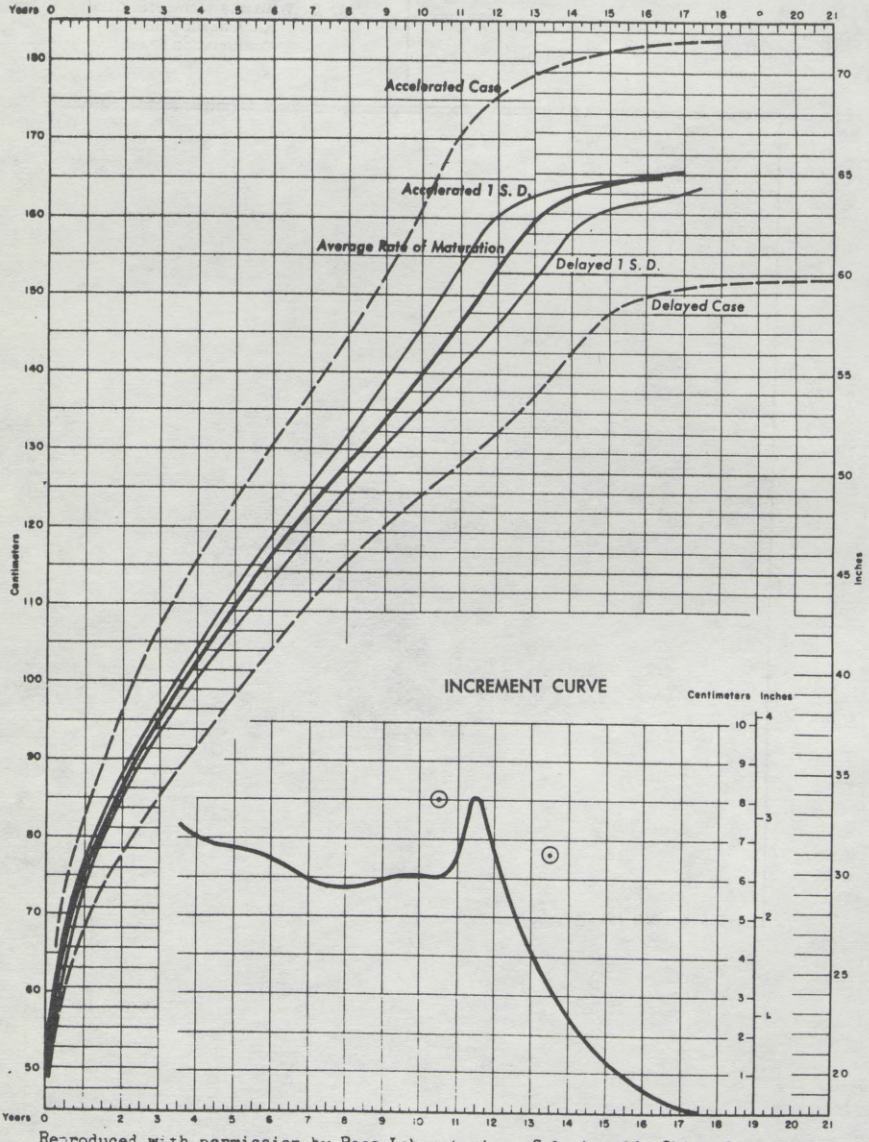
Medical College of Virginia
College Hospitals
A. D. Williams Memorial Clinic
Adolescent Clinic
Continuation Sheet

GROWTH CURVES OF HEIGHT BY AGE FOR GIRLS

(Average, Accelerated, and Retarded Rates of Maturation)

327-8

Case No.....



Reproduced with permission by Ross Laboratories, Columbus 16, Ohio, from Bayer, L., and Bayley, N.: Growth Diagnosis, University of Chicago Press, 1959.

PMH FOR GIRLS

(Per cent of Mature Height Achieved)

Age Years	Average	Accel-erated	Retarded
Birth	30.9		
1.0	44.7	48.0	42.2
2.0	52.8	54.7	50.0
3.0	57.0	60.0	55.0
4.0	61.8	64.9	59.8
5.0	66.2	69.3	63.9
6.0	79.3	73.4	67.8
7.0	74.0	76.0	71.5
8.0	77.5	79.5	74.5
9.0	80.7	83.5	77.7
10.0	84.4	87.9	81.0
11.0	88.4	92.9	84.9
12.0	92.9	96.6	88.2
13.0	96.5	98.2	91.1
14.0	98.3	99.1	95.2
15.0	99.1	99.5	97.8
16.0	99.6	99.9	98.9
16.5		100.0	
17.0	100.0		99.6
18.0			100.0

Name.....Birthdate.....

RECORD OF MEASURES

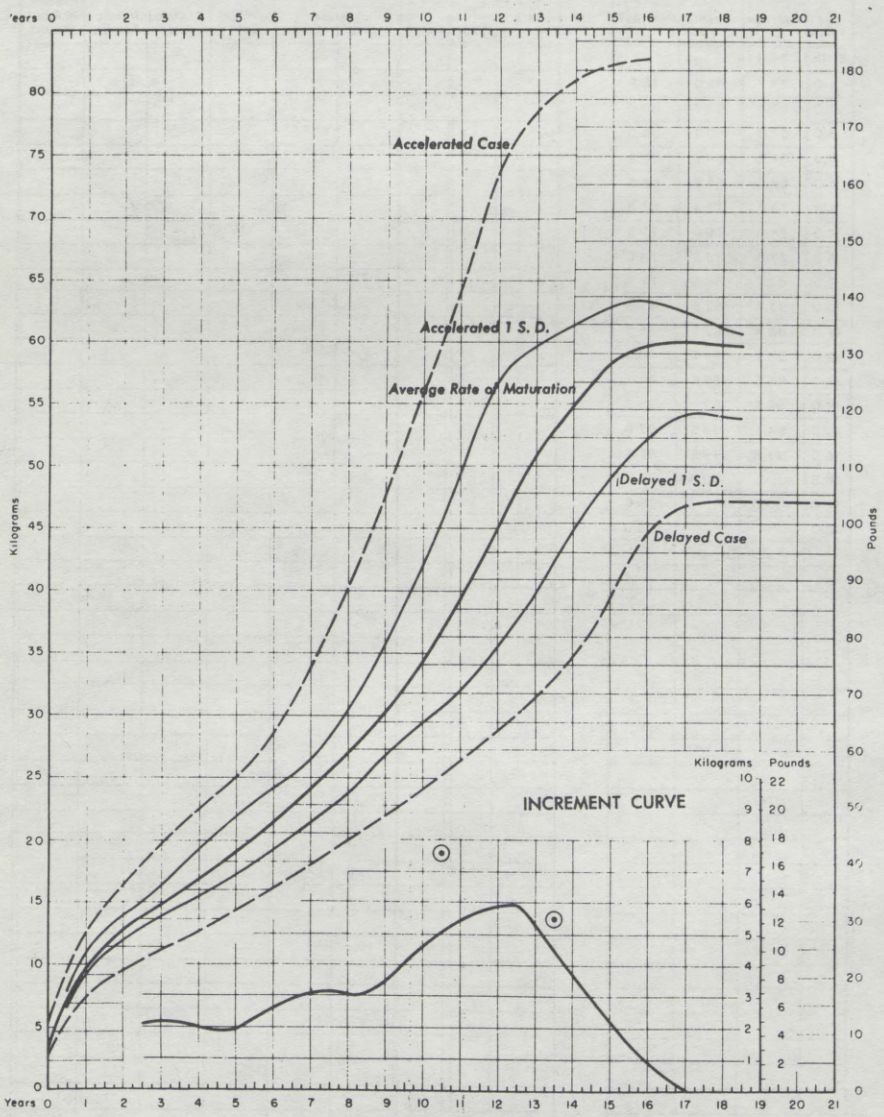
Date	Age Year	Age Month	Stature Inches	Stature Cent.	Annual Gain	Skeletal XM	Rating Age Eq	Predict. of Adult Height

66-841 O - 72 - pt. 3 - 13

GROWTH CURVES OF WEIGHT BY AGE FOR GIRLS

(Average, Accelerated, and Retarded Rates of Maturation)

Case No.....



Reproduced with permission by Ross Laboratories, Columbus 16, Ohio, from Bayer, L., and Bayley, N.: Growth Diagnosis, University of Chicago Press, 1959.

Name..... Birthdate .....

MEAN WEIGHT FOR HEIGHT: GIRLS

Age Years	Average Height Inches	Average Weight Pounds	Accelerated Height Inches	Accelerated Weight Pounds	Retarded Height Inches	Retarded Weight Pounds
Birth	19.3	7.5	20.1	–	–	–
1.0	29.1	21.5	30.6	24.0	28.3	21.2
2.0	34.4	28.0	34.4	30.2	33.3	25.9
3.0	37.5	32.4	37.8	34.7	36.7	30.6
4.0	40.6	37.5	41.3	42.1	39.4	33.7
5.0	43.1	41.2	44.1	48.1	41.7	37.9
6.0	45.9	46.7	46.9	53.2	44.5	43.0
7.0	48.1	52.9	49.2	57.3	47.2	47.6
8.0	50.4	60.0	52.0	66.8	49.2	51.1
9.0	52.7	66.4	55.1	78.5	51.5	59.7
10.0	55.1	76.1	57.3	92.2	53.3	64.8
11.0	57.5	86.6	60.4	108.9	55.5	69.9
12.0	60.7	99.2	63.1	124.8	57.7	78.0
13.0	63.0	112.4	64.3	131.2	59.8	86.9
14.0	64.2	121.0	64.8	135.0	62.4	99.0
15.0	64.8	128.8	65.0	138.7	63.8	108.5
16.0	65.2	131.6	65.2	139.3	64.5	114.6
17.0	65.3	132.3	65.2	137.6	64.8	119.3
18.0	65.3	131.8	65.2	134.5	64.9	119.0

RECORD OF MEASURES

Date	Age Years	Age Months	Weight Pounds	Weight Kilograms	Annual Gain

ADOLESCENT IN-PATIENT SERVICES

At the present time throughout our country the operation of hospital in-patient services for adolescents is practically non-existent. The importance of establishing an adolescent ward for the treatment of individuals aged twelve to twenty-one cannot be over-emphasized. The treatment of this particular age group has been lacking not only in the area of adequately trained personnel, but also in the area of proper and adequate treatment faci ities. Although many hospitals today are establishing adolescent out-patient services, the hospital must arrange an adolescent ward to provide the consistent and continuing care for these young people.

The following physical facilities are suggested to be included in the hospital's adolescent unit.

Patient's Room

Each room will be arranged on a semi-private basis with two full size electric beds provided. Patients will be assigned a room according to age so that individual roommates will fall in as close an age range as possible. Two semi-private rooms wi'l be connected by a bathroom which will include facilities for showering. The room will contain a television with an incorporated intercom that is either ceiling or wall mounted and may be operated by remote control. A telephone should be placed in each room, and the walls of the room as well as the adolescent corridors should be painted colors which are appropriate to the age range and similar to those colors which might be found in an adolescent's bedroom at home. A double curtain will be provided between the beds in each room, and at the head of each bed individual reading lamps should be contained in a headboard which should also allow for diffuse rather than direct lighting.

Recreation Area

One of the major problems of placing an adolescent patient on a pediatric or adult unit is the lack of recreational equipment appropriate to this age group. Items which might be included in this room would be a pool table, ping pong table, stereo recorder and record player, television, movie projector, and various books, records, cards, magazines, and games appropriate not only to the age but to the current popular trend of adolescent activities. This would therefore require updating of the various items to remain current. In this room an adolescent may enjoy peer support and association, as well as undergo therapy by personnel trained in the care of adolescent. It would also provide an excellent area for observation of individuals or groups and evaluation of their abilities in interpersonal relationships. The area may be used by the adolescents as they see fit within the limits set for the adolescent ward. It therefore may become not only a recreational area, but also may be used by the adolescent patients as a dining room, school room, or conference area for themselves.

The room may be situated adjacent to a nurse's station for not only convenience of the floor personnel but also for observation of the adolescents as well as supervision. It may also be separated from the nurse's station by either clear glass which is shatterproof, or by a two way observation shatterproof mirror.

Waiting Room or Receiving Room

Another room may be set aside which will be comfortably furnished for conversation. Here a patient may visit with parents, friends, other visitors, or simply meditate. This area could be furnished with chairs in an arrangement that is conducive to conversation and in itself will be a quieter and slightly more private area than the recreation room.

Kitchen or Snackbar-Kitchenette

Preparation of an attractive menu for the adolescents is extremely important in their care and treatment. A variety of diets may be used (diabetic, weight reducing, low salt diet) in smaller numbers for particular patients on the adolescent ward. A small kitchen would be ideal for the preparation of these varied and individual diets. In this area an adolescent could discuss his diet with the nutritionist. This would provide the opportunity for a patient to learn directly the value of a proper diet or gain valuable information in the preparation of a special diet to be continued even after discharge. Soft drinks, juices, and prepared snacks during the evening hours would be available. The addition of a kitchen

to an area which already includes a semi-private room, recreational area, and a living room-type visiting area creates a more homelike atmosphere than the present accepted physical arrangement of most hospital units.

Conference Room

An adolescent ward should include a conference room for the medical and nursing staff, as well as consultants to the unit. This area would be used for interviewing patients as they enter ward, consultant visits, and case presentation and discussion. A small library for the use of the ward personnel should be included.

Examining Rooms

On each ward one or two examining rooms should be available for the examination of new patients, starting intravenous fluids, and for various minor surgical procedures.

Staff

The staff of an adolescent unit should include doctors and nurses who have been trained in the medical and psychological problems of the adolescent age period. In a large medical center psychiatric consultations could easily be obtained or a psychiatrist could be employed full or part time to act as a consultant for the patients on the ward. Along with the medical and nursing personnel, a social worker should be included to work with the patients as well as the family. The social worker could evaluate the home and assist families with social and financial problems. The department of physical therapy could be utilized and a physical therapist trained in the care of an adolescent would be an asset to any adolescent unit in a hospital. A psychologist may be helpful not only in therapy but also in performing valuable and needed psychological testing. An in-service teacher would be appropriate for adolescents who have long term problems or who may be expected to remain on the ward for a period of time.

The above description is of an adolescent unit designed and prepared to take care of an adolescent with any medical or social problem. Although it would be idealistic to think that this could be arranged in every hospital in the country, after reading the above suggestions a hospital could select those portions which would enable them to plan an adolescent unit which would be both financially and physically feasible for that hospital.

METHADONE SUBSTITUTION PLAN

Adolescent Clinic, Medical College of Virginia

Ted R. Abernathy, M.D.—1970

PREFACE

The Metcalf-Volker Act of 1962 guarantees the right of the addict by law to undergo a humane withdrawal from the narcotic.

The abrupt withdrawal of the narcotic results in the "withdrawal syndrome". Without substitution therapy, the addict experiences what is commonly referred to as "cold turkey". This may be painful, sickening, and uncomfortable, but rarely fatal. To subject another human being to it without support is neither legally, morally, or medically humane.

It is with these thoughts that a treatment program utilizing methadone hydrochloride is being submitted.

Methadone Substitution Plan

PURPOSE

The purpose of this plan is to transform the adolescent narcotic addict or abuser into a productive citizen of the community.

This plan is based on the ideal of detoxifying and maintaining the adolescent patient in a state of narcotic blockade, without the euphoric action or other effects of narcotic drugs, during a comprehensive rehabilitation program.

This plan will be considered a success when the patient can live normally and work satisfactorily in a drug-free state.

METHOD

This program involves the use of methadone, a synthetic narcotic, as a means of substitution blockade for the effects of the narcotic drugs, mainly heroin. Methadone, as substitution, has been used effectively for years without evidence of toxic effects to the liver, kidney, bone marrow, or central nervous system function. Patients stabilized on methadone have a normal sensitivity to pain; therefore, surgical emergencies, etc., will not be masked.

Chemically, methadone is a dependency-inducing, synthetic analgesic. It is well absorbed from the GI tract, and therefore may be given orally. Its action is uniform and substained, and any euphoria produced initially is ab ent after a tolerance develops. It will not, however, block amphetamines or barbiturates.

Narcotic addiction in females may result in amenorrhea, infertility, and anovulation. After methadone substitution for 1–2 months, regular menses will occur. Babies born to females on methadone were normal and without congenital abnormalities. They were normal birth weight as opposed to low birth weight infants of heroin addicts, and experienced little or no withdrawal symptoms. None required treatment.

THE ADDICTOR—HEROIN

Heroin is prepared by the actetylation of morphine. This may be accomplished with acetyl anhydride or acetylchloride. When injected, it is deacetylated, mainly by the liver, to morphine and 3-monoacetyl morphine and/or 6-monoacetyl morphine. These substances enter the brain (mainly 6-monoacetyl morphine) to exert their effects. Their onset of action is faster and the duration briefer than that of morphine. When used chemically, it evokes both psychological and physical dependence. The exact addicting dose is unknown; however, 10 mg. q.i.d. for 10–30 days has been shown to produce addiction.

TOXICITY

1. Respiratory depression—slow irregular respirations to Cheyne-Stokes respirations occasionally.
2. Clammy pale skin (may become cyanotic).
3. Pin point pupils (In terminal narcosis, pupils will dilate.)
4. Slowing of the heart rate.
5. Decrease in blood pressure.
6. Shock—terminal event.

ANTEDOTE

For heroin as well as methadone, use Naloephine (Nalline). Nalorphine may precipitate an acute withdrawal syndrome. This cannot be corrected by giving more heroin or morphine, therefore, care must be taken with its usage. Nalorphine is useful in all opiate narcoses, but may enhance the actions of depressants other than narcotics. This establishes the need to ascertain if barbiturates, etc., have also been ingested in the case of an acute overdose. An adequate airway must be maintained. Pure oxygen should not be used because CO_2 drive is already depressed and pure O_2 may depress respirations even more.

WITHDRAWAL

Withdrawal symptoms begin 8–10 hours after the last narcotic dose and peak about 72 hours later. If no substitute is used, the patient experiences "cold turkey" with symptoms of:

1. Nervousness
2. Restlessness, insomnia
3. Anxiety
4. Sweating
5. Watery eyes and nose
6. Dilation of pupils
7. Muscle spasms with pains in back and legs
8. Nausea and vomiting
9. Abdominal pain
10. Diarrhea
11. Anorexia
12. Increased blood pressure
13. Loneliness, isolation, depression

These symptoms decrease over the next 8–10 days, but the feeling of weakness and nervousness may persist from 2–6 months.

Complications of Heroin Addiction

MEDICAL

1. Abscesses, local at site of injection and elsewhere.
2. Thrombophlebitis.
3. Weight loss.
4. Sepsis and subacute bacterial endocarditis, tetanus.
5. Hepatitis, serum.
6. Pneumonia.
7. Coma, leading to death.

PHYCHIATRIC

1. Psychosis—especially when combined with methadrine or LSD, etc.
2. Suicide attempts.
3. Self-injuries.
4. Depression.
5. Loss of self-esteem.

BEHAVORIAL

1. Thieving.
2. Shop lifting.
3. Prostitution.
4. Drug selling.
5. Violence.
6. Joblessness.
7. Forgery.
8. Personal deterioration.
9. Abuse of other drugs.

The Patient

Acceptance of the methadone substitution plan will be made upon the following criteria:

1. No other major physical or mental complication or disease.
2. Age 12 to the 21st birthday.
3. No regard to sex or race.
4. Proof of definite addiction to a narcotic will be made before treatment to eliminate those desiring a source of methadone to abuse. (tracks, scars, withdrawal syndrome, previous absesses, plus a positive urine indicating heroin use).
5. A sincere desire to succeed and abstain is very important for the success of this program. It is doubtful if patients will succeed if forced into therapy by parents or law enforcement personnel.
6. No more than 50 subjects will be followed at any given time.

To work with an addict successfully, a certain trust and honesty must develop between patient and doctor. To have this develop, the doctor must have some insight into the drug addict and his personality. There is no such thing as a stereotyped "drug addict" personality. Each patient is an individual and should be treated as such. The one common denominator with other drug users is the "drug" itself. If there is no "drug personality" addiction is a symptom of personality maladjustment and must be treated individually as such. Adolescent drug addicts have a great need and desire for respect and security, and this will be maintained throughout the therapeutic course.

An addict on methadone still remains an addict. He still has all the problems and conflicts he had that may have led up to the use of the narcotic in the first place. The doctor must confront the patient with himself and his problems when he is not under the influence of narcotics for treatment to be successful. He must learn that he needs no crutch or dependency—no dependence on drugs, the clinic, or the doctor—only dependence upon himself.

When placed on methadone, the adolescent will have his "drug hunger" blocked without euphoria; this will end the need to "seek his drug and the behavior involved with "coping" will no longer occur. On oral methadone the needle is eliminated, and thus the "needle desire" is hopefully decreased or destroyed altogether. The psychological "enforcer" is gone. It is said an addict must drop all of his former friends in order to escape the drug environment. He must accept a new social group which is "drug free" in order that he not be tempted to return to his narcotic. This is a monumental task for the adolescent patient at a time when his emotional development and his desire for narcotics are at a peak. On methadone he can retain his friends and feel confident in his ability to remain free of drugs.

On methadone, the adolescent usually does not want to "cop" or lay around but wants to become a productive member—self-supporting—of society, when this treatment is combined with a rehabilitation of the underlying problems and the contributing environmental factors. "The potential strengths of addicts, like their faults, cannot be judged while the addicts are trapped in the orbit of drug abuse."

THERAPY

OUTPATIENT THERAPY PLAN

100 mg. of methadone per day blocks 6–10 bags (cups) of heroin. 1 mg. methadone will substitute for 4 mg. morphine sulfate. 1 mg. of methadone will substitute for 1 mg. of heroin. 25 mg. of oral methadone is equal to 10 mg. IM and 2.5 mg. IV.

The full blocking effect of methadone does not occur until approximately the third month of maintenance therapy. It requires only 28–48 hours to aid withdrawal symptoms.

It is frequently difficult for a physician to adequately establish the exact dose of methadone required for the individual patient. It is *assumed* in the Richmond area that each capsule of heroin contains approximately 10 milligrams of acetylated morphine or heroin. If the patient states that he requires 10 caps of heroin a day, it might be assumed that the patient was using approximately 100 milligrams of actual heroin. The quantity of heroin found in this area rarely attains the level of 10 milligrams per capsule. It must be emphasized that one can never be sure of the quantity of heroin contained in a given capsule. *As a rule*, therefore, a physician may divide in half the amount of heroin the patient says he is injecting. From this half dose he may calculate the required amount of methadone. It should be noted, that in any situation the maximum dose of methadone given initially should probably not exceed 50 milligrams over a twenty-four hour period.

The detoxification schedule for MCV should include a period of up to 10 days of methadone therapy. Over the 10 day period the dose of Methadone should be dropped each day by an amount equal to the first digit of the initial methadone dose. For example if a patient is started on 50 milligrams he should be dropped by five milligrams each day over the next 10 days.

INITIAL LAB WORK

Methadone, as a substitution drug, has been used effectively for several years without evidence of toxic effects to the liver, kidney, bone marrow, or CNS function. It is essential that a thorough and complete physical examination be done prior to the institution of Methadone. Studies should include a CBC and chest X-ray. For research and protection an SMA should be drawn prior to the institution of Methadone therapy. An intake urine screen *must* be obtained.

Patients will be seen at daily intervals initially and followed at weekly intervals thereafter. Weekly urinalysis will be performed to detect narcotics. The ideal plan is to be able to reach a level of 10 mg. Methadone per day to no methadone at all. However, this may be very idealistic. Dosages of up to 100–150 mg. per day *may* be necessary to stop "drug hunger" so rehabilitation can successfully occur. At high dose levels of methadone, tolerance develops and the euphorigenic effect is diminished. This euphoria is decreased for methadone as well as all opiate drugs.

IN-PATIENT THERAPY

Plan I.—(to be used if maintenance is planned or desired). Dose; 5–10 m. p.o. b.i.d. for 1–2 weeks. After 2 weeks: increase AM or PM dose by 5–10 mg. every 4–7 days until 40–50 mg. b.i.d. is being taken. After 1–2 weeks of this dose level, a single AM dose may be taken. (Transfer 10 mg. of PM dose to AM dose q.o.d. until full dose is taken each AM.)

Plan II.—If reduction scale is desired, use outpatient reducing dosage.

COMPLICATIONS OF METHADONE

1. Sedation, lightheadedness
2. Constipation, increased sweating, puritus
3. Slow to start urinary stream
4. Urinary retention
5. Abdominal distention
6. Intolerance
7. Nausea, vomiting

8. Pregnancy (due to return of sexual libido and regular periods)
9. Abuse—injection, etc. (If desired, methadone may be mixed with 3–4 oz. of orange juice. This will prevent injection, and accumulation of the drug will not occur due to vehicle spoilage in 1–2 weeks.

WITHDRAWAL SYNDROME OF METHADONE

If methadone is discontinued abruptly, withdrawal symptoms develop more slowly and are less intense than morphine and its derivatives. Usually no symptoms occur until the third day. Then the patient will experience weakness, insomnia, abdominal pains, anorexia, headache, hot and cold flashes, usually no vomiting, diarrhea or muscle cramps occur during withdrawal. Symptoms peak on the sixth day and decrease on the 10–14th day. Lethargy and anorexia may persist.

THOUGHTS ON METHADONE MAINTAINANCE THERAPY

The main goal is to have the adolescent addict off all narcotics and methadone. This may be entirely possible, in most cases; but in some, methadone treatment will be necessary for several months before it can be completely stopped. Even still, after a period of time on no medication, the patient may have long and persistent symptoms of abstinence. They may be constant or cyclic depending on various emotional situations from the environment. The long use of the narcotic may cause irreversible or slow to reverse changes in the physiological or psychological response to unpleasant or trying emotional stimuli. These altered responses and CNS irritability, even after a long period of withdrawal, may cause the former addict to experience symptoms of "drug" as well as "needle" hunger. It is these patients who would most benefit and will need methadone maintenance, or at least reinstitution of methadone substitution to carry the patient through the period of emotional or physical stress. This will prevent the need to return to narcotic abuse.

REHABILITATION

Success will only occur when the patient is no longer using a narcotic and is functioning at a social maximum. Stopping the narcotic and substituting methadone is not enough. The patient must learn to know himself, his friends, community, and his job. This can be attained through emotional support utilizing various modalities: psychotherapy, vocational and physical rehabilitation, counseling, and advice. Channeling adolescent ambition into productive outlets hopefully will produce a productive adult for our community. The State Department of Vocational Rehabilitation as well as the Virginia Employment Commission are helping in placement and rehabilitation of many of the patients now under treatment at the Adolescent Clinic.

CONCLUSION

In 1960, it was estimated that there were 48,000 addicts in the United States. In 1969, it was estimated that there were that number alone in New York City. No longer is it a problem of the ghetto. Is is now a problem of the adolescent—no matter what class. Heroin addiction has attacked the adolescent at a time when he is preparing for his entire life. We cannot afford to lose these young people, the majority of whom are intelligent, understanding, sincere, and sensitive. We also cannot afford the increasing financial responsibility for the narcotic addict. With methadone we can salvage and rehabilitate many young people and return them to society as functioning normal citizens. In return we save billions of dollars in welfare payments and the loss from thefts and break-ins.

Our goals are simple:

1. Improve the adolescent—medically and emotionally.
2. Prevent future illnesses.
3. Return the adolescent to satisfying activities, jobs, and relating normally to friends and families.
4. Help to stop the spread of heroin addiction. Most adolescents are introduced to heroin by friends who may or may not be already addicted. Treating and rehabilitating the addicted adolescent will help stop this spread.

We could wait for the "maturing out" process to occur, but then we would have lost the adolescent and lost an adult who might have been a contributor to a better world. We prefer not to wait, but take the chance for success and accept the disappointments of relapses. We plan to continue in our efforts to *educate* and treat the adolescent so that he may develope both physically and emotionally and accept the experiences of life he would normally miss if he turned or returned to drugs.

Standard Form 89
(Rev. March 1965)
Bureau of the Budget
Circular A-52

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

89-106-01

1. LAST NAME–FIRST NAME–MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS (*Number, street or R.F.D., city of town, State and ZIP Code*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS		16. OTHER INFORMATION

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS (*Follow by description of past history, if complaint exists*)

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
WIFE				
BROTHER'S AND SISTERS				
CHILDREN				

19. HAS ANY BLOOD RELATION (*Parent, brother, sister, other*) OR HUSBAND OR WIFE

YES	NO	(*Check each item*)	RELATION(S)
		HAD TUBERCULOSIS	
		HAD SYPHILIS	
		HAD DIABETES	
		HAD CANCER	
		HAD KIDNEY TROUBLE	
		HAD HEART TROUBLE	
		HAD STOMACH TROUBLE	
		HAD RHEUMATISM (*Arthritis*)	
		HAD ASTHMA, HAY FEVER, HIVES	
		HAD EPILEPSY (*Fits*)	
		COMMITTED SUICIDE	
		BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (*Place check at left of each item*)

YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)
		SCARLET FEVER, ERYSIPELAS			GOITER			TUMOR, GROWTH, CYST, CANCER			"TRICK" OR LOCKED KNEE
		DIPHTHERIA			TUBERCULOSIS			RUPTURE/HERNIA			FOOT TROUBLE
		RHEUMATIC FEVER			SOAKING SWEATS (*Night sweats*)			APPENDICITIS			NEURITIS
		SWOLLEN OR PAINFUL JOINTS			ASTHMA			PILES OR RECTAL DISEASE			PARALYSIS (*Inc. infantile*)
		MUMPS			SHORTNESS OF BREATH			FREQUENT OR PAINFUL URINATION			EPILEPSY OR FITS
		COLOR BLINDNESS			PAIN OR PRESSURE IN CHEST			KIDNEY STONE OR BLOOD IN URINE			CAR, TRAIN, SEA, OR AIR SICKNESS
		FREQUENT OR SEVERE HEADACHE			CHRONIC COUGH			SUGAR OR ALBUMIN IN URINE			FREQUENT TROUBLE SLEEPING
		DIZZINESS OR FAINTING SPELLS			PALPITATION OR POUNDING HEART			BOILS			FREQUENT OR TERRIFYING NIGHTMARES
		EYE TROUBLE			HIGH OR LOW BLOOD PRESSURE			VD-SYPHILIS, GONORRHEA, ETC.			DEPRESSION OR EXCESSIVE WORRY
		EAR, NOSE OR THROAT TROUBLE			CRAMPS IN YOUR LEGS			RECENT GAIN OR LOSS OF WEIGHT			LOSS OF MEMORY OR AMNESIA
		RUNNING EARS			FREQUENT INDIGESTION			ARTHRITIS OR RHEUMATISM			BED WETTING
		HEARING LOSS			STOMACH, LIVER OR INTESTINAL TROUBLE			BONE, JOINT, OR OTHER DEFORMITY			NERVOUS TROUBLE OF ANY SORT
		CHRONIC OR FREQUENT COLDS			GALL BLADDER TROUBLE OR GALL STONES			LAMENESS			ANY DRUG OR NARCOTIC HABIT
		SEVERE TOOTH OR GUM TROUBLE			JAUNDICE			LOSS OF ARM, LEG, FINGER, OR TOE			EXCESSIVE DRINKING HABIT
		SINUSITIS			ANY REACTION TO SERUM, DRUG OR MEDICINE			PAINFUL OR "TRICK" SHOULDER OR ELBOW			HOMOSEXUAL TENDENCIES
		HAY FEVER			HISTORY OF BROKEN BONES			BACK TROUBLE OF ANY KIND			PERIODS OF UNCONSCIOUSNESS
		HISTORY OF HEAD INJURY									
		SKIN DISEASES									

21. HAVE YOU EVER (*Check each item*)				22. FEMALES ONLY. A. HAVE YOU EVER—		B. COMPLETE THE FOLLOWING:	
	WORN GLASSES–CONTACT LENS		ATTEMPTED SUICIDE		BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
	WORN AN ARTIFICIAL EYE		BEEN A SLEEP WALKER		HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
	WORN HEARING AIDS		LIVED WITH ANYONE WHO HAD TUBERCULOSIS		BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
	STUTTERED OR STAMMERED		COUGHED UP BLOOD		HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
	WORN A BRACE OR BACK SUPPORT		BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION		HAD IRREGULAR MENSTRUATION		QUANTITY ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (*Check one*) ☐ RIGHT HANDED ☐ LEFT HANDED

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		27. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC
		B. INABILITY TO PERFORM CERTAIN MOTIONS
		C. INABILITY TO ASSUME CERTAIN POSITIONS
		D. OTHER MEDICAL REASONS *(If yes, give reasons)*
		28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
		29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? *(If yes, give details)*
		30. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*
		31. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? *(If yes, describe and give age at which occurred)*
		32. HAVE YOU EVER BEEN A PATIENT *(Committed or voluntary)* IN A MENTAL HOSPITAL OR SANITORIUM? *(If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic)*
		33. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*
		34. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? *(If yes, give complete address of doctor, hospital, clinic, and details)*
		35. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? *(If yes, which illnesses)*
		36. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*
		37. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for misfitness or unsuitability)*
		38. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*

WARNING: A FALSE OR DISHONEST ANSWER TO ANY OF THE QUESTIONS ON THIS FORM MAY BE PUNISHED BY FINE OR IMPRISONMENT (18 U.S.C. 1001)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

39. PHYSICIAN'S SUMMARY AND EVALUATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 20 thru 38)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

★ U.S. GOVERNMENT PRINTING OFFICE : 1963 O—247-459

Standard Form 88
Revised April 1965
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.5

REPORT OF MEDICAL EXAMINATION

88-117

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS (Number, street or R.F.D., city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEAT OF KIN

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

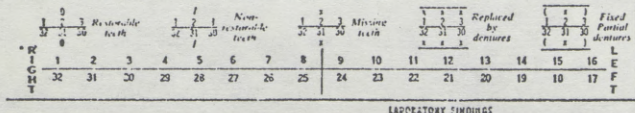
CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	16. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Ext. & int. canals (Auditory acuity, under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 39, 40 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Proctoscopic, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviates)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

(Continue in item 73)

44. DENTAL (Use appropriate symbols. Show as examples, above or below number of upper and lower teeth.)



REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS. A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. CHEST HAIR	54. COLOR EYES	55. BUILD ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56. TEMPERATURE

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. / DIAS.	B. RECUM-BENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	MY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	MY	S.	CX	CORR. TO	BY

62. HETEROPHORIA (Specify direction)

CS°	LX°	R. H.	L. H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 CPS	500 CPS	1000 CPS	2000 CPS	3000 CPS	4000 CPS	6000 CPS	8000 CPS
LEFT WV	/15 SV	/15	RIGHT								
			LEFT								

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS: FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☐ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
81. TYPED OR PRINTED NAME (IF DENTIST OR PHYSICIAN (*Indicate which*))	SIGNATURE	
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE	NUMBER OF ATTACHED SHEETS

* U.S. GOVERNMENT PRINTING OFFICE : 1960 O—314-940

METHADONE INTAKE

NAME_____

ADDRESS_____

AGE_____ SEX_____ RACE _____MARITAL STATUS_____

EMPLOYMENT:

1. Are you working now? _____ Where?_____
   What do you do? _____
   Salary?_____ If not working, what is your source of income?_____
2. Do you like what you do?_____ If not, why?
   _____
   What would you like to do?_____
3. How many jobs have you had in the last 2-3 years?_____
4. Does your employer know that you're trying to get on the methadone program?_____

EDUCATION:

1. What is the maximum grade reached?_____
   Where did you attend school? Grammer_____
   Secondary_____College_____
   Graduate_____
2. Are you interested in finishing school?_____ or training?_____ If so, how far?_____
   Where?_____ In what?_____
3. How did you like school? _____ If not, why?_____
   _____

FAMILY:

1. With whom do you live?_____

   What is their relationship to you?_____

   Are all the immediate members of your family living together? _____

2. Do you live in: Home_____ Apartment_____

   Dormatory_____ Other_____

3. Does your family know you're applying for methadone program? _____ What do they think about it?_____

   _____

4. Does anyone in your family use drugs?_____ If so, which drugs?_____

SELF-INFORMATION:

1. What are your special interests?_____

   _____

2. Do you have transportation?_____

3. Have you been arrested? _____ How many times?_____

   Reason for arrest_____

   Are you currently under parole or probation?_____

   Have you ever been convicted of a felony?_____

DRUG INFORMATION:

1. What drugs have you used? (Please list in order of use)

	Drug	How long used	Age when started	Still using
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
D:	_____	_____	_____	_____

2. Why did you start using drugs?_____

_____

3. Why did you start using heroin?_____

_____How much heroin are you using now?

_____ How often?_____ How did you get the money for the heroin?_____

How did you use it?_____

Did you ever get off heroin completely?_____

When?_____ How long were you off?_____

How did you stop?_____

Were you assisted by a physician?_____ Have you ever been a participant in another drug rehabilitation program?_____

Why did you start back on heroin again?_____

_____

4. How long do you plan to be on the program?_____
5. Do you think heroin has kept you from doing what you would really like to do?_____
6. What are your ambitions and what do you expect to get out of the program?_____

_____

7. Did you have or do you have now any medical complications or reactions to any of the drugs you listed above?_____

If so, please describe_____

_____

8. Are you taking any medications now, prescribed or otherwise?

_____

9. Have you ever sought psychiatric counseling?_____

If so, what was the result?_____

_____

10. Have you ever overdosed?_____

How often?_____

WOMEN ONLY:

1. Have you been pregnant while on heroin?_____ If yes, how often?_____ Were all pregnancies carried to full term? _____ If no, how many were not?_____ Were any of those lost abortions?_____

2. Did you experience any problems during pregnancy on heroin? _____ if so, please describe_____

_____

3. Have you delivered while on heroin?_____ if yes, how often?_____ Did the children live?_____ If no, please describe._____

Were there any complications at birth?_____ If yes, please describe_____

4. Were you periods regular while you were on heroin?_____

Date filled out_____

66-841 O - 72 - pt. 3 - 14

PATIENTS CONSENT FORM
METHADONE PROGRAM

I understand that the use of methadone on a long-term basis in order to achieve a drug-free state is new therapy for heroin addiction. Although no long-term side effects of methadone have to this date been discovered, I realize that these effects may become known at some time in the future. I also understand the therapeutic value of methadone is not known at present.

By entering into this program I agree to the following:

1. I agree to stop using all other narcotics other than those prescribed for a valid, medical reason.
2. I will not allow anyone else to use the methadone assigned to me.
3. I agree to an intake urine test for heroin.
4. I agree to periodic tests on 24 hour notic of my urine for heroin, other narcotics, barbituates (downs) and amphetamines (ups).
5. I understand that violation of agreements (1) and (2) may cause me to be dropped from the program.

Because this is an experimental program, I relieve Dr. Bright and the Adolescent Clinic as well as the Medical College of Virginia of any responsibility for conditions resulting from or through the use of this drug.

Parent or Guardian
Consent_____ (Signed)_____

Witness _____ Date _____

Date

Clinical Diagnosis:

Deliver Report To:

Examination Indicated: (This slip valid for one examination.)

NAME:

M. C. V. HOSPITALS

LABORATORY REPORT

BARBITURATES	
QUININE	
MORPHINE	
CODEINE	
COCAINE	
METHADONE	
AMPHETAMINES	
+ = Positive	+ = Trace

EXAMINATION 0 = Not Detected

M. T.

DATE

THE METHADONE SCREENING TEST

GUIDELINES FOR METHADONE THERAPY IN THE EMERGENCY ROOM

(Ted R. Abernathy, M.D.—1971)

The following guidelines for methadone therapy have been prepared to instruct the MCV Emergency Room physician in the treatment of the narcotics addict. This program involves the use of methadone. a synthetic narcotic, as a means of alleviating the withdrawal effects of any of the narcotic drugs, but more specifically heroin.

(1) *Methadone.*—Clinically, methadone is a dependency inducing synthetic analgesic. It is absorbed well from the GI tract and therefore, may be given orally. It's action is uniform and sustained. Any euphoria produced initially is absent after tolerance develops. It will not, however, block the amphetamines or barbiturates. A patient stabilized on methadone will have normal sensitivity to pain. Therefore, surgical emergencies, etc. will not be masked. The full blocking effect of methadone does not occur until approximately the third month of maintenance therapy. The onset of action begins within thirty minutes to an hour after the intake to relieve the withdrawal symptoms. It is therefore an ideal drug to be used for short term detoxification in an emergency room situation.

(2) *Determination of Definite Addiction.*—Before prescribing methadone it is extremely important that definite addiction to a narcotic agent be established. An individual may be assumed to be addicted if he presents symptoms of withdrawal: bilateral "track marks", a positive urine test for either quinine or a narcotic, or symptoms of narcotic toxicity.

(3) *Outpatient Therapy Plan.*—One milligram of methadone will substitute for approximately 4 milligrams of morphine sulfate. One milligram of methadone will substitute for one milligram of heroin.

It is frequently difficult for an emergency room physician to adequate establish the exact dose of methadone required for the individual patient. It is *assumed* in the Richmond area that each capsule of heroin contains approximately 10 milligrams of actylated morphine or heroin. If a patient states that he requires 10 caps of heroin a day, it might be assumed that the patient was using approximately 100 milligrams of actual heroin. The quantity of heroin found in this area rarely attains the level of 10 milligrams per capsule. It must be emphasized that one can never be sure of the quantity of heroin contained in a given capsule. *As a rule*, therefore, a physician may divide in half the amount of heroin the patient says he is injecting.

From this half dose he may calculate the required amount of methadone. It should be noted, that in the emergency room situation, the maximum dose of methadone given should probably not exceed fifty milligrams over a twenty-four hour period. When dispensing methadone in the emergency room a patient should be informed that this is only an acute detoxification plan. rather than any form of maintainance. Maintainance therapy with methadone could not legally or ethically be carried out in the emergency room.

The detoxification schedule for the emergency room at MCV shou'd include a period of up to ten days of methadone therapy. Over the ten day period the dose of methadone should be dropped each day by an amount equal to the first digit of the initial methadone dose. For example, if a patient is started on fifty milligrams he should be dropped by five milligrams each day over the next ten days.

(4) *Initial Lab Work.*—Methadone, as a substitution drug. has been used effectively for several years without evidence of toxic effects to the liver, kidney, bone marrow, or CNS function. It is essential that a thorough and complete physical examination be done prior to the institution of methadone. Studies should include a CBC and chest x-ray. For research and protection an SMA should be drawn prior to the institution of methadone therapy. An intake urine screen *must* be obtained.

(5) *Complications of Methadone.*—(*a*) sedation; (*b*) abdominal distention; (*c*) urinary retention; (*d*) constipation; (*e*) nausea.

If a patient exhibits any of these symptoms after 12 to 24 hours on methadone, the dose level should be regarded as an overdose, and the amount decreased immediately. If an overdose syndrome exists with respiratory depression, coma, seizures, etc., Nalline (Nalorphine) may be used in the same manner as is used in the treatment of heroin toxicity. (0.1 mg./1 kg. should

be given—not to exceed 10 mg. Nalorphine, I.V. every 10 to 20 minutes or until the patient is stabilized over a 12 hour period.) It should be noted that methadone is longer acting than heroin and continued treatment of an overdose may require up to 72 hours.

(6) *Methadone Maintenance in the ER:* If a patient already on a methadone program at MCV presents himself to the ER desiring more medication for various reasons (lost medication, withdrawal, etc.) no additional drug will be given to this patient. As an alternative the patient should contact the physician in charge of his case. Only then should more methadone be given to the presenting patient. The amount should be established by the patient's individual physician.

(7) *Conclusion:* Methadone, when administered in proper dose levels, should not cause significant euphoria or any behavior distortions or over-sedation. At the proper dose level, a patient should remain alert, function normally, and any symptoms or signs should be prevented. Referral of all ER patients to either the adult methadone or adolescent clinics is impossible at all times. However, the history and physical of a patient may be sent to the proper clinic for screening and possible intake to a regular methadone program.

METHADONE TREATMENT—ADULT SERVICES

Ninth Floor, E. G. Williams Hospital, Medical College of Virginia, 770–4610.

CLIENTS

Over 21; self-referred; currently approximately 200 persons.

PROCEDURE

1. Patient presents himself to the Alcoholic Study Group voluntarily or is referred by another agency or person (Ex. law enforcement agency, court, minister, school counselor, friends, etc.).
2. Patient meets with physician who explains what the methadone treatment involves.
3. Patient reports to Methadone Dispensing Area. Urine is collected, initial medical and social history is taken and an appointment with the screening committee is set up.
4. Patient meets with screening committee who try and analyze the commitment of the patient to the proposed treatment plan and determine more accurately the length and size of the opiate habit. Urinalysis results and histories are available to committee at this time.
5. Patient is rejected by committee. This may occur because of a lack of sincerity towards the program or an obvious lack or ability to stay with the program.
6. Patient is referred to a program such as R–CAP Halfway House since it appears the drug-free approach is most suitable.

This program is in essence one of methadone maintenance and detoxification. Included are the medical and psychological support services which are necessary for rehabilitation. All aspects of the program available for maintenance patients would also be available for detoxification patients and vice versa. The sole difference in the two segments of the program are dosage schedules of methadone and the direction taken by individual counselors. As a total, the program would consist of the following services:

A. Medical services available to the patient:
   1. Methadone maintenance and detoxification;
   2. Biannual general physicals;
   3. Continuing medical review with referral service.

B. Psychological services available to the patient:
   1. Therapy sessions;
   2. Job counseling;
   3. Social guidance;
   4. Various psychiatric services.

The patient coming into the program may come through referral by another agency within the metropolitan area or may enter the program through his own initiative. The first step in entering the program is an interview with a screening

committee which consists of Rubicon staff members, methadone program staff members, and one or two former addicts. Rubicon, Affiliate Agency #1, is an in-house therapeutic committee located in Richmond at 2718 E. Franklin Street and is federally funded by OEO. The screening committee would function at the Rubicon offices at 1010 E. Marshall Street, also in Richmond. This combination reviewing board would see each patient coming into the program for a 15 minute to 1 hour interview. The purpose of such interviews would be to determine (1) the length and size of the patient's habit, (2) the direction the patient desires to take, (3) a generalized picture of the patient's drug taking patterns, (4) the patient's present legal, communal, and personal status, and (5) the committee's recommended treatment program for that individual. It will be the responsibility of this committee, in cooperation with the patient, to establish a program for the patient best suited to his needs whether that be solely therapy or a combination of therapy and methadone. The patient may refuse the recommendation of the screening committee and choose the program in which he feels he will best succeed. He must agree, however, that if he fails, he can re-enter the program only by accepting the course of therapy recommended by the committee.

Having been seen by this committee, the patient will then come to the Medical College of Virginia Hospitals, located three blocks from the building in which screening is held. Here the patient will be given a monitored urine test which will be checked for opiates, amphetamines, barbiturates, methadone, cocaine, and quinine. It will be essential that this test is positive for opiates to insure that no person is placed on the program who is not using opiates. A complete social history, a history of drug abuse, and a medical history will be taken from the patient. When these have been completed, he will be seen by one of the physicians of Affiliate Agency #2. He will receive a general physical examination, SMA, complete blood count, serology, and dipstick urinalysis. He will also be scheduled for a chest X-ray to determine any possible contact with tuberculosis. When all these have been completed, the patient will be given a prescription for methadone based on the size and length of his habit, the physician's evaluation, and the evaluation of the screening committee. He will then begin receiving methadone in 30 cc. of orange syrup (see IND) on a daily basis seven days a week. This will be dispensed from a pharmacy area within the Medical College of Virginia complex on presentation of a picture identification card which the patient will be given at the time of intake. The patient must drink his full dose of methadone for each day in the presence of a pharmacist.

There will be two treatment techniques being used simultaneously on the methadone program: maintenance and slow detoxification. When indicated by the physician and screening commitee, the patient will be placed on a maintenance program, meaning that he will receive a standardized dose of methadone with no planned change or graduation in his dosage. The purpose of such a program will be to provide a complete blockage of the desire for heroin, to block the euphoric effects of heroin should the patient attempt to use it, and to give us the time to return this patient to a normal life style. The detoxification program will be selected for a more highly motivated patient, a patient with a shorter term habit, or with a low dose habit. The rationale for this particular technique is that methadone, on a very slowly dose reduction schedule, in combination with an increasing schedule of therapy sessions, will allow us not only to overcome the physical addiction but hopefully to readjust and correct the emotional and psychological dependency factors in the patient. If at any time during therapy it is determined by the physician and other members of the staff that a patient should be switched from maintenance to detoxification or from detoxification to maintenance, such may be done. From a medical viewpoint, there will be no difference between those patients on maintenance and those on detoxification other than the dosage scheduling of the methadone itself. All other medical services will remain the same for all patients on the program.

Once weekly on a totally random schedule, each outpatient will be subjected to a monitored urinalysis. At this time, we will check for opiates, methadone, amphetamines, barbiturates, quinine, cocaine, and pheno hiazines. Should we receive either a positive test for opiates or a negative test for methadone, the patient will be warned. If such a result is repeated within a short period of time, the patient may be dropped from the program. The analysis of urine specimens will be done by a state agency on a contract basis. At this time, the State Department of Agriculture and Commerce laboratories are preparing to handle as many tests as the program will require. We will contract with this agency to handle the necessary testing.

Every six months while a patient is on the Methadone Treatment Program, he will receive a repeat of the initial intake medical examination including a general physical, an SMA, complete blood count, serology, and dipstick urinalysis. These will be reviewed by the affiliate medical staff in light of the patient's present schedule of methadone, the results of past examinations, and the patient's general physical condition. If at any time between these scheduled examinations the patient has a medical complaint or feels he needs medical attention, he will be seen by the physician. If the problem is a minor one and can be handled with the facilities available at the methadone clinic, the problem will be handled there. Should it require further attention, however, the physician will refer the patient to whichever facility or treatment center he thinks appropriate for that patient. This may mean a private physician, hospital facility, or one of the various free medical clinics within the city.

Those members of the staff directly concerned with the medical aspects of the program would include physicians to perform physicals, to draw samples for laboratory work, to judge the patient's medical conditions and needs, to aid in evaluating the patient's medical progress on methadone, to coordinate the patient's physical and psychological progress on methadone, and to provide for any medical necessities that the patient may have. A second group of medical professionals would be the pharmacists who will be employed. The reasons for employing pharmacists in this program are based on both their medical training and their ability to deal with drugs from a control aspect. The responsibility of the pharmacist in this particular program will not be one merely of mixing and passing out bottles of methadone; rather, it will be his responsibility to insure total control of the methadone in terms of inventory control procedures and enforcement of federal regulations pertaining to methadone. This will insure a minimum abuse of methadone within the community. It will also be the pharmacist's responsibility to discuss with the patient, on a daily basis, the patient's progress, how he is feeling physically, how the methadone is affecting him, or if he has any ancillary problem. The pharmacist will then record and comment on such conversations in the patient's chart. The pharmacist, since he does have a medical background and since he will be seeing the patient on a daily basis, will then be able to discuss and work with the physicians, counselors, and social workers in judging the patient's progress, both physically and psychologically.

The program plans to conduct research projects and publish any pertinent data. The specific areas of interest for research identified at this time are edema, pulmonary function, and maternity care associated with methodone. Here again, it is hoped to use the experience and education of the pharmacist to compile and evaluate such data. The program will also employ a number of pharmacy assistants (technicians). The duty of these people within the methadone program will be to help prepare and aid in the dispensing of methadone under the supervision of a pharmacist.

Psychological services of the program will be: (1) psychiatric services, (2) job counseling, (3) social guidance, and (4) therapy sessions. As mentioned earlier, the methadone program is cooperating with the Rubicon program in providing a total rehabilitation program for the addict. It is with the therapy sessions that the Rubicon structure will be most actively involved. Therapy groups will be conducted at the 1010 Marshall Street offices of Rubicon on an outpatient basis. Scheduling of therapy sessions will be adjusted to the individual patient, meaning that a patient may come 7 days a week for 14 hours a day, he may come during the day 7 days a week, he may come for night sessions only, or to 2 to 3 one-hour sessions weekly. The schedule will depend on the patient's job and school commitments, his motivation, and the severity of his problems. Such sessions will be conducted by former addicts and trained staff members of the Rubicon program. They will include encounter sessions, static sessions, and therapy groups. Also included will be such programs as cultural studies and educational training. It is hoped that through such sessions that the addict will be able to evaluate himself, to realize his social and psychological problems, and learn how to cope with them, and learn to face the stress situations which occur within a normal life style. Such sessions will be heavily stressed for those patients on a detoxification schedule, but will also be required for people on a maintenance program with the hope that they may eventually be transferred to a detoxification schedule. Both the psychological and medical portions of the program will be interdependent so that to continue with therapy sessions the patient must have fulfilled all obligations regarding the methadone component and to receive methadone he must have regularly attended therapy sessions.

The programming of such sessions would be flexible. Should the patient be on an all day therapy schedule and attain a job, he may have his schedule adjusted to suit his working conditions. The same would be true for schooling or for family problems.

The program will also employ two medical social workers in the Rubicon affiliate. The function of such people will be to help the patient readjust to life within the community in terms of school, monetary, family, and personal problems. They will counsel the patient in these areas, refer him to appropriate agencies for aid, and help him to alter his social environment. The program would also contain two job developers whose responsibility will be to open up job positions within the community for those people that are doing well within the program. The job developers will be able to use the resources of the State Vocational Rehabilitation Agency in both training and placing patients within an employment situation. These positions will be partly that of community public relations.

A psychiatrist will, likewise, be incorporated into the Rubicon affiliate staff on a part-time basis. Whenever it is determined that a particular patient has a psychiatric problem, he will be referred to this physician staff member. This would not be to take the place of therapy sessions or any other aspect of the program, but to treat the various psychiatric problems that might develop or be uncovered while a patient is on the program.

Since the methadone program has been coordinated with the Rubicon program so that each provides a part of the total treatment plan, we feel the psychological services component should be housed at Rubicon and coordinated within the Rubicon structure. For this reason, we have listed those people involved in psychological services as an affiliated agency. They will work with the Rubicon counselors in treating methadone patients and will in effect be part of the Rubicon staff and paid by Rubicon. The Department of Pharmacy Services will then be invoiced by Rubicon for the total of such salaries (see letter of agreement). This arrangement will best serve the program for a number of reasons: (1) It will keep all psychological services in one area so that the patient may have access to whichever combination of services he may need. (2) It will save funds and personnel by preventing duplication of positions by the two programs. (3) It will allow for the essential unity of psychological services through easier communication, immediate accessibility of information, and a simple coordinated approach to each patient. (4) It will allow each program to best use the strengths, experience, and expertise of the other. Unlike many areas, Richmond has been able to maintain excellent cooperation between the different modality treatment programs rather than developing the fragmentation and competition common in some localities. It is felt that this has strengthened both treatment modalities and offers the patient much more. This cooperative approach will be continued and further developed.

