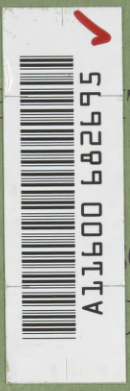
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DRUG ABUSE, PREVENTION, TREATMENT, AND REHABILITATION, 1971

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

ON

S. 2217

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

AND RELATED BILLS

AUGUST 2, 4, AND 5, 1971

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

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DRUG ABUSE, PREVENTION, TREATMENT, AND REHABILITATION, 1971

MONDAY, AUGUST 2, 1971

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

The subcommittee met at 9:30 a.m., pursuant to call, in room 4200, New Senate Office Building, Senator Harold E. Hughes (chairman) presiding.

Present: Senators Hughes and Javits.

Staff members present: Wade Clarke, counsel; and Jay B. Cutler, minority counsel.

Senator HUGHES. The Subcommittee on Alcoholism and Narcotics will get underway. Due to the necessity of a considerable amount of questioning, I am going to start and hope other members of the subcommittee will be present before we get too far down the line.

I want to take this opportunity, Dr. DuVal, to welcome you and your associates and assistants to the subcommittee. It is nice to see so many of you again.

Today, the Subcommittee on Alcoholism and Narcotics begins 3 days of hearings on S. 2217, the Federal Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act of 1971, and, in addition, S. 2146 and S. 2155, two bills introduced by Senator Humphrey.

(A copy of S. 2217, S. 2146, S. 2155, and S. 2097 follow:)

92D CONGRESS
1ST SESSION

S. 2217

IN THE SENATE OF THE UNITED STATES

JUNE 30, 1971

Mr. HUGHES (for himself, Mr. JAVITS, Mr. MUSKIE, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To provide a comprehensive Federal program for the prevention and treatment of drug abuse and drug dependence.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act of 1971".

TITLE I—FINDINGS AND DECLARATION OF POLICY; AND DEFINITIONS

FINDINGS AND DECLARATION OF POLICY

SEC. 101. The Congress hereby finds—

(1) that drug abuse and drug dependence are rapidly increasing in the United States and now afflict

not only inner city residents, but all urban, suburban, and rural areas of this Nation as well;

(2) that drug abuse and drug dependence contribute to crime and can seriously impair health;

(3) that the adverse impact of drug abuse and drug dependence inflicts pain and hardship on individuals, families, and communities;

(4) that the effectiveness of efforts by State and local governments and by the Federal Government to control drug abuse and drug dependence in the United States is hindered by a lack of coordination among those levels of government; and

(5) that for these reasons the increasing rate of drug abuse and drug dependence constitute a threat to national health and welfare and an emergency requiring immediate and effective Federal Government response involving improved intergovernmental and intragovernmental coordination and increased health, education, and rehabilitation efforts.

DEFINITIONS

SEC. 102. As used in this Act—

(1) "drug abuser" means any person who uses any controlled substance (as defined in section 102 of the

Controlled Substances Act) under circumstances that constitute a violation of law;

(2) "drug dependent person" means a person who is using a controlled substance (as defined in section 102 of the Controlled Substances Act) and who is in a state of psychic or physical dependence, or both, arising from administration of that substance on a continuing basis. Drug dependence is characterized by behavioral and other responses which include a strong compulsion to take the substance on a continuous basis in order to experience its psychic effects, or to avoid the discomfort caused by its absence; and

(3) "prevention and treatment" includes all appropriate forms of educational programs and services (including but not limited to radio, television, films, books, pamphlets, lectures, adult education, and school courses); planning, coordinating, statistical, research, training, evaluation, reporting, classification, and other administrative, scientific, or technical programs or services; and screening, diagnosis, treatment (emergency care services, inpatient services, intermediate care services, and outpatient services), vocational rehabilitation,

job training and referral, and other rehabilitation programs or services.

TITLE II—OFFICE OF DRUG ABUSE PREVENTION AND TREATMENT

ESTABLISHMENT OF OFFICE

SEC. 201. (a) There is hereby established in the Executive Office of the President, an office to be known as the Office of Drug Abuse Prevention and Treatment (hereinafter in this Act referred to as the "Office").

(b) There shall be at the head of the Office a Director (hereinafter referred to as the "Director") who shall be appointed by the President, by and with the advice and consent of the Senate, and shall be compensated at the rate now or hereafter provided for level III of the Executive Schedule (5 U.S.C. 5314).

(c) There shall be in the Office a Deputy Director of the Office who shall be appointed by the President, by and with the advice and consent of the Senate, and shall be compensated at the rate now or hereafter provided for level IV of the Executive Schedule (5 U.S.C. 5315). The Deputy Director shall perform such functions as the Director from time to time assigns or delegates, and shall act as Director during the absence or disability of the Director or in the event of a vacancy in the office of the Director.

(d) There shall be in the Office not to exceed three

Assistant Directors who shall be appointed by the Director and shall be compensated at the rate now or hereafter provided for level V of the Executive Schedule (5 U.S.C. 5316). Each Assistant Director shall perform such functions as the Director from time to time assigns or delegates.

(e) The Director may, subject to the civil service and classification laws, select, employ, and fix the compensation of such officers and employees, including attorneys, as are necessary to perform the functions vested in him and to prescribe their functions.

(f) The Director may, without regard to the civil service and classification laws, select, appoint, and employ not to exceed five officers and to fix their compensation at rates not to exceed the rate now or hereafter prescribed for GS–18 of the General Schedule by section 5332 of title 5 of the United States Code.

(g) Upon request of the Director, the head of any Federal Agency is authorized to detail, on a reimbursable basis, any of its personnel to the Director to assist him in carrying out his duties under this Act.

(h) The Director may obtain services as authorized by section 3109 of title 5 of the United States Code, at rates not to exceed the rate now or hereafter prescribed for GS–18 of the General Schedule by section 5332 of title 5 of the United States Code.

CONCENTRATION AND COORDINATION OF FEDERAL EFFORT

SEC. 202. (a) The Director shall provide overall planning and policy, and shall establish objectives and priorities, for all Federal drug abuse prevention and treatment programs and activities.

(b) As used in subsection (a) of this section and all subsequent provisions of this Act, the term "Federal drug abuse prevention and treatment programs and activities" includes, but is not limited to programs and activities relating to drug abuse and drug dependence conducted directly or indirectly by the Departments of Defense, State, Justice, Housing and Urban Development, Treasury, Labor, Health, Education, and Welfare, the Civil Service Commission, Veterans' Administration and Office of Economic Opportunity.

DUTIES AND AUTHORITY OF DIRECTOR

SEC. 203. (a) In carrying out his functions with respect to the programs and activities covered under section 202 (b) of this Act, the Director shall—

(1) determine priorities for the use of Federal funds for drug abuse and drug dependence programs and activities;

(2) promulgate regulations establishing policies, requirements, criteria, standards, and procedures for the administration of such programs and activities;

(3) analyze, evaluate, and prepare written recom-

mendations with respect to budget requests for such programs and activities;

(4) maintain overall supervision of such programs and activities, evaluate the performance and results achieved by the Federal departments and agencies directly or through grants or other assistance to public or private nonprofit agencies or organizations, and recommend organizational, managerial, personnel, standards, priority, policy, and program changes whenever he deems such changes to be advisable to implement the priorities, policies, and other requirements he has established pursuant to this section;

(5) strengthen coordination among Federal departments and agencies engaged in prevention and treatment efforts;

(6) develop yearly, and submit to the President and the Congress, prior to March 1, a detailed and comprehensive written Federal drug abuse and drug dependence prevention and treatment plan to implement the objectives and policies of this Act on local, State, National, and International levels. The plan shall specify how all available health, welfare, educational, law enforcement, and rehabilitation resources, and how funds, programs, services, and facilities authorized under all relevant existing Federal legislation, should be utilized;

(7) develop yearly, and submit to the President and the Congress prior to March 1, an analysis and evaluation of the programs conducted, expenditures made, results achieved, plans developed, and problems discovered in the operations and coordination of the various Federal drug abuse and drug dependence prevention and treatment programs and activities;

(8) develop yearly, and submit to the President and the Congress prior to March 1, a plan for effective cooperation with international institutions (such as the World Health Organization, the Food and Agricultural Organization, Interpol, and international lending agencies) for the development and implementation of methods of controlling the international traffic in drugs subject to abuse.

(b) No Federal officer, department, or agency shall be deemed to be relieved of any responsibility that such officer, department, or agency may have had on the date of enactment of this Act with respect to Federal drug abuse or drug dependence prevention and treatment programs or activities.

(c) The Director may require departments and agencies engaged in any activity involving Federal drug abuse or drug dependence prevention and treatment programs or activities to provide him with such information and reports, and to conduct on a reimbursable basis such studies and

surveys, as he may deem to be necessary to carry out the purposes of the Act.

(d) Where funds are made available by more than one Federal department or agency to be used by an agency, organization, or individual to carry out a Federal drug abuse or drug dependence prevention or treatment program or activity, a single non-Federal share requirement may be established according to the proportion of funds advanced by each Federal agency, and the Director may order any such agency to waive any technical grant or contract requirement established as in regulations which is inconsistent with the similar requirement of the other Federal agency or which the other Federal agency does not impose.

(e) Nothing in the foregoing provisions of this Act shall be construed as authorizing or permitting the Director to waive or disregard any requirement, including standards, criteria, or cost-sharing formulas, prescribed by law with respect to Federal drug abuse prevention or treatment programs or activities.

VOLUNTARY SERVICE

SEC. 204. The Director is authorized to accept and employ in furtherance of the purpose of the Act or any Federal drug abuse prevention or treatment program or activity, voluntary and uncompensated services notwithstanding the

provisions of section 3679 (b) of the Revised Statutes (31 U.S.C. 665 (b)).

TRANSITIONAL PROVISIONS

SEC. 205. (a) The President may authorize any person who immediately prior to the date of enactment of this Act held a position in the executive branch of the Government to act as the Director of the Office for Drug Abuse Prevention and Treatment until the office of Director is for the first time filled pursuant to the provisions of this Act or by recess appointment, as the case may be.

(b) The President may similarly authorize any such person to act as Deputy Director.

(c) The President may authorize any person who serves in an acting capacity under the foregoing provisions of this section to receive the compensation attached to the office in respect of which he so serves. Such compensation, if authorized, shall be in lieu of, but not in addition to, other compensation from the United States to which such person may be entitled.

TITLE III—NATIONAL INSTITUTE ON DRUG ABUSE AND DRUG DEPENDENCE

ESTABLISHMENT OF INSTITUTE

SEC. 301. (a) There is hereby established within the Public Health Service of the Department of Health, Education, and Welfare a National Institute on Drug Abuse and Drug Dependence (hereinafter referred to as the "Insti-

tute") to administer or coordinate drug abuse and drug dependence prevention and treatment programs and activities assigned to the Secretary of the Department of Health, Education, and Welfare (hereinafter referred to as the "Secretary") under this Act and other Federal law. The Secretary, acting through the Institute, shall develop and conduct a comprehensive health, education, research, and rehabilitation program for the prevention and treatment of drug abuse and drug dependence.

(b) The Institute shall be under the direction of a Director who shall be appointed by the Secretary. Acting through the Institute, the Secretary shall take any action consistent with the intent and purpose of this Act, including but not limited to the functions stated in this part.

PLANNING FUNCTIONS

SEC. 302. The Secretary shall—

(1) cooperate with the Director in preparing the comprehensive Federal drug abuse and drug dependence prevention and treatment plans provided for under sec. 203 (a) (6) of this Act, insofar as they relate to prevention and treatment programs and activities assigned to the Secretary;

(2) develop and encourage the enactment of model drug abuse and drug dependence prevention and treatment plans and legislation for State and local govern-

ments, utilizing the concepts incorporated in the comprehensive Federal plan and specifying how all types of community resources and existing Federal legislation may be utilized;

(3) encourage and promote the adoption, throughout the country, of public health procedures for the handling of drug abuse and drug dependence as alternatives to present criminal procedures; and

(4) review and provide in writing an evaluation of the adequacy and appropriateness of any provisions relating to the prevention and treatment of drug abuse and drug dependence contained in the comprehensive State health, welfare, and rehabilitation plans submitted to the Federal Government pursuant to Federal law, including, but not limited to, those submitted pursuant to section 5(a) of the Vocational Rehabilitation Act, sections 314(d)(2)(K) and 604(a) of the Public Health Service Act, section 1902a(a) of title XIX of the Social Security Act, and section 204(a) of part A of the Community Mental Health Centers Act.

COORDINATION FUNCTIONS

SEC. 303. The Secretary shall—

(1) insure that all Federal drug abuse and drug dependence prevention and treatment programs and activities assigned to him under this Act and other Federal law are carried out in a coordinated manner;

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(2) assist and serve in a consulting capacity to Federal courts, departments, and agencies in the development, maintenance, and coordination of a full range of programs, facilities, and services for education, diagnosis, planning, counseling, treatment, and rehabilitation with respect to the drug abuse and drug dependence problems they encounter among their employees and among the public they serve;

(3) encourage and assist State and local government programs and services and programs and services of other public and of private agencies, institutions, and organizations for the prevention and treatment of drug abuse and drug dependence; and

(4) serve as a clearinghouse and information center for the collection, preparation and dissemination of all information relating drug abuse and drug dependence including State and local drug abuse and drug dependence treatment plans, availability of treatment resources, training and educational programs, statistics, research, and other pertinent data and information.

RESEARCH FUNCTIONS

SEC. 304. The Secretary shall—

(1) conduct, encourage, and coordinate all forms of research relating to the cause, epidemiology, sociological aspects, prevention, diagnosis, treatment, toxicol-

ogy, pharmacology, chemistry, and effects on the health of drug abuse and drug dependence;

(2) make research facilities and resources of the Secretary available to appropriate authorities, health officials, and individuals engaged in special studies related to the purposes of this Act, and establish and maintain research fellowships in the Institute and elsewhere;

(3) investigate and publish information concerning uniform methodology and technology for determining the extent and kind of drug use by an individual and effects which individuals are likely to experience from such use;

(4) evaluate existing and proposed new programs and services for the prevention and treatment of drug abuse and drug dependence; and

(5) gather and publish statistics pertaining to drug abuse and drug dependence, and promulgate regulations specifying uniform statistics to be obtained, records to be maintained, and reports to be submitted on a voluntary basis by public and private departments, agencies, organizations, practitioners, and other persons with respect to drug abuse and drug dependence.

TRAINING FUNCTIONS

SEC. 305. The Secretary shall—

(1) establish and encourage the establishment of

training programs for professional and paraprofessional personnel, including recovered drug dependents, with respect to drug abuse and drug dependence; and

(2) establish and maintain training fellowships in the Institute and elsewhere.

EDUCATION FUNCTIONS

SEC. 306. The Secretary shall—

(1) develop and encourage the development of a broad variety of educational materials and techniques for use by schools (including elementary, secondary, adult education, professional and graduate schools) public and private agencies, organizations, and individuals concerning the use and abuse of drugs; and

(2) evaluate and encourage the evaluation of educational materials and techniques.

TITLE IV—DEVELOPMENT OF STATE AND LOCAL PREVENTION AND TREATMENT PROGRAMS

PART A—EMERGENCY SUPPLEMENTAL STATE ASSISTANCE PROGRAM

PROGRAM AND AUTHORIZATION

SEC. 401. (a) An emergency supplemental State assistance program is hereby established to provide immediate aid to States in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more

effective prevention, treatment, and rehabilitation programs to deal with drug abuse and drug dependence.

(b) There are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1972; $35,000,000 for the fiscal year ending June 30, 1973; and $50,000,000 for the fiscal year ending June 30, 1974, for grants to carry out the purposes of this part.

(c) For the purposes of this part, the term "State" includes the District of Columbia, the Virgin Islands, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Trust Territory of the Pacific Islands, in addition to the fifty States.

STATE ALLOTMENT

SEC. 402. (a) For each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated for such year pursuant to section 401 among the States on the basis of the relative population, financial need, and need for more effective prevention, treatment, and rehabilitation of drug abuse and drug dependence; except that no such allotment to any State (other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands) for any fiscal year shall be less than $200,000.

(b) Any amount so allotted to a State (other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands) and remaining unobligated

at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that any such amount, remaining unobligated at the end of the sixth month following the end of such year for which it was allotted, which the Secretary determines will remain unobligated by the close of such next fiscal year, may be reallotted by the Secretary, to be available for the purposes for which made until the close of such next fiscal year, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this part, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the States for the same period. Any amount allotted under subsection (a) to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year and remaining unobligated at the end of such year shall remain available to it, for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in addition to the amounts allotted to it for such purpose for each of such next two fiscal years; except that any such amount, remaining unobligated at the

end of the first of such next two years, which the Secretary determines will remain unobligated at the close of the second of such next two years, may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to any other of such four States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this part, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

(c) At the request of any State, a portion of any allotment or allotments of such State under this part shall be available to pay that portion of the expenditures found necessary by the Secretary for the proper and efficient administration during such year of the State plan approved under this part, except that not more than 10 per centum of the total of the allotments of such State for a year, or $50,000, whichever is the least, shall be available for such purpose for such year.

STATE PLANS

SEC. 403. (a) Any State desiring to participate in this part shall submit a State plan for carrying out its purposes. Such plan must—

(1) designate a single State agency as the sole agency for the preparation and administration of the

plan, or designate such agency as the sole agency for supervising the preparation and administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) (hereafter in this section referred to as the "State agency") will have authority to implement such plan in conformity with this part and with Federal policy established under this Act;

(3) provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of public agencies concerned with the prevention and treatment of drug abuse and drug dependence, from different geographical areas of the State, to consult with the State agency in carrying out the plan;

(4) set forth, in accordance with criteria established by the Secretary, a survey of the local and State needs for the prevention and treatment of drug abuse and drug dependence, including a survey of the health facilities needed to provide services for drug abuse and drug dependence, and a plan for the development and distribution of such facilities and programs throughout the State;

(5) provide for coordination of existing and planned

treatment and rehabilitation programs and activities, particularly in urban centers, and require compliance with the plan and cooperation with other programs and activities as a condition for financial support under this title;

(6) provide a scheme and methods of administration which will supplement, broaden, and complement State health plans developed under section 314 (d) (2) of the Public Health Act;

(7) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(8) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

(9) provide that the Comptroller General of the

United States or his duly authorized representatives shall have access for the purpose of audit and examination to the records specified in paragraph (7);

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary a candid analysis and evaluation of the effectiveness of the prevention and treatment programs and activities carried out under the plan, and any modifications in the plan which it considers necessary;

(11) provide reasonable assurance that Federal funds made available under this part for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs described in this part, and will in no event supplant such State, local, and other non-Federal funds; and

(12) contain such additional information and assurance as the Secretary may find necessary to carry out the provisions and purposes of this part.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a).

PART B—MODEL AND EXPERIMENTAL PREVENTION AND TREATMENT PROGRAMS

PROGRAM AND AUTHORIZATION

SEC. 411.(a) The Secretary, acting through the Institute, shall—

(1) make grants to public and private nonprofit agencies, organizations, and institutions and enter into contracts with public and private agencies, organizations, and individuals to establish, conduct, and evaluate model and experimental drug abuse and drug dependence prevention and treatment programs;

(2) make grants to groups of private, non-profit agencies, organizations, and individuals, representing a broad cross-section of community-based programs providing a broad range of services in the area to be served, to jointly establish, conduct, and evaluate coordinated drug abuse and drug dependence prevention and treatment programs.

(3) make special emphasis research grants to public and private nonprofit agencies, organizations, and institutions and enter into contracts with public and private agencies, organizations, and institutions, and individuals for expanded research efforts to discover, develop, or improve substances or techniques for using

substances for use in the prevention and treatment of drug abuse and drug dependence, including but not limited to, (A) a long-lasting blocking or antagonist drug for treatment of drug dependence; (B) improved detoxification agents; and (C) improved drug maintenance techniques or programs; and

(4) include in the annual report under section 203(a)(6) of this Act, a separate section describing the various existent model and experimental methods for the treatment and rehabilitation of drug abusers and drug dependent persons and the advantages of each; describing their indications of success or failure or both; making recommendations for future development of these areas; making such recommendations for community implementation of the treatment and rehabilitation methods as may be appropriate; and making such recommendations for legislation and administrative action in these areas as he may deem appropriate.

(b) There are authorized to be appropriated $35,000,000 for the fiscal year ending June 30, 1972; $60,000,000 for the fiscal year ending June 30, 1973; and $85,000,000 for the fiscal year ending June 30, 1974, to carry out the purposes of this part. Any appropriated funds shall remain available until expended.

ADMINISTRATION OF GRANTS AND CONTRACTS

SEC. 412. In administering section 411(a)(1) and (2),

(a) The Secretary shall require coordination of all applications for programs in a State and, in view of the local nature of the drug abuse problem, shall not give precedence to public agencies over private nonprofit agencies, institutions, and organizations, or to State agencies over local agencies.

(b) Each applicant within a State, upon filing its application with the Secretary for a grant or contract under this section, shall submit a copy of its application for review by the State agency designated under section 403, if such agency exists. Such State agency shall be given not more than thirty days from the date of receipt of the application to submit to the Secretary, in writing, an evaluation of the project set forth in the application. Such evaluation shall include comments on the relationship of the project to other projects pending and approved and to the State comprehensive plan for treatment and prevention of drug abuse and drug dependence under section 403. The State shall furnish the applicant a copy of any such evaluation. A State, if it so desires, may, in writing, waive its rights under this section.

(c) Approval of any application for a grant or contract by the Secretary, including the earmarking of financial assistance for a program or project, may be granted only if the application substantially meets a set of criteria established by the Secretary that—

(1) provide that the activities and services for which assistance under this section is sought will be substantially administered by or under the supervision of the applicant;

(2) provide for such methods of administration as are necessary for the proper and efficient operation of such programs or projects;

(3) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for Federal funds paid to the applicant; and

(4) provide reasonable assurance that Federal funds made available under this section for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs described in this section, and will in no event supplant such State, local, and other non-Federal funds.

PART C—ADMISSION OF DRUG ABUSERS AND DRUG DEPENDENT PERSONS TO HOSPITALS

ADMISSION TO HOSPITALS

SEC. 421. Drug abusers and drug dependent persons who are voluntary patients shall be admitted to and treated in private and public general hospitals on the basis of medical need and shall not be discriminated against because of their drug abuse or drug dependence. No hospital that violates this section shall receive Federal financial assistance under the provisions of this Act or any other Federal law administered by the Secretary. No such action shall be taken until the Secretary has advised the appropriate person or persons of the failure to comply with this section, and provided an opportunity for correction or a hearing.

PART D—COMMUNITY MENTAL HEALTH CENTERS

EXPANDED HEALTH CENTER PROGRAM

SEC. 431. (a) Section 221 of the Community Mental Health Centers Act (42 U.S.C. 2688a) is amended by adding at the end thereof the following new subsection:

"(c) No grant may be made under this part with respect to any community mental health center for any fiscal year beginning after June 30, 1972, unless the application for a grant for such center contains assurances satisfactory to the Secretary that—

"(1) the center will provide in such fiscal year a

treatment and rehabilitation program for persons with drug abuse and drug dependence problems; and

"(2) the center will enter into agreements with Federal departments and agencies under which agreements the center may be used to the maximum extent practicable in prevention and treatment programs provided by such departments and agencies for persons with drug abuse and drug dependence problems."

(b) Section 224 (a) of such Act (42 U.S.C. 2688d (a)) is amended by striking out "$60,000,000" and inserting in lieu thereof "$120,000,000".

SEC. 432. (a) Section 341 (a) of the Public Health Service Act (42 U.S.C. 257 (a)) (relating to care and treatment of narcotic addicts and other drug abusers) is amended by adding at the end thereof the following new sentence: "In carrying out this subsection, the Secretary shall establish in each hospital and other appropriate medical facility of the Service a treatment and rehabilitation program for persons with drug abuse and drug dependence problems; except that the requirement of this sentence shall not apply in the case of any such hospital or other facility with respect to which the Secretary determines that there is not sufficient need for such a program in such hospital or other facility."

(b) Section 341 of such Act is amended by adding at the end thereof the following new subsection:

"(c) The Secretary may enter into agreements with the Administrator of Veterans' Affairs, the Secretary of Defense, and the head of any other Federal department or agency under which agreements hospitals and other appropriate medical facilities of the Service may be used in treatment and rehabilitation programs provided by such department or agency for persons with drug abuse and drug dependence problems."

PART E—GENERAL

LEASING OF FACILITIES

SEC. 441. (a) Section 251(a) of the Community Mental Health Centers Act is amended (1) by inserting "or leasing" after "construction", and (2) by inserting "facilities for emergency medical services, intermediate care services, outpatient services, or" immediately before "post-hospitalization treatment facilities".

(b) Section 251(b) of the Community Mental Health Centers Act is amended by inserting "or leasing" after "construction".

RECORDS

SEC. 442. (a) Each recipient of assistance under this Act pursuant to grants or contracts entered into under other than competitive bidding procedures shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the

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proceeds of such grant or contract, the total cost of the project or undertaking in connection with which such grant or contract is given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(b) The Secretary and Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such recipients that are pertinent to the grants or contracts entered into under the provisions of this Act under other than competitive bidding procedures.

PAYMENTS

SEC. 443. Payments under this Act may be made in advance or by way of reimbursement and in such installments as the Secretary may determine.

AVAILABILITY OF SERVICES

SEC. 444. Drug abuse or drug dependence shall be regarded as a health problem, sickness, illness, disease, disability, or other similar term, for purposes of all Federal legislation relating to health, welfare, and rehabilitation programs, services, funds and other benefits. Any Federal legislation providing for medical assistance, medical care, treatment, rehabilitation, or other similar services, shall be regarded as

including programs and services for the prevention and treatment of drug abuse and drug dependence.

TITLE V—THE NATIONAL ADVISORY COUNCIL ON DRUG ABUSE AND DRUG DEPENDENCE

ESTABLISHMENT OF COUNCIL

SEC. 501. (a) Section 217 (a) of the Public Health Service Act is amended—

(1) in the first sentence thereof, by inserting "the National Advisory Council on Drug Abuse and Drug Dependence," immediately after "the National Advisory Mental Health Council,";

(2) in the second sentence thereof, by (A) inserting "the National Advisory Council on Drug Abuse and Drug Dependence," immediately after "the National Advisory Mental Health Council," and (B) inserting "drug abuse and drug dependence" immediately after "phychiatric disorders," and

(3) in the fourth sentence, (A) by inserting "and the members of the National Advisory Council on Drug Abuse and Drug Dependence" after "(other than the members of the National Advisory Council on Alcohol Abuse and Alcoholism"; (B) by striking out "and" before "(3)"; and (C) by striking out the

period at the end and inserting a semicolon and "and (4) the terms of the members of the National Council on Drug Abuse and Drug Dependence first taking office after the date of enactment of this clause, shall expire as follows: Three shall expire four years after such date, three shall expire three years after such date, three shall expire two years after such date, and three shall expire one year after such date, as designated by the Secretary at the time of appointment.".

(b) Section 217 (b) of such Act is amended, in the second sentence thereof, by inserting "drug abuse and drug dependence," immediately after "mental health,".

(c) Section 217 of such Act is further amended by adding at the end thereof the following new subsection:

"(e) The National Advisory Council on Drug Abuse and Drug Dependence shall advise, consult with, and make recommendations to the Secretary on matters relating to the activities and functions of the Secretary in the field of drug abuse and drug dependence. The Council is authorized (1) to review research projects or programs submitted to or initiated by it in the field of drug abuse and drug dependence and recommend to the Secretary any such projects which it believes show promise of making valuable contributions to

human knowledge with respect to the cause, prevention, or methods of diagnosis and treatment of drug abuse and drug dependence, and (2) to collect information as to studies being carried on in the field of drug abuse and drug dependence and, with the approval of the Secretary, make available such information through appropriate publications for the benefit of health and welfare agencies or organizations (public or private) or physicians or any other scientists, and for the information of the general public. The Council is also authorized to recommend to the Secretary, for acceptance pursuant to section 501 of this Act, conditional gifts for work in the field of drug abuse and drug dependence; and the Secretary shall recommend acceptance of any such gifts only after consultation with the Council."

APPROVAL BY COUNCIL OF CERTAIN GRANTS UNDER PART D OF COMMUNITY MENTAL HEALTH CENTERS ACT

SEC. 502. Section 266 of the Community Mental Health Centers Act is amended (1) by inserting "and part D" immediately after "(other than part C", and (2) by adding at the end thereof the following new sentence, "Grants under part D of this title for such costs may be made only upon recommendation of the National Advisory Council on Drug Abuse and Drug Dependence established by such section."

TITLE VI—PREVENTION AND TREATMENT FOR FEDERAL EMPLOYEES

DRUG ABUSE AND DRUG DEPENDENCE AMONG FEDERAL GOVERNMENT EMPLOYEES

SEC. 601. (a) The Civil Service Commission shall be responsible for developing and maintaining, in cooperation with the Secretary and other Federal agencies and departments, appropriate policies and services for the prevention and treatment of drug abuse and drug dependence among Federal civilian employees, consistent with the purposes and intent of this Act. Such policies and services shall make optimal use of existing governmental facilities, services, and skills. Federal civilian employees who are drug abusers or who are drug dependent shall retain the same employment and other benefits as other persons afflicted with serious health problems and illnesses, and shall not lose, solely because they are drug abusers or drug dependent persons, pension, retirement, medical, or other rights. A good faith attempt shall be made to find appropriate work within the Government which does not involve the national security during the employee's rehabilitative treatment, rather than placing him on sick leave.

(b) The Secretary, acting through the Institute, shall be responsible for fostering similar drug abuse prevention,

treatment, and rehabilitation services in State and local governments and in private industry.

(c) No person may be denied or deprived of Federal employment or a Federal professional or other license or right solely on the ground of prior drug abuse or prior drug dependence, except with regard to positions involving national security as specified in regulations promulgated by the department or agency in which he is employed.

CONFIDENTIALITY OF RECORDS

SEC. 602. (a) All patient records prepared or obtained pursuant to section 131 of this title, and all information contained therein, shall remain confidential and may be disclosed, with the patient's consent, only to medical personnel and only for purposes of diagnosis and treatment of the patient, or to Government or other officials for the purpose of obtaining benefits due the patient as a result of his drug dependence or, for research purposes, to public or private research organizations, agencies, institutions, or individuals whose competence and research programs have been approved by the Secretary. Disclosure may be made for purposes unrelated to such treatment, benefits, or research upon an order of a court after application showing good cause therefor. In determining whether there is good cause for disclosure, the court shall weigh the need for the information sought to be disclosed against the possible harm of disclosure to the person to whom

such information pertains, to the physician-patient relationship, and to the treatment services, and may condition disclosure of the information upon any appropriate safeguards. No such records or information may be used to initiate criminal charges against a patient under any circumstances.

(b) All patient records and all information contained therein relating to drug abuse or drug dependence prepared or obtained by a private practitioner shall remain confidential, and may be disclosed only with the patient's consent and only to medical personnel for purposes of diagnosis and treatment of the patient or to Government or other officials for the purpose of obtaining benefits due the patient as a result of his drug dependence.

TITLE VII—PREVENTION AND TREATMENT FOR VETERANS

DRUG ABUSE AND DRUG DEPENDENCE AMONG VETERANS

SEC. 701. (a) Appropriate treatment facilities and services for drug abuse and drug dependence shall be made available within Veterans' Administration hospitals, or by the Veterans' Administration through contract with other public or private agencies, organizations, or individuals, as a matter of high priority.

(b) Notwithstanding any other provision of law, former members of the Armed Forces who served on active duty or active duty for training shall be entitled to prevention and

treatment services by the Veterans' Administration for drug abuse or drug dependence.

(c) If the Administrator of the Veterans' Administration finds that any person who was discharged under conditions other than honorable as a result of drug abuse or drug dependence has successfully completed a treatment and rehabilitation program, and has been recovered for a period of one year or more, such veteran shall thereafter be deemed to have been discharged under honorable conditions for the purpose of eligibility for any benefits due to veterans.

TITLE VIII—DRUG ABUSE PREVENTION AND TREATMENT SERVICES IN CORRECTIONAL INSTITUTIONS AND ON PROBATION AND PAROLE

FEDERAL OFFENDERS

SEC. 801. (a) The services established by this Act shall be used by the Bureau of Prisons and the Board of Parole for drug abuser or drug dependent offenders (including persons sentenced under the Federal Youth Corrections Act, chapter 402 of title 18 of the United States Code) placed on work release, probation, parole, or other conditional release. The Secretary and the Bureau of Prisons shall cooperate in establishing and encouraging the establishment of community based drug abuse treatment services and of drug abuse treatment services in Federal correction institutions.

(b) The conditional release of any drug abuser or drug dependent person convicted of any Federal offense may be conditioned on the person's agreement to periodic urine analyses or other means of detecting narcotic drugs within the body.

(c) The Bureau of Prisons and the Board of Parole may transfer an offender placed on conditional release from one treatment service to another depending upon his response to treatment. The decision whether to retain or to restrict or to revoke probation or parole or other conditional release after failure to conform to a schedule for rehabilitation shall be made on the basis of what is most consistent with both the rehabilitation of the individual and the safety of the community. All reasonable methods of treatment shall be used to prevent relapses and to promote rehabilitation. The Secretary shall provide periodic reports and recommendations to the Bureau of Prisons and the Board of Parole on persons being treated pursuant to this section.

TITLE IX—GENERAL

SAVING PROVISION

SEC. 901. If any section, provision, or term of this Act is adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, provision, or term of this Act, and the remaining sections, provisions, and terms shall be and remain in full force and effect.

REGULATIONS

SEC. 902. The Director and the Secretary may promulgate regulations pursuant to subchapter II of chapter 5 of title 5, United States Code to implement this Act.

92D CONGRESS
1ST SESSION

S. 2146

IN THE SENATE OF THE UNITED STATES

JUNE 24 (legislative day, JUNE 23), 1971

Mr. HUMPHREY introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To require community mental health centers and hospitals and other medical facilities of the Public Health Service to provide needed treatment and rehabilitation programs for drug addicts and other persons with drug abuse and other drug dependence problems, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 221 of the Community Mental Health Centers Act (42 U.S.C. 2688a) is amended by adding at the end thereof the following new subsection:

"(c) No grant may be made under this part with respect to any community mental health center for any fiscal year beginning after June 30, 1972, unless the application for a

grant for such center contains assurances satisfactory to the Secretary that—

"(1) 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 dependence problems who are in the area served by the center or 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; and

"(2) the center will enter into agreements with departments and agencies of the Government under which agreements the center may be used (to the maximum extent practicable) in treatment and rehabilitation programs (if any) provided by such departments and agencies for drug addicts and other persons with drug abuse and other drug dependence problems who are in the area served by the center."

(b) Section 224 (a) of such Act (42 U.S.C. 2688 (a)) is amended by striking out "$60,000,000" and inserting in lieu thereof "$220,000,000".

SEC. 2. (a) Section 341 (a) of the Public Health Service Act (42 U.S.C. 257 (a)) (relating to care and treatment of narcotic addicts and other drug abusers) is amended by adding at the end thereof the following new sentence: "In carrying out this subsection, the Secretary shall establish

in each hospital and other appropriate medical facility of the Service a treatment and rehabilitation program for drug addicts and other persons with drug abuse and drug dependence problems who are in the area served by such hospital or other facility; except that the requirement of this sentence shall not apply in the case of any such hospital or other facility with respect to which the Secretary determines that there is not sufficient need for such a program in such hospital or other facility."

(b) Section 341 of such Act is amended by adding at the end thereof the following new subsection:

"(c) The Secretary may enter into agreements with the Administrator of Veterans' Affairs, the Secretary of Defense, and the head of any other department or agency of the Government under which agreements hospitals and other appropriate medical facilities of the Service may be used in treatment and rehabilitation programs provided by such department or agency for drug addicts and other persons with drug abuse and other drug dependence problems who are in areas served by such hospitals or other facilities."

92D CONGRESS
1ST SESSION

S. 2155

IN THE SENATE OF THE UNITED STATES

JUNE 24 (legislative day, JUNE 23), 1971

Mr. HUMPHREY introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To establish a Drug Cure and Control Authority to coordinate Federal agency programs relating to drug abuse treatment, education, rehabilitation, and law enforcement.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Drug Cure and Control Authority Act".

FINDINGS AND DECLARATION OF POLICY

SEC. 2. (a) The Congress finds that there has been less than adequate information exchanged among Federal agencies necessary to mobilize and sustain an all-out campaign against drug abuse; that because of this lack of information and effort

by several Federal agencies, it has been difficult to coordinate major efforts against drug abuse; that the effectiveness and efficiency of efforts to protect against further widespread abuse of drugs requires the full coordination of all Federal agency programs relating to drug abuse treatment, education, rehabilitation, and law enforcement.

(b) It is the purpose of this Act to establish a Drug Cure and Control Authority that would implement recommendations from advisory panels to undertake a comprehensive Federal effort directed at the control of drug abuse and the elimination of illegal trafficking in narcotics.

DRUG CURE AND CONTROL AUTHORITY

SEC. 3. (a) There is hereby established an independent agency within the executive branch of the Federal Government to be known as the "Drug Cure and Control Authority" (hereinafter referred to as the "Authority"), having as its objective the control and cure of drug abuse.

(b) The Authority shall be headed by an Administrator who shall be appointed by the President, by and with the advice and consent of the Senate, for a term of five years. There shall be in the Authority two Deputy Administrators who shall be appointed by the President, by and with the advice and consent of the Senate, for terms of five years. At the time of his appointment by the President, one Deputy Administrator shall be designated by the President to serve

as Chairman of the Advisory Council on Drug Abuse Control Through Drug Education, Treatment, and Rehabilitation, and the other shall be designated as the Chairman of the Advisory Council on Drug Abuse Control Through Law Enforcement. Each Deputy Administrator shall perform such additional functions as the Administrator may prescribe and shall, if designated by the Administrator, be the Acting Administrator during the absence or disability of the Administrator. Upon the expiration of his term, the Administrator or any Deputy Administrator, as the case may be, shall continue to serve until his successor has been appointed and has qualified.

COMPENSATION OF THE ADMINISTRATOR AND DEPUTY ADMINISTRATORS

SEC. 4. (a) Section 5313 of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

"(20) Administrator, Drug Cure and Control Authority."

(b) Section 5314 of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

"(56) Deputy Administrators, Drug Cure and Control Authority (2)."

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STAFF

SEC. 5. (a) The Administrator may appoint such personnel as he deems desirable without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and may fix their compensation without regard to the provisions of chapter 53 of such title relating to classification and General Schedule pay rates, except that no individual so appointed may receive compensation in excess of the annual rate for grade GS–18 of the General Schedule.