Complete records will be maintained of all medical and psychological changes noted with each patient. All data would periodically be collected and summarized for publication or report. Evaluation will be done on the medical effects of methadone, the effects of combining methadone with therapy, the progress of people on therapy or methadone alone as opposed to those on a combination program, the relationship of the patient's former background, both socially and drug-wise, to his progress on any of the programs, and the effect of social and vocational readjustment to the progress of the patient.

As is being done now, the patient will continue to be charged for his methadone on a daily basis. Cost, however, will be prorated in proportion to the patient's income at that time. The purpose of the charge is not merely financing, but therapy. It is believed that both the discipline and responsibility of having to provide for one's self can be therapeutic for patients in such a program.

METHADONE PHARMACY

Operating Procedures

1. METHADONE

(*a*) We order one kilogram of methadone powder at a time from Mallincrodt. Allow at least a month for it to arrive.

(*b*) On arrival we form a concentrate from the powder of 100 mg/cc methadone. The formula is:

Methadone, 1,000 gm.
Propyl Parabens, 2.0 gm.
Methyl Parabens, 20.0 gm.
Distilled water qs., ad 10,000 cc.

Dissolve the Methadone in 7,000 to 8,000 cc. water. Dissolve the parabens in ethyl alcohol, and add to the Methadone. Qs. with distilled water to 10,000 cc.

We keep 2 ounces for any further reference, send 2 ounces for assay and store the rest in gallon jugs, which are kept in the pharmacy. We keep only one gallon in the dispensing area.

(*c*) In the dispensing area we prepack about a two day supply of Methadone in orange syrup. The syrup is obtained from Pharmaceutical Services and comes plain and bitter. Any dosage below 30 mg. is placed in the bittered (Methabase-B) syrup. This keeps the patient from knowing when he is detoxified. The bitterness is equivalent to that of 30 mg. of Methadone. The packaging is done with a pipetting syringe and the strength written from 20 mg.–100 mg. in increments of 5 mg. (ie. 20 mg., 25 mg., 30 mg., 35 mg., etc.) Above 100 mg. we prepact 110 mg., 150 mg., and 160 mg.

(*d*) Any odd doses, or those below 20 mg. are prepared with a disposable 1 cc. syringe using the 100 mg./cc concentrate or a 20 mg./cc dilution, which we prepare in liter quantities in the dispensing area.

(*e*) On Friday we add psyllium seed to the supply to be taken out on Saturday and Sunday. By running a total of the number of each strength dispensed on Thursday we can prepack twice the amounts and come quite close to the exact number needed for the weekend.

2. DISPENSING

(*a*) The patient receives his dosage in a paper cup and must drink it in front of the pharmacist. Be sure he has swallowed it; some of our people attempt to hold it in their mouth and resell it once out of the hospital. They also will turn around and pass the cup back and hand you a second empty cup.

(*b*) Each bottle leaving the pharmacy is labelled with patient name and doctor. We also stamp the date on the label.

METHADONE STUDY

For Investigational Use Only

TAKE AS DIRECTED
KEEP OUT OF THE REACH OF CHILDREN

_____, M.D.
Medical College of Virginia

(*c*) We maintain a working index-card system using two sets of indexed alphabetical dividers. As the patient receives his medicine, the necessary recordings are made and the card filed in the second indexed section. This serves a number of purposes: you do not have to number through all the cards each time, it gives an indication of volume left for the day, it provides an easy means of determining who has skipped and needs to be warned.

(*d*) Our index cards are as follows:

NAME:_____ DR._____ AGE:_____

ADDRESS:_____ PHONE:_____ HBT:_____

DATE	Dose	No.	Pb.	Owe	OBS.	Comment

Each day when the patient comes to the pharmacy he is identified by his I.D. card, his index card is pulled from the file, that day's date is stamped on the card under the heading "date", his dosage strength in milligrams is written under "Dose", the number of bottles which is dispensed to the patient is entered under the heading "no."; (Usually this is always "1" except on Friday when it is "3" because they drink Friday's dose here and take with them a bottle for Saturday and a bottle for Sunday); the amount of money he pays each day is entered under "Pd." and if he does not pay for one day, the amount is marked under "Owe". The OBS. (observed) column on the card used to be when the patients took out more than a day's supply of methadone. At that time everyone was not required to drink his dose in the pharmacy, so if a patient did drink his dose in the presence of the pharmacist the "observed" column was checked. The last column on the card is used for any comment that is pertinent to the patient concerning how he feels on any day, any changes in his dose ordered by the doctor, any warnings that we want given to the patient (ie., missing his daily dose, a positive urinalysis, negligence in paying his bill, etc.)

(*e*) Each patient is given an I.D. Card when he first enters the program, and he is instructed to carry it with him at all times and present it when he comes to receive his medicine. Hopefully, this minimizes any chance of the wrong person getting methadone. We recently had printed new I.D. card forms which will have each persons picture on his I.D. card. The following is a sample of the New I.D. Card.

DEPARTMENT OF PHARMACY SERVICES
Medical College of Virginia Hospitals
Richmond, Virginia
METHADONE TREATMENT PROGRAM (1ND5796)
703-770-5631

_____
Patient Name

_____
Signature

_____
Identification No.

Picture

(*f*) Periodic urine specimens are taken on each patient. Dates for urines are selected from an IBM random number sheet and then marked on each patient's index card so on the particular day when the urine specimen should be gotten it will be immediately evident when his card is pulled. Urine specimens are taken about once every 7–10 days and sent to the hospital lab for testing. Drugs tested for are barbiturates, quinine, morphine, codeine, cocaine, methadone, amphetamines and phenothiazines. Enclosed is a copy of the lab sheet on which our data comes back from the lab. Under each drug column there is an "O" for negative findings for a "+" for positive findings. Also, one of the forms is put in each patient's file with his individual results on the form. When the patient is asked to give a specimen, if he refuses, it is counted as a positive urine. Each patient is monitored by a member of the clinic staff for the urine specimen to keep people from bringing in clean specimens or having someone else give the specimen for them. An intake urine specimen is gotten from each new patient trying to get on the Methadone Program which is sent to the lab to be tested for quinine and morphine. This helps us determine whether or not we are dealing with a true addict.

(*g*) There is a charge of $1.50/day for methadone for each patient. One dollar of the charge goes for paying for the methadone and fifty cents is for the urinalysis. Each urinalysis costs us $5.00, so every ten days each patient pays for one urinalysis to be run.

3. RECORDS

(*a*) Each patient on our program has a medical and social history taken on them. These are filled in usually by volunteer workers or by a member of the staff, as time permits. Enclosed is a copy of the history we use.

(*b*) Consent forms must be signed by each patient before getting on the Methadone program. Enclosed is a sample consent form.

(*c*) Right now we are in the process of setting up appointments for all patients for a complete physical. According to government stipulations a physical is to be done on each patient every six months and each of them is to get a chest X-ray. Medical students, interns, and residents are doing the physicals on a volunteer basis at this time.

(*d*) Each patient has an individual file for any and all information, medical or social, concerning him. These are filed numerically and are kept permanently even though the patient drops off the program.

PROPOSAL FOR INVOLVEMENT OF CIVIC CLUBS AND ORGANIZATIONS IN ADOLESCENT ACTIVITIES AT THE MEDICAL COLLEGE OF VIRGINIA

(By Ted R. Abernathy, M.D., Adolescent Clinic, Medical College of Virginia, Richmond, Va., presented to Richmond Civic Clubs, December 17, 1970, Richmond, Va.)

It has come to the attention of the Director of the Adolescent Clinic at the Medical College of Virginia that several civic clubs and organizations in the Richmond area have expressed an interest in the Adolescent Clinic and the activities of adolescents who are or have been involved with drug abuse and the Methadone Maintenance Program at the Medical College of Virginia.

Each club may wish to involve itself in one or more of the activities outlined. The extent of involvement will depend on financial backing as well as member participation in each organization.

The following suggested guidelines are:

1. *Job Bank.*—The importance of job placement for adolescents addicted to drugs cannot be over emphasized. A major problem facing the Adolescent Clinic is finding jobs for patients who may or may not be on the Methadone Program. Members of civic organizations could notify us when they have a position open or when they are willing to employ a young person with a history of drug abuse. A continuous flow of employment would shortly become available. Patients in the Adolescent Clinic involved in our program are many and from varied backgrounds. A variety of employment opportunities could be utilized for most.

2. *Scholarship Program* (gift or loan).—Many adolescents, because of their use and abuse of drugs have dropped out of college or high school, or are no longer in any active educational program. A civic club could provide a scholarship fund to be used by adolescents in our program so they could return to the high school

or college of their choice. Many of our adolescents are intelligent and with appropriate financial backing could return to school. The size of the scholarship fund would depend entirely upon the civic organization and the adolescent who used the fund. The recipient would be responsible to that organization for occasional progress reports. When the patient is in a satisfactory financial condition he or she could repay the scholarship fund money used for his education, thereby, providing a continuing self-supporting fund.

3. *Sponsorship Program.*—This program would allow an organization to sponsor an adolescent on the Methadone Program at the Medical College of Virginia. The organization could pay one-half of all the cost of the methadone. The patient would in turn be responsible to that organization for monthly reports on his or her activities, whether they have jobs or are returning to an educational setting. It is suggested the one-half payment plan be used to promote more responsibility in the adolsecent drug addict. Further explanation of the methadone program can be found in the Methadone Protocol included in this book. At the present time each adolescent patient on methadone pays $1.50 per day for their medicine which includes periodic urine checks for heroin, morphine derivatives, and quinine

4 *Education.*—Due to an increasing drug problem in our community, state, and country, it becomes the responsibilty of each organzaton to supply ts members with drug abuse information which is both accurate and as complete as possible. This can be accomplished through speeches, by conversation with select patients previously involved in drug experimentation, and by reading material for its members. The Adolescent Clinic is agreeable to help in this educational role and most adolescents in our program are quite concerned and willing to help in expressing their ideas in an educational program. Education *is* a primary tool in preventing drug abuse.

5. *Contributions.*—The Adolescent Clinic at the Medical College of Virginia is involved in a major education and rehabilitation program. Needless to say these programs are essential to the state of Virginia. Contributions will be used to purchase educational materials, to reprint articles on drug abuse, and to build a library containing information on adolescent behavior and drug abuse for the public. These contributions are tax deductible and are used for the expansion of the entire program.

The degree of involvement of each organization will depend entirely upon the group. It has been said, "If we all work together today, we will have no drug problem tomorrow." Involvement, education, and research will help us to eliminate one of our major problems facing our population today.

HOTLINE

Richmond Crisis Intervention Center

PURPOSE

The Richmnd Hotline 358–9191 is an emergency telephone service staffed by volunteer listeners trained in crisis intervention. It is an attempt to prevent the growth of health and psychiatric problems in the community by providing more direct services when traditional agencies are not available. The hotline also is a communication center for helping resources in the community and exposes gaps in the health care system. More specifically it provides a listening post for individual problems, an opportunity for discussion of constructive alternatives, and maintains an extensive file of resource persons and agencies. The advantages of the Hotline are its anonymity for both caller and worker, convenience, orientation to youth, and comprehensive community coverage.

OPERATION

The Richmond Hotline has been in operation since April 29, 1970. It is currently based in donated church space in the Fan area, a target area for youth problems. There are two phones on a rotary mechanism. Hours are from 7 p.m. to 1 a.m. seven days a week. At least two volunteers answer the telephones each night. These volunteers and the Hotline location are anonymous. Funds are from the Adolescent Clinic of MCV and private donations. Advertising time is donated Those wishing to contact Hotline for business reasons should write: Beth Moyer, Coordinator, Hotline, C/O Adolescent Clinic, Box 151, MCV Station, Richmond, Virginia 23219.

STAFF AND TRAINING

Initially the Hotline was staffed primarily by medical and other health professional students, but now the volunteers include more young people from the community itself. There are no age limits for Hotline workers but the majority are between twenty and twenty-eight years of age. They are selected for their knowledge of the youth culture and their demonstrated success in the conventional community. It is felt that they will be able to communicate with the wide variety of callers to Hotline. Almost all have had at least two years of college. Some of Rubicon's residential facilities are homes and the prospect soon learns that the people living in those homes are his brothers and sisters. Together they are a family.

Residents are assigned daily tasks designed to help them assume responsibilities—first for themselves, later for themselves and others. They participate in frequent encounter groups and educational-cultural seminars. A large function of the program is to provide education and job training so that those in the treatment can successfully build a good life upon re-entry to the community.

THE OUTPATIENT PROGRAM

The Outpatient Program is designed for those whose recovery does not require 24-hour treatment. Open seven days a week, Outpatient participation is tailored to the individual's employment, family and personal needs. There are three basic Outpatient Schedules:

1. Full participation, with daily attendance from 10 a.m. to 11 p.m. The major difference between full participation and residential treatment is that the individual on full participation goes home each night.
2. Weekly participation, with attendance from 7:30 to 11:00 p.m., seven nights per week.
3. Two groups and a weekly seminar requires attendance at two encounter groups and one seminar each week.

The outpatient program essentially offers the same type of activities and group experiences as does the residential treatment program. However, because of limited involvement, the outpatient program is less intensive and more flexible.

THE COMMUNITY PROGRAM

In the summer of 1971 Rubicon is opening two community education and prevention centers. These centers will be gathering places for young people and will work to create options for alternatives to the drug culture-life style. Tentatively, these centers have been scheduled for the Fan District and the Blackwell Community of South Richmond.

The staff of these centers will also work with parents, teachers and professionals to help them understand the causes of addiction and abuse so that families, schools and institutions can become increasingly supportive of young people.

RESEARCH AND EDUCATION

Confidential data sheets are completed on each call. These data sheets are designed for computer use. Information from the computer analysis enables the Richmond Hotline to keep this training consistent with its caller population and their problems. It has also encouraged the development of new referral resources.

Medical and occupational therapy, including students from outside Virginia, have received academic credit for their participation in the Hotline and such programs with other professional schools may be developing in the future.

Informal communication is maintained with other hotlines and crisis centers across the nation. The Richmond Hotline is part of the Southern U.S. division on the International Hotline Conference but is also in contact with centers in Washington, D.C., Philadelphia and other eastern cities.

DRUG MANUAL

HOTLINE—RICHMOND CRISIS INTERVENTION CENTER

Training Manual Revised: November, 1970

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DRUG INFORMATION AND TREATMENT PROGRAMS
RICHMOND, VIRGINIA

Drug Information:
Mr. Miles Matthews
Council on Drug Abuse Control (CODAC)
701 East Franklin, Suite 810
644-6110

Emergency Phone Services:
HOTLINE 358-9191 (7-12pm, every day)
YES 355-3256 (4-10pm, Mon.-Thur.; 6-12pm, Fri.-Sun.)
FISH 649-2555
MCV Emergency Room (North) 770-5955,5956,5957
Poison Control 770-4815

Treatment Programs:
Dr. George M. Bright
Department of Adolescent Medicine
Medical College of Virginia
770-6506, 6507, 6508
(By appointment, ages 12-21)

Dr. Ted R. Abernathy
Medical College of Virginia
770-6506

Dr. Joseph Byrne
Department of Alcoholic Studies and Rehabilitation
E.G. Williams Hospital
Medical College of Virginia
770-5620
(By appointment, ages 21 and over)

Richmond Community Action Program
Allan Crabb, Narcotics Program
649-8661, Ext. 2
J.J. Franklin, Screening
Halfway House

GUIDELINES

The following guidelines were outlined by Mr. Emmet K. Reid, Assistant Director, MCV Hospitals:

1. NURSES NOTES AND MEDICAL RECORDS - the term "drug addict" should not be used on the emergency room record unless clearly substantiated by recorded medical evidence. In the possible event of this record being used at a future time in a public court, a patient might have good cause to bring action against a person using this term without substantive evidence.

2. IF THE PATIENT IS A MINOR - if the patient is under the age of 18, and unaccompanied by a parent, the clerical staff will make a reasonable effort to promptly notify a parent or other adult relative to advise that the patient is being treated in the emergency room. If the patient is over 18, or living away from parents, or in school, a parent will be notified only if requested by the patient, or if the condition of the patient is considered critical.

3. IF THE PATIENT IS A COLLEGE STUDENT - in the case of a college student, the patient will be told that we generally advise the appropriate college authorities of the problem presented, and that unless specifically prohibited by the patient, this will be done. Most colleges have been very helpful in assisting students with drug problems.

4. NOTIFICATION OF POLICE - no police authority will be advised of the treatment of a patient resulting from drug abuse, except through the medical examiner in case of death.

5. POLICE EVIDENCE - if the patient has in his possession what is alleged to be an illegal drug or one not obtained by prescription, this is not to be reported to any police authority. The patient may be advised to dispose of it forthwith. The only exception would be in a case where the patient was already under arrest and then any physical evidence should be called to the attention of the arresting officer.

6. PRIVILEGED COMMUNICATION - a statement by a patient to a physician about the possession of a drug is a privileged communication.

7. INFORMATION FROM THE PATIENT - if a patient volunteers information about the identity of a supplier, seller or pusher, the patient should be told that this information should be handled through administrative channels and a representative from the superintendent's office called to talk to the patient if agreeable to the patient.

These policies are primarily for the benefit of any patient who seeks and expects our help. These policies have been reviewed in detail with the Attorney General's staff and are acceptable as consistent with current legal requirements.

THE EMERGENCY ROOM AND DRUG REFERRAL PLAN

As with any emergency the MCV Emergency Room is prepared to handle drug abuse cases. The ER has a flexible but efficient protocol to follow for patients with drug problems.

If a Hotline worker finds that the ER is the best course of action under the circumstances, there are several points that Dr. Hilkovitz, Director of the ER, suggests that we follow:

1. Ascertain what drug(s) was supposedly taken, the time, dosage, etc.

2. Have the individual get to the ER (North) with a friend.

3. Because he will be a patient, he must register when he arrives at the ER, so encourage him to take an ID or if he is incoherent and a friend is bringéng him, remind the friend to have the ID.

4. It is most important to have a good friend with him, as he will be in a strange place, with strange people and the drug he has taken may well amplify any anxieties he has already developed.

5. If the caller asks...tell him it is <u>not</u> the policy of the ER to call the police on drug cases...their purpose is treatment.

6. Generally the patient must be 21 years old, but can sign himself in if he is 18 or older. If he is 18 but is not coherent, a responsible party (his friend) can take the responsibility for signing him in.

7. Tell the person to LEAVE ALL DRUGS AT HOME, unless unidentified "caps" were ingested. In this case they SHOULD be brought in for identification as this will aid treatment.

8. Reassure the abuser and his friend and explain to them again that the effects that he feels or sees are only from a chemical...they will subside.

9. Finally, call the ER, tell them who you are and give pertinent information about the patient you have referred to ER.

ER phone: 770- 5955, 5956, 5957

Recap: Drug, Friend, ID, Age and/or Responsible Party, Leave drugs at home unless unidentified, Reassurance, Call ER.

66-841 O - 72 - pt. 3 - 15

MARIJUANA
Alcapulco gold
"B"
Bethesda gold
Bhang
Bo bo bush
Charas
Charge
Chicago green
Columbus black tea
Dirt
Fu
Gage
Gigglesmoke
Gold
Grass
Grasshopper
Greifo
Hay
Heife
Hemp
Indian hay
Jive
Joint (the cigarette)
Joy
Llesca (Spanish)
Locoweed
Love weed
Mary Jane
Mary Warner
Mexican brown
Mezz
Mohasky
Mor a Grifa
Mota (Spanish)
Mooters
Muggles
Mutah
Nail (the cigarette)
Number (the cigarette)
Panama Red
Pod
Pot
Reefer (the cigarette)
Roach (cigarette butt)
Root
Rope
Smoke
Sniper (cigarette butt)
Splim
Stick (the cigarette)
Sweet Lucy
Texas tea
Tennessee blue
THC
Tuskie
Viper's weed
Weed

HEROIN
Boy
Caballo
Carga (Spanish)
Crap
Doojee
Dope
Dugie
"H"
Hairy
Harry
Horse
Junk
Joy
Joy Powder
Pack
Piece of stuff
Pony
Powder
Schmeck
Shit
Skag (Skagg)
Smack
Stuff
Sugar
Tecata
White stuff
Whitey

COCAINE
Bernies
Bernice
Burese
Carrie
Cecil
Charley
Cholly
Corine
"C" (big C)
Coke
Dust
Flake
Girl
Gold dust
Happy dust
Haven dust
Ice
Snow (Snow bird)
Star dust
White heroin

AMPHETAMINES
"A's"
Black beauties
Bombido (injection)
Bottle (injection)
Browns
Cross Roads
Drivers
Eye openers
Footballs (+ dex.)
Jolly beans
Jugs (injection)
L.A. turnabouts
Lid proppers
Roses
Truck Drivers
Ups
Whites
(BENZEDRINE-amphetamine sulfate)
Bean
Bennie
Benny
Cartwheels
Crosstops
Hearts
Peaches
Splash
(DEXEDRINE-dextroamphetamine)
Copilots
Dex
Dexies
Greenies (+ amobarbital)
Hearts
Horse hearts
Oranges
Pep pills (usually dex.)
Wake-ups
(METHEDRINE-methamphetamine)
Crank
Chris
Christine
Crink
Crystal
Dice
Meth
Speed (especially meth.)
Strawberry Shortcake
Water

*M.D.A. (combination speed, L.S.D., and sometimes cocaine--also called Speedball)

BARBITURATES
Barbs
Candy
Dolls
Goofballs
Peanuts
Sleeping pills
(AMYTAL-amobarbital)
Blue Angels
Blue Birds
Blue Devils
Blue Heavens
Blues
Greenies (+ dex.)
(LUMINAL-phenobarbital)
Phennies
Purple hearts
(NEMBUTAL-pentobarbital)
Nimbly or Nimby
Yellow bullets
Yellow dolls
Yellow jackets
(SECONAL-secobarbital)
Pinks
Pink Lady
Red Birds
Red Bullets
Red Devils
Red Dolls
Reds
Seccy
Seggy
(TUINAL-amobarbital + secobarbital)
Christmas trees
Double trouble
Rainbows
Red and Blues
Tooies

HALLUCINOGENS
Atropine
Bufotenine
DET
DMT
DPT
Hash (Hashish)
Ibogaine
LBJ
LSD (LSD-25):
"A"
Acid
"25"
Blue caps
Cubes
Juice
Lucy in the Sky with Diamonds
Orange Triangle
Pink Wedge
Purple Owsley's
Quarter trip
Sandos
Strawberry fields
Sugar
White lightening
Marihuana (Marijuana)
Mescaline:
buttons
cactus
mesc
Peyote (Peyotl):
Sick Dizzy's
Barf Tea
Morning glory seeds:
Flower Power
Heavenly Blue
Pearly Gates
Weak Acid
Nutmeg
Psyilocybin (Psilocin):
magic mushrooms
Scopolamine
STP or DOM
"Serenity, Tranquility, and Peace"
Long trip
THC

NARCOTICS (Natural & Synthetic)
Blue (Numorphan)
Codeine (Paregoric):
P.G., P.O., Gee
Fours
Schoolboy
(Paregoric + Amphetamine-blue velvets)
Dolophine (Methadone, Dollie, Dolly, Dolls)
Heroin
Morphine & derivatives:
(Dilaudid-Hydromorphone)
(Demerol-Meperidine)
(Percodan-Oxycodone)
(M.S.-Morphine sulfate)
Dope
Emsel
"M"
Miss Emma
Morphie, Morpho
Unkie
White stuff
Numorphan (Oxymorphone)

SLANG TERMS

"A" - LSD
"A's" - amphetamines
*ABB - an abcess caused at point of injection from unsterile drug or needle
ACAPULCO GOLD - a supposedly superior grade of marijuana some what gold in color and supposedly grown in the vicinity of Acapulco, Mexico
ACID - LSD
*ACTION - selling narcotics
ACIDHEAD - a chronic user of LSD
AMPHETAMINE - stimulants which include dexedrine, methedrine, and benzedrine
AMP - ampule
AMPED - "wired" or crystal or methedrine (methamphetamine)
AROUND THE TURN - to have passed through the severest part of withdrawal distress; also OVER THE HUMP
ARTILLERY - equipment for injecting drugs
"B" - marijuana
BACKTRACK - to withdraw the plunger of the syringe before injecting drugs to make sure the needle is in the proper position
BAD TRIP - an unpleasant trip with LSD
BAG - a container of drugs
BAGMAN - a drug supplier or peddler
BALL - 1. a party; 2. absorbtion of stimulants and cocaine via genitalia
BALLOON - a small package of narcotics; container for heroin
*BAMBOO - an opium pipe
BANG - to inject drugs
BARBS - barbiturates
BARF TEA - peyote
BEAN - capsule, benzedrine
*BEAT THE GONG - to smoke opium
BEEN HAD - arrested; "laid"; had intercourse
*BELLY HABIT - taking the drug orally
BENNIES - benzedrine (amphetamine)
BENNY - intoxication after using benzedrine
BENNY JAG - intoxication after using benzedrine
BENT OUT OF SHAPE - under the influence of LSD
BERNIES - cocaine
BERNICE - cocaine
BHANG - marijuana
BIG JOHN - the police
BINDLE - small package of narcotics usually wrapped in paper
*BIRD-CAGE HYPE - poorest class of addicts who have trouble supporting their habits
BIRD'S EYE - extremely small quantity of narcotics
BIZ - equipment for injecting drugs
BLACK AND WHITE - patrol car
BLANKS - poor quality narcotics or low grade narcotics, also DUMMY or TURKEY
BLAST - party
BLAST A JOINT - smoke marijuana
BLOW (A STICK, HAY, JIVE, NUMBER, TEA, POT) - smoke marijuana

*indicates those terms taken from Lindesmiths classic book "Addiction and Opiates". Most of these terms are of historical interest because they are infrequently used by the adolescent abuser.

BLOW THE VEIN - the use of too much pressure on a weak or sclerosed vein which caused it to rupture
BLUE BIRDS - amobarbital (amytal)
BLUE CAPS - LSD
BLUE ANGELS - amobarbital (amytal)
BLUE DEVILS - same as above
BLUE HEAVENS - same as above
BLUES - same as above
BLUE (BLUE MORPHINE) - numorphan (oxymorphone), a narcotic used in a maintenance program (i.e., methadone type); the name blue comes from the fact that it turns blue during cooking
BLUE VELVET - Paregoric (tincture of camphorated opium) and an amphetamine
BO BO BUSH - marijuana
*BOO GEE - paper used to make the medicine dropper fit snugly into the needle
BOOST - to shoplift
BOOT - effect of a drug by injection; IV shot in which blood is drawn into the syringe
BOXED - in jail
BOY - heroin
BOMBIDO - injected amphetamine
BOMBITO - same as above
BOTTLE - same as above
BREAD - money
BREW - beer
*BRODY - feigned illness to obtain drugs from a doctor
BROWNS - amphetamines
BUFOTENINE - (5-Hydroxy-N-N-dimethyl tryptamine), hallucinogenic drug with effects similar to DMT; usually snuffed or taken IV
BULL - a federal narcotic agent; a police officer
BUMMER - an unpleasant trip on LSD
BUM TRIP - same as above
BURESE - cocaine
BURN - to make money for heroin with no plans to deliver "stuff" or phony drugs
BURNED - to receive phony drugs or badly diluted drugs
BUSH - marijuana
BUSINESS - paraphenalia for injecting drugs
BUSINESSMAN'S TRIP - an experience with DMT (di-methyl tryptamine)
BUSTED - arrested
BUZZ - to try to buy drugs
BUTTON - the sections of peyote cactus
"C" - cocaine
CABALLO - heroin
CACTUS - mescaline
CAN - marijuana container
CANDY - barbiturates
CANDYMAN - dealer of cocaine
CAP - a container of drugs (usually a capsule); to put down
CARGA - Spanish for heroin
CARRIE - cocaine
CARTWHEELS - amphetamine sulfate (benzedrine); round, white, double-scored tablets
CECIL - cocaine
CHAMPS - drug abusers who won't reveal their suppliers, even under pressure
CHARAS - marijuana
CHARGE - same as above
CHARGED UP - under the influence of drugs

CHARLEY - cocaine
CHICAGO GREEN - dark green marijuana said to be popular in Chicago
CHIPPING - taking small amounts of drugs on an irregular babis
CHIPPY - an abuser taking small amounts irregularly; a prostitute
CHLORAL HYDRATE - when mixed with alcohol called a MICKEY FINN
CHOLLY - cocaine
CHRISTMAS TREES - tuinal (amobarbital + secobarbital), green and white cap.
CLEAR UP - to withdraw from drugs
COASTING - under the influence of drugs
COCAINE - also called Bernies, Bernice, Burese, Carrie, Cecil, Charley, Cholly, Corine, "C", Coke, Dust, Flake, Flakey, Gold dust, Happy dust, Ice, Snow, white heroin, etc.--a stimulant
COKE - cocaine
COCTAIL - ROACH used in regular cigarette
COKED UP - under the influence of cocaine
COLD TURKEY - sudden dry withdrawal (see discription under HEROIN), also see IRON CURE
COLUMBUS BLACK TEA - marijuana
COMING DOWN - emerging from any "trip"
CONNECT - to purchase drugs
CONNECTION - a drug supplier
CONTACT HIGH - getting visual high from surroundings or from watching someone else who is high
COOKER - any spoon or bottle cap used in preparation of heroin
COOK UP A PILL - to prepare a drug for smoking
CO-PILOTS - dexedrine (an amphetamine)
COP - to process purchase drugs; copping-"they went copping four hours before making a strike"; also called RE-Up
COP-OUT - to confess; to alibi; quit; inform; defect
CORAL - chloral hydrate (Noctec)
CORINE - cocaine
COTTON - a small piece of cotton through which the drug is strained as it is drawn from the cooker into the syringe
COTTONHEAD - user who re-cooks the cotton fibers found in cookers when their supply is used up and they are in need of an injection
COTTON TOP - same as COTTONHEAD
COUNT - amount or purity of a drug
CRANK - methamphetamine (methedrine); also CHRIS, CHRISTINE, CRINK
CRAP - heroin
CRASH PAD - place where users withdraw from amphetamines
CRINK - same as above
CRIS-- same as above
CRISTINA - same as above
CROKER - doctor
CRIB - home
CRYSTAL - methedrine (an amphetamine)
CUT - to dilute drugs, usually by adding milk, sugar, and other inert substances
CUBES - LSD; referring to putting LSD on sugar cubes; also a cube of morphine containing a grain or two
DABBLE - to take small amounts of drugs on irregular basis
D.D. - a fatal dose of narcotic or other drug
DEALER - a drug supplier
DECK - a small package of narcotics
DEX - dexedrine (dextroamphetamine)
DEXIES - same as above
DET - diethyltryptamine, see DMT; an hallucinogen
DICE - methedrine
DILLIE - Dilaudid (Hydromorphone)

DIME BAG - a $10 purchase of drugs, especially grass
DIRT - grass
DIRTY - in possession of narcotics
DITCH - inside of elbow which has two large veins
DOLLS - barbiturates
DOLLIES - Dolophine (methadone), a synthetic narcotic used therapeutically in maintenance programs for heroin addiction
DMT - dimethyl tryptamine; short acting (1-3 hours) hallucinogen; sometimes used with marijuana, usually inhaled
DOMINO - to purchase drugs
DOOJEE - heroin
DOM - 4 methyl-2, 5 dimethoxy amphetamine; same as STP
DOPE - any drug, especially narcotics
DOPE FIEND - term used by drug users to parody society's view of them
DOPER - drug user
DOUBLE TROUBLE - Tuinal, combination amobarbital and secobarbital
DO UP - smoke marijuana
DOWNERS - sedatives, alcohol, tranquilizers, and narcotics
DOWNS - same as above
DPT - an hallucinogen
*DRECK - heroin, German word meaning mud, filth, or excrement
DRIPPER - equipment for injecting drugs, usually eyedropper, also dingers, dingtuzen, take, take-a-too
DRIVERS - amphetamines
DROP - to swallow a drug (i.e., dropping acid)
DROP A DIME - to call the police to cause a raid or arrest
DROPPED - arrested
DUGIE - heroin
DUMMY - a purchase which didn't contain narcotics
DUST - cocaine
DYNAMITE - narcotics of high potency (i.e., high grade heroin); may be any drug
EGO GAMES - a deprecatory term applied to social conformity and to normal activities, occupations, and the majority of people
EIGHTH - 8th of an ounce
ELECTRIC COOL AID - cool aid with LSD in it
EMSEL - morphine
ENDS - money
EXPERIENCE - an LSD trip
EYE OPENERS - amphetamines
FACTORY - equipment for injecting drugs
*FIGURE EIGHT - a feigned illness to get a doctor to give them dope
FIT - same as FACTORY
FIVE CENT BAG - a five dollar bag of heroin, grass, or other drugs
FIX - an injection of narcotics, usually intravenous
FLAKE - cocaine
FLASH - the intense orgasm-like euphoria experienced immediately after an intravenous injection
FLEA POWDER - poor quality narcotics
FLIP - become psychotic; also to be knocked unconscious
FLIP CHICK - crazy girl
FLOATING - under the influence of drugs
FLOWER POWER - morning glory seeds
FLY - take narcotics
FOIL - small package of narcotics
FOOL PILLS - barbiturates

FOOTBALLS - oval shaped tablets containing ampetamine + dexedrine
FOURS - Empirin Compound with codeine gr. 1
FREAK - to be afraid; wild sex; crazy person
FREAK-OUT - unpleasant reaction while on a trip; also a chemical high
FRESH AND SWEET - out of jail
FU - marijuana
FUNKY - unpretentious, earthy
FUZZ - police
GAGE - marijuana
GASKET - anything that can be placed on the small end of an eyedropper to prevent air from leaking between the dropper and the needle; also see BOO GEE
GEE - intravenous injection
GEE-HEAD - paregoric abusers
GEETIS - money
GEEZE - heroin or narcotics
GEEZER - a narcotic injection, usually a small shot
GET DOWN - an IV injection of drugs
GET HIGH - smoke marijuana
GET ON - an IV injection of drugs
GIGGLESMOKE - marijuana
GIMMICKS - equipment for injecting drugs
GIRL - cocaine
GLAD RAG - cloth material or handkerchief saturated with a chemical
GLUEY - a glue sniffer
GOLD - marijuana
GOLD DUST - cocaine
GOODS - narcotics
GOOD TRIP - a pleasant experience with psychedelics
GOOFBALLS - barbiturates
GOOFERS - sedatives
GOOFING - under the influence of sedatives
GOOFHEAD - an opium addict
GRAPES - wine
GRASS - marijuana
GRASSHOPPER - marijuana smoker
GREENIES - green, heart-shaped dexedrine and amobarbital combined
GRIEFO - marijuana
GUN - a hypodermic needle
GURU - guide, mother, travel agent, sitter
"H" - heroin
HAND TO HAND - person to person delivery
HANG -UP - personal problem
HAPPENING - a pseudo experience obtained through the use of lights and sound; to have the same type experience that one has with a drug; an event
HAPPY DUST - cocaine
HARD STUFF - morphine, cocaine, or heroin or the opiates
HARNESS BULLS - uniformed police officers
HAIRY - heroin
HARRY - same as above
HASH - hashish; the resin of Cannabis (marijuana), usually four times as potent as marijuana
HAVEN DUST - cocaine
HAY - marijuana
HEAD - user of drugs; a high
HEARTS - dexedrine and benzedrine
HEAT - police; a gun (also heater)

HEAVENLY BLUE - a hallucinogenic variety of morning glory seed, usually triangular in shape
HEELED - having narcotics; having money
HEIFE - marijuana
HEMP - same as above
HEROIN - boy, caballo, crap, doo jee, "H", Harry, Hairy, horse, junk, schmeck, smack, shit, tecata, white stuff, scag, etc. An addictive derivative of opium.
HIT - to purchase drugs; an arrest; a single successful injection of narcotics; a drag of smoke
*HITCH UP THE REINDEER - preparing to shoot cocaine
HIGH - euphoria under the influence of a drug
HOCUS - a narcotic solution ready for injection
HOLDING - possession of narcotics
HOOKED - addicted
HONKIE - white person
HOPHEAD - narcotic user; *originally used for opium smokers
HOPPED UP - under the influence of drugs
HORSE HEARTS - dexedrine
HORN - to sniff pwdered narcotics
HORSE - heroin
HOT - wanted by the police
HOT SHOT - fatal dose; an injection of poison instead of dope (i.e., strychine)
HOT TURKEY - lighting the roach between two matches and inhaling smoke through nose
HUSTLE - activities involved in obtaining money for drugs, especially heroin
HYPE - narcotic addict; someone who injects drugs
HYKE - Hycodan, dioxcodinine
ICE - cocaine
ICE CREAM HABIT - small, irregular habit
IBOGAINE - extracted from African shrub (Tabernanthe Iboga)-in high doses it causes excitement, mental confusion, and a drunken state
INDIAN HAY - marijuana
IRON CURE - see also COLD TURKEY, STEEL AND CONCRETE CURE
JAB - to inject drugs
JACKING OFF THE SPIKE - relaeasing pressure on the pacifier before all the liquid has gone into the vein allowing blood to re-enter the outfit. Sometimes repeated several times supposedly to wash all of the drug into the blood.
JAG - intoxication after using an amphetamine
*JAM - an overdose or O.D.
JIVE - marijuana
JOINT - marijuana cigarette; prison; penis; *an addict's works; *an opium den
JOLLY BEANS - pep pills, amphetamines
*JONES - a habit
JOY - marijuana and heroin
JOY POP - to inject small amounts of drugs irregularly
JOY POWDER - heroin
JUG - ampule or multi-dose vial of liquid drugs (for injection)
JUICE - "hard" liquor or alcohol
JUNK - narcotics
JUNKIE - a narcotic addict; one who uses heroin; sometimes one drug user will call another whom he feels is worse off than himself a junkie; also DOPE FIEND, HOPHEAD, SMECKER, USER, GOWHEAD, COOKIE, DOPE-HOP, YENSHEE QUAY
JUVIES - juvenile officers
KEY - kilogram or 2.2 pounds of marijuana
*KEYSER PLANT - a finger stall with drugs in it which is concealed in the rectum
KICK - to abandon a drug habit
KICK PARTIES - parties or sessions where LSD is used

KILO - large amounts of narcotics
KIT - equipment for injecting drugs
KNOCKED OUT - under the influence of drugs
KNOCKED UP - pregnant
LACE - money
LAYOUT - equipment for injecting drugs
LBJ (LBL) - JB-336-N-Methyl-3-Piperidyl benzilate HCL; a new hallucinogen
L.A. TURNABOUTS - amphetamines
LEMONADE - poor quality narcotics
LID - about one ounce of marijuana
LID PROPPERS - amphetamines
LIPTON TEA - poor quality narcotics
LIT UP -under the influence of drugs
LLESCA - Spanish word for marijuana
LOCOWEED - marijuana
LONG GREEN - money
LOVE WEED - marijuana
LSD (25) - lycergic acid diethylamide; an hallucinogen
LUNCH HOUR TRIP - trip on DMT
LUCY IN THE SKY WITH DIAMONDS - LSD
"M" - morphine
MACHINERY - equipment for injecting drugs
MAGIC MUSHROOM - psilocybin
MAINLINE - to inject drugs directly into a vein
MAINTAIN - keeping at a certain level of drug effect
MAKE A BUY - to purchase drugs
MAKE A MEET - same as above
MAKE A SPREAD - to lay out the equipment for taking a fix
MAN - the police; one's connection; white people; Honkie
MANICURE - high grade of marijuana (no seeds or stems)
MANITA - sugar or milk used to adulterate or cut heroin
MARIJUANA - classified as an hallucinogen; Mary Jane, Mary Warner, fu, gage, gash, grass, griefo, hay, joy, jive, smoke, love weed, mezz, pot, rope, tea, Texas tea, Tennessee blue, Viper's weed, weed, bo bo bush, Mor a Grifa, muggle, mutah, etc.
MARY JANE - marijuana
MARY WARNER - same as above
MATCH BOX - marijuana container
MEMBER - Blacks or someone other than white people
MESCALINE - also mesc, the alkaloid of peyote cactus
METH - methedrine (methamphetamine)-speed
METH FREAK - person who likes to use methamphetamine
METH HEAD - same as above
METHADONE - dolophine (dolly); a synthetic narcotic used in maintenance programs to ease addicts off heroin
MEXICAN BROWN - brown marijuana from Mexico
MEZZ - marijuana
MICKEY FINN - chloral hydrate and alcohol
MIKES - microgram (one millionth of a gram)
MILTOWN - a tranquilizer
MISS - when the tip of the needle slips out of a vein or goes through the vein and the drug is injected into the surrounding tissue
MISS EMMA - morphine
MOHASKY - marijuana
MOJO - narcotics
MONKEY - a drug habit where physical dependence is present
MOOD ELEVATORS - anti-depressants
MOR A GRIFA - marijuana

MORPHINE - "M", almost any word beginning with "M" (i.e. Martha) can be used in a sentence to mean morphine
MORNING GLORY SEEDS - contain lysergic acid amide, related to LSD but only 1/10th as potent
MOOTERS - marijuana
MOTA - Mexican word for good marijuana
*MOUNT SHASTA - to be from; to be addicted
M.S. - morphine sulfate
MUGGLES - marijuana
MUGGLEHEAD - marijuana user
MUSCLE - to inject the drug intramuscularly because you cannot find a good vein; to conceal the needle marks; to lengthen the effects of the drug
MUTAH - marijuana
NABS - police; fuzz
NAIL - the marijuana cigarette
NARCOS - the law; narocotic agents
NARKS - same as above
NEEDLE - hypodermic syringe
NEEDLE FLASH - a short high that might come between the time the needle enters the tissue and the drug enters the blood
NEEDLE FREAK - one who enjoys using the needle, in fact they may get greater enjoyment out of using the needle than the drug itself
NICKLE BAG - a five dollar purchase of drugs
NIMBLY (NIMBY) - nembutal; (pentobarbital); a barbiturate
NUMBER - the marijuana cigarette
NUMORPHAN - trade name for oxymorphone, commonly called "blue morphine" or just "blue"; a narcotic used in maintenance programs
"O" - opium
OP- opium
O.D. - overdose of drugs; usually fatal
OFF - withdrawn from drugs
OIL, TO - to get an IV injection
ON A RIP - under the influence of drugs
ON A TRIP - under the influence of LSD or other hallucinogens
ON THE BEAM - under the influence of marijuana
ON THE NOD - under the influence of drugs, especially opiates
ON THE STREET - out of jail
ON THE STUFF - regular user of drugs or addict
ORANGES - dexedrine (dextroamphetamine), an amphetamine
OUTFIT - eyedropper or cooker used to prepare fix, see WORKS
OUT OF THE BODY - feelings a person experiences while under the influence of LSD
OUT OF THIS WORLD - under the influence of drugs
OUTSIDE OF MYSELF - feelings experienced under influence of LSD
PACK - heroin
PAD - drug user's home; bed
PANAMA RED - marijuana
PANIC - shortage of drugs (especially narcotics) on the market
PAPER - a prescription or package or narcotics; a small square of paper folded into a rectangle to contain powdered drugs
PEACHES - benzedrine (amphetamine sulfate)
PEANUTS - barbiturates
PEARLY GATES - morning glory seeds
PEDDLER - dealer in drugs
PER - prescription
P.G. - paregoric

PHENNIES - phenobarbital (luminal)
PICKELED - under the influence of a drug
PICK UP - an injection
PIECE - a container of drugs; one ounce; girl; gun; pistol
PIECE OF STUFF - heroin
PILL FREAK OR PILL HEAD - dangerous drug user; someone who likes to take pills
PILLY - same as above
PINK WEDGE - LSD
PIN SHOT - when an injection is made by using a pin or sharp object to make a wound into which the end of the medicine dropper is directly inserted; also a penitentiary shot
PIN YEN - opium
PINKS - seconal (secobarbital), a barbiturate
PINK LADY - same as above
PIPE - large vein; joint; penis
PINNED EYES - pin-point pupils
PLANT - a cache of narcotics; stash; supply of narcotics
P.G. - paregoric (codeine)
P.O. - by mouth; paregoric
POINT - equipment for injecting drugs; needle
POINT SHOT - a shot made with the broken point of a needle or a sewing machine needle. The point is inserted into the vein or skin, then the medicine dropper is slid over it and held in place while the injection is made.
POD - marijuana
PONY - heroin
POP - to inject drugs subcutaneously
POPPERS - amyl nitrate
POT - marijuana
POTHEAD - marijuana user
POWDER - amphetamine in powdered form; also heroin
PURE - pure narcotics of very good grade
PURPLE HEARTS - combination dexedrine and amobarbital
PURPLE OWSLEY'S - LSD
PUSHER - narcotic or other drug seller; dealer
PEYOTE - the cactus from which mescaline, an hallucinogen, is derived
PSILOCYBIN - hallucinogen from mexican mushroom
QUARTER TRIP - LSD
QUILL - a folded matchbox cover from which narcotics are sniffed or snorted
RAINBOWS - tuinal; combination amobarbital and secobarbital, a barbiturate
RAT - to inform; an informer
READER - a prescription
RED AND BLUES - tuinal; see RAINBOWS
RED BIRDS - seconal (secobarbital), a barbiturate
RED BULLETS - same as above
RED DEVILS - same as above
REDS - same as above
REEFER - marijuana cigarette
RE-UP - to buy drugs, also to cop
RFD DOPEHEAD - an addict who travels around in rural areas and small towns and gets his drugs from local doctors
RIG - works
RIP OFF - general stealing
REGISTER - when the blood appears in the outfit indicating the vein has been punctured
ROLLER - a vein that will not stay still to let you put the needle in it

ROPE - marijuana
ROACH - the butt of a marijuana cigarette
ROACH PIN - a device to hold the butt of a marijuana cigarette; also ROACH CLIP
ROOT - marijuana
ROSES - amphetamines
RUMBLE - police in the neighborhood; a shake-down or search; a fight
RUSH - the intense orgasm-like euphoria experienced immediately after an intravenous injection of a drug
SAM - federal narcotic agents; army
SANDOS - LSD
SATCH - to saturate any absorbent material with a drug solution; method used in smuggling
SATCH COTTON - cotton used to strain narcotics before injection, may be used again if supplies of drugs are low
SCAB - heroin
SCAT - heroin,(diacetylmorphine)
SCHMECK - same as above
SCHOOLBOY - paregoric, codeine
SCORE - to purchase drugs; when the blood appears in the eyedropper
SCRIPT - a doctor's prescription
SCRIPT WRITER - a sympathetic physician; someone who forges prescriptions
SEEDS - slang reference to morning glory seeds
SECCY - seconal (secobarbital)
SEGGY - same as above
SHIT - heroin, sometimes marijuana or any abused drug
SHOOTING UP - to inject drugs, also MAINLINE, taking it main, in the gutter, in the sewer
SHOOTING GALLERY - place where narcotic addicts inject drugs
SICK DIZZY'S - peyote, an hallucinogen
SILK - a white person; Honkie
SILVER BIKE - syringe with chrome fittings or a chrome hypodermic needle
SITTER - an experienced LSD user who helps a new user
SKAG - heroin
SKIN POPPER - injecting the drug subcutaneously
SLAMMED - in jail
SMACK - heroin
SMACK FREAK - heroin addict
SMASH - acetone extracts of marijuana which added to hash, rolled in little balls and smoked; recently (1970) exported from Mexico
SMOKE - marijuana
SNIFF - to sniff drugs (usually heroin, cocaine, or glue) through the nose
SNORT - same as above
SNIPER - butt of a marijuana cigarette
SNITCH - to inform
SNOW - cocaine, white heroin
SNOW BIRD - cocaine (user)
SPEED - any amphetamine, but especially methedrine (methamphetamine)
SPEEDBALL - an injection which combines a stimulant and a depressant..often cocaine mixed with morphine or heroin; LSD and speed
SPEED DEMON - someone who uses amphetamines frequently
SPEED FREAK - same as above
SPEEDSTER - an amphetamine user, speed freak
SPLASH - benzedrine (amphetamine sulfate), an amphetamine
SPIKE - the needle used for injecting drugs; to inject drugs
SPLIM - marijuana
SPOON - 1/16th of an ounce of heroin
SQUARE - a non-addict
STACK - a quantity of marijuana cigarettes

STAR DUST - cocaine
STASH - a cache of narcotics
STEAMBOATING - smoking marijuana through a toilet paper roller or glass tube especially designed for this use
STICK - marijuana cigarette
STONED - under the influence of drugs
STRAWBERRY FIELDS - LSD
STRAWBERRY SHORTCAKE - methedrine (methamphetamine)
STOLL - informer
STP - "serenity, tranquility, and peace"; same as DOM, an hallucinogen
STRAIGHT - in possession of narcotics; person who is not a drug user
STRUNG OUT - regular user or addict; uncontrolled habitual use of drugs
STUFF - narcotics (heroin, usually)
SUGAR - powdered narcotics, especially heroin
*SUGAR CUBE - large cubes of bulk morphine; also LSD
SUDS - beer
SUPPLIER - drug source; dealer; pusher
SWEET LUCY - marijuana
SWINGMAN - a drug supplier
TENNESSEE BLUE - marijuana
TEXAS TEA - same as above
THC - delta-1, tetra hydrocarmabinol; active principle of marijuana
TOM CAT - an improvised hypodermic needle made with a sewing machine needle
TOOIES - tuinal (combination amobarbital and secobarbital) a barbiturate
TRACKS - scars along veins after many injections
TRIPPING OUT - getting high on psychedelics
TURNED ON - under the influence of drugs
TOXY - small amount of prepared opium
TRUCK DRIVERS - amphetamines
TUINAL - combination amobarbital and secobarbital, a barbiturate
TUNING IN - feeling the effects of LSD
TURKEY - a capsule purported to be narcotic but filled with a non-narcotic
TURNED OFF - withdrawn from drugs
TURPS - elixir or Terpin Hydrate with Codeine, a cough syrup
TUSKIE - marijuana
TWIST - marijuana cigarette
25 - LSD (from chemical designation as LSD-25)
UNCLE - federal narcotic agent
UNKIE - morphine
UPPERS - stimulant, amphetamines, also UPS
VIC - one who has been given a hot shot, a victim
VALLEY - inside of elbow, which has two large veins
*VERIFICATION SHOT - during an intravenous injection allowing blood to enter the syringe to verify that it is in the vein
VIPER'S WEED - marijuana
WAKE-UPS - amphetamines; the first shot of the day
WASHED UP - withdrawn from drugs
WATER - methedrine (methamphetamine)
WASTED - under the influence of drugs
WEAK ACID - morning glory seeds
WEED - marijuana
WEED HEAD - marijuana user
WEEKEND HABIT - a small, irregular drug habit
WHISKERS - federal narcotic agent
WHITES - amphetamines
*WHITE, DOCTOR - camoflauged reference to drugs, i.e.,"I'm sick and only Dr. White can help me"

WHITE HEROIN - cocaine
WHITE LIGHTENING - LSD
WHITE STUFF - morphine, heroin
WHITEY - heroin
*WING DING - a feigned illness performed so a doctor will give an addict dope
WIRED - under the influence of drugs
WORKS - equipment for injecting drugs, also LAYOUT, FACTORY, MACHINERY, GUN, ARTILLERY, THE BUSINESS, BIZZ, *JOINT
YATA - Mexican slang for someone who is crazy
YELLOW BULLETS - nembutal (pentobarbital) a barbiturate; also YELLOWS
YELLOW DOLLS - same as above
YELLOW JACKETS - same as above
YEN - desire for drugs
YEN HOOK (HOCK) - instrument used in opium smoking to prepare the opium
YEN SHEE - opium ash
YEN SHEE SUEY - opium wine
YEN SLEEP - drowsy period during opium withdrawal
YOUNGBLOOD - young person starting to use marijuana
*YEN SHEE QUAY - an opiate addict
ZONKED - under the influence of drugs

GENERAL POISONING MEASURES

I. Poisoning by mouth.

Objective: To dilute the poison as fast as possible, then except as advised, to induce vomiting.

A. Dilute the poison with water or milk or both.

B. When fluids can be administered, give large amounts to induce vomiting.

1. Baking soda solution - several teaspoonsful/1/2 glass water OR
2. Milk of Magnesia OR
3. Stick finger or spoon in victim's mouth to induce gagging and vomiting.

II. Exceptions to above:

1. Strong acids, such as carbolic acid.
2. Strong alkali, such as lye (NaOH)
3. Strychnine
4. Kerosene
5. Unconscious victim, convulsions or exhaustion

1. Strong acids - give milk, water to dilute poison. Milk of magnesia in small amounts to neutralize. DO NOT VOMIT. Give milk, olive oil, or egg white to protect stomach lining.

2. Strong bases - give water quickly. Neutralize base with vinegar or lemon juice. Follow with milk, olive oil or egg white. DO NOT VOMIT.

3. Strychnine poisoning - the slightest disturbance of patient may induce convulsions, give fluids and induce vomiting if ONLY a few minutes has elapsed since poison was taken.

HEROIN

Slang	Horse, "H", smack, scag, stuff, dope, junk, harry, hairy, pony, shit, carga (Spanish), joy, powder, skag, jive
Chemical name	Diacetylmorphine
Source	Opium poppy, a semi-synthetic opiate
Classification	Narcotic
Medical use	None accepted; heroin use is banned in U.S.
How taken	Injected or sniffed
Usual dose	Varies with tolerance, black market heroin is variable. Spoon, bag, paper or balloon of 5-10% heroin
Duration of effect	6 to 10 hours
Effects sought	Euphoria, pain killing, prevent withdrawal once addiction is established, "rush" upon injection lasting about a minute and compared by addicts to a "total body orgasm", lethargy (decreased alertness), drowsiness, peace, raised self-esteem and confidence.
Physiological effects	Loss of appetite, constipation, diarrhea, nausea, vomiting, prone to infection
Possible ill effects	Above, abcessed veins, hepatitis, body lesions, addiction, painful and devastating withdrawal like "D.T.'s", loss of appetite, placental transfer, intense sickness or death (from acute pulmonary edema) Withdrawal symptoms: craving, anxiety and tremors to the full-blown picture of delirium tremors, hallucinations, convulsions, vomiting, fever, increased heart rate, nervousness, sleeplessness, yawning, running eyes and nose, sweating, enlargement of pupils, "gooseflesh", muscle twitches, severe aches in back and leg muscles, hot and cold flashes, diarrhea, increased breathing rate, blood pressure and temperature, a feeling of desperation, and an obessional desire to secure a "fix". Intensity of withdrawal symptoms varies with degree of physical dependence and amount of drug customarily used. Symptoms begin about

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HEROIN Continued

	6 to 12 hours after the last dose and increase in intensity and reach a peak in 36 to 72 hours.
Psychological dependence	Yes, marked
Physical dependence	Yes, very addictive - addiction may be established after one to four weeks of daily or thrice weekly use.
Treatment or antidote	Methadone or Apomorphine maintenance for decreasing addiction. For overdose - maintain respiration, keep warm and force fluids except in unconsciousness. CALL A DOCTOR IMMEDIATELY.

NOTE: Two different types of heroin are used by addicts:

1) Brown or Mexican grade
2) White or French grade - most popular

MORPHINE AND DERIVATIVES

Dilaudid, Demerol, Porcodan, Morphine, sulfate, etc.

Slang	White stuff, "M", hard stuff, morpho, junk, Miss Emma, dope, m.s.
Chemical name	Hydromorphine, meperidine, oxycodone, morphine, oxymorphine
Source	Natural (from opium), semi-synthetic from morphine
Classification	Narcotics
Medical use	Relief from pain
How taken	Orally, injected, snorted
Usual dose	8-15 mg, 200 mg = minimal lethal dose
Duration of effect	4 to 6 hours
Effects sought	Euphoria, lethargy (decreased alertness), relief from fear, tension or anxiety, relieves pain, sleep, excitation (sometimes).
Physiological effects	Constipation, constriction of pupils, decrease respiration
Possible ill effects	Above, respiratory depression, tolerance developed, addiction, placental transfer, (baby will be addict and undergo withdrawal symptoms of birth), possibly fatal to asthmatics, withdrawal symptoms (see Heroin), and death
Psychological dependence	Yes
Physiological dependence	Yes
Treatment or antidote	Supportive measures; methadone, apomorphine, nalorphine, see Heroin.

CODEINE AND EXEMPT NARCOTICS

Slang	Robo, Robitussin, PG, GEE, fours, and schoolboy
Chemical names	Paregoric (camphorated tincture of opium), Terpen hydrate and codeine, Robitussin AC, Brown's Mixture, dextronethorphan (Romilar), charcoal, hycodan
Source	Opium poppy
Classification	Anti-tussive, analgesic, anti-diarrheal. Exempt narcotics and over-the-counter preparations. Some contain as much as 40% alcohol.
Medical use	Treatment of cough, diarrhea; relieve pain, prevention of withdrawal symptoms
How taken	Injected or oral (usually boiled down - i.e., paregoric)
Usual dose	2-4 oz (for euphoria)
Duration of effect	4 hours
Effects sought	Euphoria, to avoid withdrawal symptoms, rebellion, to ease cough and pain for the alcohol and/or codeine content
Physiological effects	Euphoria, sedation, impaired coordination, constipation, CNS depressant, relieve pain
Possible ill effects	Above, loss of appetite and weight, addiction, temporary impotency and sterility, and withdrawal symptoms
Physiological dependence	Yes
Psychological dependence	Yes, high
Treatment or antidote	Supportive measures, methadone, apormorphine, nalorphine

NOTE: The drugs in this class are exempt narcotics; therefore, they can be purchased without a prescription, within minimal restrictions on purchase. Others can be purchased over-the-counter in other drug stores.

METHADONE

Slang	dolly
Chemical name	Dolophine, Methadone
Source	Synthetic
Classification	Narcotic
Medical use	Addiction withdrawal (in maintenance program), antitussive, analgesic
How taken	Swallow pill or inject; dispensed at MCV as heat coaguable liquid (not injectable)
Usual dose	5-10 mg.; lethal dose is 60-120 mg. for the non-addict; maintenance doses for those addicted to heroin may be much higher
Duration of effect	4 to 24 hours
Effects sought	Relief from withdrawal symptoms, relief from cough or pain specifically, euphoria, rush, sedation
Physiological effects	Sedation, muscle spasm, respiratory depression, nausea, constipation (less than morphine), constricts pupils
Possible ill effects	Increase in above, dizziness, excitation, addiction, loss of appetite, depression, hallucination, delerium, respiratory depression
Psychological dependence	Yes
Physical dependence	Yes
Treatment or antidote	Supportive measures--see Heroin Medical antidote is Nallorphine (Nalline)

MARIJUANA

Slang	THC, pot, marihuana, grass, tea, heife, weed, boo, Chicago green, Texas tea, Tennessee blue, Bethesda gold, (in cigarette form called reefers, joints, sticks, "J", nail), Mexican brown "Kilo" = 2.2 lbs. quantity "Ozzio" = 1 oz. quantity "lid" = 1 oz. quantity "nickle bag" = $5.00 quantity
Chemical name	Cannabis sativa
Source	Flowers and leaves of female Cannabis sativa plant (hashish is the concentrated resin from the above); geographically grows everywhere, and isolated active ingredient is THC (3,4 tetrahydroxy-carbanicol).
Classification	Euphoric
Medical use	None presently in U.S.; projected uses: treatment of depression, tension, loss of appetite, sexual maladjustment, and addiction
How used	Smoked (most common method), swallowed (i.e. cookies, beverage), and injected (rarely - very fatal)
Usual dose	one or two "joints"
Duration of effect	3-8 hours, depending on potency
Effects sought	Relaxation, euphoria, sociability, fun, kicks, lower inhibition and intensity sexual pleasure (not an aphrodisiac)
Physiological effect	Dilated pupils, dry throat, itchy red eyes, depressed blood pressure, sleepiness, hunger and thrist, affects sense of time, but not motor and perceptual skills
Possible ill effects	Above physiological effects heightened, inexperienced user may experience paranoid reactions, dry throat, immature user may experience flashbacks, and long term or very heavy user may have respiratory irritation
Physical dependence	1. Grass itself - none 2. THC - not determined

Psychological dependence Possibly in unstable individual

NOTE: Pot is often cut with rhubarb or catnip on Black Market.

HASHISH

Slang	Hash
Chemical name	Hashish (concentrated resin of marijuana)
Duration of effect	Same as marijuana
Source	Resinous extract of marijuana
Classification	Euphoric
Medical use	None presently in U.S. - projected: see "pot"
How used	Same as "pot"
Dose	50-200 mg.
Effect sought	Same as "pot"
Physiological effect	Same as "pot"
Possible ill effects	Same as "pot"
Physiological dependence	Same as "pot"
Psychological dependence	Same as "pot"
Treatment or antidote	Sleep or calming

LSD

Slang	Acid, sugar, strawberry fields, sunshine, purple owsley's, orange triangle, cubes, "25", sandos, "A"
Chemical name	D-lysergic acid diethylamide-25
Source	Synthetic chemical from ergot alkaloids
Classification	Hallucinogen
Medical use	Studies of mental function; used in treatment of alcoholism; possible use in treating schizophrenics; being tested as an analgesic
How taken	Swallowed or injected (comes in tablets or liquid of variable concentrations). Also deposited on a piece of paper with eyedropper and eaten. Sometimes dropped directly into the eye.
Usual dose	100 mcg to 500 mcg (micrograms)
Duration of effect	8-12 hours
Effects sought	Insightful experiences; hallucinations and other preceptive changes; religious experiences; personal analysis; "massive sensory impact" due to blocking of normal brain filter system; dissolve reality
Physiological effects	"massive sensory impact" due to blocking of normal brain filter system; dilation of pupils; increased awareness; impaired coordination; sometimes consciousness expansion
Possible ill effects	1. "Flashback" - recurring "trip-like" sensation possibly may occur several months after quitting the drug; more frequent in mmmature users 2. Occasional psychotic reactions during a "bump" or "bomber" (bad trip) - most trips are neither all bad or all good 3. Chromosomal damage - conflicting results at present are statistically non-conclusive 4. May intensify a pre-existing psychosis; more commonly can produce a panic reaction when user is improperly prepared.
Physical dependence	No

LSD Continued

Psychological dependence	Has not been established, but probably not
Treatment or antidote	Thorazine (phenothiazines)

Do not forcibly restrain the subject except in dire emergency. This will make a bad situation worse. Calm surroundings are the most important factor in easing a bad trip. Do not leave the subject alone. Psychological reassurance that the experience will subside with elimination of the drug from the body is important.

"Bad acid" sometimes cut with systemic poisons as arsenic and strychnine.

MESCALINE (peyote)

Slang	"Buttons", "cactus", mesc
Chemical name	3,4,5-trimethoxyphemothylamide
Source	From the buttons of Peyote cactus; synthetic
Classification	Hallucinogen
Medical use	None
How taken	Tablets, capsules, or natural Buttons chewed.
Dose	350-1000 mg
Duration of effect	8-24 hours
Effect sought	Native American Church ritual (as in LSD); same effects sought as with LSD, except not as intense
Physiological effects	Nausea with non-synthetic variety; flashbacks and psychosis not reported except in previously disturbed patients, see LSD
Physical dependence	None, no physical effects known
Psychological dependence	Has yet to be reported, but probably not
Treatment or antidote	Thorazine or other phenothiazine. Calm reassurance. Bad experiences are rare with this drug.

PSILOCYBIN

Slang	"Magic mushrooms"
Chemical name	3(2 dimechylamino) Ethylindol-A-oldibydrogen Phosphate
Source	Psilocybe mexicana or aminita muscae
Classification	Hallucinogen
Medical use	None
How taken	1. Swallowed as tablets, pills, etc. 2. Sometimes put in Marijuana and smoked
Dose	25 mg
Duration of effect	6-8 hours
Effects sought	Same as LSD
Physiological effects	1. More intense visual effects, otherwise like LSD 2. Others
Physical dependence	None
Psychological dependence	None
Mental	None
Treatment or antidote	Thorazine, Phenothiazines

DMT

Slang	(DET, DPT), businessman's high
Chemical name	Dimethyl tryptamine
Source	Synthetic
Classification	Hallucinogen
Medical use	None
How taken	Orally, injected, inhaled
Usual dose	
Duration of effect	Short-acting, 1-3 hours
Effects sought	Insightful experiences, sense distortion
Physiological effects	Milder than LSD
Possible ill effects	
Physical dependence	No
Psychological dependence	Yes
Treatment or antidote	Supportive measures; Thorazine I.M. 25-50 mg. may be given

STP (DOM)

Slang	STP, DOM, "Serenity, tranquility, and peace"
Chemical name	4Methyl 2.5 dimethoxy alpha methyl phenethylamine
Source	Synthetic
Classification	Hallucinogen
Medical use	None
How taken	Orally, injected
Usual dose	10-20 mg. (maximum)
Duration of effects	12-24 hours
Effects sought	More intense psychedelic experience than LSD
Physiological effects	More intense than LSD
Possible ill effects	Prolonged "down" period, greater rise in blood pressure than LSD, pupils dilated more than LSD
Physical dependence	None
Psychological dependence	None
Treatment or antidote	Do Not use Thorazine or phenothiazines (deaths have resulted from combination STP and thorazine); supportive measures; see Heroin

PCP

Slang	(Sernyl) "Peace pill"
Chemical name	Phencyclidine
Source	Synthetic
Classification	General veterinary anesthetic and analgesia; hallucinogen
Medical use	No current use
How taken	Injected, smoked with parsley
Usual dose	
Duration of effect	
Effect sought	Hallucination
Physiological effects	Excessive salivation, no respiratory or circulatory depression, anesthesia, analgesia, no usual hallucinogen
Possible ill effects	Prolonged trance-like effect, produce a variety of "schizoid" states; such as body image changes; intensify schizophrenia
Physical dependence	No
Psychological dependence	Minimal
Treatment or antidote	Lack of treatment

MORNING GLORY SEEDS

Slang	Heavenly blue, pearly gates, flower power, weak acid
Chemical name	Lysergic Acid Monoethylamide, Ologui
Source	Rivea couymbosa, Iponnoea versicolor - morning glory seeds
Classification	Hallucinogen
Medical use	None
How taken	Orally (seeds soaked, then chewed) injection of extract
Usual dose	Up to several hundred seeds
Duration of effect	
Effect sought	See LSD
Physiological effects	Drowsiness, perceptual distortion, confusion, dizziness, intense anxiety, euphoria
Possible ill effects	Nausea, vomiting, diarrhea, possible recurrences, soaked in DDT before marketed: so possible GI effects, uterine stimulation
Physical dependence	None
Psychological dependence	None
Treatment or antidote	Thorazine

NUTMEG AND MACE (Condiments)

Slang	Spice, musket balls
Chemical name	Myristicin (nutmeg)
Source	East Indian tree - Myristica iragrams (nutmeg)
Classification	Hallucinogen
Medical use	None, but used to season foods
How taken	Orally
Usual dose	Mace - 1 can per teapot
Duration of effect	Nutmeg: 1-2 hours Mace: 1-2 hours
Effects sought	Hallucinations, euphoria, giddiness, feelings of intoxication, emotional lability, increase taste of food
Physiological effects	Abdominal cramps or spasm, severe liver damage
Possible ill effects	Acute psychotic reactions, agitation, apprehension, depersonalization, vomiting, nausea, flashing, dry mouth, abdominal cramps or spasms. Possibly severe liver damage
Physical dependence	None
Psychological dependence	None
Treatment or antidote	Castor oil or petralutum. Induce vomiting, give laxative. If none available give milk or mineral oil and induce vomiting.

AMPHETAMINES

Slang	Speed, crystal, meth, bennies, dex, pep pills, hearts, rainbows, kid proppers, ups, roses, footballs, greenies, black beauties, cartwheels, splash, peaches, co-pilots
Chemical or trade name	Methamphetamine (Methedrine), Amphetamine Sulfate (Benzedrine), Dextroamphetamine (Dexedrine); Preludin; M.D.A. (Methyline dioxy amphetamine)
Source	Synthetic
Classification	Sympathomimetic, stimulant
Medical use	Weight loss, mood elevation, some psychoses, narcolepsy, depression, appetite depressant
How taken	Oral, injected
Usual dose	2.5-5.0 mg. every four hours (medical, oral dose). Much stronger doses are taken for intoxication - this can produce dangerous side effects (M.D.A. - 100 mg.)
Duration of effect	4-20 hours
Effects sought	Stay awake, activeness, mood elevation, rush, sharpen physical reaction, increase confidence
Physiological effects	Increased heart rate, raises blood pressure, dilates pupils, dry mouth, dizziness, diarrhea, loss of appetite, pallor, nausea, vomiting
Possible ill effects	Intensification of above effects with higher dosages, convulsions, coma, dyspnea, nervousness; loss of sleep and appetite can be detrimental to health; abnormal mental states
Physical dependence	No - but some tolerance is developed
Psychological dependence	Yes - many dieters may be havituated without knowing it - very heavy habits develop
Treatment or antidote	Barbiturates (prescription only)

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COCAINE

Slang	Bernice, coke, corine, dust, flake, gold dust, happy dust, star dust, snow
Chemical name	Methylester or benzoylecgonine
Source	Natural (from coca, not cacoa)
Classification	Stimulant, local anesthesia
Medical use	Local anesthetic
How taken	Sniffed, injected or swallowed ("snorted" or "horred", also topically to penis and vaginal mucosa to prolong erection and enhance tactile sensation for both partners) (Cocaine is absorbed topically)
Usual dose	Varies, fatal dose after application to mucus membranes may be as low as 30 mg. Ingested cocaine is much less toxic than that taken or administered by other methods
Duration of effect	Varies, short. Effect of each injection fleeting and to recapture it, the addict injects repeated doses at 5-15 minute intervals. May last as long as four hours.
Effects sought	Euphoric, talkitiveness, feelings of grandiose, strong excitation (often of orgastic proportion), sexual desire, spontaneous ejaculation in absence of genital stimulation, anesthesia
Physiological effects	Pyrexia, dilated pupils, tachycardia, irregular respiration, abdominal pain, vomiting, and major convulsive hallucinations (visual, auditory and tactile.) Paranoid delusions
Possible ill effects	Death from medullary paralysis and respiratory failure. Perforation of nasal septain, occurring as a result of ischemic necrosis and prolonged vasoconstriction, weight loss.
Psychological dependence	Yes (?)
Physical dependence	No
Treatment of antidote	Remove drug from skin or mucous membranes with tap water or normal salve. Delay absorption of injected cocaine with ice pack.

Short acting barbiturate may be useful in treatment, i.e., Pentobarbitail, secobarbital.

CAFFEINE

Coffee, tea, colas, over-the-counter stimulants, APC

Slang	Java
Chemical name	Caffeine
Source	Cacao plant
Classification	Stimulant (mild)
Medical use	Stimulation, stay awake, treat coma
How taken	Swallowed as pill, liquid, in food or injected
Usual dose	1-2 cups of coffee, 1 bottle of pop 100-150 mg
Duration of effect	2-4 hours
Effects sought	Pick-up, taking a social break=
Physiological effects	Respiratory stimulation, circulatory stimulation, clonic convulsions
Possible ill effects	Insomnia and excitation, habituation, tolerance develops
Psychological dependence	Yes
Physical dependence	No
Treatment or antidote	Medically give prescriptions of barbiturates or other depressants

NICOTINE

Cigars, cigarettes

Slang	Fag, coffin, nail
Chemical name	Nicotine
Source	Tobacco plant
Classification	Stimulant, sedative
Medical use	Sedative, emetic, insecticide
How taken	Smoked, sniffed, chewed, injected
Usual dose	Varies, each cigarette contains 20-30 mcg.
Duration of effect	Varies usually 1-2 hours
Effects sought	Calmness, sociability, pick-up, stimulation, ready availability
Physiological effects	Stimulation, elevation of blood pressure, increased bowel activity, retention of liquids
Possible ill effects	Emphysema, lung cancer, other types of cancer, heart disease, loss of appetite, high blood pressure, habituation, air pollution, fire
Psychological dependence	Yes
Physical dependence	Yes, but mild withdrawal symptoms
Treatment or antidote	Medically atropine is given, supportive measures - maintain respiration

ANTI-DEPRESSANTS

Brand name	a.Ritalin b. Tofranil c. Flavil d. Nardil e. Parnate
Chemical name	a. Methylphenidate hydrochloride b. & c. Dibenzapine d. & e. MAO inhibitors
Source	Synthetic
Classification	Anti-depressant; mood elevators
Medical Use	Treatment of moderate to severe depression
How taken	Orally (pills or capsules)
Usual dose	a. 10 mg. b. 25 mg. c. 10 mg. d. 15 mg. e. 10 mg.
Duration of effect	4-6 hours
Effect sought	Relief of depression; stimulation
Physiological effects	Same as above
Physical dependence	No
Psychological dependence	Minimal
Treatment or antidote	Same as amphetamine overdose; see Amphetamines

BARBITURATES

Slang names	Yellow jackets, barbs, candy, goofballs, sleeping pills, peanuts, nimbies, reds, pinks, red birds, red devils, dolls, seggy, downs, purple hearts, rainbows, red and blues, double trouble, tooies, blues, blue birds, blue devils, blue heavens, blue dolls, blue bullets, nembies, yellows, seccy
Chemical name or Trade name	Nembutal (pentobarbital), Amytal (amobarbital), Tuinal, Seconal (seco-barbital). Luminal (phenobarbital), Surital (thiamylal), Pentothal, Thiopental, Butisol (butabarbital)
Source	Synthetic
Classification	Sedative-hypnotic
Medical use	Sedation, hypertension, hyperthyroidism, epilepsy, sleep
How taken	Orally - swallow cap or tab, injected
Usual dose	50 to 2,000 mg (max dose for death)
Duration of effect	3 to 6 hours
Effects sought	Sleep, death, calming, sometimes euphoria, relieve anxiety and tension
Physiological effects	Depress action of nerves, skeletal muscles and heart muscles, slows heart and breathing, and lowers blood pressure; in higher doses get drunkedness; deep sleep
Possible ill effects	Death, toxic psychosis, convulsions, irritable, potentiate alcohol, respiratory depression, pulmonary and cerebral edema, tolerance, weight loss, habituation
Physical dependence	Yes, more difficult than narcotic addiction. Withdrawal symptoms - cramps, nausea, delerium, and convulsions
Psychological dependence	Yes, particularly in reference to sleeping pills
Treatment or antidotes	Clear airway, artificial respiration, maintain blood pressure; if taken orally can delay absorption with charcoal or tap water; if injected use an ice pack to delay absorption Antidotes - caffeine General measures - elevate feet, turn the patient and massage skin, maintain body temp.

ALCOHOL

Whiskey, gin, beer, wine, etc.

Slang	Booze, juice, hooch, suds, brew, grapes, hard stuff, gut rot, white lightening, scuffs
Chemical name	Ethanol, ethyl alcohol
Source	Natural (from grapes, grains, etc. via fermentation)
Classification	Sedative, hypnotic
Medical use	Solvent, antiseptic, sometimes used as sedative (for tension)
How taken	Swallowed
Usual dose	Varies; usual adult single dose is 1½ oz. gin or whiskey and 12 oz. beer. The fatal dose for adults is 300-400 ml. of pure alcohol (600-800 ml. of 100% proof whiskey) if consumed in less than one hour
Duration of effects	1-4 hours
Effects sought	High, euphoria, relaxation, to escape tensions, problems, and inhibitions. Seeking manhood or rebellion (particularly those under 21). Social custom conformity. Massive advertising and promotion. Ready availability. Sense alteration.
Physiological effects	CNS depressant, relaxation (sedation), sometimes euphoria, drowsiness; impaired judgment, reaction time, coordination, and emotional control. Tolerance develops.
Possible ill effects	Cirrhosis, psychosis, neurologic damage, addiction, diversion of energy and money, possible obesity with excessive blurred vision. Slurred speech, weight gain, coma, irreversible brain and liver damage, depressed respiration and reflexes.
Physical dependence	Yes (severe withdrawal illness-D.T.'s)
Psychological dependence	Yes
Treatment or antidote	Readministration of alcohol and gradual withdrawal, with aid of non-alcoholic depressant, and tranquilizers. Give sodium bicarbonate. If hypoglycemic give glucose.

TRANQUILIZERS

Brand name	a. Thorazine b. Compazine c. Stellazine d. Reserpine
Chemical name	a. Chlorpromazine b. Prochorperazine c. Trifluoperazine d. Rauwolfia
Source	Synthetic
Classification	Tranquilizers
Medical use	Treatment of anxiety, tension, alcoholism, neurosis, psychosis, psychosomatic disorders, and vomiting
How taken	Orally (pill or liquid), I.M. or I.V. injection
Usual dose	a. 10-25 mg. b. 10 mg. c. 2 mg. d. 1 mg.
Duration of effect	4-6 hours
Effect sought	Relaxation, relief of anxiety-tension, improved functioning; suppression of hallucinations, and delusions
Physiological effects	Same as above; dry mouth, blurred vision, skin rash, tremor
Possible ill effects	Same as above
Physical dependence	No
Psychological dependence	Minimal
Treatment or antidote	Same as barbiturates; See barbiturates

INHALANTS

Glue, gasoline, paint thinner, lacquer, nail polish remover, cleaning fluids, varnish remover, moth balls, freen, xenon, insecticides

Slang	Poppers, whiffenpoppers
Chemical name	Hydrocarbons, petroleum distillates, carbon tetrachloride
Source	Natural and synthetic
Classification	Solvents
Medical use	None
How taken	Swallowed or inhaled
Usual dose	
Duration of effect	2 hours
Effects sought	Euphoria, hallucinations
Physiological effects	Judgment impaired, vomiting, cough, pulmonary irritation, dizziness, nervousneds, pain in the limbs
Possible ill effects	Damage to bone marrow, kidneys, lungs; temporary blindness, and death.
Psychological dependence	?Yes
Physical dependence	No
Treatment or antidote	Total removal of inhalant

AMYL NITRITE

Slang	Snappers, poppers, whiffen poppers, pearls, vaporols
Chemical name	Amyl nitrite or trade name
Source	Synthetic (?)
Classification	Anti-anginal agent
Medical use	To relieve angina pectoris, to relieve some episodes of fainting, dilate coronary vessels, reduce blood pressure
How taken	Inhaled
Usual dose	1 or 2 ampules
Duration of effect	
Effects sought	Sense of exhilaration, and light-headedness, pleasant hallucinatory experiences. Curiosity to get "high" (euphoric) thrill seeking, ready availability
Physiological effects	Impaired coordination and judgment, anti-social behavior, impaired reality perception
Possible ill effects	Variable, can do serious damage to liver or kidney; headache, flushing of skin, vomiting, dizziness, collapse, marked high blood pressure, cyanosis, coma and respiratory paralysis, metahemoglobinemia
Physical dependence	None
Psychological dependence	Minimal to moderate
Treatment or antidote	Delay absorption with water, milk, or activated charcoal. Maintain blood pressure, treat metahemoglobinemia with methylene blue injection.

LEGAL REGULATION AND CONTROL

I. NARCOTICS: available by special narcotics medical prescription (except Heroin); exempt narcotics and codeine available over-the-counter; other manufacture, sale, or possession prohibited; severe penalties; extensive illicit traffic

II. COCAINE: Same as narcotics

III. HALLUCINOGENS: available only to a few medical researchers or other members of the Native American Church; other manufacture, sale, or possession prohibited by state or federal dangerous drug laws; moderate to severe penalties; extensive illicit traffic

A. Marijuana: unavailable by prescription; possession, sale, and cultivation prohibited by state and federal narcotic or marijuana laws; severe penalties; extensive illicit traffic

IV. BARBITURATES: available in large amounts by ordinary medical prescription which can be repeatedly refilled or obtained from more than one physician; widely advertised and "detailed" to physicians and pharmacists; other manufacture, sale, or possession prohibited under federal drug abuse and similar state dangerous drug laws; moderate penalties; widespread illicit traffic

V. AMPHETAMINES: same as barbiturates

VI. TRANQUILIZERS: same as barbiturates except not usually included under special federal or state drug laws; negligible illicit traffic

VII. ANTI-DEPRESSANTS: same as tranquilizers

"THE ADOLESCENT IN TODAY'S SOCIETY"

(By George M. Bright, M.D., Director of Adolescent Medicine, Address at the Second Childhood Mental Health Seminar, Norfolk, Va.—April 16, 1969)

Adolescents *are* different! The approach to the adolescent differs from the approach to children or adults. During this period of life the physiological and psychological characteristics and needs are of utmost importance to the doctor working with his patient, for it is the combination of these characteristics and needs that makes an adolescent an individual. What is Adolescent Medicine? It is more of a general approach to this individual. The two chief purposes of Adolescent Medicine are first, to discuss and understand those illnesses that are peculiar to the adolescent, specifically problems of growth and development. Second, it is important to take the adolescent himself, his characteristics, his hopes, and his fears into account in treating *him* not just his illness or disease process. The requirements for the physician who works with the adolescent, and this can be any physician regardless of speciality or interest, are not only to understand the nature of disease processes and injuries, but also to understand people and their environment.

In the past few years medicine has become specialized to the point that some medical training centers are becoming system-oriented in their approach to illness. In these centers people are being treated in relation to their circulatory or nervous systems. The practice of medicine, on the other hand, appears to be directed to age groups. The Pediatrician has developed clinics for children from birth to 12 to 14 years of age. The Internist has set up clinics for the adult and geriatric patient. Certainly not all practices are set up like this, nor is it always desirable. The general clinic devoted to the care of a single age-group fosters a physician's tendency to look at his patient as a whole and not necessarily the disease alone. In most Adolescent Clinics, the general age group we are talking about, is from 12 to 21 years of age.

In dealing with any patient it is equally important to be aware of what has gone on before the patient comes to see you and what will transpire in his life after he leaves your care. Pediatricians, for instance, are interested in the pre-natal, post-natal and early developmental milestons in the care of their patients. Physicians caring for the adolescent must understand athletic injuries, blood pressure changes, anxiety states, adjustment reaction, diabetes, obesity, and dysmenorrhea in terms of what effects these problems will have on the adolescent, as well as the adult life that follows. This in essence, therefore, is not only the practice of medicine, but the art of medicine as well. It is this art of medicine that is truly the human side and what we in Adolescent Medicine strive to achieve.

Dr. Leona Bumgartner, Visiting Professor of Social Medicine, Harvard Medical School, suggested that, and I quote, "I want, you want, everyone wants a doctor, a nurse, a someone who is interested in us . . . not only our blood chemistry . . . but someone who will talk to us, someone whom we can trust, someone who will help us to understand what we must do to stay well". This is particularly true in the adolescent age group.

Until recently there were very few medical centers with hospital facilities for adolescents. Now there are Adolescent Clinics in most major teaching hospitals, and a few doctors in the practice of Adolescent Medicine exclusively. The medical school arrangement provides for communication among physicians who care for both younger and older people. This setting also provides an ideal situation for training the undergraduate and postgraduate nurse and medical student, and those students and faculty engaged in research directed at adolescent disorder.

The more that is known about adolescents and their diseases, the better will be their medical care. It is to this end that the new services of Adolescent Medicine at the Medical College of Virginia were begun in August, 1968.

The need for such services become even more important when we consider that recent statistics suggest that by 1970 approximately 50% of our population will be 25 years of age and under. The individuals represented by these figures have the same medical, social, emotional and educational needs as have adolescents of preceeding generations. It is these needs, and how they are being met in today's society, that I wish to discuss for the remainder of our time this evening.

Six thousand years ago an Egyptian priest carved on stone: "Our earth is degenerate, children no longer obey their elders." This statement represents rebellion . . . a common part of adolescent developmental behavior. It is also a lament that has been repeated throughout the ages by parents. In our present society we

need more than ever to stop complaining about the youth, rather to plan and develop programs to help them develop responsibility. In order to develop programs it is important to look at the adolescent in our society, first, and then for you to decide what programs are pertinent to your local community.

What makes the adolescent so special? The tasks facing each adolescent in reaching maturity are essentially unchanged, namely, to free himself from dependence on his parents and be treated as a separate person; to learn self-control; to learn how to deal with authority, with hypocrisy; to develop a mature sexuality; to find a way of feeling adequate and wanted by friends and family, and to evolve a set of values. Only the process by which these tasks are accomplished changed.

There are numerous factors in our complex and accelerating society that influence this process . . . perhaps positively, perhaps negatively, some of them are our affluence, the new morality, the mass media, the drug scene, and the effectiveness of communication between youth and his elders, just to mention a few. I am going to discuss mainly the negative aspects of these various factors as they influence our young people.

Affluence has brought more free time, personal possessions, and greater educational opportunities. With free time comes boredom. Adolescents have an unlimited amount of energy to expend and characteristically they look for exciting ways to get rid of this energy. The once constructive forms of activity usually identified with rural living are now replaced by the confusion of the megalopolis. Their behavior consequently takes the form of fads, rock and roll music, long hair, drugs, political protests, and combinations of all of these. For most adolescents, this is only a transient fascination. More than a few, however, have become so involved with this way of life that they have lost sight of the ideal originally motivating them. The life they have chosen is in reality a life of protest and becomes self-defeating.

Certain elements in the mass media of television and radio, peer groups and commercial groups are constantly bombarding youth with ideas and messages of violence, free expression of sex, soft selling of all kinds of foods, toys, and clothes. We should be especially cognizant of the "pleasure at all costs" and anti-intellectual attitudes appearing in some mass media programs. I am by no means implying that all the influences in the mass media are negative, but those negative influences that do exist cannot help but have an effect on the developing character of the adolescent. It is encouraging to see progress being made in several areas as evidenced by the development of better educational programs for television and more education stations.

This leaves parents, school and churches with even greater responsibilities of maintaining their influences in helping youth develop constructive attitudes. It is indeed sad that many of these institutions have not developed programs that seem relevant to our bright well educated youth. They have not learned to give them the responsibilities and challenges to meet their abilities. Too many students fell they are "marking time" in school. In so many instances, we encourage our youth to work for grades rather than understanding.

If those in positions of responsibility let our adolescents pass through the early formative years accumulating material possessions, and being pressured by negative Madison Avenue advertising, then they fail to develop positive attitudes, habits, and, perhaps more important, motivations. The result in later adolescent years can be, and has been, apathy and confusion.

What can you do? You are the people in responsible positions, the ones to whom they look with respect. Look at the *nature* of the values presented to the youth and what values are being upheld by them. If these values seem false, perhaps it is time to reassess our own values. It is these individual values that they are incorporating into their developing personalities that will not only fulfill their needs but the rest of society's as well.

The "new morality" is being discussed in great depth these days. It has various meanings to be sure, but to the youth, it generally refers to sexual practices and the unlimited freedom to express their sexual desires. To other students it refers to questions of traditional morality . . . what should be changed and what values are still pertinent to today's society.

Those who propose unlimited freedom of expression are perhaps questioning their elders on what they "preach and practice." They see a great deal of hypocrisy and lip service in their elders values and morals. Those who are protesting about the older forms of morality, are actually asking if we have any standards and values worth defending. Unfortunately, their choice of morality

is resulting in increasing numbers of illegitimate babies and spiralling rates of venereal disease. It is doubtful that the question of where the responsibility for such behavior lies was ever considered in their earlier years of formal or informal education. In discussing the new morality with my patients and students, I find that it is the issues and interpersonal relationships the youth of today really want to discuss. Far too often the anatomical and physiological functions are the only part of sex education explained, and this is usually in vivid detail and living color.

The "drug scene," as a form of protest, is the most hazardous . . . not only to the body but to the mind. One of the main points of contention for the youth is the disagreement with and protest about the laws regarding marijuana. Unrealistic through they may be, the fact remains that the illegal and illicit use of any drug distorting the mind is of doubtful benefit to anyone.

The lack of communication between youth and their elders is not new. In our schools students are finding fewer opportunities of discussing issues with those people to whom they look with respect. This is due in large part to overcrowding in class rooms, more mechanical teaching devices, the increasing administrative and research demands for teachers and professors.

In order for students to formulate their own ideas, there must be direction, encouragement, and intellectual stimulation from these elders. There is no substitute for wisdom. One of the more disturbing consequences of all these factors is the conviction that the only way to change school policies, laws or customs is the right to use physical force. The sit-in demonstrations, hecking of public officials, riots on college campuses are all examples of protest. Youth can be taught to disagree without burning and violence; further that differences of opin'on can be settled without using force.

I fear that the adolescent has been thought of as a public nuisance. If this attitude prevails, more subcultures, such as the hippie movement and the drug scene, will surely evolve. We are not faced with a problem of surviving this period called adolescence, but one of helping them become involved with the essential issues. This involves applying principles that speak for themselves. If the younger years have been characterized by a stable family, warm and loving relationships, then these principles will be easier to follow:

"1. *Listen to them.*—Recently a very intelligent youth expressed himself in this way "Many young people would be more eager to assume an active societal role if only the older members of society would *speak with them* and *not simply to them*".

2. *Give Them The Facts.*—No matter what the issues are, no matter how controversial it may be, there is no excuse for withholding the truth.

3. *Trust them.*—They may not always deserve it, but they will become much more responsible much quicker if trusted rather than being watched or mistrusted.

4. *Be Consistent.*—It is important at any age, but particularly so at adolescence, for the young person to know what he can get away with and what he cannot get away with and certainly the reasons why.

5. *Maintain Firm and Friendly Discipline.*

6. *Train Students for Independence in Every Way Possible.*

7. *Remember Your Own Feelings During Adolescence.*

8. *Set Limits.*—Set limits and enforce them, but never make a promise you cannot keep or a threat you cannot enforce. Standards should be enforced flexibly and firmly, not rigidly and without reference to the issue at hand.

9. *Avoid Setting Group Against Group.*—It is of no consequence if this be one racial group against another, teacher against students or one ethnic group against another ethnic group. The conflict should be between good ideas and inferior ones. The question is not *who* is right, but *what* is right.

10. *Exhibit Standards of Good Taste and Behavior.*—It is of the utmost importance that these standards are those that you would like adolescents to emulate, but don't demand agreement from them."*

In summary then, the problems you face in developing programs for your adolescents are essentially the same as in the past. There is one decided difference, however, they are your problem and my problem today. If we hope and want a better tomorrow, then we must begin to solve these problems now. Our adolescents want to know where we, as parents and teachers, stand on all the issues. They must sense some strength and consistency in us as elders, even in principles with which they disagree. Surely, we are all limited by our own inadequacies, but this does not mean we should be afraid to define and clarify our faulty value-systems honestly.

*From "How To Survive Our Adolescents" by Dana L. Farnsworth, M.D.

DRUG ABUSE IN OUR COMMUNITY

By George M. Bright, M.D., Director of Adolescent Medicine, Medical College of Virginia, Richmond, Va., Address at the Virginia Public Health Conference, Roanoke, Va.—April 30, 1969

What is new about people taking drugs? Nothing! Our society is a drug oriented society. We have been both using drugs and, at times, abusing them for years. Furthermore, drug abuse has been written about for hundreds of years. What is alarming today, however, is the number of youth who are joining the drug scene from our junior high, high schools and colleges throughout the country. Fortunately, many of these will be involved only temporarily. Others will develop physical and psychological problems as a consequence of their involvement. Our responsibility is not limited just to the small percentage that have short or long term consequences, but to all youth in our community and country. Your presence indicates a desire to acquaint yourselves with the issues. Hopefully we can answer some of the pressing questions facing each of you as parents, teachers and professionals.

The questions I hear from throughout the community are: "What is 'pot' . . . 'acid' and 'speed'? What does glue sniffing really do?" "What are our children doing to themselves and why?" "What can we do to get our children off this dope?" The answers are not simple! The answers come only through a better understanding of the total problems and implementing means to solutions that will be beneficial for the youth and their elders as well. What we are really talking about is education and communication.

There are two general classes of drugs that are abused, the narcotic drug and the non-narcotic drug. The narcotic drugs include heroin, morphine, codeine, opium and meperidine. The non-narcotic drugs include all the hallucinogens, the amphetamines or stimulants, and the depressants such as barbituates, alcohol and volatile solvents. Marijuana will be discussed separately. It is the non-narcotic drugs that I wish to discuss at some length.

The first group are the depressants, which include the volatile solvents such as glue, lighter fluid, cleaning fluid, gasoline, kerosene, ether, and a variety of other organic solvents. The volatile solvents, like all forms of drugs abused, provide a chemical escape from reality achieved by inhaling their vapors. Glue sniffing is the most commonly used drug. Its abuse is usually found in the younger adolescents in the junior high school and early high school years. The active chemical ingredient in glue is toluene. When sniffed, it is squeezed into a plastic bag or handkerchief and held over the face or mouth and inhaled. The effects are almost immediate and are usually described as a true "shock" to the nervous system, or feelings of dizziness, euphoria and drunkenness. Some users have described loss of self-control, have spotty amnesia, or simply say that "they don't care about anything". Others may have visual hallucinations of vivid colors.

Glue may be purchased in almost any store in a variety of forms. The onset of action is almost immediate and may last from 15 minutes up to a few hours, depending on the length of exposure. The chronic sniffer is very likely to develop tolerance to the effects of toluene. This means that the user must expose himself for longer periods of time to get the same "high" or desired effect. Habituation or dependence on the state of intoxication, also occurs but this habituation is not necessarily specific to the chemical substances found in glue. Gasoline sniffers, lighter fluid sniffers also develop the same habituation. Chronic sniffers may have some transient symptoms suggestive of withdrawal, such as irritability, nausea, lethargy and depression. These symptoms are unusual in most users.

There has been a great deal of controversy regarding the toxic effects to vital organs such as brain, liver and kidney. It is true that some studies have found abnormal urine findings of a transient nature. Transient abnormal findings of liver and kidney function tests, electroencephalographic tracings, or EEG, and blood counts are also reported in a small percentage of "sniffers". The question of chronic brain damage is still unclear. The fatalities that have occurred are attributed to suffocation by the plastic bags, after prolonged periods of intoxication.

The second group of drugs are the stimulants or amphetamines. These drugs have been used successfully and effectively for a variety of medical problems, most notably diet control, obesity, and narcolepsy. They are mood elevators in mild emotional or psychological problems. Since the amphetamines are so widely used and produced in such large numbers, it would not be surprising to find

them being abused as well. Amphetamines on the "drug scene" are commonly referred to as "pep pills", "Beanies", "Dexies" and "purple hearts". The amphetamine referred to as "speed" is methylamphetamine or methedrine. This particular preparation can be purchased in the tablet or the crystalline form for 25¢ to 50¢ a pill or cap. Speed has a more marked stimulating effect on the user than the usual amphetamine. It causes a "rush", gives a sensation of excitement and sudden available energy which is pleasurable to the user. The pharmacological effect of amphetamines in general is stimulation of the central nervous system resulting in euphoria, feelings of alertness, elevation of moods and absence of fatigue.

The common medical complications by the intravenous injection, or "mainlining" of "speed" are infectious hepatitis and cellulitis. The instances of infectious hepatitis in some drug communities have risen to epidemic proportions because of the communal use of non-sterile needles and syringes.

When combined with LDS, the methedrine or "speed" prolongs and intensifies the LSD trip or experience. It may even re-activate the trip in regular users without further LSD intake.

By increasing the dosage over a period of weeks or months the amphetamines can produce a gradual and increasing tolerance without bringing about actual physical dependence. The psychological dependence that occurs in the habituated user is a very real factor that is of major concern. This group is frequently "mainlining" or using higher oral doses and may develop an "amphetamine psychosis" characterized by disorganized behavior, hallucinations and paranoia. Upon withdrawal of the drug prolonged periods of sleep, marked hunger for food, depression and panic may occur lasting from several days to several weeks. The person with an unstable personality in this depressed state may attempt suicide or become involved in other anti-social or acting out behavior. The habituated high school or college student frequently has difficulty studying, becomes disheveled, losses weight, is more susceptible to illness, and eventually may drop out of any productive endeavor.

The third group of drugs are the hallucinogens, the "psychedelics" or the "psychotominetics" LSD or "acid," lysergic acid diethylamine, DMT, dimethyltryptomine, STP, 2,5-dimethoxy-4-methylamphetamine, are the most powerful. Peyote, mescaline and psilocybin and such exotics as nutmeg and morning glory seeds are also included in this group as well.

All of these drugs act qualitatively in much the same manner as LSD; only the quantity of drug needed to produce the same effect will vary from drug to drug because of differences in chemical activity or "potency."

When LSD first appeared there was much interest in its medical application specifically for the treatment and evaluation of emotional problems. The most encouraging reports to date have come from it's clinical application in the treatment of chronic alcoholism.

To give you some idea of the effects of LSD, one ounce of LSD can "turn on" a city of 300,000 people. Most of the LSD or "acid" appearing on the drug scene is being manufactured illegally and "pushed" or dispensed in tablet or capsule form in dosages of 50 to 150 micrograms. This dose when "dropped" or ingested, will start a "trip" or psychedelic experience. His or her experience will depend on the users personality make up, his emotional state at the time of ingestion, past experience with other drugs, and the quality of the drug itself. "Acid" can be purchased for $5 00 to $10.00 a pill, depending on the available supplies. Increased dosages lead to prolongation of the trip rather than intensification. Tolerance develops and disappears rapidly, and there is no evidence of physical dependence.

Within 20 to 45 minutes after ingestion the psychedelic experience begins and may last from 10 to 16 hours. The user will almost invariably experience one of the following: distortion of sense perception, depersonalization, disorientation of time and space, visual illusion, psuedo-hallucinations involving shape, size, color and apparent plasticity. Thought processes are frequently disturbed resulting in changes of mood ranging from euphoria to anxiety. Some users may react with overwhelming fear, confusion and panic, while others appear to be withdrawn into themselves in a somewhat catatonic state. These adverse reactions are more likely to occur in a person with emotional instability. These individuals are the most unfortunate for the drugs only potentiate borderline problems and magnify existing ones. Contrary to popular belief, the proper preparation of the user, and the presence of a well experience "guide" does not guarantee a good "trip."

The somatic complications of LSD include the chromosomal abnormalities. Current research activity by responsible investigators continues to support

earlier observations of the "breaks." I am not aware of any knowledge of the relationship of dosage, or frequency of use, to the effeects on chromosomes.

Answers to these questions will come with time.

"Flash backs" or recurrent experiences weeks to months after the last dose of LSD ingested are reported with increasing frequency. What triggers these trips and how long they will continue to occur is still unclear.

DMT, dimethyltryptomine is prepared as a liquid. Tobacco or marijuana can be dipped into the liquid preparation, dried and smoked in a pipe or a "reefer". The effects are milder than LSD, but DMT tends to give a greater proportion of visual illusions. The onset is more rapid and lasts only about 30 minutes. You can, no doubt, imagine the effects this may have when it is combined with marijuana.

STP stands for "Serenity, Tranquillity and Peace". It is related chemically to the amphetamines and mescaline and its effects are more intense and prolonged than LSD. It has been called by the unflattering name of a "megahallucinogen". Its effects may last up to 72 hours or five days in a dose as small as 10 microrgams.

The complications are greater, both psychologically and physiologically. Abdominal discomfort, blurred vision, elevations of temperature and delirium are not uncommon complications accompanying the usual psycedelic experience. Death has been reported from respiratory depression and convulsions.

Nutmeg has been known for a long time among sailors and even prisoners as a psycedelic agent. The experience is similar to LSD. The onsets of effects are usually two to five hours after ingestion and may last 12 to 24 hours. Again, the side effects of malaise, headache, dry mouth, dizziness and abdominal discomfort usually discourage most people after their first or second experience.

Morning Glory Seeds contains two alkaloids of lysergic acid, as the active ingredients. Only two varieties of the plant produce the psycedelic effects. Many young adolescents who eat morning glory seeds find either no effect at all or a "bum trip" since the Agriculture Department is spraying them with insecticides and nauseating chemicals to discourage their ingestion.

Last, but certainly not least, is marijuana or Cannabis Sativa. It is known by a variety of names, "pot", "hashish", "gagga", "weed", "grass" and others. Marijuana has been written about for thousands of years. but has no known use in medical practice throughout the world, including the United States. The chemical compound THC, tetrahydrocannabinol, produces the euphoria or "high". It is only one of the cannabols found in the resin, which comes from the flower of the female plant and leaves near the flower. The amount of chemical activity in marijuana will depend on the climatic conditions where it is growing. The ideal climate is tropical or semitropical such as India and Mexico. Marijuana grown in the U.S. has very little activity. THC has been recently synthesised and is now a greater source for research with responsible investigators.

In this country marijuana is usually smoked, although it may be eaten or drunk. The cigarettes are generally referred to as "joints", "sticks" or "reefers" and are a mixture of the leaves and the flowering top of the cannabis plant. The set, or the people involved, and the setting in which the drug is smoked, will influence the experience a great deal. Marijuana has its effects on the central nervous system, although the actual mode of action is still unclear. After inhaling the smoke, the user may begin to get a "high" within a matter of minutes. depending upon how much is smoked and the quality of the mixture. The effects may last from three to five hours. Smokers usually describe a feeling of well-being, euphoria, or an "inner joy," distortation of time, space and depth perception. In compatible groups people may enjoy singing, laughing or talking about irrelevant issues. An experienced smoker may become quite anxious, paranoid, have panic reactions, or depressed . . . again, depending on the person's personality. The dangers of a prolonged reaction, called psychosis, seen with LSD are small with marijuana in this country. In India the incidence is much higher. Hallucinations, both auditory and visual, have been reported, although these are also unusual.

There is no physical dependence; and there are no withdrawal symptoms, but there is very definitely psychological dependence in the chronic user. This is particularly true of the person who uses marijuana as an escape from a psychological conflict such as depression, anxiety or a sense of failure. It is the chronic user who will frequently become victimized by the pusher, who is anxious to get him on more expensive drugs such as the narcotics. The extent of physiological dependence on marijuana is not generally known for several reasons. The quality

of marijuana will vary from batch to batch. Where it was grown, how it was mixed, how it is being dispensed, whether it is being laced with other drugs such as DMT, are factors affecting studies and statistics.

The laws concerning possession of small amounts, smoking or selling marijuana are a great source of contention among adolescents and young adults. On the basis of *available* knowledge of the potential hazards, the answer is clearly that these laws should be re-evaluated in terms of their harshness and penalties. Should marijuana be legalized? This is perhaps the most difficult question of all to answer for there is a tremendous amount of emotionalism and puritanical prejudice involved on both sides. There is no way to answer this as a flat "yes" or "no". I do feel that laws imposing penalties out of proportion to the seriousness of the offense contribute to disregard for the law. If the younger generation continues to find inequities or inaccuracies in one small area such as the laws regarding marijuana, they will disbelieve totally and fail to heed other warnings which are well founded.

The next major question is: Why do adolescents become involved with the "drug scene"? (It is alarming when we consider the high instances of intelligent youth who are involved.) Four years ago the use of drugs by young people was a casual topic of conversation. Today it is a major symptom of youth's turmoil. It can be related to a multitude of factors in our society such as; the current social conditions, the international and national dilemmas, the ineffectiveness of many people they look to as authority figures, and our affluence. As a result of youth's frustration and confusion they criticize all of society and what it represents, and a number turn to drugs as a false instrument to find their values. Taking drugs is in a sense a form of "acting out" behavior. Dr. Graham Blaine, who is chief of psychiatry at Harvard University Health Services, suggested that drug takers be divided into three very broad categories, realizing in some respects their complaints about today's society are justified, but this does not mean they should give up or stop striving for reforms in the areas of freedom and social justice. If we are to make progress in these areas, we cannot afford to lose an estimated 300,000 young people who fill their ranks.

A closer look at some who are "turning on" in order to "drop out" frequently reveals outward expressions and feelings of contempt, but underlying feelings are of fear, inadequacy and incompetence. Perhaps it is because they are unable to meet, not only, their own expectations, but those of their parents and the expectations they feel society demands of them.

The drug scene then, through it's illusions and pseudo-hallucinations, transports them out of this world into the false security of the psychedelic world. There they feel free of fear and failure which bothered them consciously or unconsciously before joining the drug scene. In others there is a struggle for independence which they feel can only be otained by repeated drug experience. The results in the habituated user, unfortunately, are only dulled senses that make their confused world a little more tolerable.

The *oblivion seekers* take greater risks and are more likely to become accidently the victims of overdosages and medical complications.

The third group are the *personality change seekers.* Many of these young people are trying to bring about basic changes in their personalities. They are the ones who are most likely to become addicted and permanently incapacitated by repeated drug use. They feel compelled to combine drugs and increase dosages to overcome frustration and disappointment. Unfortunately, their goals are never reached for continued participation brings rapid deterioration. They are usually identified and labeled as the "freak out" or the "kooks". The psychiatrically ill person, such as a psychopath, severe neurotic, and schizophrenic, often join these ranks. This group, which comprises approximately 3 to 5%, is probably responsible for most of the crimes and violence that occurs in various drug communities around the country.

There are other young people who do not belong in these categories and should be mentioned. The "new morality" has brought changes in our youth's sexual activities. Sexual intercourse tends to be experienced at earlier ages by greater numbers. This brings pressure for performance at a time when most young people are physically or emotionally incapable of such experiences. The result may be feelings of sexual abnormality, which not infrequently result in a search for drugs to make them more sexually more mature. There is no drug that is a true aphrodesiac.

One additional group claims they are imitating the use of transquilizers by their parents. These mood elevators and stabilizers are prescribed and dispensed in large numbers and readily available in many homes. This, undoubtedly, leads

a few of the young to seek similar peace of mind through drugs such as marijuana rather than taking their parents chemical escapes. Perhaps it goes beyond this, for in our society we live with "the myth of the magic of the drug".

This presents a rather bleak picture and we have good reason to be concerned about the sale and use of drugs among high school and college students and young adults. There are measures that can be taken to remedy these problems, but they are not simple. As I have mentioned, drug abuse, is only a symptom. These symptoms do not always stem from individual home environments but from society as well.

1. Education is of primary importance. These programs should include factual knowledge of the risks involved, what we do and do not know about the long and short term effects of drugs and the medical complications. This education is directed at those who are involved and those contemplating taking drugs. It will also satisfy the curiosity of a few who may not need to try drugs once they know the true facts about them. More important than bringing education to the students, is the instruction of faculty and administrators. Young people who are indecisive will turn to respected elders for advice. If they find ignorance or get false information, they will not heed any further advice or warnings from these individuals. Any state, federal or school sponsored educational programs should include teachers, guidance counselors, principals and parents within the scope of their instruction.

2. Further research is being done by many responsible investigators concerning the physiological and psychological effects of LSD, marijuana, and the newer synthetics, Our present suspicions about the long term effects of drugs can be proved or disproved only by sound thorough investigation.

3. I have already mentioned the re-examination of the laws concerning marijuana.

4. Looking for adventure or challenging things to do is, by nature, one of adolescents most noteworthy traits. Community Centers for youth, work in local community mental hospitals, or tutoring of programs in the under-privileged areas can be just as exciting and challenging as joining the drug scene. This approach can have a doubly beneficial effect. Programs contributing to knowledge and understanding to the elimination of some of the ghetto conditions will help in relieving racial tension, thereby eliminate factors contributing to heroin addiction.

I would like to close by using a quote from Dr. Graham Blaine's book, "Youth and the Hazards of Affluence", and I quote: "More important than providing these essentials is the willingness on our part to try to understand and respond to the unspoken demand which comes from the young. These demands are for firmness, consistency and respect from parents and teachers. These are so often covered over by the belligerent request for unlimited freedom, by expectations that we tolerate ridiculous extremes in dress and behavior, and by surly defiance, that we have missed the message that lies beneath. We must learn to translate the language of the adolescent if we are to understand him. His true message is often the opposite of what his words and actions seem to imply. He tells us so often the opposite of what his words and actions seem to imply. He tells us so often and so clearly to leave him alone, but at heart he may want us to pay attention. The students at Berkeley are demanding freedom at one moment and asking for more personal interest and authority in the next. There is no way to achieve a permanent harmony between the generations, but in today's society there is wide room for improvement."

THE OTHER MAN'S GRASS IS *NOT* ALWAYS GREENER

By Ted R. Abernathy, M.D., Adolescent Clinic, Medical College of Virginia, Richmond, Virginia, addressed to the Virginia Educational Association Roanoke, Virginia—December 11, 1970

"You can take Salem out of the country; but, you can't take the country out of Salem."

"Take a puff and it's springtime."

All cigarette commercials are designed to get you to take up smoking as a means of relaxation. We see these ads everywhere—and, the only difference between cigarettes and the marijuana our youth uses today is that for many marijuana really works—take a puff and it *is* springtime. In our society, we have been using pills for years as an instant cure for our problems. Pills to pep us up, pills

to calm us down, alcohol to relax us, and pills to put us to bed. So, how can we—the drug abusers of the 20th century—the glowing 60's and 70's—be alarmed when our youth tells us that they have finally found what many of us have been looking for—the drug that will blow your mind?

The alarming facts are that our children and many of our friends are not being relaxed, or having their minds expanded; but they are flipping out, freaking out, getting strung out, and they are dying. The drug scene has now entered the colleges, the high schools, and even the junior high schools. Parents, teachers, doctors, laymen, lawyers, and even the kids are beginning to ask—what happened? Where are we going? *And*, what can we do about our friends and children who are on "dope"? The problem is hard and real—and its solution is far from easy; but maybe here tonight we can at least gain a little more understanding into the drug scene and what it means today. Drug abuse by strict definition is the consumption of drugs, whether they be medically useful or not, without medical authorization, to alter mood or behavior, or the ingestion of a drug for a purpose other than it was prescribed.