(b) The Administrator may procure temporary and intermittent services to the same extent as is authorized by section 3109 of title 5, United States Code, but at rates for individuals not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule.

(c) Upon request of the Administrator, the head of any Federal agency is authorized to detail, on a reimbursable basis, any of its personnel to the Administrator to assist him in carrying out his duties under this Act.

(d) The Administrator may secure directly from any Federal agency information necessary to enable him to carry out the provisions of this Act, and upon the request of the Administrator, any such Federal agency shall furnish such information to the Administrator.

DUTIES AND FUNCTIONS OF ADMINISTRATOR

SEC. 6. (a) The Administrator shall, in consultation with the appropriate advisory council established pursuant to sections 7 and 8 of this Act, carry out the following functions and duties—

(1) INTERGOVERNMENTAL DRUG ABUSE PREVENTION, TREATMENT, AND REHABILITATION PROGRAM.—The Administrator shall prepare for the President a comprehensive program for the cure of drug abuse in the United States, including a program for coordination of Federal programs with those of State and local governments. Such program may provide for—

(A) stimulation of an expanded research program to create a synthetic analgesic to replace opium and its derivatives in medical use;

(B) stimulation of an expanded research program into the development and dissemination of a long-lasting blocking or antagonistic drug for treatment of drug addiction;

(C) stimulation of expanded research into the development of a detoxification agent, which, when administered, will ease the physical effects of withdrawal from heroin addiction;

(D) development of programs of methadone

maintenance, with appropriate supporting services, or similar programs for any methadone substitute, if and when developed;

(E) development of programs for the control of the production and distribution of psychotropic substances including a program for the development of a computer capability to monitor their manufacture, distribution, and dispensing; and

(F) development and evaluation of drug abuse prevention education programs.

(2) INTERNATIONAL DRUG CONTROL PROGRAM.—The Administrator shall prepare for the President a program for the effective use of facilities and personnel of governmental and international organizations in controlling drug abuse, including law enforcement programs. Such program may provide for—

(A) the offer to international organizations or foreign countries of technological assistance including—

(i) advanced computer technology,

(ii) the use of infrared sensors and radioactive and chemical tracer elements,

(iii) sophisticated administrative techniques, and

(iv) agricultural expertise for use in crop diversification; and

(B) effective cooperation with international institutions (such as the World Health Organization, the Food and Agricultural Organization, Interpol, and international lending agencies) for the development, implementation, and financing of crop diversification programs, alternative employment opportunities for persons engaged in drug production and distribution, and methods of controlling the international traffic in drugs subject to abuse.

(3) COORDINATION OF FEDERAL, STATE, AND LOCAL PROGRAMS.—The Administrator shall prepare for the President a plan for the coordination of drug abuse cure and control programs among the various Federal agencies which carry out such programs, and between such agencies and State and local agencies which carry out similar programs, including—

(A) law enforcement programs of the Department of Justice, the Treasury Department, and of State and local governments;

(B) medical research and treatment programs of the Department of Health, Education, and Welfare, the Veterans Administration, the Office of

Economic Opportunity, and of State and local governments;

(C) technological research conducted by the Department of Defense, the National Aeronautics and Space Administration, and of State and local governments;

(D) agricultural research and technical assistance programs of the Department of Agriculture, and of State and local governments;

(E) programs utilized to reach large numbers of potential drug abusers, including programs located in the Offices of Education and Child Development in the Department of Health, Education, and Welfare, in the Department of Defense, in the Department of Housing and Urban Development, in the Office of Economic Opportunity, and in State and local governments; and

(F) international programs developed or implemented by the Department of State or the Agency for International Development.

(b) Upon approval by the President of a plan submitted under subsection (a), the Administrator shall carry out such plan. The President shall take such administrative action, and shall submit to Congress requests for such legislation, as may

be necessary to enable the Administrator to effectively carry out each such approved plan.

(c) The President shall transmit to each House of Congress each approved plan prepared by the Administrator and every six months after a plan is transmitted to Congress the President shall make a report to each House of Congress describing the activities undertaken pursuant to the plan and any revisions made in the plan.

(d) The Administrator may, from time to time, make recommendations to the President, with respect to—

(1) the expenditure of funds by Federal departments and agencies for programs related to drug abuse control, including, but not limited to, law enforcement, the fields of agriculture, education, training, health and welfare, defense, foreign affairs, commerce, border control, and manpower; and

(2) such additional Federal, State, and local legislation as the Administrator deems necessary to further the purposes of this Act.

ADVISORY COUNCIL ON DRUG ABUSE CONTROL THROUGH LAW ENFORCEMENT

SEC. 7. (a) There is hereby established in the Authority the Advisory Council on Drug Abuse Control Through Law Enforcement, which shall be composed of the following members:

(1) the head of each Federal agency (or his designee), who is charged with the administration of any law or program involving the control of drug abuse through law enforcement;

(2) five members appointed by the President of the United States from persons specially qualified by training and experience to perform the duties of the Council, none of whom shall be an officer or employee of the United States; and

(3) the Deputy Administrator designated by the President as the Chairman of the Advisory Council on Drug Abuse Control Through Law Enforcement.

(b) Any member appointed pursuant to paragraph (2) of subsection (a) shall be appointed to serve for a term of six years. Any such member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall serve only for the remainder of such term. Members appointed pursuant to such paragraph (2) shall be eligible for reappointment and may serve after the expiration of their terms until their successors have taken office. A vacancy in the Council shall not affect its activities.

(c) The Council shall meet at the call of its Chairman, but not less than four times during each twelve-month period.

(d) It shall be the duty of the Council to consult with, advise, and assist the Administrator in the development and execution of programs under this Act involving or relating to the control of drug abuse through law enforcement.

(e) The Administrator of the Authority shall designate a member of the staff of the Authority to act as Executive Secretary of the Council.

(f) The Council shall submit a report to the President for transmittal to the Congress not later than January 31 of each year on the progress of the Authority toward the accomplishments of its objectives under this Act involving or relating to law enforcement in connection with drug abuse control.

(g) Members of the Council who are not officers or employees of the United States shall receive compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, for each day they are engaged in the actual performance of their duties, including traveltime and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as the expenses authorized by section 5703, title 5, United States Code, for persons in the Government service employed intermittently.

(h) The Administrator shall make available to the

Council such staff, information, and other assistance as it may require to carry out its activities.

ADVISORY COUNCIL ON DRUG ABUSE CONTROL THROUGH DRUG EDUCATION, TREATMENT AND REHABILITATION

SEC. 8. (a) There is hereby established in the Authority the Advisory Council on Drug Abuse Control Through Drug Education, Treatment and Rehabilitation, which shall be composed of the following members:

(1) the head of each Federal agency (or his designee), who is charged with the administration of any law or program involving drug education, treatment, or rehabilitation;

(2) five members appointed by the President from persons specially qualified by training and experience to perform the duties of the Council, none of whom shall be an officer or employee of the United States; and

(3) the Deputy Administrator designated by the President as the Chairman of the Advisory Council on Drug Abuse Control Through Drug Education, Treatment and Rehabilitation.

(b) Any member appointed pursuant to paragraph (2) of subsection (a) shall be appointed to serve for a term of six years. Any such member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall serve only for the remainder

of such term. Members appointed pursuant to such paragraph (2) shall be eligible for reappointment and may serve after the expiration of their terms until their successors have taken office. A vacancy in the Council shall not affect its activities.

(c) The Council shall meet at the call of its Chairman, but not less than four times during each twelve-month period.

(d) It shall be the duty of the Council to consult with, advise, and assist the Administrator in the development and execution of programs under this Act involving or relating to the control of drug abuse through drug education, treatment, or rehabilitation.

(e) The Administrator of the Authority shall designate a member of the staff of the Authority to act as Executive Secretary of the Council.

(f) The Council shall submit a report to the President for transmittal to the Congress not later than January 31 of each year on the progress of the Authority toward the accomplishments of its objectives under this Act involving or relating to the control of drug abuse through drug education, treatment and rehabilitation.

(g) Members of the Council who are not officers or employees of the United States shall receive compensation at rates not to exceed the daily equivalent of the annual rate in

effect for grade GS–18 of the General Schedule, for each day they are engaged in the actual performance of their duties, including traveltime and, while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as the expenses authorized by section 5703, title 5, United States Code, for persons in the government service employed intermittently.

(h) The Administrator shall make available to the Council such staff, information, and other assistance as it may require to carry out its activities.

SEC. 9. There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this Act.

92D CONGRESS
1ST SESSION

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IN THE SENATE OF THE UNITED STATES

JUNE 18, 1971

Mr. PERCY (for himself, Mr. MCCLELLAN, Mr. RIBICOFF, Mr. JAVITS, Mr. SCOTT, Mr. BYRD of West Virginia, Mr. ALLEN, Mr. BEALL, Mr. BROCK, Mr. CHILES, Mr. GURNEY, Mr. JACKSON, Mr. MATHIAS, Mr. MUSKIE, Mr. ROTH, and Mr. SAXBE) introduced the following bill; which was read twice and referred to the Committee on Government Operations

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Special Action Office for Drug Abuse Prevention Act".

FINDINGS

SEC. 2. The Congress hereby finds—

(1) that drug abuse is rapidly increasing in the United States and now afflicts urban, suburban, and rural areas of this Nation;

(2) that drug abuse contributes to crime, particularly to crimes of violence;

(3) that the adverse impact of drug abuse inflicts increasing pain and hardship on individuals, families, and communities;

(4) that for these reasons the increasing rate of drug abuse constitutes a threat to national health and welfare and an emergency requiring immediate and effective Federal Government response.

PURPOSE

SEC. 3. (a) It is the purpose of this Act to focus the comprehensive resources of the Federal Government and bring them to bear on drug addiction and drug abuse with the immediate objective of promptly and significantly reducing the incidence of drug addiction and drug abuse in the Nation within the shortest possible period of time.

(b) To accomplish these objectives (1) all Federal drug abuse prevention, treatment, rehabilitation, training, education, and research activities will be placed under the direction and policy setting of a new Special Action Office for Drug Abuse Prevention, established in the Executive Office of the President; and (2) major drug abuse programs will be centrally developed, funded, managed, and evaluated to achieve maximum effectiveness.

SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

SEC. 4. (a) There is hereby established in the Executive Office of the President, an office to be known as the Special Action Office for Drug Abuse Prevention (hereinafter in this Act referred to as the "Office").

(b) There shall be at the head of the Office a Director of the Office (hereinafter referred to as the "Director"). He shall be appointed by the President, by and with the advice and consent of the Senate, and shall be compensated at the rate now or hereafter provided for level III of the Executive Schedule (5 U.S.C. 5314).

(c) There shall be in the Office a Deputy Director of the Office who shall be appointed by the President, by and with the advice and consent of the Senate, and shall be compensated at the rate now or hereafter provided for level IV of the Executive Schedule (5 U.S.C. 5315). The Deputy Director shall perform such functions as the Director from time to time assigns or delegates, and shall act as Director during the absence or disability of the Director or in the event of a vacancy in the office of the Director.

(d) There shall be in the Office not to exceed three Assistant Directors who shall be appointed by the Director and shall be compensated at the rate now or hereafter provided for level V of the Executive Schedule (5 U.S.C. 5316).

Each Assistant Director shall perform such functions as the Director from time to time assigns or delegates.

CONCENTRATION OF FEDERAL EFFORT

SEC. 5. (a) The Director shall provide overall planning and policy, and shall establish objectives and priorities, for all Federal drug abuse training, education, rehabilitation, research, prevention, and treatment programs and activities (exclusive of law enforcement activities and legal proceedings).

(b) In addition, the Director shall provide overall planning, policy, direction, management, and funding for all Federal drug abuse training, education rehabilitation, research, prevention, and treatment programs and activities (exclusive of law enforcement activities and legal proceedings) conducted pursuant to the authorities described in subsection (c) (1) of this section and programs and activities designated by the President pursuant to subsection (c) (2) of this section.

(c) As used in subsection (b) of this section and all subsequent provisions of this Act, the term "Federal drug abuse training, education, rehabilitation, research, prevention, and treatment programs and activities" means—

(1) all such programs and activities (exclusive of law enforcement activities and legal proceedings) con-

ducted pursuant to the following-described provisions of law:

(A) the Narcotic Addict Rehabilitation Act of 1966;

(B) part D and part E (to the extent that such parts pertain to drug abuse) of the Community Mental Health Centers Act;

(C) title I of the Comprehensive Drug Abuse Prevention and Control Act of 1970;

(D) section 502 (a) (1) of the Comprehensive Drug Abuse Prevention and Control Act of 1970, to the extent that it pertains to public education not involving law enforcement;

(E) the Drug Abuse Education Act of 1970;

(F) section 222 (a) (9) of the Economic Opportunity Act of 1964 and all other provisions of that Act to the extent that they pertain to drug abuse;

(G) section 306 (a) (2) of the Omnibus Crime Control and Safe Streets Act of 1968, to the extent that it pertains to drug abuse;

(H) the Manpower Development and Training Act of 1962, to the extent that it pertains to drug abuse;

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(I) the Public Health Service Act, to the extent it pertains to drug abuse; and

(J) title 38 of the United States Code, to the extent it pertains to drug abuse; and

(2) subject to the provisions of subsections (d) and (e) of this section, such other Federal drug abuse related programs and activities (exclusive of law enforcement activities and legal proceedings) as the President may from time to time designate, including those which constitute a part of some larger program or activity.

(d) Whenever a designation is proposed pursuant to subsection (c) (2) of this section, a notice thereof shall be transmitted to the Congress. Such designation shall become effective on the thirtieth day (exclusive of periods of adjournment or recess of either the House or the Senate in excess of three days) following such transmittal, but only to the extent that, between the date of transmittal of the proposed designation and such effective date—

(1) there has not been enacted into law a statute which otherwise deals with the program involved;

(2) neither House of the Congress has enacted legislation which specifically disapproves the designation involved.

(e) Any such designation by the President may, in accordance with the designation notice transmitted to the Con-

gress, be made operative on a date later than the date on which that designation otherwise would have taken effect.

AUTHORITY OF DIRECTOR

SEC. 6. (a) In carrying out his functions with respect to the programs and activities covered under section 5 (b) of this Act, the Director shall—

(1) prescribe policies, requirements, criteria and standards, regulations, and procedures for the administration and management of such programs and activities;

(2) prepare budget requests for such programs and activities;

(3) determine priorities for the use of funds for such programs and activities;

(4) make funds available for program implementation to Federal departments and agencies and establish an implementation plan for each program setting forth policies, procedures, performance requirements, manpower levels, key personnel qualifications, time schedules, and other requirements;

(5) maintain overall supervision of such programs and activities and evaluate the performance and results achieved by the Federal departments and agencies, and recommend organizational, managerial, personnel, and program changes whenever he deems such changes to be advisable;

(6) take such steps as may be necessary to evaluate and assure the most effective utilization of all drug abuse programs and activities conducted by Federal departments and agencies, and by public or private agencies and organizations engaged in such activities under Federal grants or other assistance; and

(7) strengthen coordination among Federal departments and agencies engaged in non-law-enforcement efforts involving drug abuse prevention and control, and assure that those non-law-enforcement efforts are coordinated with related law enforcement efforts being conducted by other Federal departments and agencies.

(b) (1) The Director may, with the approval of the President (A) exercise any powers or perform any functions conferred by any of the statutory provisions enumerated in section 5(c) (1), or any statutory provisions relating to programs and activities designated by the President pursuant to section 5(c) (2), or (B) provide for their exercise or performance by an officer of any Federal department or agency other than the department or agency on whom such powers or functions are conferred by such provisions.

(2) To the extent that the Director or his designee exercises any powers or performs any function pursuant to

paragraph (1) of this subsection, the Director or his designee, as the case may be, may exercise in relation to those powers and functions any related authority or part thereof available by law, including appropriation Acts, to the official or agency from which such power or functions were derived.

(c) Except as otherwise provided by the Director, no Federal officer, department, or agency shall be deemed to be relieved of any responsibility that such officer, department, or agency may have had on the date of enactment of this Act with respect to Federal drug abuse training, education, rehabilitation, research, prevention, and treatment.

(d) The Director may require departments and agencies engaged in any activity involving Federal drug abuse training, education, rehabilitation, research, prevention, and treatment to provide him with such information and reports, and to conduct on a reimbursable basis such studies and surveys, as he may deem to be necessary to carry out the purposes of the Act.

(e) Nothing in the foregoing provisions of this Act shall be construed as authorizing or permitting the Director to waive or disregard any requirement, including standards, criteria, or cost-sharing formulas, prescribed by law with respect to Federal drug abuse programs or activities.

GRANTS AND CONTRACTS FOR DRUG ABUSE PREVENTION AND TREATMENT PROGRAMS

SEC. 7. (a) The Director is authorized to make grants to any public or nonprofit private agency, organization, or institution and to enter into contracts with any agency, organization, or institution, or with any individual—

(1) to develop and demonstrate new approaches, techniques, and methods with respect to drug abuse prevention, treatment, and rehabilitation;

(2) to evaluate those new approaches, techniques, and methods;

(3) to foster the establishment of new or expanded drug abuse programs and activities;

(4) to acquire, construct, improve, repair, operate, or maintain facilities, and to acquire and improve real property, necessary to the establishment or maintenance of drug abuse programs and activities; and

(5) to otherwise carry out the purposes of this Act.

(b) To the extent he deems it appropriate, the Director may require the recipients of a grant or contract under this section to contribute money, facilities, or services for carrying out the program and activity for which such grant or contract was made.

(c) Payments under this section pursuant to a grant or

contract may be made (after necessary adjustment, in the case of grants, on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and in such installments and on such conditions as the Director may determine.

(d) Notwithstanding any other provision of law, any Federal department or agency (including the Veterans' Administration) may enter into grant or contractual arrangements with the Director and pursuant to such a grant or contractual arrangement, may exercise any authority or use any personnel or facilities otherwise available to such department or agency for the performance by it of related functions.

PERSONNEL—SPECIAL PERSONNEL—EXPERTS AND CONSULTANTS

SEC. 8. (a) The Director may, subject to the civil service and classification laws, select, employ, and fix the compensation of such officers and employees, including attorneys, as are necessary to perform the functions vested in him and to prescribe their functions.

(b) The Director may, without regard to the civil service and classification laws, select, appoint, and employ not to exceed five officers and to fix their compensation at rates not to exceed the rate now or hereafter prescribed for GS–18 of the General Schedule by section 5332 of title 5 of the United States Code.

(c) The Director may obtain services as authorized by section 3109 of title 5 of the United States Code, at rates not to exceed the rate now or hereafter prescribed for GS–18 of the General Schedule by section 5332 of title 5 of the United States Code.

TRANSITIONAL PROVISIONS

SEC. 9. (a) The President may authorize any person who immediately prior to the date of enactment of this Act held a position in the executive branch of the Government to act as the Director of the Special Action Office for Drug Abuse Prevention until the office of Director is for the first time filled pursuant to the provisions of this Act or by recess appointment, as the case may be.

(b) The President may similarly authorize any such person to act as Deputy Director.

(c) The President may authorize any person who serves in an acting capacity under the foregoing provisions of this section to receive the compensation attached to the office in respect of which he so serves. Such compensation, if authorized, shall be in lieu of, but not in addition to, other compensation from the United States to which such person may be entitled.

TRANSFER OF FUNDS

SEC. 10. The Director of the Office of Management and Budget is authorized to provide for the transfer to the Office

of such unexpended balances of appropriations, and of other funds, available or hereafter made available for Federal drug abuse training, education, rehabilitation, research, prevention, treatment programs and activities, as he may deem to be appropriate to carry out the provisions of this Act.

APPROPRIATIONS AUTHORIZED

SEC. 11. There are hereby authorized to be appropriated to the President such sums as may be necessary to carry out the purposes of this Act. Any of those sums may be appropriated without regard to fiscal year limitations.

JOINT FUNDING

SEC. 12. Notwithstanding any other provision of law, where funds are made available by more than one Federal agency to be used by an agency, organization, institution, or individual to carry out a Federal drug abuse training, education, rehabilitation, research, prevention, or treatment program or activity, any one of the Federal agencies providing funds may be designated by the Director to act for all in administering the funds advanced. In such cases, a single non-Federal share requirement may be established according to the proportion of funds advanced by each Federal agency, and any such agency may waive any technical grant or contract requirement (as defined in such regulations) which is inconsistent with the similar requirement of the administering agency or which the administering agency does not impose.

VOLUNTARY SERVICE

SEC. 13. The Director is authorized to accept and employ in furtherance of the purpose of the Act or any Federal drug abuse training, education, rehabilitation, research, prevention, or treatment program or activity, voluntary and uncompensated services notwithstanding the provisions of section 3679(b) of the Revised Statutes (31 U.S.C. 665 (b)).

SEC. 14. (a) The provisions of this Act shall take effect thirty days after the Director or Acting Director first takes office or on such earlier date as the President may prescribe and publish in the Federal Register, except that any of the officers provided for in section 4 of this Act may be nominated and appointed and any of the interim officers provided for by section 9 may be authorized to serve at any time after the date of enactment of this Act.

(b) This Act shall terminate on June 30, 1974, unless extended by the President, in which case it shall expire on June 30, 1976, or such earlier date after June 30, 1974, as the President may prescribe and publish in the Federal Register.

Senator HUGHES. These hearings are not to be regarded as simply a continuation of the already abundant and sometimes redundant dialog about the drug problem, U.S.A., and what should be done about it.

S. 2217 is a serious effort to put together in one comprehensive bill the leading current proposals for action on drug abuse control. It combines basic features of the President's new and commendable initiative on drug programs with those of legislation already proposed by Members of the Senate and the House.

It is, therefore, a bill of many authors so far as its substance is concerned and a practical basic blueprint to catalyze the fragmented proposals on drug abuse control into a unified, inclusive plan of action that is so urgently needed in response to the critical national need.

It is essential that we act with speed as well as wisdom in getting a comprehensive national program underway. There is convincing evidence that the many-faceted drug plague is rapidly growing in both our civilian society and among our armed services. Even a few weeks' delay can make a substantial difference.

An effective national drug program must combine a number of different elements—treatment, rehabilitation, preventive education, enforcement of existing laws and new initiatives for curtailment of illegal drug traffic.

However, the solution does not lie in a further proliferation of fragmented, ad hoc laws such as we have now. On July 16, 1971, Congressman Scheuer placed in the record a list of all of the Federal drug abuse programs presently on the books.

This lengthy list will be placed in the record of this hearing at the conclusion of my opening remarks. Obviously, there is a compelling need for central direction and coordination of these scattered efforts.

Moreover, I am convinced that we must lay the foundations for a long-range, ongoing national effort. There is a current school of thought, including some intelligent students of the problem, who regard the drug epidemic as a passing fad in our national life that will phase out in a few years like the hula hoop frenzy of yesteryear. It is true that historically such epidemics tend to run in cycles.

But I believe it would be sheer folly to count on the drug abuse plague phasing out of its own accord. It is too deeply hooked into the emotional and social malaises of our drug-oriented society.

To date, we have scarcely scratched the surface of getting at the problem at its source—the addiction and dependence, the demand for drugs. Nor have we yet had any conspicuous success in shutting off the supply of illegal drugs and narcotics.

In the meantime, the social conditions, such as the large city ghettos where drug abuse first became epidemic, remain unchanged. The chronic, high unemployment does not help. And whatever the true figures are relating to the level of drug abuse and dependence in our armed services, the fact that a substantial number of discharged servicemen who are drug-users returning to every part of the country cannot help but have a serious impact on compounding the grave drug problem we already have.

In this context, I want to say quite bluntly that public officials who accuse those who are trying to deal realistically with the very serious problem of drugs in the armed services of maligning our fighting men are performing a distinct disservice to the cause.

It is this obdurate, head-in-the-sand attitude that permitted drug use to proliferate in the armed services in the first place.

In the enlightened view, drug abuse or dependence is a sickness, not a crime. Above all, it is a fact, a dangerous, tragic fact that must be dealt with and that can't be solved by ignoring that it exists.

We owe a special obligation to those who have risked their lives in the service of their country to do everything within our power to protect them from the tragedy of addiction.

Any other course is to condemn these men who have been fighting our wars to return to their home communities hooked with a deadly disease, a drug craving, that can, for the most part be sustained in our society only by criminal acts.

No one knows for sure what the actual percentages are of drug abusers in either our civilian society or the military. But whether you accept the minimum or maximum estimates, it is overwhelmingly apparent that we are confronted with a national problem of staggering proportions and complexity.

As one last comment to those who subscribe to the passing-phase theory about drug abuse, I would point out that alcoholism, which is the most widely practiced form of drug abuse we have, has been with us from time immemorial.

Rather than phasing out, it has been permitted to grow to a point where it causes more death, human suffering, and economic waste than all other forms of drug abuse combined.

In drafting drug control legislation, it must be admitted that we are dealing with an area in which much is still unknown. There are no sure-fire solutions on which all can agree. In response to the dire urgency, we must take the best solutions available and move.

S. 2217, which I introduced on June 30, together with Senators Javits, Muskie, and Williams, is a joint, broadly based effort to answer this need.

In briefest words, the provisions of the bill are as follows: It creates a new office in the Executive Office of the President to give powerful direction and impetus to Federal drug abuse prevention, treatment, and rehabilitation efforts.

It creates in the Department of Health, Education, and Welfare a new Institute on Drug Abuse and Drug Dependence which will coordinate and guide that agency's main activities relating to drug abuse.

It develops and assists State and local treatment and prevention programs, professional planning on State and local levels, and innovation and research in the field of drug abuse treatment and rehabilitation.

It creates a new National Advisory Council on Drug Abuse and Drug Dependence which makes it possible to tie into the overall program the ranking talent in the country outside of the Federal Government.

It provides special treatment and rehabilitation services for veterans, civil servants, and inmates in Federal correctional institutions.

We have a full schedule of witnesses for today and on Wednesday and Thursday. If additional hearings prove necessary, they will be promptly scheduled. For this is no easy field in which to legislate and time is of the essence.

We will now receive for the record a statement from the junior Senator from the State of Utah, the Honorable Frank E. Moss.

(The statement of Mr. Moss and the Congressional Record excerpt, previously mentioned, follow:)

STATEMENT OF HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

Mr. Moss. Mr. Chairman, I thank the committee for the opportunity to briefly state my full support of S. 2217, the Federal Drug Abuse and Drug Dependence Treatment, and Rehabilitation Act of 1971. This committee is to be highly commended for its imaginative, effective leadership in scheduling extensive hearings to explore innovative ideas, new approaches, and progressive programs necessary to the enactment of a comprehensive Federal program for prevention and treatment of drug abuse and drug dependence.

For too long the record of Government activities in combating drug abuse has been inadequate. The price of such inaction is measured in terms of high crime rates, broken homes, devastated lives, and lost productivity.

S. 2217 now provides for an effective partnership between all levels of Government, in utilizing our national resources to combat the serious drug proglem, and in creating an effective instrument that consolidates Government activities with concise allocation of functions and authorities. The Office of Drug Abuse, Prevention and Treatment, in the Office of the President provides for effective coordination of total Federal efforts in this area. Moreover, the Federal assistance and coordination as proposed by this measure primarily directs the thrust of the preventative effort to the local level where the social and economic costs of addiction are most particularly felt. New financial support is channeled into those organizations which are doing much of the frontline work against drug abuse. I especially endorse the total approach of S. 2217. Truly it is the most comprehensive and thorough legislation on drug abuse thus far introduced into the Congress.

Our Nation is experiencing a tremendous explosion in illegal drug use. The prophets of the drug culture have urged the younger generation, "Tune in, turn on and drop out." Americans also face a continual barrage of advertisements promoting the notion that the solution to any medical ailment is to pop a pill. President Nixon, in his message to Congress of June 17, stated:

> We must now candidly recognize the deliberate procedures embodied in the present efforts to control drug abuse are not sufficient to themselves. The problem has assumed the dimensions of a national emergency.

I concur with the President in his assessment of the problem.

I believe that S. 2217 provides the most effective and comprehensive means for dealing with this national drug emergency. I urge the committee to report favorably S. 2217, which I am cosponsoring, at the earliest possible date. Thank you.

[From the Congressional Record, July 16, 1971]

Federal Drug Abuse Efforts Seriously Fragmented

HON. JAMES H. SCHEUER OF NEW YORK IN THE HOUSE OF REPRESENTATIVES

Thursday, July 15, 1971.

Mr. Scheuer. Mr. Speaker, on March 24, over 60 colleagues and I introduced a bill to create an Office of Drug Abuse Control in the White House. This bill was the result of an investigation of Federal drug abuse programs which convinced us of the need for a comprehensive multi-disciplinary, multi-faceted plan of attack which would coordinate the now seriously fragmented Federal approach to the problem.

In order to document our belief that current programs are uncoordinated and disjointed in origin, largely unevaluated and of doubtful efficacy, poorly designed and just as poorly led, I have attempted to compile a comprehensive list of all Federal agencies which operate such programs. At the same time, administration officials have attempted to compile their own list.

Neither list is thus far entirely comprehensive. The administration list at this time, for example, does not include programs operated by the Veterans' Administration, HUD or the Department of State. My list also contains omissions.

The very fact that each list describes programs that the other omits dramatically illustrates how difficult it is to even determine the scope of the Federal effort in this area. Therefore, I wish to include both lists in my remarks at this point:

LIST OF FEDERAL DRUG ABUSE CONTROL PROGRAMS COMPILED BY REPRESENTATIVE JAMES H. SCHEUER LAW ENFORCEMENT

Department of Justice, Bureau of Narcotics and Dangerous Drugs

Program: Law Enforcement Assistance—State Legislation

Objective: To assist States in drafting enforcement and regulatory legislation relating to controlled substances, and to effect uniform drug laws among the States and the Federal Government.

Program: Law Enforcement Assistance—Training

Objective: To acquaint appropriate professional and enforcement personnel with: 1) techniques in the conduct of drug abuse investigations; 2) aspects of physical security in legitimate drug distribution; 3) techniques in the analysis of drugs for evidential purposes; 4) pharmacology, socio-psychological aspects of drug abuse education, and investigatory techniques.

Law Enforcement Assistance Administration

Program: Criminal Justice Improvement Program—Block Action Grants to States

Objective: A program of grants to States for the purpose of improving and strengthening law enforcement. Components of a State plan, which must be approved by LEAA may include programs for the treatment, education, and rehabilitation of narcotic addicts.

Program: Criminal Justice Improvement Program—Discretionary Grants to State and Local Governments

Objective: To make discretionary grants designed to assist States and local governments in implementing "special emphasis" law enforcement activities. Each city may select its programs from seven categories of projects, one of which is drug abuse education.

Program: Narcotic Detection

Objective: Detect the presence of narcotics by remote means. Based on the findings of these projects, the National Institute of Law Enforcement and Criminal Justice will develop additional narcotics detection systems and procedures.

Department of State, Agency for International Development

Program: Public Safety Program

Objective: Extensive assistance to local and narcotic police to discover illicit usage and traffic of narcotics in East Asia. In coordination with the Bureau of Customs, AID provides advisors to custom officials. Vietnam receives the most

extensive assistance. Programs are presently being expanded in Laos and Thailand.

Program: Agricultural Development and Control

Objective: Loan of three million dollars to provide equipment for law enforcement agencies and administrations of agriculture in Turkey for its crop substitution program.

Department of the Treasury, Bureau of Customs

Program: Narcotic Identification Program

Objective: Training of special customs agents in advanced and basic schools for the purpose of identifying narcotics.

Department of Agriculture

Program: Marijuana Control Program

Objective: Help farmers identify and eradicate marijuana.

Department of Defense

Program: Prevention of Drug Traffic, Navy

Objective: Elimination of drug abuse by individuals aboard naval ships and installations. Intensification of enforcement measures directed at individual navy men trafficking in drugs. Primary attention is focused upon the pusher.

Program: Detection of Marijuana

Objective: Both the Army and Navy are involved in pilot programs using trained dogs to detect marijuana.

RESEARCH AND OTHER SUPPORT

Department of Health, Education, and Welfare, National Institute of Mental Health

Program: Addiction Research Center

Objective: Plans and conducts direct research on the causes, diagnosis, prevention, and treatment of drug addiction, on the nature of the addictive process and on the addiction liability of new drugs.

Department of Justice, Law Enforcement Assistance Administration

Program: Effects of Methadone Treatment on Criminality

Objective: The program is assessing the value of methadone treatment in reducing the incidence of crime in area with a heavy concentration of heroin addiction and evaluating the change in individual behavior resulting from protracted administration of methadone to addicted persons.

Program: Chronic Effects of Marijuana

Objective: Two marijuana studies are currently underway. The first is assessing the effects of its chronic use on brain and on behavior. The second study is examining the social and cultural basis of youthful drug use.

Program: Heroin Detection

Objective: The objective of this project is to find a means to detect minute traces of heroin in the air. A device to detect the presence of traces of heroin in the atmosphere to indicate the location of hidden quantities of heroin could be a major breakthrough in the apprehension of traffickers.

Program: Termination of Drug Abuse

Objective: An analysis of the careers of drug addicts in order to identify those factors which distinguish continuing users from those persons who terminate their drug abuse.

Department of State, Agency for International Development

Program: Income Substitution

Objective: Aid to study the possibility of income substitution for the production of opium in East Asia.

Department of Justice, Bureau of Narcotics and Dangerous Drugs

Program: Laboratory Analysis

Objective: To provide drug evidence analysis, expert testimony in court, and technical assistance to law enforcement agencies concerning narcotics, other abused drugs, and their analysis.

Department of Defense

Program: Selectivity in Recruitment—Screening Program, Navy

Objective: Research and improve screening at recruiting level for drug addicts and drug abusers.

EDUCATION AND TRAINING

Office of Education

Program: Teacher Training

Objective: Under the authority of the Education Professions Development Act to grant funds for the specific purpose of training school personnel in the fundamentals of drug abuse education. The program is aimed at educators working with the 5–17 year old age group. Although States may use their grants as they see fit, they are encouraged to use the Government training centers operating in key locations around the country. These centers are responsible for training teams of teachers, counselors, school administrators, students and community leaders from the local school districts.

Department of Housing and Urban Development

Program: Drug Abuse Projects, Model Cities Administration

Objective: Make funds available for drug abuse projects in prevention, education, treatment, rehabilitation, and evaluation related to or incorporated in model cities programs.

Department of Health, Education, and Welfare, National Institute of Mental Health

Program: National Clearinghouse for Drug Abuse Information

Objective: Give the public one central office to contact for help. The Clearinghouse collects and disseminates material and data from Federal and appropriate private State and local projects. It also maintains a computer data bank on a wide variety of drug abuse control programs to enable the Government to give detailed answers to queries.

Program: Center for Studies of Narcotics and Drug Abuse

Objective: Development of new treatment techniques for addicts—improved methods of measuring the social readjustment of addicts under treatment, the increase of knowledge concerning the abuse of drugs of various types, and the training of workers in the special problems of drug abuse. Various types of grants and contracts, as well as consultation services, are made available to investigators and State and local agencies.

Department of Justice, Bureau of Narcotics and Dangerous Drugs

Program: Public Education on Drug Abuse: Technical Assistance

Objective: To provide advisory services to groups desiring to establish an educational program of drug abuse.

Program: Law Enforcement Assistance—Technical Laboratory Publications

Objective: To disseminate scientific information on the detection and analysis of narcotics and dangerous drugs.

Program: Training of Foreign Narcotic Officers

Objective: Two week training program to teach foreign narcotic officers American techniques of law enforcement.

Department of Agriculture

Program: 4–H Educational programs

Objective: The Department of Agriculture has been involved in drug abuse education efforts through its 4–H educational programs. These programs are underway in at least twelve states.

Department of Labor

Program: Regional Workshops—Drug Seminars

Objective: Education of personnel and enrollees in Job Corps Centers and other manpower training programs.

Program: Drug Survey of Adolescents

Objective: To collect a random sample of Job Corps employees to discover their knowledge of drugs and utilization patterns.

Department of Defense

Program: Drug Abuse Awareness, Navy

Objective: Promote drug abuse awareness at flag officer and commander level. Use of written and visual media to provide information about the effects of drugs and treatment available.

Program: Drug Abuse Education Specialists

Objective: Provide specialists at each major command to advise all servicemen about drug abuse. These specialists will educate and counsel active duty naval personnel, navy reserve personnel, and dependents of naval personnel.

Program: "Dope Stop Teen" Program, Navy

Objective: Utilizes volunteer high school teen counsellors to provide effective drug abuse information to children of all naval personnel in the elementary and junior high school grades.

Program: Drug Abuse Education, Air Force

Objective: The Military Airlift Command has contracted with a local drug rehabilitation agency to obtain the services of several ex-addicts in conducting seminars at each of its installations. A pilot traveling drug abuse indoctrination team project incorpating the use of an ex-addict as a team member has also been completed in the Air Force and the results are presently being evaluated.

TREATMENT AND REHABILITATION

Office of Economic Opportunity

Program: Community Action Programs: Economic Opportunity Act of 1964

Objective: Funding of community action programs for the prevention of narcotic addiction and the rehabilitation of narcotic addicts. Funds may also be granted to projects concerned with treatment and rehabilitation of abusers of depressant and stimulant drugs, as well as of narcotics. They encourage the use of neighborhood facilities and the services of recovered drug addicts and drug abusers as counselors.

Program: Drug Rehabilitation

Objective: Provide grants for community-based programs to 1) discover the causes of drug abuse and addiction and 2) treat the drug abuser and drug addict, emphasizing their re-entry into society rather than institutionalization. Utilize the services of recovered drug abusers and addicts as counselors.

Department of Health, Education, and Welfare, National Institute of Mental Health

Program: Narcotic Addict Treatment (Narcotic Addiction Rehabilitation Act)

Objective: To provide for civil commitment of narcotic addicts for examination and treatment, and for rehabilitation and aftercare services for addicts.

Program: Community Mental Health Centers (General Mental Health Centers)

Objective: Provide for grants to States and communities for the construction and staffing of public and other nonprofit mental health centers. The General Mental Health Centers may be used (but not exclusively) for the treatment and care of narcotic drug addicts.

Program: Community Mental Health Centers (Specialized Facilities for Narcotic Addicts)

Objective: Grants to States for the construction and staffing of facilities specifically concerned with the treatment of narcotic addicts. Funding of training and development activities and of surveys to evaluate the addiction treatment and prevention programs receiving assistance.

Program: Clinical Research Centers.

Objective: To serve currently as hospital facilities for the inpatient phase of treatment of persons participating in the Federal program for the treatment and rehabilitation of narcotic addicts. Under NARA the Centers are designated to examine, evaluate, and treat addicts who voluntarily commit themselves (Title III) and those given a choice by the Federal court to accept commitment rather than trial for certain charges (Title I).

Department of Health, Education, and Welfare, Social and Rehabilitation Service

Program: Juvenile Delinquency Prevention and Control.

Objective: Grants to assist communities in furnishing diagnosis, treatment, rehabilitative and preventive services to youths who are delinquents or in danger of becoming delinquent.

It encourages States to utilize resources under programs in the areas of general and vocational education, job training, prevention and detection of crime, and health and welfare.

Program: New Career Opportunities for the Handicapped.

Objective: To enable state vocational rehabilitation agencies and other public and private non-profit agencies to develop new programs to recruit and train handicapped individuals for new career opportunities in the fields of rehabilitation, health, welfare, public safety, law enforcement, and other appropriate public service employment. The Social and Rehabilitation Service Administration

conducts a program which includes activities specifically aimed at the drug abuser group. These activities include grants to States for research and demonstration projects, grants to State agencies, innovation grants, and training grants.

Department of Justice, Bureau of Prisons

Program: Treatment Program for Drug Abuse.

Objective: Development of treatment programs for offenders under Title II of the Narcotic Addict Rehabilitation Act. It is a self-help program within a Federal prison similar to the therapeutic community programs of Synanon and Daytop.

Veterans' Administration

Program: Drug Dependence Treatment for Veterans.

Objective: To provide two to eight weeks of hospitalization followed by long periods of out-patient care. The five centers are located at VA hospitals which will provide methadone maintenance, psychiatric care, and counselling.

Department of Labor

Program: Screening Program.

Objective: Individuals who are addicts are screened out from enrolling in manpower training programs. These individuals are provided with assistance and counselling.

Department of Housing and Urban Development

Program: Drug Abuse Projects, Model Cities Administration.

Objective: Make funds available for drug abuse projects in prevention, education, treatment, rehabilitation, and evaluation related to or incorporated in model cities programs.

Department of Defense

Program: Treatment and Rehabilitation Programs, Navy.

Objective: Provide every naval man with the assistance—counselling, treatment, and rehabilitation—to overcome drug problems. Rehabilitation of the hard drug user is the priority.

Program: Drug Abuse Exemption Program, Navy.

Objective: Provide counselling and assistance to any indivdual with drug abuse problems. The heroin addict, by applying to a representative at his command will receive exemption from punishment and undesirable discharge.

Program: Voluntary Treatment Program, Army.

Objective: This is the first voluntary treatment program to be initiated in the military services. Any individual may now seek treatment without fear of punitive measures.

Program: Urinalysis Test.

Objective: The purpose of this test is to identify military members who are dependent on drugs prior to their return home. Military members who are identified as drug addicts are insured further treatment.

DEPARTMENT OF AGRICULTURE

Prevention

The Department of Agriculture has been involved in drug abuse prevention efforts through its 4–H educational programs. These programs are underway in at least a dozen States. For a brief description of several of these programs, see attached letters. Other informational efforts are directed toward farmers and aimed at the identification and eradication of marihuana.

Treatment

No programs.

Research

No programs reported which are directly related to non-enforcement aspects of the drug abuse problem.

Training

No information available beyond what is contained in the attached prevention program descriptions.

DEPARTMENT OF DEFENSE

Prevention

Information and preventive campaign involving American Forces Radio and Television Service and wide dissemination of information including posters, handbooks for commanders, programs currently in operation for military dependents in Pacific, Atlantic, and European areas. More than nine dependents' high schools have established pilot programs involving the use of high school age students to communicate about drugs to younger students. These programs are modeled after DOPE STOP in Phoenix, Arizona. Implementation of drug abuse prevention education in Overseas Dependents Schools cost $85,472 in school year 1970–71. The Domestic Action Program of DOD can also be seen as being preventive in nature providing alternatives to youth involvement with drugs.

Treatment

DOD reports that information to reply to this section is not available at this time. New reporting procedures will furnish this information for future reports.

Research

See DOD report for description of types of research being conducted and surveys to determine (1) percentage of hard drug users in the separated population, and (2) prevalence of drug abuse and demographic factors related to the problem.

Training

The Army, Air Force, and Marine Corps have all had personnel attend DHEW-sponsored drug abuse training programs. (Only figure reported indicating the numbers of personnel involved was 94—that many spaces were provided to the Air Force at one of the DHEW Training Centers.)

The Navy has been operating a Drug Abuse Education Specialist School since early this year. The school has a current capacity of graduating 20 students a month. Plans are underway to increase this capacity to 30 per month. An East Coast school is also contemplated. Current training capacity would then be 240 students per year. As plans are implemented, training capacity could increase to 360 or double that amount if an East Coast school with identical capacity is opened.

Fifty dependents' school teachers will receive training in drug abuse educational procedures during the period June 21–July 17, 1971 in Wiesbaden, Germany. Hq. U.S. Army (Europe) has received funds from the Educational Professional Development Act for this purpose.

OFFICE OF ECONOMIC OPPORTUNITY

Prevention

The Office of Economic Opportunity is authorized to conduct a "Drug Rehabilitation Program" under Section 222(a)(9) of the 1969 Amendments to the Economic Opportunity Act of 1964. The authority relates to discovering the causes of and providing treatment and rehabilitation for drug dependency and narcotic addiction. The major emphasis is on treatment and rehabilitation services, developing community support, and utilizing neighborhood resources and ex-addicts as staff. Community education and prevention activities take place in the context of comprehensive treatment and rehabilitation programs rather than separately, and our programs are by and large funded in such a way that they relate closely to existing OEO-funded Neighborhood Service Center and Neighborhood Health Center delivery systems. Research activities are service program oriented. Funding levels are as follows.

Fiscal year 1970	$4, 500, 000
Fiscal year 1971	12, 800, 000
Fiscal year 1972	18, 000, 000

(Requested budget, about $15,000,000 would be available for new programs.)

Treatment

See Table 1, Treatment Programs for Heroin Addiction and Other Drug Dependencies (p. 81).

Also, in the area of treatment and rehabilitation there are two contracts for operational Integrated Addict Rehabilitation-Manpower Training Programs: one in Baltimore, Maryland, and one in New Orleans, Louisiana. Each contract will

run for a 24-month period, will cost about $1,000,000, and will serve 650 addicts. (That is, the total for the two contracts will be $2,000,000 with 1,300 clients served.) The projects will utilize methodone maintenance, counseling, residential services, and supportive modalities. In addition, Department of Labor funding (about $1,500,000 for each project) will be obtained to provide job-training and employment services. This will be a major effort to develop a coordinated system of services and to open up the private employment sector to ex-addicts. Followup, evaluation, and cost effectiveness systems will be a major part of the effort. The RFP is out and proposals will be due about July 15, 1971.

Research

A national evaluation contract which will provide a base for comparative drug treatment program evaluation is scheduled for completion June 30, 1971. This project is to evaluate OEO-aided Drug Rehabilitation Program, providing comprehensive analysis of relative program effectiveness including descriptions of various program components, their relationships to each other, and patterns of client-flow through various services.

Training

A grant is being made for the period 6/1/71–6/31/72 in the amount of $430,000 to the Center for Human Services to operate a National Training Institute in Washington, D.C. This will provide an intensive 6-month training program for ex-addict staff from various local projects with followup back at the local program. It will also provide shorter courses for professional staff and program administrators, especially focused on the peculiarities of an OEO-funded program in terms of its orientation toward the community and its goals of assisting clients out of poverty in addition to providing drug treatment services. There will also be a technical assistance capability to help local programs utilize ex-addict staff more effectively and to develop career ladders and certification procedures. The training project is based on a previously funded research grant which looked at present patterns of utilization of ex-addict staff, effectiveness of ex-addict staff, and current training practices. No capacity for this training endeavor was given.

TABLE 1.—TREATMENT PROGRAMS FOR HEROIN ADDICTION AND OTHER DRUG DEPENDENCIES[1]

Locale	Period	Modality	Approximate number serviced	Total expenditures
Detroit, Mich	July 1, 1970, to July 31, 1972	Outpatient methadone maintenance (therapeutic community serving 50 clients to be developed).	1,200	$1,200,000 [2] (1,000,000)
Los Angeles, Calif.[3]	July 1, 1970, to Aug. 31, 1971	Drug-free outpatient with hospital detoxification, counseling, crisis intervention, job placement.	800	690,000 [2] (340,000)
Washington, D.C	July 1, 1970, to July 31, 1972	Youth program (under age 17) utilizing drug-free residential treatment, outpatient counseling and family service.	300	480,000 [2] (110,000)
Chicago, Ill	Aug. 1, 1970, to Dec. 31, 1971	Hospital detoxification, residential (halfway house), outpatient counseling and vocational services. Drug-free.	300	330,000 [2] (120,000)
Boston, Mass	July 1, 1970, to Sept. 30, 1972	Outpatient and residential services for youth (under age 16) experimenting with drugs	500	550,000 [2] (150,000)
New Jersey (Hudson, Essex, and Monmouth Counties).[3]	Aug. 1, 1970, to Aug. 31, 1971	Drug-free therapeutic community. Outpatient counseling and supportive services. Small methadone maintenance (about 50 clients) being developed.	[4] 200 [5] 500	1,000,000 [2] (500,000)
New York City	July 1, 1971, to Sept. 30, 1972	Part of comprehensive system involving primarily drug-free inpatient and outpatient modalities.	[6] 1,500 [7] 4,000	4,000,000 [2] (2,500,000)
Philadelphia, Pa	July 1, 1970, to Dec. 31, 1971	Methadone maintenance (outpatient) with supportive services	200	250,000 [2] (110,000)
Atlanta, Ga	July 1, 1971, to June 30, 1973	Methadone withdrawal, methadone maintenance (about 100 clients), drug-free outpatient and inpatient services, group therapy, counseling, crisis intervention and supportive services.	500	900,000 [2] (250,000)
El Paso, Tex	do	Community outreach, followup and counseling services. Development of contacts with existing methadone maintenance and drug-free modalities for low-income Mexican-American heroin addicts.	400	580,000 [2] (250,000)
Tucson, Ariz	do	Similar to El Paso project	300	500,000 [2] (150,000)
Southern Alameda County, Calif	do	Outpatient and residential drug-free modalities for low-income youthful drug abusers	300	550,000 [2] (150,000)
Vermont (statewide)	July 1, 1970, to Dec. 31, 1972	Drug-free inpatient and outpatient services primarily to drug abusers (nonopiate). Therapeutic community being developed.	400	550,000 [2] (150,000)
Richmond, Va	July 1, 1970 to July 31, 1972	Therapeutic community and outpatient counseling, supportive and rehabilitative services. Drug-free modalities for heroin addicts. Also provides supportive services for methadone maintenance program.	500	730,000 [2] (220,000)
Los Angeles, Calif	July 1, 1971 to June 30, 1973	Drug-free residential, supportive and job-placement services for incarcerate and heroin addicts.	300	590,000 [2] (300,000)
South Carolina (statewide)	do	Counseling and group therapy services for addicts and drug-dependent persons in correctional facilities coupled with supportive services in community prerelease centers.	500	830,000 [2] (250,000)
Chattanooga, Tenn	do	Methadone maintenance and therapeutic community (drug-free) services for heroin addicts.	200	350,000 [2] (100,000)
Cincinnati, Ohio	do	Residential, outpatient, group therapy, counseling, and supportive services. Part of ex-offender halfway house system.	200	350,000 [2] (120,000)

[1] All figures given represent annual estimates.
[2] Non-Federal funds.
[3] Funding to be assumed by NIMH.
[4] Inpatients.
[5] Outpatients.
[6] Adults.
[7] Youth.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

Prevention—OE has funded a wide variety of preventive efforts in FY 71. $6 million was appropriated for programs to be conducted in FY 72.

$2 million will go in grants to 55 State Education agencies to support continuing programs to train educational personnel.

Twenty-six comprehensive community projects will be supported for a total of $2,100,000. These projects are intended to involve a variety of community agencies and groups in a cooperative effort to deal with local drug abuse problems.

Twenty college-based projects have been funded for a total of $700,000. These are intended to serve as pilot projects. They are initiated, designed, and directed by students.

Eleven drug education projects have been initiated by local school districts using $1.3 million in ESEA Title III funds. These programs call for heavy community involvement.

Seventeen programs are being supported by the Office of Nutrition and Health Services of OE. The programs for the most part are being funded under Title I of the Higher Education Act. ESEA Title III funds are also being used as well as funds under Title IV Regional Research Program. These programs are primarily educational and informational in character, intended to involve and educate a variety of target groups including students, teachers, law enforcement personnel, hospital and nursing home staffs, and the general public regarding drug use.

For a list of 13 projects supported by the Bureau of Higher Education under Title I, HEA, see attached chart. According to the information given, these projects with two exceptions are due to be completed on or before June 1971. An estimated 11,460 persons have been or will be involved as participants in these programs which are primarily, but not exclusively, educational in character. (For other projects specifically concerned with training, see section on Training below.)

Treatment.—While no OE funds have supported treatment programs per se, $197,847 from the Bureau of Adult Vocational Technical Training has been awarded to the Blackman's Development Center in Washington, D.C. for a multi-occupational training program designed to offer occupational alternatives to drug users and addicts. (According to Department of Labor figures approximately 200 drug addicts are serviced by the Blackman's Development Center.)

Research.—The National Center for Education Research and Development of OE is supporting a project which is designed to study and evaluate current trends in drug abuse education. This project is being conducted by the Far West Laboratory for Educational Research and Development in Berkeley, California and is scheduled for completion late this year. It has received $44,712 in Federal funds.

Training.—A total of $2 million will be expended to provide formula grants to State Departments of Education. In 1970 over one million educators and students were trained through the National Drug Education Program.

The Awareness House project will be expanded to serve as a training center for community personnel who will be trained to develop community drug abuse prevention projects. It will be funded at a level of approximately $200,000. No information on the capacity of this project is given in the OE report.

A project to train 50 teachers in schools for Department of Defense dependents in drug abuse educational procedures has been funded at a cost of approximately $100,000.

Of particular interest is a program being funded in FY 72 by the Division of College Support, under EPDA, Part E, entitled "Institute of Drug Education for Personnel of Eight Black Colleges," Alabama A & M, Huntsville, Alabama ($68,000). No estimates as to the number of participants is given.

Several of the projects being funded by the Bureau of Higher Education involve training programs. An estimated 100 persons participated in a training program entitled "The Development of Resource Personnel for Community Drug Abuse Programs" (University of Georgia). Another BHE project for FY 71 was entitled "Seminars for School Personnel on Personal Problems of Teenagers with Special Emphasis on Drug Abuse." An estimated 2,000 school personnel and youth counselors participated (Medical College of Virginia—Virginia Commonwealth University).

BHE has also funded a project entitled "Students in Community Service" involving some 500 students as participants. These students have worked under faculty direction with a community of young people at Odyssey House in Newark, New Jersey. The purpose of this project is to provide social support for the patients at Odyssey House.

Food and Drug Administration

Prevention—FDA efforts in this area are minimal.

Treatment—No programs.

Research—The Bureau of Drugs of FDA reports that its efforts in research related to narcotics and dangerous drugs are concerned with drug testing methodology and with the screening of new analgesics—defining their propensity for causing habit formation and physical dependence.

Training—No programs.

National Institute of Mental Health

Prevention—NIMH prevention activities take the form of promoting the development and dissemination of education materials. These materials and their distribution are described in the attached Fiscal Year 1971 Summary and "A Guide to Drug Abuse Education and Information Materials."

Treatment—The National Institute of Mental Health funds treatment and rehabilitation programs for narcotic addicts and drug abusers under both grant and contract machanisms. The grant program includes staffing grants to comprehensive drug treatment centers under Part D of the Community Mental Health Centers Act and special project grants for single or separate services under P.L. 91–513, the Comprehensive Drug Abuse Prevention and Control Act of 1970. The contract program is limited to the Narcotic Addict Rehabilitation Act of 1966 (NARA).

The grant program. Currently there are twenty-three community-based grant funded programs for the treatment of narcotic addicts and drug abusers. Eighteen of these funded programs are now operational and the additional five are in the process of commencing operations (New Orleans, D.C., Pittsburgh, Miami, Philadelphia). The number of individuals treatment approaches and location for these grants are shown in the accompanying Table T_1. At the present time, it is not possible to separate funds used for treating narcotic addicts from those used for other drug abusers. The Institute is currently reviewing grant applications pursuant to section 256 of P.L. 91–513 (detoxification, institutional, aftercare services). It is anticipated that up to fifteen new programs will be funded in Fiscal Year 1971 with the $5 million appropriated under this authority.

The contract program. The contract program under NARA includes examination and evaluation services, inpatient treatmnet services, and aftercare services carried out in facilities other than Fort Worth and Lexington Hospitals. The majority of examination and evaluation and inpatient treatment services, however, is carried out at these two hospitals. On March 31, 1971 there were 2,074 individuals in the NARA program distributed as in Table T_2.

2. Los Angeles Center for Group Psycholtherapy Grant #T15 MH12319–01 $81,443.

To train 90 school counselors, probation officers and mental health professionals in group techniques appropriate for treating adolescent and young adult drug abusers.

3. Roosevelt Hospital (New York) Grant #T15 MH12320–01 $3,222.

To train physicians in the scope of the drug abuse problem and prevention and treatment techniques.

4. University of California (Berkeley) Grant #TO1 MH12564–01 $150,378.

To establish a specialized drug abuse training unit in the Post-Master's Community Mental Health Program of the Department of Social Welfare.

Social and Rehabilitation Service

Prevention—SRS has supported a number of projects in the prevention area.

Examples include the Community Services Administration's support of family life education efforts in various locales and other educational programs which include a focus on drug abuse prevention among children and youth.

The Youth Development and Delinquency Prevention Administration of SRS has supported or is supporting a variety of projects in the area of drug abuse prevention. These include the recently funded project of Boston Model Cities

Administration. This project focuses on an informational approach to prevention as well as providing counseling and referral services. Other projects in this area supported by YDDPA include the "Drug Use, Misuse and Abuse Education Program," conducted by the State Planning Bureau in Atlanta, Georgia; the Youth Drug Abuse Prevention Project conducted by Flight, Inc., in Rochester, N.Y.; and the "Store-Front Drug Program" conducted by the Berkshire Farm Institute for Training and Research, Inc., Canaan, N.Y.

TREATMENT

See Table 1, Treatment Programs for Heroin Addiction and Other Drug Dependencies (p. 85).

Also in the area of treatment and rehabilitation, the Rehabilitation Services Administration is planning to stimulate and implement 15 to 20 Expansion Grant projects aimed at increasing substantially the number of drug abusers rehabilitated into gainful employment.

Research—The major emphasis of the demonstration project of the Oregon State Mental Health Division is to evaluate the effectiveness of two methods of treatment on the vocational rehabilitation of young adult drug abusers. Pre- and post-data on performance variables and psychological and social functioning will be collected and compared. This project is being supported by Division of Research and Demonstration Grants, SRS, monies.

The Division of Disability Services, Rehabilitation Services Administration, SRS, is planning to develop and initiate four to five Research and Demonstration projects designed to find new and improved methods for rehabilitating the drug abuser.

The Community Services Administration of SRS is soliciting information on whether adult public assistance recipients are known by the public welfare agency to be suffering from drug addiction.

Training—The Rehabilitation Services Administration of SRS plans to support five bi-regional training conferences for State rehabilitation agency staff in rehabilitation of the drug abuser.

The Rehabilitation Services Administration also supports a training grant program authorized under the Vocational Rehabilitation Act. This program is aimed at increasing the supply of personnel in the rehabilitation fields by helping training programs to expand and by offering aid to students. The objectives of this grant program also include working with professional groups to improve the quality of preparation; facilitating communication and working relationships among the professional rehabilitation fields; and to give workers in the rehabilitation field opportunities to improve their skills. No figures were given as to the capacity of these training efforts.

The Community Services Administration of SRS has supported a variety of training programs sponsored by State public welfare departments. The purpose of these training programs included the development of the skills and capacities of a variety of social service staff. Community Services Administration does not maintain data on the capacity of these training programs for prevention, community organization, and treatment personnel in specific problem areas such as drug abuse.

TABLE 1.—TREATMENT PROGRAMS FOR HEROIN ADDICTION AND OTHER DRUG DEPENDENCIES

Locale	Period	Modality	Approximate number serviced	Total expenditures
Washington, D.C	Fiscal year 1971	VR services to methadone maintained	240	$112,000
Minneapolis, Minn	do	VR services to hospital inpatient narcotic addicts	75	27,778
Nassau County, N.Y	do	Evaluation and VR services to disadvantaged addicts	250	25,810
Hartford, Waterbury, Conn	do	VR services and counseling	75	38,330
Tulsa, Okla	do	Counseling and psychiatric	25	12,500
Portland, Oreg.[1]	do	Individual or group psychotherapy, detoxification and medical, vocational, social, occupational, recreational, and educational services in addition to family casework services and religion.	100 clients annually	[2] 194,095
Brooklyn, N.Y.[3]	July 1, 1970–June 30, 1971	Detoxification as often as necessary under medical supervision, group treatment (Guided Group interaction model).	25 girls, ages 12 to 16	168,866
Anchorage, Alaska [3]	Not given (recently funded)	Halfway house to aid drug users in kicking their habit and reentering society	150 to 250 youths, 16 to 22	55,414

[1] This program is in the Psycho-Social Study Section, Drug Abuse Research and Demonstration Project SRS.
[2] 2d year, $209,000; 3d year, $207,000.
[3] These programs are funded by the Youth Development and Delinquency Prevention Administration, SRS.

Note: The first 5 programs are in the Division of Disability Services of SRS.
There is no data available on drug dependence or addiction treatment per se from the Office of Service Delivery, SRS.

DEPARTMENT OF HOUSING AND HUMAN DEVELOPMENT

HUD was unable to comply with the deadline set for receipt of information because this information is available only through its regional offices. The regional offices of the Department have been contacted and should be responding to the request for program information within a week or two. HUD will then send this information to NIMH to be collated and forwarded to the White House at the earliest possible date.

DEPARTMENT OF JUSTICE

Law Enforcement Assistance Administration

Prevention—The Prevention/Public Education program has been attended to largely in Large City/County Special Grants Program. Likewise, the Narcotics and Dangerous Drug Control Program (K–1 and K–2) have also provided a vehicle by which this area can be addressed. The major focus of prevention has been directed at the nation's youth through the development and implementation of preventive education programs in all grades of the public school system; e.g., grammar, junior high, and senior high. State and local medical, educational, and law enforcement personnel have worked jointly in the preparation and presentation of these programs. The National Institute of Mental Health and BNDD have likewise assisted in the development of informational materials for this purpose.

Public Education response to the narcotics/dangerous drug abuse problem is seen in programs developed for presentation to parents, civic groups, church organizations, and other interested citizen bodies. The intent here is perhaps three-fold: (1) to inform the adult community of the nature and extent of the problem; (2) to inform adults of what is being done; and (3) to prepare them for a possible personal confrontation with drugs as it may affect their own children.

Treatment—See Table 1, Drug Abuse Programs (Discretionary Grants Only—Action Grants Not Available) FY/71 Available Data (p. 87).

Research—Information regarding only two discretionary grants involving research/data collection is available for FY 70–71. These are the Police/Community Information Program in Anchorage, Alaska funded for $40,000 and the Commission on Drug Abuse-Treatment Program and Facility, Memphis, Tennesee, funded for $75,000. The Anchorage, Alaska project involves establishing a data and information bank. The Memphis Tennessee project involves studying and researching the causes of alcoholism and drug abuse related problems.

Training—Intensive training for the members of these special enforcement units have been emphasized throughout LEAA programs, the establishment of close liason between local and state agencies and BNDD have been insisted upon regarding development of training programs, utilization of existing programs, and further continuous unit training. No figures representing the number of persons trained or to be trained were given.

TABLE 1.—DRUG ABUSE PROGRAMS (DISCRETIONARY GRANTS ONLY—ACTION GRANTS NOT AVAILABLE) FISCAL YEAR 1971 AVAILABLE DATA

Locale	Period	Modality	Approximate number serviced	Total expenditures
Broward County, Fla	Aug. 1, 1970–July 31, 1971	Detoxification, physical and psychiatric evaluation, rehabilitation through psychiatric treatment and counseling, guided group interaction therapy.	500 (30 to 40 in residential care program).	$200,000
Chicago, Ill. (drug abuse rehabilitation program—addict offenders).	Aug. 24, 1970–Aug. 23, 1971	Group and individual counseling	200 to 300 addict offenders	200,000
Boston, Mass. (Norfolk County comprehensive interconventional drug addict treatment program).	Apr. 15, 1971–Apr. 14, 1972	Includes methadone maintenance and a self-help-type halfway house, therapy, and counseling.	No estimate given	154,318
Whitmore Lake, Mich. (serving adolescents from Detroit, Flint, Grand Rapids, and Highland Park) adolescent drug use limitation and treatment.	Aug. 15, 1970–Aug. 14, 1971	do	360 adolescents	92,475
Royal Oak, Mich. (alcohol and drug abuse treatment center).	Fiscal year 1971	No information given	No information given	101,046
St. Louis, Mo. (community-based treatment and supersion of selected offenders—narcotics).	Dec. 1, 1970–Dec. 30, 1971	Prewithdrawal counseling, withdrawal under medical supervision, short-term residential accommodations, crisis intervention, varied counseling and guidance.	Estimated 200 can be handled on a post-release basis.	79,285
Trenton, N.J. (drug addiction treatment, rehabilitation; and prevention).	July 1, 1970–June 30, 1971	Includes residential treatment center (modeled after Dayton Village, New York City, with total utilization of ex-addicts as staff).	Residential center designed to serve 70.	139,600
Columbus, Ohio (preventive program for metro narcotics and drug abuse enforcement).	Sept. 7, 1970–Sept 6, 1971	Includes medically supervised withdrawal program	No information given	75,000
Memphis, Tenn. (commission on drug abuse-treatment program and facility).	Aug. 15, 1970–Aug. 14, 1971	Psychological and sociological counseling included in voluntary treatment program.	22-bed facility	75,000
Travis, Tex. (comprehensive treatment program for young drug users).	Sept. 7, 1970–Sept. 6, 1971	Inpatient and outpatient therapy, including voluntary "walk-in" referral and crisis services.	No information given	52,470

DEPARTMENT OF JUSTICE

Bureau of Narcotics and Dangerous Drugs

Prevention—BNDD's efforts in the area of prevention include a public inquiry program which responds to requests for information on the problem of drug abuse, drugs being used, and various aspects of the drug problem as related to preventive enforcement and the problem of illegal drug use in the community. In addition, a community organizational program involving 13 pilot projects is being conducted. The emphasis of this is to promote a total community effort to prevent drug abuse, which includes law enforcement and other elements in the criminal justice system.

BNDD's preventive efforts also include a dissemination of information on drug laws and regulations to the registrants under the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Other preventive efforts include stimulating program activities among the pharmaceutical manufacturers and associations. Other developmental activities in which the Bureau has been involved have recently included a conference for artists to explore means of utilizing the artistic community at the local level in providing alternatives to drug abuse. Other activities have involved the clergy, educators, law enforcement, and media people.

Treatment—BNDD has no treatment programs.

Research—See BNDD report (attachment 1).

Training—No estimate of numbers of persons who can be or have been trained through BNDD was contained in its report.

Major training efforts are conducted for professionals in the enforcement field and related areas to orient them to the need and the advantages of preventing drug abuse as opposed to concentrating only upon the enforcement aspects of the drug problem.

DEPARTMENT OF JUSTICE

Bureau of Prisons

Prevention—No programs reported on.

Treatment—Two categories of treatment programs: one functioning under the Narcotic Addict Rehabilitation Act (NARA) ; the other—Drug Abuse Program—treating offenders currently in the Federal prison population who have drugs as a contributing cause to their criminal behavior and who do not qualify under NARA. See Table 1, Treatment Programs for Heroin Addiction and Other Drug Dependencies (p. 89).

Research—No research findings as yet to report. Collection of data in progress to help determine significant variables affecting treatment outcomes.

Training—Since NARA provides for an aftercare phase, a series of conference workshops with community agencies and probation agents have been held. (No figure is given as to the numbers of persons who have participated in these programs.)

Of some interest is the fact that several of the releases from the NARA programs have been hired by community organizations who are concerned with the "drug problem." The releasees are functioning as counselors and lecturers to various groups in the community. The Bureau of Prisons has contracted with some of these releasees to help in the containing development of an effective treatment program.

TABLE 1.—TREATMENT PROGRAMS FOR HEROIN ADDICTION AND OTHER DRUG DEPENDENCIES—NARA (NARCOTIC ADDICT REHABILITATION ACT)

Locale	Period	Modality	Approximate number serviced (capacity)	Total expenditures
Danbury, Conn	Fiscal year 1971	Primarily therapeutic community approach	200	See below.
Milan, Mich	do	do	50	Do.
Alderson, W. Va	do	do	100 women	Do.
La Tuna, Tex	do	do	100—50 women	Do.
Terminal Island, Calif	do	do	100 men, 50 women	Do.
5 programs funded for				[1] $560, 400

[1] Salaries, $436,200; operating costs, $124,200. Also, $525,000 in aftercare contracts have been let with community agencies, fiscal year 1971.

Note: Drug abuse program (for those not qualified to receive treatment under NARA): Facilities at Lewisburg, Pa.; Petersburg, Va.; Terre Haute, Ind.; El Reno, Okla.; and Lompoc, Calif.; will be providing treatment in fiscal year 1972 for drug abusers who do not qualify under NARA. To date, $80,000 has been allocated for fiscal year 1971 to cover the costs of construction

The major emphasis of the information program on drug smuggling and abuse by the United States Bureau of Customs is to stress law enforcement activities. This serves several purposes: one, it reinforces that there is a drug abuse crisis and tells the public what is being done to combat the problem; two, it asks the public to cooperate with local, state and federal authorities so that more can be done to solve the problem; and, three, it acts to deter amateur smuggling of illegal drugs into the United States.

This information program by Customs is implemented: from the speaker's platform; through news releases that generate editorials, news and feature articles; and, by use of posters, flyers, and radio and television public service announcements to inform the public of certain inconveniences they may experience because of the search for illegal drugs.

The Bureau cooperates with the travel industry and other government agencies in programs to slow drug smuggling and abuse in the United States. It has also participated in presentations by the White House for the television and radio industries on ways to curb drug abuse in America.

Additional information may be obtained from the Bureau of Customs, Office of Information and Publications, Treasury Department, Washington, D.C. 20226. Telephone 202–964–2475

DEPARTMENT OF LABOR

Prevention—A special film and other educational materials are being developed specifically for lower class and inner city populations because of the paucity of suitable material for Job Corps training programs. Guidelines for conducting drug education and counseling have been prepared for use in Job Corps training programs.

Treatment—See Table 1, Treatment Programs for Heroin Addiction and Other Drug Dependencies (p. 91).

Other efforts supported by DOL in the treatment and rehabilitation area include the VERA Institute of Justice of New York City which takes people arrested for less serious crimes and, prior to trial, gives these people (many of whom are drug addicts) an opportunity for rehabilitation and training.

Another similar program—not specifically geared to drug abusers but involving many—is Project Crossroads in Washington, D.C. This project is sponsored by the National Committee for Children and Youth and funded by the Department of Labor. It is a pretrial diversion program for youthful offenders. The program stresses career development, using employment, training, and other supportive services. Project Crossroads, like the VERA Institute of Justice program, relies heavily upon non-professional staff.

Research—DOL has contracted with the New York State Narcotic Addiction Control Commission to make some special tabulations from an ongoing survey of drug use among the general population of New York State in August 1970 which would show the extent of drug use among different occupational groups in the labor force. See the attached report for further specifics regarding the survey findings.

Training—A most extensive training effort has been undertaken by the Job Corps in DOL. The Job Corps organized a series of nine technical assistance seminars which could aid in the recognition of symptoms and in dealing with drug users. The first seminar was held in mid-January 1971 in Washington, D.C. Other seminars are scheduled for June 21–23 in Philadelphia. The six remaining seminars will be conducted July through September 1971. No specific information is given as to the number of persons who can participate or who have participated in each technical assistance seminar. The DOL report states that approximately 70 people in each Manpower Administration region were found to need background information and training in the drug area. This would bring the intended number of participants to no less than 630 persons."

TABLE 1.—TREATMENT PROGRAMS FOR HEROIN ADDICTION AND OTHER DRUG DEPENDENCIES

Locale	Period	Modality	Approximate number serviced	Total expenditures
Washington, D.C.,[1] Residential Manpower Center	Mar. 15, 1971	Methadone treatment (program for detoxified addicts who are physically and psychologically capable of undertaking job training).	No information given	No information given.
Baltimore, Md., Westinghouse Learning Corp	Fiscal year 1971	Job training and placement of ex-addicts	3 treatment programs but no information re numbers services.	Do.[2]
New Orleans, La., New Orleans Association of General Contractors.	do	Job training and placement of ex-addicts	No information given	Do.[3]
Washington, D.C., Blackman's Development Center	Feb. 26, 1971	Institutional training program for rehabilitated drug addicts (training courses 26 weeks in length).	200	$325,000 (plus $198,000 from HEW).

[1] 2 other similar demonstration projects are scheduled to begin prior to the end of fiscal year 1971 at 2 other Job Corps centers yet to be announced.

[2 3] On both of these projects DOL is working in conjunction with OEO. OEO plans to award operation contracts for 8 more cities in fiscal year 1972.

Senator HUGHES. Dr. DuVal, you may proceed with your testimony as you desire.

STATEMENT OF MERLIN K. DuVAL, M.D., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); CHARLES C. EDWARDS, M.D., COMMISSIONER, FOOD AND DRUG ADMINISTRATION; VERNON E. WILSON, M.D., ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; JAMES D. ISBISTER, DEPUTY DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; KARST J. BESTEMAN, ACTING DIRECTOR, DIVISION OF NARCOTIC ADDICTION AND DRUG ABUSE: NATIONAL INSTITUTE OF MENTAL HEALTH, HSMHA; JAMES M. SPILLANE, CHIEF, SPECIAL PERSONNEL DEVELOPMENT NEEDS BRANCH, BUREAU OF EDUCATIONAL PERSONNEL DEVELOPMENT, OFFICE OF EDUCATION

Dr. DUVAL. Thank you, Senator Hughes. I would like to introduce my colleagues. On my far left is Mr. Besteman, Acting Director, Division of Narcotic Addiction and Drug Abuse.

Next to him is Mr. Isbister, Deputy Director, National Institute of Mental Health, Health Services and Mental Health Administration.

On my immediate left is Dr. Wilson, Administrator, Health Services and Mental Health Administration.

On my right are Dr. Zapp, Deputy Assistant Secretary for Legislation, Dr. Edwards, Commissioner of the Food and Drug Administration, and Mr. Spillane, Chief, Special Personnel Development Needs Branch, Bureau of Educational Personnel Development, Office of Education.

It is a pleasure for my associates and me to appear before you today and testify on S. 2217 and related bills to be considered by the subcommittee, including S. 2097, 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.

It is well known that the Chairman and members of the subcommittee are among the most informed legislators on the problem of drug abuse.

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 will soon take up the President's proposal.

In the past decade, this Nation has experienced an alarming increase in the use of drugs. The precise dimensions of drug use and its effects 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. These additional funds will raise the total available for fiscal year 1972 for such activities to $381.4 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 nonlaw 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.

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; and

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

To achieve coordination of the Federal effort the President has proposed in S. 2097 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.

S. 2217 proposes an Office of Drug Abuse Prevention and Treatment and several of its functions are compatible with S. 2097. The President's proposal reflects his 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 and Congress initiates no opposing legislation.

The Special Action Office will assume overall responsibility for all major non-enforcement 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 effort 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 the programs over which he has budgetary authority pursuant to sections 5(b) and 5(c) of the bill and he 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, S. 2097 will provide the Director with all the tools necessary for effective coordination of the Federal drug abuse effort.

Since Dr. Jerome Jaffe, Special Consultant to the President for Narcotic and Dangerous Drugs, is scheduled to appear before you on August 4, I will not go into greater detail about the functions of that Office at this point.

However, it might be pointed out 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 anti-poverty functions of community action agencies at the neighborhood level.

Similar non-law-enforcement 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 effectively 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 existing programs and to achieve the necessary interdepartmental coordination.

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 agencies 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.

As I have noted, the Special Action Office proposed under S. 2097 is a key factor in pulling together Federal departments and agencies, but to be effective there must be a parallel coordination effort within the individual Federal departments.

Intra-departmental 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.

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.

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.

NIMH supports 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 a 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 treatment programs.

NIMH funds a wide range of drug abuse information and education aspects of all Federal drug programs. 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.

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.

With your permission, Mr. Chairman, I would like to at this point insert in the record a more detailed statement describing the drug programs of the Food and Drug Administration, National Institute of Mental Health, and the Office of Education.

Senator HUGHES. Without objection, it will be entered.

(The information subsequently supplied follows:)

ACTIVITIES RELATED TO DRUG ABUSE—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

NATIONAL INSTITUTE OF MENTAL HEALTH

The NIMH, a component of the Health Services and Mental Health Administration, has major responsibility for many of the Department's drug abuse activities.

Treatment programs.—(Expenditures in FY 1971—$26.1 million) NIMH provides community-based and rehabilitation services to narcotic addicts through grants funded under Public Law 90–574 and subsequently Public Law 91–211, and through contracts with community agencies under the Federal civil commitment program authorized by the Narcotic Addict Rehabilitation Act of 1966 (NARA), Titles I and III (Public Law 89–793).

Narcotic addict community-based treatment and rehabilitation services.—(Expenditures for FY 1971—$18.9 million) The original six narcotic addict treatment centers established under Public Law 89–793, Title IV, continue to receive full operating support. The ten treatment centers supported by staffing grants, originally funded in FY 1969, are now serving addicts. Where necessary, NIMH is providing guidance and technical assistance to the program staffs of these centers. Thirteen staffing grants were awarded in FY 1971. The 23 centers currently in operation are treating approximately 3,000 patients receiving drug free therapy and 5,000 patients receiving chemotherapy. When fully operational, the 36 centers will have the capacity to treat approximately 21,000 patients at any one time.

Federal Civil Commitment Program (NARA).—(Expenditures for FY 1971—$7.2 million) Under the Civil Commitment Program, contracts providing a wide range of rehabilitation services for narcotic addicts have been awarded to 164 mental health, family service, vocational rehabilitation, and other community agencies in 44 states and Puerto Rico. Prior to this year, primary effort has been given to the development of a network of facilities capable of providing services for addicts. There is now the ability to provide these services to 2,300 patients. This year, however, the need for community-based examination and evaluation service has been empasized. As a result, community-based contractors will provide examination and evaluation services for more than 1,200 patients.