There are two general classes of drugs that are abused: the narcotic drug and the non-narcotic drug. The narcotic drugs are those which produce insensibility or stupor due to their depressant effect on the central nervous system. In this class is opium and its derivatives: morphine, codeine, heroin, and the synthetics, mereridine and methadone. Narcotic drugs have been used successfully in medicine for many years to relieve or modify pain. They work by decreasing the perception of pain and induce lethary or sleep. These drugs have the capacity to produce euphoria and to relieve fear, tension, and anxiety. To many narcotic users, it is a "total body orgasm". But, to use the narcotics, heroin being the most abused now, is to become physically and psychologically addicted. It means eventually to have your entire life revovle around a capsule; and it means an increasing financial habit from three dollars to seventy dollars a day.

To stop these drugs after once addicted results in withdrawal. By this I mean symptoms of nervousness, restlessness, anxiety, increased sweating, water eyes and nose, dilation of the pupils, pains in the back and legs, vomiting, abdominal pain, diarrhea, amorexia, increased blood pressure, and most important, feelings of loneliness, isolation, and depression. These symptoms peak at about 72 hours after withdrawal of drugs and decrease over the next 8 to 10 days to the next several weeks. Death may occur during withdrawal (only in extreme cases) or it may occur from a contaminate in the heroin or narcotic capsule itself. Narcotics are usually injected intravenously, but may be sniffed or injected subcutaneously.

The non-narcotic drugs include the amphetamines, barbiturates, marijuana, the hallucinogens, alcohol, and the volatile solvents. The barbiturates are useful medically to sedate or calm individuals, and they are used in states of anxiety, insomnia, high blood pressure, and in the control of epilepsy. When abused, they produce lethargy, mental confusion, euphoria, drunkeness, slurred speech, staggering gait, and when overdosed, coma, convulsions, and death occur. Barbiturates can lead to physical dependence and withdrawal may be more severe than with the narcotics. Twelve to sixteen hours after the drug is withdrawn, the individual may experience nervousness, headaches, anxiety, nausea, vomiting, insomnia, orthostatic hypertension, convulsions, delirium, and hallucinations. These symptoms may perist from 36 to 72 hours to several days.

The amphetamines are known as the stimulant drugs. They have the ability to stimulate the central nervous system and cause excitation, alertness, and appetite suppression. They are used successfully in medicine for treatment of narcolepsy, obesity, and in mild emotional disorders as mood elevators. The amphetamines are usually referred to as "pep pills", "bennies", "Dexies", and "purple hearts". "Speed" is an amphetamine, usually methylamphetamine or methadrine. Amphetamines do have the capacity to produce euphoria, mood elevation, erase fatigue, and in general, make tired depressed people feel alert and alive. Unfortunately, this feeling leads to abuse. Tolerance develops and if mainlined, thrombophlebitis and/or hepatitis may occur. If large doses are used over a short period of time, "amphetamine psychosis" may result. This is characterized by delusions, hallucinations (visual and auditory) and paranoia. The amphetamines are not addicting; however, dependency does occur. Withdrawal usually causes hunger, prolonged periods of sleep, and depression. This depression may be severe enough to lead to feelings of panic and in some individuals, suicide. If used in combination with other drugs such as barbiturates, withdrawal may include symptoms of both drugs, the most dangerous being convulsions.

The hallucinogenic drugs include LSD, DMT (dimethyl tryptamine). STP (serenity, tranquility, and peace), marihuana, mescaline, nutmeg, and morning glory seeds. These compounds produce distortions of perception, dream images, and hallucinations. None of these drugs have been found to be useful in medicine.

LSD is probably one of the most powerful substances known to man. One ounce of LSD is sufficient to "turn on" a city of 300,000 people. Usually taken orally, the LSD trip begins within 30 minutes to 45 minutes and may last up to 10 or 16 hours. Depending on the user's personality make-up, his or her emotional state at the time of ingestion, and the quality of the drug itself, the LSD trip involves a sense of depersonalization, disorientation of time and space, visual illusions and hallucinations. A common description of a good trip is that one is completely content and relaxed, seeing sounds and hearing colors. That particular trip may also be a "bummer" involving overwhelming fear, confusion, panic, withdrawal, and accidental death because of the delusional state of the tripper. There is no guarantee that your trip will be a good one or a bad one, even if you have tripped once or 200 times. The reports of LSD and chromosomal breaks are not all in at present so a definite conclusion cannot be drawn now. However, most of the respected studies seem to indicate these breaks do occur and more importantly, there is no guarantee that these will not occur even if it is your first trip. Very real complications, however, are flashbacks which are reappearances of the psychedelic experience without further ingestion of the drug. It may occur several weeks to several months after the ingestion and may occur if you have tripped 200 times or only once.

Dimethyl tryptamine (DMT) is a liquid or power that is prepared synthetically but is also a natural constituent of the seeds of certain plants found in the West Indies and South America. DMT gives similar effects to those of LSD but requires larger doses. The onset is rapid, but its effects last only about 30 minutes, causing it to sometimes be called the "businessman's trip". It may be combined with marijuana to enhance the effects of both drugs. STP is serenity, tranquility, and peace. It is a more powerful, longer acting drug, and is more dangerous than LSD. Its effects may last from 72 hours to 5 days (STP is 2.5 dimthoxy 4 methylamphetamine). Along with the psychedelics trip, one may experience abdominal discomfort, delirium, and deaths (reported from respiratory depression and convulsions).

Nutmeg and morning glory seeds have been used for years. Both have effects similar to LSD, producing feelings of intoxication and exhiliration.

The solvents are non-drug substances which include glue, lighter fluid, cleaning fluid, gasoline, kerosene, and ether. Acting as depressants, these substances produce dizziness, stupor, and a feeling of intoxification. The solvents are probably the most abused drugs of the younger set—the junior high individual. The solvent is placed in a plastic bag usually, and the fumes are inhaled. Acting very much like an anesthetic agent, the fumes send the user deeper into the various levels of anesthesia or unconsciousness. If the user falls and the bag remains over the face, suffocation may occur. If the bag falls away from the face, the user begins to return from the lower planes of anesthesia, and one of these planes is excitement. It is in this plane that vomiting may occur, followed by aspiration and death.

Another complication of solvent misuse is anemia, especially among Negroes with sickle cell disease. Transient damage to the liver, kidney, and brain have been observed, but these effects appear to be reversible when the solvent has been discontinued. Some habituation or dependence on the solvents has been encountered; however, withdrawal is usually mild, occasionally accompanied by symptoms of nausea, lethargy, depression, and irritability.

The last drug we will discuss is marijuana. Commonly known as "pot", "grass", "hemp", and "Mary Janes", marihuana acts to produce feelings of euphoria, a dream-like state accompanied by a free flow of ideas. It loosens the inhibitions and increases suggestibility. It is grown best in tropical climates, and therefore the activity or quality of the marijuana grown in Mexico is better than that grown in the United States. The quality also depends on how it was mixed and whether it was dipped in such things as embalming fluid or DMT.

It is smoked most commonly, but it may be eaten or drunk. The setting in which it is smoked, the person involved, and the personality traits of the individual that existed prior to the use of marijuana all influence the experience one receives from the grass. An individual may sing, laugh, become gentle and friendly; but a person may also become belligerent, anxious, feel panicked, or depressed. Hallucinations, auditory and visual, may occur. No physical depend-

ence occurs, and there are usually no withdrawal symptoms. However, a psychological dependence does occur especially in those who use it as an escape from depression, anxiety, or a psychological conflict. There is always the danger of "moving up in the world" or going on to harder drugs because of the individual's entering the drug culture and his resultant exposure to other drugs.

These are the drugs that are presently being used and abused by the adolescent and young adult populations. And how many of you are probably asking why—why do they want to use drugs? Four years ago the used of drugs by young people was a casual topic of conversation. Today it is a major symptom of the turmoil of the youth. It can be related to a multitude of factors in our society such as: the current social conditions, the international and national dilemmas, the ineffectiveness of many of the people they look to as authority figures, and our affluence.

As a result of youth's frustration and confusion, they criticize all of society and what it represents, and a number turn to drugs as a false instrument to find their values. The transition from children to adults is rarely smooth and many of these people are not emotionally prepared to meet many of the pressures which are placed on youth today. Family ties are loosening, parental authority is decreasing, and requests for responsible activities are increasing. Pressures for performance, even sexually in this time of new morality, are being placed on the adolescent at a time when many are unequipped to handle these things emotionally and physically.

When faced with feelings of anxiety, frustration, fear of failure, and inner conflicts and doubts, the adolescent discovers that amphetamines and marijuana promote conversation and friendship, barbiturates loosen inhibitions, and hallucinogens brighten sensations and narcotics provide relief and escape.

It becomes our responsibility to learn as much as we can about drugs and then explain to our youth the truth of drugs in the form of accurate information and not the myths that so many youths believe today. We must give our young people a meaningful role in life, a responsibility for helping to bridge the gap between social and technological progress. Our youth must accept this responsibility to help in social change rather than committing themselves to drugs. Drugs and drug abuse will continue to be a problem I fear for many years to come. But, perhaps through education and understanding, we can learn what those young people, who face up to the challenge and seek a more realistic hope for themselves than drugs can offer, mean when they say "the other man's grass is not always greener".

DRUG IDENTIFICATION SHEET

Prepared for Upjohn Drug Company by: George M. Bright, M.D.,
Ted R. Abernathy, M.D.

HALLUCINOGENS

NAME	CLASS	SOURCE AND CHEMICAL OR GENERIC NAME	SLANG NAME	HOW TAKEN	DURATION OF ACTION
MARIJUANA AND HASHISH	Relaxant mild hallucinogen	Cannabis sativa natural	Stick or joint, pot, grass, weed, tea, or hash (hashish); reefers	Smoked, occasionally swallowed or sniffed	1-8 hours, depending on potency
LSD	Hallucinogen	D-lysergic acid diethylamide semi-synthetic - prepared from alkaloids of ergot	Acid, sugar, Big D, cubes, sunshine, "25", "A"	P.O. or I.V. dropped into eyes, swallowed, tablet or capsule 100 - 500 micrograms	8-12 hours
PSILOCYBIN	Hallucinogen	2-3-dimethylamino ethylindol-4-ol dihydrogen phosphate natural from psilocybe mushroom	"Maggie" mushrooms	Swallowed, sometimes put in marijuana and smoked	6-8 hours
MESCALINE	Hallucinogen	3-4-5-trimethoxy-phenylethylamine alkaloid derived from buttons of peyote cactus	Cactus, Mesc, Buttons, Peyote	350-1000 mg. swallowed; natural buttons chewed	8-24 hours
DMT	Hallucinogen	Dimethyltryptamine synthetic	DET, DPT, Businessman's Trip	Smoked, soaked in marijuana or tobacco, or injected. 1-3 mg.	30 min., 1-3 hours
DOM or STP	Hallucinogen	2-5-dimethoxy-4 methylamphetamine synthetic	STP (Serenity, Tranquility, Peace)	10-20 mg. P.O. or I.V.	In low dose same as LSD - 12 hours Up to 2-3 days in 10-15 mg.

HALLUCINOGENS (page 2)

NAME	PHYSICAL DEPENDENCY	HABITUATION	POSSIBLE PHYSICAL DAMAGE	MEDICAL USE	SHORT TERM EFFECTS
MARIJUANA	no	yes	none known as yet	none	Euphoria, heightened sensory awareness. Time/space distortions. Lessening of inhibitions, sleepiness, hunger, thirst, itchy red eyes
LSD	no	no	none known as yet	research with mental disorders and alcoholism	Distortion and intensification of sensory perceptions. "Massive sensory impact", dilated pupils, impaired coordination. Ego fragmentation, hallucinations
PSILOCYBIN	no	possible	none known as yet	none	Initial reactions of nausea, muscular relaxation, headaches, followed by more intense visual effects like LSD
MESCALINE	no	possible	none	none	Some general effects of LSD, but accompanied by nausea and vomiting.
DMT	no	no	none	none	Produces a "blast" when taken I.V. Smoking effects are milder with some distortion.
DOM or STP	no	no	none	none	More intense psychedelic effect than LSD, higher doses produce disorientation, identity confusion

HALLUCINOGENS (page 3)

NAME	LONG TERM EFFECTS	OVERDOSE SYNDROME	TREATMENT
MARIJUANA	Bronchitis or conjunctivitis, psychological dependence. paranoid reactions, may precipitate flashbacks in LSD users	Psychosis or schizophrenic reactions in latent schizophrenics	In extreme cases or paranoid ideas, cholorpromazine may be administered.
LSD	"Flashbacks", may intensify latent psychotic behavior, panic, anxiety, suicide, infertility problems, possible abortions, non-conclusive evidence for chromosomal damage	Marked anxiety, fearful, dilated pupils, confusion, psychotic behavior, possible to combine with other drugs, such as amphetamines and atropine. Most common cause of death is from behavorial toxicity, delusional ideas of omnipotence	Reassurance, patient in hyper-suggestible state. Keeping eyes open reduces reaction. Chemical sedation chlorpromazine 25-100 mg. Beware of adulterants such as anti-cholinergics. Short acting barbiturates - pentobarbital 250-500 mg.- produce relaxation and sleep. Chloridiazepoxide 50 mg. or diazepam 10mg. IM or I.V. preferred by some.
PSILOCYBIN	not known	similar to LSD	same as LSD
MESCALINE	"Flashbacks" not reported no physical dependence	Psychotic reaction in previously distorted patients	Phenothiazines, calm reassurance
DMT	Milder than LSD, no physical dependency, has psychological dependency	like LSD	Phenothiazines, thorazine 25-50 mg.
DOM or STP	Prolonged "down" period, greater rise in blood pressure than LSD, pupils more dilated. Psychotic reactions	Generally more intense and prolonged than LSD	Do not use thorazine or phenothiazines because they may cause shock or death. Supportive measures and a quiet room.

DEPRESSANTS

NAME	CLASS	SOURCE AND CHEMICAL OR GENERIC NAME	SLANG NAME	HOW TAKEN	DURATION OF ACTION
HEROIN	Narcotic	Diacetylmorphine opium poppy plant-semi-synthetic	"H", horse, junk, scag, pony, stuff, Harry	Intravenous(mainline) skin popped, sniffed, snorted 2-14 per cent in bag or cap	4-6 hours, plus or minus adulterants
MORPHINE	Narcotic	Morphine sulfate natural from opium poppy plant	"M", morpho, Miss Emma, dope, white stuff	P.O. or I.V. snorted 8-15 mg. MLD 200 mg.	4-6 hours
METHADONE	Narcotic	Methadone hydrochloride synthetic	Dolly	P.O. or I.V. 10-20 mg. (60-120 mg. may be lethal in non-addict)	4-24 hours
CODEINE	Narcotic	Methylmorphine semi-synthetic from morphine	Robo, A.C., schoolboy	P.O. or I.V. 30 mg.	4 hours duration 2-4 hours for euphoria
BARBITURATES	Sedative-hypnotic	Phenobarbital, Amobarbital Secobarbital, Pentobarbital synthetic	Downs, redbirds, red devils, barbs, rainbows, blue devils, candy, yellow jackets, peanuts	P.O. or I.V. 50-100 mg.	3-6 hours (phenobarbital - 6 plus hours) (amobarbital- intermediate 3-6 hours) (secobarbital - short plus or minus 3 hours) (pentobarbital - short, plus or minus 3 hours)
SOLVENTS, plastic or cement, glue or cleaning fluids	Depressant	Carbon tetrachloride, acetone, benzene, plus toluene Commercial sources	Poppers, whifferpoppers	Sniffed	2 hours

DEPRESSANTS (page 2)

NAME	PHYSICAL DEPENDENCY	HABITUATION	POSSIBLE PHYSICAL DAMAGE	MEDICAL USE	SHORT TERM EFFECTS
HEROIN	yes	yes	If injected, hepatitis, thrombophlebitis, local abcesses at injection site with generalized seeding possible	Banned in U.S. once used to relieve pain	"Rush" followed by euphoria when injected intravenously; drowsiness, lethargy, tolerance develops rapidly; psychic dependence.
MORPHINE	yes	yes	as above - may be fatal to asthmatics	pain relief	Similar to heroin, but lacks "rush" or total body orgasm
METHADONE	yes	yes	none unless abused via overdose syndrome or local damage secondary to injection	pain relief prevent withdrawal (tool in narcotic addict rehabilitation)	Analgesia, euphoria, short term withdrawal from opium addiction; psychic dependence
CODEINE	yes	yes	none	pain relief cough syrup	Euphoria, to avoid heroin withdrawal; large amounts give excitement, restlessness;
BARBITURATES	yes	yes	toxic psychosis, pulmonary and cerebral edema	sedation, seizure disorders; hypertension, hyperthyroid	Relaxation, sedation, relief from anxiety, impaired memory, lack of coordination
SOLVENTS	no	possible	liver, kidney, brain - usually reversible after discontinuing	none	Euphoria, impaired perception, coordination, judgement; slurred speech; excitation, followed by depression or stupor

DEPRESSANTS (page 3)

NAME	LONG TERM EFFECTS	OVERDOSE SYNDROME	TREATMENT
HEROIN	Physical dependence, loss of appetite and sexual drive, needle or "track" marks, infections, constipation, abstinance or withdrawal syndrome	Respiratory depression, coma, seizures, fever, pupils constricted, leukocytosis (lymphocytosis), pulmonary edema- 2/3 of cases, lower blood pressure, pupils may dilate in terminal narcosis	Maintain airway, ventilate, Nalline I.V. (Nalorphine) 0.1 mg./kg. every 10-15 minutes or until stabilized over 12 hour period; Fluid maintainance; Possibilty of mixed overdose: $NaHCo_3$ for acidosis; dialysis. Lavage if taken P.O. and not too depressed. Methadone for the withdrawal syndrome.
MORPHINE	Same as heroin	Same as heroin	Same as heroin
METHADONE	Like heroin - less severe when tapered; muscle spasm, constipation, physical dependence; withdrawal syndrome	Respiratory depression, delerium, hallucinations, heroin-like syndrome	Nalline treatment every 2-3 hours up to 72 hours (average 24-48 hours). Methadone is longer acting.
CODEINE	Psychic dependence, physical dependence with large doses	Similar to heroin if taken in large quantities; rare due to dilution factors of cough preparations	Supportive, same as heroin. Rarely use Methadone.
BARBITURATES	Physical and psychic dependence; high tolerance; severe withdrawal syndrome; drunken behavior; irritability; potentiate alcohol	Drowsiness, slowed reflexes, pulse and respiration; toxic psychosis; ataxia; respiratory depression; pulmonary and cerebral edema; pupils normal; withdrawal syndrome may result in convulsions & death	Acute or chronic overdose requires hospitalization; airway ventilation; Lavage 8-10 liters activated charcoal - mineral oil; Dialysis and diuretics; Mannitol good for phenobarbital. For abstinance syndrome, gradually diminish with decreasing doses of pentobarbital 200-500 mg. Also chlordiazepoxide every 6 hours.
SOLVENTS	Bone marrow, kidney and liver toxicity; death from aspiration	Suffocation from bag; aspiration from respiratory depression and stupor	Remove inhalant; airway ventilation; supportive;

STIMULANTS

NAME	CLASS	SOURCE AND CHEMICAL OR GENERIC NAME	SLANG NAME	HOW TAKEN	DURATION OF ACTION
AMPHETAMINES	Stimulant sympatho-mimetic	Methamphetamine(methedrine) Amphetamine sulfate (benzedrine) Dextreamphetamine (dexedrine) Preludin; M.D.A. (methyline dioxyamphetamine) synthetic	Speed, meth, black beauties, uppers, bennies, crystals	Swallowed, injected, sometimes sniffed 2.5 - 5.0 mg. every 4 hours (MDA up to 100 mg.)	4-24 hours
COCAINE	Stimulant classed as narcotic because of abuse potential not addiction potential	Benzoylecgoine	Snow, coke, star dust, Bernice, gold dust	Dose varies; 30 mg. may be fatal; Sniffed, ingested, injected;	May last 4 hours

STIMULANTS (page 2)

NAME	PHYSICAL DEPENDENCY	HABITUATION	POSSIBLE PHYSICAL DAMAGE	MEDICAL USE	SHORT TERM EFFECTS
AMPHETAMINES	none	yes	Unknown as yet; convulsions, psychotic states, weight loss, poor general state of health	Narcolepsy Used but not recommended for appetite suppression and to relieve depression	Stay awake, feeling of energy, excitation, rush, increased confidence, mood elevation, tolerance leads to large doses, loss of appetite, pupils dilated, DTR up, BP up, HR up.
COCAINE	none	yes	Perforation of nasal septum; convulsions; same as heroin if it is injected	Anesthetic	Variable, short euphoria, 15-30 minutes. May require repeated injections.

STIMULANTS (page 3)

NAME	LONG TERM EFFECTS	OVERDOSE SYNDROME	TREATMENT
AMPHETAMINES	Psychic dependence, malnutrition (2 per cent weight loss, 15-30 lbs.) infections from mainlining; withdrawal syndrome	Cardiac arrythemias, tachycardia, restlessness, deep tendon reflexes, tremor, psychosis resembling paranoia. The central stimulant effects are dry mouth, sweating, dilated pupils, shallow respiratory and circulatory collapse. Higher temperature, convulsions, coma are terminal signs. MLD 100-200 mg. of dextromaphetamine.	Support of vital signs, barbiturates or phenothiazines for O.D.S. Withdrawal syndrome due to tolerance. Also tricyclic antidepressants / death while speeding accidental.
COCAINE	No physical dependence or tolerance. Great psychic dependence. Paranoid reactions; possible preforation of nasal septum	Respiratory depression; medulary paralysis; seizures; DTR's up; excitement; HR up.	If pre-convulsive, inject anti-convulsants slowly. If respiratory depression exists, treat symptomatically. Hospitalize when withdrawing and depressed to avoid suicide. Wash mucus membrane often. Pentobarbital.

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FILMS

Beyond LSD—High School or Adult Audience.
Crisis House—High School or Adult Audience.
A Day in the Death of Donny B.—High School or Adu't Audience.
Drugs and the Nervous System—Junior High or High School.
Marijuana—High School or Adult.
Nice Kid Like You—Adult.
People Next Door—High School or Adult Audience.
Speedscene: Problem of Amphetamine Abuse—High School or Adult Audience.
Filmstrips and Records: (with discussion and showing guides)

1. Stimulants
2. Sedatives
3. Psychedelics
4. Narcotics
5. Marijuana—What Can You Believe?
6. LSD: The Acid World

ADOLESCENT CLINIC AUDIO-VISUAL MATERIALS

Title	Distributor	Description	Audience
Beyond LSD	BFA Educationa Media, 2211 M ch gan Ave., Santa Monica, Calif.	Medical and sociological aspects of LSD use: color	High schoo adut.
Crisis House	Churchill Firms, Los Angeles, Calif	Description of a halfway house and a presentation of discussion of residents there; color.	Do.
A Day in the Death of Donny B	National Audiovisual Center, General Services Administration, Washington, D.C.	Story of a day of a street junkie; B. & W	Do.
Drugs and the Nervous System	Churchil Firms, Los Angeles, Calif	Explanation of how drugs affect the different parts of the body, with special emphasis on the effects on the nervous system; color.	Junior high school.
Marihuana	BFA Educational Media, 2211 Michigan Ave., Santa Monica, Calif.	Description of the effects of marihuana use and discussion of controversial questions about it; color.	High school adult.
Nice Kid Like You	University of California, Extension Media Center, Berkeley, Calif.	College students discussing sex, drugs, social revolution; B. & W	Adult.
People Next Door	BFA Educational Media 2211 Michigan Ave, Santa Monica, Calif.	CBS production dealing with 2 families and their involvement with drugs; B. & W.	High school adult.
Speedscene: Problem of Amphetamine Abuse	Do.	Medical and sociological aspects of amphetamine abuse; color.	Do.

RICHMOND REGIONAL PLANNING DISTRICT COMMISSION

CODAC—Council on Drug Abuse Control

The Council on Drug Abuse Control was established in August, 1970 as the review and action arm of the Richmond Regional Planning District Commission for drug abuse programs. CODAC's purpose is to develop a comprehensive, multi-level program via its four committees: Public Education, Juvenile Education, Enforcement, and Rehabilitation. The twenty-seven members of CODAC represent a broad base of expertise including medicine, education, pharmacology, law enforcement, community action, government, narcotics research, and public health. CODAC works closely with the Governor's Council on Narcotics and Drug Abuse Control and is recognized as the umbrella planning and coordinating agency for the City of Richmond and the Counties of Charles City, Chesterfield, Goochland, Hanover, Henrico, and New Kent and Powhatan.

Programs presently under consideration by CODAC include:

Public Education.—Assistance to and coordination of civic and service organizations in developing and implementing drug abuse education programs; assistance in the establishment, operation, and training of a regional Speaker's Bureau; development of drug abuse exhibits for public display, State Fair, Federal Bar Association, etc.; serve as the Regional Clearing-House for information on drug abuse.

Juvenile Education.—Examination of current drug abuse curricula offered in primary and secondary schools; formulation of drug abuse educational units to be correlated with and incorporated into the various disciplines; assistance in developing assemblies and special programs to supplement educational units; developing programs to educate schol officials and teachers on drug abuse and drug education.

Enforcement.—Evaluation of each jurisdiction's enforcement capability; development of in-service training programs for criminal justice system personnel; equipment pools to combat organized crime.

Rehabilitation.—Evaluation of treatment capabilities and new treatment methods; development of programs such as medical detoxification, peer-houses, half-way houses, out-patient services, job placement services, psychological and psychiatric services, encounter and group therapy groups.

All programs, where applicable, will be assisted in seeking state and federal grant funds.

Rubicon

2718 East Franklin Street
Richmond, Virginia 23223
Telephone: 643–1849

Rubicon is a multi faceted project offering treatment to drug addicts and abusers and providing drug abuse prevention and education services to the Richmond Community. The project is primarily funded by the U.S. Office of Economic Opportunity.

There are two ways for persons seeking help with a drug problem to enter a Rubicon treatment mode. They can either enter voluntarily or through special arrangement with Richmond area courts.

People awaiting to enter Rubicon must write a letter to the Rubicon Legal Services Department, 2718 East Franklin Street, Richmond, 23223. The letter must explain the reason why the prospect wants to enter Rubicon. Upon receipt of the letter, arrangements will be made for a Rubicon resident to visit the prospect.

People seeking help voluntarily must appear before the Clinical Induction Committee which meets at the Rubicon Outpatient Facility in the rear of 1010 East Marshall Street. Appointments to appear before the committee can be made by calling 648–8351. The Committee meets on Monday, Wednesday, and Friday between 10 a.m. and 5 p.m.

After completion of either induction process, the prospect is given an option of one of four treatment modes. The four modes are:

I. Residential, Drug Abstinance
II. Residential, Methadone Support
III. Outpatient, Drug Abstinance
IV. Outpatient, Methadone Support

THE RESIDENTIAL PROGRAM

Prospects who enter the residential treatment mode usually spend from six to eight months in residence. This period is followed by four to six months in a phase out sequence.

The intensive residential treatment mode has traditionally been called a therapeutic community. In reality, it is simply a place where people come to learn to live positively. Residents in treatment learn to free themselves of the control of former negative experiences. They learn to assume responsibility for themselves and for their community and to assume a way of life that is honest, consistent, and satisfying. In other words, they learn that they don't have to be addicts any more. Ever.

Training consists of at least six sessions plus role-playing and supervision on the phone by an experienced listener. Lectures are given by health professionals for half the training. The other half is conducted in small groups with experienced listeners on such telephone techniques as "creative listening" and sensitivity to real needs. The volunteers are acquainted with nondirective counseling theory and learn to build on the resources of the caller before suggesting any of the many referrals on file. It is hoped that by using such crisis intervention techniques the caller will develop coping mechanisms within himself. Thus each call involves the exploration of the problem by the caller with the listener providing support, guidelines, and resources. Federal Government material (NIMH) is used in training for drug problems as well as a comprehensive drug manual developed by some of the Hotline workers in medicine and pharmacy. The intensive suicide training is based on material from the NIMH Center for Studies of Suicide Prevention. Workers are instructed not to diagnose medical problems or give legal advice.

TYPES OF CALLS AND PROCEDURE

It is only possible to give a very general impression of the types of calls received by Richmond Hotline since each call is unique. Twenty-eight percent of the calls are about romantic problems and 16 percent concern parent problems. In these calls the worker is an empathetic listener, lets the caller ventilate, and attempts to reopen communication channels between the persons involved. Twenty percent of the calls concern drug problems which are often handled with factual information and discouraging the use of hard drugs such as heroin and speed. The problem often is to distinguish between drug use and drug abuse. If the person is having a "bad trip" the worker reassures him and stays in contact until the effects begin to lessen. As with the suicide attempts an effort is made to get someone to stay with the caller and it may be necessary to arrange hospitalization. Suspected pregnancy is involved in about six percent of the calls and the worker reassures the caller and encourages her to get confirmation of the pregnancy before exploring alternatives such as marriage, facilities for the unwed mother, or abortion. Suicide attempts are involved in five percent of the calls and the worker determines the lethality of the call by looking for typical clues before arranging or suggesting help and counseling for the caller. Many other types of problems are also presented to the Hotline, including school, sexual deviation, abortion, alcoholism, birth control, legal, employment, and housing problems.

Referrals are made in ten percent of the calls. The most frequent resources used by the Richmond Hotline have been clergy, clinics, and private social agencies.

The Rubicon Youth Corps will work closely with the community centers. This is a committed group of high school students who have been trained in peer level counseling to help their friends work through drug related and other problems. The Rubicon Youth Corps will augment counselors and other professionals as well as carry the alternative living modes experienced in the centers to homes and schools.

THE RUBICON SPEAKERS BUREAU

Former addicts in advanced stages of treatment and Rubicon staff members are available to talk to organizations and educational and professional groups about all phases of the drug problem. To arrange for a speaker, call 643–1849.

Fan Free Clinic

P.O. Box 5669
1721 Hanover Avenue
Richmond, Virginia

Hours: Tuesday, Thursday, 7:00 p.m. to 9:30 p.m.
Purpose: To provide medical care for the young people of Richmond. It is for the purpose of counseling and information.
Organization: Open door. First Come First Serve. No Fees required—($1.00 pregnancy test). Staffed by volunteers, physicians mostly from the Medical College of Virginia and some city private doctors. Equipment donated. Supplies—drugs—City Health Department and Pharmaceutical Companys.
Services: General practice services. Tuesday, Thursday—general Medical problems, abortion counseling, Dentist on call for emergencies only, gynecologist.
Clients:
Desired Number: 15 gynecological problems; 15 assorted medical problems weekly; BCP refill—3 months unlimited.
Average at Present: 60–70 assorted medical and Gynecological problems weekly.
Lab Work:
CBC
Urinalysis
Pregnancy Test-2 min.
Mononucleosis
SMA
Have Pharmacy.

Rap Center

816 West Grace Street
Phone: 359–2375

Hours:
6–9 p.m. Tuesday, Wednesday, Thursday
6–12 midnight Friday
1–4:30 Saturday
8–12:00 Saturday

ORGANIZATION

The Rap Center which is sponsored by the Jewish Family Services is located at 316 West Grace Street in the Fan District of Richmond. Our phone number is 359–2375. The Center is open on Tuseday through Thursday from 6:00 p.m. to 9:00 p.m., on Friday from 6:00 p.m. to midnight, on Saturday afternoon from 1:00 p.m. to 4:30 p.m., and on Saturday night from 8:00 p.m. to midnight. Glenn Scarboro is coordinator.

PURPOSE

The Rap Center's purpose is to offer professional counseling services to young people who reside in or visit the Fan. We address ourselves to a wide range of psycho-social problems including drug use, family and interpersonal conflict, emotional difficulties, school problems, etc. We do offer referral services to other agencies when appropriate. Primarily we serve people in the 15 to 25 year age group who would not ordinarily use a more traditional source of help. The Center is quite informal in its structure: no appointment is necessary, no fees are charged. Confidentiality is maintained. Our staff is composed of graduate students from the School of Social Work at VCU who practice under the direct supervision of a professionally trained social worker and other qualified community persons and spsychological consultation is available.

SERVICES

Since we serve alienated young people, our program is designed to offer help in a way the client can use. The Rap Center for some kids is a place they can come to where they'll be with people who care. One doesn't have to have a "problem". We try to help kids come to grips with whatever is troubling them, and to help them find a way to solve their difficulty meaningfully. The Clients are met with individuals or groups. Many clients are seen on a short term basis. Depending on the client's needs, we offer extended services. A very brief intake sheet is completed on the clients who are often anonymous.

Referrals may be made in two ways. One may suggest to a client that he come to the Rap Center when we are open. He would be seen then by a worker. One could also call Jewish Family Services, or have the client call, to arrange an appointment for the client at the Rap Center. We would be happy for the Adolescent Clinic to use this source.

Fish Is Sos Help

FISH

There are five FISH Organizations with the same telephone number.

Hours: 24 hour basis.

Organization: Supported by contributions from the participating churches. Staffed by about six hundred volunteers in the Richmond area.

Services: Counseling. Referral to existing agencies.

Sheets included: Operating Guide and Narrative; Guidelines for Volunteers and Team Leaders; Resources in the Community; Flyer.

Fish Organization--West End—Richmond

Operating Guide—February 16, 1970

What is the Fish? It is a project operated by a number of West End Richmond churches to provide short-term emergency help to their neighbors in the community. The services they offer are of the type not rendered by existing city or community agencies such as Red Cross, Salvation Army, etc.

How did Fish get started? In ancient times the Greek letters ICHTHUS—standing for Jesus Christ, Son of God, Savior—spelled "fish". Christians of the first and second centuries used the fish as a symbol of their faith, as a sign of their brotherhood throughout the period of persecution. This meaning has carried down through the ages.

In modern times FISH is the name given a movement which had its origin in England and which has since been introduced into the United States. A number of churches in different parts of the country are joining in the program of brotherhood and aid to neighbors. First of the American churches to adopt FISH, so far as we know, was the Church of the Good Shepherd, a small Episcopal church in West Springfield, Massachusetts. For the past few years they have conducted an outstanding lay ministry in an area of about 25,000 people. We have applied their experience in the preparation of this manual and hope to emulate their effectiveness.

Organization

Fish Board—Two members from each participating church.

Team Leaders—Seven Team Leaders from each church or group of churches participating as a unit.

Team Workers—Minimum of twenty-eight members from each church or group of churches participating as a unit.

Operation

Each Team Leader is to cover a 24-hour period rotation with a minimum of four team members. It is preferable to have husband-wife combinations, if possible. The Team Leader is to be responsible for taking calls referred to him by an answering service. The Team Leader will call the individual requesting aid to determine course of action and either refer the individual to a specific agency or dispatch Team Members to aid the individual.

Participants

Member church members and other interested individuals, who must affiliate with one of the member church groups.

Area To Serve

Broad Street to the James River.

Foushee Street to the Western City Limits.

Organization of Fish Board

Chairman
Vice-Chairman
Secretary
Treasurer

Financial Support

By member churches and individual donations. Financial requirements minimal.

Community Agencies

The "Directory of Social Services" published by the Richmond Area Community Council will be distributed to all Team Leaders. In addition, all volunteers will have a list of Night and Weekend Resources.

Participation Requirement

Each church or group of churches participating as a unit will be responsible for a seven day period.

Revision

This manual will be reviewed and revised periodically by the FISH Board.

Services Offered by FISH

The following types of emergency services will be provided on a non-recurring basis. If prolonged assistance is required, FISH will find a professional agency to provide the service.

1. Baby sitting—only when no responsible adult or relative is available to baby-sit. Services such as feeding, bathing, dressing, etc. may be provided. Will baby-sit in home of individual unless conditions prohibit, then baby-sit in FISH member's home.
2. Procurement of food—Fish member not to provide unless an extreme case; then limited to five dollars ($5.00). The extreme case will then be referred to the appropriate agency.
3. Preparation of meal.
4. Essential errands within local area.
5. Transportation within metropolitan area.
6. Aid transients in trouble.

The following may be provided on a recurring basis:

1. Visits to elderly and invalids.
2. Non-professional counseling.
3. Referral services—by *Team Leaders* ONLY.
4. Reading to blind and invalids.
5. Rides, services and errands for shut-ins.
6. Prayers and spiritual comfort.

Operating Procedures

1. A telephone answering service will take all incoming calls. Telephone Number is 649–2555.
2. The incoming calls will be referred to the Team Leader on duty.
3. The Team Leader will call the party calling to determine the individual's needs.
4. The Team Leader will assign team member(s) to aid the calling individual if he decides it is necessary or he will refer the individual to a specific agency.
5. Maintaining Records: Records are to be posted in logbook by Team Leader. Team Leader is responsible for delivering logbook to succeeding Team Leader by 6:30 p.m. Postings should show:

(*a*) A record showing person calling, phone number, and time referred from Answering Service.

(*b*) A record showing time return call made, action taken, such as assignment of individuals and their name or referral to another agency.

6. Duty period: The 24-hour duty period shall begin at 6:00 p.m. The duty week shall begin at 6:00 p.m. Sunday.

Do's and Don'ts

Team Leader:

1. Don't dispatch youths or ladies after dark. In cases where services of a lady are essential, call Richmond Police Department for escort.

2. Do secure and record information required to make decisions and assigning individuals.
3. Do record all calls received on your duty period.

Team Members:

1. Do obtain all necessary information to carry out call and fill out report.
2. Do keep the Team Leader informed on unusual aspects requiring additional aid (people, funds).

Both:

1. Don't accept any payments. Donations to be sent to: Harry H. Warner, Treasurer, Metropolitan National Bank, P.O. Box 1335, Richmond, Virginia 23210.
2. Do use the buddy system as much as possible on non-recurring calls.
3. Do not reveal identity of individuals calling FISH. Respect their privacy.
4. Don't try to perform emergency aid. Refer to appropriate agency.
5. Don't commit your material resources of more than five dollars ($5.00). In extreme cases, consult Team Leader.
6. *Area to Serve:*

Team Leaders may accept calls slightly beyond our geographical area, provided such calls are not in an area served by another FISH Group.

7. *Nuisance Calls:*

Service-type organizations usually find they attract critics as well as friends. Serious, well-informed critics should be used to the betterment of the FISH; but cranks, crackpots, pranksters, drunks, chronic complainers, etc. are nuisances who can sap the time and energy of the project and tie up main telephone circuits unless handled firmly. A list of such persons will be posted on the back page of the logbook.

8. Team Leaders should refer policy considerations to a Board Member.

FISH

West End-Richmond—Guidelines for Volunteers

Read the Operating Guide.

Be thoroughly familiar with the agencies and other community resources. A list of night resources is attached. A complete list is contained in the "Directory of Social Services" published by the Richmond Area Community Council. Team Leaders have a copy.

Remember at all times that we are a church-sponsored, non-professional organization of volunteers dedicated to serving our neighbors. As such, we are trying to supplement, to a limited degree, the work of the many established agencies, private and public, like the Visiting Nurses Association, Red Cross, Salvation Army, Rescue Squads, the City Social Service Bureau, etc. It has been determined that there are many kinds of problems and needs which these groups cannot or do not normally handle. From the many areas of possible need, we respond to those where THE FISH, with its supporting churches and friends can assist.

To perform effectively, the members of FISH will obviously require a thorough knowledge of their own organization and its capabilities, of the many resources available through the churches and other community agencies and groups, and of the interrelations among all these bodies—areas of overlap or duplication, gaps, special rules or limitations, etc.

THE FISH has no legal or official church status; nor does it have any formal affiliation with the city government. This is added reason (i.e. beyond the delicacy of its mission) why it must be circumspect in all its dealings with the public and with the community agencies and places of business. Careless errors by THE FISH could do serious damage to the reputation of the group and to the churches involved.

The kind of people and problems encountered will often call for patience and understanding, tact, and quick presence of mind.

Volunteers, when "in doubt," should call Team Leaders for advice.

Team Leaders and Assistant Team Leaders

Answering incoming calls and assigning FISH aid

The manner in which Team Leaders handle calls for help is important and different methods may be developed for the variety of cases expected. It is recommended that a Team Leader when going on duty, read through the recent entries in the log as a guide for handling calls.

Wherever time and circumstances permit, the Team Leader should assure himself of the following before reaching a decision on a case:

1. That the need appears real and there is no prior adverse report.
2. That no other agency or institution is known to be taking action on the matter.
3. That the need is clearly within FISH competence and resources *at that time.*
4. That the necessary assistance is on hand and can be dispatched at once.
5. Don't panic—just keep talking until you can think through what should be done. If necessary, call back later.

Where it is clear that the need is not consistent with FISH goals, or is clearly beyond FISH capabilities, the Team Leader will decline the request as diplomatically as possible. In the event that a professional agency might be able to assist, the Team Leader will so advise the applicant, providing information to the best of his ability. He may also offer to have a volunteer take the individual to an agency the next day.

In summary, Team Leaders answering calls will either dispatch aid, make a referral or decline the request. Should special or unusual circumstances develop at any time, volunteers should consult their Team Leaders. Team Leaders should consult a resource person if that proves desirable.

From the foregoing, it is obvious that real teamwork is essential and that reasonable control must be kept on what is going on at all times; otherwise we may commit ourselves to too much or to a response which is beyond our capacity.

Youth Emergency Service

YES

This was an outgrowth of Fish, originally supported by them, but financed by outside sources.

Hours: Monday–Thursday 4 p.m.–10 p.m.; Friday–Sunday 6 p.m.–12 a.m.

Organization: Staffed by 76 trained listeners on duty two at a time, maintaining complete anominity, on an average of 100 calls per week. At the commencement of the program, there were about 15 per cent put-on or crank calls, but these have now dropped off to about 4 per week.

Youth Emergency Service

BYLAWS

1. *The Name* of this corporation shall be Youth Emergency Service, Inc. (in Virginia), hereinafter referred to as "YES."
(of Richmond)

2. *The purpose* of YES is to furnish anonymous telephone listening to those who feel a need to discuss a problem of any type. The service is aimed at and designed for youth of junior and senior high school age, but this will not limit the subsequent development of programs for younger or older groups. Any direct counseling beyond referral to appropriate professional resources, and any face-to-face contact with callers without Board approval is a violation of these bylaws.

3. *The membership* of YES includes qualified Listeners, Board members, Trainers, Team Captains, and Assistant Team Captains. Qualifications for membership shall be set by the Board of Directors of YES. Membership in YES can be terminated at any time by the Board of Directors.

4. *The Board of Directors* is composed of two members from each sponsoring FISH organization and such other professional members considered necessary by the existing Board. The total number of directors shall not exceed eighteen, and after the first year shall be elected at large by the Board. Terms of directors shall be three years beginning January 1, 1971, with terms of original directors staggered one, two and three years by lot.

The duties of the Board shall be to establish all policies of YES which shall include but not limited to methods of operation, qualifications for membership, reasons for termination of membership, and qualifications, recruitment, training, and scheduling of telephone Listeners (Paragraph 6).

5. *The Officers* and their duties will be as follows:

Officer	*Duties*
President	Preside at meetings and be the official spokesman and representative of YES.
Vice-President	Preside in the absence of the president and perform other presidential functions delegated by the president.
Treasurer	Receive, disburse and account for the funds of YES.
Secretary	Record proceedings of board meetings and perform correspondence at the direction of the president.

6. *Qualification and Training of Listeners.* The Board shall establish qualifications for Listeners, provide for Listener Training, and supervise Listeners on duty. Supervision of Listeners shall be done by individual Board members who have qualified as Listeners or by qualified Trainers. Not less than four Review and Retraining meetings for all Listeners will be held each year. These shall include review of calls, resources, and policies.

7. *A Meeting of the Membership* shall be held at least once each year, which may coincide with one of the Review and Retraining Meetings (Paragraph 6).

8. *The Meeting of the Board of Directors* shall be held at least quarterly as determined by the members of the Board. Special meetings may be called by the president or a majority of the Board. A quorum shall be at least one-third of the membership of the Board.

9. *YES Will Be Not for Profit.* Costs will be financed by voluntary giving.

10. *Amendments to Bylaws.* These Bylaws may be amended by a majority vote of the Board at any Board meeting, provided that directors receive written notice three weeks in advance of such meeting.

YES

YOUTH EMERGENCY SERVICE

Telephone 355-3256

INFORMATION SHEET—OCTOBER 5, 1970

The Youth Emergency Service is a telephone counseling service that provides young people with an opportunity to discuss anonymously their problems with an unidentified listener. A young person simply calls YES and is assured of an understanding and patient listener who has been trained in aiding the individual to better cope with his problem. When callers ask for or seem to need specific advice, they are referred to appropriate local resources for professional help.

There appears to be a need for an alternative sounding board for young people beyond confiding in parents, ministers, or school guidance counselors. Experience in other localities which have services of this type indicates that young people will discuss many adolescent problems freely with an anonymous counselor whereas they are reluctant to discuss these same problems with parents or someone else who knows them.

It is the purpose of the Youth Emergency Service to serve the youth of the Richmond Metropolitan Area. With the approval and cooperation of the Richmond, Henrico and Chesterfield School Systems and various private secondary schools, cards with the YES telephone number are being distributed to junior and senior high school students in the area. Other methods of informing students about YES are used, such as radio and the press.

YES is sponsored and financed by the Richmond Area FISH Organization. Policies and procedures are established by an advisory board made up of members of FISH and professional personnel. Space for the service is generously provided by a district church with adjacent parking.

YES operates seven days a week, 52 weeks a year. Hours are from 4 p.m. to 10 p.m. Monday through Thursday and from 6 p.m. to 12 a.m. on Friday, Saturday and Sunday. Each listener serves one three hour shift every other week. Two listeners serve together since two lines are provided for callers.

NOTICE TO STUDENTS—NOVEMBER 16, 1970

Each of you have received a card with the telephone number of Youth Emergency Service—or more simply YES. Keep it—it may come in handy.

If you have any problem that you would like to talk over with someone, call 355–3256 during the hours shown. You will find an understanding and patient listener on the other end of the line, who will remain unidentified. You do not have to give your name, and whatever you say will be held in strict confidence.

Listeners have been trained to discuss your problem with you and to help you to better cope with it. They will try to make helpful suggestions, and they will not be critical or tell you what you should or should not do.

Hours: Monday, Tuesday, Wednesday, Thursday, 4 p.m.–10 p.m.; Friday, Saturday, Sunday, 6 p.m.–12 midnight.

Beginning: Monday, November 16, 1970.

COMMUNITY SPEECHES

(Given by: George M. Bright, M.D., and Ted R. Abernathy, M.D., 1970–71.)

MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION
DR. GEORGE M. BRIGHT, JAN. 1, 1970–JAN. 1, 1971

Date	Location	Group	Title of speech	Number attending
Jan. 6, 1970	Richmond	All Saints Episcopal Church, Men of the Church.	Drugs and Adolescence	50
Jan. 7, 1970	do	Stuart Circle Clinical Meeting, Stuart Circle Hospital.	Adolescent Problems: with special emphasis on Drug Abuse.	75
Jan. 8, 1970	do	Richmond First Club	Challenge of Drug Education: How the Richmond First Club Can Help.	75
Jan 9, 1970	do	Junior League	Drug Abuse and Use in Richmond	200
Do	do	WRVA—Open for Opinion	Half hour show on the Adolescent Clinic and Drug Abuse in Richmond	
Do	do	Grace and Holy Trinity Church	Panel on Drugs	50
Jan. 11, 1970	do	Entire Community	Trip or Trap Drug Program	1,500
Jan. 12, 1970	Chester	Women's Club of Chester	Drugs and the Adolescent	35
Jan. 13, 1970	Richmond	American Association of United Women.	Drug Abuse	50
Jan. 14, 1970	do	Department of Welfare and Institutions, Nurses and Sanitarians.	Drug Abuse in Richmond	75
Do	do	Rotary Club	How the Richmond Rotary Club can help the work with the Richmond Drug Abuse Problem.	50
Jan. 19, 1970	do	Richmond Forum Club	Drug Abuse in Richmond	75
Jan. 20, 1970	Virginia Beach.	Virginia Beach General Hospital	How to Develop a Drug Abuse Program	40
Jan. 21, 1970	do	Dupont Industries	How to Recognize Drug Users in Major Industry.	100
Do	do	Rotary Club	The Adolescent and Drug Abuse	300
Jan. 22, 1970	do	School of Pharmacy	do	250
Jan. 23, 1970	do	State Department of Public Welfare and Institutions.	The Psychedelic and Addictive Drugs	35
Jan. 24, 1970	do	Virginia Congress of PTA	Establishment of School Nursing Services and Drug Education.	500
Jan. 26, 1970	do	Cerebral Palsy Center	Sex Education	10
Do	do	West End Manor Civic Association.	Sex Education in the Schools	25
Jan 28, 1970	Abington	Johnston Memorial Hospital	Adolescent Medicine and Drug Abuse	75
Feb. 1, 1970	Richmond	ETV (Statewide Broadcast)	Drugs	
Feb. 2, 1970	do	Technical Center Home Economics Class.	Youth Communications and Drugs	50
Feb. 5, 1970	do	Virginia Pharmacy Association, Public Relations Committee.	Drug Use and Abuse	15
Feb. 7, 1970	Lynchburg	Fort Hill United Methodist Church	Drugs and Youth	350
Feb. 9, 1970	Richmond	St. Bridgette's School	Why Young People Use Drugs	150
Feb. 15, 1970	do	Overbrook Presbyterian Church	Drug Panel	75
Feb. 22, 1970	do	Second Presbyterian Church	Drug Abuse	150
Feb. 24, 1970	do	St. Catherine's School	Drug Abuse in Richmond	200
Do	do	St. Bartholomew Episcopal School	Drugs	150
Feb. 25, 1970	do	Meadowbrook High School	The Adolescent and Drugs	1,200
Do	do	VCU	The Campus Scene Today	150
Feb. 26, 1970	do	Children's Home Society of Virginia.	Drug Experimentation and Drug Abuse—The Difference.	75
Mar. 3, 1970	do	Virginia Occupational Therapy	Adolescents and Problems in 1970	75
Do	do	Good Shepard Methodist Church	Sex Education	50
Mar. 4, 1970	do	University of Richmond Faculty	Drug Abuse	50

MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Continued
DR. GEORGE M. BRIGHT, JAN. 1, 1970–JAN. 1, 1971—Continued

Date	Location	Group	Title of speech	Number attending
Mar. 5, 1970	do	Monacan Junior Women's Clubs	Drug Use and Abuse	75
Mar. 9, 1970	do	Virginia Federation of PTA	Drug Abuse and the Adolescent	350
Mar. 10, 1970	do	All Saints Church Women	Adolescent Clinic	50
Do	do	WTVR Richmond Roundtable	Adolescents and Drug Abuse in Richmond	
Do	do	Henrico High School PTA	Drug Abuse in Richmond	150
Mar. 12, 1970	do	Brookland Junior High School PTA.	Explosion of Drug Abuse in Richmond	120
Mar. 14, 1970	Lynchburg	Virginia Education Association	Drug Abuse in Richmond—A Growing Problem	600
Mar. 23, 1970	Richmond	WXEX—Richmond Today	Drug Abuse	
Do	do	George Wythe High School	Drugs and Veneral Disease	50
Do	do	Committee for the Visually Handicaped.	Drug Abuse	25
Mar. 25, 1970	Highland Springs.	Highland Springs Key Club	Drug Use and Abuse	150
Mar. 26, 1970	Richmond	Friends Church	Drugs	125
Mar. 30, 1970	do	Sandston Rotary Club	Challenge of Drug Education	200
Apr. 1, 1970	do	Meadowbrook High School	Drug Panel	1,200
Do	Suffolk	Suffolk General Hospital	Drug Use and Abuse	125
Apr. 6, 1970	Richmond	St. Gertrude's School	Drug Abuse	150
Apr. 7, 1970	do	St. Luke's Hospital	The Physician's Role in Drug Education	100
Apr. 8, 1970	Danville	Danville PTA, Junior and Senior High Students.	Three talks on Drugs	1,500
Apr. 12, 970	Richmond	WWBT	Drug Abuse	
Apr. 13, 1970	do	Tuckahoe High School	Adolescents and Drugs	600
Apr. 20, 1970	Bristol	Virginia Intermont College	Drugs on the College Campus	800
Apr. 22, 1970	Richmond	Meadowbrook High School	Adolescents and Drug Abuse	1,200
Apr. 23, 1970	do	WXEX	Hour Panel Tape	
Apr. 25, 1970	do	Association for Childhood Education.	Children and Drugs	75
Apr. 29, 1970	do	MCV Family Practice Club	Sex Counseling to the Adolescent	600
Apr. 30, 1970	do	Maggie Walker High School Faculty.	Teacher's Role in Drug Education	50
May 4, 1970	do	Lee Davis High School	Drug Use and Abuse	1,500
May 5, 1970	do	Trinity Methodist Church	Communication and the Adolescent	150
May 6, 1970	do	Westwood Club	Drug abuse in Richmond	200
May 12, 1970	do	St. Giles Presbyterian Church	Drug Panel	200
May 15, 1970	do	Virginia Baptist Men's Association.	Three one hour lectures on Drugs	1,500
May 18, 1970	Charlottesville.	University of Virginia	Report on Title I—Drug Abuse	200
Do	Richmond	Sacred Heart School	Drug Use and Abuse	100
May 19, 1970	do	Maternal Child Health Conference	The Adolescent in our Society	200
May 20, 1970	do	Saint Paul's Church, Men's Association.	Drugs in Richmond	50
May 21, 1970	do	John Tyler Community College	Drugs on the College Campus	200
June 1, 1970	do	First Africa Church	Drug Abuse in the Richmond Community	225
June 3, 1970	do	St. Elizabeth's School Parents	Why Young People Use Drugs	75
June 4, 1970	do	Department of Welfare and Institutions, Nurses and Sanitarians.	Introduction to Health Sciences	100
June 7, 1970	do	Antioch Baptist Church	What can the Church do in Helping Young People with Drugs?	250
June 9, 1970	do	Reville United Methodist Church	Youth and Drugs	200
June 10, 1970	do	Westover Hills Schools	Challenge of Adolescence	75
June 15, 1970	do	Glen Allen Baptist Church, Youth Group.	Drug Scene in a Rural Community	50
Do	do	Grace Covenant Presbyterian Church, Ladies of the Church.	Drug Education	200
June 16, 1970	Richmond	St. Stephen's Church, Parents and Children.	Drug Abuse jin Our Community—A Year Later.	75
June 24, 1970	do	Jewish Community Center Parents.	Parents' Responsibility about Drug Abuse	50
Aug. 4, 1970	do	Housestaff Orientation	Adolescent and Medicine	
Aug. 5, 1970	do	Jewish Community Center, Youth—Drug Clinic.	It's Your Decision about Drugs	200
Aug. 15, 1970	Farmville	Longwood College, Student Cooperation Association.	Challenge of Drug Education for Youth	500
Aug. 17, 1970	Petersburg	WXEX-TV Appearance	Adolescent Medicine and Drug Abuse	
Sept. 9, 1970	Richmond	Family Service of Richmond	Drugs	25
Sept. 11, 1970	do	Westhampton College Student Counselor Orientation.	Counselor's Role in Working with Fellow Students on Drug Abuse.	50
Sept. 14, 1970	do	St. Christopher's/St. Catherine's Schools, Orientation for Parents and Students.	Drug Abuse: The Private School's Role in Dealing with the Offender.	300
Sept. 16, 1970	do	Douglas Freeman High School, Teachers' Meeting.	Drug Abuse in the School	50
Sept. 17, 1970	do	Department of Welfare and Institutions, Nurses and Sanitarians.	Introduction to Health Sciences	75
Sept. 19, 1970	Lynchburg	Baptist Men's Association, Eagle Erie Baptist Church.	Series of six lectures on Drug Abuse	60

MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Continued
DR. GEORGE M. BRIGHT, JAN. 1, 1970–JAN. 1, 1971—Continued

Date	Location	Group	Title of speech	Number attending
Sept. 22, 1970	Bridgewater	Bridgewater College, Freshman and Sophomore Orientation.	Drug Abuse on the College Campus	500
Sept. 23, 1970	Richmond	Virginia State Police	The Medical Problem Encountered by Undercover Agents in Dealing with Drug Abuse.	50
Sept. 28, 1970	do	Christian Life Conference, Mount Vernon Baptist Church.	How the Church may become more involved in Educational Programs for Young People.	50
Oct. 1, 1970	do	State Department of Welfare	Welfare Worker's Role in Working with the Drug Abuser.	25
Do	do	Friends of the Children's Home, Parents and Young People.	Drug Abuse in Richmond Today	125
Oct. 2, 1970	Norfolk	Norfolk County School Teachers' Conference.	Drug Abuse in the Schools	500
Oct. 6, 1970	Richmond	First Presbyterian Church, Women of the Church.	Drug Abuse in Richmond	200
Oct. 7, 1970	do	Professionals of the Junior League	Followup to the "Drug Scene" Supplement	45
Oct. 9, 1970	Portsmouth	Naval Hospital, Orientation for residents, interns, and faculty.	Adolescence—Medical, Social Problems with Special Emphasis on Drug Abuse.	75
Oct. 12, 1970	Richmond	Mid-Atlantic Institute on the Adolescent and Drugs.	Challenge of Drug Education	250
Oct. 13, 1970	do	Medical Society of Virginia	Drug Abuse—Why?	300
Oct. 15, 1970	do	St. Mary's Emergency Care Symposium.	Drugs and Emergency	100
Oct. 17, 1970	Woodberry Forest.	Woodberry Forest School Parent's Weekend.	Parents and Their Role in Drug Education	225
Oct. 20, 1970	Richmond	Hugenot High School Students	Student's Role on Drug Education	1,000
Oct. 27, 1970	do	Virginia Education Association	Working with Adolescents	250
Oct. 29, 1970	do	Patrick Henry High School Faculty	Drug Abuse and Treatment Programs	50
Oct. 30, 1970	do	Virginia Education Association, School Nurses' Department.	The Dilemma of Adolescence	25
Nov. 3, 1970	do	Reville United Methodist Church	Work of the Adolescent Clinic	50
Nov. 5, 1970	do	Welfare and Institutions	Drug Abuse as a Growing Problem	75
Do	do	Thomas Jefferson High School Community Meeting.	Panel with Ann Landers and members of the community.	1,000
Nov. 8, 1970	Arlington	Virginia Retail Merchants Association.	Drug Abuse and its Effects on the Retail Industry.	50
Nov. 10, 1970	Richmond	Richmond City Nurses	The City Nurses' Role in Drug Abuse	100
Nov. 11, 1970	Highland Springs	Highland Springs High School	Students' Use of Drugs in Richmond	1,000
Do	Petersburg	Richard Bland College	Drugs on the College Campus	350
Do	Richmond	Westhampton Elementary PTA	The Current Drug Scene in Richmond	50
Nov. 12, 1970	do	Providence High School	Drug Problems Today	1,000
Do	do	Department of Welfare and Institutions, Nurses and Sanitarians.	Introduction to Health Sciences	50
Nov. 13, 1970	Williamsburg	State Board for Community Colleges	Panel on Drug Abuse	250
Do	Roanoke	Roanoke Medical Society	The Methadone Program	75
Nov. 16, 1970	Richmond	Mosby School	Why Youths Use Drugs	450
Nov. 17, 1970	do	VCU Undergraduates	Adolescent Medicine	25
Nov. 18, 1970	do	Faculty Forum Committee VCU	Drug Abuse	75
Do	do	Board of Directors, C. & P. Telephone Co.	The Adolescent Clinic and the Drug Program at MCV.	20
Nov. 19, 1970	Hopewell	James E. Mallonee School	Drug Use and its Effects on Teens	450
Do	Richmond	Saint Mary's Parochial School PTA.	Drug Use and Abuse	150
Nov. 23, 1970	Roanoke	Hollins College	Drugs on the College Campus	350
Nov. 24, 1970	Richmond	Crestview PTA	The Parents' and Teachers' Role in Drug Education.	75
Nov. 30, 1970	do	Public Health Nurses, Chesterfield County.	Adolescense	
Dec. 3, 1970	do	Graves Elementary School	Drug Use and Aubse	
Do	do	School of Physical Therapy	Drug Abuse in Richmond	
Dec. 4, 1970	Williamsburg	Virginia Education Association	Drug Education	
Dec. 7, 1970 Dec. 8, 1970	Richmond	St. Christopher's School, Woodberry Forest School, St. Catherine's School, Collegiate Schools.	Drug Seminar	
Dec. 10, 1970	do	Richmond Area Community Council.	Drugs: The Cost and Cure	
Dec. 11, 1970	Roanoke	Virginia Education Association	Discussion and Film on Drugs	

MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Continued

STAFF—SEPT. 7–DEC. 6, 1970

Date	Location	Group	Title of speech	Number attending
Sept. 7, 1970	Richmond	Friends of the Children's Home	Problems of Drug Abuse	20
Sept. 13, 1970	do	Henrico High School, Seventh and Eighth Graders.	Drugs in the Community	400
Sept. 14, 1970	do	Rona Bowser School	Problems of Drug Education and Drug Abuse.	25
Oct. 6, 1970	Williamsburg	Williamsburg County Schools Faculty.	Drugs and Drug Abuse	175
Oct. 7, 1970	Richmond	Varina High School, Humanities Class.	Problems of Drug Abuse	35
Oct. 9, 1970	do	Collegiate Schools	Drugs in the Schools	200
Oct. 10, 1970	do	Douglas Freeman High School PTA.	Drug Abuse in Richmond	100
Oct. 15, 1970	do	Hamlet Women's Club	Drug Abuse in the Richmond Community	30
Oct. 17, 1970	Powhatan	Powhatan Rescue Squad	Drug Abuse and Emergency Treatment	30
Oct. 20, 1970	Richmond	Juvenile Domestic Relations Court	Drug Abuse in Richmond	50
Oct. 21, 1970	do	VCU Physical Educat on Class	Drug Abuse	100
Oct. 30, 1970	do	Varina High School, Humanities Class.	Drugs in Richmond Today	35
Nov. 11, 1970	do	Optimist Club Father-Son Banquet.	Drug Abuse in Richmond	60
Do	Blackstone	Ladies Home Demonstration Club, State Convention.	Growing up Ain'5 Easy	150
Nov. 16, 1970	King George	King George County Teachers	Drug Abuse Among Adolescents	105
Nov. 19, 1970	Richmond	Richmond Home for Boys	Illegal Drug Use in Richmond	45
Nov. 23, 1970	do	Friend's Association for Children.	Drug Abuse in Richmond	20
Do	Charles City	Charles City Schools	Youth Communications and Drugs	100
Nov. 24, 1970	Richmond	Jonston-Willis Hospital, School of Nursing.	Current Methods of Drug Abuse Rehabilitation.	118
Dec. 1, 1970	do	Henrico County Council of PTA's.	Drug Abuse in the County of Henrico	70
Do	do	Henrico Home Demonstration Club.	Parents, Drugs, and how to cope with it	35
Dec. 2, 1970	do	YMCA Executive Committee	Drug Abuse Today	15
Dec. 3, 1970	do	MCV Physical Therapy Staff	Drug Abuse at VCU	15
Dec. 6, 1970	Goochland NAACP.	Goochland NAACP	Drug Abuse in Your Community	150

DR. TED R. ABERNATHY, JAN. 1, 1970–JAN. 1, 1971

Jan. 7, 1970	Richmond	Nurses and Welfare Workers	The Nurses' Role in Drug Education	50
Jan. 8, 1970	do	Richmond First Club	Challenge of Drug Education: How the Richmond First Club Can Help.	75
Jan. 20, 1970	Virginia Beach.	Virginia Beach General Hospital	How To Develop a Drug Abuse Program	40
Jan. 26, 1970	Hopewell	Hopewell Junior Women's Club	Drug Abuse and Your Family	100
Feb. 1, 1970	Richmond	ETV (Statewide Broadcast)	Drugs	50
Feb. 7, 1970	Lynchburg	Fort Hill United Methodist Church	Drugs and Youth	350
Feb. 11, 1970	Richmond	Armstrong High School PTA	Drugs and High School Students	1,500
Feb. 15, 1970	do	Oak Grove Elementary School	Adolescence and Drugs	100
Feb. 25, 1970	do	Meadowbrook High School	The Adolescent and Drugs	1,200
Feb. 10, 1970	do	John Marshall High School	Drugs and the High School Student	1,500
Mar. 1, 1970	do	Beulah Baptist Church	Drugs and Your Children	500
Mar. 6, 1970	do	WXGI Radio	Adolescent Clinic and Drugs	
Mar. 10, 1970	do	Henrico High School PTA	Drug Abuse in Richmond	150
Mar. 12, 1970	Ashland	Patrick Henry High School	Challenge of Drug Education	600
Mar. 14, 1970	Lynchburg	Virginia Education Association	Drug Abuse in Richmond—A Growing Problem.	600
Mar. 23, 1970	Richmond	Mary Scott School	Drugs, Communicable Diseases, and Common Diseases in Children.	100
Apr. 1, 1970	do	Meadowbrook High School	Drug Panel	1,200
Do	Suffolk	Suffolk General Hospital	Drug Use and Abuse	125
Apr. 8, 1970	Danville	Danville PTA, Junior and Senior High Students.	Three talks on Drugs	1,500
Apr. 20, 1970	Bristol	Virginia Intermont College	Drugs on the College Campus	800
Apr. 22, 1970	Richmond	Meadowbrook High School	Adolescents and Drug Abuse	1,200
Do	do	Robbins Elementary School	Drug Education for Teachers	50
Do	do	Westhampton School	Drugs and Their Effects on Your Children	50
Apr. 26, 1970	do	State Presbyterian Convention	Three one hour lectures, Drugs: It's Your Decision.	1,500

MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Continued

DR. TED R. ABERNATHY, JAN. 1, 1970–JAN. 1, 1971—Continued

Date	Location	Group	Title of speech	Number attending
Apr. 29, 1970	do	MCV Family Practice Club	Sex Counseling to the Adolescent	600
Apr. 30, 1970	Ashland	Randolph Macon College	Drugs on the College Campus	1,000
Do	Richmond	Maggie Walker High School Faculty.	Teacher's Role in Drug Education	50
May 4, 1970	do	Lee Davis High School	Drug Use and Abuse	1,500
May 14, 1970	do	Meadowbrook High School	Drug Panel	1,200
May 15, 1970	do	Virginia Baptist Men's Association.	Three one hour lectures on Drugs	1,500
May 18, 1970	do	Girl Scouts Groups	Education for Girl Scout Leaders on Sex and Drugs.	50
Do	Charlottesville.	University of Virginia	Report on Title I—Drug Abuse	200
May 21, 1970	Richmond	Armstrong High School	Drugs and High School Students	600
Do	do	John Tyler Community College	Drugs on the College Campus	200
Do	do	American Society of Personnel Administration.	Instruction for Executives in Recognizing Drug Abuse in Business.	50
Sept. 19, 1970	Lynchburg	Baptist Men's Association, Eagle Erie Baptist Church.	Series of six lectures on Drug Abuse	60
Sept. 22, 1970	Bridgewater	Bridgewater College, Freshmen and Sophomore Orientation.	Drug Abuse on the College Campus	500
Oct. 1, 1970	Richmond	Friends of the Children's Home	Drug Abuse in Richmond Today	125
Oct. 17, 1970	Woodberry Forest.	Woodberry Forest School, Parents Weekend.	Parents and Their Role in Drug Education	225
Oct. 18, 1970	Richmond	St. Edward's CYO Youth Group	Drugs and You	150
Nov. 8, 1970	Arlington	Virginia Retail Merchants Association.	Drug Abuse and Its Effect on Retail Industry.	50
Nov. 10, 1970	Richmond	Pilots International	Understanding Methadone	50
Nov. 13, 1970	Roanoke	Roanoke Medical Society	The Methadone Program	75
Nov. 23, 1970	do	Hollins College	Drugs on the College Campus	350
Dec. 7, 1970	Richmond	St. Christopher's School, Woodberry Forest, St. Catherine's School.	Drug Seminar	
Dec. 12, 1970	Roanoke	Virginia Education Association	Discussion and Film on Drugs	
Dec. 14, 1970	Richmond	Diocese of Richmond	Approach to Adolescent Drug Experimenters	
Dec. 9, 1970	do	Armstrong High School PTA	Drugs—A Year Later	
		Acne Study for Mead Johnson [1]	Evaluation of Acetylcystine	

[1] Continuing program.

ADOLESCENT CLINIC.MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION

DR. GEORGE M. BRIGHT AND DR. TED R. ABERNATHY, JAN. 1–SEPT. 30 1971

Date	Group	Title of speech	Number attending
Jan. 4, 1971	Ginter Park Women's Club	"Adolescent and Drug Abuse"	30
Jan. 5, 1971	Grand Rounds—MCV	"Drug Intoxication in Teen Years"	50
Jan. 6, 1971	Education Class—VCU	"Adolescent Medicine in Richmond"	40
Jan. 10, 1971	Roanoke Rapids School System, Roanoke Rapids, N.C.	"The Why and Wherefores of Drug Abuse"	1,200
Jan. 12, 1971			
Jan. 13, 1971	Village Presbyterian Church	"Effect of TV Drug Advertising on Youth Drug Use".	50
Jan. 15, 1971	VEA School of Nurses	"The Nurses Responsibility in Drug Abuse"	350
Jan. 18, 1971	Fisher PTA	"Treatment Centers for Drug Abuse"	125
Jan. 20, 1971	Virginia Western Community College	"Drugs on the College Campus"	325
Do	Roanoke City School Teachers	"Youth and Drugs"	1,200
Jan. 21, 1971	Summerhill School	"Drug Abuse in the Elementary School"	50
Do	St. Mary's Parochial School	"Drug Abuse in Richmond"	350
Jan. 23, 1971	University of Richmond	"Drugs and College Scene"	75
Jan. 25, 1971	Colonial Heights School System	"Teachers Role in Drug Abuse Education"	500
Jan. 26, 1971	Huguenot Women's Club	"Drug Abuse in Suburban Richmond"	40
Jan. 27, 1971	Fort Lee Officer's Wives Club, Fort Lee, Va.	"Drug USE and Abuse"	125
Jan. 28, 1971	Albert Hill School	"The Problems of Drug Experimentation"	150
Jan. 29, 1971	Department of Vocational Rehabilitation	"Whys and Wherefores of Drug Abuse"	200
Feb. 2, 1971	Women of St. James Church	"Drug Scene—1971"	100
Feb. 3, 1971	Midlothian High School	"Physiological and Psychological Aspects of Drug Abuse".	1,200
Feb. 8, 1971	Pearsons Corner PTA	"Why Drugs and What to Do"	175
Feb. 9, 1971	Graves Elementary	"The Problems of Drugs in School"	200
Feb. 10, 1971	Brighton Green Com. Association	"Students Responsibility in Drug Education"	200
Feb. 11, 1971	Armstrong High School	"Why Use Drugs at All?"	1,000
Feb. 15, 1971	Mayberry PTA	"PTA and Drugs"	500

ADOLESCENT CLINIC, MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Con.

DR. GEORGE M. BRIGHT AND DR. TED R. ABERNATHY, JAN. 1-SEPT. 30, 1971—Continued

Date	Group	Title of speech	Number attending
Feb. 16, 1971	Virginia State Police	"Effects of Narcotics and Dangerous Drugs on the Body"	45
Do	Blue Cross/Blue Shield Nurses and Staff	"Occupational Hazards of Drug Abuse"	50
Do	Bellwood Elementary	"Drugs in the Elementary School"	275
Feb. 17, 1971	Wednesday Women's Club, Danville, Va.	"Challenge of Drug Education"	250
Do	Averette College, Danville	"Role of College Administration in Drug Abuse"	50
Feb. 18, 1971	Chester Methodist Church	"Parents Role in Drug Abuse"	125
Do	Fairfield Court PTA	"Teachers Role in Drug Education"	100
Feb. 23, 1971	Douglas Freeman High School	"Drugs in the Local High School"	300
March 1, 1971	Roanoke Medical Society	"Physician's Role in Drug Abuse"	150
March 2, 1971	Collegiate School	"Drug Abuse—Why?"	300
March 3, 1971	Staunton PTA	"Recognition and Rehabilitation"	250
March 9, 1971	Women of the Church, Grace Covenant Church	"The Church's Role in Combating Drug Abuse"	75
Mar. 10, 1971 Mar. 11, 1971	Tactical Air Command Personnel—USAF	"Uses and Abuses of Drugs"	250
Do	Junior League of Hampton Roads	"Why We Need Your Help with Drug Abuse"	300
Mar. 18, 1971	Middlesex-Essex High School	"Drug Rehabilitation"	300
Do	TV Tape—Channel 23	"Adolescent Clinic"	
Mar. 23, 1971	Thirteen Acres School	"Emotional and Discipline Problems"	60
Do	St. Paul Catholic School PTA	"Let's Talk about Drug Abuse in Your School".	50
Mar. 25, 1971	Rotary Club, Waynesboro, Va.	"Drug Abuse 1971"	90
Do	Waynesboro High School	"The Whole Truth"	600
Do	Waynesboro Town Meeting	"Parents Role in Controlling Drug Abuse"	250
Mar. 29, 1971	TV—Channel 8	"Drug Problems and Parental Direction"	
Mar. 30, 1971	St. John's Vianney Seminary College Campus Priests.	"Priests Role in Drug Abuse on the College Campus.	25
Apr. 2, 1971	Western Branch High School, Chesapeake, Va.	"Truth About Drugs"	900
Do	Oscar Smith High School, Chesapeake, Va.	"Student and Drugs"	600
Apr. 5, 1971	VCU Police	"Drug Problems at VCU"	30
Apr. 7, 1971	Sandston Women's Club	"Why's of Drug Abuse"	125
Apr. 8, 1971	Nurses and Sanitarians, State Department of Welfare and Institutions.	"Drug Abuse—An Overview"	125
Do	Tidewater Mental Health Association	"Drug Abuse—Everybody's Fight"	120
Apr. 14, 1971	Elementary School Task Force, San Antonio, Tex.	"Drug Abuse—A Community and School Call to Action."	50
Apr. 15, 1971	Junior High School Task Force, San Antonio, Tex.	"Drug Abuse in the Schools"	75
Apr. 16, 1971	Senior High School Task Force, San Antonio, Tex.	"Drug Education"	75
Apr. 20, 1971	National Republican Governor's Conference, Williamsburg, Va.	"Drug Abuse 1971—The Problems of Youth Today."	50
Apr. 22, 1971	South Richmond Rotary Club	"Parents' Role in Drug Abuse"	135
Apr. 23, 1971	Pediatric Day MCV	"Drug Rehabilitation Programs"	200
May 3, 1971	Richmond Public School Nurses	"New Programs for School Nurses in Drug Abuse."	75
May 5, 1971	Blackwell Elementary School	"Drugs in your School and What Do You Do?"	400
May 11, 1971	University of Richmond	"Students and Drug Abuse"	40
May 13, 1971	Nurses and Sanitarians, State Department of Welfare and Institutions.	"Drug Abuse—A Changing Scene"	135
May 18, 1971	University of Virginia Medical School	"Methadone Program—An Approach to the Addict."	
May 19, 1971	13 Acres School	"Let's Talk About Drugs"	24
May 20, 1971	U.S. Naval Hospital, Camp Lejeune, N.C.	"Rehabilitation Programs in Virginia for Drug Abusers."	
May 25, 1971	Clark Spring School	"Problems Youth Face"	25
Do	Tidewater Academy of General Practice	"Physician's Role in Combatting Drug Abuse."	
May 27, 1971	M-74 Class MCV	"Drug Abuse—A Clinical Approach to the Problem".	120
June 8, 1971	Norfolk Police Academy	"Rehabilitation Program for Youthful Drug Offenders".	150
June 14, 1971 July 1, 1971	Department of Education VCU Course	"Adolescent Medical and Social Problems"	
June 14, 1971		"Introduction to Adolescent Medicine and Social Problems".	
June 15, 1971		"Film Presentation-Day in Death of Donny B".	
June 16, 1971		"Adolescent Patient"	
June 17, 1971		"Hotline-Crisis Intervention"	
June 18, 1971		"Rap Center"	
June 21, 1971		"Fan Free Clinic"	
June 22, 1971		"Learning Disabilities"	
June 23, 1971		"YES and FISH"	
June 24, 1971		"Adolescent Social Worker"	
June 25, 1971		"Rubicon"	
June 28, 1971		"Governor's Council on Drug Abuse"	

ADOLESCENT CLINIC, MEDICAL COLLEGE OF VIRGINIA—SPEECHES ON DRUG ABUSE AND DRUG EDUCATION—Con.

DR. GEORGE M. BRIGHT AND DR. TED R. ABERNATHY, JAN. 1-SEPT. 30, 1971—Continued

Date	Group	Title of speech	Number attending
June 29, 1971		"Council on Drug Abuse Control"	
July 9, 1971	Medical Society of Bristol, Tenn	"Drug Abuse"	100
Do	WRNL Radio	"What is Rehabilitation"	
July 12, 1971	Temple Bethel	"Adolescent Crime and Drug Abuse Program".	275
Do	Downtown Civitan Club	"Drug Abuse-The Civic Clubs' Responsibility".	30
July 15, 1971	Soroptomist Club	"Drug Abuse Programs in Richmond"	30
Aug. 18, 1971	Quantico Dependents School System	"Medical and Psychological Aspects of Drug Abuse."	30
Aug. 19, 1971	Virginia State Police	"Drugs and Narcotic Effects on the Human Body."	50
Aug. 31, 1971	National Council of Juvenile Court Judges, Charlottesville, Va.	"A Rehabilitation Program for Adolescents"	35
Sept. 7, 1971	Residents/Housestaff Workshop Medical College of Virginia.	"Physical Problems—Drugs"	75
Sept. 10, 1971	University of Richmond	"College Student and Drug Abuse"	35
Sept. 14, 1971	Nurses and Sanitarians, State Department of Welfare and Institutions.	"Drug Abuse—1971"	100
Sept. 17, 1971	Willow Lawn Retail Merchants Association—	"Drug Fair—Your Role in Helping"	1,000
Sept. 18, 1971	"Drug Fair."		
Sept. 25, 1971	Norfolk Catholic High School	"Drug Symposium"	
Sept. 29, 1971	St. Christopher's School	"Parent's Role in Preventing Drug Abuse"	200

Mr. ROGERS. Thank you very much, Doctor, for an excellent statement.

Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman. Dr. Bright, I appreciate very much your taking the time to give us the benefit of your experience. Because you delivered it to me some time ago, I have seen this book, and I think it most informative. I would like to ask a couple of questions which come to mind, and in listening to your remarks this morning. One is about the adolescents clinic, about which you spoke. I assume admittance to this clinic is on a voluntary basis?

Dr. BRIGHT. Yes.

Mr. SATTERFIELD. I think you said that 51 percent of those that come to the clinic have a drug problem?

Dr. BRIGHT. Yes, sir; or are drugs related.

Mr. SATTERFIELD. Do you know what percentage of them have a problem related to heroin?

Dr. BRIGHT. We have gone through the charts recently of 497 young people. Of this total number, 135 have been on the methadone program.

Mr. SATTERFIELD. Are all of the heroin addicts who come to the clinic placed on methadone?

Dr. BRIGHT. No, sir; they are not.

They are carefully screened by the social workers, the nurses, and the prime physician, occupational therapist, to determine what program is most suited for them. Unless they have a history of relatively long addiction, 6 months or perhaps even greater, then a detoxification program would be more appropriate for them to see if they can manage this aspect of the medical problem, but working at the same time with the other problems that certainly will come out in the personality social area.

We refer them to psychiatry, to a detoxification program which is

part of it, to the Rubicon or therapeutic community. We work very closely with these other modalities in determining what is the best approach for these particular patients, but each patient's case is considered on an individual basis.

Mr. SATTERFIELD. The detoxification program, does this involve hospitalization?

Dr. BRIGHT. No, sir. In very few instances do we find that young people need to be hospitalized for detoxification. We establish the estimated dose of the heroin that they are using. We see them every day. Their methadone is given to them daily.

Mr. SATTERFIELD. You are talking about methadone medication?

Dr. BRIGHT. This is detoxification.

Mr. SATTERFIELD. Without methadone?

Dr. BRIGHT. Without methadone, if they are addicited, they are going to be sick.

Mr. SATTERFIELD. Then all of them who are addicited will go on some form of methadone withdrawal, I take it?

Dr. BRIGHT. Yes, sir; if they require this.

Mr. SATTERFIELD. I am interested in the methadone withdrawal technique. We had some testimony in New Orleans and several other places about the difficulties some people have in attempting to withdraw from methadone. I wonder if your clinic has noticed anything unique about it? Is this a problem, or do you find you can readily withdraw someone from methadone addiction without any undue complications?

Dr. BRIGHT. There are two prorams that we use, one detoxification, and the other long-term maintenance.

In a detoxification program, a young person can be detoxified in a week to 10 days with no significant withdrawal symptoms. However, many of these young people may continue to have mild withdrawal symptoms up to and including 6 months after they have been withdrawn from methadone.

In maintenance program, we have found that a low dosage of methadone will indeed block the effects of withdrawal; but as we increase the dose, this does indeed block their hunger, and it allows them to function normally.

When we have determined that this person's personality traits, life style, educational level, social problems are more stabilized, we then discuss with them the gradual detoxification or decrease in the dose of methadone to where they are drug free. The followup aspects of the program is as important as instituting the program.

We have found that some of them have mild insomnia, that some have mild complications such as constipation, which are readily treated with medication while they are on methadone. We have found few difficulties in withdrawal.

Mr. SATTERFIELD. One of the things that has disturbed this committee with methadone programs is whether or not people are even completely cured.

I think one of the things which has disturbed us as much as anything else is the obvious lack of followup. I wonder if you perhaps have any observations which would throw light on this particular point?

Dr. BRIGHT. We are in the process now of compiling all of our statistics after a year with a Federal grant, and we will have this

information for the Governor's Council, and for your committee, as you so choose, by the first of the year.

We feel that there are going to be recurring problems with people who are involved with heroin, perhaps from the personality standpoint, but also, perhaps from the metabolic standpoint, and I do not think we have all of the research and information that we need.

It is our recommendation that all of the programs, methadone, nonmethadone, therapeutic communities, psychiatric programs, compile statistics, put it into a computer that will tell the country what is a better approach to this problem.

Mr. SATTERFIELD. Do you think there is a need for a program along this line, perhaps promoted by the Federal Government, to help assess and collect this information all over the country?

Dr. BRIGHT. Yes, sir; I do. Yes, sir.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

Dr. Bright, somewhere in your testimony, I think you said if you carried on this program, you would hope to stop the use of heroin and drugs by adolescents.

What so far, in your operation of your adolescent clinic and your drug program, has given you any belief that this will happen?

Dr. BRIGHT. My information comes from the young people that we have seen in the schools, the students who are involved with drugs becoming patients.

I can give you an example of what young people can do for themselves.

In a West End school last year, one of our patients who was involved with drugs was aware that heroin was being introduced to this school.

He and his peers were very concerned about this. They came to the clinic seeking significant information concerning heroin.

This was given to them. These young people began to put pressures on their peers who were involved with heroin in the school.

There was no heroin in that school for the remainder of the year to his knowledge or to my knowledge.

We find that young people involved with the methadone program, or with the therapeutic community program, who have been addicts, the bright verbal individual, and we have seen a great many of these, of the high school graduate to college student can be very effective in an educational process and program, by discussing the relevant issues of drug abuse, giving these young people the real tools with which to talk about drugs among themselves.

When young people have a hotline, when they can go to a free clinic, perhaps not necessarily in an established institution, and get good professional help; this reinforces their feelings that there are people who are concerned for them as individuals and will give them factual information to help make rational decisions when confronted with the opportunity to use drugs.

They in turn by the filtering process will go back to the community and do something about the drug problem, we feel, from the hard drug standpoint.

Mr. KYROS. Becoming more specific, although I certainly commend you for what seems to be an outstanding approach to this problem, you say in this written statement of a thousand families that have utilized your clinic over the period of one and a half years, 119 young people under the age of 21 have come to us as heroin addicts.

Do you have any statistics to indicate that this percentage of a thousand is decreasing?

Dr. BRIGHT. These statistics were recently compiled within the week, and I would not be able to give you a specific answer to your question at this time.

Mr. KYROS. I know that we have a lot of witnesses this morning and many questions, but there is one more question I want to ask you.

Together with the chairman, with your Congressman, Dave Satterfield, we went out to Vietnam, Thailand, and all of the other areas we have talked about with regard to heroin, and one of the things we saw in the military, and they deal with the young men 18, 19, or so, they saw in using heroin in Vietnam, where they smoke it, where they did not inject it into their bloodstream, where they want to take the men off heroin, frequently they did do it as you called it, cold turkey, and they had cramps, and a couple of nights of no sleep, and some young Army doctors, not people inhumane or anything, thought the experience of getting off that was was better than to give somebody some drug.

They had the drugs they could give them to make them feel better when they get off, but they said the experience was worthwhile for them to remember that you should be able to shift back and forth, like some of the young soldiers were doing.

They would get off what they call skag, when they smoked heroin, and then they would go through maintenance and then come back and be maybe at a lesser level of smoking it, not maybe five bags a day, but maybe two.

What I am concerned, and I would like to ask you, are we getting into the kind of society through the use of methadone, somebody can go through heroin, do whatever he wants to, and then we can just lightly let him off through methadone and maintain him on that drug.

Dr. BRIGHT. No, I do not believe we are getting into that type of society.

I do believe as far as I am concerned as a physician, and the patients that we have seen, almost all of them, I would say 95 percent, have experienced an abstinence syndrome somewhere in the course of their addiction.

They are very familiar with the watery eyes, runny nose, abdominal pain and cramps, therefore, it is my contention we do have a medication that will allow us to work with them as a tool, that will allow us to set a limit for this young person, in order that we may begin to work with the other problems that exist in association with this drug.

If we can do that, and utilize the other services, I do not feel a person should necessarily go through an abstinence syndrome, which is a medical illness.

I do not agree with that.

Mr. KYROS. Thank you very much, Dr. Bright. I certaintly want to add my congratulations to what I think is an outstanding adolescent clinic, and the idea of having an inpatient, outpatient facilities

for youngsters is something I think we ought to have throughout the United States.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

Dr. Bright, I, too, want to commend you on your program and multidisciplined aspects of it.

The educational aspects of it also seem to me particularly impressive where you are trying to get the young people to turn themselves off.

We have heard testimony that heroin addiction is becoming an epidemic.

It is a word that we often hear, that the heroin addict infects 20 other people, so you get this progressive widening.

Do you feel with your programs here, and with your adolescent clinic, that your community has been able to get the epidemic under control, and that you are gaining ground on it rather than losing ground?

Dr. BRIGHT. I have no statistics to give you on that particular question.

It is my feeling, however, with this particular community's commitment, from many standpoints, that we will and are beginning to see an awareness of the young people of the true problems associated with this drug.

Perhaps as we have seen with some of the hallucinogens in the older-age group, I do not think we have seen this in the younger-adolescent-age group, where they are less discriminating in any involvement they would choose to be in.

I do feel now that we have a more aware older-age group, the younger-age group may become involved in experimentation, and I am very concerned about this.

Mr. PREYER. You speak in terms of age groups, of the people in your clinic.

Is there any breakdown by economic levels? Are these middle-class young people, lower-class ghetto-area people, or a cross section of the entire population?

Dr. BRIGHT. The 496 or 497 patients whose charts were reviewed are all from middle class, or lower socioeconomic groups.

When we first started the program, we found that most of the young people that were coming were from middle-class white families, but now we find them pretty much an equal distribution.

Of the 135, for instance, just as far as breakdown by race, 67 have been black, of that 55 male, 12 female, of the whites, 51 male and 19 female.

This gives no socioeconomic breakdown. This is just by race.

Mr. PREYER. We will certainly study your programs here with interest.

You mentioned a narcotic blockade, were you referring to the blocking-agent drugs, or have you used those at all?

Dr. BRIGHT. Only methadone has a way of blocking the hunger, and for instance, if a young person is at a blocking dose, he will continue.

We have interest in using those other drugs, and perhaps we will pursue that in the next year.

Mr. PREYER. Thank you very much, Dr. Bright, and I congratulate you on your program.

Mr. ROGERS. Mr. Symington.

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

Dr. Bright, you mentioned giving young people drug education that they take back to their schools. That is one of the criticisms leveled on certain forms of drug education.

Is it clear in your own mind that you could devise a form of drug education that would be safe and salutary in every respect as distinct from possibly inviting the very thing it was intended to prevent?

Dr. BRIGHT. That is a difficult question, Mr. Symington, but when we first started with what we felt was drug education, I think we did perhaps encourage the use of drugs by discussing the physiological and pharmacological effects of the drugs and that only.

This in a sense gave these young people a pretty good store of knowledge as to what drugs were safe and not safe, what were the side effects.

We now feel the young people have been bombarded with this information through the media, television, newspapers, magazines, and perhaps the curriculum that has been developed in the schools.

It is our feeling when we go for a drug-education program, it is more a discussion of the issues, interpersonal relations, social problems that do exist, what can this young person do to resolve some of the problems that have caused him to become involved with the subculture, where can he be referred, what agencies are available to this young person.

It is more of a rap session of the relevant issues, and to me this is part of the educational process.

I think another part of the educational program that is very important is in the schools, but I do not think it should be presented as a unit, a unit on heroin this week, or a unit on marihuana next week.

I think it can be brought into the curriculum in vocabulary, what is a kilo of marihuana, or what are some of the sociological implications or phychological problems, in classes of history and science, with a variety of drugs.

Young people will pick up with this, rather than; we have memorized the side effects of marihuana today.

To me this is relevant education.

Mr. SYMINGTON. In the meantime do you feel the laws regarding marihuana should be changed?

Dr. BRIGHT. I think the laws regarding marihuana are being changed and have been in many cases from a felony to a misdemeanor.

I feel that we do not have enough indepth information to make any decision in regard to legalization of this drug.

I feel we have enough problems to deal with without arguing over the legalization of the drug that we do not know that much about yet.

My major concern is what the development, the body image, and the self-image of an adolescent, and I do not mean to get off on this, but I would like to make a point.

In discussing legalization of marihuana with young people, I think you could use as an example maybe the adolescent who enjoys a nip of beer or Jack Daniels.

Now, how many adolescents are going to take Jack Daniels to class and drink between classes. It is a dose-related response on the effects of the alcohol.

If marihuana were available, and it is in many cases, and it does affect your performance, how many will take an opportunity to take two or three joints during class, and what does this do to their performance, and what does this do to their intellectual abilities over a period of time?

This is of major concern to me. Adolescents are going to experiment, they want to experiment, and they must, but if they become involved with drugs, then this blocks their development, and this is of major concern to me as a physican.

Mr. SYMINGTON. The figure of 135 adolescent heroin addicts that you give here, what percentage of the total potential visitors to your clinic do you think this represents?

Dr. BRIGHT. About a fifth.

Mr. SYMINGTON. About a fifth?

Dr. BRIGHT. Yes.

Mr. SYMINGTON. Have any veterans been included in these groups?

Dr. BRIGHT. Yes, sir.

Mr. SYMINGTON. The subcommittee determined, I believe, in its trip to Southeast Asia, that it was not so much fear as boredom that resulted in the addiction of the serviceman overseas.

How would you compare that form of motivation toward drug addiction to what you are discerning in the high schools. High school students become involved, and college students, is this also out of boredom, or is there another variance?

Dr. BRIGHT. Boredom is a major factor in the young people that we have seen in giving talks to schools throughout the State and country.

They simply are not stimulated.

There may be a variety of things, but boredom is a factor that we have seen is predominating.

Mr. SYMINGTON. I think your answers have been as excellent as your opening statement.

It raises many questions. We have other witnesses. I do not want to take further time with this witness, Mr. Chairman, but I do want to thank him for his excellent observations and statement to the subcommittee.

Mr. ROGERS. Dr. Bright, let me ask you this.

How many of your patients do you have on methadone maintenance?

Dr. BRIGHT. Methadone maintenance now, as of today, we have 48.

Mr. ROGERS. Forty-eight?

Dr. BRIGHT. Yes.

Mr. ROGERS. What period of time would you say that these people were on heroin to indicate that they should have a maintenance program?

Dr. BRIGHT. Most of them, 6 months, up to a year.

Mr. ROGERS. And they are being put on a maintenance program.

How long would they be on a maintenance program?

Dr. BRIGHT. Three to 6 months, perhaps even up to a year, depending on how long it took us to work with the total individual.

Mr. ROGERS. You do not think they can go through the withdrawal of cold turkey?

Dr. BRIGHT. Without methadone?

Mr. ROGERS. Yes.

Dr. BRIGHT. I think they can, yes, sir, and I think if they have a very structured environment such as a therapeutic community that can provide a great deal more for them on an inpatient basis, that this can be done, yes.

Mr. ROGERS. Is that preferable, do you think?

Dr. BRIGHT. I think it depends on this person, and what this person's needs are.

I think there are many approaches to this problem. I do not say that this is the only solution.

Mr. ROGERS. I am somewhat concerned about the overuse of methadone in the Nation.

I think we are at the point now where this is being sold as the answer, and I do not think it is, and I think most authorities in the field would agree with that.

Dr. BRIGHT. I agree.

Mr. ROGERS. And I think we are moving into an area of a great deal of maintenance, particularly in short addiction, rather than long-term addiction, and this is one of our concerns, and we are going to have to look into this in some detail to see what can de done about this.

Now, let me ask you this too.

What is your funding, are you sufficiently funded, have you got enough money to run your programs?

Dr. BRIGHT. No, sir, we are not sufficiently funded.

Mr. ROGERS. Where do you get your funds?

Dr. BRIGHT. The funds to develop this clinic initially came half from the institution and half donations from the community.

Mr. ROGERS. So it is a community-donated project?

Dr. BRIGHT. That is the way the clinic was begun.

It is now funded by the Division of Crime and Justice and title I, for education and for the development of the staff and the inpatient section.

We could use more Federal money. I do not anticipate any problem with the community support in matching for Federal grants.

Mr. ROGERS. You feel you have sufficient community support to match whatever grant you get?

Dr. BRIGHT. Yes.

Mr. ROGERS. Have you put in any applications for additional funds?

Dr. BRIGHT. Yes, sir. They are pending.

Mr. ROGERS. Are you planning to expand your activity?

Dr. BRIGHT. We would like to, yes, sir.

Mr. ROGERS. Do you find any difficulty with getting people to come to you, or should you have some store-front operation?

Dr. BRIGHT. No, sir, we have no trouble with young people or their families coming for care.

We do not have enough staff to provide the continuity that we would like to provide for these young people.

Mr. ROGERS. Is it open 24 hours?

Dr. BRIGHT. No, sir, it is open just during the day, but the department of pediatrics does provide emergency care during the evening.

Mr. ROGERS. Is it open on weekends?

Dr. BRIGHT. No, sir. This is also taken care of through the emergency room in the department of pediatrics, if necessary.

Mr. ROGERS. Do you have any connections with any community mental health centers, or are there any centers here in Richmond?

I presume there are.

Dr. BRIGHT. We work very closely with all of the agencies in the city.

Mr. ROGERS. I was thinking specifically of community mental health centers.

Dr. BRIGHT. We work primarily with the Mental Health Association and the Department of Psychiatry within MCV.

We work very closely with the other guidance clinics that are available throughout the city.

Mr. ROGERS. Now, the President has proposed that we give authority to his Special Action Office for Drug Abuse. He has already selected Dr. Jerome Jaffe to head this office, although we have not yet passed the legislation.

Do you feel that he should have the right of changing funding from agency to agency, would this be a reasonable approach, or it has been proposed, I am not sure whether you have had a chance to look at the legislation, it has been proposed he would have the right to take funds from the mental health agency, for instance, NIMH, and perhaps change it over to OEO, or vice versa, do you think this should be done?

Dr. BRIGHT. I do not know whether I am qualified to answer that.

Mr. ROGERS. All right. I will not pursue that.

What is the youngest person that you treated in your clinic for heroin addiction?

Dr. BRIGHT. Fourteen.

Mr. ROGERS. I noticed in the paper today, this morning, they think a young child of 7 in Washington has been on heroin today, but 14 is the youngest.

How long had that young person been on heroin?

Dr. BRIGHT. About 6 months.

Mr. ROGERS. Do you have any therapeutic communities here?

Dr. BRIGHT. Yes, sir. One of the speakers this morning is the Director of the Therapeutic Community.

Mr. ROGERS. All right. I will not pursue that at this time.

Now, on the people you simply have detoxification for, I presume you have to look at each case, but is there a general rule of using methadone, you say about 6 months?

Dr. BRIGHT. No, sir; there is no general rule.

We would try to determine, based on this person's complete evaluation, medical, social, educational, job possibilities, how long we would need to maintain this young person on a methadone program.

Mr. ROGERS. Now, you give a urinalysis once a week?

Dr. BRIGHT. Yes, sir.

Mr. ROGERS. What does that cover, a 72-hour period or 48?

Dr. BRIGHT. Well, this would cover, depending on the drug, because some drugs would appear in the urine up to 5 days.

Generally we are concerned with the appearance of quinine, methadone, morphine products, such as heroin.

This is done on a random sampling basis. The patient has no idea when we will do this.

They are observed collecting the specimen, and as you well know, there are or have been problems in this area.

Mr. ROGERS. What about the giving of methadone, is it supervised?

Dr. BRIGHT. Yes, sir, by a pharmacist.

Mr. ROGERS. Who actually watches the person take it?

Dr. BRIGHT. Yes, sir.

The director of the methadone pharmacy will speak with you on that this morning.

Mr. ROGERS. Doctor, thank you very much. Your testimony has been most helpful.

Our next witness is Dr. James Mathis, professor of psychiatry.

Dr. Mathis, the committee welcomes you, and we will be pleased to receive your testimony.

STATEMENT OF DR. JAMES MATHIS, PROFESSOR OF PSYCHIATRY, MEDICAL COLLEGE OF VIRGINIA, RICHMOND, VA.

Dr. MATHIS. Thank you, Mr. Rogers, members of the subcommittee.

I would like to confine my remarks to something a little more etherial, and to the etiological aspects, since Dr. Bright and Mr. Harrison will cover the treatment, as we are doing it here in Virginia quite well.

The etiology, although I think very, very abstract, must be a major concern else we are sort of like the Dutch boy holding his finger to the dike.

Throughout history men have found it necessary to escape for some reason or other, and we have had activities like vacations, social drinking, and so forth, and every now and then a certain number of men have found it necessary to escape rather permanently, but this remained a fairly insignificant percentage of the whole.

However, after World War II this insignificant percentage of adults began to explode into a very major percentage of young people.

We had to think that something had changed, something sociological had arrived here.

As this grew more and more alarming, we began to look at what modalities had changed, what sort of living situations had made a major imprint upon young people.

I would like to talk about one of them, television. Dr. Sam Hyakawa, of whom we have all heard of from California, said some years ago after some research that the 16-year-old, and I think this was 3 years ago, had spent roughly 20 to 22 percent of his waking hours by that age in front of the television set.

Now a more recent study by a psychologist in the Northeast, whose name right now slips me, shows that by the time a child enters school he has spent 64 percent of his waking hours in front of a television set.

This means by far and away the greatest single molding influence upon a central nervous system by age 5 or 6 is the television set.

Now, why do we think in behavioral science of this as such a major significance?

We have been learning more and more about the fact that there is such a thing called imprinting. The work of Konrad Lorenz and others have shown that certain basic ways of facing life, certain basic identification, occur within the first few years, and that these are relatively inflexible and at least in the lower animals, and we think in the human being, may remain indelible.

The central nervous system finishes 90 percent of its growth by the age of 5. At no other time in life will it possess this extreme plasticity and receptivity. The fundamental methods by which an individual faces all of his adult life then are laid down, as far as we can deter-

mine now, fairly well by the time he begins grade school. These can be modified; they can be changed, but basically they are fairly well determined.

Now, if in fact the child is spending 64 percent of this very significant part of his life before the television set, just what is being imprinted upon him? He is learning that he has a whole world of fantasy at his pleasure, and in effect, he has an Aladdin's lamp. He rubs it, he turns it on, as it were, and later on in his adolescence he still uses this phrase "turn on" quite significantly. He tunes in and out, again in adolescence, he still uses the phrase "tune in," "tune out," and in effect he has learned that he can control pleasure without any output of energy on his own. He not only can control it, but he learns it can be there instantaneously.

Many others that have worked with youngsters, especially at colleges, have been impressed with the fact they seem to have a confusion about time. They want instant things done that would require months and years, but they do not seem to conceptualize this, so the thought comes, how does one learn this? How does one learn that things can, in fact, occur with these very fuzzy boundaries of motivation and time?

The television world is one of here and now. Time is, as you can well perceive, quite flexible. This very young child is not concerned about the content of the programs per se. As you know, a 4-year-old child can tell you very little of the program he has just seen, but if you have children, you know he can tell you quite well what the commercials were. As a matter of fact, he can usually repeat them verbatim by the time he is 4 or 5, because they are tuned to his attention span, and they are also intellectually tuned by and large to children. The television industry does not have to listen to that. He is not learning the content, but he is learning a way to face life.

Now, when he becomes a bit older, when he passes the early years of school, he learns some other things from television. But now he learns content: he is listening to the concept, and to the content.

He learns how one controls the environment and how one faces discomfort.

It would take only 2 hours of watching television to know that we have a society which is totally devoted to the aspect of avoiding anxiety and seeking comfort. There are things to go to sleep on, there are things to wake up on, there are things to control one's anxiety, and with which to become composed. Just listening to the ad always composes me to a state of tranquility, and if you have taken too many of these pills, there are good pills that alleviate the stomach discomfort that the others cause.

Now, all of this programing of a readily available means of escape, one must conceptualize as coming in upon a central nervous system that has already learned that this box has the answer, and I think that this is what makes it significant.

No one agrees that this is the total answer; no one. It is just a fraction of it. However, it seems to many others in behavioral science to be such a basic factor that all other things must be discussed or talked about in relationship to this.

There is something else that the elevision has done for us, or, if you will, to us. It has become the built-in babysitter. It is the limit

setter of the preschool child. Now, most of us, of course, have been pleased to be able to park the youngster before the television set, but as he grows older, limits still are not being set by our society. There are many others who have thought that much of the permissiveness and of the adulation of youth has gone hand in hand with this wonderful, or at least this potentially wonderful, modality.

We have known for years from people like Bruno Bettelheim and Fritz Redl, what occurs as a child gets older when he has no limits set upon him, lives in a structureless world, so to speak. He becomes anxious.

When an adult gets anxious, he may just get nervous, or he may develop a neurotic symptom, or he may do one of many things. The child and the adolescent almost invariably acts out when anxious. Now, he is already programed in his brain to act out in a specific manner—one which adults find unacceptable—with drugs.

The drugs furnish two beautiful things. No. 1, they are wonderful antianxiety mechanisms.

No. 2, they create furor in the adult world, and this, as you know, is quite gratifying to the adolescent who becomes not only the center of attention, but controls this world by what he wishes to take into his mouth.

I think any programs of etiology and prevention must consider these two basic factors, again emphasizing the hundreds of others which one can think of, and which perhaps are of equal importance.

One concept that says the central nervous system is imprinted, as it were, with this need for instant gratification and the ways in which it can be obtained, and the other in essence says that the adult world abdicated from the responsibility of setting limits upon its children.

The adolescent who is taking drugs is demonstrating very loudly and quite effectively his own inability to set limits, and he is asking in the only way he knows for external controls. He is a prime example of that old adage that action speaks louder than words. Regardless of what he says, his action says, "Please control me, because I have demonstrated I cannot do it myself."

Psychiatry feels very strongly that the problem of drug abuse is not only a psychiatric problem, nor is it primarily a sociological problem. It is a conglomerate, and, as Doctor Bright said, a thing that requires a multidisciplinary approach if it is to have an answer.

The two factors which I have discussed very briefly, I feel, are of major significance; and although they have very little input for a treatment program such as may be of interest to you here, they are things which you must consider in the background of your thinking.

Mr. ROGERS. Thank you very much, Dr. Mathis.

Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

Dr. Mathis, I appreciate those remarks. I think they are most interesting.

You may know, perhaps, the committee on which we all serve does have jurisdiction in the area of communications, radio, and television; and in the light of the remarks you have just made, looking at this thing the way we must look at it, I wonder whether or not you might suggest some answers which we could consider in terms of legislative action.

Dr. MATHIS. Unfortunately, my theories fall down when it comes to answers, Mr. Congressman, except that I am strongly convinced that a major part of the money spent on this should be on research toward this answer.

This is the only thing that concerns me greatly. I seem to see vast sums of money going, as I said, to the finger in the dike, but I do not see a great deal being done about the force of the water behind the dike, the actual working power behind the dike.

I liken it to the fact, as you will recall, that back in 1953, we did wonderful work in polio. Many of us young doctors spent night after night with respirators, but contrast that with the Salk vaccine, the beauty of not having to deal with these treatment programs. That is what I would like to see in drug work, some real work toward what is going on behind the scenes.

Mr. SATTERFIELD. Just one other brief question, to go back to television, it does interest me.

I realize there is a broad problem here. You mentioned the appealing aspect of advertising to the young mind because it is geared to this attention span, and more or less projected to their level of mentality.

Would you suggest, perhaps, as a result of this observation, that some type of short timespan program, not advertising, could be used to impart into these young minds an awareness of the dangers of the drugs, might be worth considering? Do you think it would help?

Dr. MATHIS. I have doubts about it, Congressman, because the youngster has a peculiar psychological aspect that has been called omnipotentiality; that is, the old thing called thee but not me.

It is the thing that prompted a general during the Korean war to say, "If you want to fight an offensive war, you want 18-year-olds, because they have not got enough sense to know that they can be hurt."

What he was saying is that they have got this feeling of omnipotentiality. They really are convinced it will not happen to them.

Scare tactics, or even education of children about the realistic dangers, not scaring them, but just the realistic dangers, seems to have very little effect because of this wonderful ability they have to say, "Well, isn't it too bad that this will happen to Johnny."

Mr. SATTERFIELD. What disturbs me about that is the fact that we have felt one of the best ways to combat drug abuse is through education. Obviously, a great deal of this kind of education must be imparted to the young mind before it is 6 years of age. If I interpret what you say correctly, there is some doubt about whether or not an education program directed to that aged child would be productive.

Dr. MATHIS. That is right, Congressman. If the education is devoted strictly to the drug problem.

Now, if you did just the opposite; if you tried to do some experimental work on how you could program this child before 6, how you could educate him to know that there is no instant gratification, dismissing drugs entirely; would it be possible to program him into thinking that when you want pleasure in this world, you have got to work for it to a certain degree?

When you want something good to happen, there is no Alladin's lamp, but that this is only a nice fairy story. This might be the education that would work, I think that if we could imprint upon him a sense of responsibility, a sense of the need to do things for one's self, a sense

of not expecting instant answers to severe problems, then we would be approaching the educational aspect that might work.

Mr. SATTERFIELD. Thank you very much. I think your remarks have been both enlightening and helpful to us.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

Your remarks have also been very disheartening, too, because if I understand what you are saying, something like B. F. Skinner has just said, you want us to have some kind of belief that the whole system of the kids that we are bringing up, and now the programing by television, and the kind of technology that we have, we now have some pleasure, pain, input cycle so that they are twisted around. Is that what you are saying?

Dr. MATHIS. No. I am saying this is the sort of thing being done.

Mr. KYROS. If indeed the kids are programed by the time they go to grade school, what chance do you and I have working here today or the next day to stop them from using drugs or anything else?

Dr. MATHIS. Congressman, I have asked that question myself many times, and it is disturbing to me. I hope I am wrong; I hope that those of us who feel this way are all wrong, because otherwise it is discouraging. However, we do feel it is modifiable. I do not say this is totally indelible. It can be modified. I think what we are saying is that simultaneous with our efforts to modify, we must be giving consideration to the cause.

If we do this, it takes us away from the punitive attitude toward the child. We are not so apt to look at the 12- and 15-year-old today and say, "You are a bad person."

We are apt to understand, "Well, maybe you are not totally responsible, maybe we have programed you in some way so that we need to look upon you as someone who needs limit setting, but not as a bad person willfully doing this to yourself."

Mr. KYROS. What is most shocking to me is to hear the way your testimony comes out; it is frightening, because it seems to me there is some truth in it, but it is devoid of morality, and just behaviorist viewpoint, like Skinner's that the kids will come out like automatons, and that we have no chance whatsoever no matter what we do from now on to try to set up blocking agents and methadone and other pain principles for them, so that they just have to avoid certain things.

The whole country then would be void of any moral sense, there really is not any purpose to the whole thing, it is just the mechanics, is that what you are saying?

Dr. MATHIS. Not at all. I am sorry you have misunderstood me, or that I have misstated it.

I thought I said that part and parcel of this was the lack of limit setting for our kids, and if you wish to translate this to standards and morals, I think you can. But this has gone hand in glove with this other thing, and youth are asking us, if you will, for the moral aspect, the limit setting, and that this is equally significant. Attention to one factor without attention to the other would be wasted.

Mr. KYROS. Last year we had hearings on the drug abuse control bill, and for 2 years we have listened to hundreds of people, but your testimony goes to the heart of the matter.

It reminds me of Dr. Dana Farnsworth from Harvard, when you say these things that you do, and if they are really as true as you say

they are, which I do not have any cause to doubt, it is frightening, because we are not going to get out of this drug problem very easily.