Research programs.—(NIMH expenditures for FY 1971—$17.7 million) Through the various units of the Division of Narcotic Addiction and Drug Abuse, NIMH is seeking by both contract and grant mechanisms new knowledge about the mechanisms of addiction and the totality of factors contributing to drug abuse. Research undertaken has already led to a number of notable advances. These include a more complete nowledge of the physiological mechanisms of addiction, a better understanding of the social and psychological forces impelling some persons to use heroin and other drugs, and improved methods of detecting drug use. A vigorous program of marihuana research has been mounted to clarify many of the uncertainties surrounding the drug. Current priority investi-

gations include such areas as epidemiological research to better identify and describe heroin populations and to evaluate the effectiveness of various treatment modalities; evaluation of methadone and narcotic antagonists; development and evaluation of long-acting antagonists and implants; detection of metabolites and biochemical mechanisms of tolerance and marihuana effects; logitudinal studies of heroin and other drug users with correlates; preclinical and clinical studies of long-term use of marihuana; biological effects of LSD, effects of use of methamphetamine; biochemistry, pharmacology, and toxicology of non-opiate drugs.

Clinical research centers.—(Expenditures for FY 1971—$11.3 million) Included in the total services and research effort are the two clinical research centers administered by NIMH at Lexington, Kentucky, and Fort Worth, Texas, providing direct inpatient treatment and research. We anticipate an early transfer of the Fort Worth Clinical facility to the Bureau of Prisons of the Department of Justice.

Training programs.—(Expenditures for FY 1971—$2 million) Emphasis was placed on four major areas in FY 1971 to reach the objective of accelerating the national training effort in drug abuse prevention, treatment, and rehabilitation: (1) training of professionals and paraprofessionals working or planning to work in the drug field; (2) training of health and social service personnel to counsel drug abusers; (3) preparation of innovative training materials for teachers; and (4) development and dissemination of materials for practicing health professionals.

Education and information programs—NIMH drug abuse campaign projects.—(Expenditures for FY 1971——$1.9 million) There is continuing development and dissemination of a variety of information materials in drug abuse, using a wide variety of media, designed to fit the differing needs of varying target groups such as minority groups.

Education and information programs—National Clearinghouse for Drug Abuse Information.—(Expenditures for FY 1971—$663,000) This branch of the NIMH Office of Communications was set up in March 1970 by White House directive. Its three main functions are: (1) distribution and publication from all government agencies in the field of drug abuse; (2) computer-based information and retrieval services for material in the drug abuse field; (3) referral services for inquiries.

Education and information programs—Special Projects.—(Expenditures for FY 1971—$1.5 million) Under recently enacted legislation the Comprehensive Drug Abuse Prevention and Control Act of 1970, PL 91–513, 15 awards were made for a variety of community-based drug abuse education activities.

THE OFFICE OF EDUCATION

The Office of Education is responsible for the National Drug Education Training Program, funded in the amount of $6 million, which trains school personnel, particularly teachers, in the fundamentals of drug education. The program has the goal of reaching every school district in the Nation during this year.

The White House drug abuse education curriculum and training subcommittee is chaired by the Office of Education and consists of representatives from NIMH, the Bureau of Narcotics and Dangerous Drugs, the Office of Economic Opportunity and the Department of Defense. Its charge is to advise on coordination of a national curriculum review and coordination of Federally supported school-based training and education programs to prevent overlap and identify and fill in gaps.

An educational TV teacher-training film series is also currently being developed under the sponsorship of the Office of Education and NIMH under contract to the UCLA Media Extension Center. This training program will include 12 half-hour films and accompanying materials for the training of educational personnel in drug abuse prevention. This series is scheduled for release later this summer.

The Office of Education has for two years funded an innovative special project which trains carefully selected ex-drug addicts as counselors to work with youth, parents, and school personnel in communities to help find solutions to the drug abuse problem. Preliminary evaluation shows program as demonstrating positive results. Six school-community Awareness Houses are now in place in Arizona and California.

Among seven priority areas for Title III ESEA 15 percent discretionary funds is drug abuse prevention. In FY 1971 $1.3 million will be made available for drug education projects to local education agencies nationwide.

In February 1970 the U.S. Office of Education, in cooperation with NIMH, BNDD, and OEO, conducted a curriculum review from a nationwide survey of drug education curricula. Outside experts and young people assisted in the review process. Ten curricula were selected for placement and distribution as samples, not models, in the National Clearinghouse for Drug Abuse Information. Eight of these curricula are now being disseminated by the Clearinghouse. Close cooperation with the Clearinghouse is maintained. The review of promising new and innovative curricula will be an ongoing concern of the Office.

THE SOCIAL AND REHABILITATION SERVICE

As the Federal partner in the State-Federal program of vocational rehabilitation, the Rehabilitation Services Administration provides fiscal support and technical assistance to State rehabilitation agencies. Under this program, the State rehabilitation agencies provide rehabilitation services to physically and mentally disabled people, including the drug abuser, to assist them in becoming gainfully employed. In 1969, there were 564 rehabilitants from this disability category, 800 in 1970 and over 1,000 in 1971.

The Federal expenditure by the Rehabilitation Services Administration for rehabilitation of the drug abuser for FY 1971 was $1,834,000. Of this amount, approximately $1.5 million was channeled to State rehabilitation agencies under the basic support grant program for the provision of direct services to the drug addict. The remaining monies were used for innovation, expansion, and New Careers projects in drug abuse.

The SRS is assisting NIMH in defining a rehabilitation addict in preparation of certification to the U.S. Courts of a NARA patient. Informal but regular consultation on the part of NIMH with SRS is ongoing in the area of defining eligibility of narcotic addicts to participate in existing programs of that agency.

To the extent that drug addicts are hospitalized for detoxification, Title XIX funds are a resource sponsored under the auspices of the Medical Services Administration. It is currently not possible to estimate the extent to which Title XIX funds are so utilized, however.

In FY 1971, the Youth Development and Delinquency Prevention Administration funded six drug abuse programs. Program emphasis was given to prevention of drug abuse and drug education programs among youth.

The Community Services Administration is engaged in a number of activities which have special pertinence for the provision of social services related to drug addiction. It is a participant in the proposed SRS research and demonstration projects in drug addiction which should yield information to strengthen social services programs for drug addicts. CSA encourages State public welfare agencies to utilize their social service programs to a greater degree in the prevention and treatment of drug abuse.

The Office of Planning, Research, and Demonstration of SRS provides partial support for research or demonstration projects that hold promise of contributing substantially to the vocational rehabilitation of handicapped people, including those handicapped by drug dependency. One such research demonstration project is being funded at present for $194,095 to test a number of elements and techniques that may be used in vocational rehabilitation of the drug abuser.

THE FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is the responsible agency in the determination of the safety and efficacy of methadone use.

The FDA is also responsible to see that labeling on prescription drugs accurately reflects the drug dependence characteristics of tranquilizers, analgesics, sedatives, and stimulants. Recently enacted legislation provides that the HEW Secretary require regulation of FDA which will provide for a warning on the label of a controlled drug when dispensed to the patient to the effect that it is a crime to transfer the drug to a person other than the patient.

Research in hallucinogenic drugs is jointly monitored by FDA and NIMH with the recommendation of an advisory committee.

The FDA cooperated with the NIMH drug abuse prevention campaign through its involvement in the joint sponsorship of the Psychotomimetic Committee, staffed by the Center for Studies of Narcotic and Drug Abuse personnel, and through NIMH participation as advisor on the Methadone Maintenance Policy Committee established with FDA.

Dr. DuVAL. To insure coordination of these programs within HEW, the Secretary has designated the National Institute of Mental Health as the "lead agency" for all the Department's drug abuse activities. The Director of the National Institute of Mental Health also serves 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 in the drug abuse area and (2), coordinate and plan its activities with those of other components of the Department. NIMH is a central source of information for the Secretary on all departmental drug abuse programs.

There are at least two major differences between S. 2097 and S. 2217 which we believe are critical. The scope of the proposed Office of Drug Abuse Prevention and Treatment in S. 2217 encompasses too many diverse substantive areas. The combining of law enforcement, treatment and prevention and international strategies upon one organizational unit is unwise. Skills, training, philosophy and public contact, and acceptance in these areas is quite different. Treatment programs sponsored by an office charged with control and enforcement responsibilities may quite possibly expect nonacceptance by the very clients it hopes to serve. It is our opinion that the treatment and other nonlaw-enforcement activities are of sufficient size and complexity to warrant the full attention of the office.

Additionally, S. 2217 does not propose sufficient authority to the Director of the Office. If limited to nonenforcement issues the Director can be effective only with authorities beyond pure coordination. The degree to which budget and manpower resources can be allocated and performance measured will determine the ultimate effectiveness of the Office. S. 2097 will provide the Director with the authority necessary for effective coordination of the Federal drug abuse effort.

S. 2217 also proposes the establishment of a National Institute of Drug Abuse and Drug Dependence within the Public Health Service. The many duties assigned to the proposed institute are congruent with and duplicate the duties and authorities presently assigned by statute to the Secretary of Health, Education, and Welfare. The creation of such an institute within the Public Health Service could interfere with the responsibilties of the Director of the Special Action Office, or require extensive internal reorganization within the Public Health Service. We, therefore, recommend against the establishment of such an institute.

We believe the proposals within S. 2217 to establish yet additional grant programs and mechanisms, should be evaluated in the context of the total authorities of the Federal Government in the drug abuse area.

In addition, there are a number of specific concerns I would bring to your attention. Of concern to us is the legislative emphasis on particular research areas. While some of the areas specified in S. 2217 are ones which require additional study and investigation, to single them out in such a specific legislative mandate may provoke responses which ultimately will hamper the total research endeavor. Such specificity can easily cause a concentration of effort and focus to the exclusion of other equally promising efforts. Furthermore, these research areas, if specifically mandated in this fashion, may achieve a life and momentum beyond their real value and pay-off. When activities have a legis-

lative mandate they often are additionally difficult to halt. In research, the greatest flexibility is needed to pursue promising leads but the same flexibility must exist to abandon fruitless and unproductive areas.

Another section of concern to us in S. 2217 is found in title IV, part C, sec. 421. As we interpret the intent of this section, it is to assure treatment of a medical need without discrimination because of the person's status as a drug abuser. Our concern is that if the medical need involves treatment beyond the acute medical emergency, facilities which are basically not equipped to treat drug abusers or render treatment are forced to do so or face loss of Federal support.

It is, I think, not reasonable to expect every "public and private" general hospital to have the trained staff and physical capacity to treat drug abusers. Additionally, our experience in the last few years points to the fact that drug abusers usually enter the health care system at points other than the general hospital. In its present form it represents an unwarranted threat to the general hospitals and the health care system.

Section 432 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 limited experience has generally demonstrated instead that community-based treatment programs are more successful. In addition, as the subcommittee knows, our department has launched an intensive study reviewing the alternative uses of the PHS hospitals for serving the comunity where they are located.

Pending the completion of that study and consideration of alternative community facilities for drug abuse programs, we oppose enactment of this provision.

In conclusion, Mr. Chairman, for these reasons and because Dr. Jerome Jaffe, the special consultant to the President for Narcotics and Dangerous Drugs, is undertaking a review of all current laws pertaining to drug treatment, we believe that no amendments to drug treatment laws should be enacted other than those already proposed by the President.

Therefore, enactment of S. 2097 is very clearly needed and I urge the subcommittee to act on it promptly upon referral.

Senator HUGHES. Thank you very much, Dr. DuVal. We appreciate your comments. I had read your testimony before I came to the hearing and I had an opportunity to think about it as you went over it again.

Do any of your colleagues have any additions or anything to say other than that?

Dr. DUVAL. I think not, Senator, but they are prepared to answer any questions you may address.

Senator HUGHES. I have some extensive questioning prepared here which I am sure you understand, and we may or may not get through it. That which we do not get through, I would like to submit to you for answers in writing.

Since 1969, the administration has been testifying before this subcomittee that there is sufficient Federal coordination in drug programs. I think most of you men sitting here are aware of this fact.

In opposing the coordination provision of the legislation which we passed in the Senate last year, Dr. Egeberg stated, and I will quote:

> There is, of course, the need to coordinate our efforts with those of other Federal agencies, and this is being accomplished at the White House level through a committee established specifically for that purpose.
>
> Represented on the committee are the Departments of Health, Education and Welfare, Justice, Defense, Labor, and the Office of Economic Opportunity. The functions of this committee are, one, to provide existing programs and materials on drug abuse, two, to improve methods of making materials on drug abuse available to the public, three, to improve coordination among departments and agencies concerned with drug abuse, and four, to improve on and seek new ways in which concerned groups of citizens can fight drug abuse.
>
> Thus, I believe that we now have within the Department and among the various agencies of the Federal Government effective mechanisms for the coordination of drug abuse activities.

That was the testimony of Dr. Egeberg, and perhaps some of you men sitting here helped prepare it at the time, and in all probability, you did.

There has obviously been a strong change of attitude, which I commend you for, but when did that committee that was mentioned begin meeting?

Dr. DuVal. Mr. Besteman, what was the first meeting date of that committee?

Mr. Isbister. That committee has been meeting over the last year. I don't have the date, Mr. Chairman, of the first meeting.

Dr. DuVal. We can get you a date of the first meeting.

Senator Hughes. Can you furnish us the dates of the first annual intervening meeting of that coordinating council?

(The information subsequently supplied follows:)

> The first meeting of the Federal Drug Abuse Prevention Coordinating Committee was held on February 19, 1971. Subsequent meetings were held on the following dates: February 19, 1971, April 12, 1971, May 10, 1971 and July 26, 1971.

Senator Hughes. I would like you to tell me why you feel that coordinating council is insufficient, when your testimony stated before that you thought nothing else was needed.

Dr. DuVal. Senator, I think we have all been concerned with the rate at which the drug abuse has been changing, and we don't feel coordination is sufficient now. This is the reason we have taken a stronger proposal and have suggested through legislation that has been introduced that a Special Action Office is necessary, with power to coordinate and to actually oversee the operation of the programs in the multiple agencies of Government.

Senator Hughes. Do you think you were wrong, then, when you testified like this before?

Dr. DuVal. We think the situation has changed.

Senator Hughes. So drastically changed in the last year?

Dr. DuVal. I think that coordination, which we thought was sufficient at that time, is not sufficient to do this job.

Senator Hughes. Do you think it was sufficient then?

Dr. DuVal. I am not in a position to say, because I was not in this position at the time.

Senator Hughes. Dr. Wilson, you were.

Dr. Wilson. I think based on the information we had at that time, Senator Hughes, which is the only way one can form a judgment, that it was an adequate tool. Based on retrospection with some of the new information we have, I suspect we would have reached a different opinion at an earlier date.

Senator Hughes. Could you tell me, then, why Justice and Defense were necessary for that coordinating vehicle but are not necessary components to the new office you are now proposing?

Dr. DuVal. We believe coordination is still desirable. I think the issues we are concerned with are certain operating responsibilities, budget recommendations with regard to the agencies.

We believe that coordination will be more effective if it is put in a single office involving only the nonenforcement agencies.

Senator Hughes. Isn't a good portion of our problem the fact that we have been conveying two completely different philosophies to the public in reference to drugs and drug abuse?

Dr. DuVal. I am not clear as to which two philosophies you have reference to, Senator.

Senator Hughes. Those of the Departments of Justice and HEW.

Dr. DuVal. I think, as in many other areas of life, Senator, there are, of course, programs that are directed at an individual because of his problem, and then there are enforcement aspects of the problem that take over when the first program has failed.

They are related, of course, and they must be coordinated, and I concur completely with that view. I do not think that persons responsible have to have responsibility for both.

Senator Hughes. Do you think you can adequately work together now?

Dr. DuVal. Yes, sir.

Senator Hughes. Do you think you have in the past?

Dr. DuVal. I think we did in the situation we thought was there at the time. As we plan the Special Action Office, I believe we plan to invest that office so that it will be able to do a much more successful job and the coordination will then take on a different meaning.

Senator Hughes. If you think you can work together, why do you need a White House office?

Dr. DuVal. The number of agencies is too great to do this with something less than a position in the White House.

Senator Hughes. You didn't recognize the fact a year ago that you needed a coordinating agency due to the existence of so many agencies, so many approaches, and so many different fundings?

Dr. DuVal. The problem at that time, Senator, could, we felt, be managed by coordinating capability through the coordinating committee. We have found since that it would be best to vest full authority in a single individual.

Senator Hughes. Isn't it a fact that we weren't getting the job done, Dr. DuVal?

Dr. DuVal. I think we have not gotten the job done, Senator Hughes.

Senator HUGHES. We have recognized that fact now and the President has recognized it.

Dr. DUVAL. Yes.

Senator JAVITS. Would the Chairman yield?

Senator HUGHES. Yes.

Senator JAVITS. I think it illustrates that all wisdom is not vested in the Executive department. The chairman of this committee recognized what the Executive department didn't recognize at least a year before they did.

Senator HUGHES. I might add the Senator from New York recognized it, too. We have been trying to do the same thing. I want to ask you a question with relation to this. What about the Civil Service Commission in this coordinating effort? What are you going to do through the Civil Service Commission with respect to Federal employees?

Dr. DUVAL. Mr. Besteman?

Mr. BESTEMAN. The Civil Service Commission, some 5 months ago, started meeting with both governmental and private industry consultants to look at what its policy should be and what it should set forth as policy to all Government agencies for the employment situation or treatment of Federal employees who should have a drug abuse problem.

They are continuing to work on this, and I have participated in this and recently have gotten some preliminary drafts from them, and I would suspect that in the next several months they will come forth with a policy that will be Government-wide.

Senator HUGHES. What is your deadline for having a policy?

Mr. BESTEMAN. I am working as a consultant to them, and I do not know.

Senator HUGHES. Do you think it is critical that they have a deadline?

Mr. BESTEMAN. I think they have one, yes.

Senator HUGHES. Are you the one they are depending on for advice in what they should do?

Mr. BESTEMAN. They are using both the NIMH resources and outside, both industry and outside private associations.

Senator HUGHES. What are you advising them to do, as a consultant?

Mr. BESTEMAN. In general, to try to pattern a situation where the abuser, if he can function in the employment, is not subjected to dismissal, this being the sole cause.

In other words, working in the context of whether a person can in fact function on the duties assigned.

Senator HUGHES. Are you going to give them in effect the same protection you hope to give them in the military?

Mr. BESTEMAN. I can't say that that will be the final outcome.

Senator HUGHES. In other words, we don't have a national policy yet as to how we are going to treat Federal employees, whether they are in the military or in civil service positions, as far as you know?

Mr. BESTEMAN. As far as I am personally involved, no. I don't know that.

Senator HUGHES. What about the State Department, Dr. DuVal, in the same relationship?

Dr. DuVal. I believe, Senator, that the issue of how the State Department will be involved is going to be determined by Dr. Jaffe, and that would be a proper question for him on Wednesday, that is not in our jurisdiction.

Senator Hughes. Let me ask you one that is in your jurisdiction. What about HEW employees? What are you doing about them? Do you have a policy for HEW employees who may have used drugs?

Dr. DuVal. I will also give that to the drug abuse person, Mr. Besteman.

Mr. Besteman. I don't believe such a policy has been set forth by the Department. I think our cooperation with the Civil Service Commission is working at coming to this.

Senator Hughes. Do you think you should have one?

Mr. Besteman. Yes.

Senator Hughes. Can you give me an estimate of when you will have one?

Dr. DuVal. Again, I think the deadline schedule that you draw our attention to comes within the jurisdiction of Dr. Jaffe. We can, of course, do this within the Department. We felt that we should do this, obviously, with his knowledge.

Senator Hughes. Do you have one for alcoholics?

Dr. DuVal. We have a program for alcoholics.

Senator Hughes. When did it begin?

Dr. DuVal. It is approximately a year old, Senator.

Senator Hughes.. The last time you testified that you had a program, we, the very day before, had communications from your agency stating that they didn't have a program, and asking where to find help, as you can recall, Dr. Wilson. You were here that day.

Dr. Wilson. I think there is a matter of definition in this. We have, as you will recall from our testimony this spring, been developing a specific ongoing special program for alcoholics, for their treatment. That is one issue, the treatment of alcoholics. I think that insofar as attitude toward alcoholics, the Civil Service Commission has had a policy over a period of several months. I am not sure to which issue we are speaking.

Senator Hughes. Well, as the leading health agency of the country, surely you are advising the Civil Service Commission, are you not?

Dr. Wilson. Yes.

Senator Hughes. What their approach should be in relationship to civilian employees of the Federal Government, with respect to both alcoholism and drug abuse. What are you advising them?

Dr. Wilson. We are advising them that this is an illness, that it should be treated as far as they are concerned, and we believe it needs a pattern of treatment similar to that which we are working out within HEW.

Senator Hughes. Will you explain for me how the NIMH and Office of Education programs are coordinated?

Dr. DuVal. Both gentlemen are here to speak to that, but they are coordinated within the Department. There is a high level of coordination between the National Institute of Mental Health and the Office of Education, and maybe Mr. Spillane would like to speak to that.

Mr. Spillane. We are trying to make efforts, Senator, to see if we can avoid overlap and duplication, since this is entirely possible. Since

the beginning of our interagency subcommittee and the White House task force, we have also been collaborating on a variety of activities.

I think one of the most important things we have collaborated on is a teacher training film series which NIMH supported but to which we contributed heavily in terms of substance and content.

We do have an arrangement whereby each agency will at least clear with the other agencies its projected plans in the area of education, in the area of school and college based programs, so that again we can react and also avoid duplication.

Senator HUGHES. Do you hve any particular documents that spell out the relationship between these two programs?

Mr. SPILLANE. We have nothing in writing. We can give you some examples of projects on which you have collaborated.

Senator HUGHES. Do you think there should be instructions or guidelines written?

Mr. SPILLANE. By all means. I should also point out that when the Office of Education started its drug education program last year, we, of course, consulted heavily with NIMH in terms of setting up guidelines for our teacher training programs.

Dr. DUVAL. We have such a document, Senator. I could ask Mr. Isbister to describe it.

Senator HUGHES. Would you furnish it for the record?

Dr. DUVAL. Yes.

(The information subsequently supplied follows:)

NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION
REPORT SERIES

SERIES 7, No. 1 AUGUST 1971

DRUG ABUSE PROGRAMS: A GUIDE TO FEDERAL SUPPORT

Introduction

Federal funding for drug abuse programs is diverse and spans many Government agencies. In order to provide a practical resource on Federal funding, the Clearinghouse has prepared this guide. It is intended to serve primarily as a source of information on the various contact points and sources of detailed information and is not a compilation of complete regulations or procedures. In all cases, additional information about specific funding may be obtained from the administering agency listed at the beginning of each entry. The guide contains funding information for education, information, treatment, research, training, law enforcement, and other activities in the field of drug abuse and is organized along the lines of the CATALOG OF FEDERAL DOMESTIC ASSISTANCE.

The strengthening of Federal regional offices has provided a convenient first stop for citizens dealing with the Federal government. Regional office addresses for many agencies working the drug abuse field are printed in this guide. In most cases, the regional office should be the first step in seeking Federal support.

Federal funding as treated in this guide refers primarily to the grant-in-aid concept. Directed Federal projects are funded using the contractual mechanism and are not amenable to extensive coverage. Federal contract needs may be monitored by scanning the Commerce Business Daily published by the Department of Commerce.

Recently, in the new expanded effort to curb drug abuse, the President proposed the establishment of a new Special Action Office for Drug Abuse Prevention. While legislation is pending, the Office is operating under an Executive Order. This new effort "...would provide strengthened Federal leadership in finding solutions to drug abuse problems. It would establish priorities and instill a sense of urgency in Federal and Federally-supported drug abuse programs, and it would increase coordination between Federal, State and local rehabilitation efforts."

I. Department of Health, Education, and Welfare

Agency: Division of Narcotic Addiction and Drug Abuse
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

Authority: Public Health Service Act, Section 301 (d)
Public Law 78-410.

Purpose: Research into the causes, diagnosis, treatment, control and prevention of mental illness, with emphasis on special areas of interest including narcotic and drug abuse.

Activities funded:
1. Research, including support of conferences, translation of publications (when appropriate).
2. Large-scale research programs (usually interdisciplinary).
3. Small-scale pilot or exploratory projects.
4. Research development.

Kind of Assistance: Project Grants.

Who is Eligible: Public or non-profit private agencies.

How to Apply: Application kits for research grants are available from the Grants and Contracts Management Branch, NIMH or from the National Clearinghouse for Drug Abuse Information. The Center for Studies of Narcotic and Drug Abuse provides consultation and assistance on proposed projects. All applications are reviewed by a committee of experts from outside the Government and by the National Advisory Mental Health Council. Deadlines for submission of applications are October 1, February 1, and June 1 of each year.

Agency: Division of Narcotic Addiction and Drug Abuse
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

Authority: Public Health Service Act, Section 301, 433
Public Law 78-410.

Purpose: To provide training for research relating to mental health problems, including drug abuse.

Activities funded: Predoctoral, postdoctoral, and special fellowships for individuals sponsored by organizations.
Allowance for training to institutions such as universities, community mental health centers, research institutes, and other mental health research programs who sponsor individuals for training.

Kind of Assistance: Project Grants.

Who is Eligible: Individuals (must meet scholastic qualifications).
Sponsoring institutions.

How to Apply: Consult the Division of Narcotic Addiction and Drug Abuse for training grant applications.

Agency: Division of Narcotic Addiction and Drug Abuse
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

Authority: The Community Mental Health Centers Act, as amended by the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Public Law 91-513).

Purpose: Treatment and rehabilitation of narcotic addicts and drug dependent persons.

Activities funded: Assistance in funding a portion of costs of programs for treatment and rehabilitation of drug abusers which include one or more of the following:

1. Detoxification services or
2. Institutional services (including medical, psychological, educational, or counseling services) or
3. Community based after-care services.

Kind of Assistance: Grants.

Who is Eligible: Any public or nonprofit private agency or organization.

How to Apply: Applicants for Special Projects for Narcotic Addicts and Drug Dependent Persons should contact the Division of Narcotic Addiction and Drug Abuse.

Deadlines for submission of applications are:

Submission by	Council Review	Earliest Possible Beginning Date
March 1	June	July 1
August 1	November	December 1
December 1	March	April 1

MATCHING REQUIREMENTS: The amount of any grant with respect to any projects may not exceed 80 percent for each of the first two years, 75 percent for the third year, 60 for the fourth, 45 for the fifth and 30 for each of the next three years. In the case of any such program providing services for persons in an area designated as an urban or rural poverty area, such grants may not exceed 90 percent for each of the first two years, 80 percent for the third year, 75 for the fourth and fifth years, and 70 percent for each of the next three years.

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Agency: Division of Narcotic Addiction and Drug Abuse
National Institute of Mental Health
Health Services and Mental Health Administration
5600 Fishers Lane
Rockville, Maryland 20852

Authority: Community Mental Health Centers Act, as amended by Public Law 91-513, the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Purpose: To bring information about drug abuse to school age children and special high risk groups and to prepare and disseminate drug abuse information.

Activities funded:
(from Sec. 253). . .(1) the collection, preparation, and dissemination of educational materials dealing with the use and abuse of drugs and the prevention of drug abuse, and (2) the development and evaluation of programs of drug abuse education directed at the general public, school-age children, and special high-risk groups;
(3) development of ". . .workshops, institutes, and other activities for the training of professional and other personnel to work in the area of drug abuse education. . ."

Kind of Assistance: Grants and Contracts.

Who is Eligible: Public or nonprofit private agencies and organizations. Contracts are available to public, profit or nonprofit private agencies and organizations.

How to Apply: Information concerning applications for grants is available from the administering agency. Contracts in drug abuse education are solicited through advertising specific contract requirements in the Commerce Business Daily. Deadlines for submission of grant applications are:

New and Supplemental	Renewal	Council Review
October 1	September 1	March
February 1	January 1	June
June 1	May 1	November

Agency: Division of Narcotic Addiction and Drug Abuse

Authority: The Community Mental Health Centers Act, as amended by the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90-574).

Purpose: To help prevent and control narcotic addiction and drug abuse.

Activities funded:

1. Construction of treatment facilities for narcotic addiction, and the compensation of personnel for the initial operation of such facilities, or of new services in existing treatment facilities for drug abusers.

2. Training and Evaluation grants to: (a) provide part of all of the cost of developing specialized training programs or materials relating to the provision of public health services, for the prevention and treatment of narcotic addiction and drug abuse or developing in-service training or short term or refresher courses with respect to the provision of such services; (b) training personnel to operate, supervise, and administer such services; and (c) conducting surveys and field trials to evalute the adequacy of the programs for the prevention and treatment of narcotic addiction within the several States with a view to determining ways and means of improving, extending, and expanding such programs.

Kind of Assistance: Construction and Staffing Grants.
Training and Evaluation Grants.

Who is Eligible: Staffing and Construction:

1. A community mental health center.
2. An affiliate of community mental health center.
3. A public or private nonprofit agency or organization located in an area where there is no community mental health center. Such applicants must agree to utilize existing community resources appropriately and to apply within a reasonable time for affiliation with any future community mental health center servicing the area.

The applicant must be able to assure coordination of services and continuity of care and must show that the following essential services will provide:

1. Inpatient Services
2. Outpatient Services
3. Intermediate Services such as day or night care, halfway houses, or other sheltered living arrangement;
4. 24-hour emergency services, and
5. Consultation and education services to community agencies, professionals and concerned groups.

Training and Evaluation Grants: Any public or nonprofit private agency or organization.

How to Apply: Applicants snould contact the Division of Narcotic and Drug Abuse for details. Deadlines for Submission of Applications are

Submission by	Council Review	Earliest Possible Beginning Date
March 1	June	July 1
August 1	November	December 1
December 1	March	April 1

Agency: Office of Education, Bureau of Educational Personnel Development, Division of Program Resources, Drug Education Branch, 400 Maryland Ave., S.W., Washington, D.C. 20202

Authority: Drug Abuse Education Act of 1970 (Public Law 91-527).

Purpose and Activities funded:

1. Development of curricula on drug abuse (includes preparation of materials and evaluation and selection of materials which already exist).
2. Demonstration or testing of drug abuse curricula.
3. Dissemination of curricular materials or information on drug abuse education programs (includes public and private elementary, secondary, adult and community education).
4. Evaluation of the effectiveness of curricula.
5. Preservice and inservice training programs on drug abuse for educational personnel.
6. Community education programs. Community education projects include, but are not exclusive to: seminars, workshops, conferences, telephone counseling and information services which provide advice, information, or assistance to individuals with respect to drug abuse problems.
7. Evaluation of training and community education programs.
8. Projects to recruit, train, organize, and employ persons to organize and participate in public education programs.

Principles: The principles which were basic to the National Drug Education Program are also applicable to the new program to be funded under Public Law 91-527. These principles are:

1. Federal, State, and local commitment and cooperation.
2. Participation of the community.
3. Heavy involvement of youth in planning and conducting programs.

4. An approach to drug education which is integrated into the educational program at all levels.

5. An unbiased presentation of facts and information about drugs and drug use.

6. A humanistic approach designed to encourage people to come together to explore their attitudes toward drug use and misuse.

Kind of Assistance: Project Grants.

Who is Eligible:

1. Institutions of higher education including junior and community colleges.

2. State and local educational agencies.

3. Other public and private education or research agencies, institutions, and organizations.

4. For community education projects, (section 4 of the Act) public or private non-profit agencies, organizations and institutions are eligible for funds.

How to Apply: Applicants should submit a preliminary proposal of no more than 10 pages in length, double-spaced, which will be reviewed by Federal agency staff and other experts. Proposals which are deemed to have most potential for drug education projects will be eligible for submission of formal proposals, to be reviewed by USOE and other Federal staff assisted by outside experts.

Agency: Office of Education
400 Maryland Avenue, S.W.
Washington, D.C. 20202

Authority: Elementary and Secondary Education Act, Title III.

Purpose and
Activities funded: Demonstration projects in drug education intended to involve local educational agencies in programs which will adapt, adopt and demonstrate new or innovative solutions to national education problems in high priority areas.

Principles: These basic principles of the National Drug Education Program should be incorporated into proposals as with the Drug Abuse Education Act.

a. State and local cooperation and commitment
b. Participation of entire school community
c. Youth involvement
d. Integration of drug education into school program at all levels and into a wide variety of subjects
e. Accurate information about drugs
f. Humanistic people-to-people approach
g. Interagency cooperation
h. Interdisciplinary - interprofessional participation.

Kind of Assistance: Project grants for one fiscal year, with the possibility of continuation under the Drug Abuse Education Act of 1970 (Public Law 91-527).

Who is Eligible: Only local education agencies.
Activities will be coordinated with the State Department of Education or Public Instruction.

How to Apply: Letters of intent are to be followed by preliminary proposals and finally by formal proposals. Final proposals must be prepared in accordance with the EDAA Title III, Section 306, "Manual for Project Applicants and Grantees."

Additional information may be obtained from:

1. State or territorial Coordinator, Title III, ESEA, in Department of Education or Public Instruction

2. U.S. Office of Education
Special Programs and Projects Branch
Division of Plans and Supplementary Centers
Bureau of Elementary and Secondary Education
Washington, D.C. 20202

or

Drug Education Branch
Division of Program Resources
Bureau of Educational Personnel Development
400 Maryland Avenue, S.W.
Washington, D.C. 20202

Agency: Social and Rehabilitation Service
330 C Street, S.W.
Washington, D.C. 20201

Authority: Vocational Rehabilitation Act, as amended, Section 4 (a) 1 (Public Law 83-565).

Purpose: To provide for the solution of vocational rehabilitation problems, common to all or several states, through research or demonstration projects which hold promise of contributing new knowledge, techniques, or procedures to ameliorate handicapping conditions which are obstacles to an individual's ability to engage in remunerative employment.

Kind of Assistance: Research or demonstration grants and contracts.

Who is Eligible: Awards may be made to organizations (never to individuals). Grant awards are made to applicant organizations which have a non-profit status.

How to Apply: Application forms and instructions may be requested from the Office of Research and Demonstrations, SRS (address above) or from the relevant State Division of Vocational Rehabilitation or from any of the 10 DHEW Regional Offices. Submission deadlines are February 1, June 1, and October 1 of each year. Applications are reviewed by staff, panels of outside technical consultants, (Study Sections), and the National Advisory Council on Vocational Rehabilitation Service and the Office of the Secretary, DHEW. The review Process requires from two (for pilot studies) to six (for full applications) months, subject to the availability of funds. If a project receives a recommendation of approval, additional time may be required before funds become available for its support.

THE APPLICANT ORGANIZATION MUST PROVIDE MATCHING FUNDS. More than a token contribution is required, and for demonstrations, it is expected that the matching contribution will grow, and the Federal share decrease, over the life of the project.

Agency: Youth Development and Delinquency Prevention Administration
Social and Rehabilitation Service (SRS)
Washington, D.C.

Authority: Juvenile Delinquency Prevention and Control Act of 1968 (Public Law 90-445) and the Juvenile Delinquency Prevention and Control Act Amendments of 1971.

Purpose: To help States and communities combat juvenile delinquency through assistance:

1. To achieve an average reduction of at least 2% in the ratio (per 100,000) of youth, 10 to 16 years of age, referred to the juvenile justice system through 13 delinquency prevention systems initiated in inner city, suburban, and rural communities.
2. To provide training and technical assistance in juvenile delinquency prevention systems and to support State planning in the areas of youth development and delinquency.

Activities funded: Drug abuse activities related to the purposes of this Act, with emphasis on prevention.

Kind of Assistance: Demonstration and Training Grants (nonprofit).
Technical Assistance Grants of Contracts.
Planning Grants.

Who is Eligible: State or local, public or private non-profit agencies.

How to Apply: Consult the SRS Regional Offices (listed in this guide) or National Offices.

II. Department of Justice

Agency: Bureau of Narcotics and Dangerous Drugs
1405 I Street, N.W.
Washington, D.C. 20405

Primarily a law enforcement agency, this bureau does not support extensive research or other projects. Mission oriented research in the forensic sciences and other areas related to drug abuse law enforcement are funded by the Bureau to meet its needs. Requirements will be published in the Commerce Business Daily when they are funded through contract.

Agency: Law Enforcement Assistance Administration
633 Indiana Avenue, N.W.,
Washington, D.C. 20530

Authority: Omnibus Crime Control and Safe Streets Act of 1968
Public Law 90-531.

Purpose: To reduce crime in the United States by providing financial and technical assistance to strengthen the criminal justice system.

Kind of Assistance: Block grants for planning agency, block action grants to States. Discretionary grants for anticrime programs.

The type of assistance given by LEAA, as it relates to narcotics and dangerous drugs is outlined in the following programs.

1. Program K-1

Activities funded: Planning, establishment and operation of new State level narcotic and dangerous drug bureaus or units within existing State investigation bureaus or enforcement agencies.

The functions of these units provide for the organization of bureaus or units capable of handling illicit drug investigation; the initiation of, or participation in, drug abuse prevention and education; and the collection and dissemination of drug abuse statistics.

Who is Eligible: A State block grant commitment requires that the proposal must include a State Planning Agency commitment of State block grant funds to the project (or to other narcotic and dangerous drug programs) equal to half of the amount of the grant applied for.

Discretionary grants can be made only to States and to local units of government or combinations of local units.

Although programs may contemplate action by a particular type of law enforcement agency, or perhaps an effort conducted for State or local governments by a university or private agency, application must be made by either (1) department of State government under whose jurisdiction the project will be conducted, or (2) a unit of general local government or combination of such units, whose law enforcement agencies, systems or activities execute or benefit by the grant. LEAA will fund 75% of this category with the grantee matching 25%.

How to apply: In addition to the normal grant application data (available from LEAA) proposals should include material on the scope and size of the State's narcotic program, the size, staff make-up and organizational location of the new unit, and projected program for the new unit.

2. Program K-2

Activities funded: Planning, establishment, and operation of metropolitan narcotic and dangerous drug enforcement units. These units would, in enforcement and prevention of jurisdictional problems, reduce existing duplication of efforts, and develop effective programs in the major metropolitan areas where drug abuse problems are the greatest. Prevention, treatment, and education programs on drug abuse may be included provided that endorsement of major non-law enforcement agencies and resources have been obtained and the advisory structure is implemented.

Who is Eligible: Same as K-1.

How to Apply: For block grant funds, proposals must include a State Planning Agency commitment of block grant funds equal to at least half of the amount applied for. When activities of prevention, treatment and education are included, an advisory board must be provided to advise on citizen education and prevention programs. Such boards should include both public representation and non-law enforcement professionals with technical expertise relevant to education, prevention and treatment programs.