We will be in it for an awfully long time.

Dr. MATHIS. That is right.

Mr. KYROS. All of the prayers and wishes of all of the Congressmen, the mothers and fathers, priests and social workers in the world are not really going to help us, except as a hard task of going back and reexamining everything all over again.

Dr. MATHIS. I think that it was expressed very well by a Frenchman a long time ago, that we are raising up a group of youngsters who lack a sense of a norm, a sense of a standard, and that we must inculcate this or reinculcate it. It must be this sense of what am I supposed to do. How is it that I could act in order that I could create not only personal pleasure, but a reasonable society? This is the question.

Mr. KYROS. Of course, if you were in Moscow, and you watched that State television for a while, you could not stand it, it would be a pain to watch all of those endless speaches, even then we might consider something like that.

Dr. MATHIS. I would hate to see the cure worse than the disease though.

Mr. KYROS. Thank you very much, Doctor.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

Doctor, you put the finger on the instant gratification point as the peak of appeal of drugs, and that goes along the line with the other testimony we have heard.

We had an expert in New Orleans, a doctor at Tulane University, who had conducted a series of experiments, whereby he could show that the brain wave reactions from taking drugs were similar to the brain wave reactions you could stimulate in a monkey electrically to hit the principal pleasure centers of the brain. Apparently, this similar reaction gives you the effects of love without courtship, the illusion of achievement without having to work for it.

One of the interesting things he said was that in his brain wave studies marihuana did give this similar brain wave as the other drugs, but alcohol did not.

His implication was that alcohol did not give to the same degree at least an instant gratification like marihuana, and he used that as one reason for legalizing marihuana. He like you agrees that instant, easy gratification is the great charm of drugs. You put a heavy emphasis on that, and maybe you are right.

I wonder if there is any one thing like TV that is the cause of it.

Dr. MATHIS. No; it is a thing but not it.

Mr. PREYER. There are probably a lot of countries that do not have TV, where you run into the same problems. There are probably many countries that do have TV, like Japan, Russia, China—perhaps China does not have that problem—so I do not know how important it is.

Basically on TV, maybe our commonsense will save us. I remember—you are perhaps too young to remember, when Kate Smith was a great popular heroine.

Dr. MATHIS. Thank you, but I remember that very well.

Mr. PREYER. I remember we had a presidential election, and Kate Smith, who was the queen of the airwaves at that time, was announc-

ing she was coming out for one of the candidates. Everyone thought this would ruin our country, because anyone as popular as Kate Smith, once she came out for somebody, everyone would back that candidate. There was a great hue and cry about radio providing the means to control our elections, because a popular figure can come out for them, and it will sweep everything before them.

Well, Kate Smith came out for one of the candidates, and it made absolutely no difference at all.

I think what we always overlook is that there is a difference, and the human being is pretty good in determining that difference between what is important and what is unimportant. I hope we will say when we look at television, that this part of it is important, and this part of it is zilch, and I will reject it.

Dr. MATHIS. But, Congressman, I am afraid, you see, the 4-, 5-year-old cannot do that, when he is getting the basic imprint.

Yes, I hope maybe education could produce this in the older child, maybe this is where the savings grace will come in.

Mr. PREYER. Does the mere fact the very young person being able to turn on a pretty picture, impress his central nervous system?

Dr. MATHIS. Many of us feel this is worth looking at, even though it cannot be proven at present.

Mr. PREYER. I agree it is worth looking at, and it is a very disturbing thing if it is true.

Dr. MATHIS. I feel the same way.

Mr. PREYER. Thank you for your very interesting testimony.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. Thank you, Mr. Chairman.

I wonder if on the one hand the society not being static, and certainly today adult society finding fault, both specific and general, and sometimes somewhat mystical with television, there is not some kind of self-generated blocking agent for the evils of that medium.

Certainly, however, as you pointed out, the content of television of young people will have something to do with their search for gratification, and the degree of anxiety they experience when they are deprived of it.

Do you have any suggestions concerning content of television for youngsters, or concerning parental time limitations on TV viewing for youngsters?

Dr. MATHIS. Not specifically, Congressman.

I think that this imprinting I am talking about is something that is here to stay. It is not a thing that will change. Television will not go away, nor will the other advancements of civilization.

It is here, and it is going to be here, and what we need to think about are ways of making this modality beneficial. Could we do positive programing that could be just as effective? Immediately this raises the specter, as you pointed out, Congressman Kyros, of the Skinner brain control bit, which frightens all of us. What I think what we are saying is that this power does exist, and that we have already demonstrated, whether you are for or against it, that certain advertising has been forbidden.

I think that men like yourself, who are going to make these final decisions, have a hell of a decision to make, if you pardon the expression. I do not have any suggestions as to how this could be done.

There is a group at Harvard doing research on this right now, sir.

Mr. SYMINGTON. I think the very best could be said for what we do is a rather high level form of trial and error, with a great infusion of error, I might add. When you are dealing with ideas, and the right of people to project ideas, ideas as may suit their purpose, you are really dealing with men's minds, and to place any limitation on the exercise of the mind is a serious matter for society.

Perhaps the Western culture, and our own in particular, becomes more susceptible to the dangers of the sophisticated medium like television, whereas we know that television is certainly not responsible for what is going on in Pakistan at this moment, that there are primitive societies that are suffering in ways that we merely dream about or see on television, so while on the one hand we must acknowledge that what you say is true, many young people today have been led to believe that there are answers, quick answers to their questions.

On the other hand, let's go from that point, recognizing that this is just a generation passing through, and where there is life, there is hope, that we will not be defeated by this, we will try to think our way through it to the next generation, and actually they are coming all the time.

The very dialog we are having with you, and we are grateful to you for bringing in the thought that you have, shows that we are not unaware that there could be dangers here, and that there probably are, but I noticed a note of pessimisim in the dialog between you and Mr. Kyros, about the situation, which I think is unwarranted, because man is not defeated as long as he can think.

I don't know, not being a behaviorist, I am not prepared to accept or reject your suggestion that the 5-year-old has established his pattern of responses.

This is a big subject, and one thinks of Henley's lines, "Out of the night that covers me," et cetera, "I thank God for my unconquerable soul." I think it is unconquerable until the day I turn it over, and that to me is what keeps us going. To get back to a more specific response to your remarks, it seems to me the 18-year-old who seeks these answers is willing to listen to straight talk, and that is really what we would want to give them within the limits of our understanding, and that is what we intend to give them.

Thank you.

Mr. ROGERS. I have enjoyed your testimony, however. It is disturbing.

Let me ask you this. We do not permit prescription drugs to be advertised on TV, should we prohibit over-the-counter drug advertising on TV?

Dr. MATHIS. One man's opinion; yes, sir.

Mr. ROGERS. You feel it should be prohibited?

Dr. MATHIS. I do.

Mr. ROGERS. The Congress of course as you know is looking at this now, and in a number of instances, and I am glad to have your testimony on that.

Maybe the answer is to get a nonaddicting drug that has no side effects.

Is that your answer?

Dr. MATHIS. That has been proposed, but I feel the battle can be fought without that. I would hate to see that otherwise miraculous sounding drug on the market.

Mr. ROGERS. Well, it might answer the problem and end this whole pleasure-bent atmosphere.

Why is it, you suppose, they do not have the same problem in Japan.

Have you had an opportunity to study that?

Dr. MATHIS. I did not know they did not have it. I thought they did have.

Mr. ROGERS. I think you will find it is quite contrary to our experience.

We have been in Japan. There are some, but they have a very small number of addicts.

Maybe it is the way they handle it. I do not know.

Dr. MATHIS. I think it would probably be many factors. I really do not know, sir.

Mr. ROGERS. Well, over there they do not have quite the constitutional guarantees that we do, and they will go into a community and everyone that has been taking drugs, they just throw them into jail, and they can hold them there for up to 23 days, and they go through cold turkey, and it is not a very pleasant experience, and they say they do not have too much recidivism.

It is pretty rough, but that gets to your point that maybe we make everything so easy.

Do we make it too easy with coming in and making the withdrawal an experience that is not too unpleasant?

Dr. MATHIS. I did not intend to give the impression that I am against the withdrawal under medication.

When I talk about limit setting, I am really more concerned about parental limit setting, about the parents taking responsibility for their child's actions, and to begin by setting limits at a very early age.

Mr. ROGERS. Well, a course, I think everybody would agree that probably the parents can do more, but I do not know how we can get that in the legislation.

The most I think we can do is try to probably have educational programs that go to the problem, that are realistic, and I think it has been brought out that it does not have any credibility gap, that we will recognize as being realistic.

Perhaps we can do something with that.

They think so, some of the experts we have talked to, think this can be done.

The Army in Japan, the people we talked to, tell us their educational program seems to be having some effect, that as soon as young people are brought into the service there, they are exposed to some drug education that is pretty realistic.

You say here it is, and you make your judgment, and they say coming then into the scene in the Far East, they are having they feel a lesser number beginning to experiment with the hard drugs.

Whether this will prove out, we do not know yet, but there seems to be some indication that education is beginning to have some effect.

I think the points that you have brought out have been most helpful.

It is a problem that I think is going to be difficult to handle.

Perhaps TV is the villain that has kind of gotten us all into this matter. I think it has had a very great effect, no question about it, and we are concerned with mood drug advertising, this committee is.

Thank you very much for your very interesting testimony.

Dr. MATHIS. Thank you, sir.

Mr. ROGERS. Our next witness is Mr. Willard L. Harrison, M. Sc., director, Department of Pharmacy Services, and project director, methadone treatment program, Medical College of Virginia Hospitals; associate professor of pharmacy, School of Pharmacy, Medical College of Virginia, and Health Sciences Division, Virginia Commonwealth University.

STATEMENT OF WILLARD I. HARRISON, M. SC., DIRECTOR OF THE DEPARTMENT OF PHARMACY SERVICES AND PROJECT DIRECTOR, METHADONE TREATMENT PROGRAM, MEDICAL COLLEGE OF VIRGINIA HOSPITALS

Mr. HARRISON. Mr. Chairman and members of the Subcommittee on Health and Environment, I would like to give a brief history of the evolution of the methadone treatment program here at the Medical College of Virginia Hospitals, and try to point out some of the possibilities of the pharmacist's role in the rehabilitation of the drug dependent person, as well as his role in conducting definitive clinical research to help combat this problem.

Approximately 18 months ago representatives of the department of pharmacy services and the adolescent clinic decided that a better methodology of control was needed for the very few adolescent patients being treated with methadone.

Certain procedures were worked out with Dr. George Bright, the director of this clinic, for these patients.

Shortly thereafter we had our first contact with an adult, hard-core addict who walked into the pharmacy department seeking help.

Dr. Joseph Byrne, of the bureau of alcohol and drug studies and rehabilitation of the State health department agreed to see this patient, and he was placed on a methadone dosage schedule.

Within 3 weeks we were bombarded with nearly 200 adult patients who were seeking help.

Meetings with Drs. Bright and Byrne followed and the department of pharmacy services filed an IND (investigational new drug) application and protocol with the Food and Drug Administration to allow us to legally dispense methadone to these patients.

This application was rapidly approved and expansion of the program began.

Protocol, methodology, control procedures, and dosage forms of the drug have continually been improved over the past few months.

Several unique characteristics of our program should be mentioned prior to a more detailed discussion of the program.

To the best of my knowledge the methadone treatment program at the Medical College of Virginia is the only program in the country where the basic IND sponsor is the department of pharmacy services with the physicians acting as investigators in the protocol.

In addition, prior to this month, the program was entirely supported by fees collected from the addicts themselves.

Because of severe funding limitations, which necessitated a very small staff, our early concerns were primarily with getting the addict off the street and coming to the dispensing area on a routine basis.

Until recently our staff consisted of two pharmacists and one pharmacy technician on a full-time basis, and the physicians on a part-time basis.

This staff was supplemented by volunteer help from some medical students, nurses, pharmacists, and interested lay persons.

Initially we gave 2 or 3 days' supply of the methadone to many patients after they had come to the clinic on a daily basis for approximately 1 month.

This proved unsuccessful and by November 1970 we were forced to require that nearly every patient visit the dispensing area daily and drink the medication in the presence of a staff member.

In late 1970, Rubicon, an OEO funded therapeutic community, began operation in Richmond, and a cooperative effort between our program and theirs began to develop.

We have attempted to utilize the positive points of each program to complement the other.

Some of the new residents or clients of the therapeutic community receive methadone support and/or slow detoxification from our program, and some of the outpatients on our program participate in group counseling sessions conducted by Rubicon personnel.

This cooperation is exemplified by the shared facility which you will visit today. We hope to occupy this building within the next few days.

I would like to submit some reasons for, and advantages of, the heavy involvement of pharmacists in our program.

First, and most importantly, is a high interest level in the program of drug abuse.

Since the pharmacology of chemicals is the backbone of the pharmacists education, we are interested in the concomitant abuse of these agents.

In addition, the contemporary pharmacist is much more "patient oriented" and more aware of sociological problems.

Second, the pharmacist is usually more administratively oriented than many other members of the health care team.

Sound administration is necessary in any treatment program to insure proper evaluation of results, and the most effective use of dollars and manpower.

A third advantage of pharmacy involvement, particularly in a methadone program is the pharmacist's knowledge of methods of drug distribution and control.

Hospital pharmacists have always been required to develop and maintain close systems of control on narcotic drugs within their institutions.

Diversion of the drug is a problem in many methadone programs.

A pharmacist is best equipped and trained to avoid this pitfall.

A fourth advantage in our program has been the pharmacist's knowledge of dosage formulation.

In cooperation with a local firm we have developed a unique dosage form to be used whenever a patient will be taking doses of methadone out of the clinic.

This dosage form is a gelatinous material which must be diluted with water up to 5 ounces to reach a normal consistency for drinking.

Since it must be scraped out of the original container and does not pour, it greatly reduces the chance of pediatric toxicity which has been seen frequently in some parts of the country.

A fifth advantage is that the pharmacist, with his knowledge of drugs and their idiosyncracies has the opportunity of seeing the patient on a daily basis and acting as a monitor for the physician to help catch medical problems at early stages.

In addition, the pharmacist can easily be trained to aid in the counseling component which we feel is necessary for any methadone treatment program.

Finally, we are very interested in doing research on other approaches to help the drug dependent person. We hope to work with narcotic antagonists such as cyclazocine, naloxone, psychoactive agents such as Haldol, and any other chemicals which show promise in this area.

The pharmacist in our institution is well versed in the handling and evaluation of investigational drugs.

"Success" with methadone nearly always entails the extensive use of other treatment modalities and support such as psychiatric counseling, vocational and educational training, social services; and legal advise to name a few.

We feel very strongly that the primary purpose of methadone is to allow the patient to return to a relatively stable life style, which is more socially palatable, so his other problems may manifest themselves and be dealt with.

Methadone is, in a sense, a "bait" which allows us access to the patient, to hopefully work on a program to produce a completely drug-free individual.

As a pharmacist, I would hope that we could detoxify or "wean" all of our patients off methadone eventually.

We have some patients who have been detoxified and are drug free at this time. However, it is too early to determine the recidivence rate on these patients.

Through its entire evolution the program has been hampered by lack of funds.

In April of this year a grant application was submitted to Health Services and Mental Health Administration of the Department of Health, Education, and Welfare.

This application had the support and endorsement of all appropriate agencies at both the local and State levels.

Action was deferred because of five minor administrative technicalities:

1. Comments on this application from the State drug abuse authority.
2. Model cities endorsement.
3. Assurances have to be signed.
4. Budget discrepancies have to be clarified.
5. The amount of matching funds expected from the Richmond Rotary Club has to be assured.

The application was resubmitted on July 23, 1971, with these deficiencies corrected.

We received notification from HSMHA that our resubmitted application was in order. However, we recently received word that this

application was deferred again for the reasons stated in attachment A.

(Attachment A follows:)

ATTACHMENT A

1. Failure to provide for a full-time mental health professional who would be responsible for all psychological treatment.
2. Failure to provide for a medical director to assume responsibility for all medical aspects of patient care.
3. Lack of an adequate plan for the training of pharmacy students participating in the counselling program.
4. Inadequate justification for the number of staff requested and their responsibilities.
5. A lack of evidence that Rubicon is a non-profit making agency.
6. Lack of needed affiliate agreements.
7. Failure to provide an adequate methadone maintenance treatment plan which would be in compliance with FDA and NIMH guidelines.

Mr. HARRISON. The reasons stated for deferral on this occasion seem to relate to a hesitancy to fund a program which is administratively directed by the Department of Pharmacy Services rather than a mental health professional.

It is hard to understand this reasoning, since we have had an ongoing program which has steadily improved over the past 18 months, and has appeared to have had some success in the Richmond area, as well as some success with U.S. Army personnel at Fort Lee, Va.

We currently have limited funding help for a 6-month period from the Virginia Division of Justice and Crime Prevention.

This funding expires on March 15, 1971. Since the division of justice and crime prevention has limited funds available for the treatment and rehabilitiation of drug addicts the only other source of funding is the National Institute of Mental Health.

The program will face a possible shutdown at that time if other funding is not forthcoming. This means that 2 years of work by local and State officials and medical personnel will have been useless; that the 200 addicts presently in treatment will again be in the streets; and that a city with one of the highest per capita drug problems in the country will be without any form of medical treatment program to aid in alleviating the problem of drug addiction.

Mr. ROGERS. Thank you very much.

May I just ask one question?

What is the estimated drug population, drug abuse population in Richmond?

Mr. HARRISON. Drug abuse or heroin addiction?

Mr. ROGERS. Well, I guess we will start with heroin addiction.

Mr. HARRISON. This, as you are well aware, is a very debatable and hard to nail down figure.

I think most of us who have looked at this thing feel there are probably in the metropolitan area between 5,000 and 8,000 heroin addicts.

Mr. ROGERS. And your drug abuse population you would estimate it at?

Mr. HARRISON. I think this is very difficult to do, because I consider drug abuse to be those people that are getting prescriptions from their physicians also.

I do not know quite how to handle it. I would say it would be 30,000 to 50,000.

Mr. ROGERS. Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

I enjoyed your remarks, but I am a little concerned at what you are saying, that you have gotten financing for your program from the Department of Justice, but you have been unable to get financing from HEW.

Mr. HARRISON. That is correct, sir.

Mr. SATTERFIELD. I am interested, too, in what you say about your application. In my own view, this situation seems to be more the rule than the exception.

Do I understand correctly, that when your application was resubmitted, the second time, the objections to it which are listed on annex A, were being raised for the first time, and they were not reflected in the original rejection?

Mr. HARRISON. That is correct, sir.

The first time we received the final statements, the second time——

The first time it was all administrative, minor technicalities, some of which really were not in error, the second time, basically it looks like they had programatical problems.

Mr. SATTERFIELD. Is the application now pending with HEW?

Mr. HARRISON. It had been deferred. It had not been turned down. We had the opportunity to resubmit December 1 again.

Mr. SATTERFIELD. It is still there then?

Mr. HARRISON. Yes.

Mr. SATTERFIELD. I was interested to read on page 2 of your statement, that prior to this month the program had been entirely supported by fees collected from the addicts themselves.

This appears to be similar to a situation we ran into in New Orleans. What happened this month to change that?

Mr. HARRISON. This month we just began utilizing the limited funds that were available from the Division of Criminal Justice, and so we just started in with this, and the facility we are visiting this afternoon is one of the first results of that fund.

Mr. SATTERFIELD. What is your experience with respect to patient-supported programs?

Mr. HARRISON. Well, basically we feel very strongly that we will never go to a free program.

We feel that certainly this is a very important part of therapy, the responsibility the individual must show on a daily basis to at least support the program to some extent economically.

However, our big limitations were basically not being able to give the paramedical, paraprofessional kinds of services, and extensive counseling and vocational rehabilitation, some of these things I mentioned, we just were not geared to do this because the patients could not foot the bill for that large or extensive program.

Mr. SATTERFIELD. So you feel you need these outside funds to really make it work?

Mr. HARRISON. Yes, sir, I do.

Mr. SATTERFIELD. I appreciate very much your remarks. I think they were to the point. I, and I am sure this committee, will be interested in looking into this application and how it and others like it are being handled.

Mr. HARRISON. Thank you, sir.

Mr. SATTERFIELD. Thank you very much.

Mr. ROGERS. I think with your member on the committee, I am sure we will be looking at it, and we will ask why we have not had a little better response, where you have got an ongoing program, it is absurd, and I am sure your member will do something about it, and this committee will stand behind him.

Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

I have just one question, on page 5 of your statement you talk about narcotic antagonists, or blocking agents, I assume.

You say: "We hope to work with narcotic antagonists such as cyclazocine, naloxone, psychoactive agents such as Haldol, and any other chemicals which show promise in this area."

Now, have you yourself ever seen any of these agents used.

Mr. HARRISON. We have not attempted to use these as yet, Mr. Kyros.

We are gathering as much data as is available now on these.

We have had contact with some of the people in Lexington in terms of their results with these.

These are antagonists that we are really talking about versus what is commonly known as a blocking agent.

Mr. KYROS. They themselves do not addict the patient?

Mr. HARRISON. That is correct. These are drugs which would merely counteract the physiological reaction of heroin, so that no affect would be obtained.

Mr. KYROS. But as yet, from what you know of, they are not out for distribution?

Mr. HARRISON. No, sir. Well, naloxone is, but it does not have FDA sanction to be used in this way, so it is available for other therapy, but not in this area.

Mr. KYROS. Thank you very much.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I certainly agree with your point that pharmacists and the pharmacological field ought to be more deeply involved in the whole drug picture, and that it is appropriate that you be heavily involved.

I also agree with Congressman Satterfield and the chairman that to turn down your application on the grounds that you do not have a full-time mental health professional, when you have learned pharmacologists involved is absolutely ridiculous.

Incidentally, on this question of marihuana, which we come down to every now and then, I think it is true to say that in all of the testimony we have heard on that subject, we have never heard a pharmacologist suggest that it ought to be legalized.

We have heard testimony from psychiatrists, from social workers, people who are concerned about the generation gap and the social effects of not legalizing marihuana, that it should be legalized, but the nitty-gritty researchers, the pharmacologists who examine what the drug does or does not do have all been very cautious on legalizing it.

Do you feel that way?

Mr. HARRISON. Yes, sir. I do not think that there has been enough work done, and I would hate to see us just impose another chemical on a society, which I think already has too many of these at its dis-

posal, and I think it would be a very difficult thing to try to control dosage range.

Anytime you talk about that, I think you have got problems.

Mr. PREYER. One of the areas in which I think you can do a good job is controlling the use of methadone. Apparently you have run into a diversion problem, and you have worked out some ways to lick it.

You have a 5-day daily treatment.

What happens on the weekends?

Mr. HARRISON. Currently we are giving a 2-day supply, when they go out on Friday, and when we get into the new facility next week, we will be opened at least through Saturday, because we have been able to expand the staff somewhat, so there will be only a 1-day supply going out with the patient, and, if I might, I will show you what kind of dosage form we send.

Basically, during the week, all dosages are given in this type of plain orange syrup called methabase, which we have worked out with a local firm in developing.

This particular syrup, they can dilute it with water if they want to, or they can just drink this straight.

For the weekend doses, we add a little something extra to it, and it becomes this type of a product, which is gelatinous in nature. It must be scraped out of the bottle and diluted up to about 5 ounces with water, so that at that point it becomes 5 times greater in volume. Our key point in doing this, is to avoid the overdoses that you may have seen in the emergency rooms. Any of these things you see going out onto the street, particularly in orange syrup, or a brightly colored container such as this is tempting to a child and he will tend to try to get hold of this. It is, of course, fairly palatable. We think we have done a pretty good job in licking this problem, which it has been quite high in the D.C. area, if I am not mistaken.

Mr. PREYER. That is very interesting.

Does the fact that is gelatinous have any security, or any diversionary features over the regular liquid form?

Mr. HARRISON. It probably is a lot tougher to inject, but most of the time, you are not going to stop diversion completely.

If somebody wants to sell his dose, there is just no way that you can avoid this, unless you do have the patient in the clinic on an absolute 7-day schedule. We may have reached that point. I would hope this dosage form would tend to avoid the problem of having the individual inject this intravenously. Methadone if injected intravenously—and we have had them inject this much, although it hurts a lot—would give a high very similar to heroin. Again anybody that wants to inject 5 ounces, after they dilute this down would be able to do so. I do not think we can go much beyond that control.

Mr. PREYER. Thank you very much.

I am impressed with the realistic program you have, and the creative side of it with this new form, I hope that will be widely publicized.

It seems to me that would be very useful in other methadone programs.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. Harrison, you opened your statement by pointing out that pharmacists should be involved in these efforts, because of their interests in controlling drug abuse.

Let me give you a scenario and get your reaciton to it.

I am afraid we have to go back to television to get it.

You turn on the set, it shows a fellow coming home after a hard day at work, and his dog nips at his trousers, his children are nasty, his wife is nagging him, and things look pretty bleak, at which point, some friend of the family, possibly the wife, a child, comes up to him with a bottle of pills, and offers him one, an anxiety relief drug, a mood changing drug.

He injests it, and a smile comes over his face, and he is at peace with his world.

Now, is that drug abuse?

Mr. Harrison. Yes, I feel it is. I think the individual in our society, has to learn to handle some reactions by himself; however, any drug abuse is dose related, and I think this is the thing that you must keep in mind.

It is not that all drugs are bad. I tend to be more nihilistic perhaps than a physician may be, and some physicians are more nihilistic than others in terms of the use of drugs.

If he does this every night, and this is the only way he can face the wife, the kids, the nipping dog, and the whole business each and every night, then I think it might be drug abuse.

Occasionally, probably not.

Mr. Symington. There are really two levels of the question.

You chose to address yourself as to whether or not this particular gentleman was abusing drugs and might be, but the larger question is whether the ad itself is not a form of drug abuse, in that young people in watching such an ad might well conclude, "he has his, and I have mine," and I think that the pharmaceutical industry has a role to play in helping society to determine with some precision where the line is drawn between safe and approved drugs and dangerous drugs, and I do not really feel that many of these ads help us to draw that line very effectively.

Mr. Harrison. This is why I made the statement I agree 100 percent with Dr. Mathis. I do not feel that television advertising of over-the-counter medications really should be allowed.

I feel, No. 1, the people who can evaluate these best, the Food and Drug Administration, really have their hands tied, as I understand it, in terms of controlling any types of advertising for over-the-counter medications. This comes under the Federal Trade Commission as far as jurisdiction, and so it becomes a very lengthy involved process to try to even have an ad altered, much less make it come off the air; but I do feel that this is vastly overused and abused.

Mr. Symington. And also there are alternatives to contents of bottles to achieve a greater degree of serenity. I think the medical profession owes it to the people to indicate this, and, yet, we seem to be sliding more deeply into the easy assumption that the quick and safe way is to take a pill or a drink.

It is my understanding that there is some consideration being given to approving methadone as a prescription drug to be used at the discretion of the physician. What do you think of that?

Mr. HARRISON. I am violently opposed to that, sir.

Mr. SYMINGTON. So am I.

Second, with respect to those little bottles you have there, did you indicate that the gelatinous material was less dangerous to children less attractive to them?

Mr. HARRISON. It is less dangerous to children in that it does not pour. They would have to scrape it out, and let's say the possibility or the probability of them ingesting this material, I think you would have to agree, is much less.

Mr. SYMINGTON. Of course, if they are used to sticking their finger in, as in a jar of marmalade, to get it out, that looks not unlikely to me.

Mr. HARRISON. A child can possibly find a way to do anything, but I think the opportunity is less.

Mr. ROGERS. I think most children do not like marmalade.

Mr. SYMINGTON. Oh, I see, not even from Florida oranges?

I am concerned about those little bottles, but I suspect that in your own mind, based on your understanding of their use, is that they are pretty well controlled.

Mr. HARRISON. We will never make an absolute statement that they are not getting out. We know that there are diversions that happen, but again, because of our staff limitations, and so forth, this is the only way we could run a program.

Mr. SYMINGTON. Just a final thought on my first comment, we have been making some efforts to get ahold of the advertising budget of the pharmaceutical industries, with the thought that they might give a clue to the proportion of their effort in that direction to get people interested in their products.

Would you say from your own experience, that a disproportionate amount of effort is made to interest the general public in drugs as a solution to their problems?

Mr. HARRISON. I think basically this would relate to over-the-counter drugs. Certainly, some of these same manufacturers manufacture what we call prescription items, so to that extent there is a crossover. Of course, there are many manufacturers who advertise not at all to the general public, but rather only through medical and pharmaceutical publications.

Mr. SYMINGTON. Even there, I understand that there are something like 20,000 so-called detail men that pound the offices of physicians with the latest cure-all, and the physicians are not unsusceptible to this kind of suggestion.

Mr. HARRISON. No, sir; they are not, or there would not be 20,000 detail men.

Mr. SYMINGTON. Don't you think it is a legitimate concern of society to ask itself to what extent efforts are made to hook physicians in the commercial point of view?

Mr. HARRISON. There have been some studies done here in the clinical pharmacology department, trying to evaluate ads that appear only in medical journals. There are some pretty astounding kinds of ads that appear in these journals.

Mr. SYMINGTON. You are evaluating these things now?

Mr. HARRISON. The Department of Clinical Pharmacology did a study approximately a year and a half ago, with senior medical students, having them evaluate their responses to various ads which appeared only in medical journals.

Mr. SYMINGTON. Could you provide this committee with a copy of that report?

Mr. HARRISON. Yes, sir; I could get this for you.

(The report referred to was not available to the committee at the time of printing.)

Mr. SYMINGTON. I would very much appreciate it.

Thank you, Mr. Chairman.

Mr. ROGERS. What is the price of heroin here in Richmond?

Mr. HARRISON. That depends on supply and demand, but it is basically about $3 a cap.

Mr. ROGERS. What is methadone selling for, do you think?

Mr. HARRISON. I am not positive. I could not give a statement. Joe Higgins from the vice squad is in the back of the room. Do you have any idea, Joe?

Mr. HIGGINS. We do not have too much information on methadone. There is not too much on the street in that paricular form that you see here.

Mr. ROGERS. Do you have any experience at about what it was sold for?

Mr. HARRISON. One of my associates could find out. The difference, being, if in fact this is a blockage dose which happens to match up with that patient, it will handle the heroin need for a day.

Mr. ROGERS. That is what I wonder, where you keep your clinic opened 5 days, and sometimes on Saturday, but mostly 5 days.

Mr. HARRISON. We will be going to Saturday.

Mr. ROGERS. But you have not yet?

Mr. HARRISON. That is right.

Mr. ROGERS. So you have given them dosage for 2 days, but which they can sell for more than they have to pay for heroin?

Mr. HARRISON. No, sir. With most of the habits, if they are going to buy heroin at $3 a cap, and are using 20 caps per day, you are talking about quite a differential here. You are talking about $60 versus $5 for a day.

Mr. ROGERS. When you first put them on it, don't you have to put them at the same level that they are on heroin, on methadone?

Mr. HARRISON. At a milligram-per-milligram basis, there is no difference in terms of our charge to the patient. In terms of what they happen to sell this for on the street, if they do, it may contain 10 milligrams, or it might contain up to 160 milligrams.

You see, each of these doses are prepared for an individual patient, and their dosage range may range anywhere from 10 milligrams to 160 milligrams. Any dose would be in exactly the same container, in exactly the same volume, because we use a concentrated methadone, so that they cannot tell the dosage level by the volume of liquid. They cannot tell how much methadone is in there.

Mr. ROGERS. I was just wondering how easy it would be for one to come in and get on your program, and then he has a weekend supply he sells, and gets back on heroin during the weekend.

Do you think this would happen?

Mr. HARRISON. We would pick this up on our urinalysis, and so forth.

We do discharge patients when they habitually are offenders.

Mr. ROGERS. Have you had to discharge many patients?

Mr. HARRISON. Yes, we have.

Mr. ROGERS. About how many?

Mr. HARRISON. Oh, I think probably 50 or 60 over the last year, some of them for economic reasons because the bill just gets too high.

Mr. ROGERS. Now, what do they do when they are discharged, there is no help for them, as I understand?

Mr. HARRISON. Basically there is no cross-referral, and if after a period of time they want to come back to the screening process, and if it is agreeable with the people on that committee, then they could go into the therapeutic community, or they might be able to come back in.

We feel many time, that they will bust three or four times before you really ever get to them, so that we do not like to shut the door completely. If they fail once, therefore, they may have a second chance.

Mr. ROGERS. I understand that this is generally the pattern, and, of course, you have not been running your program long enough to evaluate to see what is your rate, and so forth.

Mr. HARRISON. No, sir; we have not. This is some data that we very definitely want, and we would like to work toward attaining.

Mr. ROGERS. Are there any other clinics that dispense methadone in Richmond besides yourself?

Mr. HARRISON. No, sir; this is the only one. I believe it is the only one in the State of Virginia. Unless the IND came through for the Norfolk area, or Roanoke.

Mr. ROGERS. Do you keep a register?

Mr. HARRISON. Yes, sir.

Mr. ROGERS. Should methadone you think be changed from an IND to an ND, from an investigational status to a new drug?

Mr. HARRISON. Being available to any practitioner?

Mr. ROGERS. Yes.

Mr. HARRISON. No, sir.

Mr. ROGERS. The Food and Drug Administration is now considering that. I do not know whether you are aware of it.

Mr. HARRISON. I think the problem is that outside of some kind of an institutional atmosphere, the control problems and the ability to see these people is gone. I just think it is a big mistake if we do this.

Mr. ROGERS. I agree. I think they should keep it in the investigational state.

Now, do you turn in reports on your investigational drug permit?

Mr. HARRISON. Yes, sir; to the FDA. I have a copy of this report that I could make available.

Mr. ROGERS. I think it would be interesting to this committee if you could supply one for the record.

(The report referred to was not available to the committee at the time of printing.)

Mr. HARRISON. In terms of patient status, some questions were asked of Dr. Bright earlier. I could briefly run down statistics on patients now currently on methadone, which include both the adolescents and adults. We have 181 patients as of this morning, 137 of these are over 21 in the adult category, and 44 are adolescents.

We have 123 black patients, 44 white. We have 137 males and 30 females.

Mr. ROGERS. Suppose a person comes in and says I am addicted, and I want you to help me, what happens to him?

Mr. HARRISON. The first contact is with a joint screening committee, which is set up with Rubicon and the staff of our program.

These patients are then seen by this group, at which time they are interviewed and discuss what some of their problems have been. We try to determine at least to some extent the level of motivation in terms of the individual doing something about their own problem.

At that time we have them return to the clinic and a urine specimen is taken. With this we must verify that they are on the opiates.

They are seen by the physician, and depending upon what the screening committee's recommendations were, there are many avenues which they can choose in terms of treatment. The individual would only then be started on methadone.

The intake procedure normally will run from 2 to 3 days.

Mr. ROGERS. Are they put in an inpatient facility?

Mr. HARRISON. No, sir. We have, again, as Dr. Bright indicated earlier, found very little need thus far for inpatient facilities, either for detoxification or for handling the patients initially.

Now, the related medical problems, that is another story. Of course, a lot of the patients end up being hospitalized for other ailments.

Mr. ROGERS. How do you determine the level of methadone that you would issue to the patient?

Mr. HARRISON. Basically this is done by the physician. We attempt to find out how many caps they say they have been using, probably cut it in half, and then maybe half of that again, because the percent concentration of heroin in Richmond at this time in the streets is fairly low. So we try to "guesstimate" at a blockade level, and we watch the patient very closely.

If we are a little too high, he is going to be sleepy the next day, and if we are too low, he will tell you about it.

Mr. ROGERS. That is not a very scientific way of doing it, is it?

Mr. HARRISON. Well, not as of this point.

Mr. ROGERS. Do you use his testimony?

Mr. HARRISON. Well, that plus the physician's evaluation.

Mr. ROGERS. Well, that is difficult for the physician, unless you get him in there and see what his withdrawal is?

Mr. HARRISON. Right. Basically we usually will start on the first day with maybe a 20- to 50-milligram dose and go from there.

Very rarely do they write for anything higher than that.

Mr. ROGERS. Suppose he says I am on 20 pills a day.

Mr. HARRISON. Well, with the guidelines we are using, the maximum that patient would get would probably be 50 milligrams. The average blockade dose right now in our program is probably around 90 milligrams.

Mr. ROGERS. About 90?

Mr. HARRISON. Right.

Mr. ROGERS. How much is maximum?

Mr. HARRISON. 160 milligrams in our program right now, which is what the FDA guidelines previously used as a maximum.

They will now allow you to go beyond that for certain individuals, but we have not done that.

Mr. ROGERS. Now, some start out at the top and bring them down.

You are starting out taking about half of what they say is their top?

Mr. HARRISON. Half of what they say, and then half of it again, so about one-fourth basically is what we are starting them with.

Mr. ROGERS. Is there enough education in the medical schools on clinical pharmacology, do you think, from what you have seen?

Mr. HARRISON. No, sir. I do not think there is.

I think we are moving in that direction by virtue of a joint approach in educating pharmacists along with physicians.

I think we are starting to get into this area much more extensively.

Mr. ROGERS. We are trying to increase that in this educational bill, incidentally, to put some emphasis for additional funding for clinical pharmacology to be taught.

Thank you very much.

Mr. SYMINGTON. I wonder if I could ask to see that little jar of gelatinous material.

Mr. HARRISON. You can have them all if you would like. You can even taste them. There is no methadone in them.

Mr. SYMINGTON. I notice you can unscrew this cap easily.

Would it be possible to put a safety cap on this?

Mr. HARRISON. You could, but again, it has been a matter of expense.

You are talking about more expensive containers, we could do this if it was felt necessary.

Mr. SYMINGTON. You know, if you put a handgrenade in here, you would have a safety device on it, and that would be a matter of expense too, but when one of these things is opened, what is the cost if it is opened by the wrong person?

Mr. HARRISON. That is right. It is very difficult to asign a dollar figure to this risk.

I think it is the same kind of thing you get into with any legislation, on the kind of safety closures required on any kind of materials for children. It is a matter of relevancy, and you cannot assign certain dollar figure costs to the possibility that you might have a toxicity problem with a child, but it is a fact of life.

Mr. ROGERS. You mentioned that there was some 8,000 heroin addicts in the Greater Richmond area?

Mr. HARRISON. I think it is felt by most people, there are 5,000 to 8,000. We are just talking in ranges.

Mr. SYMINGTON. It is conceivable if your program was working with optimum effectiveness, there would be thousands of addicts receiving these bottles?

Mr. HARRISON. This is conceivable, but on a voluntary program it is not a very realistic assumption.

Mr. SYMINGTON. But if it is a very effective voluntary program, it will become more and more effective.

In other words, you are not banking on its ineffectivenes in order to reassure yourself that there are not too many of these bottles going out into the community?

Mr. HARRISON. No, sir, not at all.

We certainly work to do everything we can to control this.

I think the first step is that we are going to a 6-day coverage, and hopefully, if we do get some funding, we will be open 7 days. There would then be none available for the street, but we just realistically have not been able to do this at this point in time.

Mr. SYMINGTON. Let me ask, how much is this again, this bottle?

Mr. HARRISON. The cost to the patient for the total program, is $1.50 per day, and this includes the urinalysis.

Mr. SYMINGTON. How much is that again?

Mr. HARRISON. $1.50 per day.

Mr. SYMINGTON. $1.50 per day?

Mr. HARRISON. Yes.

Mr. SYMINGTON. And what would be the increment to that if you had a safety cap on it?

Mr. HARRISON. Well, I don't know that there would be any increment. We would not change this rate to the patient. It would be perhaps something that can be done now if we have some funding available.

There is no problem in doing it. I don't think we felt that the need was there.

I don't think the problem has manifested itself, but we certainly could put safety caps on these.

Mr. SYMINGTON. Well, at best I would hope that you consider this, and at worst I would say good luck.

Mr. ROGERS. Thank you very much. We appreciate your testimony.

Our next witness is Mr. Edmund Menken, project director, Rubicon, Inc., Richmond, Va.

STATEMENT OF EDMUND MENKEN, PROJECT DIRECTOR, RUBICON, INC., RICHMOND, VA.

Mr. MENKEN. Mr. Chairman, members of the committee, the magnitude of testimony regarding drug use and abuse previously presented to Government committees and subcommittees is, to be sure, occupying innumerable volumes of congressional record.

I would hope that the testimony given here this morning would add something of value to that which has already been heard.

I should like to speak first to the issues of drug treatment and rehabilitation.

The chronological history of responding to the drug abuse problem in this Nation has provided a fantastic illustration of incongruity.

Once upon a time it was a medical problem, then a legal problem, and now again a medical problem.

Some people, of course, have still not made up their minds.

And still others espouse that there is no problem.

Regardless of individual opinion, any reasonably educated view would indicate that someone, somewhere, if not everyone everywhere, is on a collision course.

Crisis response, public hysteria, and political expediency have resulted in the all too rapid establishment of new agencies, departments, and councils, in which experts are abruptly born who are usually ill-equipped to deal effectively with the situation and who create programs, rhetoric, and motion which wastes precious energies, valuable time, and human lives, not to mention millions of tax dollars.

Decisions and actions are made out of inaccurate assumptions and simplistic, erroneous analyses of the problem.

History is repeating itself. We, as a society, are no closer to success in this area than we were a decade ago.

The only difference is that we have streamlined the failure model. We have invented verbiage and vernacular which has now taken on shape, form, and substance of its own.

The grandiose plans, ideas, and arbitrary decisions regarding drug abuse, what it is, what should be done about it, and so forth, are colorfully visible everywhere we look.

Posters, flyers, brochures, booklets, films, records, and even comic books.

We might do well to ask ourselves who is profiting more from drug abuse today.

The drug pushers or the drug information pushers?

This Nation can no longer afford to make repetitive mistakes. We cannot afford the luxury of always doing things over, starting anew, reexploring.

We cannot afford this for a very simple reason: We have reached the abyss.

The New York State Narcotics Addiction Control Commission in 1966 was established with great fanfare, publicity, and a promise from all those involved that that effort would produce the effective solution to the problem in that State.

For its first year of operation, the NACC had the second largest appropriation in the entire New York State budget—over $260 million.

Now, some 6 years and one-half billion dollars later, the New York populace, the man in the street, is well convinced that drug addiction is incurable.

When public officials elected or appointed, and their bullpen of "experts" announce to their constituencies that an all-out effort is being undertaken, that the problem will be handled and controlled, the public has a right to expect the promises to be fulfilled.

But, after all those energies have been expended, after all that money has been invested, indeed after all was said and done, how now may we convince the public that drug rehabilitation is possible?

How are they expected to believe it?

And, in another sense, how is the addict to believe it?

A generous description of the New York State Commission is that of a network of human warehouse producing virtually no meaningful effect whatsoever.

Any realistic effort to treat and rehabilitate drug addicts and abusers can only be borne out of an understanding that a multiplicity of necessary factors must be included.

Any conceptual framework for a program which is to treat these people must be shaped around settings which are microcosmically established as places for people to learn how to work, play, and relate to themselves and other human beings in a fashion that would be corrective and genuinely therapeutic.

Socially disabled persons must have opportunities to become socially able.

They must see, smell, taste, and feel that there is a chance to recover and to make a reasonable place for themselves in our culture.

They must have a setting available to them where genuine trust and confidence can be felt, where identification is omnipresent and where

tolerance without indulgence can establish the underpinnings for personal growth and development.

No institution—hospital, clinic, prison, et al.—of the historical or traditional variety can offer this opportunity.

No prison guard can fulfill the need for having a role model, someone to emulate, a living example of a possible alternative.

The concrete caverns of institutional life provide everything that the social failure does not need.

The loss of and inability to develop any personal identity, the regimentation and extreme custodial discipline, the character dichotomies that exist between the element of supervision and the inmates, patients or clients, the gaps between classes and types, and the unwritten guarantee that society really does not care anyway, all amounts to perfect and perpetual prescriptions for failure.

If social education and personal development can ever be acknowledged as a vital part of a definition of need, if the real problem has to do with the total person and how he might best learn the ways to live in a world among people, to arrive at a place which is reasonably tolerable if occasionally frustrating, if we ever accept, on a large enough scale, that each individual situation which causes to emerge a person in need of help, in need of learning and growing and becoming functional and competitive, then we must recognize that this cannot be accomplished in a warden's office, a jail cell, or a physician's examining room.

The totality of the treatment and rehabilitation of drug abusers cannot be regulated solely to any single area, profession, or discipline.

In addition to the New York State fiasco mentioned above, we have seen the tragic history of the traditional medical models at Lexington, Ky., and Fort Worth, Tex., the two Federal institutions designed for this purpose. We have witnessed the failure and eventual disappearance of the program at Riverside Hospital in New York City, and the revolving door travesty of Manhattan General Hospital.

Where and when will it end? Successful therapeutic methods can only be determined in an after-the-fact view.

If a person has been able to develop a positive self-image, if he is able to display a willingness to compete and strive for personal achievement, if he is equipped to handle the occasional discouragement of everyday life, if he gives evidence to indicate that his humanness with all its strengths and frailties is enough to work with, and if he can emotionally appreciate the value of trying, then his helpers deserve to feel proud.

The input for that kind of achievement must come from many sources. It must come from people who care enough, who are not insulated by self-defeating ethic or objectivity, it must come from a setting wherein the environment nourishes that which is good and educable in every person, it must come through the genuineness of opportunity for change, and it must come from the individual himself.

The advent of methadone in recent years arrives on the scene at a very crucial time. The synthetic narcotic may, in a sense, be likened to atomic energy. It is an agent which, if used intelligently, resourcefully, with understanding and programmatic integrity, can be a godsend as a vehicle in an overall treatment process.

If, on the other hand, it is used without appropriate care, without a full enough understanding of the implications of this chemical and its alternative relationships to the addictive personality, if it is emphasized as a cure-all or magic potion, if it is overemphasized in value, if it is not strategically administered within the context of truly substantive treatment models which include all the other elements mentioned above, then it has the potential for profound disaster.

It is more than a few cities that are reported to have developed problems where methadone has become the drug of choice among significant numbers of drug users. There are other, more vital facets of this drug dilemma that must be considered. And considering it all may even be uncomfortable.

There are no real experts in this field. Some people have been in school longer than others, and most of those who have been in school longer would agree that drug addicts, once they have become deeply involved in the drug scene, do not really want to get well.

It is that issue that most of the cynics would prefer to address themselves to; but the factor that must be made known, yelled and bellowed if necessary, is that those people who really do not want to get well simply do not believe that they can.

That is the vital element, that is the enemy within, that is what real treatment must address itself to.

We must pull in the reins of national smugness and pomposity, which reflect the standards of middle-class living and blindily perceive the American dream to be attainable for all—except those who have gone astray, and then we totally abdicate any real responsibility.

It is out of this absoluteness that the insensitive and inhuman platitude echoes from coast to coast, "Everyone can make it." But if the pace cannot be kept, the fallen and the crippled are left behind.

It is precisely that attitude, the blindness and intolerance of our values and standards, that negates any validity to the possibilities of rehabilitation. Human beings by the hundreds of thousands have fallen and/or are crippled. Those of us who comprise the adhering and supportive social masses, who by definition have been able to survive and occasionally "make it," leave no room for the socially disabled.

We can acknowledge and accept the tragedies or disabilities such as physical amputation, cystic fibrosis, and the like, and we might even send on a check; but the socially disabled, those who have varying and sometimes despicable symptoms of illness or malady, arrive at our prisons and correctional institutions, hospitals, and reformatories, and are cast aside and forgotten.

Dostoevski stated, "The degree of civilization in a society can be judged by entering its prisons." Today, it can also be judged by viewing its drug-abusing population and the Nation's response to it.

The terms "correction" and "rehabilitation" are little more than hollow sounds. The institutions and programs created and charged with these responsibilities are little more than warehouses and usually reinforcement for the futility felt by so many. Our pattern of response to those individuals who, through whatever symptomatic means, have displayed an inability to adjust to the social milieu, are time and again herded off to institutions and environments that could be nothing further from that which is needed. The person who has had difficulty

in learning how to make it in this society must receive the kind of social education that can only occur within that social milieu. Rehabilitation can only occur in a place where the individual's problems can be actualized and overcome. To believe that a human being, disorganized, disoriented, and brutalized, both by himself and his environment, can be placed in a setting or an institution which is so completely alien to the source of his problem and expect that he should some day return successfully rehabilitated is about as absurd as demanding that a paraplegic walk. It is precisely this absurdity that looms so unalterably overhead, prohibitive inhibitive and insurance on failure. The response to the problem of drug abuse control has still other interesting and classic characteristics. Our nation seems to have a pat type of reaction to acute social problems. The model can be viewed in this account: In the not too distant past, our Nation was stricken with a rash of assassinations of noted national figures.

Apart from the grief and anguish, the response was to cry out for gun control legislation. Gun control, the move to relieve the problem by this type of legislation, would not in any way address itself to the root of the problem. If we were to dump every firearm into the Atlantic and Pacific Oceans, that still would not prevent a person bent on murder from using a knife, a club, poison darts, or dropping a flowerpot from a fifth-story window.

In much the same fashion, the drug abuse dilemma has been responded to with efforts and measures directed toward the control of drug traffic; and while this, of course, is a necessary activity, it is merely responding symptomatically.

The fact of the matter is that for many and varied reasons, we are alive at a time in which millions of people are determined to use chemicals for euphoriclike purposes.

The simple truth is that if heroin—or for that matter any opiate, amphetamine, halucinogen, et cetera—were to suddenly disappear from the face of our country, someone would have to invent it.

Legal or illegal, a market exists.

The proof of this is easily seen in the history of the banana peel phenomenon of a few years ago.

That was when, in Orson Welles fashion, the word went out from coast to coast, almost overnight, about banana peels, and a tale of how if they are properly roasted, toasted, or whatever, they could be used to get high.

Like the run on the banks in 1929, we were able to witness a run on fruit stores and stands around the country.

The farce in this situation was exposed quite quickly, but not before we had an opportunity to observe the real problem in motion.

As an aside, a number of my colleagues and I during that situation, had a pathetically humorous vision of certain law enforcement groups busily preparing appropriate legislation while, simultaneously, a combine of produce merchants gathered their forces of lobbyists.

The single most important lesson out of the banana peel madness is that the drug market exists because there is a demand for it, that the demand creates the market and that we had better be able to readjust the emphasis, direction, and concepts of drug abuse control.

We must recognize that the desirability for the use of drugs is born out of circumstances and situations in the lives of growing numbers

of people and that no punitive process, no "deterrent" action or the shaking of a warning finger can ever do the job of healing the wounds that precipitate the drug abuse syndrome.

If convinced that some mysterious, active ingredient contained in horse manure could possibly get someone high, we might indeed see those masses so disposed, pouring into the streets with shovels.

Desperation, frustration, efforts to sedate, anesthetize, or otherwise alter the physical norm is what the problem is all about.

All else, the Mafia, organized crime, profiteers and marketeers, only are of peripheral importance.

Attention must be called to the fact that drug abuse is nothing more than one part of a very broad spectrum of contemporary social problems; violence, suicides, climbing divorce rates, bulging institutions for the insane, prison riots, drug abuse, ad infinitum.

For the sake of understanding, we might wonder—Attica may be drug abuse turned inside out.

We must accept and acknowledge once and for all the factors which are inherently causal to drug addiction, and we must do something about them.

We must invest greater energy in the conditions of poverty, commit resources to genuinely develop those areas and communities—the barrios and ghettos of this Nation where young children by the thousands make choices every day to anesthetize themselves rather than dwell with the pain produced by such grotesque conditions.

We must put a halt to the activity of continually developing layer upon layer upon layer of agency, department, task force, council, and the like, as a response to this problem.

We must stop the kind of proliferation born out of ignorance, crisis response, and political need.

We must work diligently to insure that all levels of government exercise complementary and positive movements and put an end to destructive obstacles, unreasonable complications, and all that which has placed us in the unenviable position of today.

And we must refrain from our inclination to sidestep the enormity of our responsibility and dump the problem into the laps of the overnight experts.

We must swallow our embarrassment and avoid defensiveness in the face of questions from younger people who ask, "Where are you going? What is it all for? Why do you make things so complicated? What about us?"

We must allow for history to continue to produce change. Indeed, we must support the motion of it.

We must leave room in our otherwise hallowed halls to allow for forums where young people in a peaceful and sincere way may have an opportunity for dialog with their leaders and elders, even if that dialog contains differences of opinion.

We must project the willingness to compromise if we are to expect that young people should compromise.

There is no way around it, the onus is on the leadership.

We must remove our blinders and be able to learn some valuable lessons from situations that are usually ignored out of distaste.

We must recognize, for example, that the Black Muslims and other minority activist groups have reformed more drug abusers than all the treatment programs in the United States put together.

And, whether the philosophies or beliefs of these groups are agreed with or not, we must recognize that they have provided something that no one else was able to.

That something is the abounding self-pride, cultural definition, and personal identity.

A dear friend and close colleague, during a recent lecture, put the whole thing quite beautifully into the proverbial nutshell.

He said, "Many people ask why people use drugs. The answer is simple; they do the job."

Drugs do the job of relieving pain, drugs satisfy the need to shut oneself off, drugs serve the purpose of pulling in all the nerve ends that would otherwise be exposed to the weather of the world.

Drugs do the job.

If we ever hope to make any reasonable dent in the so-called drug problem, the task is to provide alternatives, to offer something different, something palatable, to give something that can do the job better.

There are many who are quick to offer answers and solutions. I have none. The statements above are merely a piece of a very big picture.

And, I only know that after a good many years of being in this field, optimism is difficult to muster.

That should not be taken as a reflection of an attitude toward the ability of an addict to recover. Rather, it has to do with what I see happening in the treatment areas generally, and in the very confused arena of drug education and prevention.

By the way, if the committee should find it relevant to anything I have said here, I am a former drug addict.

Thank you.

Mr. ROGERS. Thank you, Mr. Menken, for a very interesting statement.

Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

I would like to thank you for your statement. We congratulate you and others like you who have experienced this firsthand, and are now willing to dedicate yourself to finding the causes, the cures, and the other things that we are all seeking to banish this scourge from our Nation.

You mentioned one thing which I am sure has occurred to most of us. That is the question of whether or not we are optimistic.

I am, if for no other reason, than that it is quite obvious to me, that the general public, slowly perhaps, is now beginning to appreciate that there is a problem, and that society in general will have to solve it.

We have come to realize the truth of many things that you say, that there is a need to understand the problem, that there is a need to understand the requirements for the addict if he is going to be rehabilitated and cured, and we have heard on other occasions the need for acceptance, not merely a realization that an addict can be cured, but that he can perform a useful place in society and needs to be accepted by that society.

Our problem as legislators is that we are limited in what we can do in that capacity, because there are obvious limitations to the kind of legislation we can develop. However, this committee is vitally interested in enacting legislation which will help solve some of these problems which you have mentioned.