3. Discretionary Fund Program D. (Large City/County Special Grants)

Activities funded: Supplemental support for projects directly addressing law enforcement and crime control needs, including rehabilitation programs, narcotic education programs and enforcement. Program D supports projects within specified categories which seek to test, implement or develop new approaches and techniques for law enforcement and crime prevention or control within the affected city or county.

Who is Eligible: The Nation's 64 largest counties (those with populations in excess of 200,000); the nation's largest counties (those with population in excess of 350,000) and total criminal justice budgets of at least $4 million; and model cities of more than 50,000 population whose overall plans have been submitted to, and approved under The Demonstration Cities and Metropolitan Development Act of 1966 and can thus qualify for model city action funds; high crime cities of more than 75,000 population defined as cities with metropolitan area crime indexes based on the FBI 1969 Uniform Crime Reports of more than 3,000 known offenses per 100,000 population.

III. Department of Housing and Urban Development

Agency: Office of Community Development
451-7th Street, S.W.
Washington, D.C. 20410

Authority: Demonstration Cities and Metropolitan Development Act of 1966, (Public Law 98-754) (Model Cities).

Purpose: To improve the quality of urban life by conducting programs which attack the social and physical problems in certain communities designated as model neighborhoods.

Activities funded: Within the broad framework of the purpose of this act, social needs such as the education, treatment and rehabilitation of addicts apply to improving the quality of life.

Kind of Assistance: Project Grants from Model Cities supplemental grant to participating city.

Who is Eligible: Only areas which have been designated as Model Cities. At present there are 147 in the United States currently conducting programs.
Anyone living within a model neighborhood is eligible for assistance in the neighborhood.

How to Apply: The city, in cooperation with the citizens of the designated neighborhood, would prepare and submit to HUD a plan of action which among other things, calls for effective use of the Model Cities supplemental grant roughly equal the size of the Model Cities fund.

Agency: Metropolitan Planning and Development
415 - 7th Street, S.W.
Washington, D.C. 20024

Authority: Housing and Urban Development Act of 1965, Section 703 Public Law 89-117.

Purpose: Funding construction and/or rehabilitation of neighborhood centers offering community services. Drug-related facilities may be included in the center.

Kind of Assistance: Project Grants.

Who is Eligible: Local public bodies or agencies having authority under State or local law.

How to Apply: Contact the appropriate HUD Regional Office where the budget is divided. Applications should be submitted before April 1 of each year.

IV. Department of Labor

Agency: Manpower Administration
U.S. Department of Labor
14th & Constitution Avenue, N.W.
Washington, D.C. 20210

Authority: Manpower Development and Training Act, Title II.

Activities funded: Training activities for the disadvantaged, including narcotics addicts undergoing rehabilitation.

Purpose: To train unemployed or under-employed persons in skills needed in the local labor market.

Kind of Assistance: Formula grants.

Who is Eligible: Individuals who are without employment or who are under-employed and who need training or retraining to gain employment. To receive regular training allowances, an applicant must be unemployed, head of household, or member of family in which head of household is unemployed, and must have at least one year's experience in gainful employment. Disadvantaged youth, age 17 through 21, may be eligible for youth allowances.

How to Apply: Contact the local office of the State employment service.

Agency: Job Corps
Manpower Administration
1111-18th Street, N.W.
Washington, D.C. 20210

Authority: Manpower Development and Training Act, Title I.

Purpose: To undertake experimental research, to ascertain the knowledge, attitudes, and patterns of the use of drugs by differing socio-economic, geographic, environmental and cultural origins.

Kind of Assistance: Contracts.

Who is Eligible: Individuals or organizations with experience in conducting surveys among disadvantaged adolescents.

How to Apply: When contracts are available, information will be advertised in the Commerce Business Daily. Applicants may be placed on a bidders' list by sending their names and resumés to the Chief, Contracts Staff, Job Corps, 1111-18th Street, N.W., Washington, D.C. 20210.

V. Office of Economic Opportunity

Agency: Office of Health Affairs
Office of Economic Opportunity
1200--19th Street, N.W.
Washington, D.C. 20506

Authority: Economic Opportunity Act of 1964, as amended.

Purpose: The treatment of drug addicts through community-based programs which use ex-drug addicts as counselors and which emphasize the drug abuser's reentry into society.

Activities funded: Staff and Facilities for rehabilitation services including out reach, halfway houses, remedial education, and training of ex-addicts as counselors, prevention programs with youth, and community education activities.

Kind of Assistance: Project Grants.

Who is Eligible: The local community action agency or other organization demonstrating professional competence and community acceptability.

How to Apply: Applications are to be completed in accordance with OEO Instruction 6710-1. There should be a 20% non-Federal share.

Additional information is available from OEO regional offices or the Director, Addiction and Mental Health Services Division, Office of Health Affairs, at the Office of Economic Opportunity.

VI. Department of Agriculture

Agency: Department of Agriculture through the Bureau of Narcotics and Dangerous Drugs

Authority: Comprehensive Drug Abuse Prevention and Control Act of 1970 (Public Law 91-513), Section 503.

Purpose and
Activities funded: Eradication of crops from which narcotics or other dangerous substances may be extracted. This project is presently being conducted on an experimental basis which may or may not be continued.

Who is Eligible: Farmers & landowners.

How to Apply: Only individuals in the 11 selected counties may apply through their County Extension Service.

Counties:	State	County
	Illinois	Henderson
	Iowa	Mitchell
	Indiana	Kosciusko
	Kansas	Marshall
	"	Reno
	Kentucky	Jessamine
	Michigan	Cass
	Minnesota	Meeker
	Missouri	Andrew
	S. Dakota	Moody
	Wisconsin	Walworth

APPENDIX - REGIONAL OFFICES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Regional Offices

Region 1

John F. Kennedy Federal Building
Government Center
Boston, Massachusetts 02203
(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island)

Region 2

Federal Building
26 Federal Plaza
New York, New York 10007
(New York, New Jersey, Puerto Rico, Virgin Islands)

Region 3

Post Office 12900
401 North Broad Street
Philadelphia, Pennsylvania 19108
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601 East 12th Street
Kansas City, Missouri 64106
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Region 8

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Denver, Colorado 80202
(Colorado, Montana, North Dakota, South Dakota, Utah Wyoming)

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Office of Education State Coordinators

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Alaska.....Mrs. Mary Beth Hooten, Drug Abuse Education Consultant, Department of Education, Pouch F, Juneau 99801 (907/586-5227)

Arizona.....Mr. Gus W. Harrell, Administrative Assistant, Room 165 State Capitol Building, Phoenix 85007 (602/271-4361)

Arkansas.....Mr. James Albright, Supervisor of Health Education, State Department of Education, Little Rock 72201 (501/371-1861)

California.....Dr. C. Carson Conrad, Chief, Bureau of Health, Education, Physical Education, Athletics and Recreation, State Department of Education, 721 Capitol Mall, Sacramento 95814 (518/474-5357)

Colorado.....Miss Janice R. Schneider, Project Director, State Department of Education, State Office Building, Denver 80203 (303/892-2242)

Connecticut.....Dr. Ruth Byler, Consultant for Health, and Physical Education, State Department of Education, Box 2219, Hartford 06115 (203/566-2073)

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District of Columbia.....Mr. Vincent Reed, Public Safety Director, Presidential Building, Room 1205, 415 12th Street, N.W., Washington 20004 (202/737-7630)

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231 West Lafayette
Detroit, Michigan 48226
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312/353-7875

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Room 723
Dallas, Texas 75202
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Mexico 525-91-00, Ext. 378

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Region 17

Paris Regional Office
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THE LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
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Alabama Law Enforcement Agency
State Capitol
Room 117, Public Safety Building
Montgomery, Alabama 36104
205/269-6665

Alaska

Criminal Justice Commission
Office of the Governor
Pouch AJ
Juneau, Alaska 99801
907/586-1112-Thru Seattle FTS

Arizona

Arizona State Justice Planning Agency
2985 West Osborn Street
Phoenix, Arizona 85107
602/271-5467

Arkansas

Commission on Crime and Law Enforcement
1009 University Tower Building
12th at University
Little Rock, Arkansas 72204
501/371-1305

California

California Council on Criminal Justice
1108 14th Street
Sacramento, California 95814
916/445-9156 (1740)

Colorado

Colorado Law Enforcement Assistance Administration
600 Columbine Building
1845 Sherman
Denver, Colorado 80203
303/892-3331

Connecticut

Planning Committee on Criminal Administration
75 Elm Street
Hartford, Connecticut 06115
203/566-3020 or 246-2349

Delaware

Delaware Agency to Reduce Crime
1208 King Street
Wilmington, Delaware 19801
302/654-2411

District of Columbia

Criminal Justice Planning Agency
Room 1200
711 14th Street N.W.
Washington, D.C. 20005
202/629-5063

Florida

Inter-Agency Law Enforcement Planning Council
Tallahassee Bank Building, Suite 608
Tallahassee, Florida 32301
904/224-9871 (FTS 904/791-2011)

Georgia

State Planning Bureau
270 Washington Street S.W.
Atlanta, Georgia 30304
404/524-1521 (FTS 404/526-0111)

Guam

Law Enforcement Planning
Office of the Attorney General
P.O. Box DA
Agana, Guam 96910

Hawaii

Law Enforcement and Juvenile Delinquency Planning Agency
1010 Richard Street, Room 412
Honolulu, Hawaii 96813
808/536-1991

Idaho

Law Enforcement Planning Commission
State House
7th and Washington Streets
Boise, Idaho 83707
208/384-2364

Illinois

Illinois Law Enforcement Commission
Room 204
134 North LaSalle Street
Chicago, Illinois 60601
312/236-8431

Indiana

Indiana Criminal Justice Planning Agency
Room 1025, State Office Building
Indianapolis, Indiana 46204
317/633-4773

Iowa

Iowa Crime Commission
520 East 19th Street
Des Moines, Iowa 50319
515/281-3241

Kansas

Governor's Committee on Criminal Administration
525 Mills Building
Topeka, Kansas 66603
913/296-3066

Kentucky

Commission on Law Enforcement and Crime Prevention
Room 130, Capitol Building
Frankfort, Kentucky 40601
502/564-6710 (FTS 502/582-5011)

Louisiana

Louisiana Commission on Law Enforcement and Administration of Criminal Justice
P.O. Box 44337, Capitol Station
Baton Rouge, Louisiana 70804
504/539-5859

Maine

Maine Law Enforcement Planning and Assistance Agency
295 Water Street
Augusta, Maine 04330
207/289-3361

Maryland

Governor's Commission on Law Enforcement and Administration of Justice
Executive Plaza One, Suite 302
Cockeysville, Maryland 21030
301/666-9610

Massachusetts

Committee on Law Enforcement and Administration of Justice
Little Building, Room 1230
80 Bolyston Street
Boston, Massachusetts 02116
617/727-5497

Michigan

Michigan Commission on Law Enforcement and Criminal Justice
474 Hollister Building
Lansing, Michigan 48933
517/373/3992

Minnesota

Governor's Commission on Crime Prevention and Control
Capitol Square Building
550 Cedar Avenue
St. Paul, Minnesota 55101
612/221-6433

Mississippi

Division of Law Enforcement Assistance
345 North Mart Plaza
Jackson, Mississippi 39206
601/354-6525 or 6591 (FTS 601/948-7821)

Missouri

Missouri Law Enforcement Assistance Council
500 Jefferson Building
Jefferson City, Missouri 65101
314/435-9241

Montana

Governor's Crime Control Commission
Capitol Building
Helena, Montana 59601
406/449-3604

Nebraska

Governor's Crime Commission
State Capitol Building
Lincoln, Nebraska 68509
402/473-1395

Nevada

Commission on Crime, Delinquency and Corrections
Suite 53, State Capitol Building
Carson City, Nevada 89701
702/882-7118

New Hampshire

Governor's Commission on Crime and Delinquency
3 Capitol Street
Concord, New Hampshire 03301
603/712-3601

New Jersey

State Law Enforcement Planning Agency
447 Bellevue Avenue
Trenton, New Jersey 08618
609/292-5800

New Mexico

Governor's Policy Board for Law Enforcement
302 East Palace Avenue
Santa Fe, New Mexico 87501

New York

New York State Office of Crime Control Planning
250 Broadway, 10th Floor
New York, New York 10007
212/227-0610

North Carolina

Law and Order Division
North Carolina Department of Local Affairs
422 North Blount Street
Raleigh, North Carolina 27601
919/829-7974 (FTS 919/828-9031)

North Dakota

Law Enforcement Council
State Capitol Building
Bismarck, North Dakota 58501
701/224-2215

Ohio

Department of Urban Affairs
Room 3200
50 West Broad Street
Columbus, Ohio 43215
614/469-5462

Oklahoma

Oklahoma Crime Commission
820 N.E. 63rd Street
Oklahoma City, Oklahoma 73105
405/521-3392

Oregon

Law Enforcement Planning Council
302 Public Service Building
Salem, Oregon 97310
503/364-2171 Ext. 1729

Pennsylvania

Pennsylvania Criminal Justice Planning Board
Federal Square Station
P.O. Box 1167
Harrisburg, Pennsylvania 17108
717/787-2042

Puerto Rico

Puerto Rico Crime Commission
G.P.O. Box 1256
Hato Rey, Puerto Rico 00936

Rhode Island

Governor's Committee on Crime, Delinquency and Criminal Administration
265 Melrose Street
Providence, Rhode Island 02907
401/227-2620

South Carolina

Law Enforcement Assistance Program
915 Main Street
Columbia, South Carolina 29201
803/758-2654 (FTS 803/253-8371)

South Dakota

State Planning and Advisory Commission on Crime
State Capitol
Pierre, South Dakota 57501
605/224-3429

Tennessee

Tennessee Law Enforcement Planning Agency
216 Capitol Boulevard
Suite 604
Nashville, Tennessee 73219
615/741-3521 (FTS 615/242-8321)

Texas

Criminal Justice Council, Executive Department
810 Littlefield Building
Austin, Texas 78711
512/478-7468

Utah

Law Enforcement Planning Council
Utah State Capitol, Room 409
Salt Lake City, Utah 84114
801/328-5731

Vermont

Governor's Commission on Crime Control and Prevention
43 State Street
Montpelier, Vermont 05602
802/223-2311, Ext. 645

Virginia

Law Enforcement Administration
9 North 12th Street
Richmond, Virginia 23219
703/770-6193

Virgin Islands

Virgin Islands Law Enforcement Commission
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St. Thomas, Virgin Islands 00801
809/774-6400

Washington

Law and Justice Office
Planning and Community Affairs Agency
1306 Capitol Way
Olympia, Washington 98501
206/753-2235

West Virginia

Governor's Committee on Crime, Delinquency and Corrections
1704 McClung Street
Charleston, West Virginia 25311
304/348-3689 or 348-3692

Wisconsin

Wisconsin Council on Criminal Justice
110 East Main Street
Madison, Wisconsin 53702
608/266-3323

Wyoming

Governor's Commission on Criminal Administration
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Cheyenne, Wyoming 82001
306/777-7716

American Samoa

Territorial Law Enforcement Planning Agency
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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
Regional Offices

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   2. Law Enforcement Assistance Administration
III. Department of Housing and Urban Development
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   2. Neighborhood Facilities
IV. Department of Labor
   1. Manpower Administration
   2. Job Corps
V. Office of Economic Opportunity
VI. Department of Agriculture

Appendix

The National Clearinghouse for Drug Abuse Information, operated by the National Institute of Mental Health on behalf of the Federal Agencies engaged in drug abuse education programs, is the focal point for Federal information on drug abuse. These Federal agencies are the Department of Justice, Bureau of Narcotics and Dangerous Drugs; Department of Health, Education, and Welfare; Office of Economic Opportunity; and the Department of Defense. The Clearinghouse distributes publications and refers specialized and technical inquiries to Federal, State, local, and private information resources. Inquiries should be directed to the National Clearinghouse for Drug Abuse Information, Box 1080, Washington, D.C. 20013.

Senator HUGHES. If you have such a director, why doesn't he know it? Can you tell me that, first of all?

Mr. SPILLANE. There could be an oversight on my part.

Mr. ISBISTER. I am referring to a comprehensive statement which will describe the various programs of the departments and the purposes served by each, and which is now on its way to the printer.

Senator HUGHES. In other words, it isn't printed and he doesn't have it yet?

Mr. ISBISTER. It is on its way to the printer. The additional, I think, critical feature is that the Office of Education and NIMH have jointly participated in the review of actual proposals submitted to us by the public in the education area. We assure that Office of Education representatives participate actively in the review of those proposals.

So they actually get to read the documents that come to us, and they have also consistently had our personnel on their committee. We operate and add resources to each other in this area, and this has been consistent with every major activity that we have had.

Senator HUGHES. Are you allowed to do anything other than read?

Mr. BESTEMAN. At the end of that, we are expected to give our professional judgment concerning the worth, value, technical needs, the relationship to other activities. We joint-site visit some of these projects to see whether or not one agency or the other would be best in the funding processes.

Senator HUGHES. Who makes the final decision?

Mr. BESTEMAN. The agency that does the funding.

Senator HUGHES. On May 7 of this year, Dr. Brown testified that the Food and Drug Administration which has the responsibility for determining the safety and efficacy of drugs, has determined that the exact degree of methadone maintenance treatment is unknown at this time.

The FDA at the same time has investigated over 300 investigational new permits for use of methadone in research. NIMH has 4,700 patients, as I understand it, in drug programs, more than in drug-free programs.

The VA tells us that over half the veterans in treatment will be on methadone.

Could you explain to me how this is a coordinated policy with HEW and with outside organizations? You know, we will be hearing from FDA on Thursday. Why is it being used if the exact degree of safety and efficacy of methadone maintenance treatment is unknown?

Dr. DUVAL. I will fall back on other witnesses, Senator, but I think the issue here is the risk of the use of methadone related to the degree of supervision of the patient. Where you have a relatively fixed population of persons also under your scrutiny, as it were, such as in the VA, methadone is a proper drug to be used under appropriate scrutiny.

Senator HUGHES. Then you do know the exact degree of the safety and efficacy of methadone maintenance?

Dr. DUVAL. It is not exact, because we don't know its limits. We are falling back on experience, however, under the research efforts that have been underway in this country for 3 years.

Senator HUGHES. Are you saying, in effect, that there are programs that are not properly supervised and controlled?

Dr. DuVal. I think I prefer to call on Dr. Edwards from FDA, who can describe the degree of control.

Dr. Edwards. Mr. Chairman, let me first speak to the subject of safety and efficacy. While we do have relatively good data that relates to the short-term safety and efficacy of methadone, we do not have the kind of information that would allow us to give an unqualified answer as to the safety and efficacy of methadone used long term.

One of the problems is, very frankly, that there has not been adequate control until recent months of some of these investigational programs.

Let me say that going back a year, together with the National Institute of Mental Health and the Bureau of Narcotics and Dangerous Drugs, we have been developing guidelines for adequate, meaningful methadone programs.

It did take a while to get these through, but they are now finalized and we are using these guidelines to judge the various methadone programs.

We have over the past several months inspected over 50 programs. We have closed several down, and we have put others on notice that if they don't come up to our guidelines, they will be closed down.

Senator Hughes. Are you using the same standards on methadone that you use on other new drugs and narcotics?

Dr. Edwards. Scientifically, yes. There are other factors that have to be taken into consideration. There are certain social factors that we feel have to be judged in the approval of methadone.

This is why I think this has to be a coordinated program, not only between the FDA, the NIMH, and others, because there are other factors that have to be taken into consideration.

Senator Hughes. When do you think you will have a judgment on it?

Dr. Edwards. We now have a new drug application that has been submitted to us by Eli Lilly & Co. This new drug application has been given to members of our methadone advisory committee and we hope to have made a decision on this no later than the early part of September.

The committee's next meeting is on September 15, and they do have the information. If they don't have it now, they will be getting it in the next week. So a decision will soon be made in this regard.

Senator Hughes. Do you have other drugs in which social factors are a basic consideration?

Dr. Edwards. Yes; I think that in any of the mood drugs and any of the psychotropic drugs there are social factors that have to be taken into consideration. I think, however, our primary responsibility is safety and efficacy from a scientific point of view.

But certainly, with any of the mood drugs I think other factors have to be considered.

Senator Hughes. Are you giving a different emphasis in methadone than you are in other research drugs?

Dr. Edwards. I think we are to the extent that the abuse potential for methadone, the diversion potential, is probably greater than for most other drugs we deal with.

Senator Hughes. How about amphetamines?

Dr. EDWARDS. Well, I would say the abuse potential is greater for methadone than for amphetamines, but by making that statement, I wouldn't want to downgrade the abuse potential for amphetamines.

Senator HUGHES. Barbiturates?

Dr. EDWARDS. Barbiturates, again, it is a matter of degree. They all have tremendous abuse potential, and it has occurred.

Senator HUGHES. How much of a social factor do you consider in amphetamines?

Dr. EDWARDS. To be very frank, Mr. Chairman, I don't think when the new drug applications for amphetamines were originally approved that social factors were considered. I don't think we recognized at that point in time what the abuse potential was. I think our information and realization of the abuse potential came about after the approval, rather than being present at the time.

In retrospect, I think any evaluations of these drugs have to be considered along with social and other factors.

Senator HUGHES. Isn't there an organized national plan for the eradication and control of heroin addiction?

Dr. DUVAL. No; not at this time. Not a total national plan.

Senator HUGHES. Are plans being studied?

Dr. DUVAL. Yes; it is starting with a rather massive survey being undertaken by Dr. Jaffe to review all existing laws. We expect that he will follow that with the assembling of enough information to make a national plan for the total management of the heroin problem in the United States.

Senator HUGHES. Can you give me such an estimate of what such a plan would cost?

Dr. DUVAL. I am not in a position to at this time, but I am confident that Dr. Jaffe will be prepared to address that question on Wednesday.

Senator HUGHES. Do you have any idea what it would include?

Dr. DUVAL. No, sir; I think you would have to ask Dr. Jaffe.

Senator HUGHES. Have you got any input into the plan?

Dr. DUVAL. We are serving as consultants, of course, to Dr. Jaffe, and we are in fact staffing his office, and I think we are also having a great deal of input at this time.

I think Mr. Isbister can be more specific.

Mr. ISBISTER. Yes, Mr. Chairman. Various members of the NIMH staff have been working with Dr. Jaffe on specific tasks, development of proposals for treatment and rehabilitation programs, for research and for manpower development programs. Our staff is intimately involved in the development of this national plan.

Senator HUGHES. We will go into that more when Dr. Jaffe gets here.

You have indicated to me that basically you do not have any employee personnel program that exists in HEW for drug addiction at this time. Is that correct? You are relying on the overall plan of civil service?

Dr. DUVAL. That is correct, Senator.

Senator HUGHES. Are you asking industry to set up programs?

Mr. BESTEMAN. Mr. Chairman, we are dealing with industry in meetings at their request and are consulting with them on how they can set up plans. There are two right now, two forces that are working toward this. One is industry and the other is the labor unions within industry,

which are expressing, particularly in the last 6 or 8 months, considerable concern and initiative in how to handle this among employees.

Senator HUGHES. If you don't have one of your own, how can you advise them?

Mr. BESTEMAN. I think we advise them from the experience that we have had in dealing with drug abusers, what their performance and behavior has been when we have had them in the employment situation, what kind of supervision and services associated with that employment have made for continuous and productive employment——

Senator HUGHES. How do you get this information?

Mr. BESTEMAN. From programs that we support that are treating drug abusers. Some of those drug abusers are working and we deal with them in the context of the employment they hold.

Senator HUGHES. You are talking about individual cases, then, not industry programs.

Mr. BESTEMAN. Right; in many others, we have to find ways in which to make them employable, even to improving basic job habits and these are areas of common technical concern. Each industry seems to approach its particular hazards or needs slightly differently, but some of this experience is useful to them in seeing how it could apply to a given job category.

Senator HUGHES. Do you know of a single industry program in America today relating to this subject?

Mr. BESTEMAN. No; I do not know of one.

Senator HUGHES. Not a single one?

Mr. BESTEMAN. I am not aware of one.

Senator HUGHES. Do you think HEW ought to be a model or industry and have their own?

Mr. BESTEMAN. Yes.

Senator HUGHES. How many employees do you have in HEW?

Dr. WILSON. Roughly 100,000.

Senator HUGHES. Roughly 100,000. What do you think, Dr. Wilson, is the abuse potential among 100,000 employees? Do you think it would be different there?

Dr. WILSON. It would be different than the national figure, because we deal with employed groups, and in the national figure it contains the unemployed in some areas. It would be the same as the national figure for the employed.

I would like to place this, if I can, Mr. Chairman, in a slightly different context. It seems to me that the NIMH staff are providing advice counsel and counsel to the industrial and other groups. The plan, as you know, for handling this type of problem, whether for alcoholic drug abuse or the others within the Federal Government, is of course, subject to an agreement between a number of different groups who have a responsibility for many other things besides our agency, the Civil Service Commission, specifically.

So I don't find it disturbing that we do not have a fully worked out policy. I would find it disturbing, as I know you would, if we weren't aiming for one and weren't setting realistic deadlines to get the job done.

Senator HUGHES. Do you have a written plan to recommend to anyone, Dr. Wilson?

Dr. WILSON. No, we do not, and I think it would be premature for us to have a written plan on this one until we have basic policies and guidelines.

Senator HUGHES. Aren't you expecting the military to have a written plan, a developed plan, for narcotics abuse, treatment rehabilitation, and the whole works?

Dr. WILSON. They do not at the moment have one.

Senator HUGHES. Isn't that what the President indicated you were going to have?

Dr. WILSON. Yes; if you are dealing with the future, I think there is a complete affirmative. We should have one, and we are in the process of evolving one. If you ask whether we have one at the moment, the answer has to be negative.

Senator HUGHES. Were you caught flatfooted by this problem, Dr. Wilson, absolutely beyond your expectations of the magnitude of the problem we have? Is that the reason you don't have a plan, or even recommendations to make now? You said it would be premature.

Dr. WILSON. For us to have an announced plan.

Senator HUGHES. You should have been more aware of what is happening than anyone else.

Dr. WILSON. Senator, we fall back on what Dr. DuVal said a little bit earlier. Within the span of the time when Dr. Egeberg testified a year ago and the present time, certainly our base of information from which we are making administrative decisions has shifted, and one might call that being flatfooted, as I think you have, without a plan.

I think on the other hand it is reasonable to assume that situation has changed somewhat.

Senator HUGHES. What input do you have into DOD programing for the military in relationship to their health and well-being of the military personnel, I mean. Do you have an input into that through the national director?

Dr. DUVAL. We have an input, and we have served as counselors to DOD on drug abuse. But I think the degree of coordination that we thought was necessary in the past is not sufficient because of the magnitude of this problem, and this is precisely why we are with you in moving into a special office at the level of the Presidency.

Senator HUGHES. Can someone give me some hope as to when you are going to have a plan?

Dr. DUVAL. I think that has to be directed to Dr. Jaffe on Wednesday.

Senator HUGHES. Aren't you the man who is giving him advice, Dr. DuVal? Aren't you the man saying why and how? Isn't your agency the one doing all that, that has the expertise?

Dr. DUVAL. We would be construed as the lead agency to this time, but Dr. Jaffe has the responsibility for this.

Senator HUGHES. You are staffing his office, you are giving him professional expertise and everything else. What are you advising him to do?

Dr. DUVAL. He is receiving staff from many sources.

Senator HUGHES. Someone just told me you were staffing his office, and I assumed that meant professional staff as well as others.

Dr. DuVal. That is correct, Senator. We are giving him professional staff assistance.

Senator Hughes. Then as an agency, do you have a line of policy or advice you are giving Dr. Jaffe?

Dr. DuVal. I will have to ask NIMH if they are in fact giving him advice in that direction.

Senator Hughes. Or are you relying on him to give you advice?

Mr. Isbister. I think it is a two-way street, Mr. Chairman, where we have been providing advice on the kinds of treatment and rehabilitation programs that should be developed. Dr. Jaffe has views of his own and the subject is now under discussion and hopefully will lead to the plan we are looking for within a relatively short period of time.

Senator Hughes. Give me an idea. What do you call "a relatively short period of time?"

Dr. DuVal. Senator, I am not sure how we can. Our problem is compounded by the fact, as you know, that Dr. Jaffe felt it was critical for him to get to Vietnam and visit the situation there. He has done so and has been in town now between 2 and 3 weeks and that, I think, only part time, so it has been difficult to move as rapidly as you and I would like.

I do know he is dedicated to an early solution. We are not prepared to answer on his behalf as to how fast that will come.

Senator Hughes. All of us respect Dr. Jaffe's ability, his background, the work he has been doing, but you have the whole agency behind you. That one man surely can't be expected to be sitting out there acting alone without your having a great deal of input into it.

Surely you are going to have a heavy voice in formulating national policy—not Dr. Jaffe. He is going to follow your advice, or a lot of it, along with some of his own experience, ideas, and background.

Surely you are not expecting the President to pick one man out of Chicago and bring him in here and say he has everything available to him and he has all the know-how that we need in this country. You are not doing that, are you?

Dr. DuVal. No. sir; we are just simply doing the best we can until such time as he can get the other elements of Government input. This can't be done unilaterally within HEW, especially because of the way we envision the responsibilities of his role.

Senator Hughes. Don't you have the major responsibility in health, education, and rehabilitation?

Dr. DuVal. Yes.

Senator Hughes. Then what are you doing about it with Dr. Jaffe? You say you are staffing his office, you say you have the major responsibility, you say the emphasis is on health, you say it is a national crisis and you agree with the President.

I don't want to pursue this point any longer. I am getting to a point of harassment, and I apologize for that, because I don't mean to be harassing. What I am trying to do is encourage you, and this is the wrong approach to do that, I guess.

What I want to know is what you are doing, if anything, and I think you think you are doing everything you can. I agree with you on that, but can you tell me what that is?

Dr. DuVal. Senator, I wonder if the answer to that question doesn't include an essentially complete rundown of the educational training and research and rehabilitation programs that we are undertaking. Is that what the Senator had in mind?

Senator Hughes. That is going to be helpful if that is what Dr. Jaffe is going to develop as part of national policy.

Dr. DuVal. He will, of course, develop a national policy, within which we will have certain input. We have been prepared and have already been telling him what aspects of our program we can place at his disposal, but he has to fit that into something somewhat larger, related to Defense, the Veterans' Administration, and so forth. We do not know yet how those pieces will come together.

Senator Hughes. Do you have an input into the Veterans' Administration as well as into Defense?

Dr. DuVal. Yes; we have given courses in the Veterans' Administration hospitals and have given instructions to personnel in the Veterans' Administration.

Senator Hughes. Did you in fact have an input into the training of the personnel sent to Vietnam to take over the program in the training of the paramedics?

Dr. DuVal. I don't think we did. No specific training programs for those persons from us.

Senator Hughes. No input from you into personnel training for that purpose. The military primarily relied on their own capabilities in this field,

Mr. Isbister. Many of the individuals could have received training through programs we support, including our three regional training centers. Many of the people who have been going through those training centers are personnel in the Defense Department and the Veterans' Administration.

In addition, personnel from those two agencies have received training at our Lexington Clinical Research Center as individuals.

Senator Hughes. As individuals?

Mr. Isbister. Yes, sir.

Senator Hughes. Does, in fact, Dr. Jaffe now have all the decisionmaking power in relationship to the program?

Dr. DuVal. Senator, I think the only way we can answer that is we have forfeited decisionmaking power while awaiting legislation. He has technically no authority.

Senator Hughes. You are sort of waiting to follow the President's wishes, is that correct? I don't want to be unfair. I realize this is a new situation, you are faced with a completely new set of circumstances, you have a man in the White House to coordinate the programs.

Dr. DuVal. That is a very fair appraisal of the situation. We have never been in a situation before where a Special Action Office of this kind has been set up almost overnight, trying to find a way to coordinate multiple departments of Government. We are doing our very best to work as fast as possible to implement that objective.

Senator Hughes. That is a tremendous undertaking. It requires a great deal of change and flexibility on your behalf, on everyone's elses.

I think I can understand what you are trying to do. The decisionmaking power is not yet clear, I think.

Senator Javits, I will be glad to yield to you.

Senator JAVITS. Thank you, Mr. Chairman. Mr. Chairman, I have a few questions, and I am very grateful to the Chair for holding the hearings.

We are interested in something you were asked in May. We asked specifically of Dr. Wilson, to furnish us with a professional judgment budget on what is the optimum amount of funding needed in the drug area, and what are the priorities in that optimum budget that you wish to establish?

Now, at the time of the request, there was an agreement that we would get that information. Later, you advised us that you would not give it to us. Could we know why this turnaround occurred?

Dr. WILSON. As you would recall, this was comparable to the one on alcohol, where we did in fact produce a professional judgment budget.

In this instance, you will recall the timing of my appearance before this committee, which preceded only by a brief period the appointment of Dr. Jaffe and the introduction of the President's new drug abuse initiative.

I think it is our attitude, Senator, that we believe that with a professional in the office of the President who has a much better capacity to deal with the wide variety of programs external to HEW that we should await the issuing of a professional judgment budget until we have had a chance for that kind of coordination of professional judgment.

For us to come forth with a comparable budget, with now office established, at this point in time would be misleading and perhaps disruptive.

Senator JAVITS. Dr. Wilson, look at our side of this. Suppose that as members we wished to strive not for the $381 million that you are asking for, but for twice that amount. Because the President makes a bureaucratic change, how many months do you feel we ought to be "hung-up"?

I mean of there is complete good faith in the fact that we are going to pursue this situation, and the Congress has as much right as the President to determine the priorities, what you are making us do, just because the President makes a bureaucratic change is that you say "We are sorry, boys. The boom is lowered, and just wait."

Then if we extrapolate and do whatever we think is right, the first thing we know you will do is come in and tell us how wrong we are because we didn't wait for you.

How do you reconcile that? I don't speak only to you, but to the administration as well. You were ready to give it to us in May, and you must have this information. Maybe what we ought to do is just subpena the records of the HEW which contain it.

Dr. WILSON. We did not develop it.

Senator JAVITS. You did not develop it?

Dr. WILSON. We did not. We do not have any kind of budget of this kind. We did not go through that process, because there were certain basic assumptions of costs which are going to be heavily related to the policy we pursue. The relative emphasis on methadone treatment is one that might run costs heavily in one direction or another.

The estimates of numbers of people involved also has been under a substantial amount of discussion. The question of whether we restrict in this activity to dealing with the use of heroin specifically or expand it to other drugs; all of these issues have a tremendous impact on the amount of money that would be called for.

In order to develop a professional judgment budget, we would have had to make that kind of a series of assumptions. We would have hoped we would have had that series of assumptions before us, and then we would be quite happy, I think, once we have the assumptions, to give you the professional estimate.

One would assume this would not be a long delay. We apologize for the fact that something did occur in the interim that did not allow us to come through in the way we had intended.

Senator JAVITS. As a practical matter, you are applying for a $155 million supplemental, and you must make adjustments as to the budget you are seeking. Isn't that really at least what you requested and what the Budget Bureau may cut you down from, isn't that really your professional judgment budget?

Dr. DUVAL. Yes, sir; it is the professional judgment budget for 1972.

Senator JAVITS. Ths one, or what you asked OMB for? You asked OMB for more money, didn't you?

Dr. DUVAL. We believe this year in cranking up a new program that we can, without a carry-forward, that we can do this for approximately an additional $155 million, part of which is reprogramed from the Department of Defense.

Senator JAVITS. So you are representing to us that the budget which you have presented is for the purpose of 1972 the professional judgment budget?

Dr. DUVAL. There is a reconciliation here. I am going to ask Dr. Wilson here.

Senator JAVITS. I feel like Senator Hughes, we are merely trying to get the facts.

Dr. WILSON. As I recall your request to me for the professional judgment budget, it was in the same context as the one for alcohol where the chairman said, if we didn't have the problems of production, if we didn't have a manpower problem and other kinds of variables, what would you expend in order to meet the need?

Now, it was in that context that we were addressing the professional judgment budget for drug abuse.

Senator HUGHES. Without other funding priorities, too, Dr. Wilson.

Dr. WILSON. Right.

Senator HUGHES. I think that was the statement of the question.

Dr. WILSON. So that would be one figure. The figure we have here takes into account the many restrictions on personnel, time to gear up the program, competition with other budget items, and so I think you must make these to different kinds of issues, really.

Senator JAVITS. Dr. DuVal, suppose we served notice on you that we intend, at least I do—I have little doubt that the chairman feels as I do on this matter—that we intend to request of Dr. Jaffe this type of budget, and we intend to keep at it until we get it. Could you convey that information to him, since he is coming up on Wednesday?

Dr. DUVAL. We will convey that information.

Senator JAVITS. Is that satisfactory to my Chairman?

Senator HUGHES. It is satisfactory, Senator Javits. I would also like to get the break-down from these people, if you want to pursue that matter.

Senator JAVITS. We would also like a chart showing in detail which grant programs in the drug abuse and treatment areas your requested budget amounts are still below the congressional authorization, and the reasons for it.

Dr. DUVAL. We can provide that, Senator.

(The following information was subsequently supplied for the record:)

COMPARISON OF AUTHORIZATIONS AND APPROPRIATIONS

Only the drug abuse programs authorized under the Community Mental Health Center Act have specific dollar limitations. These authorizations by section are identified below:

COMMUNITY MENTAL HEALTH CENTERS ACT AS AMENDED

	1972 authorization	1972 appropriation
Section 261—New grants for staffing, special projects, evaluation, planning and initiation	$60,000,000	
Section 253—Drug abuse education	12,000,000	
Section 256—Drug abuse special projects	30,000,000	
Subtotal	102,000,000	$92,910,000
Continuation grants for staffing	(1)	22,083,000
Total, community assistance programs		114,993,000

[1] Sums necessary.

Note: The authorization shown above for section 261 includes both the narcotic addiction and alcoholism programs. Of the $92 910,000 total appropriated for the specific sections listed above, $82,217,000 is for narcotic addiction and $10,693,000 for alcoholism. Of the $22,083,000 appropriated for staffing grants continuation costs, $14,583,000 is for narcotic addiction and $7,500,000 for alcoholism.

Treatment facilities will be established with a view toward maintaining maximum flexibility by tailoring the range of services and the methods employed to the carefully assessed needs of the communities to be served. Our intent is to be as responsible as possible to the specific drug treatment needs of communities. For this reason, a distribution of appropriated funds by specific section is not currently available.

Senator JAVITS. One other thing, and that goes for methadone. I hope you will understand my background in asking you about methadone, because the human factor is very important. It is now believed that as much as 70 percent of the serious crime in the largest city in the world, or the largest city in the United States, New York City, is attributable to narcotics addiction, because we don't know, but we must assume that most of it is because of the need to satisfy the addiction.

The only single method of treatment that has been mass enough to keep this dreadful horror in some kind of restraint is methadone, because that is the only thing that really reaches huge volumes of people.

We have a comparison between roughly 20,000 on methadone maintenance, and at the most 7,000 in every kind of treatment program you can imagine.

Now, I have read your material on where you stand with methadone, and like the Chairman, I feel you are working very hard from the point of view of the professional standards which you apply to a drug.

You are doing everything you can do. But the question is, under these exigencies, where this city is really in mortal danger of disintegration

because of 100,000 narcotics addicts, do you have any other or better suggestion, either for accelerating the effort to find out about methadone, or for taking a chance on it instead of keeping the lid on it which, if we follow this program, we must?

Dr. DuVal. Senator, we obviously share your deep concern for the human element in this, and the element of crisis that exists is a matter of our first priority.

We are optimistic that when the committee meets in September, they will grant the first NDA for methadone and it will be possible to make it more generally available. I know that you would agree with me that the record should show again that methadone is itself a dangerous drug, it is capable of killing, it is capable of abuse, and it is very expensive. We do not know its long-range effects.

So we must find out, as you know, where the middle of the road is that will work most effectively for most people.

Senator Javits. When you say "expensive," you are not speaking about the drug per se.

Dr. DuVal. I am speaking of the total cost of keeping a person on methadone.

Senator Javits. Incidentally, what you just said, that you do think there will be NDA classification in September, is sensational news, because for New York, that this could be a matter of life and death.

I would like to ask you this in terms of the methadone problem. You say "permanent." Don't you expect as a very important figure in the field yourself, that this is, rather than permanent, temporary, because we await the development of some antibody, or whatever else science research comes up with, as I am confident it will, and this really is the first time that we have zeroed in in a big way on this drug problem, and that methadone is just a way of carrying us over, minimizing.

These addicts are going to die anyhow, whether from heroin or methadone, and isn't the question whether in the process of dying how many they are going to take with them? They figure they are dead when they start. You know that. That is the psychology of the user.

The question as I see it is, isn't it temporary until you do better in your research to find what is really needed in this? I assume you will come up with something which will make the addict hate heroin, that it will be his principal hate in life when you get through with him.

Dr. DuVal. Senator, we agree. I don't think any of us here would consider that methadone represented the ideal answer at this time to the problem you describe. We would hope we would do better with other agents.

I would say for the record that my reference to the committee action was not to anticipate what the committee will do, and it is important that not be read as anticipatory. Perhaps Dr. Edwards could qualify that part of the testimony.

Dr. Edwards. Thank you, Senator Javits. I could only add to what Dr. DuVal has said. I think without any question the committee will be taking definative action on methadone in September, and I would want to point out that if an NDA is approved for methadone, it will

have to be an unusual approval, because we can't let methadone be used like any other prescription drug.

Supervision of methadone use obviously has to be rather significant so that while I think we will approve the drug, I think it will be approved under unusual circumstances which will allow us to give the supervision, or allow someone to give supervision.

Senator JAVITS. Dr. DuVal, could you tell us how much is being spent on heroin antagonist research? Do you know that?

Dr. DUVAL. I think we have a figure that we can put in the record for you, if you will wait just a moment, Senator.

Mr. ISBISTER. A total of $1.8 million for 29 projects in fiscal 1971 from the NIMH program.

Senator JAVITS. Could you give us a breakdown on that figure as to what precise heroin antagonist research programs are being funded and also what heroin antagonist research proposals have not been funded and why?

Mr. ISBISTER. We will provide that for the record.

(The information subsequently supplied follows:)

NATIONAL INSTITUTE OF MENTAL HEALTH NARCOTIC-ANTAGONIST RESEARCH FOR FISCAL YEAR 1971

The National Institute of Mental Health supports 32 grant projects which include studies on narcotic antagonists as a portion of their overall research. Of the total of $1,800,000 awarded in FY 1971 to fund the 32 projects, it is estimated that $524,000 and 25 man-years will be specifically focused on narcotic antagonist research. This research involves heroin as well as other opiate drugs.

Senator JAVITS. In corrolary activities in the Congress, I have been dealing with community mental health centers and I would like to ask your views, Dr. DUVAL. You will recall that at my own insistence we used the community health centers as a place for narcotics addict treatment.

Since that time I have gotten very concerned about that, because apparently narcotics addicts have a phobia about being considered mental health cases. I am concerned we may be spending our money the wrong way and in the wrong place and would appreciate it if you could enlighten us.

Now, the answer given to me, if I may just add to the facts, is that community mental health centers set up treatment for narcotics addicts under separate auspices rather than having them come to the mental health clinic, because apparently that is not good for the mental health of other patients, or for them.

But, again, it seems to me that some reevaluation of it, if you have not already made it, might be dictated, because as I say, we may be trying to do something in the wrong place and thereby not utilizing resources.

Dr. DUVAL. Senator, your comment obviously reveals a very deep knowledge of the human factors involved in treating a person who is under the influence of drugs.

We have, as I think you know, about 452 of these centers that have now been funded, 300 are seeing patients, and of those 80 have separate staffing and capability for managing the drug abuse problem. Inci-

dentally, only 25 of those were separately funded, that is, targeted for drug efforts, so that the others have taken this on by themselves.

But it is a universal fact, and I think you have correctly identified it, that because it is there does not mean that it will be used, and we are obviously going to put our efforts in multiple directions to reach the addicts in areas other than the community mental health centers.

Senator JAVITS. But you would not as yet advise us to abandon the effort there and use the money somewhere else?

Dr. DUVAL. No, sir.

Senator JAVITS. Dr. Wilson?

Dr. WILSON. May I add to the record in a slightly different way, to say that the people and the activities within the community mental health centers are our most important resource for dealing with the problem.

We are dealing here with the matter of at what place or to what place does the individual go for his contact, and what will his contact be.

The community mental health center program really should be viewed as a program, because in almost all instances, as you know, it is a collection of community activities, and it does not all take place in a single building or a single place.

So I think we would like very much to assure everyone that this is an important authority for the community mental health center program to have, but there ought to be considerable latitude in the exact geographic location of the drug abuse activities.

Sometimes it is in the building, or the neighborhood, depending on the locality.

Senator JAVITS. You gentlemen, then, are alert to this factor and you feel you are dealing with it effectively. Thank you.

Senator HUGHES. Thank you, Senator Javits.

I might ask on behalf of the subcommittee. Dr. Edwards, if you could have someone from your office brief our subcommittee staff on Thursday on policy relating to methadone, amphetamines, and barbiturates. If you could do that, it would be helpful to us.

I am sure Senator Javits' staff, and my own staff, and the committee staff would like to know what you are doing in the policy.

Dr. EDWARDS. We will arrange that, yes.

Senator HUGHES. I have a considerable number of questions here, too many by far to go into, because so far we have been going into policy and not into the bill, as you know, which is the primary purpose of this.

I know you gentlemen all understand that the reason I didn't list the President's bill in my opening statement was the fact that this subcommittee doesn't yet have the bill. It will be referred here after Senate Muskie's committee is through with it, but we did want the testimony you have given on the bill. It will be a timesaving factor for you and for us if we can get it in relationship to the other bills that are presently in the subcommittee.

I did not omit that in my opening statement by desire. The bill is not yet referred to this subcommittee.

But because of time, I am going to ask just a few questions more and submit primarily the questions relating to the bills in writing for

your response to them and as rapidly as possible. It is obvious that, with the Congress going to recess Friday night some time, we are not going to get these bills acted on before the recess. Nevertheless, it is important over the recess that staff and all of us have the opportunity to get as much ground into this legislative process as we can so that early in September we can get rapid action on it.

I had a number of questions I wanted to submit in addition to those Senator Javits asked with relationship to research, and I think I will submit those in writing, too, to avoid the consuming of time here.

I am interested right now in the following matter. Senator Javits implied, and I want to reenforce his implication, that in searching for the dollar amounts we are searching for, we are considering adding additional dollar amounts to S. 2217, or the President's bill. The new figures could run as high as 10 times the money that has been requested.

We are the authorization committee for this legislation and I think Senator Javits wanted to tell you directly, and I do, that we need every bit of input we can get anyway and every way we can get it from you to make some sort of honest consideration on dollar input and authorization.

Without that, we have to go on judgments which we get as best we can. But they would not be as helpful as those which you sent.

Dr. DuVAL. We will see that you have it, Senator.

Senator HUGHES. I wanted to reenforce that.

On the matter of departmental organization, assuming that our subcommittee and the committee determine that an additional coordination, authority, and advisability are needed for the problem in HEW. I would like your comments today and in writing later on each of the following alternatives. Of course, in earlier hearings and in the bill we recommended and which passed the Senate last year, improved coordination was recommended. I will just bring these out, because I don't want to get into a long dissertation on them now.

One is an institute in NIMH for drugs. Two is pulling out of NIMH the health services and creating an institute of mental health, which contains drugs, alcohol, mental illness, which would report directly to the Assistant Secretary.

Three is a new separate drug abuse administration reporting directly to the Assistant Secretary as the Ash Commission recommended. That is what they recommended, isn't it?

Dr. DuVAL. Yes, sir; that is correct.

Senator HUGHES. And also, there is the possibility of a completely separate agency on drugs reporting directly to the President. We have a number of alternatives before us, and it is very difficult for us in considering these in the legislative process to get all of the best advice about them, both with the numerous bills that are before us and alternatives that we didn't have before us.

Also, in the grant procedures and organization, we are going to ask you to furnish us with documentation which spells out the various review procedures necessary and so on down the line, on grants.

One of the grant programs developed under S. 2217 allows for application for grants by groups of programs serving specific areas. If you recall the bill specifically, that is what it provides.

We are going to want to know some things about this approach, too. But I think for the time being, because of the volume of questions and the need to get replies to this, I would expect that there will be probably 40 or 50 pretty pointed questions we want responses to. I would appreciate it if you could get these responses back to the subcommittee as rapidly as possible.

I realize you are in a critical situation over there, staffing Dr. Jaffe's office and proposing complete new approaches and everything else, but if you can get this to us in a couple of weeks it will enable us over the recess to be in a better position the first week we are back to be active on the legislation.

Dr. DuVAL. We will be as helpful as we can.

Senator HUGHES. I appreciate that. Senator Javits, if you have no further questions, I will submit the balance of mine and yours in writing to these gentlemen.

I again express my appreciation for your cooperation.

(The following was subsequently supplied for the record:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

AUG 31 1971

SEP 2 197

Honorable Harold E. Hughes
Chairman, Subcommittee on Alcoholism
and Narcotics
Committee on Labor and Public Welfare
United States Senate
Washington, D. C. 20510

Dear Senator Hughes:

Enclosed are responses to the questions contained in your letter of August 3. I hope you will find them informative and helpful.

Sincerely yours,

Merlin K. DuVal, M. D.
Assistant Secretary for
Health and Scientific Affairs

Enclosure

Question 1. Please give a brief description of the types of drug abuse research now being supported by NIMH.

Research now being conducted under Institute aegis covers a wide range. It includes studies of: the basic neurophysiological mechanisms of action of drugs; psychomotor effects of drugs; epidemiology of drug abuse; new treatment approaches; long-term chronic effects of drug use; psychosocial correlates of drug use. The attached table gives a breakdown of research expenditures in FY 1970.

a. Are you concentrating on determining the properties of the substances and on how they affect the human system or are you more interested in treatment methods or in etiology?

The Institute is not narrowly concentrating its attention either on drug effects or on drug abuse etiology and treatment. All of these are important. For example, to develop effective treatment approaches and to understand the etiology of drug abuse, it is essential to clarify: (a) the properties of the drugs which are abused; (b) their physiological mode of action; (c) the psychosocial correlates of drug use; and (d) the results to date of treatment methods.

b. Why hasn't HEW had a coordinated research plan in the drug abuse area? As I understand it, for the most part, the research money has been given out largely on the basis of the applications which come in, rather than according to a written plan. Is that correct?

Within the overall resources available to it for drug research, the NIMH establishes general priorities and plans under the guidance of the Office of the Director, NIMH, and utilizing the following advisory mechanisms:

Question 1 (cont'd):

(1) Once a year, outside experts in the drug abuse research come together to review the research program of the Institute and to make recommendations regarding priorities, emphases and directions that the research program should take, both long range and short range.

(2) Three times a year, a group of non-Federal experts come together to review specific research proposals. In their deliberations, this group is guided, not only by the work of the policy-making body, but also by the nature and quality of the research proposals. The job of this committee is to insure that the research proposed in a given priority area is scientifically sound.

(3) Four times a year, the National Advisory Mental Health Council, composed of both professional and lay members, meets to review general NIMH policy issues and particular grant applications. In the course of these meetings, drug research policy and grant proposals are considered. No grant may be funded by the NIMH without approval of both the initial review group of non-Federal experts and the National Advisory Mental Health Council.

In addition, the Institute sponsors conferences such as the recent Third National Conference on Methadone, at which researchers and service personnel come together to share results and map out promising directions. Finally, the Institute staff

Question 1 (cont'd):

by means of professional contacts, site visits and staff papers helps to shape drug abuse research emphases.

This system insures that two types of decisions are made in an appropriate manner: (1) broad policy decisions regarding priorities, and (2) decisions regarding particular research protocols intended to further our knowledge within priority areas.

The NIMH approach to drug abuse research coordinates both highly targeted applied research and less targeted basic research. Basic research provides the raw material from which applied research can fashion useful applications. For example, the Institute's targeted research programs with regard to marihuana and narcotic antagonists initially grew from foundations laid by less targeted, basic research.

Applications which are received for research grants are by no means adventitious. They represent the culmination of many hundreds of hours of staff and consultant time devoted to discussing research needs and specific projects with prospective grantees in order to generate interest in work of programmatic interest.

c. What do you demand in return for funding a project?

In return for funding a project whether under contract or grant, we require the investigator to furnish annual reports as well as a final report on work carried out. Quite frequently

Question 1 (cont'd):

(invariably in the case of contracts) more frequent contact is maintained and more frequent reports are supplied describing progress that is being made. Since grants are renewed annually (if they extend over a year's duration), such renewal is contingent on having made good progress. It is true, however, that in the past the number of scientists employed by the Institute in the area of drug abuse has not permitted as detailed a followup as might be optimal. Finally, in order to maintain his own scientific reputation, the individual researcher is under considerable pressure to adequately report his findings to the scientific community at the many conferences and in the many scientific journals concerned with his work.

d. Why isn't more work done on a contract basis so that the Government could make more stringent demands with respect to length of projects and their purposes?

The choice between use of the contract and the grant mechanism depends on the nature of the problem to be investigated. In areas where specific attainable goals can be adequately specified, the contract mechanism has been used to the extent permitted by available funds. Areas which lend themselves to this are those in which a specific product can be specified. For example, the necessary research supplies for the marihuana program are provided for by contract. In certain areas in which the type of research is well standardized and easily specified--for example, certain types of drug testing

Question 1 (cont'd):

in animals and humans that is required prior to other farther ranging research--the contract mechanism is also utilized. It must, however, be recognized that this mechanism has both advantages and equally serious disadvantages. It is considerably better suited to the support of projects which have clearly defined product outcomes than it is for the support of a line of inquiry that may be frankly more speculative, less focused on ultimate applications of knowledge, and accompanied by greater risk. The flexibility provided by a grant is far more attractive to the highly able researcher since the way in which the problem is attacked is to a greater extent determined by his initiative.

e. Do you need additional legislative authority if you switch from granting to contracting?

Please see answer to Question 1.d.

Attachment

TABLE II-A

NIMH RESEARCH GRANTS RELEVANT TO DRUG ABUSE AWARDED OUT OF FY '70 FUNDS

	Amphetamines and other Stimulants		Barbiturates and other Depressants		Opiates, other Narcotics and their Antagonists		LSD and Similar Hallucinogens		Marihuana and THC		Drugs Not Specified		No Drugs and Other Drugs		Total	
	No. of Grants	Amt. of Awards	No. of Grants	Amt. of Awards	No. of Grants	Amt. of Awards	No. of Grants	Amt. of Awards	No. of Grants	Amt.of Awards	No. of Grants	Amt. of Awards	No. of Grants	Amt. of Awards	No. of Grants	Amt. of Awards
DRUG ABUSE FUNDED BY DNADA																
Single Drug Categories	3	$148,356	1	$ 26,265	23	$ 954,366	5	$164,729	13	$568,525	3	$299,286	--	-------	48	$2,161,527
Multiple Drug Categories	19	427,101	17	408,190	13	289,381	12	217,791	9	146,010	--	-------	--	-------	26	1,488,473
Total	22	575,457	18	434,455	36	1,243,747	17	382,520	22	714,535	3	299,286	--	-------	74	3,650,000
DRUG ABUSE FUNDED BY OTHER NIMH DIVISIONS																
Single Drug Categories	—	-------	1	103,858	4	488,781	--	-------	--	-------	2	173,131	2	33,655	9	799,425
Multiple Drug Categories	7	401,138	10	597,821	4	217,308	4	261,568	1	72,637	--	-------	--	------	10	1,550,472
Total	7	401,138	11	701,679	8	706,089	4	261,568	1	72,637	2	173,131	2	33,655	19	2,349,897
TOTALS																
Single	3	148,356	2	130,123	27	1,443,147	5	164,729	13	568,525	5	472,417	2	33,655	57	2,960,952
Multiple	26	828,239	27	1,006,011	17	506,689	16	479,359	10	218,647	0	0	0	0	36	3,038,945
Total	29	$976,595	29	$1,136,134	44	$1,949,836	21	$644,088	23	$787,172	5	$472,417	2	$33,655	93	$5,999,897

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

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Q. 1
Att. #1

Question 2. Why has HEW still not put together model treatment legislation for distribution to the states, like what was done in the enforcement area?

The question of model treatment legislation must be viewed against a backdrop which illustrates the diverse groups of persons lumped together as "drug abusers." Since the psychological, social, economic and sociological reasons for their drug abuse differ, and since the effects of different drugs of abuse on their lives and persons vary, no one treatment can be effective for all drug abusers. Indeed, some abusers may not be helped by any currently available treatment modality.

The term "model treatment legislation" is often used as a euphemism for civil commitment of drug addicts. Following the Supreme Court ruling in Robinson vs. California (1962) that drug addiction is a disease and cannot be outlawed as a crime, civil commitment of drug addicts was codified in New York and California. The general pattern is to place addicts in public hospitals for their alleged addiction to drugs, and to keep them in custody for various statutory periods until "cured." It is this State experience that has given rise to discussion of the value of a nationwide proposal to hospitalize drug addicts.

The commitment of noncriminal addicts by Federal and State governments is a drastic step. The purposes of such commitment may be listed as confinement, care, treatment, and rehabilitation; but the last three are not necessarily concomitants of the first. Further, it is well known that motivation of

Question 2 (cont'd):

narcotic addicts is a very real predictor of potential success of any treatment program. When this ingredient is lacking as in involuntary commitments, it does not augur well for any success rate.

As the Task Force on Narcotics and Drug Abuse of the President's Commission on Law Enforcement and Administration of Justice (1967) pointed out in its report, many professionals in the field oppose involuntary commitment of noncriminal addicts because "it holds out the promise of a known method of treatment, or a reasonable prospect of cure, which does not exist" (p. 17). Because we are still uncertain of which treatment offers the best hope for each addict and because some addicts do not respond well to any currently available modality, the Department is reluctant to urge large-scale civil commitments. Since civil commitment is meant to lead to effective treatment, not punishment or incarceration, we can only call for more research. The Department is supporting evaluative studies which will increase our knowledge of such effective treatments.

In the face of this uncertainty regarding treatment methods, "model treatment legislation" is not feasible. Our experience to date, however, indicates (1) that community-based treatment programs offering guidance and psychiatric help on an outpatient basis are more successful than centralized hospitals or clinics; and (2) that a multiplicity of treatment modalities must be employed to effectively combat the drug abuse-drug dependence syndrome.

Question 3. During our last hearings, you indicated that you would have completed by July 1 a document which described for committees the various federal direct and grant and contract services available to communities in the drug area. Is the document completed? May we have some copies of it? You also indicated, as I understand it, that you would submit to us by the end of this week a paper for communities and for the Subcommittee describing the various treatment methods currently employed to treat drug abusers and containing professional judgments concerning the relative success, and advantages and disadvantages of each method. Is there any reason why we will not have that document for our consideration by that time? If not, why not?

I am enclosing several preliminary copies for the Subcommittee of a document entitled "Drug Abuse Programs: A Guide to Federal Support." The photo-offset printed edition of this document will be available September 6, a typeset edition will be available October 11.

No single document has as yet been prepared which both describes various treatment methods for drug abusers and presents professional judgments concerning their relative success; however, the statement on May 7, 1971 by Dr. Bertram S. Brown, Director, NIMH, before the Subcommittee on Alcoholism and Narcotics of the Senate Labor and Public Welfare Committee (copy enclosed) does contain a description of the treatment modalities currently employed. While professional judgments of a most general nature can be made, e.g., that treatment programs should offer more than one modality in order to meet the needs of a larger percentage of drug abusers, the data required for a sound, scientific evaluation of the relative merits of different treatment modalities is not yet available.

Question 3 (cont'd):

The Department is currently supporting a large evaluative research project which, over time, will provide us with the data needed to compare the utility of various treatment methods for different groups of drug abusers. This contract, with a researcher at Texas Christian University, provides for the collection of information on patients being treated under the grants funded by the National Institute of Mental Health. Grantees submit a "Patient Progress Report" form to the contractor on every patient at two-month intervals. While we recognize the need for arriving at sound evaluations of treatment methods, we are not prepared to offer judgments before adequate data have been collected, evaluated, and critically examined.

Enclosures

4. I wonder if you could provide for the record a detailed breakdown of the supplemental funds which the President has requested for the drug area, showing which specific statutory program they are going into? Also, would you please furnish a chart showing in which grant and contract programs in the drug abuse prevention and treatment areas your requested budget amounts are still below Congressional authorizations?

In response to your question, Mr. Chairman, we are submitting the following three documents for the record: 1) an agency distribution of the $155 million supplemental funds which the President has requested for the drug area; 2) the NIMH operating plan for the HEW portion ($67 million) of the supplemental; and 3) a table showing the differences between amounts requested and authorized for narcotic addiction community assistance programs in NIMH.

Attachments

13.
Question 4
Attach. #1

Administration Amendment

Distribution of $155 Million White House
Initiative on Drug Abuse **

Treatment and Rehabilitation	
National Institue of Mental Health	$43,000,000
Veterans' Administration	14,100,000
Department of Defense	48,525,000 *
Subtotal	105,625,000 *
Research & Other Support	
Special Action Office	3,000,000
Department of Agriculture	2,100,000
NIMH (Research: 12m; Planning: 2m)	14,000,000
Subtotal	19,100,000
Law Enforcement	
Treasury	25,640,000
Bureau of Narcotic and Dangerous Drugs	9,600,000
Subtotal	35,240,000
Training & Education	
National Institute of Mental Health	10,000,000
Subtotal	10,000,000
Total	169,965,000 *

* $14.3 reprogrammed from within existing resources at DOD.
** Information supplied by OMB.

1972 Budget Amendment
Narcotic Addiction and Drug Abuse
Prevention and Rehabilitation Programs

Research	$12,000,000
Statutory Program - Sections 301, 302 - Public Health Service Act	
For increased knowledge to aid our prevention and rehabilitation efforts. Included are funds to be used at the NIMH Addiction Research Center to provide clinical evaluation of drugs for abuse potential as required by Public Law 91-513.	
Training	10,000,000
Statutory Program - Sections 301, 303 and 433 - Public Health Service Act	(4,000,000)
To establish two regional training centers and to develop educational materials for use in these centers and elsewhere.	
Statutory Program - Part D, Community Mental Health Centers Act.	(6,000,000)
To expand the manpower pool to staff the increased prevention, treatment, and rehabilitation programs throughout the nation.	
Treatment	43,000,000
Statutory Program - Part D, Community Mental Health Centers Act.	

To provide a broad variety of narcotic addiction and drug abuse treatment services to meet the general and particular needs of communities across the Nation. Emphasis in the first year would be placed on extending opportunities for treatment and rehabilitation to those drug abusers and addicts, particularly heroin addicts, who have a strong motivation for recovery, but for whom community services are not available. Existing mental health and health delivery systems, such as Community Mental Health Centers and General Hospitals, would be supplemented to include narcotic and drug abuse facilities where needed, and in the absence of systems which could be supplemented to meet these needs, independent narcotic and drug abuse facilities would be created.

Treatment facilities in all cases would be established with a view toward maintaining maximum flexibility by tailoring the range of services and the methods employed to the carefully assessed needs of the communities to be served. Within this basic framework, there would be, for example, a special effort to provide treatment services in areas where there is a heavy concentration of heroin usage among youth. Large scale methadone maintenance programs would also be established where the need is indicated.

1972 Budget Amendment
Narcotic Addiction and Drug Abuse
Prevention and Rehabilitation Programs
(Continued)

Planning..... $2,000,000

Statutory Program - Part D, Community Mental Health Centers Act

For planning grants to States, metropolitan areas, cities, and small towns to insure coordinated, adequately focused programs at State and local levels.

Included in the above allocations are funds to be utilized for support of additional positions required to administer the expanded programs.

16.
Question 4
Attach. #3

Comparison of Authorizations and Appropriations

Only the drug abuse programs authorized under the Community Mental Health Center Act have specific dollar limitations. These authorizations by section are identified below:

	1972 Authorization	1972 Appropriation
CMHC Act as amended:		
Section 261 - New grants for: Staffing, Special Projects, Evaluation, Planning & Initiation	$60,000,000	
Section 253 - Drug Abuse Education	12,000,000	
Section 256 - Drug Abuse Special Projects	30,000,000	
Subtotal	102,000,000	$92,910,000
Continuation grants for:		
Staffing	"Sums Necessary"	22,083,000
Total, Community Assistance Programs		114,993,000

Note: The authorization shown above for Section 261 includes both the narcotic addiction and alcoholism programs. Of the $92,910,000 total appropriated for the specific Sections listed above, $82,217,000 is for narcotic addiction and $10,693,000 for alcoholism.

Of the $22,083,000 appropriated for staffing grants continuation costs, $14,583,000 is for narcotic addiction and $7,500,000 for alcoholism.

Treatment facilities will be established with a view toward maintaining maximum flexibility by tailoring the range of services and the methods employed to the carefully assessed needs of the communities to be served. Our intent is to be as responsibe as possible to the specific drug treatment needs of communities. **For this reason, a distribution of appropriated funds by specific section is not currently available.**

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Question 5. I understand that during fiscal 1971 you received 331 requests for grant assistance in the fields of training, research, education and services, and that the requests totaled approximately $57.8 million. How many of these requests were funded? How many of the remaining grants were approved or approvable?

The attached table labeled "Grants - FY 1971" furnishes the answer requested in this question. Three hundred thirty-one applications totaling $60,074,338 were received, and of these 134 totaling $15,269,255 were approved and funded. All approved grants were funded. Of those not approved for funding in research, training, education, fellowships and services (NARB), none were at the time of review approvable. As a result of consultation, many have since been resubmitted, and these are soon to be reviewed. One additional comment: When action on a grant application is deferred, the applicant receives consultation in order to assist in improving the application. These applications are then resubmitted for a second review. Applicants whose applications were disapproved are given the reasons for disapproval, and consultation is offered if desired. The applicants are also free to modify their application and resubmit for a second review.

18.

Question 5
Attachment #1

GRANTS - FY 1971

Division of Narcotic Addiction and Drug Abuse

	Applications Received		Awards Made	
	No.	Amount	No.	Amount
Center for Studies of Narcotic and Drug Abuse:				
Fellowships	8	$ 49,370	6	$ 44,070
Training	21	2,628,780	6	663,780
Research	143	8,715,977	81	2,997,017
Total	172	$11,394,127	93	$ 3,704,867
Narcotic Addict Rehabilitation Branch (Service)	109	$42,207,987	28	$10,789,388
Education	50	$ 6,472,224	13	$ 775,000
TOTAL	331	$60,074,338	134	$15,269,255

Question 6: How many additional grant applications do you presently have on hand for this present fiscal year and what is their total dollar amount? If you receive the appropriations which the President is requesting, how much money will you have available for new programs? Would you please break this information down into specific grant areas and submit it to the Subcommittee -- I mean the information as to applications as well as to available funding for new programs?

There are presently 85 grant applications for staffing grants and special projects service grants in house totaling $21,023,130. There are 69 research applications in house totaling $5,502,675. There are 31 education applications (under PL 91-513) totaling $4,532,896. The total dollar amount for these 185 grants is $31,058,701. It should be pointed out that while approval rates will vary, only one-third to one-half of these applications will in all probability be of sufficient quality to pass review.

The table below provides estimated funds available for new awards in FY 1972. These amounts will vary slightly as actual continuation requirements of projects funded prior to 1972 become known.

Funds Available for 1972 New Projects

Research Grants	$ 7,449,000
Training Grants	905,000
Fellowships: Narcotic addiction and drug abuse	200,000
Community assistance grants:	
Staffing	20,302,000
Service Projects	25,000,000
Initiation and Development	2,200,000
Consultation Services	100,000
Total estimate	$ 56,156,000

Question 7: How do you justify divorcing the alcohol problem from the drug problem? Why isn't it included in the White House office?

We do not believe that the alcohol and drug problems have been divorced; the primary responsibility for both of these problems within the Department of Health, Education, and Welfare resides with the National Institute of Mental Health. Both alcoholism and drug abuse require programs which can come to grips with the problems of drug-dependent individuals. The location of both programs within the Institute allows staff members to share perspectives and ideas so that experiences gained in one area are applied to the other. However, regardless of how one feels about the similarities among diseases of drug dependency, the exigencies of the current crisis surrounding the problem of drug abuse have required that a special approach be employed for an interim period.

Question 8. Assuming that our Subcommittee and the Committee determine that additional coordination, authority, and visibility are needed for the drug problem in HEW -- and, of course, this is what we determined last year -- several alternatives become available to us. I'd like your comments on each of these alternatives:

a. Pulling out NIMH from the Health Services and Mental Health Administration, creating an Institutes of Mental Health (containing Drugs, Alcohol, Mental Illness, and Miscellaneous divisions) which would report directly to the Assistant Secretary, i.e.: [Descriptive charts omitted.]

The HSMHA is the Federal agency charged with providing leadership and direction to programs and activities designed to improve health services for the people of the U.S. and achieving the development of health care and maintenance systems adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in all socioeconomic and ethnic groups. Two primary objectives underlie the broad spectrum of HSMHA's activities: (1) to make excellent and abundant health care available to all, and (2) to diminish the need for health care by application of knowledge to prevent illness, and promote good health.

The NIMH plays its part in this program with the inauguration, demonstration and support of services to promote and sustain mental health, prevent mental illness and treat and rehabilitate mentally ill persons. More than one-third of the resources of NIMH are related to the provision and support of mental health services. In addition, however, NIMH is concerned with the discovery and demonstration of new knowledge,

Question 8 (cont'd):

and both conducts and supports a large program of research. It is equally concerned with the training and development of specialized manpower to make possible the provision of the services so vitally needed.

We would be opposed to separation of NIMH from HSMHA. Mental health programs, including drug abuse and alcoholism activities, should be integrally related to general health programs. In all of our ongoing and developmental activities, such as Health Maintenance Organizations, mental health is a key consideration. The creation of coequal organizations, one concerned with general health, and the other exclusively with mental health, would unnecessarily complicate an already complex and difficult task.

b. A new, separate Drug Abuse Administration, reporting directly to the Assistant Secretary, as the Ash Commission recommended.

Establishment of a separate Drug Abuse Administration would not only require these programs to sever their present important relationships to the general health programs of HSMHA, but would also interfere with their even more important relationships to the mental health programs of NIMH. For example, much of the research conducted and supported by the Institute, while not directed at the drug abuse problem specifically, results in findings about human behavior and/or physiology which can be

Question 8 (cont'd):

extremely useful in understanding the motivation and behavior of drug abusers and the possible physiological causes and effects associated with drug abuse.

There is also a close relationship between the effort to establish community based mental health services throughout the Nation and the need to provide increased facilities and services for drug addicts and abusers.

Further, the relations between drug abuse programs and the manpower development program of NIMH, which contributes significantly toward filling the ever-increasing requirements for persons with the specialized skills needed for research and services for drug addicts and abusers, would be impaired.

The drug abuse programs of the Institute benefit from the management and support services provided by NIMH and HSMHA, which would have to be duplicated for a separate organization--a waste of manpower we can ill afford.

Other disadvantages of the isolation of drug abuse programs from other related social and health programs would be the tendency to reduce the sense of responsibility and concern about drug abuse in Departments and agencies other than DHEW, and the disruption of some ongoing programs which have well developed administrative relationships with States and localities.

Question 8 (cont'd):

In considering the establishment of a new, separate drug abuse organization within DHEW, it should be kept in mind that resources and functions probably cannot be concentrated in such a way as to make coordination with other programs and agencies unnecessary.

Question 9: Please furnish us with a document which spells out the various review procedures which are necessary for the different types of grants which HEW makes in the drug abuse area, and the average time such reviews take, along with whatever legislative or administrative recommendations which you may have about how to speed up your grant procedures? We hear numerous complaints that they take too long. Please indicate, also, how often your review boards meet -- why can't they meet more often?

National Institute of Mental Health. A grant application may be initiated by an individual researcher, a community agency or other qualified individuals. It may also be stimulated by NIMH staff, a process which may result in an application for funds or a precis of a potential application. Wherever possible, NIMH headquarters and regional office staff attempts to give consultation to any potential grantee. A grant application is received by NIMH staff, processed and reviewed by a committee of experts in the particular area for which resources are sought. Following this action, the application is reviewed by the National Mental Health Advisory Council and recommendations are acted upon within available resources. Review bodies may recommend approval, disapproval or deferral. In deferrals, the application is returned for further work and consultation is provided. Initial criteria for judging applications are found in the law and program guidelines. In addition, the committee of experts bring with them extensive knowledge of the state of the art in their respective areas and the priorities and needs within these areas.

Question 9 (cont'd):

Applications are reviewed three times each year. The National Advisory Mental Health Council meetings are held in March, June, and November each year to review applications. Deadlines for new applications range from three to five months prior to final Council review. After approval, and subject to the availability of funds, approved grants may begin as soon as the beginning of the month following Council action.

We strongly support the concept of "peer review" as a basis for quality control. The primary responsibility of each Review Committee is to select from the applications submitted those proposals which appear most likely to make significant contributions to research, training, or services in the drug abuse field.

We try to be responsive to the needs of applicants and grantees, and our procedures are reviewed periodically in an effort to simplify them and reduce the burden to applicants. For example, two separate review groups have been established for concurrent review of applications for support in the drug area. Many delays are mistakenly attributed to the review process. Often the delays are due to uncertainties related to funding. Appropriation and subsequent apportionment of funds well after the start of the fiscal year tend to contribute to the problem.

Question 9 (cont'd):

Office of Education--National Drug Education Program. Funds for this program were not received until February 1971. Guidelines for project grants were established in March with a deadline for proposals set for April 16. Teams consisting of outside consultants and staff were established to review each proposal. Because of the number of applications received, initial review of each proposal was made by only three members of the team. Those identified as highly recommended were subsequently reviewed by each team member. Those to be approved within the limitations of available funds were finally selected by staff by May 15, and funds obligated by June 30.

Social and Rehabilitation Service. Drug abuse grants under SRS programs are processed in the same manner as NIMH grants. Applications are submitted to study sections for review, then to a National Advisory Council for recommendations. The study sections and the SRS Advisory Council meet three times a year, and processing time for applications for drug abuse projects averages four months.

Question 10: One of the grant programs developed under S. 2217 allows for application for grants by groups of programs serving specific areas -- what are you doing in this area at the present time? Should we be considering local umbrella agencies through which all federal drug money should flow? Could you comment on this concept?

Part B, Sec. 411(a) of S. 2217, para. 2, states: "make grants to groups of private, non-profit agencies, organizations and individuals representing a broad cross-section of community based programs providing a broad range of services in the area to be served, to jointly establish, conduct, and evaluate coordinated drug abuse and drug-dependence prevention and treatment programs." Several of the community based treatment facilities we have established are of the type described in S. 2217. In many communities where there are several discrete agencies that offer a part of the treatment service complex that is needed for treatment of the addict, this administrative mechanism is the most obvious way to create the type of treatment program needed for the addict. This is particularly true when none of the component agencies has the ability or the interest to modify its present service to include all of the treatment capability that a good program for narcotic addict rehabilitation should have.

The use of "affiliate agencies" in the community mental health centers program has been a successful mechanism for bringing together the varied services of different agencies in an area into an integrated, coordinated program. Most

Question 10 (cont'd):

currently operating community mental health programs consist of two or more agencies that have entered into formal contractual agreements to provide specified services for the persons in their area.

By using such affiliation agreements, small drug abuse agencies, such as a storefront drop-in facility, a primarily self-help communal living program, and a teenage "hot-line" service can combine their resources with those of other larger drug abuse services. In this fashion these less traditional--but equally essential--components of a comprehensive drug abuse program are enabled to receive Federal support for their services which they otherwise probably could not obtain. Under such arrangements the Federal grant is made to the primary applicant who then in turn provides funds for specific purposes to each of the affiliated agencies.

In our administration of the NIMH drug abuse grant program we are encouraging various drug abuse agencies in an area to develop affiliation agreements with a primary applicant. This applies both to those instances where the primary applicant is a community mental health center and to those where the primary applicant is another community agency.

Question 11: Nearly a year and a half ago, Dr. Egeberg, testifying against legislation in this area being proposed by this Subcommittee, stated: "I am not suggesting that the present arrangements are the best that might be achieved. There is, as you know, an Advisory Council on Executive Organization which reports to the President and is making a comprehensive study of the organization of the executive branch with the objective of recommendations for needed improvements. The council is at present investigating the organization of Federal drug abuse activities as part of its broader mission. I am not in a position to speculate on what recommendations the council may make in this area, but I believe it would be inadvisable for the Congress to enact law relating to the subject before the council has completed its investigations and offered whatever recommendations for reorganization it feels are necessary."

In your conclusion yesterday, you stated that because Dr. Jaffe "is undertaking a review of all current laws pertaining to drug treatment, we believe that no amendments to drug treatment laws should be enacted other than those already proposed by the President."

How long do you expect that Congress should wait for legislative reviews by the executive branch before enacting supplemental legislation? May we have a copy of the Ash Commission's June, 1970 recommendations in this area? Will we receive a section-by-section comment on each of the bills which we are considering today?