We all realize that we can only make a start. In the final analysis, it will have to be the people themselves, with knowledge and with a determination to achieve a fixed objective, who must supply the solution.

We hope that we will be able to develop the kind of legislation which will give impetus to that kind of reaction by the public and which in the long run will solve the problems which you have clearly enunciated in your remarks.

Thank you, sir.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

I think that was a very eloquent statement, Mr. Menken.

You certainly have shown some relish in punching holes in some of the dogmas about drugs, but I think particularly this committee, we do not know any answers, we spent 2 or 3 years on it so far, and we have heard many people like yourself explain there really is no fixed path.

One thing that confuses me is this little brochure called Rubicon.

While you were testifying, I went through it quickly. I still do not know what Rubicon means.

Could you explain that?

Mr. MENKEN. I would be happy to answer that question to whatever extent you wish.

I understand you will be visiting there this afternoon, that is why I took the privilege of just avoiding it, and then we can answer questions then.

Mr. KYROS. Well, then, let me ask you this question.

Another interesting thing you said, on page 12, which I think should be documented, you said:

> We must recognize, for example, that the Black Muslims and other minority activist groups have reformed more drug abusers than all the treatment programs in the United States put together.

That is a pretty strong statement.

What I would like to know, what kind of general minority activists groups.

We have met some in St. Louis, New Orleans and other places, but what are you referring specifically to?

Mr. MENKEN. I mean generally across-the-board spectrum, Mr. Kyros.

I am not supportive of any one of them in any way other than I am happy at least in this respect they are getting something done.

Again one begins to question whether the cure is better than the problem.

I am not really sure, I do not know whether or not they would be in all fairness a way to characterize all of those situations collectively.

I think some of those organizations have exactly the kind of thing that most people need, who have become so deeply involved in drugs, and because I think at the root, or at least part of the nucleas of that root, has a great deal to do with the kind of emotional void, of not feeling connected to, not feeling enough of a sense of belonging, the kind of identification and comfortability that can come only from a feeling of reasonably secure connections to other people, and I think those organizations, apart from everything else they do, certainly provide that.

Mr. KYROS. My question is, what organizations, what numbers of people are we talking about, if indeed this statement of yours is the fact, the documented fact, we ought to really use these groups even more, so what are the groups, and what are the numbers of people they have helped in drugs?

Mr. MENKEN. Let me say this one thing in response to that, documentation for that particular situation obviously would be very difficult.

The frame of reference that I offer to you for that statement is generally a consensus of field people who are, as I am, involved in the treatment programs, and who have or sought out a part of an overall national network of programs, and who have come in contact with these groups, and have seen them, and have seen the work that they are doing in relation to drug abuses, and we have conclusively arrived at a point where we said they are doing a really great job.

Now, that is not their focal point. They do not define that as their purpose, which is another interesting thing.

I would also suggest if you have a greater degree of interest in that particular area, I believe that OEO has some informal information about it.

I do not know what they have in the way of statistics, but they have community people who have brought back information about that, and they have been very interested in watching that and seeing it, and trying to put some sort of value to it.

Mr. KYROS. Thank you.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I enjoyed your testimony. Like Mr. Kyros, I think we will be interested in Rubicon, how it works, the facts and figures, but I gather you will go into that this afternoon.

I liked your emphasis on the no easy answer. I am afraid there is a tendency in this country to say that with methadone we have got the quick solution.

I think your emphasis there is very good. I find your testimony very discouraging; however, because what you indicate is necessary to do the job is almost beyond our reach.

For example, on page 8, you say there are really no effective institutions or programs today, that the inpatient-type institutions are little more than warehouses, and that we need a type of institution which really involves a whole social reeducation of the individual, and so that he can learn how to make it in society.

I agree with you that is what we need, but that is an awful tall order.

The institution which has come closest has been one we visited on Staten Island in New York, in which they have all sorts of psychiatric help and recreational programs. It is enormously expensive, and there is some question of how effective it is.

When we project the expense of that type of institution all over the country, it takes you almost right out of any sort of range of possibility. Even that program, I am sure you say, does not do enough. I agree with your goal, that we want to work toward these things, but I am afraid I would not agree with your impression here, which says if we cannot do everything, we should do nothing.

I do not think you are saying that, but we are not going to be able to in the foreseeable future to come up with this institution which will socially reeducate everybody. However, I hope you will not use that as an excuse for not doing anything, and for not moving along with such programs as we can.

Do you know of any such institution which you would say is doing this social reeducation function? Is there a model anywhere in existence?

Mr. MENKEN. I think that there are a number of models that should not be viewed as the point of arrival. I think that there are models in motion, and that is what I have really been trying to say, talking about and addressing the issue of the model in motion, developing those models, that while I certainly would subscribe to the concept that no human being is perfect, I could not subscribe to the fact that no human being is perfect, I could not subscribe to that as that rationalization, as an excuse not to try to be, and I believe that we could try to do the very best we can within realistic parameters, and scrape as much of the air of doom, if I might put it in those terms, off of what seems to be some determined failures.

What I really mean is that all over the country we are seeing situations, where, for example, you just recently visited New Orleans, you mentioned it a few times.

I was down there not too long ago also, and I was really frustrated about the situation there.

There is an area that could use a tremendous amount of help to bring it up at least to par with some of the other areas that are models in motion.

No one has arrived to the point. I think for example one of the things that the committee might be interested in seeing sometime soon is what I have heard about, and I have not seen it myself, I intend to very, very shortly, and that is the Department of Correction model in the State of South Carolina, which was just awarded recently a Federal grant through OEO to develop a drug treatment program, within and also without of the correctional system, and my understanding at this point, at least according to the information that I have received, is that it is doing things that are revolutionary, that are truly innovative and creative, and that they are able to anticipate some long-range differentials, things that are clearly departures from our history than what the experience has been, so I think we can move.

Mr. PREYER. I think it is going to be a very difficult problem.

Mr. MENKEN. It certainly is.

Mr. PREYER. We do want to move on poverty, and all of these other elements of society which we will never solve completely, and I hope we can do something else to make a little dent in it in the meantime.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. Thank you, Mr. Chairman, and I thank you for your eloquent statement.

I notice the description of Rubicon that we have—there is appended to it the note that opinions expressed are those of the author, and not of the OEO, or of the Federal Government.

Are you the author of this?

Mr. MENKEN. No. We had an advertising firm that volunteered its services to put it together, and that statement you referred to there is required by Federal funding agencies; that must be in it.

Mr. SYMINGTON. I think only an advertising man could come up with a straight face with a thought that for the patients at Rubicon "there is no yesterday, only now or tomorrow."

Mr. MENKEN. It is a little glamorous, yes.

Mr. SYMINGTON. "Although the patient's entry into the Rubicon system is accompanied by rigid discipline in no sense of the word is the person's individuality impaired."

Mr. MENKEN. That is a very interesting kind of paradox there regarding that particular experience.

Again, I would like very much for you to see it this afternoon, and I will try to point it out to you.

Mr. SYMINGTON. I wish to reassure you that none of us here consider ourselves overnight experts.

Mr. MENKEN. I was not referring to that.

Mr. SYMINGTON. I am sure you were not, but we have become very wary, as you can imagine, of generalizations, whether they are those of people who have given up, or those of people who feel that hope is right around the corner.

We have heard many things from many people, and I think one of the most revealing observations you made to us, and one which accords with the subcommittee's findings in Japan, is that there might be cultural approaches to therapy.

Mr. MENKEN. Most definitely.

Mr. SYMINGTON. And just for the record, reading the chairman's words here, that perhaps the principal reason for Japan's apparent success in combating drug abuse is cultural in nature, that after the Government mounted its campaign, opium use became distasteful to the country's homogeneous, disciplined people.

Clearly, the American people are neither homogeneous or disciplined, and what you have suggested is that a certain direct ethnic approach, calling on some deep-seated qualities in people, might do more than all of the treatment that is not so related.

In fact, you have not just suggested it, you have stated it, that the Black Muslims have clearly done what they have done without Federal assistance.

I am wondering if there are no easy answers; it appears sometimes there are not even any hard ones, but perhaps the best thing for us to do is to report out a blank bill, and let everyone go back to their ethnic support for these things.

I know you would not recommend anything as far as that, but your testimony leads us to this kind of speculation, should we be dividing people into ethnic groups in order to find some solution to this particular problem, is one man's cure another man's problem, or are we doing this all wrong.

Mr. MENKEN. I think some of the things we are doing are all wrong.

I think that we do not necessarily have to divide up by direction or through legislation any programmatic effort by ethnic frames of reference, or socioeconomic, or whatever.

In the Rubicon system, we have approximately 67 percent black, and the balance white.

We had one oriental, and he dropped out.

We give tremendous emphasis to an educational cultural program, that is one of the components of the overall treatment process.

Tremendous emphasis is placed on the cultural frame of reference for education, which gives us an opportunity to do some very unusual kinds of things, things that are not very easily adaptable to public education systems.

An example of this might be that we have many semiliterate, though bright, poor, very disenfranchised black young people, who we are putting in at an appropriate point of their treatment experience, to this educational cultural process, and they are exposed to a brand new way of learning.

The learning is born out of that frame of reference, and it enables them to begin to understand, for example, their own language, teach someone how to spell a word that comes out of his cultural imprinting, and make it relevant to him, give him an air of comfortability, and out of that, you can then perhaps, and we are testing it, provide the broader framework where he can take the correct spelling of that, and put it into a dramatically, reasonably well-shaped sentence, et cetera, et cetera, and the reading then becomes more exciting, and something that is palatable, if not a good challenge to look forward to, so that these are the kinds of things where cultural imprinting, and a very definite programmatic regard for the backgrounds of individuals, and the very unique status of each as such must be involved.

That is a vital factor.

There are many, many others, which you get into. I know that you are kind of running late.

Mr. SYMINGTON. Thank you very much.

Mr. ROGERS. Thank you very much.

We are anxious to see Rubicon this afternoon. We will be there, and I am sure there will be a lot of questions.

I will not pursue questions at this time, because of the lateness of the hour.

We appreciate your being here.

Our next witness today is M. Miles Matthews who is representing the Richmond Regional Planning District Commission's Council on Drug Abuse Control.

STATEMENT OF M. MILES MATTHEWS, DIRECTOR, COUNCIL ON DRUG ABUSE CONTROL (CODAC), RICHMOND REGIONAL PLANNING DISTRICT COMMISSION

Mr. MATTHEWS. Mr. Chairman, I am M. Miles Matthews, director of the council on drug abuse control (CODAC), a functional committee of the Richmond Regional Planning District Commission.

I am pleased to appear before this subcommittee to discuss my planning district's response to the phenomenon of drug abuse, for I am fully cognizant of your interest in coping with the drug abuse problem and your efforts in developing meaningful legislation toward that end.

First, for your edification, I would like to give a brief description of the planning district concept in Virginia.

In 1968, the general assembly adopted a majority of the recommendations proposed by the Virginia Metropolitan Areas Study Commission.

This legislation resulted in the delineation of 22 planning district areas, and it enables local governments to join together for the planning and coordination of solutions to mutual problems.

One of the vehicles for such planning, development, and coordination of regionally significant programs is called the planning district commission.

In planning district 15 the Richmond Regional Planning District Commission has been formed to represent the city of Richmond and the seven surrounding counties.

The commission's membership includes the city of Richmond and the counties of Henrico, Hanover, Goochland, Powhatan, New Kent and Charles City.

Chesterfield County, while represented on several functional committees, including CODAC, has not formally joined the commission.

Seated on the commission are 21 men selected by their respective board of supervisors or city council to represent their jurisdiction.

The Richmond Regional Planning District Commission plans and coordinates programs in 42 functional areas under nine major committees, one of which is the council on drug abuse control.

Many contemporary issues such as air pollution, housing, water resources, and drug abuse control, do not respect political boundaries, and consequently must be dealt with as regional problems.

I shall now comment on the formation of CODAC. The commission, faced with an 1,800-percent rise in the number of drug offense arrests in Richmond and the surrounding area during the decade 1960–70, as compared to a national increase of 400–500 percent, recognized the serious proportions of the drug abuse problem.

Therefore, the commission was receptive to the suggestion that a regional planning and coordination agency for all phases of drug abuse control be established.

This suggestion, led to the formation of the council on drug abuse control (CODAC) as a new part of the commission.

This new agency was originally funded through 3-year, $30,000, federally matched pledges from the area's 35 major corporations.

Operation of CODAC began on September 1, 1970. In November, 1970 CODAC was recognized by the Governor's Council on Narcotics and Drug Abuse Control as the official regional planning, review, and coordinating arm of the Richmond Regional Planning District Commission for all programs relating to drug abuse control in planning district 15.

I would now like to draw from the comprehensive drug abuse control plan, adopted by CODAC and the commission, to discuss the estimated magnitude of the drug problem in the Richmond region.

A copy of this plan is being made available to you today.

I enclose this for the record.

(See "Comprehensive Drug Abuse Control Plan," p. 1320, this hearing.)

Mr. MATTHEWS. The trafficking in illicit drugs respects no jurisdictional lines in the region, State or Nation.

There is a growing network of drug traffickers making large profits and also, individual traffickers transporting drugs for themselves or a few friends. The use and abuse of controlled drugs is no longer a problem of the black community; every socioeconomic class is experiencing an increased incidence of drug abuse.

Nationally, and this region is no exception, the increase in drug abuse is greatest in the middle- and upper-class white community.

The average age of the addict has dropped in recent years from 25 to 19.

Not only colleges but also high schools, junior high schools and, in some few instances, elementary schools are witnessing the use and abuse of controlled drugs.

Estimates of the narcotics addict population vary. The Richmond Vice Division estimates 5,000–8,000 drug abusers, of which one-half are probably addicts.

This means an addict population in Richmond of 2,500–4,000.

This estimate presupposes a 10-percent arrest rate for all drug abusers.

With an arrest rate of 13 percent for reported major crimes—larcency, robbery, burgarly, auto theft, murder, rape, aggravated assault—crimes with complainants, this addict population estimate is probably low.

Drug abusers certainly victimize themselves, but complaints of the magnitude attributable to major crime do not come forth from this clandestine activity.

Area medical personnel involved with the treatment of drug abusers have estimated the addict population to be as high as 10,000. However, this figure is based on the verbalizations of patients and may be considered high.

Other indicators may give a more accurate estimate. There are at least 350 persons professionally involved in trafficking in narcotics and dangerous drugs, according to the Richmond vice division.

They certainly must have a rather large market for their contraband.

Operating as a loose confederation of criminals, they do not comprise a syndicate or "family" in the Cosa Nostra sense of the words.

Their purpose is the purchasing, transporting, processing, storing, distributing, and selling of controlled drugs of all types, but principally the narcotics.

From information gathered 1 year ago, the Richmond vice division estimated 220,000 capsules of 2.5 to 3 percent "street dose" heroin a week could be produced based on what was known regarding the distribution of genuine hydrochloride, one of several adulterants or "cutting agents" for heroin.

Probably not all of this quinine was used in the Richmond area, and this is but one cutting agent.

Delegate Stanley C. Walker, chairman of the State crime commission, supports this estimate.

Crime in the urban portion of the region rises 28 to 30 percent every year compared to a national average rise of 13 percent.

The Richmond commonwealth attorney estimates that 35 percent of crime is drug related. A large addict or drug-abusing population could therefore be expected to exist where crime rise is sharp.

The courts of the Richmond area report a caseload of some 300 persons a month which judges can identify as drug abusers.

The Richmond commonwealth attorney reports one-third of his office caseload are drug charges, compared with 20 percent a year ago.

The Governor's Council on Narcotics and Drug Abuse Control estimates that 75 percent of persons ages 5 to 25 years experiment with drugs.

Use of drugs regularly is estimated at 25 percent of that age group. This means that of the city's youth population of 125,000, some 30,000 belong to the drug subculture, or 70,000 young persons in the region.

Taking into account these indicators relating to drug abuse, it is still difficult to estimate the addict population.

Perhaps 5,000 to 8,000 exist in the metropolitan area. This figure is in line particularly with the heroin production estimates cited earlier. At any rate, it is evident that the region is experiencing a rapid rise in addiction and drug abuse.

Narcotics, of course, are not the only drugs of abuse.

Nationally 200 million prescriptions for psychoactive drugs were filled last year. This comprises 40 percent of all drugs prescribed.

There are over 7,000 types of drugs under 22,000 brand names.

Drugs are being abused for a wide variety of reasons. Curiosity, adolescent peer pressures, alienation, the need to escape, ease of availability, the profit motive, and the need to achieve new levels of consciousness are some reasons for drug abuse.

Two points must not only be recognized immediately but also acted upon.

They are the foundation on which all programs must be based.

1. As Sonnedecker, in "Passport to Paradise" writes:

> Measures to deal with these concepts cannot be found quickly and easily. So we return again, at a new level of understanding to the intuitive 18th century remark that "the mischief is not really in the drug but in the people."

2. There is no one approach in dealing with the problem of drug abuse. All approaches must be attempted with vigorous application of each method.

CODAC, through its committee structure, composed of 30 men and women nominated by the local governments, takes a fourfold approach to solving the area's drug abuse problem:

(1) Public education to inform the general public of the drug-abuse problem and what must be done;

(2) Juvenile drug-abuse education to prevent an increase in the number of abusers;

(3) Training and equipment aid to enforcement and criminal justice personnel to control illicit trafficking, and;

(4) Expansion of treatment programs working with drug abuse to promote effective rehabilitation.

EDUCATION AND INFORMATION

These are programs to head off drug abuse before it begins.

These campaigns must be initiated to keep those who have not experimented with drugs from every beginning, and to convince those who can still make choices to give up drugs before choice is no longer possible.

These programs should be directed at the attitudes and level of awarness that contribute to a drug problem, as well as the various known facts on drug action and abuse.

This point should be reemphasized.

The direction of drug education in the school systems must now focus on the socialization process and those adverse factors which tend to predispose young people toward counterproductive behavior.

Once drug abuse is seen as an inadequate coping mechanism in dealing with social and psychological problems, it becomes evident that informational programs can do little, if anything, to deter drug abuse.

The feelings and problems inherent in the adolescent maturational process, which often extends far beyond adolescent years, must be dealt with by the schools with the goal being the inculcation of viable, personal coping mechanisms and ego strength, and the offering of alternatives to self-abuse and nonproductive behaviors.

In short, drug education programs which will have a chance of meeting their stated goals will have to focus primarily on assisting adolescents in developing the skills to above normal, personal adjustment problems and enabling them to live in a society fraught with rapid social change.

REHABILITATION

Programs to treat the victims of drug abuse must be expanded.

Treatment services means a combination of medical, social, and psychiatric services designed to help the drug dependent person to cease taking drugs or to ease his pain as withdrawal is accomplished.

Therapeutic services can include psychotherapy, family therapy, general medical treatment with combined chemical psychiatric elements, individual psychiatric counseling; and group therapy.

Rehabilitation aftercare can include extensive counseling or the encounter-group method of psychological rebuilding.

Social services, personal health counseling, vocational refresher training or job-skills development are also essential.

Rehabilitation and treatment also mean attention to serious psychological or mental disturbances which are long term in nature, and which might pose harm to the ex-abuser long after his habit is broken.

LAW ENFORCEMENT

Programs to cut off the supply of drugs must be upgraded.

Law enforcement programs are generally aimed at eliminating the supply and availability of drugs which feed the habit of the abuser.

These programs may include adding men to a squad; creating specialized narcotics units; training in general and intensive enforcement techniques; governmental agreements where drug traffic crosses boundaries; crime laboratory services; and investigatory equipment systems.

Programs which include elements of the above approaches, but are to the layman perhaps less directly involved in the solution, must nevertheless be instituted.

These are programs which attempt to alleviate social conditions which breed drug abuse.

Most professionals recognize that several social conditions—poverty, unemployment, ghetto tension, boredom, the absence of parental or peer guidance, fadishness—can contribute to the incidence of drug abuse and drug dependence among various segments of the public.

Therefore, there might be implemented programs aimed at these underlying social conditions: job-training, organization of youth groups and channeling of youthful energies and curiosities, establishment of volunteer service core groups, the establishment of "crisis intervention" or "drop-in" centers; and expansion of emergency telephone services.

These approaches have been adopted by CODAC and have resulted in the development of several programs currently operating in the region.

A summary of CODAC implemented or assisted projects is attached to this testimony.

I would like this to be made a part of the record.

(See "Progress Report"—The First 12 Months of Operation of the Council on Drug Abuse Control, Richmond Regional Planning District Commission," p. 1361, this hearing.)

Mr. MATTHEWS. Generally, past progress and indications of future programs activity may be summarized as follows:

JUVENILE EDUCATION

CODAC operates formal training programs and awareness sessions for teachers, guidance counselors, school administrators, and students and assists in developing drug education programs for the eight school systems in planning district 15.

PUBLIC EDUCATION

CODAC plans with and coordinates the various broadcast, information, and news media to create awareness of the existence of drug abuse, the dangers of drug abuse, and potential solutions to the problem.

In addition, CODAC provides medical, guidance, law enforcement, education, pharmaceutical, and other volunteer personnel through its regional speakers' bureau to talk about these, and related topics.

CODAC serves as a regional clearinghouse for drug abuse information and control programs.

Part of this attack on the roots of drug abuse is carried out in conjunction with the City of Richmond Drug Information Center, which provides films, literature, and exhibits to schools and the general public.

CODAC has presented exhibits at the State fair and in other areas which attract large numbers of people, and has assisted in the production of three local television series, "Drugs in Richmond," "Weeks I and II," and the "Turned On Crisis."

CODAC was also instrumental in providing funds for a second "Turned On Crisis" series to be retelecast.

ENFORCEMENT

There are few law enforcement officers working full time on illegal drug trafficking in the region.

CODAC works to assure efficient detection of traffickers and dealers and their drug sources.

CODAC has assembled sophisticated investigative equipment for use by police and sheriffs in combating high level narcotics trafficking through a regional equipment pool.

CODAC has assisted in the development, funding, and implementation of officer training programs ranging from 3-day awareness seminars through 80-hour courses, to sending men to the 10-week Bureau of Narcotics and Dangerous Drug Training School.

Also, in the final planning stages is the establishment of a regional narcotics strike force, similar to the MEG forces operating in a few other urban areas of the Nation.

REHABILITATION

Merely locating and jailing drug traffickers and abusers will not solve the problem.

Rehabilitation and therapeutic programs such as Rubicon, the RAP Center, the city health department Narcotics Addict Rehabilitation Act program, the MCV Adolescent Clinic and the Methadone Therapy Clinic at MCV have been assisted in project design, coordination, and filing applications for funds.

The commission has been awarded grant funds to maintain and expand this last program.

Consolidation in new facilities of the MCV methodone therapy program, Rubicon's outpatient counseling, and consultant medical service is expected to begin next week.

I would like to make a recommendation voiced by the head of the Narcotics Addict Rehabilitation Act program in Richmond.

The current NARA program has a limited impact due to the fact that only referral by Federal courts enables Federal parolees to be followed in aftercare.

I agree that referrals from local courts for such aftercare would add greatly to the impact of this program.

These programs have in part been made possible through a planned, cooperative effort utilizing CODAC as the vehicle for action.

However, the planning deve'opment and coordination of these and future programs cannot rest only on the spirit of cooperation that is demonstrated by the policymakers and program implementors.

It is here that Federal and State planning legislation, the Richmond Regional Planning District Commission and the council on drug abuse control come together.

Under Federal legislation, including provisions of section 204 of the Demonstration Cities and Metropolitan Development Act of 1966 and title IV of the Intergovernmental Coordination Act of 1966, implemented by the Office of Management and Budget Circular A–95, the commission serves as the regional clearninghouse for applications seeking State and Federal funds.

Under the Virginia Redevelopment Act, section 15.1–1410 of the Code of Virginia, planning district commissions must receive for review and comment any application for State or Federal funds.

Finally, the Governor's Council on Narcotics and Drug Abuse Control has recognized the commission's council on drug abuse control as

the areawide review and coordination agency for all drug abuse control programs in planning district 15.

With this review and comment mandate, the commission is empowered to coordinate programs to avoid duplication of effort, and to reduce fragmentation of services.

Since the majority of meaningful programs rely on State and Federal funding, the ability to plan and coordinate via this mandate is clear.

Combined with the support of the community and the overall willingness to cooperate, the commission and CODAC have been able to foster strong, new programs in these past 13 months.

However, it is clear that these programs and the alliances forged have not been without their problems.

The coordinative review and comment process, which has been highly effective in this region, would be substantially improved, in my opinion, if the Federal legislation regarding all drug abuse control programs included mandatory State clearinghouse and, where applicable, sub-State regional clearinghouse review and comment processes.

It seems obvious that better coordination of drug abuse control projects is needed, in light of the information emanating from Washington regarding the consolidation of programs under one Federal authority.

This need, in my opinion, can be seen to logically extend to the local level, where a plethora of funding sources and program categories may easily foster the fragmentation, duplication, or overlapping of projects.

Notwithstanding a coordinated Federal programs approach, it is my recommendation that all drug abuse control programs include State and regional review and comment processes in line with current legislation operant in the Commonwealth of Virginia.

Mr. Chairman, I believe this recommendation, incorporated into all applicable drug abuse control programs would strengthen their effectiveness and promote mechanisms for community action beyond the sphere of Federal funding.

I should point out that the recommendations made in this testimony are my personal opinions and do not necessarily represent those of the Commission or CODAC at this time.

I thank the subcommittee for this opportunity to submit my comments and would like to express my desire to further operate in this activity which hopefully will lead to further legislation to alleviate the drug abuse problem.

(The attachments referred to follow:)

COMPREHENSIVE DRUG ABUSE CONTROL PLAN

CHAPTER SEVEN OF THE

Criminal Justice Plan for the Richmond Region

ADOPTED BY THE COUNCIL ON DRUG ABUSE CONTROL RICHMOND REGIONAL PLANNING DISTRICT COMMISSION OUTLINING EXISTING SYSTEMS AND PROPOSED PROGRAMS UTILIZING FUNDS FROM THE VIRGINIA COUNCIL ON CRIMINAL JUSTICE UNDER THE OMNIBUS CRIME CONTROL AND SAFE STREETS ACT

CHAPTER 7

DRUG ABUSE CONTROL

Introduction

The word "Drug" legally defined in the Food, Drug, and Cosmetic Act of 1938, means "articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man and other animals, and articles intended to affect the structure or any function of the body of man or other animals". As stated in the book Common Sense Lives Here, "Drugs have been known to man since the days of ancient Egypt. Some reports indicate that the Chinese used marijuana fifty centuries ago to treat various diseases." Plato described the results of excessive drinking of wine; a Sumerian Clay tablet describes an herb thought to be opium; Homer's Iliad speaks of drug use in describing the cup of Helen. 'Pain-killers have accompanied man into battle almost since the first time he took up arms". The unreserved medical use of opium and the increased self-medication with opium preparations created so many addicts as a by-product, that addiction became known as the 'army disease' and the 'soldier's illness' during the American Civil War. Drug use, then, is a part of our human history -- and so is drug abuse.

Today there are over 7,000 types of drugs under 22,000 brand names. Amphetamines, barbiturates, heroin, hashish, marijuana, cocaine, LSD, STP, FDA, DMT, psilocybin, peyote, mescaline, and PCP are some of the drugs being abused for a wide variety of reasons. Curiosity, adolescent peer pressures alienation, the need to escape, ease of availability, the profit motive, and the need to achieve new levels of consciousness are some reasons for drug abuse. Sonnedecker, in Passport to Paradise writes, "Measures to deal with these concepts cannot be found quickly and easily. So we return again, at a new level of understanding to the intuitive 18th century remark that 'the mischief is not really in the drug but in the people'."

Drug abuse is symptomatic of deeper, under-lying problems. As stated in Common Sense Lives Here, "Poverty, racial friction, urban blight, taxes, the Vietnam War, school and campus unrest, soaring prices, the intense pressure on young people to be excellent and to 'succeed' -- on and on goes the catalogue of social pressures and perils. Frequently, instead of trying to resolve the social conflicts and closing the gaps that our world creates, we use drugs to 'buffer' for us -- we use them as substitutes for genuine problem-solving. Pills and compounds and liquids that offer temporary escape or relief from reality do not let us live genuine lives, but because genuine

life is sometimes very painful, or very boring, drugs may seem to some to be the best -- or at least one -- substitute for reality ... Drug abuse can follow on the heels of an individual's indiscriminate and unconsidered replacement of problem -- solving with artifical substitutes ... (Therefore) we need to look long and hard at social mechanisms as well as body chemistry and human psychology.

"Risk behavior is a part of growing up." Young people take chances. "Drug experimentation has, in some quarters, become the paramount kind of risk behavior ... Risks usually create fads, whole clusters of behavior followed just because 'they' are doing it ... The influence of the peer group, and what the group is doing, is often the deciding factor in a young person's drug-related choices.

"Drugs may seem magic, but aren't ... as science and medicine developed many life-saving drugs, it became popular to talk about 'wonder' drugs. (However) we shouldn't expect a pill-supported kingdom to emerge, were everyone is beautiful, no one fights wars, and the sun always shines. Although drugs can help heal and preserve the well-being of the body, they cannot be expected to change the world by solving all of life's problems."

Finally, the trafficking in illegal drugs is big business. "A 10-kilogram bag of raw opium, worth about $400 at its overseas source, can bring nearly $250,000 here in the U. S. when reduced to heroin, cut, and sold in $5 packets. Marijuana and opium smuggling from various foreign countries is big business, although the governments involved have tried cooperatively to put an end to the flow. There is the potential to manufacture an estimated 10 billion tablets of all kinds in the U. S. each year, and unfortunately many of these tablets find their way into the illegal market.

"So, drug traffic that is illegal is also occasionally very profitable ... Since the demand is high for illegal drugs, and the supply relatively low, the prices are still significant and the business of drug trafficking thrives."

APPROACHES TO SOLVING THE DRUG ABUSE PROBLEM

There is no one approach in dealing with the problem of drug abuse. All approaches must be attempted with vigorous application of each method. The various modalities may be generally arranged in four categories, education, information, rehabilitation, and enforcement.

Education and Information

These are programs to head off drug abuse before it begins. These campaigns must be initiated to keep those who have not experimented with drugs from ever beginning, and to convince those who can still make choices to give up drugs before choice is no longer possible. These programs should employ various communications and educational devices -- the schools, the mass media, public speakers. Education and information programs should be directed at the attitudes and level of awareness that contribute to a drug problem, as well as the various known facts on drug action and abuse.

Rehabilitation

Programs to treat the victims of drug abuse must be expanded. Treatment services means a combination of medical, social, and psychiatric services designed to help the drug dependent person to cease taking drugs or to ease his pain as withdrawal is accomplished. Therapeutic services can include psychotherapy, family therapy, general medical treatment with combined chemical/psychiatric elements, individual psychiatric counseling, and group therapy. Rehabilitation aftercare can include extensive counseling or the encounter-group method of psychological rebuilding. Social services, personal health counseling, vocational refresher training or job-skills development are also essential. Rehabilitation and treatment also mean attention to serious psychological or mental disturbances which are long-term in nature, and which might pose harm to the ex-abuser long after his habit is broken.

Law Enforcement

Programs to cut off the supply of drugs must be upgraded. Law enforcement programs are generally aimed at eliminating the supply and availability of drugs which feed the habit of the abuser. These programs may include adding men to a squad; creating specialized narcotics units; training in general and intensive enforcement techniques; governmental agreements where drug traffic crosses political boundaries; crime laboratory services; and establishing investigatory equipment capabilities.

Programs which include elements of the above approaches, but are to the layman perhaps less directly involved in the solution, must nevertheless be instituted. These are program which attempt to alleviate social conditions which breed drug abuse. Most professionals recognize that several social

conditions -- poverty, unemployment, ghetto tension, boredom, the absence of parental or peer guidance, faddishness -- can contribute to the incidence of drug abuse and drug dependence among various segments of the public. Therefore, there might be implemented programs aimed at these underlying social conditions: job-training, organization of youth groups and channeling of youthful energies and curiosities, establishment of volunteer service core groups, the display of exhibits to schools and the general public, the establishment of "crisis intervention" or "drop-in" centers; and expansion of emergency telephone services.

All the above programs require planning and coordination in order to result in a meaningful system that bridges political boundaries in step with the drug abuse problem. The regional agency for this purpose is CODAC, the Council On Drug Abuse Control of the Richmond Regional Planning District Commission.

DESCRIPTION OF EXISTING SYSTEMS AND AVAILABLE RESOURCES

Description of existing resources will be divided into six components: CODAC, Enforcement, Juvenile Education, Public Education, and Rehabilitation, and grant award programs.

CODAC

In July, 1971, Mr. William V. Daniel, Richmond City Councilman, and Mr. F. John Kelly, Executive Director of the Governor's Council on Narcotics and Drug Abuse Control approached the Richmond Regional Planning District Commission to encourage that there be established a regional planning and coordination program for all phases of drug abuse control. This approach of establishing regional drug councils within the 22 Planning District areas of Virginia was adopted by the Governor's Council to bring local jurisdictions together to solve a mutual problem. The Commission established a Study Committee on Narcotics and Dangerous Drugs at the July meeting.

On August 14, 1970, the Commission was presented the report of the Study Committee. The Commission formally adopted the program which includes nine basic charges made to CODAC:

1. To thoroughly investigate and research the extent and scope of all problems relating to narcotics and drug abuse within Planning District #15; to undertake a survey of present and potential facilities and services available in State and local, public and private, agencies, institutions, and associations which can be cooperatively applied to the solution of existing and anticipated problems.

2. To coordinate, mobilize, and utilize the research and public service resources of higher education, government, business, industry, and the community at large in the understanding and solution of these problems.

3. To promote continuous public support and the environment and public attitude necessary to develop and maintain maximum effectiveness in the performance of its authority and responsibility.

4. Consistent with Virginia planning legislation regarding review and comment procedures of Planning District Commissions, and those programs developed and being developed by the Governor's Council on Narcotics and Drug Abuse Control, the Council on Criminal Justice, and pertinent state and federal agencies, and in cooperation with those agencies and councils, to formulate a comprehensive plan for the long range development, through utilization of federal, state, local, and private resources, of adequate programs, services, and facilities for drawing together into a unified and coordinated effort all research, prevention, control, treatment, rehabilitation, and law enforcement activities for the prevention and control of narcotics and drug abuse, and for the diagnosis, treatment, and control of narcotics and drug abuse, and to revise such plan from time to time.

5. To promote, develop, establish, coordinte, unified programs and activities to accomplish the objectives of the foregoing.

6. In cooperation with the Governor's Council on Narcotics and Drug Abuse Control, to provide for the dissemination of information and the collection and encouragement of research related to narcotics and drug abuse prevention and control, and to establish an information, collection, and dissemination network within the framework of existing federal, state, local, public and private agencies and institutions having access to reliable information upon which enlightened policy decisions aan be formulated and implemented.

7. To survey and analyze, plan and implement programs, services institutions, or facilities for the study, care, treatment, rehabilitation, and after-care of persons addicted to the use of narcotics and dangerous drugs.

8. To seek, receive, take, hold, and use for the purposes herein, any and every grant, gift, devise, or bequeath made to the Richmond Regional Planning District Commission.

9. To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers.

In the latter months of the summer of 1970, Mr. Daniel and Mr. Kelly approached the area's thirty-five largest business firms for financial support for the program. Pledges for $30,000.00 per year for three years were sought, with the goal nearly realized.

CODAC officially began operation on September 1, 1970. The Director and secretary were hired, four Committees appointed, and an Action Grant application for funds to match the local monies was submitted to the State Division of Justice and Crime Prevention.

In the six months that CODAC has been operating, several strides have been made beyond the period of becoming organized for action. CODAC was on November 5, 1970 unanimously recognized by the Governor's Council on Narcotics and Drug Abuse Control as the regional coordinating agency for drug abuse programs in Planning District #15. Each local jurisdiction had nominated members to CODAC, based on a percentage of population in the region. The members, appointed by the Chairman of the Richmond Regional Planning District Commission were divided into four Committees by the Chairman of CODAC, Mr. William V. Daniel. Activities of the four Committees will be described below, as this chapter of the element is divided into components corresponding to the Committees: Enforcement, Juvenile Education, Public Education, and Rehabilitation. Existing systems, resources, needs, problems, and proposed programs will be presented in the four functional areas.

Enforcement Systems and Resources

The judicial, correctional, probation, and enforcement systems of the region have been discussed at length previously in this plan. The CODAC Enforcement Committee assessed the enforcement capability for narcotics and dangerous drug cases.

Richmond --- The Richmond Bureau of Police Vice Division was enlarged in FY 69-70 to include one Lieutenant, two Sergeants, fifteen Detectives and a

civilian Clerk Typist. One-half of the Vice Division comprises the Narcotics Squad. Officers have engaged in intensive training courses and refresher courses. Twenty-six officers attended the Commission's two-week training course. The squad cooperates with other jurisdictions as well as the FBI, IRS, and other federal and state enforcement agencies in solving drug violations. No field test kits are on hand.

Henrico --- The Henrico County Police Department has two Patrolmen working full-time on drug violations. They are supported by ten Detectives who work drugs on a part-time basis. In March 1971, the Henrico County Board of Supervisors authorized an additional one full-time Patrolman to work drug cases. The Sergeant has had intensive training and nine officers attended the Commission's two week training course. Like Richmond, the narcotics officers cooperate fully with other enforcement agencies. Eleven Narcoban field test kits are on hand. These are the Marquis Reagent type.

Chesterfield --- The Chesterfield County Police Department has six men working part-time on drug violations. One man attended the Commission's two week training course, although most officers have received a one day course in awareness training. Two field test kits are on-hand. The Department cooperates fullywith other enforcement agencies.

Goochland --- The Goochland County Sheriff's Department has three men working part-time on drug cases. Two men attended the Commission's two-week intensive training course. Cooperation with other jurisdictions is excellent. No field test kits are on hand.

Hanover --- The Hanover County Sheriff's Department has a part-time capability for durg case-work. Two men attended the Commission's two-week training course. No field test kits are on hand. Cooperation with other agencies is a matter of course.

New Kent --- The New Kent County Sheriff's Department has a part-time capability only and relies on the State Police as well. No one has attended intensive training programs and no field test kits are on hand.

Charles City --- The Charles City County Sheriff's Department has a part-time capability only and relies on the State Police as well. One man attended the Commission's two-week training program and no field test kits are on hand.

Powhatan --- The Powhatan County Sheriff's Department has a part-time capability only and relies on the State Police as well. No one has attended intensive training programs and no field test kits are on hand.

Juvenile Education

The CODAC Juvenile Education Committee has assessed the drug education programs offered by the region's school districts. The thrust of teacher training and in-class instruction of juveniles can be generally discussed.

In the Spring of 1970, the State Department of Education sent its Drug Education Coordinator to an eight-week training project in New York. In July, the Department sent four men to the eight-week National Drug Education Training Center Project at the University of Texas Medical School at San Antonio. The Director of CODAC was one of the four attending for the Governor's Council on Narcotics and Drug Abuse Control. The five men are considered the state team for consultation in developing drug education projects, although it must be stated that the four Texas attendees have not been consulted by the State.

The purpose of sending the five to the eight-week schools was to develop state-wide teacher training programs. However, in August, before the Texas school was completed, the State of Virginia began four regional conferences for division level personnel. One conference was held at Virginia Commonwealth University.

The out growth of the two-week conferences was to be the establishment, in each school district, of sessions for the training of teachers. The State Department of Education has recommended only eight to ten hours of instruction for each district, with speeches being given by whatever person is available. These sessions are described as awareness sessions and do not give full instruction on how to conduct drug education programs. Each jurisdiction in the region has participated in the various levels of instruction. The CODAC Juvenile Education Committee realizes that these teacher training sessions are not sufficient for proper juvenile education on drug abuse.

Each school district offers health and physical education to the middle and upper grades. Alcohol and Drug Education comprise a portion of the health education element. Often the instruction is presented by teachers who have of their own volition, gathered available information. Visual aids, films, and textbooks vary widely, although these needed supplies are being increased by the various districts.

The City of Richmond Public Schools are soon to adopt a drug education curricula for grades K through 12. With minor modifications, this guide is the American School Health Association's Teaching About Drugs. Henrico County and Chesterfield County Public Schools have begin consideration of curricula.

The need for more teacher instruction, curricula and teaching aids exists, and will be discussed below.

Public Education

The CODAC Public Education Committee is involved in designing, implementing, reviewing, and coordinating public information projects on drug abuse. The Richmond Regional Planning District Commission and the Governor's Council on Narcotics and Drug Abuse Control recognizes CODAC as the regional clearing-house for information on drug abuse.

Projects of CODAC engineered by the Public Education Committee in coordination with several others include the following to-date:

Regional Speaker's Bureau -- In cooperation with area enforcement agencies, the MCV Adolescent Clinic, the Methadone Center, Rubicon, CODAC members, health educators, pharmacists, and others there are some fifty persons available to speak on various drug abuse topics including the Regional Drug Abuse Problem; History of Drug Abuse; Enforcement, Drug Laws; Youth Culture, Drug Subculture; Symptomatology, Pharmacology, What Drugs Do and What To Look For; Community Action; Education, School Programs; Treatment and Rehabilitation; CODAC; and Rubicon. To-date the Speakers Bureau has provided forty speakers for various groups. The Richmond Bureau of Police Vice Division alone in FY 69-70 gave 152 talks to 8,691 persons. Dr. George Bright and Dr. Ted Abernathy of the MCV Adolescent Clinic gave 214 speeches in calendar 1970 to approximately 58,000 persons. Rubicon personnel the Methadone Center, and the other enforcement agencies have been busy as well. It is expected that the public demand for speakers will increase rapidly in the future.

Times-Dispatch Sunday Supplement -- On Sunday, September 21, 1970, the Richmond Times-Dispatch published a supplement entitled "Drug Scene -- What Every Parent Should Know". The magazine, prepared by the Junior League of Richmond, was re-printed twice and total distribution was over 300,000. A coupon to be transmitted to CODAC brought over 1000 responses.

The Junior League publication included interviews with Mr. F. John Kelly and Dr. George M. Bright, a case history of an addict, referral information, articles on what was then organized to combat drug abuse, and information on symptoms, drug action, and problems.

Exhibits -- CODAC in cooperation with the Governor's Council presented an exhibit at the Virginia State Fair in the fall of 1970. Some 14,000 persons viewed the exhibit consisting of a slide presentation on the drugs of abuse, an exhibit of drug action on internal organs supplied by the Chesterfield County Health Department, posters and pamphlets. The exhibit was manned by Phi Delta Chi, Professional Pharmacy Fraternity of MCV.

In November CODAC in cooperation with the Richmond Area Mental Health Assoication presented an exhibit at Azalea Mall as part of the two-week Federal Bar Association exhibit. Elements of the State Fair Exhibit were used plus a large electronic display depicting drug action on the human body.

Grant Review -- The Committee, and subsequently CODAC and the Commission, reviewed an Urban Assistance Incentive Fund application from the Church Hill Model Neighborhood Policy Board seeking funds to implement a series of drug forums for the Church Hill area. The Committee will review materials and visual aids prior to their public dissemination.

Television Series -- The use of radio, television and the printed media has been effective in disseminating information regarding progress in the various programs. Beyond the news release and interview articles three major public information programs have begun.

During February 21-27, 1971, station WWBT-TV, Channel 12, produced a special series of programs entitled Drugs in Richmond. The series of half-hour programs ended with two hours live during which viewers could phone in questions. Five hundred and fifty questions were recorded, and sixty-six were answered. The programs included persons from CODAC, the Governor's Council, Rubicon, Richmond Police, Richmond Courts, the Commonwealth Attorney, MCV, and the Public School System. More such programs are planned.

Television Series -- In January, 1971, the CODAC Public Education Committee was approached by station WCVE-TV, Channel 23, to review, endorse, and assist in promoting a series entitled "The Turned On Crisis". Eight hour-long programs on the many facets of drug abuse, prevention, and treatment comprise the series. Through a grant from Richmond Corporation, the programs were taped and delayed one month in order to allow the necessary audience-building campaign. In addition, two local shows are to be produced making a total of ten shows aired every Tuesday and Wednesday in March.

The Committee endorsed the series in January. CODAC likewise endorsed the series on January 21, 1971 and engaged in the promotional campaign, appointed a Screening Committee and solicited the aid of the Community Relations Manager of A. H. Robins, Inc., and the president of Martin and Woltz, Inc., Advertising Consultants.

Financial and membership support was sought from the civic organizations of the region. The public schools, Retail Merchants Associations, Public Relations Association, Richmond Clergy Association, Richmond Area Community Council and area television, radio, and newspapers supported the project through advertising and distribution of materials. Donated advertising space and time from out-door advertisers, transit advertisers, and the media resulted in the largest promotional campaign in the U. S. according to the national Public Broadcasting System (PBS).

Financial support included some contributions from area men's clubs. The Richmond Health Department contributed over $3,000.00 from its element of the LEAA Discretionary Grant and CODAC supplied some $1,200.00.

Drug Information Center -- In February, 1970, an Ad Hoc Committee was formed in the City administration to develop drug abuse control programs. A Large City Special Grant application was prepared seeking LEAA funds to implement a Comprehensive Metropolitan Narcotics and Dangerous Drug Control Program. Funded in December, 1970, the program provides over $51,000.00 to establish public information programs for the City.

Since the drug problem respects no jurisdictional boundaries, a cooperative arrangement has been instituted between CODAC and the LEAA funded Drug Information Center of the Richmond Health Department. A common phone line has been established. This will enable the public to phone one number for speakers, printed matter, guidance on projects, or answers to questions.

Pamphlets, booklets, etc. -- CODAC has disseminated some 3,000 resource lists for drug abuse information. Two thousand booklets -- 1000 Primer on Drugs and 1000 Guidelines to Community Action -- are available for distribution by the CODAC/Richmond Drug Information Center. The Center will prepare for distribution some $14,000.00 worth of pamphlets designed by N.I.M.H. and B.N.D.D. In addition, the Center will develop a referral pamphlet describing what agencies can be contacted for help with drug problems. CODAC is preparing a pamphlet outlining its activities so as to prompt the public to seek guidance and assistance in developing programs.

The public information activities have been highly successful to date, but have only begun to inform the public and mobilize them to action.

Rehabilitation

The treatment of the victims of drug abuse is of paramount importance in solving the drug abuse problem. The CODAC Rehabilitation Committee has assessed the current treatment capability of the region. The members represent every program in the region with an organized treatment approach.

The existing rehabilitation systems and available resources are described as follows.

Area Hospitals -- The Director of the Richmond City Health Department contacted thirteen hospitals in the region. The results of that survey are the following:

	Hospital	Drug Abuse Treatment
1.	Johnston-Willis Hospital	None
2.	Retreat For the Sick Hospital	None
3.	St. Elizabeth's Hospital	None
4.	St. Mary's Hospital of Richmond, Inc.	None
5.	St. Luke's Hospital	None
6.	Stuart Circle Hospital Corp.	None
7.	Veteran's Administration Hospital	None
8.	Richmond Memorial Hospital	No organized program. Emergency room and small amount of psychiatric care.
9.	Tucker Hospital, Inc.	No organized program. private psychiatric care only.
10.	Central State Hospital at Petersburg	No organized program, short term detoxification; 30 day maximum; very few voluntary admissions.

11.	Eastern State Hospital at Williamsburg	No organized program, Volunteer admission for 3-4 days for detoxification; facilities for patients committed for only 3 weeks, no follow-up.
12.	Westbrook Psychiatric Hospital, Inc.	No organized program, only private patients, although N.A.R.A. do use it for after-case.
13.	Medical College of Virginia	Well organized Methadone Clinic; Bureau of Alcohol and Drug Abuse Studies, MCV Adolescent Clinic.

Although all hospital emergency rooms can treat acute narcotism or other drug toxicity reactions (over-doses), only the Medical College of Virginia houses any organized, long-term treatment program.

The elements housed in MCV are the following.

Methadone Center -- The only recipient of the Food and Drug Administration's Investigative New Drug (I.N.D.) authorization in Virginia, the program is operated out of the MCV Department of Pharmacy Services. The program can legally dispense methadone to narcotics addicts for a period exceeding ten days. Methabase in orange syrup and "paste" form, containing the proper dosage of methadone, is dispensed on the premises of the Center. Several authorized satellite pharmacies in the region also dispense methadone under the Center program. Counseling is an informal operation of the pharmacy staff and requires upgrading. Some 185 patients are currently involved in the program, which for the greatest majority is a reducing dosage rather than maintenance. Financial support is derived from fees charged to patients.

Bureau of Alcohol and Drug Abuse Studies -- The Bureau is an agency of the State Department of Health. Dr. Joseph T. Byrne, a staff physician, assisted by a medical student, conducts the required physical examinations, collection of urine samples and

blood samples. Dr. Byrne prescribes the methadone for the patients and monitors their medical needs. Recently the State Health Department stated that laboratory testing, detoxification, physical examinations, and urinalysis would be funded by the Department. It is expected that Dr. Byrne will be assigned to full-time drug abuse case work, as he is now devoting many hours of his own time. Financial support is derived from fees charged to patients.

The Methadone Center and Dr. Byrne work hand-in-hand, a required relationship.

MCV Adolescent Clinic -- The Clinic directed by Dr. George M. Bright exists to treat all adolescent medicine problems. However, some 95% of cases treated include a history of drug abuse. More than 50% of the case-load is directly drug-related. Part of the MCV Department of Medicine, the Clinic is an out-patient clinic. There is a great need for in-patient facilities. Currently approximately 70 patients are in the treatment of Dr. Bright or his only assistant Dr. Ted Abernathy. A small number of medical students assist as part of an elective course.

A medical drug abuse library is being expanded with the assistance of a Title I grant. An LEA grant assisted in furnishing and equiping the clinic.

The clinic makes use of the Methadone Center, and is the only operation in the U. S. which involves adolescents in methadone therapy. Counseling is provided by the clinic staff.

Testing Capabilities -- The State Department of Health has recently become involved in providing the needed laboratory testing capability for the Methadone Clinic and Dr. Byrne's closely related program. The Chief Toxicologist of the Office of the State Medical Examiner, conducts the urine surveillance. Blood tests are conducted by the State Department of Health as well.

The MCV Adolescent Clinic has its testing done by the MCV Department of Medicine.

Currently, both testing facilities are over-taxed, and plans are being discussed to provide a full laboratory capability for all drug abuse programs.

Rubicon -- Rubicon is a project of the Richmond Community Action Program (R-CAP) and is funded 80% by a grant from the Office of Economic Opportunity matched by 20% in in-kind medical services through the Bureau of Alcohol and Drug Abuse Studies of the State Department of Health and the Methadone Center.

Rubicon is a therapeutic community consisting of a two phase program; in-residence or out-patient. The project is directed by former addict and specialist for the New York Addiction Services Agency, Mr. Edmund H. Menken.

The in-patient program is housed at 2718 E. Franklin in a three-story home restored by the residents. Having a capacity of 30 residents, the project is now operating, after three months, with 45 residents. Voluntary admissions and court referrals are the primary courses of entry. Other referral sources are being developed pending acquisition of additional facilities. A staff of fourteen operates the facility and the out-patient program.

Located at 1010 E. Marshall Street in the R-CAP head-quarters, the Clinical Induction Unit of Rubicon maintains a small office staff and conducts Screening Committee meetings. The out-patient program is centered there, with the majority of counseling being conducted at Rubicon on Franklin Street.

An addict or drug dependent person seeking admission to Rubicon or the Methadone Center program must first be screened at the Clinical Induction Unit. If he seems committed to the self-help program he is referred to Dr. Bryne at the Alcohol and Drug Abuse Studies Unit at MCV for medical examination, urinalysis, and blood testing. The Screening Committee, made up of Rubicon and Methadone Center

personnel then develcps a Preferred Treatment Plan which generally is catagorized as: 1) in-patient, drug-free; 2) in-patient, methadone therapy; 3) out-patient, drug-free, or 4) out-patient, methadone therapy. The applicant may decide to develop his own treatment plan, called the Selected Treatment Plan, again following the four categories. He is given the option to enter the Selected Plan only if he agrees to enter the Preferred Plan should a return to heroin or other drug use or criminal behavior arise.

The therapy offered by Rubicon consists of a highly structured hierarchyof responsibility matched with group therapy, encounter therapy, and counseling. A process of individual maturation is compressed into a 6-8 month period of in-residence. The out-patients engage in the therapeutic community treatment, encounter groups, and counseling on a scheduled basis.

The second phase of treatment involves days spent in work, training or school, with nights spent at Rubicon in-residence, engaging in group sessions. The third phase consists of re-entry to the Community. Coming perhaps one year after induction the resident moves from the house and leads a separate life, returning only to the house perhaps once a week for group sessions. Finally he "graduates" and has no required contact with the house except to return to visit friends.

No one has completed the first phase as yet, although success can be measured at this point by examination of the holding power of Rubicon. Seventy-five per cent of inductees remain, as opposed to the national average of forty per cent. There is great need to expand the in-patient, out-patient, and related activities. This will be discussed below.

N.A.R.A. -- The Narcotics Addict Rehabilitation Act program is conducted by the Richmond City Health Department, directed by Dr. Freeman C. Hays. The program consists of after-care follow-up for returnees from the Clinical Research Center located in Lexington, Kentucky. An addict may apply for court referral to the C.R.C. after conviction for a drug charge or another criminal charge. He spends six months at Lexington in the federal hospital and is released to the after-care program. Westbrook Psychiatric Hospital is used by the Richmond N.A.R.A. Program for counseling. A social worker in the City Health Department

maintains contact and offers assistance to the former addicts. Approximately twelve persons are currently in follow-up after-care in Richmond.

Existing Grant Programs - (DJCP)

The Omnibus Crime Control and Safe Streets Act of 1968 was administered in Virginia by the Law Enforcement Administration, now the State Division of Justice and Crime Prevention. Seven grant programs have been funded with these funds.

CODAC Action Grant Award

The Council On Drug Abuse Control of the Richmond Regional Planning District Commission received in December, 1970 an award of $13,500.00 to support the CODAC program. A Director and Secretary, office equipment and supplies, and funds to disseminate information in a small quantity were awarded for the period September 1, 1970 through June 30, 1971. These funds enabled the maximizing of the local contributed funds, allowing a total budget of $26,300.00. The grant program has enabled a vehicle to be established wherein experts and implementors in various fields can come together for the necessary planning, development and coordination of the programs described in this planning component.

Diagnostic Treatment and Training Center

In the summer of 1969, the MCV Adolescent Clinic was awarded $35,476.00 to equip the adolescent clinic when it expanded to 1220 East Marshall Street. The program includes the diagnosis of drug abuse cases, treatment by out-patient counseling and medical care, and the training of medical and nursing students in drug abuse treatment.