Dr. Jaffe will complete his review of all current laws pertaining to drug treatment as rapidly as possible. It is our understanding that the Ash Commission report on the organization of Federal programs on narcotic addiction and drug abuse has not yet been released by the White House, and therefore we are unable to furnish you with a copy. The Department is currently preparing legislative analyses of the bills before your Subcommittee as requested.

Question 12. In New York City, a recent survey revealed that 70% of the inmates of the city jail were addicts and that approximately 95% of these individuals will return to heroin use upon their release. The New York situation is far from uncommon. It has been estimated that between 50 and 60 percent of the inmates in our big city jails are narcotics addicts and that once they are released, there is a 70 to 90 percent chance that they will return within one year.

a. What new steps has HEW taken to develop programs in prisons? Please furnish us with a list of the grants and contracts which you have made for development of prison programs.

DHEW has not developed programs for drug abusers in State and city prisons. The Department's authority under section 323 of the Public Health Service Act is limited to Federal prisoners. Services for Federal prisoner addicts are, however, provided under Title II of the Narcotic Addict Rehabilitation Act of 1966 administered by the Bureau of Prisons. The NIMH has encouraged and facilitated use by the Bureau of Prisons of NIMH contractors providing services to addicts under Titles I and III NARA. The NIMH provides the Bureau of Prisons with the names and service capacities of all of its contractors. In addition, the Institute and the Bureau have agreed to jointly fund the salaries of some service providers to encourage these providers to attend equally to criminal and noncriminal addicts.

b. Have you funded methadone detoxification programs such as that run by Dr. Dole in New York? Please furnish us with whatever written information you have on programs which are proving themselves effective in this area.

Dr. Dole administers a methadone maintenance program rather than a methadone detoxification program. The Department provides support to programs which employ these as well as other treatment modalities.

Question 12 (cont'd):

The attached charts describe programs supported by the NIMH and the Social and Rehabilitation Service.

Since the NIMH chart was prepared, additional programs have become operational or have been approved and funded. Of the 23 programs now operational, 19 include methadone maintenance as a treatment modality. Of the 22 programs approved and funded but not yet operational, 10 include methadone maintenance.

The National Clearinghouse for Drug Abuse Information is now compiling a list of all Federally and non-Federally supported drug abuse treatment programs for the new Special Action Office. I will make this available to the Committee when it is completed.

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Table T_1

NIMH DRUG TREATMENT GRANTS

Tot. Fed. Sup. FY/71	Location of Agency	Start Date of Grant	Drug-Free Therapy	Chemo-Therapy	Total Patient	Treatment Modality				
						TC	DF	MM	MM+	Other
$1,430,4[illegible]7	New York (ASA)	5-1-68	262	10	262	X				
626,758	West Philadelphia	6-1-68	18	779	797			X		
448,235	Albuquerque	6-1-68	24	401	425	X		X		
444,110	Chicago	6-1-68	258	927	1185	X		X		X
537,785	New Haven	6-1-68	93	190	283	X			X	X
447,397	St. Louis	6-1-68	51	333	384	X			X	
396,549	Baltimore	8-1-69	17	158	175		X	X		
1,073,880	New Jersey	9-1-69	538	96	634	X	X	X		
536,593	Hartford	11-1-69	254	73	327	X			X	
1,373,242	Brooklyn (ARTC)	11-1-69	27	733	760		X	X		
1,330,120	Puerto Rico	4-1-70	38	411	449	X		X		
299,204	San Antonio	5-1-70	12	283	295		X	X		
602,575	Eagleville	2-1-70	431	0	431	X	X			
404,323	Marlsboro	1-1-70	188	0	188	X	X			
262,439	Kansas City	1-1-70	6	20	26		X		X	

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Q. 12
Attach. #1
page 1

Tot. Fed. Sup. FY/71	Location of Agency	Start Date of Grant	Drug-Free Therapy	Chemo-Therapy	Total Patient	Treatment Modality TC	DF	MM	MM+	Other
$ 588,850	Detroit	10-1-70	9	207	216		X	X		
457,629	Boston	1-1-70	267	12	279	X	X	X		
365,121	Phoenix	10-1-70	200	0	200	X	X			
297,774	New Orleans						X			
923,779	Washington, D.C.					X		X	X	
653,079	Philadelphia							X		X
503,030	Pittsburgh							X		X
760,755	Miami							X		X
$13,643,000	TOTAL									

TC Therapeutic Community
DF Drug-Free non TC
MM Methadone Maintenance
MM+ Enriched Methadone Programs
Other Including Antagonists Such as Naloxone and Cyclazocine

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Attach. #1
Page 2

Tab 1

SRS TREATMENT PROGRAMS FOR HEROIN ADDICTION AND OTHER DRUG DEPENDENCIES

Locale	Period	Modality	Approx. No. Serviced	Total Expenditures
Washington, D.C.	FY 71	VR services to methadone maintained.	240	$112,000
Minneapolis, Minn.	FY 71	VR services to hospital inpatient narcotic addicts.	75	$ 27,778
Nassau County, N.Y.	FY 71	Evaluation and VR services to disadvantaged addicts.	250	$ 25,810
Hartford-Waterbury, Conn.	FY 71	VR services and counseling	75	$ 33,330
Tulsa, Okla.	FY 71	Counseling and psychiatric	25	$ 12,300
[1] Portland, Oreg.	FY 71	Individual or group psychotherapy, detoxification and medical, vocational, social, occupational, recreational, and educational services in addition to family casework services and religion.	100 clients annually	$194,095 (2nd year, $209,000; 3rd year, $207,000)
[2] Brooklyn, N.Y.	7/01/70-6/30/71	Detoxification as often as necessary under medical supervision, group treatment (Guided Group interaction model).	25 girls ages 12 - 16	$168,866
[3] Anchorage, Alaska	Not given (recently funded)	Halfway house to aid drug users in kicking their habit and re-entering society.	150-250 youths 16 - 22	$ 55,414

Note: The first five programs are in the Division of Disability Services of SRS.

There is no data available on drug dependence or addiction treatment per se from the Office of Service Delivery, SRS.

1 This program is in the Psycho-Social Study Section, Drug Abuse Research and Demonstration Projects, SRS.

2&3 These programs are funded by the Youth Development and Delinquency Prevention Administration, SRS.

Question 13: On page 10 of your statement you state: "If limited to non-enforcement issues, the Director can be effective only with authorities beyond pure coordination?" Could you expand on that? What if he is not so limited?

In his August 4 statement before the Subcommittee on Alcoholism and Narcotics of the Senate Committee on Labor and Public Welfare, Dr. Jerome Jaffe addressed himself to this question. He indicated that to accomplish his mission as Director of the Special Action Office he would need authorities over policy, budget and management, and powers to evaluate programs and to award grants and contracts. Dr. Jaffe stated, for example:

> "So that there can be assurance that the enunciated policy will be uniformly implemented . . . the Special Action Office is granted budgetary and management authorities . . . . Without this clear grant of authority to the Director I feel it would be most difficult for him to make any assurance that his policies would be carried out and most difficult for him to insure coordination of even the Federal programs."

He went on to describe the necessity for the other authorities mentioned above.

Although we do not believe that joining the enforcement and nonenforcement areas of the drug abuse program in one Office would be beneficial, we believe that were this to happen, the Director of the Special Action Office would continue to need authorities beyond pure coordination.

Question 14: On page 11 of your statement you state: "The creation of an Institute within the Public Health Service could interfere with the responsibilities of the Director of the Special Action Office, or require extensive internal reorganization within the Public Health Service." Why do you say that?

One of the responsibilities of the Director of the proposed Special Action Office for Drug Abuse Prevention is to determine how best to organize Federal drug abuse programs. To create an Institute of Drug Abuse and Drug Dependence might be contrary to proposals developed by the Director of the Special Action Office, and in fact impair the freedom he should be given to develop his recommendations.

Question 15: On page 11 of your statement you also state: "We believe the proposals within S. 2217 to establish yet additional grant programs and mechanisms should be evaluated in the context of the total authorities of the Federal government in the drug abuse area." What does that mean?

The statement referred to the review of all existing laws and authorities which is currently being conducted by Dr. Jerome Jaffe with an eye to suggesting whatever consolidations and new authorities are needed.

Senator JAVITS. I would like to join with our chairman.

Senator HUGHES. The committee will recess for about 3 minutes.

(A brief recess was taken.)

Senator HUGHES. The subcommittee will come to order.

The Chair calls Mayor Joseph Alioto, and we want to welcome the mayor and thank him for his willingness to come and testify this morning.

Mayor, we welcome you to Washington and to the subcommittee. I want to say for the record that the Chair is informed Senator Moscone was delayed, and we are going ahead with the testimony of the mayor and hope that the Senator will be here later.

Mayor, you may proceed.

Senator JAVITS. If he does not get here, Mr. Chairman, may the record be kept open for a few days to give him a chance to speak?

Senator HUGHES. Yes.

STATEMENT OF HON. JOSEPH L. ALIOTO, MAYOR OF SAN FRANCISCO

Mr. ALIOTO. Thank you very much for the opportunity to talk to you about a problem which concerns us very much. I did see Senator Moscone this morning. He came in on the "Red Eye Special," as we call it. I am sure he will be here a little later. I thank you for keeping the record open for him. He represents a view from the standpoint of the State level and I represent a view from the standpoint of the city.

I would like first of all to file the formal statement I have written, and not to read it, but to comment in connection with some things which have developed in San Francisco that I think are important.

Senator HUGHES. Your prepared statement will be put in the record at the end of your testimony.

You may proceed in any way you desire.

Mr. ALIOTO. Thank you very much. I know this problem exists not only in the big cities of America, and I had a very interesting talk recently, Senator Hughes, with the distinguished mayor of Ida Grove, Iowa, and the sheriff. The sheriff was telling me that about half a dozen drug cases turned up in the last year—marijuana, pills, and an occasional LSD trip showed up in his records and even the existence of some pushers in town.

So problems go from San Francisco and New York down to every community in the country. That is a truism now, and nobody has to spend time on it.

Let me refer specifically to the bill. I am speaking here this morning not only for the city of San Francisco, but for the U.S. Conference of Mayors. At our recent convention in Philadelphia, we adopted, after some considerable study, a recommendation that the Congress spend not $100 million but that it spend a billion dollars.

We don't think $100 million is going to begin to do the job as we view it, and I would like to discuss some of the statistics for you in just a moment.

Second, we think that you ought not set up another higher bureaucratic layer between the Federal Government and the cities. We think so far as at least 25 big cities are concerned, that we ought to have a direct relationship with the Federal Government on this most important problem.

As a matter of fact constitutionally it is the Federal Government which has preempted the field in connection with dangerous drugs, and therefore, there is no reason why we have to set up an intermediate bureaucratic apparatus at the State level, and we think you ought to deal directly with the cities.

The San Francisco Committee on Crime is a committee funded by the Ford Foundation and the city and county of San Francisco. It is a committee composed of lawyers, psychiatrists, doctors, community leaders, and others, representatives of all the minorities.

It came out with a recommendation on nonvictim crime. There are some parts of that report that are controversial and that some of us don't accept. By a vote of 17 to 9, that committee recommended marijuana be legalized. I will tell you why I don't agree with that in a moment, although I agree with all the factual bases on which that conclusion was made.

It also has a section on heroin, and I would like at this time with your permission, Mr. Chairman, to file with this committee a late report dated July 19, 1971, on dangerous drugs and narcotics, a section of our report on nonvictim crime in San Francisco, because I think it gives an interesting insight and it is a very up to date one.

Senator HUGHES. The committee will see the report is filed, without objection.

(The information subsequently supplied follows:)

THE SAN FRANCISCO COMMITTEE ON CRIME

A REPORT ON NON-VICTIM CRIME IN SAN FRANCISCO

PART III

DANGEROUS DRUGS AND NARCOTICS

Moses Lasky, Co-Chairman
William H. Orrick, Jr., Co-Chairman
Irving F. Reichert, Jr., Executive Director
Richard M. Sims, III, Asst. Exec. Director

THE ELEVENTH REPORT OF THE COMMITTEE

July 19, 1971

This Report is being submitted to the Law Enforcement Assistance Administration of the United States Department of Justice in partial satisfaction of the conditions of O.L.E.A. Grant #374.

THE SAN FRANCISCO COMMITTEE ON CRIME

Members:

Mr. Moses Lasky, Co-chairman
Mr. William H. Orrick, Jr., Co-chairman

Mr. Alessandro Baccari
Mr. Clarence W. Bryant
Mrs. Ruth Chance
Mr. William K. Coblentz
Mr. Gene N. Connell
Dr. Victor Eisner
Dr. Leon J. Epstein
Mr. Welton H. Flynn
Mr. Frederick Furth
Dr. Donald Garrity
Dr. David Hamburg
Rev. Albert R. Jonsen, S.J.
Mr. Samuel Ladar
Mr. Lawrence R. Lawson
Mr. Orville Luster
Lt. William Osterloh
Mr. Michael Parker
Mr. Stuart Pollak
Mr. William K. Popham
Mr. Lee D. Rashall
Mrs. Becky Schettler
Mr. Louis S. Simon
Mr. Garfield Steward
Mr. Edison Uno
Mr. Zeppelin W. Wong

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Mr. Richard M. Sims, III, Assistant Executive Director
Mrs. Carolyn French, Consultant
Miss Kathleen Thomas, Consultant

Secretarial Staff:

Miss Karen Hagewood
Mrs. Nancy Henshall
Mrs. Maria T. Strong

THE VOTE OF THE MEMBERS ON THIS REPORT

I. On the Marijuana Section:

FOR	AGAINST	NOT PARTICIPATING
1. Mr. Bryant	1. Mr. Baccari	1. Dr. Hamburg
2. Mrs. Chance	2. Mr. Connell	
3. Dr. Eisner	3. Dr. Epstein	
4. Mr. Flynn	4. Father Jonsen	
5. Mr. Furth	5. Mr. Ladar	
6. Dr. Garrity	6. Mr. Lawson	
7. Mr. Lasky	7. Mr. Osterloh	
8. Mr. Luster	8. Mrs. Schettler	
9. Mr. Orrick	9. Mr. Wong	
10. Mr. Parker		
11. Mr. Pollak		
12. Mr. Popham		
13. Mr. Rashall		
14. Mr. Steward		
15. Mr. Simon		
16. Mr. Uno		
17. Mr. Coblentz		

II. On the Heroin Section:

FOR	AGAINST	NOT PARTICIPATING
1. Mr. Baccari	1. Mr. Ladar	1. Dr. Hamburg
2. Mrs. Bryant		2. Father Jonsen
3. Mrs. Chance		3. Mr. Luster
4. Mr. Connell		4. Mr. Steward
5. Dr. Eisner		
6. Dr. Epstein		
7. Mr. Flynn		
8. Mr. Furth		
9. Dr. Garrity		
10. Mr. Lasky		
11. Mr. Lawson		
12. Mr. Orrick		
13. Mr. Parker		
14. Mr. Popham		
15. Mr. Pollak		
16. Mr. Rashall		
17. Mrs. Schettler		
18. Mr. Simon		
19. Mr. Uno		
20. Mr. Wong		
21. Mr. Coblentz		

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IRVING F. REICHERT, JR.
EXECUTIVE DIRECTOR

July 19,1971

Honorable Joseph L. Alioto,
Mayor of the City and County
of San Francisco,
City Hall,
San Francisco, California 94102.

Dear Mr. Mayor:

On behalf of the San Francisco Committee on Crime, we submit to you, as the Committee's Eleventh Report, a report on Dangerous Drugs and Narcotics. The Committee's term of existence, under the resolutions of the Board of Supervisors creating it, came to an end at the close of June 30, 1971, but this Eleventh Report was adopted before June 30th. The Committee's principal funding came from the Ford Foundation, and, as we informed you in our Tenth Report, Ford Foundation extended the period of its grant to July 31, 1971, to permit an orderly winding up and the publication and distribution of the Committee's reports. Because this Eleventh Report, although adopted before June 30th, has been released after that date, only funds received from Ford Foundation have been used for its publication and distribution; no funds from the City

have been used for that purpose.

All the previous reports of the Committee have been unanimous or virtually so. This is not true of the Eleventh Report. That report consists of two sections, in addition to a preliminary discussion, one on marijuana and the other on heroin. The section on heroin has been adopted by the virtually unanimous action of all members of the Committee participating. The section on marijuana has been adopted by a vote of not quite 2/3 of the participants. A 2/3 vote on any of the important and difficult subjects with which this Committee has dealt would be a notable achievement; it is particularly notable with respect to a subject so charged with emotion and fears as dangerous drugs and narcotics.

Yet, in a very real sense, there is unanimity,- unanimity that the present marijuana laws are too rigorous and repressive. Attached to the report are two minority reports which speak for themselves. One minority report states that "it is not necessarily in agreement with the existing laws and procedures which may be too punitive with respect to adults who use or possess small amounts of marijuana"; the other minority report believes that the present laws are "unreasonable" as respects the

"severity of punishment for such offenses as the possession of small amounts". And these suggestions for amelioration come on top of the fact that California law was amended to ameliorate the penalties in 1969.

The minority reports were received as the Committee Report was about to go to the printer, and therefore the Report itself does not respond. Some brief comment, however, is in order.

The present restrictive criminal laws on marijuana were adopted in the 1930's. It was then believed that marijuana made its users into dangerous criminals. No one who has looked into that subject even slightly any longer believes that. The present fears about marijuana are, largely, of two kinds: (1) That its use leads to the use of "harder" drugs, and (2) that it makes its users "amotivational", that is, that it reduces its users to a state of passive vegetation. The Report fully discusses these two questions. The consensus at the present time is that the deleteriousness of marijuana, or its extent, remains largely unestablished. Those who oppose change in the law do not appear to contend that if those laws were not already in effect it would now be appropriate to enact them in the present state of knowledge. The view of one minority

report is that, as the laws are on the books, they should stay there in view of the uncertainty of knowledge. The majority of the Committee believes that laws that would not have been adopted on the basis of present knowledge ought not be retained.

The further statement in one minority report, that the Committee has not gathered enough data on the subject, is completely unwarranted, and it is rejected out-of-hand by the Chairmen, the staff, and the majority of the Committee. The present literature is abundant and fairly uniform in its conclusions, which, as the Report states, add up to a Scotch verdict. As late as Friday, July 2, 1971, at the Commonwealth Club, Dr. Leo Hollister of the Veterans Administration Hospital at Palo Alto reported the state of present knowledge about the pharmalogical aspects of marijuana quite in accord with the majority report.

Another reason for dissent expressed in the minority reports is the belief that the repeal of present laws on marijuana may be regarded in some areas as an approval of the use of the drug and might lead to the spread of its use. The majority of the Committee does not dismiss that objection lightly; the Report discusses

it with care and gives it the weight it deserves. One minority report speaks of the Committee report as recommending "legalization" of marijuana as respects adults; the recommendation, of course, is for regulating the sale, possession and use relative to adults by a system adapted from the control of alcoholic beverages.

We realize that previous portions of our report on non-victim crime, such as those dealing with prostitution and pornography, have been carelessly read by portions of the public, including those who should know better. The Committee thoroughly deplores prostitution and has the utmost detestation for pornography. Yet our reports have been carelessly interpreted as an endorsement of these vices. We resign ourselves to a like misinterpretation that the Committee approves the use of marijuana, despite our reiteration that we disapprove the use of marijuana and encourage all non-criminal processes to prevent it.

In the last analysis, the basic question is exactly the same as this Committee emphasized with respect to every type of non-victim crime. That question is simply this: Is the criminal process the correct and effective way by which society should seek to meet a problem; are the resources of society best spent on the

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criminal process? We have said that the law cannot successfully make criminal what a substantial portion of the public does not want made criminal, and we know that a vast number of the citizenry--perhaps an overwhelming number of the younger generation--cannot understand and will not accept the marijuana laws. We have said that not all the ills or aberrancies of society are the concern of government; that when the government acts, it is not inevitably necessary that it do so by means of criminal processes; that every person should be free of the coercion of criminal law unless his conduct injures others or damages society; that when criminal law seeks to express a sense of public outrage, it should be sure that its sense of outrage is that of substantially the public as a whole. We have said that there is a matter of priorities in the expenditures of the energies and resources of criminal law enforcement. If we are correct in all these statements--and we are convinced that we are--, then we are convinced that the conclusions expressed in the majority report are also correct, and that only formless fears deter the minority members from following to its rational end their own belief that the present law needs some change.

Honorable Joseph L. Alioto 7.

Inasmuch as the reports and recommendations of this Committee on matters entirely within the hands of this City have yet to be put into effect, the Committee is not so sanguine as to believe that its recommendations on marijuana, the control of which lies in the State and National sphere, will be speedily adopted. We submit the Committee Report and the minority reports in the hope that they will, at least, encourage and focus thoughtful consideration.

The control of heroin lies even more largely in federal hands, and our report on that subject is confined to an analysis and delineation of the difficulties and to pointing out the matters to which serious attention should be given.

With this Eleventh Report, the work of the San Francisco Committee on Crime comes to an end.

Respectfully,

Moses Lasky

William H. Orrick, Jr.

Co-Chairmen

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IRVING F. REICHERT, JR.
EXECUTIVE DIRECTOR

July 19, 1971

Honorable Dianne Feinstein,
President of the Board of Supervisors
of the City and County of San Francisco,
City Hall,
San Francisco, California 94102.

Dear Mrs. Feinstein:

The San Francisco Committee on Crime submits to you with this letter Part III of its report on non-victim crime. Sufficient copies are enclosed for all members of the Board of Supervisors. We also enclose a copy of the letter by which we are concurrently submitting the report to the Mayor.

With this Eleventh Report, the work of the San Francisco Committee on Crime comes to an end.

Respectfully,

Moses Lasky

William H. Orrick, Jr.

Co-Chairmen.

ML/nh
Enclosures

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INTRODUCTION

This is the third in a series of reports by the Committee on "non-victim crimes" in San Francisco. The first report on this subject dealt with basic principles and public drunkenness. The second report discussed gambling, sexual conduct and pornography. This report covers "drugs and narcotics," concentrating on laws concerning marijuana and heroin.

Throughout our examination of laws dealing with "non-victim crime," we have been guided by the seven "basic principles" set out and discussed in some detail in Part I of this Report. We list those principles again, for they are referred to in this Report. Readers interested in the origins of these guidelines can return to Part I of this Report, which is available in local bookstores and through the Public Library. Our principles are:

1. The law cannot successfully make criminal what the public does not want made criminal.

2. Not all the ills or aberrancies of society are the concern of the government. Government is not the only human institution to handle the problems, hopes, fears or ambitions of people.

3. Every person should be left free of coercion of criminal law unless his conduct impinges on others and injures others, or if it damages society.

4. When government acts, it is not inevitably necessary that it do so by means of criminal processes.

5. Society has an obligation to protect the young.

6. Criminal law cannot lag far behind a strong sense of public outrage.

7. Even where conduct may properly be condemned as criminal under the first six principles, it may be that the energies and resources of criminal law enforcement are better spent by concentrating on more serious things. This is a matter of priorities.

The only aspect of drug and narcotic use that comes within the assigned task of this Committee or within the area of its competence is to determine the part to be played by criminal law. We cannot pass on morals.

In 1960 in California, 4,245 adults were arrested for violating laws on marijuana; in 1969 there were 38,670, an increase of over 800%. In 1960 there were 910 arrests of juveniles under the same laws; in 1969 there were about 16,000, an increase of more than 1650%. For dangerous drugs the increase was even greater, both for adults and juveniles.[1]

Other available data are equally startling. In January of this year, the Federal Department of Health, Education and Welfare (H.E.W.) reported that 31% of American college students had used marijuana by 1970, and that in that year, 42% of the students in the San Mateo County High School system asserted that they had used marijuana. H.E.W. summarized a study showing that 40% of college-age residents of San Francisco who were not in school had tried marijuana by 1969.[2]

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[1] California Bureau of Criminal Statistics, Drug Arrests and Dispositions, 1969, p. 1.

[2] United States Department of Health, Education and Welfare, a Report to Congress: Marihuana and Health, Jan. 31, 1971, pp. 35-38.

Professor John Kaplan of the Stanford Law School has estimated that in 1968 state and local government agencies in California spent $72 million enforcing the marijuana laws.[3]

In 1969, 14% of all felony arrests in San Francisco were for violating the marijuana laws,[4] but 38% of all so arrested were released without prosecution,[5] doubtless because the District Attorney's Office believed that it had insufficient legally admissible evidence. Since 1969, State Law has permitted District Attorneys to charge either a felony or a misdemeanor for possession of marijuana.[6] In San Francisco, a defendant is ordinarily charged

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[3] John Kaplan, Marijuana, The New Prohibition, World Publishing Co., 1970, p. 29.

[4] California Bureau of Criminal Statistics, Crime and Arrests, Reference Tables, 1969, Table II, p. 22; Drug Arrests and Disposition In California, Reference Tables 1969, Table IV, p. 9.

[5] This figure was computed by Mr. Bruce Johnson, a sociologist at the University of California at Berkeley, in connection with a study of felony release rates prepared for the Crime Committee in December, 1970. Mr. Johnson's source data consisted of Monthly Adult Felony Arrest Reports submitted by the San Francisco Police Department to the California Bureau of Criminal Statistics.

[6] See Sec. 17 Penal Code, as amended, Sec. 11530 H. & S. Code.

with a misdemeanor if he has no prior record of drug or narcotic convictions and he has been arrested for possessing not more than a "lid" (about one ounce) of marijuana. About 15% of all Municipal Court cases in San Francisco[7] involve either possession of marijuana or "visiting a place" where marijuana is being used.

Someone has said that statistics are used the same way a drunk uses a light standard, for support and not for illumination. Advocates for the repeal of criminal laws on marijuana and other drugs point to statistics like the foregoing as demonstrating that criminal law does not deter the use of these drugs. Another explanation would be that the social and economic conditions of the 1960's produced an upsurge of use that might have been even greater but for criminal laws All that is speculation. We cite the statistics for the neutral purpose of showing the gravity of the problem, the enormous drain on law enforcement money and manpower, and the lack of satisfactory effect of all this effort.

Clearing the Underbrush

This subject of drugs and narcotics is the most difficult to analyze and resolve of all those discussed in our Report on "Non-Victim Crime." A major difficulty is that the discussion in

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[7] Based on all cases filed in Municipal Court Departments 9 and 10, January 1, 1971 - May 1, 1971.

the literature is bedeviled with hyperbole, emotion, irrational argument and pedantic quibble.

On the threshold, we note that to categorize the subject as non-victim crime is itself to vault to a conclusion over thorny obstacles. "Drugs and narcotics" are placed in that category because the user acts voluntarily But whatever may be said about using drugs, the act of selling is not non-victim conduct in the case of a drug like heroin which addicts the user; one deprived of either physiological or mental power to resist is no longer a "voluntary" participant. Thus whether the act of selling can be categorized as non-victim conduct depends upon the nature and effect of a particular drug. Nor is it all crystal clear that the act of use is non-victim conduct; society can be the victim in several ways. For example, we said in Part I of this Report on Non-Victim Crime that:

> If it could be shown that the use of marijuana threatens to reduce the next generation to a state of passive vegetation, devoid of the drive that made this nation the haven of all peoples, no stronger reason would be needed for seeking to eradicate the use of the weed by almost any means.

This states a possibility. No evidence yet discovered by us shows it to be a probability, but the reported use of heroin among the troops in Vietnam could pose a worse threat to the future of the

country. The use of drugs and narcotics could also be an injury to society in ways less sweeping than that of the destruction of a generation of youth. For example, it would be so if its use were frequently to induce violent or aggressive behavior toward others. It would also be so if drug use were to make ordinary and gainful employment by the user difficult or impossible, for society would then have loaded upon its back the costs of support and medical care.

Discussion is also handicapped by the extreme positions taken by partisans on the one side or the other. At the one extreme, users are assailed as immoral or indecent, as "freaks" or misfits or as a disgrace to society. This kind of reaction gets one nowhere; the law would have no business whatever trying to prohibit adults from using drugs to get "high" or to alter their perceptions unless injury to society were also present. At the other extreme, society is itself assailed as the very cause of the abuse of drugs. It is argued that, while people resort to drug abuse for a variety of reasons, psychological or psychotic illness, or to find new experiences, or to do what their peers do, the unifying explanation is that drug abuse represents an attempt to reconcile serious contradictions between self and society. It is no accident, we are told, that until recently heroin was a problem confined to the ghettos of this country, and that, when young people are asked why they turn to drugs, their reply is almost uniformly that modern urban mass society is becoming increasingly inhuman. The blame is laid on

pollution, racism, poverty, "loss of identity," and so on and on. When so many young people are unable to "integrate with society," when they turn to drugs as only one of a number of means of escape, it is time to look hard at society: so the assertions go.

All this may be true, or it may be only the fashion of the moment to say so. Perhaps the causes are in the very structure of contemporary civilization. And if society could find the causes and root them out, it should do so. But that truism gets us nowhere in finding an answer to the only aspect of drug and narcotic use that comes within the assigned task of this Committee or within its area of competence, which, as already observed is to determine the part, if any, to be played by criminal law.

In the previous paragraphs we have sometimes spoken of "drug abuse" rather than "use," and of "dangerous" drugs instead of merely "drugs." We have done so to avoid the pedantry of being told that coffee, tea, nicotine and alcohol are drugs or narcotics, that there are legitimate drugs and legitimate uses for even dangerous drugs and narcotics, that "dangerous" drugs and narcotics can be administered and controlled in small doses without harm, and that even drugs like aspirin can be harmful if abused. All that is true; even LSD might have a legitimate use in the hands of expert researchers; marijuana was once prescribed by physicians for some

purposes. But observations like these simply enmesh rational analyses in irrelevant distinctions. Suffice it to say, once and for all, that when this Report speaks of drugs, it means "dangerous drugs" within the meaning of current law, and when its speaks of use it means "abuse."

Another red herring frequently drawn across the path of rational consideration is the assertion that alcohol is far more injurious to the user and society than any other drug whether legal or illegal. The late Louis S. Goodman, Chief Judge of the United States District Court in San Francisco, used to comment impatiently on the habit of attorneys to defend a charge of wrongdoing with the riposte that someone else or some other conduct was equally as bad or worse. The use of alcohol is as old as mankind and is to be found in every civilization and culture; in a sense it is symbiotic with man himself. Whole ways of living and coping with it have arisen, and mankind evidently must endure it while enjoying it. Efforts to eradicate its use have failed. The fact that alcohol is abused to the injury of society is no reason whatever for permitting the introduction and spread of other abuses not yet so ingrained in our social structure, even though they may not be so harmful, providing it is reasonably possible to prevent them. Nor should the effort to prevent them be deterred by cries from the young that their elders are guilty of "hypocrisy." The history

of the use of alcohol can, however, teach us one valuable lesson. The failure of the Volstead Act and the 18th Amendment does warn us that criminal sanctions do not work when a large segment of society is opposed to them and that, on the contrary, severe prohibition can produce evils such as organized crime. If, in what we have said above, we have expressed some impatience with certain arguments for change in drug laws, we have equal impatience with opponents of change when they speak of "legalizing (or illegalizing) marijuana or heroin." Any drug is a mere physical object. It can be neither legal nor illegal. All that can be made illegal is human conduct. The appropriate question, therefore, is: What human conduct with respect to a given drug or narcotic should be illegal? With the question thus properly stated, one can begin to distinguish between types of conduct instead of making lump judgments.

Each type of drug or drug abuse must be examined on its own and handled on its own. To that end we now review the subjects of marijuana and of heroin. We shall not touch on other substances in this Report. We refrain from doing so for lack of time and study.

A. Marijuana[8]

This Committee does not condone or endorse the use of marijuana or any drug that may be mind-altering. On the contrary, we deplore that use and encourage searching for proper and successful ways to discourage it. But the assigned area of concern of this Committee is to determine what part criminal law should play in discouraging that use.

The starting point of that consideration ought to be a determination of what deleterious effects marijuana produces. No member of this Committee is persuaded that marijuana is not really injurious to the user or only mildly so. Rather, we simply find the whole voluminous literature unsatisfactory. Partisans on both sides are intemperate, untrustworthy and unreliable; the conclusions drawn by more temperate and sober writers from their data are unpersuasive.

On the one hand we know that the active ingredient in marijuana is the same as produces hashish, and that historically hashish has been considered an evil in the Oriental countries of its use. Despite the fact that defenders of marijuana often cite the findings of the Indian Hemp Commission of 1894, India today prohibits hashish. On the other hand, medical studies are cited, from the

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8 Because of correct pronunciation of this Mexican word, its spelling is sometimes anglicized as "marihuana," as in the Report of the U. S. Department of Health, Education and Welfare.

La Guardia Report of 1944 to a recent report of the United States Department of Health, Education and Welfare[9] and a more recent one by Dr. Lester Grinspoon.[10] The various reports become involved in quibbles about what constitutes "addiction;" the defenders of marijuana claim that it is not addictive because there are no physical withdrawal symptoms, their antagonists retorting that its use creates psychic dependence. One group asserts that the use of marijuana causes users to abandon motiviation and to become socially indifferent; the rejoinder is that "present evidence does not permit the establishment of a causal relationship between marihuana and the amotivational syndrome."[11]

The antagonists of marijuana argue that its use leads to the use of harder drugs. The soberest reply is that it does not "necessarily" do so "directly," and that the fact that a high percentage of heroin addicts have used marijuana is a coincidence stemming from the character of the users.[12] While the evidence is that a large percentage of heroin users have used marijuana, the evidence does not show that a large percentage of marijuana users

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9 U. S. Department of Health, Education and Welfare, Marihuana and Health, a Report from the Secretary to Congress, January 31, 1971.

10 Lester Grinspoon, M D., Marijuana Reconsidered (Harvard University Press, 1971).

11 H.E.W. Report, p. 10.

12 Id. at p. 16.

have turned to heroin. Advocates of change in the marijuana laws sometimes do concede that denizens of the drug sub-culture use a variety of drugs and, starting with marijuana, move on to others. But they argue, quite persuasively, that what throws the marijuana user into the drug sub-culture is the fact that its sale and use are made illegal, forcing the user to procure it from drug pushers and to use it in drug-oriented surroundings.

Neutral observations concede that psychotic episodes have followed use in high dosages and even use at levels of social usage "in particularly susceptible individuals."[13] Dr. Grinspoon has written:[14]

> While there can be no question that the use of psychoactive drugs may be harmful to the social fabric, the harm resulting from the use of marihuana is of a far lower order of magnitude than the harm caused by abuse of narcotics, alcohol, and other drugs. Marihuana itself is not criminogenic; it does not lead to sexual debauchery; it is not addicting; there is no evidence that it leads to the use of narcotics. It does not, under ordinary circumstances, lead to psychoses, and there is no convincing evidence that it causes personality deterioration. Even with respect to automobile driving, although the use of any psychoactive drug must perforce be detrimental to this skill, there exists evidence that marihuana is less so than alcohol. Marihuana use, even over a considerable period of time, does not lead to malnutrition or to any known organic illness. There is no evidence that mortality rates are any higher among users than nonusers; in fact, relative to other psychoactive drugs, it is remarkably safe.

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13 Id. at p. 11.

14 Grinspoon, pp. 25, 26.

This hardly exonerates marijuana; comparison of marijuana with alcohol or other drugs is, as we have suggested, an irrelevance. But, on the other hand, Dr. Grinspoon's statement adds up to no severe condemnation.

The Crime Committee concludes that it cannot return a verdict about marijuana of either "guilty" or "not guilty." We return a "Scotch verdict" on the present evidence; that is, the evils of marijuana use are not proved. With that verdict, what is the question to be answered? It is not whether marijuana should be used. Every member of the Crime Committee opposes its use. The question is something entirely different. The critical question is this: How far is the criminal law justified in imposing its criminal sanctions on a not proved verdict?

Bearing in mind that the physical object -- marijuana -- can be neither legal nor illegal and that only human conduct can be, the question must be separately asked relative (1) to minors and (2) to adults. And as respects adults, it must be separately asked of (a) use, (b) possession, (c) sale, and (d) commercial exploitation.

1. Sale of Marijuana to Minors and Possession by Minors

The fifth principle stated in Chapter I of Part I of this Report on Non-Victim Crime is this:

Fifth principle: Society has an obligation to protect the young, and it may be appropriate for government to intervene by imposing criminal controls on adult relations with the young although controls on similar relations between adults would not accord with our other principles.

The doubts about the effect of marijuana compel us to recommend continued prohibition of sale to minors. An adult may be left free to take chances on his own condition, to play Russian roulette if he will with his own mind and character. By definition, a minor is not yet mature enough to reach sound judgments for himself, and doubt should be resolved for the minor's protection. With the trend toward reducing the age of majority to 18, the young will soon enough reach the age of choosing their own route. The law prohibits sale of alcoholic beverages to minors, although alcohol has long been with us; marijuana, a relative upstart, should fare no better. The prohibitions on use of marijuana by minors should parallel those with respect to alcohol.

2. Use of Marijuana by Adults

The case as to adults is different. And it is different for several reasons.

First, as we have seen, the verdict on marijuana is a "Scotch verdict" -- not proved. Certainly, on a not proved verdict, criminal law cannot impose its criminal sanctions on the user who is more a victim than he is a perpetrator of evil.

Opponents of change in the law argue that if the evidence is uncertain, the status quo should be maintained by leaving the law as it is. But those laws originated when legislators assumed that the dangers of marijuana were far worse than a dispassionate examination of the evidence now available warrants. If that evidence would not warrant enactment, now, of the highly restrictive laws presently on the books, it cannot justify their retention. In a free society there ought always to be a presumption against illegalizing conduct until evidence is produced to warrant criminalization.

In the second place, educators tell us that by casting the whole marijuana scene into a criminal underworld, minors are estranged from sound counselling. It is said that minors can more readily be deflected from use of marijuana if it is regulated and controlled as alcohol is.

Finally, our conclusions are fortified by the socially injurious consequences flowing from attempts to enforce the present statutes. We find, in the literature on the subject the following, which we are persuaded do exist.[15]

(1) Users of marijuana, mainly the young, perceive no rational distinction between the dangers of alcohol and cigarettes and those of marijuana. Consequently, "massive numbers of young people today

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[15] John Kaplan, "Marijuana" supra, note 3, contains a convenient portrayal of these consequences. While we do not agree with all of Professor Kaplan's book, there is much useful material in it.

regard the marijuana laws as one of the clearest examples of their elder's hypocrisy." And since numerous young persons have used marijuana, widespread disrespect for law and for law-making institutions has arisen. (The invalidity of the charge of hypocrisy would not alter the fact that young people believe it.)

(2) By exaggerating the dangers believed by the young to be possessed by marijuana, the law degrades its educational effect with more dangerous drugs.

(3) Because the enforcement of marijuana laws requires the police to conduct searches of persons, homes and cars for small quantities, feelings of hostility toward the police are created.