LEAA Large City Special Grant, Discretionary Grant Program, Comprehensive Metropolitan Narcotics and Dangerous Drug Control Program

In December, 1970, after an eight month delay, the Richmond Drug Control Program was funded by the Law Enforcement Assistance Administration in Washington, D. C. The award, granted to the Division of Justice and Crime Prevention and subgranted to Richmond, provides $137,576.00 federal funds matched by $202,256.00 in in-kind services. Three elements comprise the program; Enforcement, Juvenile Education, and Public Information.

The Enforcement element consists of a general enforcement program offering three days of awareness training to 384 enforcement personnel ($4,866.00 federal, $41,438.00 local). A second element, specific enforcement, increases the manpower of the Vice Division and provides an investigative capability in the form of rental vehicles and equipment ($45,703.00 federal, $19,354.00 local).

The Juvenile Education element provides for the training of all teachers in awareness sessions, classroom equipment, and drug abuse educational materials ($34,794.00 federal, $141,464.00 local). While not all educational efforts are funded, the program is an important step forward.

The third element, Public Information, was awarded $51,691.00 to establish a Drug Information Center in the City Health Department, employ a health educator, ex-addict, and secretary, purchase large amounts of printed matter, and supplies for media campaigns including billboards, posters, buscards, and a Drug Information Fair travelling exhibit. Coordinated with CODAC activities a common 24-hour phone line has been established (644-7601), joint projects begun, and shared financing initiated to expand the City project to the rest of the region.

The program is now beginning full operation with the initial receipt of funds. Continuation of this program is discussed below.

Organized Crime Control

The City of Richmond was awarded in the summer of 1970 $17,233.00 to initiate a program to combat the organized crime drug traffic in the City. The award provides for a small amount of investigative equipment, needed evidence purchase money and vehicle rental for Vice officers. It is reported that the program has been of great benefit to the police operation.

Training of Enforcement Personnel

In the early part of 1970, the Richmond Regional Planning District Commission was awarded $31,885.00 to conduct three courses for the region's enforcement personnel. One was an 80-hour course in Narcotics and Dangerous Drug Investigation taught at Virginia Commonwealth University by Mr. F. John Kelly, then an adjunct faculty member of the Department of Law Enforcement. Forty-five men from five jurisdictions and the VCU Police Department completed the course. The same course has been included in another grant request.

Regional Investigatory Equipment Pool

In March, 1971, the Richmond Regional Planning District Commission was awarded $54,000.00 to establish a regional pool of sophisticated electronic and photographic investigation equipment. Administered by the Director of CODAC but implemented by the various enforcement agencies, the grant award provides the needed equipment to effectively combat drug trafficking in the region. The program has not yet begun.

Model Drug Education Program

In March, 1971, the Richmond Regional Planning District Commission was awarded $24,806.00 to implement a program of seventeen sessions of sixteen hours each instruction in drug action and drug abuse. The program will be offered to 350 educators selected by the several school superintendents based on a per cent of population within the region. Taught by the MCV Department of Pharmacology faculty, the pilot session is scheduled to begin on March 22, 1971. Sixteen remaining sessions will be conducted in the summer and fall of 1971.

An understanding of the drug abuse problem and current resources to control it has been achieved in these early months of CODAC. Much more must be done if the problem is to be solved.

DESCRIPTION OF LOCAL NEEDS AND PROBLEMS

This component will describe the magnitude of the drug problem as it is estimated to exist, the needs of CODAC, Enforcement, Juvenile Education, Public Education, and Rehabilitation. The description of those needs and problems will serve as the basis for future action programs and grant requests.

Estimated Drug Problem in the Richmond Region

The trafficking in illicit drugs respects no political boundary in the region, state, or nation. There is a growing network of drug traffickers making large profits and drug traffickers transporting drugs for themselves or a few friends. The use and abuse of controlled drugs is no longer a problem of ghetto dwellers or jazz musicians. Every socio-economic class is experiencing an increased incidence of drug abuse. Nationally, and this region is no exception, the increase in drug abuse is greatest in the middle- and upper-class white community. The average age of the addict has dropped in recent years from 25 to 19. Not only colleges but also high schools, junior high

schools, and in some few instances, elementary schools are witnessing the use and abuse of controlled drugs.

Estimates of the narcotics addict population vary. The Richmond Vice Division estimates 2000-5000 drug abusers, of which one-half are probably addicts. This means an addict population in Richmond of 1000-2500. This estimate presupposes a 10% arrest rate for all drug abusers. With an arrest rate of 13% for reported major crimes -- larceny, robbery, burglary, auto theft, murder, rape, aggravated assault --, crimes with complainants, this addict population estimate is probably low. Drug abusers certainly victimize themselves, but complaints of the magnitude attributable to major crime do not come forth from this clandestine activity.

Medical personnel involved with the treatment of drug abusers have estimated the addict population as high as 10,000. This figure is based on the verbalizations of patients and may be considered high.

Other indicators may give a more accurate estimate. There are at least 350 persons professionally involved in trafficking in narcotics and dangerous drugs, according to the Richmond Vice Division. They certainly must have a rather large market for their contraband. Operating as a loose confederation of criminals they do not comprise a syndicate or "family" in the Cosa Nostra sense of the words. Their purpose is the purchasing, transporting, processing, storing, distributing, and selling of controlled drugs of all types, but principally the narcotics. Richmond drug arrests rose from 23 in 1960 to 434 in 1970. This is an increase over ten years of 1800% compared with the national rise of 400-500% for the same period.

From information one year ago, the Vice Division estimated 220,000 capsules of 2.5-30% "street dose" heroin a week could be produced based on what was known regarding the distribution of quinine hydrochloride, one of several adulterants or cutting agents for heroin. Probably not all of this quinine was used in the Richmond area, and this is but one cutting agent. On March 16, 1971, Del. Stanley C. Walker, Chairman of the State Crime Commission, stated that approximately one-quarter of a million capsules of heroin are "put up" every week in the Richmond metropolitan area. The estimate was given the Commission by "responsible authorities" discussing organized crime in Virginia.

The Retail Merchants Association expects $60 million in loss due to shop-lifting alone next year. Shop-lifting is an addict-related crime, due to the need for large sums of money every day.

Crime in the central portion of the region rises 28-30% every year, compared to a national average rise of 13%. The Richmond Commonwealth Attorney estimates that 35% of crime is drug-related. The Director of the Bureau of Alcohol and Drug Abuse Studies estimates 50% of crime is drug-related. A large addict or drug abusing population could therefore be expected to exist where crime rise is sharp.

The courts of the Richmond area report a case-load of some 300 persons a month which judges can identify as drug abusers. The Richmond Commonwealth Attorney reports one-third of his office case-load are drug charges, compared with 20% a year ago.

The Governor's Council on Narcotics and Drug Abuse Control estimates that 75% of persons ages 5-25 years experiment with drugs. Use of drugs regularly is estimated at 25% of that age group. This means that of the City's youth population of 125,000, some 30,000 belong to the drug subculture, or 70,000 young persons in the region.

Taking into account these indicators relating to drug abuse, it is still difficult to estimate the addict population. Perhaps 5000 to 8000 exist in the metropolitan area. This figure is in line particularly with the heroin production estimates cited above. At any rate, it is evident that the region is experiencing a rapid rise in addiction and drug abuse. The Richmond Vice Division states in the Bureau of Police Fiscal Report, July, 1969 - June, 1970, "The largest Vice problem facing the City of Richmond at this time appears to be the increased use and abuse of narcotics and dangerous drugs."

Narcotics, of course, are not the only drugs of abuse. Nationally 200 million prescriptions for psychoactive drugs were filled last year. This comprises 40% of all drugs prescribed. The pharmaceutical industry spends $750 million dollars for advertising to only 181,000 physicians. Amphetamine, banned in Sweden, Japan, and three Counties in Australia, continues to be widely manufactured &used in the U.S. A member of the Presidents' Commission on Drug Abuse stated in conversation with Dr. John A. Rosecrans, MCV Pharmacology faculty member, that the Commissions' report may recommend the banning of this highly abused drug.

It is estimated that 70% of the drugs manufactured are illicitly used according to Dr. Rosecrans and literature on the subject. This ranges from the sharing of one's pills with a friend to the diversion of cargo into the illicit traffic. The Richmond region is involved in the abuse of other drugs. One indicator is the record of Richmond Vice Division seizures:

Narcotics and Dangerous Drugs	1967-68	1968-69	1969-70
Heroin Seized (Other Opiates) wt.	NA	4oz. 301gr.	4573.8gr.
Cocaine Seized wt.	1/2oz.	16gr.	11gr.
Marihuana Seized wt.	NA	5lbs.	5 lbs. 7 oz.
Synthetic Narcotics Seized wt.	NA	0	547 gr.
Amphetamine (no. of pills)	2529	5445	2879
Barbituarates (no. of pills)	100	2071	1875
Hallucinogens (no. of pills)	35	341	268
Other Dangerous Drugs (no. of pills)	100	15,000	1078 1/2
Codeine Cough Syrup - Paragoric	48 oz.	152 oz.	98 oz.
Forged Prescriptions	2	53	105
Sets of Addicts Works	60	31	430

This increasing drug abuse problem must be approached on a unified, coordinated basis employing all viable methods including enforcement, juvenile education, public education, and rehabilitation.

CODAC - (Council On Drug Abuse Control)

The Council On Drug Abuse Control is the regional planning and coordination agency established by the Richmond Regional Planning District Commission and the Governor's Council on Narcotics and Drug Abuse Control. In order to meet the needs of the four Committees, to plan activities, to prepare funding proposals for several funding sources, to manage currently funded grant programs, to monitor progress in the region, to review materials for education, to offer assistance to many agencies and groups in developing projects, and to become a vehicle for the needed unified action, CODAC must expand its staff support and office space.

Local donated funds will serve as hard-match for DJCP funds. An action grant program for FY 70-71 will include the following:

ACTION PROGRAM

Director - (Salary & Benefits)	$ 14,084
Secretary - (Salary & Benefits)	7,384
Assistant Director - (Salary & Benefits)	9,864
Administrative Assistant - (Salary & Benefits)	9,015
Administrative Assistant (50%) - (Salary & Benefits)	4,407
Secretary - (Salary & Benefits)	6,624
Rental and Remodeling of Office Space	9,700
Supplies and Equipment	11,000
Meetings and Conferences	1,000
Printing and Binding	4,300
Transportation	2,200
Telephone	3,200
Dinner Meetings	300
Books and Periodicals	1,000
Postage	1,500
Organizational Dues	100
Audit, Bond, Insurance	400
Miscellaneous, Course Work	350
TOTAL	$ 86,878

ALLOCATION OF FUNDS

Division of Justice and Crime Prevention	Local Cash	Total
$49,036	$37,842	$86,878

Future program activity is expected to continue at the same funding level for FY 72-73, being matched by local hard-match. FY 73-74 and FY 74-75 is estimated at a 20% rise in funding per year with matching funds being supplied by the Commonwealth through the Governor's Council on Narcotics and Drug Abuse Control, as projected by the Councils Executive Director.

Enforcement

The needs of local enforcement agencies include training, manpower, equipment, and laboratory testing of seized samples.

Training - General

The LEAA Discretionary Grant awarded to the City of Richmond provides for the training of 384 persons in eight three-day awareness seminars. Heretofore, drug training was accomplished by two hours of instruction given to recruit trainees.

In order to afford the region the same general training available to the Richmond Police, an action grant program will be developed for the remaining enforcement agencies in PDC #15. This general in-service program is required in order to make officers aware of the drug abuse problem which they may encounter but otherwise not be aware of in their day-to-day activities. A high level of investigative expertise is not the goal of this program, but of the program described in Training - Specific.

Eight seminars are envisioned beginning in October, 1971. The classes will comprise 35-40 men. Three-days of instruction will be offered at a local motel conference room capable of providing luncheon services for attendees. Programs will be offered monthly for eight months. Projected costs include the following:

ACTION PROGRAM

Instructional personnel at $30.00/hr.	$ 5,760.00
Logistical Support, duplication, etc. by the VCU Managment Center, 24 days at $38.00/day	912.00
Salaries of 400 attendees, est.	28,800.00
Instructional materials	4,000.00
Classroom facilities, $150 per session	1,200.00
Luncheon service, $225 per session	1,800.00
TOTAL	$42,472.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local In-Kind Service	Total
$13,672.00	$28,800.00	$42,472.00

Future funding needs are expected to constant for FY 72-73, in order to instruct new personnel in the entire region, and reduced by perhaps half in ensuing years, still enabling the training of added personnel. Hard-match funds will be sought when needed, although it is envisioned that the Commonwealth's appropriation of $896,000.00 to the State Police may serve this purpose when continued.

Training - Specific

The Action Grant award of $31, 885 to the Richmond Regional Planning District Commission in the early part of 1970 enabled 45 men to attend a two-week, 80-hour course in Narcotics and Dangerous Drug Investigation. Taught by Mr. F. John Kelly and visiting instructors the course paralleled the B.N.D.D. School in Washington, D. C. A grant of $25,551 awarded to the Richmond Regional Planning District Commission in November, 1970 will enable 50 men to attend a similar course. This program has not yet begun.

In order to offer investigators and narcotics officers the needed training the course should be continued. Federal funds will be matched by local in-kind services in order to conduct the program. Hard-match will be sought when required.

ACTION PROGRAM

Instructional Staff @ $30.00/hr.	$ 2,400.00
Salaries of attendees (50 men) est.	16,000.00
Instructional Materials	1,000.00
Classroom rental - $35/day	350.00
Logistical Support -- VCU Management Center	400.00
Luncheons, coffee breaks - $75.00/day	750.00
TOTAL	$20,900.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local In-Kind Share	Total
$4,900.00	$16,000.00	$20,900.00

Future requirements are expected to continue at the same level for each ensuing fiscal year.

Manpower - City of Richmond

The need for additional enforcement officers working full-time in drug abuse control is needed. The LEAA Discretionary grant to the City of Richmond provides for three Detectives to supplement the Vice Division. Salaried at $9,880.00 each per year, it is expected that this operation will require Action Grant Support before the end of FY 71-72. If so, an amount equal to one-half of each man's salary will be required to carry him for the remainder of the fiscal year. Their activities in gathering information or organized crime drug traffickers should be quite important by this time.

ACTION PROGRAM

Partial Salaries of 3 Detectives @ $10,400		$ 15,600.00
10% of Salaries of the Vice Division Detectives supporting activities of the 3 Detectives		16,000.00
Rental of 3 Unmarked Vehicles		5,000.00
Rental of 4 Handie-Talkie Radios		1,500.00
Rental of Batteries for Radios		100.00
Evidence Purchase funds		3,000.00
Rental of surveillance sites, if needed		500.00
	TOTAL	$ 41,700.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$18,666.00	$16,000.00 (in-kind) $ 7,034.00 (hard-match)	$41,700.00

Due to the one-third rule for personnel, this action program would require a $7,034.00 hard-match from the City. Projections of future funding are unclear due to the fact that the squad may at some time be absorbed totally by the Bureau should Divisional complements be increased.

Manpower - County of Henrico

The County of Henrico is planning to establish a drug abuse control section within the Division of Police, with its primary objective to be prevention and reduction of crime and delinquency which is attributable to drug abuse. Currently, the county has one man assigned full time to this particular task. Since the demand for his services is progressively exceeding his capabilities with respect to time, it is necessary and of utmost importance that the scope of the drug abuse control effort be expanded to include an additional five personnel, one of whom would be designated a supervisor, and all of whom would devote full time to the drug abuse control program in the County of Henrico. As a part of this program, it is planned to place greater emphasis upon education of the public and school children alike, with a portion of the resources being devoted to printed material informing both groups of the dangers of drug usage, and the devotion of time to the distribution of such material, together with personal appearances throughout the county to further enhance enlightenment of these groups with respect to drug abuse.

ACTION PROGRAM

Insofar as funds requested for this program are concerned, the following itemized request for proposed action grant monies is projected:

Office space and equipment	$ 20,000.00
Printed materials	10,000.00
Necessary electronic surveillance equipment	11,000.00
Training of personnel and supervisor	3,000.00
As a matching contribution, salaries involved for the six people to be assigned this task	48,000.00 annually
Necessary operating equipment - automobiles, mobile radios, clothing, etc.	25,000.00
Auto rental and information purchasing	15,000.00
TOTAL	$132,000.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$99,000.00	$33,000.00 (Hard-match)	$132,000.00

Projected future federal funding is unclear at this time, although it is anticipated that the County of Henrico will provide necessary hard-match as required.

Regional Narcotics Strike Force

In March, 1971 discussions began regarding the establishment of a regional narcotics strike force, a group of men assigned by several jurisdictions for the purpose of inter-jurisdictional control of drug trafficking. Officers would have power of arrest in each locality, and would travel to whatever point was necessary to perform their duties. Issues regarding administrative control, needed training, vehicles, insurance, and scope of the task force remain to be discussed. It is expected that the unit would fully utilize the equipment recently funded by an action grant of $54,000 for a regional investigatory equipment pool.

It is presently impossible to estimate funding requirements, although it is expected that some equipment, evidence purchase money, rental of vehicles, and communication will require federal funding support.

Equipment

Regional Equipment Pool

The recently funded Regional Investigatory Equipment Pool has to-date not been implemented. Orders for equipment will be placed; delivery and training preceed implementation. It is fully expected that the regional pool will be of great value to drug enforcement personnel whether they comprise a formally structured Strike Force or operate independently in the several jurisdictions. Should the program prove so effective, it is conceivable that additional equipment items may be required to meet the demands of enforcement personnel.

It is estimated that such a request would be of equal funding support as the previous grant: $54,000.00 federal; $18,000.00 local in-kind services for FY 71-72. Funding need for ensuing years is unclear although it can be projected that these needs would be markedly reduced from the initial need.

Equipment - Individual Enforcement Agencies

The County of Goochland submitted on February 1, 1971 an action grant application for $2,482.35 in DJCP funds to upgrade their drug enforcement capability.

This program would supplement the Sheriff's Department to the point where the Richmond Pool could be effectively utilized.

While it is uncertain as to the equipment needs of other jurisdictions, it can be estimated that federal funds for equipment, matched by in-kind services, will be sought in the range of $2,000.00 to $10,000.00. Necessary hard-match will be sought as program guidelinesso dictate.

Laboratory Testing of Seized Evidence

Dr. Charles O'Rear of the State Department of Agriculture's Laboratories Division reports a sharp increase in the testing of samples of evidence seized by enforcement agencies. Over 1000 samples were tested from the metropolitan region last year. Projected seizures for analysis next year in the region are placed at 2,500 by Dr. O'Rear and enforcement officials.

In order to maintain the operation of the laboratories, to continue testifying in court, and to insure the high quality of the assays, it is projected that action funds will be required to meet the demands of increased numbers of samples to be tested.

ACTION PROGRAM

Additional personnel, supplies, and equipment will be required to meet the needs of the region. This program, if sought, would be on a contract basis to the Planning District by the State Laboratory.

Personnel

1 Drug Chemist C		$ 13,128.00
2 Drug Chemists B @ $11,472.00		22,944.00
2 Drug Chemists A @ $ 7,524.00		15,048.00
FICA, Retirement, etc.		3,580.00
Equipment (Instruments)		20,000.00
Reagents and Glassware		5,000.00
	TOTAL	$ 79,700.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	State Matching Funds	Total
$59,775.00	$19,925.00	$79,700.00

Hard-match funds will probably be required. The matching funds may be available from the $896,000.00 appropriated for the State Police or state allocations to the Laboratory may be utilized. Future funding requirements are expected to continue on the same level as personnel must be retained, equipment upgraded, and supplies replenished.

Juvenile Education

The system for promulgating teacher training programs from the State level to the local educational personnel has been discussed previously in the Existing Systems and Resources section.

The major problems facing the drug education efforts of the public schools are the lack of trained teachers, the lack of approved curricula, inadequate supply of teaching aids such as books, pamphlets, articles, films, and audio tapes. The offering of awareness sessions to teachers may make them alert to drug problems in the classroom and may assist in presenting short units covering the most basic facts on drugs, but it does not bring the teacher, and ultimately the student, to the informational and attitudinal level needed to understand and cope with drug abuse.

In order to teach a course, an instructor must be quite familiar with the subject matter and have a teaching guideline by which to pattern instruction. All educational personnel can and should benefit from short awareness sessions, but the instructor of drug education must be trained.

Drug Abuse Curricula

The long-range goal of CODAC and its Juvenile Education Committee is to have segments of drug education correlated with and incorporated into the various academic disciplines. A more immediate goal is to have each school district adopt a drug education curricula for grades K through 12. The State Department of Education

Dr. Rosecrans of the MCV Pharmacology faculty, and a committee of the Richmond Public Schools have recommended Teaching About Drugs produced by the American School Health Association.

It is expected that the Richmond Public School system will soon formally adopt this curriculum guide. It has been suggested that each school district in PDC #15 standardize its drug education efforts. The mutual adoption of one curriculum guide would meet this need.

Teacher Training

Recognizing the need to train teachers in drug education the CODAC Juvenile Education Committee, CODAC, and the Richmond Regional Planning District Commission endorsed a program developed by Dr. John A. Rosecrans, Associate Professor, MCV Department of Pharmacology. An action grant totaling $24,806.00 was awarded the Commission by the DJCP in March, 1971 to conduct the program. Three hundred and fifty educators from the Region will be offered the course in 1971.

It is expected that future programs reaching at least the same number of public school drug educators will be developed based on the experience of these initial sessions. Teachers will be allowed to receive two hours college credit useful for certification renewal with an option to earn one additional hour.

The success of the program will shape future endeavors requiring action grant support.

ACTION PROGRAM

Instructors (16 16-hr. sessions) @ $30.00/day	$ 7,680.00
350 Educators in training-salary est.	28,000.00
Logistical Support - VCU Management Dept.	6,080.00
Travel	300.00
Instructional Materials	8,400.00
Resource materials for instructors	300.00
TOTAL	$50,760.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local In-Kind Share	Total
$22,760.00	$28,000.00	$50,760.00

In-kind services will be used to match for federal funds in conducting the teacher training programs. Hard-match will be sought when required to maintain the programs for ensuing fiscal years at the same or slightly higher level of funding.

Drug Education Teaching Aids and Supplies

In order to properly teach a course not only the teacher but also the pupils must have immediate access to materials. Each school district purchases such supplies for their various course offerings. In order to provide sufficient teaching aids such as textbooks, pamphlets, article reprints, films, audio tapes and displays it may be necessary to utilize action grant funds. Pilot projects using certain materials may be conducted as will comprehensive instructional programs.

Since most districts have not as yet finalized their decisions on curricula and concommitant classroom materials it is not possible at this time to project cost requirements. However, it is evident that hard-match funds will be available for full or partial local support should action grant applications be submitted.

Drug Attitude and Use Survey

In March, 1971, the CODAC Juvenile Education Committee devised a 100 question survey to be conducted in the public school systems of PDC #15. A 20% sample of all high school and junior high school students is desired in order to obtain a statistically viable sample. Attitudinal questions will be factor analyzed to derive attitudinal profiles for schools or districts. Questions on drug use will be compiled to form use patterns for districts as well as in forming correlations to attitudes, opinions, and family backgrounds.

This material, gained from confidential, anonymous student responses, will enable the school districts to refine their educational efforts as well as providing heretofore unknown information on the student use patterns. A system of machine or computer scoring is envisioned in order to handle the large number of response forms.

The need for action funds to conduct this program has not been fully discussed. In-kind matching services for the administration of the program would be used, although hard-match funds would be sought if the instrument were utilized in future years for comparative purpose and drug education course effectiveness evaluations.

Public Education

The CODAC Public Education Committee has engaged in several projects to-date. Discussed above many projects have been implemented totally by means of donated service. Many agencies produce materials for public dissemination. The media has become heavily involved in public information programs beyond the news release articles.

In some of the Action Programs above the dissemination of materials is a part of the overall program of the agency, e.g. the proposed Henrico County Police drug control unit. Although CODAC serves as the regional clearing-house for drug abuse information, dissemination from all available sources is proper. However, this information should be specifically geared to the operations of the particular agency, its sphere of influence, and general drug information should flow from one source. One example is the MCV Adolescent Clinic. The Clinic disseminates printed information of particular interest to medical professionals and emergency rooms. CODAC has disseminated resource lists, material related to the TV series "The Turned On Crisis" and is planning to publish a booklet describing CODAC activities. The Drug Information Center of the City Health Department will distribute pamphlets on general drug abuse to the City and counties. Therefore, the distribution of material should flow from several sources, but organization, specialization, and inter-agency cooperation will insure that duplication of effort is reduced.

Richmond Drug Information Center/CODAC

The LEAA funded Richmond Drug Information Center of the City Health Department has cooperated with CODAC by installing a common phone line and by distributing information to persons contacting CODAC as well as the Center. In order to maintain this capability of providing material, exhibits, media advertising, 24-hour phone service, and film library for public showing, an action grant application will very likely be submitted in lieu of another Discretionary Grant application. The scope of the programs will be regional, as it now is, due to

the cooperativeness of the City administration. The program is vital in that general drug abuse information, referral services, and question answering capabilities are available and must be kept available to involve the public in seeking a solution to the drug abuse problem.

ACTION PROGRAM

Personnel

Health Educator	$ 11,000.00
Former addict	5,050.00
Clerk-Stenographer	4,400.00
Consultants	2,000.00
Travel	1,400.00
Communications	1,000.00
Postage, $125.00/month	1,500.00
Supplies for Dissemination	16,000.00
Films	1,500.00
Exhibits	1,000.00
TOTAL	$ 45,850.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$34,388.00	$11,462.00	$45,850.00

The program may be incorporated into another grant program, as was done in the Discretionary Grant, to benefit from in-kind averages. Hard-match funds will be sought where in-kind services are inadequate. Future funding is expected to be at the same level with an approximate 5% increment each year.

Television Promotional Messages

The Governor's Council on Narcotics and Drug Abuse Control was awarded in late 1970 an action grant to prepare television and radio messages on drug abuse which would direct the viewer to contact his local drug council for information or assistance. The program has not been implemented to-date.

Pending the outcome of that developmental project, production costs may be sought by the Governor's Council or by the local Councils. No final projection of costs is available at this time, although an estimate of $25,000.00 to $35,000.00 may be considered. Donation of media time and required hard-match will be sought should the need arise.

Booklet on CODAC

The Council On Drug Abuse Control is in the process of preparing a booklet for public dissemination describing CODAC activities. This document is needed to foster cooperation in planning and coordination of activities as well as informing the public on the availability of assistance in project design and implementation.

ACTION PROGRAM

Design and printing of 10,000 copies	$ 5,000.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$3,750.00	$1,250.00	$5,000.00

Hard-match funds for this and future years will be sought.

Public Service Projects

CODAC has developed and implemented public service projects. These have been discussed above. There is a need to develop volunteer service projects in the area of public forums, educational courses for citizens, fund-raising activities, public discussion meetings, and youth oriented projects such as music festivals, poster contests, assistance in exhibit presentation, and, most importantly, more involvement in the planning process. Most volunteer efforts require planning and organization rather than funding. No action grant projects have been developed.

Analysis Anonymous

Often many parents feel they must have strange chemical substances analyzed in order to determine if their children are abusing dangerous drugs.

While it can be stated that substance or no substance parents should attempt to communicate freely on drug abuse questions with their children, such a service would be of use. Also, many young people who are abusing drugs are concerned with tales of systemic poisons being used as adulterants. They need an analysis service to detect these chemicals. It seems that if such contaminated drugs were known, the news would spread among the subculture. Lives might be saved and the illicit dealer, in his efforts to replace on the market more pure substances, might reveal himself to the authorities.

A service capable of analyzing drugs and transmitting results anonymously to parents, educators, and young people has been briefly discussed. No additional funds need be sought at this time. It is hoped that legal restrictions can be cleared and that the analysis could be performed as part of workload of the Laboratory Testing of Seized Evidence.

Rehabilitation

The existing treatment systems discussed earlier do not adequately meet the needs of the region today, and must be expanded to meet the needs of tomorrow. The impact of education and information programs will achieve their impact in the future. Those experimenting with drugs now may become the chronic abusers of tomorrow. Their rehabilitation is of primary importance.

Current treatment efforts are funded by the patient himself, by State serivces, by the Office of Economic Opportunity, and perhaps in the future by N.I.M.H., U. S. Department of HEW. Four projects will require action grant support.

Expansion of the MCV Adolescent Clinic

The present operation of the MCV Adolescent Clinic offers out-patient care only. The need is great for the in-patient treatment of young people, 95% of whom have a drug experience in their background, and 50% of whom have directly related drug problems. The Clinic is the only treatment facility in the area with an organized program for adolescent drug abusers, although Rubicon has begun to admit juveniles.

No itemized breakdown of costs is available, although estimates for staff services, furnishing a ward, medical supplies and operating expenses are estimated at $100,000.00. Federal Funds will be matched by in-kind services, property (a medical ward), and hard-match. Future year funding will decrease by perhaps 50% following the initial capital outlay. Some 75 patients could be treated in the in-patient and out-patient components of the projected program. Hard-match for future funding will be sought as need requires.

Rubicon

The Rubicon treatment program has been briefly described above. The basic assumption that drug abuse behavior is symptomatic of deeper, under-lying problems covers a wide range of possible reasons for that behavior. To prevent drug abuse, therefore, education efforts in the schools, in meetings, and by printed matter, must be supplemented. The needed supplement should take the approach of providing creative outlets for adolescent energies and should provide an environment to which young people and adults can relate. A common ground wherein community action, volunteer service, and generation-gap bridging activities may be focused is needed.

Community Service Center

Such an environment is a Community Service Center. The concept which has met with initial success in Atlanta, New York, and West Coast cities involves the establishment of a large center offering a multitude of activities, many of which are devised by the participants. Youth culture projects, cultural seminars, encounter groups, parents' groups, arts and crafts, forums, theatrical presentations, and other activities for the involvement of young persons and adults would be the goals. It is expected that a building formally used as a school will be donated to Rubicon. This would enable the massive community service undertaking and provide food service as well.

Estimated action funds are approximately $100,000.00 per year for staff, supplies, and partial cost of food service. Matching funds will include the property value and funds generated by contributions to the program. Operating expenses are expected to be reduced by approximately 20% in FY 72-73, with 15% estimated annual increments for following years. While the property value is expected to serve as in-kind match, hard-match will be sought as required.

Crisis Intervention Centers

Prevention of harder drug use includes intervening at the first sign of trouble with softer drugs. A person experiencing an adverse reaction to psychedelic drugs, for instance, often requires help in the crisis beyond treating the toxic reaction. Young persons may require an over-night stay at a center where understanding and support will assist them in seeking solutions to the crisis situation in which they find themselves. Dr. Freeman C. Hays, Dr. George M. Bright, and enforcement officials concur that present facilities used are unsatisfactory. Often juveniles in need of help must be kept at the Richmond Juvenile Detention Home or in low-cost central city hotels

Neither provides the needed support and guidance.

A crisis intervention center is a "drop-in" center, often located in a store-front facility. Some activities are offered similar to the Community Service Center. However, it is not so much a place to congregate as it is a place for help, guidance, counseling, social service, and short-term residence with food service.

The out-patient programs of Rubicon could be decentralized. The centers would include the preliminary induction centers for Rubicon admission. They are needed to bring out into the community a system for interpersonal emergency response to the drug abuser and drug experimenter. Solving the problems leading to harder drug abuse and prevention at critical points in the life of the experimenter are their main goals.

Depending upon the availability of suitable facilities, four centers are planned for FY 71-72. Rubicon classified positions to staff each center are outlined below.

ACTION PROGRAM

For each crisis intervention center:

Director (Supervisory Addiction Specialist)	$10,000.00
Assistant Director (Senior Addiction Specialist)	8,500.00
2 Addiction Specialists @ $7,000.00/yr.	14,000.00
3 Addiction Aides @ $5,500.00/yr.	16,000.00
2 Clerk - Stenographers @ $5,500.00/yr.	11,000.00
Initial Furniture and Equipment	3,500.00
Renovation	2,000.00
Sub-TOTAL	$65,000.00

Rental is estimated at $500.00/month, although the donation of property will be sought.

TOTAL	$71,000.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$17,250.00	$53,750.00	$71,000.00

In FY 72-73 six centers are planned to be established. Hard-matching funds will be sought as the one-third rule and DJCP guidelines require.

Laboratory Testing - Urine Surveillance

In order to monitor the progress of narcotics addicts in therapy whether it be in Rubicon or the Methadone Center, it is necessary to conduct measures beyond psychological evaluation. Urine analysis indicates the presence of drugs in the system. Program effectiveness depends heavily on knowing the real drug usage patterns of patients on a continuing basis.

A grant application is being prepared seeking funds from the National Institute of Mental Health, U. S. Department of Health, Education, and Welfare. Several treatment components are included in this program, including expansion of the MCV Adolescent Clinic, the Methadone Center, the social service component of Rubicon, and the needed urinalysis and blood testing services. However, funds are limited and it is possible that the needed treatment programs and testing services might not be sufficiently funded, therefore, laboratory testing services may require action grant funds in order to meet program needs.

Should the N.I.M.H. grant not fully succeed, the region would require approximately $125,000.00 for urinalysis and $25,000.00 for the blood-work (SMA battery and CBC). Matching funds would be derived from state allocations or possibly from financial charges to the patients taking methadone.

Hot-line

There are in Richmond two emergency phone services, YES (Youth Emergency Services) and Hot-line, operated by students primarily from the Medical College of Virginia. Dr. George M. Bright is faculty advisor to Hotline. Access to the MCV Computor is available to Hotline for compilation of statistics.

Hotline began in April, 1970 and by November had received 1200 calls, 20% of which were directly concerned with drug abuse. As of March 1971, 50% of calls concern drug abuse. YES, operated by FISH, an interdenominational church organization, has received some 10% of its calls regarding drug abuse. Financial difficulties have existed for both services. CODAC has sought to bring the two services together without success. Therefore, the most relevant service should be supported. At this time, Hotline is that service. An action grant program may be sought in FY 71-72, supported by donated service and facilities.

Such an anonymous emergency service must be maintained to uphold the link between the drug abuser and help for his problem. Indirect counseling and referral to treatment services are the main goals.

ACTION PROGRAM

Telephone Service, two phones	$ 600.00
Office Supplies	90.00
Data Processing (reduced rates)	200.00
Card punching	125.00
Printing of Hotline Manual	500.00
Travel for Speakers	100.00
Postage	50.00
File cabinet with lock	80.00
Stipend for Director	200.00
Stipend for Scheduling Chariman	100.00
TOTAL	$2,045.00

ALLOCATION OF FUNDS

State Division of Justice and Crime Prevention	Local Share	Total
$1,534.00	$511.00	$2,045.00

Each ensuing fiscal year will require funding at the $2,000.00 level. Hard-match funds will be used as needed to match for DJCP support.

PROGRESS REPORT—THE FIRST 12 MONTHS OF OPERATION OF THE COUNCIL ON DRUG ABUSE CONTROL, RICHMOND REGIONAL PLANNING DISTRICT COMMISSION

The Richmond Regional Planning District Commission, faced with an 1800% rise in the number of drug offense arrests in Richmond and the surrounding area during the decade 1960–1970, as compared to a national increase of 400–500%, recognized the serious proportions of the drug abuse problem. Therefore, the Commission was receptive to the suggestion that a regional planning and coordination agency for all phases of drug abuse control be established. This suggestion, made in July of 1970 by William V. Daniel, member of the Richmond City Council, and F. John Kelly, Executive Director of the Governor's Council on Narcotics and Drug Abuse Control, resulted in the formulation of a Study Committee on Narcotics and Dangerous Drugs within the Commission.

In August, the study committee returned with a report which led to the formation of the Council On Drug Abuse Control (CODAC) as a new part of the Commission. This new agency was originally funded through three-year, $30,000, federally-matched pledges from the area's thirty-five major corporations.

Operation of CODAC began on September 1, 1970 with the appointment of various Committees, with the application made to the State Division of Justice and Crime Prevention for funding, and with the acquisition of staff.

In November, CODAC was recognized by the Governor's Council on Narcotics and Drug Abuse Control as the official regional planning, review, and coordinating arm of the Richmond Regional Planning District Commission for all programs relating to drug abuse control in Planning District 15.

The following is a brief outline of the progress of CODAC in its first twelve months of operation. Accomplishments rather than goals are noted.

City of Richmond awarded $17,233 to combat drug abuse and organized crime. CODAC assisted in preparing the grant application to DJCP.

MCV Adolescent Clinic awarded $35,476 to treat juvenile drug abuse. CODAC assisted in preparation of the grant application to DJCP.

Two-week abuse exhibit prepared for Virginia State Fair. Manned by Phi Delta Chi Pharmacy Fraternity.

CODAC members attended Walking Tour of Fan District to become familiar with one element of the drug scene.

October, 1970

Overview of treatment facilities presented by the CODAC Rehabilitation Committee.

CODAC received over 600 responses from Times-Dispatch Sunday Supplement—"Drug Scene", in cooperation with the Junior League of Richmond.

The four Committees set goals for planning and program development.

November, 1970

The Governor's Council on Narcotics and Drug Abuse Control unanimously recognized CODAC as the area-wide planning and coordination agency for all programs relating to drug abuse control in Planning District 15.

CODAC reviewed and endorsed the Church Hill Model Neighborhood Policy Board Urban Assistance Incentive Fund application to conduct drug education forums—$18,640 (Later funded by the State.)

CODAC awarded $500 to the MCV Hotline program for preparation of a drug abuse manual for physicians.

Thorough analysis of treatment capabilities revealed only one of thirteen area hospitals have an organized drug abuse treatment program.

CODAC Regional Speakers Bureau organized.

December, 1970

CODAC awarded $13,500 by DJCP for part of first year operations budget.

CODAC developed and submitted a DJCP action grant seeking $54,476 for a regional pool of investigative equipment to combat heroin trafficking. (Later funded $54,000.)

City of Richmond Awarded Law Enforcement Assistance Administration (LEAA) grant of $137,576 for three-part drug abuse control program: enforcement, public school education, and Drug Information Center. The Director coordinated the application preparation and participated in negotiations.

January, 1971

CODAC developed and submitted a DJCP action grant application for $24,806 to conduct formal drug education for 350 area educators. No additional local governmental appropriations required. (Later funded in full.)

CODAC Enforcement Committee reviewed and field-tested investigative equipment.

The Director assisted Rubicon in developing a request for $637,000 to the Office of Economic Opportunity (OEO) for second-year funding of the therapeutic community for narcotics addicts. (Later funded $560,587.)

February, 1971

Governor Holton declared March "Drug Crisis Month" in conjunction with the "Turned On Crisis" series, commending CODAC for its leadership.

CODAC members addressed the State Legislature endorsing the Controlled Paraphernalia Act.

CODAC reviewed the MCV Adolescent Clinic application for $12,700 to expand drug education efforts.

CODAC prepared and submitted for Goochland County a DJCP application for $2,482 in equipment to combat drug trafficking. (Later funded in full.)

CODAC coordinated a week-long series on "Drugs in Richmond" for WWBT–TV, Channel 12.

March, 1971

CODAC's promotional efforts for the "Turned On Crisis" were largest in the nation according to the national public Broadcasting Service (PBS).

City Drug Information Center established and tied to CODAC via mutual agreement.

CODAC awarded $24,806 for Model Drug Education Seminar Program.

CODAC awarded $54,000 for Regional Investigatory Equipment Pool.

April, 1971

CODAC assisted Rubicon in development of OEO proposal revision. Project reviewed and approved by CODAC.

The Director assisted MCV Department of Pharmacy Services in developing an H. E. W. Health Services and Mental Health Administration application for $346,492 to expand the methadone therapy program. CODAC approved the project. (Decision expected in June.)

Forty page comprehensive Drug Abuse Control Plan prepared by the Director outlining 30 grant program areas for next fiscal year. Sent to CODAC for approval.

May, 1971

Drug Abuse Control Plan adopted by CODAC and the Richmond Regional Planning District Commission.

The Director and Rubicon officials prepared a Neighborhood Drug Abuse Prevention program for the Office of Education. Of over 600 submitted from the nation, 26 were chosen for negotiation. Ours was the only one chosen from Virginia. $100,000 is expected.

Rubicon awarded $560,587 by OEO.

Three-day awareness seminars designed for all enforcement personnel in the region.

The first class of the Model Drug Education Seminar program sponsored by CODAC graduated thirty-three of the 350 educators to be taught in the series. Largest formal drug education effort in the State.

New Kent County DJCP grant application for $9,335 reviewed and approved by CODAC.

Second week-long series entitled "Drugs in Richmond" on WWBT–TV planned by CODAC and Channel 12 officials.

Planning began for a Regional Narcotics Strike Force to combat high level narcotics traffic.

Regional survey of all high schools and junior high schools developed by CODAC Juvenile Education Committee. It will assess attitudes and abuse patterns in order to refine education efforts. An unprecedented study in Virginia.

June, 1971

Regional Narcotics Strike Force Plan developed by area Chiefs and Sheriffs.

Booklet and Brochure on CODAC functions and potential solutions to drug abuse authorized for preparation.

Enforcement personnel selected to attend 10-week Advanced Training School at the Bureau of Narcotics and Dangerous Drugs.

July, 1971

Regional Narcotics Strike Force Plan finalized and adopted by area Chiefs and Sheriffs.

Regional Equipment Pool training week held. Equipment delivered for use by area enforcement agencies.

Virginia Association of Drug Abuse Enforcement Officers (VADAEO) proposed and grant application developed. Conference planned for state-wide participation to discuss intelligence, equipment, grants, and cooperation.

RRPDC/Methadone action grant program developed by CODAC and endorsed, seeking $167,385. (Later awarded in part.)

August, 1971

CODAC awarded $18,576 to conduct state-wide VADAEO Conference for 250 Enforcement Officers.

CODAC authorized to use $1,000 for computer compilation of Regional Drug Attitude and Abuse Pattern Survey. Actual cost is $8,000 but The Computer Company will conduct the project at less than cost.

CODAC awarded $31,801 to maintain and expand the Methadone Therapy Program for six months.

CODAC endorsed an Action Grant Program from the City of Richmond Schools for $23,910 to employ a Drug Education Coordinator.

CODAC endorsed an Action Grant Program from the Chesterfield County Schools for $19,232 to provide a Drug Education Coordinator.

CODAC endorsed an Action Grant Program for submission by the Richmond Regional Planning District Commission for $7,780 to conduct three day awareness training sessions for all enforcement officers in the Counties of Charles City, Chesterfield, Hanover, Henrico, Goochland, New Kent, and Powhatan.

CODAC endorsed an Action Grant Program for submission by the Richmond Regional Planning District Commission for $128,672 to maintain and expand the MCV Adolescent Clinic including a 10-bed detoxification ward.

All federal and state agencies who have worked with CODAC have made particular note of the high level of coordination and cooperativeness exhibited in the Richmond Region. We have been able to overcome the greatest problems of other cities and regions: lack of coordination and the abundance of duplicated effort.

We have been working hard in these initial months. Many more new programs must be developed. The recently approved staff expansion will enable CODAC to make a more decisive impact in the next fiscal year.

Mr. ROGERS. Thank you very much, Mr. Mathews, for your statement, and the suggestions you make.

I am sure they will be most helpful.

Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman.

There are many areas in your statement that interest me. However, I will direct my questions to the final part of your statement, because I think this deals with one of the things we are here to investigate.

What is the relationship between CODAC and the Governor's Council on Narcotics and drug abuse?

Mr. MATTHEWS. The Governor's council has attempted to promulgate what is called regional drug task forces into the State's 22 planning district areas, enabling the drug task forces to utilize the authority of the planning district commissions. Our relationship is that we are one of currently four operating in the State.

Mr. SATTERFIELD. The Governor's Council on Narcotics and Drug Abuse is, I understand, made up of some of the people who had been involved in drug programs in the State of Virginia, before this council came into being?

Mr. MATTHEWS. If you assume that the drug programs prior to that council were run out of State departments, then, yes, because the Governor's council is composed of State departments.

Mr. SATTERFIELD. Is it correct that these members of the council have relinquished some of their separate autonomy, but that the council itself maintains basic direction over drug abuse efforts in the State?

Mr. MATTHEWS. Well, the Governor's council maintains more of a coordinative role than that which would be considered the active role of the regional task forces.

They may be considered informally as the State clearinghouse, although they are not so mandated to review and comment on applications.

I feel, perhaps, they should be. They do not direct the activities of the regional drug councils.

We are autonomous in that we are part of a planning district commission which is by statute, considered a unit of local government.

Mr. SATTERFIELD. You are nevertheless bound by the basic outlines contained in the plan?

Mr. MATTHEWS. Our review and process must of course have a criteria.

The criteria is the local comprehensive plan as assembled, or the consensus of the council, where the plan does not cover certain new innovative projects.

Mr. SATTERFIELD. When you talk about the council, what council are you referring to?

Mr. MATTHEWS. The local regional council. The Governor's council has also developed a plan, but they really have no criteria for review and comment.

Theirs is more of a coordinative action via persuasion.

Mr. SATTERFIELD. The legislation we are considering in Congress, it is to establish one special officer in the White House, headed by one person, referred to by some people as a czar over all Federal drug programs. I am wondering if you have an opinion, in the light of the operations in which you have been involved in Virginia, whether this is the best way to proceed or whether there should be some council at the Federal level to operate, perhaps as you do in your district, or as the Governor's council does for the State of Virginia?

Mr. MATTHEWS. Well, some of my basic experience has been with utilization of omnibus crime control funds. In fact, all told, we may have used almost two and a half million dollars worth of that.

We ran into some real problems in Washington when they had a three-man administration at LEAA.

I am sure you are aware of these problems.

I would also think that there is a considerable amount of perhaps unnecessary redtape involved in council activities, mine included.

So I would be in favor of consolidation of Federal programs, and I would see it as being most easily implemented by the so-called czar, and, again, I would like to extend that logic, to the local level.

If you have, as you now do, a multitude of programs coming out of the Federal funding sources, with different applications, different criteria, and clearly different agendas, funds can come into a State or a region, and have programs established that duplicate, overlap, or work at cross purposes. So if consolidation and coordination is

logical on the Federal end, it is clearly logical on the State and local level.

Mr. SATTERFIELD. I think the question of coordination is something we all recognize as being necessary. But my question goes to whether it is really logical to take all of these Federal programs and put them under the control of one individual, leaving those persons now involved, no longer involved. Would it be better to form some sort of council, bring all of the programs together for coordination and continue to have these people involved in the Federal level, to make joint decisions, joint plans as members of an advisory council.

Mr. MATTHEWS. My recommendation in that regard, is that there not only be the chief administrators sitting on such a Federal council, but that such a council also have certain technical advisory groups—and this is again following the admission's and the CDAC model of middle management and field personnel—who can bring to the council's attention some of the problems of coordination. The consolidation again I think is necessary, because the drug programs that seem to work always extend beyond what is clearly fundable by a certain Federal program category.

For example, Rubicon is not only involved in therapy, but also community education, and a lot of other things, which go far beyond its OEO funds. It is this type of activity they must engage in to have a strong program. That model could be transposed to the Federal level, that would be fine, to do some elimination of these 11 sources, by combining them, and using portions of several Federal sources as one major grant to fund a total program.

Mr. SATTERFIELD. My question is this: In establishing the kind of administration I've referred to, should we ignore these people already involved in Federal programs, or should we feed them into our legislation, in a capacity which will allow us to utilize their experience at the executive end?

Mr. MATTHEWS. For rapidity of action, a czar would clearly be faster in providing program delivery; however, he is going to have to operate with several bureaus, which I imagine would then comprise sort of a de facto council under him, as opposed to a de facto council over him. It all boils down to the same thing.

Mr. SATTERFIELD. I think we all are interested in an effective program. Thank you very much.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

Your testimony seems to suggest, especially in listening to Mr. Menken earlier, it seems to say that no one approach, but many are needed, but your testimony is that there are many programs going on right here in Virginia, and you are worried about their coordination. In fact, you are worried so much about it, you are saying programs should have a statewide clearinghouse review before it should be considered funding by the Federal Government.

Mr. MATTHEWS. Right.

M. KYROS. So on the one hand, he seems to suggest a multidiscipline approach?

Mr. MATTHEWS. Which I agree with.

Mr. KYROS. And then, of course, that usually means many organizations, once they are set out, usually set out their own program, whereas your approach is much more coordinated?

Mr. MATTHEWS. We have several different programs being carried on by several different implementers; however, all of the implementers sit on CODAC, so they can coordinate with each other's programs. While one may be doing his own "thing" somewhere, he is nevertheless cognizant of what the others are doing. By having the review and comment authority, we would not therefore fund another methadone program, because that would be duplication. By not only having the forum for discussion, but also the reviewing and comment authority, we can clearly limit various programs, have a multimodality approach, and avoid the unnecessary overlap of programs.

Mr. KYROS. Do you have some overlap now in the State?

Mr. MATTHEWS. I think there is overlap in this State. There is some overlap in this region, and if we have not dealt with it on first-year funding, we clearly will deal with it on second-year funding.

Mr. KYROS. Do the drug problems of the District of Columbia spill over into Virginia?

Mr. MATTHEWS. I would say they provide one of the trafficking points that brings heroin down here. I think some of the cutting agents from here may be going there. We have not experienced the methadone overdose problem that they have up there, and I think it is primarily due to the controls Bill Harrison has put in, and also due to the packaging techniques.

Mr. KYROS. Thank you very much.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

Because of the hour, I will not ask you any questions, Mr. Matthews. It does look to me as if you are doing a good job, and I was particularly glad to see some mention made before we adjourned the hearings of law enforcement.

I think we get carried away at these hearings, and think of only the social order, of the sociological and medical side, but law enforcement is certainly a part of the multiapproach that we are talking about, and I am glad to have heard that.

Mr. MATTHEWS. Enforcement is a part of it, and it is clearly a good one-forth of CODAC's overall approach, but we recognize the enforcement impact as limited. The best way to tear out the top of a market is to knock out the bottom floor.

That is, to cut out demand. Education does that. Enforcement clearly can never dry up illicit sources but they do have a role to play.

Mr. ROGERS. Mr. Symington.

Mr. SYMINGTON. You have stated in your booklet, and in your statement to us, that CODAC serves as the regional clearinghouse for drug abuse information and control programs, and Rubicon, I take it, is a treatment program that uses experience and tries to share it with others.

Mr. MATTHEWS. Rubicon does so, in seating its representatives on the CODAC board, and some of its staff people who are on the CODAC task force committees. We review and comment on the grants, as they go into the funding source. CODAC is also a forum, it is an informal communication for interaction of their program with others.

Mr. SYMINGTON. I am extremely interested in this statement, inasmuch as he is head of Rubicon, that, for example, the Muslims have done more to reform drug abusers than all of the treatment programs

which the United States has put together, which would of course include his own.

To what extent do you in CODAC, of which he is a member, address yourselves to the advisability of approaching a solution to drug problems, through some kind of ethnic activity?

Mr. MATTHEWS. Well, I think that, I would agree with him on that, that any group, though not totally ethnically based, whatever their basis may be, can draw people together and give them a sense of security, harmony, and understanding. That is the kind of group which, if they are not curing drug abuse, will probably be preventing it.

CODAC has taken this approach to rehabilitation. Rubicon is in a sense similar. Drug education eventually develops an approach, that gets away from strict drug information, and gets into the socialization process. That too is an attempt to set up smaller groups with a commonality of interest and purpose not so much ethnically based, but which can bring people together as a model for interaction and understanding.

The learning and the interaction are rehabilitative in themselves. In terms of what the Black Muslims have been able to do, and the reason they have been able to do it, is based on the drawing together of persons. Other programs do this also.

Mr. SYMINGTON. Is there as good a way to draw people together than by race, or ethnic identity?

Mr. MATTHEWS. I think there are several better ways. Race and ethnic identities are only two ways.

There are several other kinds of causes and purposes that draw people together, and many examples of that I am sure are obvious to you.

Mr. SYMINGTON. So his conclusion is really unwarranted?

Mr. MATTHEWS. No, I do not think so.

Mr. SYMINGTON. We should not emulate that approach?

Mr. MATTHEWS. I think his conclusions are warranted, but his examples are severely limited.

Mr. SYMINGTON. Thank you very much.

Mr. ROGERS. Do you in effect have a czar in Virginia? I take it you do not.

Mr. MATTHEWS. There is a gentleman in Virginia that likes to consider himself a czar, but no.

Mr. ROGERS. Your setup does not provide for that as such, because you are a council?

Mr. MATTHEWS. Right. Our council is again a regional one as the Governor's council is statewide, with executive directorship.

Mr. ROGERS. Do you license in this State halfway houses, therapeutic communities?

Mr. MATTHEWS. Yes, the State department of mental hygiene and hospitals is developing now the criteria for such licensing, and I would imagine that it will be put in effect in a year.

Mr. ROGERS. So it is now an established policy, although, they are not now currently licensed?

Mr. MATTHEWS. I think they have the legal power, but they do not have the criteria at this time.

Mr. ROGERS. What is the State funding to meet the drug abuse problem; how much money?

Mr. MATTHEWS. The bulk of the State funding has been through the Omnibus Crime Control and Safe Streets Act, and they have blocked out roughly $750,000 here for drug abuse control. They are about to run out of that money, which they started awarding last July.

Mr. ROGERS. What does the State do itself?

Mr. MATTHEWS. Well, the State agencies themselves have set up a bureau of alcoholic and drug abuse studies, and funded that.

Mr. ROGERS. What is the total funding that the State has given?

Mr. MATTHEWS. Not being a State official, I could not respond.

Mr. ROGERS. Is there any way for us to get that?

Mr. MATTHEWS. I can contact Frank Kelly for that for you.

Mr. ROGERS. How many people can you provide treatment for in your region?

Mr. MATTHEWS. Currently, I would estimate, we are funded to provide methadone therapy for up to 300 people, and therapeutic community therapy for up to 400 people, and adolescent medicine for up to a hundred people.

The rest is private psychiatric, not organized, or long-term treatment projects, and I would not put too many people in it.

Mr. ROGERS. Are there any waiting lists, people waiting who want treatment?

Mr. MATTHEWS. Since most of this funding, as in Rubicon's case, is second year, so they can take more people, and Codac was recently funded for its methadone program. There is then no waiting list.

Mr. ROGERS. So anybody that wants treatment in your region gets treatment?

Mr. MATTHEWS. Yes. Assuming those programs are not filled. We will be reaching only 10 or 20 percent of the people needing treatment. There is also a deficiency in treatment for adolescents, so we clearly are in need of expanded funding on this. Unfortunately, we have had to go to law enforcement funds to get moneys.

Mr. ROGERS. Thank you very much.

Your testimony has been most helpful. This concludes the hearing this morning, as I understand.

We will take a quick lunch, and then this afternoon we will visit Rubicon.

The hearing is concluded.

(Whereupon, the hearing was concluded at 12:50 p.m., subject to the call of the chair.)

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