(4) Possession of marijuana has come to be associated with several identifiable segments of society -- those with long hair, juveniles and ethnic minorities. Enforcement "...contributes to the hostility of three groups that one might most wish to bring into the mainstream of our society: the alienated middle-class drug-user, the high school youth, and the inhabitants of our urban Negro and Spanish-American ghettos." [15a]

To this list may be added the fact that use of marijuana has made its way to some extent into the San Francisco middle-class business and professional communities. As was said in Part I

[15a] Kaplan, supra, p. 42.

of this Report:

> The law cannot outrun the public conscience -- not simply the public conscience as professed from its pulpits and by its public figures, but the public conscience as demonstrated by how the public lives.

The soundness of our recommendation that the law cease criminalizing the use of marijuana or a visit to a place where it is used is fortified by the fact that the courts by and large have come to look with distaste on enforcing these laws. A defendant who pleads guilty in San Francisco to a misdemeanor charge for one of these violations is likely to receive a suspended sentence with a year's probation; and some judges will impose a $50 fine. In 1969 the courts disposed of the cases of 328 defendants who were originally charged with felony possession but whose charges were reduced to the misdemeanor "visiting."[16] Consequently, of the 702 felony cases pending in Superior Court in San Francisco on May 1, 1971, only 43 involved isolated charges of possession or sale of marijuana.[17] During the same year only one person convicted of a marijuana offense in San Francisco was sent to state prison, and

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[16] San Francisco Police Department, Annual Report, 1969, p. 173. The common practice of reducing a charge of felony possession to "visiting a place," a misdemeanor, has since become infrequent, because state law was amended in 1969 to permit charging possession of marijuana as a misdemeanor. See Sec. 17 P.C.

[17] Source: List of Cases Pending, prepared by the San Francisco District Attorney's Office. In addition, there were 56 pending cases in which a marijuana charge was joined with other felonies.

over 75% were given straight probation.[18] In the entire state during 1969 only 1.7% of those convicted of felony possession of marijuana were sent to prison, and 56% were placed on straight probation without any jail time at all.[19]

One of the principles stated in Part I of this Report was that even where conduct may properly be condemned as criminal under other principles, "it may be that the energies and resources of criminal law enforcement are better spent by concentrating on more serious things. There is a matter of priorities." That principle is particularly applicable to marijuana where it is dubious that use should be made criminal under any principle. Because possession of marijuana is still a crime, the police spend considerable time and energy on the matter. Then each case is handled by a Deputy District Attorney, and many cases are handled by the Public Defender's Office. As already noted, 15% of all cases in the Municipal Court deal with marijuana, and they consume the time of a judge, a court reporter and two bailiffs. Yet, in the end, most of those convicted are treated with more leniency than common drunks. The judicial system is recognizing that it has more important things to do than to spend time and resources on processing most defendants arrested for possessing marijuana.

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[18] California Bureau of Criminal Statistics, Felony Arrest Dispositions in San Francisco, 1969, Table 2.

[19] California Bureau of Criminal Statistics, Drug Arrests and Dispositions in California: Reference Tables, 1969, Table 33, p. 33.

Another perversion of priorities worked by the marijuana law is with respect to the work of the San Francisco Police Crime Laboratory. That agency is responsible for conducting various scientific tests - for the police and the District Attorney - ranging from blood types to tool mark identifications. Currently it employs a criminologist and three assistants.[20] According to charts prepared by the laboratory, each criminologist handled slightly more than 200 narcotic cases in 1960, but in 1969 this peaked at 1000 (nearly five times as many), declining slightly to about 900 in 1970. The total number of narcotic cases in the laboratory in 1960 was about 400; in 1970 it was over 3,900, an increase by a multiple of about 10. During the same period the number of criminologists increased from only two to four, and the laboratory estimates that 38% of its staff time is now devoted exclusively to marijuana analysis alone.

The number of many other scientific tests, normally associated with serious offenses, has decreased. A summary of crime laboratory cases for the years 1960, 1969 and 1970 is found in Appendix A to this Report, but we note the following here.

In 1960 the laborabory processed 106 casts (either plaster, moulage or silicone) but only eight casts in 1970. It performed

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[20] Between 9 and 11 police officers are also assigned to the laboratory's "mobile units," which travel to the scene of crimes and collect evidence.

182 blood analyses in 1960 but only 85 in 1970. It made 170 tests for semen in 1960 and only 64 in 1970. It performed 19 microscopic examinations on hair and fibres in 1960 and only 5 in 1970.

The statistics for 1970 may be imprecise; an unknown number of tests may not be tabulated in the official report. Moreover, more criminal cases were disposed of on a plea bargain in 1970 than in 1960, and where a case is disposed of by a negotiated plea rather than trial, the crime laboratory may not have to perform tests. Nonetheless, the fact remains that the number of laboratory tests associated with serious offenses has declined during a period when offenses of the identical type reported to the police have more than doubled.[21] Criminologist Williams estimates that his staff would have to be doubled to do all that it should be doing. During the same period the "clearance rate" for serious crimes -- murder, manslaughter, forcible rape, robbery, burglary, aggravated assault, larceny and auto theft -- has declined by nearly a third to about 13% of all reported cases.[22]

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[21] From 30,919 actual Part I offenses in 1960 to 83,481 in 1970. San Francisco Police Department, Annual Report, for years indicated.

[22] Id. A case is "cleared" when the police believe that it is "solved," either by arrest, by the death of a known suspect, by a discovery that the reported crime did not, in fact, take place, etc.

The conclusion of the Crime Committee is that the demonstrable harm associated with marijuana does not justify the voracious demands on the resources of criminal justice made by the marijuana laws. The police, court system, and correctional resources are desperately needed to handle matters demonstrating greater harm to society. Add to these "economic" costs the social costs of the marijuana laws, and we have no doubt that the use of marijuana should be handled outside the criminal justice system.

Consequently, the Crime Committee recommends:

> Repeal the laws prohibiting the use by adults of marijuana and prohibiting adults from visiting a place where marijuana is used as now provided in the California Health & Safety Code Section 11556.

If and when medical evidence is developed that shifts the verdict from non-proved to guilty, this recommendation can be reconsidered.

3. Possession of Marijuana by Adults

Thus far we have been speaking of use of marijuana and of visiting a place where it is used. We still must answer the question, what should be recommended about possession and sale.

The answer about possession is relatively easy. Possession of a "small" amount is probably for personal use and should be treated the same way as use, that is, it should not be made criminal. Possession of a "large" amount should be treated the same way as

sale, since there is a reasonable inference that one who possessed a "large" amount will either sell it or give it away. A "large" amount is an amount more than sufficient for one person's use for several days, and, when and if it should be necessary to make the distinction, it may be left to testimony before a legislative committee to determine the dividing line.

4. Sale of Marijuana to Adults

Curiously, writers who almost feverishly oppose the marijuana laws become uncertain of their ground when they turn to consider sale to adults. We encounter proposals for a system of government monopoly of sale or government licensing of a limited number of vendors. We are not impressed by the proposal. The sale of marijuana to adults can be regulated by laws on the general order of those regulating alcoholic beverages. We recommend simply that sale of marijuana to adults, within that kind of regulation, should not be subjected to criminal sanction unless and until medical evidence, by moving the verdict from "not proved" to "guilty," requires reconsideration.

We are impelled to this conclusion by two sets of considerations:

1. Government monopoly presupposes that the traffic is evil and therefore not to be left in private industry. But if the

traffic be evil, organized society should not indulge in it.[23] Moreover, any system of licensing that is more selective or restrictive than our present system of alcoholic beverage control is fruitful for bribery and corruption.

2. The fourth principle set forth in Part I of this Report was:

> When government acts, it is not inevitably necessary that it do so by means of criminal process. * * * The methods of the criminal law may be ill suited, or there may be better ways of achieving an end, better ways to deter or rehabilitate than to arrest, charge with crime, prosecute, convict and sentence.

By criminalizing manufacture or sale of various drugs and narcotics, what the law hopes to accomplish is: (1) To deter the manufacture, or (2) to deter those who might use or experiment with the drugs or narcotics by stamping them with a stigma of dangerousness, or (3) to rehabilitate the offender.

Criminal law has not been spectacularly successful in achieving any of these goals. Where the evil is great, even modest success will justify the effort. Where the evil is dubious, that is no longer true. The lack of success in achieving its goals as respects marijuana seems inherent in the nature of the thing sought to be regulated. If the threat of criminal sanctions is to have

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[23] Addictive narcotic drugs pose a unique problem. Whether society should engage in the traffic of that peculiar evil is discussed later in this Report.

any effect, there must be a real fear of arrest. But usable quantities of virtually every illegal drug or narcotic can be carried or secreted in a coat pocket, glove compartment, drawer or other hiding place, and ordinarily in a private residence. Police detection of the "crime" is extraordinarily difficult. The contrast with robbery, burglary, assault, rape, homicide or auto theft is striking, for in these offenses the offender must intrude upon others or accomplish his crime in a public place, with greater chances of identification, detection and arrest.

Of course, the deterrent effect of making conduct criminal depends only partly on the fear of arrest. Perhaps in greater degree it rests on the stigma of social disapproval or social warning of danger. By making the possession of certain drugs illegal, the law announces that their use will result in harm to the user. But this warning of dangerousness has not been taken seriously. To the extent that criminal laws declare that certain drugs are dangerous or harmful, they are widely disbelieved by a sizable segment of young people simply because these laws are handed down by the "establishment." Moreover, young people in their twenties and even into their thirties are the largest users of marijuana. Having used marijuana, innumerable young persons believe that they have discovered for themselves that the harms from the drug are not nearly so grea as the law had

claimed. Whether their judgment in this respect is sound is irrelevant. The relevant fact is that they believe it. Some even carry this belief into distrust of warnings about the harms resulting from hard drugs.

If the sale of marijuana were no longer criminal, the cost of acquiring it would decline, for it can grow almost anywhere. There would then be no incentive for purveyors to push it, unless it can be merchandised and exploited on a large scale just as cigarette manufacturers have exploited cigarettes and brewers have exploited beer with suggestions that the use of cigarettes or beer creates virility and allure.

5. Commercial Exploitation

Advertising of marijuana should be prohibited. The very doubts which call for legalizing use call for prohibiting mass enticement to use. While no longer criminalizing use, society should continue efforts to educate against use; and those efforts would be out-matched by multimillion-dollar advertising budgets spent by the equivalent of the large cigarette companies. Were advertising permitted, any change toward prohibiting marijuana, if and when new evidence developed, would encounter the entrenchment of vested interests. Nicotine and alcohol have become vested. There is no reason to permit this to happen with marijuana.

The sale of marijuana should not become "merchandising " To that end interstate and foreign commerce in marijuana should also be prohibited, as a way of keeping the sale of the drug from becoming a large-scale operation. On the other hand, if importation into the state is prohibited, it seems evident that production of marijuana within the state must be permitted to avoid restoring the business to black market operation. Production for sale should be subjected to regulations paralleling those governing production of alcoholic beverages. Included in this type of regulation could be provisions fixing standards of potency, particularly maximal limits. Also included in this type of regulation could be stiff taxation, as in the case of alcoholic beverages. The tax should not be so stiff, as in the case of "hard" narcotics, as to drive the business underground into the hands of pushers and racketeers, but stiff enough to dampen demand and discourage idle experimentation.

More on Whether Criminalization Should Be Retained as a Deterrent

Some people who follow the chain of reasoning that has led us to our conclusions, admitting the truth of every link in the chain, balk at the end at the conclusion. They do so out of an uneasiness or tormenting fear that if criminalization is abandoned, many people will take to marijuana who do not use it now. Nobody knows the certain answer. Repealing prohibition of marijuana use might result in an increase of use of awhile by some people. Probably most of those who would turn to the weed would try it only once or twice as an

experience but would soon drop it or use it only occasionally. A few might go on to frequent use. But, in order to appraise what injury to society would follow, we must consider once more the physiological aspects of marijuana use. Unlike heroin, use of marijuana is easily ended. The hard narcotics produce an irresistible "craving;" lack of the drug produces the tortures of "withdrawal;" continued use produces increasing "tolerance," so that more and more is needed to obtain the desired effect. One thing about marijuana that seems clear is that its use does none of these things. There are no withdrawal symptoms; there is no increasing tolerance; craving is psychological, as with cigarettes, not physiological. In short, if some spread of use should follow repeal of prohibitions, it is likely to be a transitory phenomenon, subject to reversal by education without the counterproductive effect of the policeman's billy club and the filthy jail.

Moreover, the fear that repeal will lead to a spread of use is, we think, more a subconscious reaction than a rationally held belief. Many who oppose repeal favor reduction of the penalties. Indeed, California has already moved in that direction and if California fails to move even further, it may well be left behind the march of events throughout the nation. If continued criminalization is justified as a deterrent, reduction of penalties will diminish the deterrence

and leave the laws largely dead letter, resting in the books for use by police or prosecutor whenever it suits their purposes.

If one favors reduction of penalties, if he believes that smoking a half "joint" is no basis for being imprisoned, then he does not really think that the use of marijuana is a serious injury to society. Continued prohibition of use then becomes nothing more than an expression of moral condemnation. And moral condemnation is no basis for criminal law.

Among the seven basic principles enumerated in Chapter I of Part I of our Report on Non-Victim Crime was this:

> Sixth principle: Criminal law cannot lag far behind a strong sense of public outrage. This is the other side of the coin from the first principle. Although criminal law cannot outrun the public conscience in condemning conduct, neither can it hold aloof entirely from a public sense of outrage. If the law suffers when it tries to do too much, it also suffers when it does not do what most people feel strongly that it ought to do. Because the sixth principle acts as a counterbalance to some of the others, it must be applied with great circumspection. Before applying it one must be certain that his personal sense of outrage -- his personal morals -- or that of his group is that of the public as a whole.

It appears to us that the opposition to change of the marijuana laws expressed by many responsible people is explicable only under a variation of this sixth principle. It is not so much a sense of

outrage but a fear or terror of something unknown. The majority of the Committee is unable to see in the evidence any valid basis for that fear; the majority does not believe that unsupported fear is enough basis for keeping and trying to enforce laws that divide the generations so sharply.

Recapitulation

The sum of our recommendations concerning marijuana is as follows:

1. Repeal the laws prohibiting the use by adults of marijuana or forbidding adults from visiting a place where marijuana is used.

2. Repeal the laws prohibiting possession by adults.

3. Repeal the laws prohibiting sale of marijuana to adults and regulate sale to them by laws on the general order of those regulating alcoholic beverages.

4. Continue to prohibit sale to minors and possession by minors.

5. Prohibit any advertising of marijuana.

6. Prohibit the importation of marijuana into California (probably would require federal action).

7. Regulate the production of marijuana in California for sale by laws similar to those regulating the commercial production of alcoholic beverages.

8. Devise and expand a vigorous educational campaign about marijuana.

We do not propose that society discontinue efforts to deter people from using marijuana. Its use is probably not as deleterious as its most earnest detractors say, but certainly people would be better off without it. In an age when human wits are most needed, they should not be subjected to manipulation or alteration by drugs. We simply conclude that the criminal process is not the way to go about achieving the goal given the present state of evidence. Indeed, removing the stigma of criminality may remove the attraction of the illicit and eliminate the impetus to use that comes from bravado.

Criminalization has failed; we suggest that society now try non-criminalization.

We have one more recommendation: Until such time as the laws on marijuana are changed, what should the authorities in San Francisco do about enforcing them? In the Chapter on basic principles we said:

> The following chapters of this Report will propose the repeal of certain laws. Obviously, the City of San Francisco has no power to repeal State or Federal statutes. But until such time as Congress or the State Legislature sees eye to eye with San Francisco, this City can choose what it will enforce, for its coffers pay the bills. It can choose its priorities. If it should decide that it is poor policy to 'bust' a small gambling game in the Fillmore, the police need

> not arrest and can preserve its manpower for more vital work. If an arrest is made, the District Attorney need not prosecute. However, lest there be misunderstanding, we emphasize two cautions. The first is that once a case reaches a court, no judge is free to ignore the law or make up his own rules. But matters need not reach the courts. Jurists have long recognized that a system of criminal law would break down were there no play in the hinges, points where the officers of justice can exercise discretion. Our second caution is that individual policemen cannot be let to decide what laws to enforce or when. What we say is that, pending repeal of legislation, all the agencies of justice, under strong central municipal leadership, can together lay down a policy to follow, open and above-board, and proudly declared to the State and Nation.

We recommend that course with respect to marijuana to the end of laying out a policy of action as close as is possible to what it would be under the kind of law we recommend.

At the risk of repetition but so that a hasty reader may not be misled, we conclude by saying: No responsible reader of this Report should take the Crime Committee's recommendations regarding marijuana to mean an endorsement of marijuana's use. On the contrary, we oppose its use by anyone, but we believe that our present criminal laws on the subject do more harm than good in forwarding that opposition.

B. Heroin

When one turns from marijuana to the "hard" drug heroin, a wholly different set of considerations is apparent.

The use of heroin is unmitigatably bad. It is destructive to the user, and it is destructive to society. No one is more contemptible than the vendor or pusher who "hooks" another into use for the sake of profit. If society is ever justified in punishing anyone for the sake of revenge and detestation rather than for determent or rehabilitation, it would be justified in doing so to the vendor of heroin. And as already said, the sale of heroin simply is not properly in the category of non-victim conduct.

The problem with putting down the use of heroin is simply one of efficacy. What method will really work? Once again the question must be divided into user and supplier. And the first question is what to do with the supplier.

1. Possession and Sale of Heroin

We recommend that present laws making the sale of heroin criminal be kept in effect and enforced. Possession by an addict of a "small" amount is probably for personal use and should be treated

the same way as use, a subject discussed below. Possession by an addict of an amount greater than one's personal needs for several days should be prohibited as being possession for sale. Possession of any amount by a non-addict (other than a physician or researcher) should be treated as possession for sale.

But this is not enough. Little is accomplished by catching and punishing the local pusher who is himself likely to be an addict and in any event, as a retailer, is a relatively minor cog in the distribution machinery.

The addict pusher needs treatment. The non-addict pusher belongs in prison. But the local pusher is "small potatoes" in the problem.

Heroin is an opium derivative. Either it or the materials from which it is made come entirely from abroad. The major effort must be that of the federal government to stop importation, or, if possible, to cut off the source by inducing foreign countries to discontinue cultivation. What local police can do is minor. This Committee is primarily concerned with recommendations that can be carried out by the City Administration or by state law, and it is not for us to make recommendations to the federal government in the area of international relations on how more effectively to prevent the cultivation of the opium poppy or the importation of heroin.

The unvarnished fact is that the present system of illegalizing sale contributes to making the problem infinitely worse, unless something more is done. It makes the price of heroin enormously high. Thereby it makes the profits of the illicit business attractive, it becomes profitable to "hook" an innocent and convert him into a permanent customer. It drives the customer to crime to support a habit that levies a crime tax on society of $100 per day per addict. An average habit costs the user conservatively $20 per day,[24] and it is estimated that in order to fence enough to support an average habit costing $20, an addict must obtain in some manner $100 worth of property each day. Estimates of the number of addicts in the City vary, but the lowest estimate given the Committee in a survey of drug-treatment facilities in the City[25] puts the figure at 5,000 addicts. This means that if only one-half of San Francisco's minimal addict population steals only one-half of what they need to support their habits (getting the rest by pushing, pimping, hustling, or working at an honest job)

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[24] A study of 435 patients at the Haight-Ashbury Free Clinic, surveyed between November, 1969, and May, 1970, revealed that 47% had a habit costing less than $50 per day, while 38.2% had habits costing between $50 and $100 per day. About 15% of these patients had habits in excess of $100. See: Gay, Bathurst, Matzger, and Smith, Short Term Heroin Detoxification on an Outpatient Basis, Haight-Ashbury Free Clinic, 1970.

[25] Conducted during May, 1971.

addicts are responsible for more than $45 million dollars worth of property crimes in San Francisco each year. That amount of property loss exceeds the annual budget of the Police Department.

The circle is vicious, so vicious and so serious as to justify some bold experimentation. That experimentation cannot be done at the local level because the field is controlled by the federal government with its prohibitions, although changes of federal law can be supplemented by local activity.

Experimentation should start by examining what other countries are doing to ascertain their successes and failures. In England, the control of narcotic drugs by physicians was first defined by the Dangerous Drugs Act of 1920.[26] In the several years following passage of this law, there was considerable confusion as to the circumstances under which the law allowed physicians to prescribe heroin and morphine to addicts.[27] Consequently, a committee of the Ministry of Health - the Rolleston Committee - was appointed to bring more certainty to the interpretation of the law, and in 1926 this committee issued a report recommending that physicians be allowed to prescribe narcotics to patients who, after serious

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[26] 10 and 11 Geo. 5, c. 46 (1920).

[27] This history is found in Lindesmith, "The British System of Narcotics Control," 22 Law and Contemporary Problems, 140 (1957).

attempts at rehabilitation, were unable to abstain from drugs.[28] Physicians were given wide discretion as to dosage and patients were not required to register as addicts with any public authority. These guidelines of the Rolleston Committee defined the perameters of narcotic control in the United Kingdom until 1968.

For awhile this method of treating the problem seemed exemplary. The number of British addicts was small -- in the hundreds -- as opposed to the thousands of addicts in New York City alone. They were mostly middle aged, employed, and not involved in crime. Like the 19th century addicts in the United States, most British addicts had become addicts through the administration of narcotic drugs by doctors in connection with medical treatment for disease.

In the late 1950's, health officials became alarmed at the rapid increase in the United Kingdom of non-therapeutic, non-middle aged, unemployed addicts. A new committee was appointed in 1958, the Brain Committee. In a second report in 1965 it found that there had been a disturbing rise in heroin addiction, especially among young people, and attributed the main source of supply

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[28]Report of the Departmental Committee on Morphine and Heroin Addiction, Ministry of Health, United Kingdom, (1926).

to over-prescribing of these drugs by a small number of doctors.[29] Upon the recommendation of the Brain Committee, Parliament in 1968 removed dispensing of narcotic drugs from the hands of private physicians. Special treatment centers were established, particularly in the London area, where any addict who registered could receive drugs. Only doctors on the staff of the centers were allowed to prescribe heroin.

During 1968, the first year in which addicts were required to register, the number of narcotic addicts known to the Home Office rose to 2,783 from 1,729 the year before, and from 753 in 1964.[30] The most striking increase was in the number using heroin -- 2,240 in 1968, as compared with 1,299 in the previous year. The number of known addicts under age 20, nearly all heroin users, increased between 1967 and 1968 by 93%. Seventy-nine percent of all heroin addicts were under 25 years old.

If these figures represent the number of addicts who began using narcotics during the period covered, they would throw grave doubt on the English system in effect before 1968 and raise question whether the change in 1968 was sufficient. However, it is likely that until 1968, when addicts were first required to register in

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[29] Second Report on the Interdepartmental Committee, Ministry of Health, United Kingdom, "Drug Addiction in the United Kingdom," in Bulletin on Narcotics, Vol. XVIII, April-June, 1966, p. 27.

[30] See: "Drug Addicts," in Lancet, Aug. 9, 1969, p. 332.

order to obtain their narcotics, statistics were inadequate and grossly understated the facts.[31] And not all the addition to the ranks of addicts are British subjects. Many addicts have migrated to England in order to escape the sanctions of their own countries and to obtain narcotics easily.[32]

Even so, it is likely that addiction in the United Kingdom, as in the United States, has rapidly increased among the young. During the 1960's the "drug culture" among the young which originated in the United States has spread to many other nations. England, which had never before experienced widespread delinquency, dislike for the police, and violent crimes has begun to be "Americanized" in this respect. During this period it experienced an increase in use, not only of narcotics, but of all categories of drugs among the young, including LSD. No one can tell what increase in drug addiction would have occurred in the United Kingdom if the drugs had been outlawed as in the United States. Whereas the number of addicts in the United Kingdom still remains under 3,000, there are over 5,000 addicts in San Francisco alone. Moreover, there is no

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[31] See: "Drug Addicts," in Lancet, Dec. 28, 1968, p. 1398.

[32] One-fourth of all addicts recorded for the first time in Britain between 1960 and 1964 were not British citizens. See: Bewley, T., "Recent Changes in the Pattern of Drug Abuse in the United Kingdom," in Bulletin on Narcotics, Oct.-Dec., 1966, p. 4.

way to tell how much organized criminal activity has been prevented in England by the legal distribution of narcotics to addicts. We do know, however, that in 1970, the Home Office and the Ministry of Health were convinced that there was no evidence of criminally-organized control of narcotics distribution in the United Kingdom.[33]

It is impossible, as yet, to assess the success of the new English method of narcotics clinics. Addicts can no longer visit several doctors or grossly overstate their needs and thereby acquire narcotics for distribution. Each addict is registered at a clinic and may be observed and "tested" by clinic personnel before being given a narcotic.

To transplant the English system to the United States would require amendment of federal law so that the federal government, with the aid of state and local governments, would supply heroin free or inexpensively to all addicts. Were this to be done, we think that the system should be more rigorously applied than in England; the heroin should be administered to the addict at the clinic by government employed medical personnel and not allowed to be taken away on prescription.

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[33] Lieberman & Blain, "The British System of Drug Control," in Drug Dependence, March, 1970, p. 12.

The arguments in favor of this system run as follows:

No profit would be available to the private vendor, for it is inconceivable that anyone would buy or pay a high price when he could get his heroin free. With the profit gone, the whole vicious business would collapse. The government clinics would not supply heroin to non-addicts. The non-addict would not be able to obtain it privately because there would be no incentive to pushers to hook him or to risk the penalties of violating criminal law against importation and sale for the simple reason that, once a person became hooked, he would be eligible to obtain his heroin free from a clinic and would immediately cease to be a customer of any private vendor. The petty profit still available to private vendors from an occasional sale would no longer warrant the risk of violating the criminal laws. Furthermore, as all addicts would be placing themselves in trained medical hands, efforts at rehabilitation could be stepped up.

In response to the fear that supplying heroin would create crime, two facts are stated as fundamental:

1. Although heroin is a destructive drug to the addict, it is also a tranquilizer or depressant. Contrary to popular opinion, there is no evidence that heroin itself induces violent or aggressive behavior or that heroin increases sex drive. Indeed, the opposite is true. While under the influence, an addict is ordinarily extremely passive.

2. The numerous crimes perpetrated by addicts are almost all perpetrated in order to get money to obtain the drug. With the narcotic supplied free or cheaply, that drive to crime would vanish.

Such a system of government dispensing of heroin would have to be accomplished on a nation-wide level, first, because federal law pre-empts the field, and, second, because any state that attempted it alone would soon become a haven for the nation's addicts.

Objections to the English system, even as more rigorously applied, come readily to mind. There is something obnoxious about the government supplying dangerous drugs to its citizens. The use of heroin produces a "high," a kind of orgasm, and the user demands his dose four or five or six times a day. We have been told that heroin cannot be handled safely even by doctors.

Even so, if the choice lay solely between the present American system of rigorous criminalization and the modified English system, the balance might tip in favor of the latter. Fortunately, the choice may not lie solely between these two. The use of methadone may be a better solution. Methadone is a synthetic narcotic chemically related to heroin. It is addictive, discontinuance produces withdrawal symptoms, its use must be continuous. But its advocates say that it produces little "high;" it ousts the craving for heroin. Its effect lasts for 36 hours, so that infrequent dosing is necessary. Above all, while the methadone user is addicted to it, his behavior is so different from that of the heroin user

that he can live as a normal productive person in society. Since the methadone is inexpensive, it is claimed that administration of that drug has reduced crime enormously, for those who receive it no longer turn to crime to support the habit. It is claimed that in San Francisco it has worked a "cure" of 95% of the heroin addicts to whom it has been administered by converting them to methadone addiction. This is contrasted with other forms of treatment which have a cure rate of possibly 5%. Only about 395 people are under methadone treatment in San Francisco.[34]

The San Francisco Committee on Crime cannot assume to evaluate methadone. We are aware that there have always been fads and fashions in medicine and that the wonder chemicals of one decade often become the villains of another. The merits of methadone are for medical men to say. The problem of the law is not to prescribe treatment but to devise a legal system that makes it possible for medicine to bring its talents and expertise to bear.

Our recommendation: Our recommendation is simply to emphasize that the time has come for the federal government to make a thorough

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[34]The City runs four methadone clinics, serving about 260 patients. Another clinic is sponsored by Fort Help, a private organization. The Fort Help methadone program currently serves about 135 patients.

and objective analysis of the benefits and harms of a system of government controlled clinics that dispense, free or at nominal cost, methadone, heroin, or whatever other drug or treatment experts should conclude is even better. We have been told that most addicts of heroin are wearied of being tied down to the heroin rack, would welcome being taken from it, and would choose methadone were it readily available.

On the other hand, we have been told that many addicts, particularly those who have not been hooked for a substantial period of time, will not voluntarily choose methadone over heroin. Moreover, we do not know whether heroin could be dispensed successfully in conjunction with other drugs like methadone. For example, if clinic physicians were able to dispense heroin in some cases, would that in itself diminish an addict's incentive to go on methadone? These questions we cannot answer. We need immediate study by the federal government, and we then need the courage and willingness to experiment.

We are mightily persuaded that one's chances of cure or rehabilitation are better as a frequenter of the clinics than as a denizen of the drug sub-culture where the influences brought to bear are those of the pusher.

2. Use

Thus far we have been speaking of the sale and supply of heroin. We have recommended no change in the prohibitions on private

sale and supply, but we have said that something more must be added because the present system is not effective.

What, then, about our laws making use of heroin a crime?

The user is more a victim than a wrongdoer. Certainly he is a victim once he has become an addict. The United States Supreme Court has held that the condition of being an addict cannot be punished as a crime.[35] Making use of heroin a crime is a singularly ineffective procedure. One cannot tell how many people have been deterred from use by the fact that use is criminal, but we do know that alarmingly large numbers have not been deterred. We suspect that most of those who do not use heroin are deterred by intelligence, knowledge and fear of the consequences other than criminal punishment.

If some system of dispensing narcotics at government clinics should be established, then the use of the narcotic outside the clinics should be made criminal, as a measure to force the addict to the clinic. But if there are no clinics, we are troubled by the use of criminal process to prevent a man from doing what the addiction deprives him of the power to resist.

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[35] Robinson v. California, 370 U.S. 660 (1962).

Moreover, making use a crime seems in the current jargon, "counter-productive" to rehabilitation. Just as one can never know how many people have been deterred from experimenting with drugs because of the threat of criminal law, one cannot know how many drug users have been deterred from seeking treatment because of fear of arrest. The Committee's staff has surveyed many of the drug-treatment facilities in San Francisco and has found a uniform consensus that fear of arrest has been a major obstacle to successful drug treatment.

There are no rehabilitative or treatment resources for people sentenced to San Francisco's County Jail for drug abuse. For state prison, the Department of Corrections provides some psychiatric and psychological counseling (including encounter groups), but the Department's main drug treatment resource is the California Rehabilitation Center at Corona, commonly called "C.R.C."[36] Most commitments to C.R.C. occur after a defendant, in a criminal proceeding, has been convicted of a crime, often by entering a guilty plea.[37]

Unfortunately, most addicts who are sent to the California Rehabilitation Center for "treatment" have relapsed into drug use

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[36]For an analysis of the C.R.C. commitment, see Appendix B.

[37]See Secs. 3050, 3051 W. & I. Code.

after leaving this institution, according to Dr. John Kramer, formerly Research Director at C.R.C., and Richard A. Bass:[38] "By spring 1968, 6½ years after the program's inception, between 8,000 and 9,000 individuals had been committed, and about 5,200 of them were still in the program. Of the 5,200 about 2,600 (50%) were in the institution, about 1,800 (35%) were on active parole, called OPS, and about 800 (15%) were on inactive OPS, that is, at large or in jail." Out of the nearly 9,000 individuals who had been committed to the program since its inception in 1961, only 300 had been discharged for having successfully completed the outpatient program by 1968. In a follow-up of the 1,209 people placed on OPS for the first time between June 1962 and June 1964, Dr. Kramer found that two-thirds returned to the institution at least once during the first three years of their release.

The heroin user should not be punished for use; he should be treated. The utilization of criminal process as a machinery for treatment and rehabilitation has not been successful. On superficial

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[38] See Kramer and Bass, Institutionalization Patterns Among Civilly Committed Addicts, 208 Jour. Am. Med. Assoc. 2297, 2300 (July 1969).

consideration, one might therefore slip into a recommendation that unless and until some system of clinics to dispense narcotics is established, the laws making use of heroin a crime should be repealed, and that the addict should be handled through a method of civil detention.

But a study of alternatives fails to unearth anything materially better than handling use through the criminal system or anything essentially different except in terminology.

Treatment and Rehabilitation of the User

To do more for the addict than keep him addicted, society must be willing to make a very large investment in facilities and personnel to provide the "treatment" everyone agrees is required -- medical treatment, job counselling, education -- a full range of costly services over a very long period of time. So far, there has been nothing like what would be required to have meaningful treatment programs on a scale to match the problem, and nothing indicates society is willing to devote a substantial portion of its resources to costly long term rehabilitation of drug addicts. To the extent that facilities and personnel are made available, clear priority should be given to addicts enrolled in voluntary programs in view of the history of failures in the involuntary programs.

That kind of program can be enormously costly, but in the end, if it conquers the drug problem by taking the addict off drugs, it will have conquered a substantial portion of the crime problem in the United States, and it will have cost society vastly less than the tax levied by the drug addicted criminal We have estimated that heroin addicts cost San Francisco alone, by property crimes, a loss of at least $45 million per year. Multiply this figure for one city by the "crime tariff" in New York City and throughout the nation, and we can see that the public is being saddled with vast losses. Devoting even a portion of that amount to methods of cure and rehabilitation simply makes sound sense even without regard to dictates of humanity and concern for the future of the make-up of the Republic.

It must be emphasized, and it cannot be emphasized too much, that <u>any person who voluntarily places himself in the way of cure and treatment should have complete immunity from prosecution or conviction.</u>

What, then, is to be done for those who will not voluntarily place themselves in the way of cure if and when really adequate facilities are available.

If a system of government dispensing of narcotics to addicts should be adopted, then care and treatment of addicts could be handled largely on a voluntary basis. But until such a system can

be adopted, the situation continues that addicts must pay high prices for illegal narcotics and must, therefore, resort to crime, including hooking others to obtain money for their habits. The addict is therefore a constant threat to the peace and safety of society. The danger and threat are so serious that society is justified in pushing to the very limits of the Constitution in seeking ways of prevention. Prevention means detention. Detention should be coupled with efforts at cure and rehabilitation. Those efforts to date, at least until the advent of methadone, have not been singularly successful. Thus efforts at cure and rehabilitation became largely prolonged detention.

The problem is how the law can go about making it possible for the physicians, psychiatrists, and behavioral scientists to perform their task if abusers of dangerous drugs or narcotics do not voluntarily choose care or treatment.

It would be easy simply to change labels, continue to use the compulsory instruments of criminal law, and pretend that the various functions and agencies of criminal justice are now agencies of a medical model. For example, certain officials, called "Drug Abuse Diagnosticians" instead of police, would pick up possessors of dangerous drugs or narcotics, instead of "arresting" them, and hold them for review before a "Drug Abuse Civil Commitment Agency" instead of trying them before a court. Then if this agency should find that a person should be "committed" to an institution for

"care and treatment" instead of convicting him, it could so commit him instead of "sentencing him to prison." This would be an easy course, but it would also be quackery. In the end, any system of civil detention for rehabilitation or cure against the will of the detained person is essentially the use of criminal process. We might as well call it what it is, thereby retaining constitutional protections, and concurrently shape the detention toward cure and rehabilitation and away from punishment.

During the past year, the San Francisco Committee on Crime compiled a Directory of Drug Treatment Facilities in San Francisco. This Directory, the only one of its kind in the city, has gone through two printings, and more than 10,000 copies have been distributed to schools, churches, youth groups, hospitals, etc. In the course of compiling that Directory, we encountered numerous different theories and models of drug abuse treatment. While we neither endorse nor disapprove any of the drug treatment schemes operating in the City, it is likely that each abuser of drugs or narcotics is an individual with peculiar problems and needs and goals. We believe that drug abuse treatment stands the best chance for success when medical, psychiatric and behavioral experts are permitted by law to prescribe and require care and treatment in their absolute discretion.

Conclusion on Heroin

At the outset of this section of our Non-Victim Crime Report on Dangerous Drugs and Narcotics, we said that it was the most difficult subject with which we had to deal. We can now sum up some of the difficulties and dilemmas presented by heroin.

We have adverted to a system of detention for purposes of cure and rehabilitation without conviction first of crime. But to detain a man against his will in order to cure or rehabilitate him, when he has violated no criminal statute, raises feelings of discomfort, to say the least, in a free society, if not severe constitutional doubts. And, yet, an addict free of detention is likely to commit crimes of burglary and the like to obtain funds to serve his addiction. To prevent the commission of such crimes, society can arrest and incarcerate him for preventive detention. But, a free society cannot feel confortable with arrest as a means of preventive detention.[39] Of course, if the use and possession of heroin remain prohibited by criminal statute, the addict can be convicted and incarcerated constitutionally as punishment for a "crime." But to make a man a criminal and to punish him as such for committing acts

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[39] We call attention to our discussion of this subject in the Fifth Report of this Committee on "Bail and O.R. Release."

which the use of drugs has made him incapable of avoiding is also repulsive. All these difficulties can be escaped by the proposed government administration to the addict of methadone and, if necessary, heroin. But that proposal is abhorrent to some people and uncomfortable to many more. No choice is a pleasant one. Society must grapple with the difficulties and select the one that combines the best promise of success with the least abhorrence.

As an aid to making the right choice, we enumerate a number of facts:

(1) Heroin is unquestionably destructive both to the user and to society.

(2) Efforts to date by criminal law to check heroin traffic have been singularly unsuccessful. Major arrests are few and do not visibly decrease the traffic.

(3) Long-range solutions to the heroin problem must be found in efforts by the federal government to stop opium cultivation, heroin refining, and importation, and in massive educational programs aimed at the drug.

(4) The cure rate of heroin addicts by conventional involuntary treatment is very low.

(5) Heroin addicts are desperate and will get the drug one way or another. They will steal, and if necessary kill, to obtain heroin.

(6) Under the present laws, the only way they can obtain heroin is by purchasing it from the underworld.

(7) Heroin users rarely commit major crimes while under the influence of the drug. They do commit crimes in order to obtain money to buy their next fix or to keep themselves supplied.

(8) A conservative estimate of the amount of property stolen by heroin addicts in San Francisco each year is 45 million dollars. (This sum exceeds the annual budget of the Police Department.)

(9) If we cannot effectively reduce the harm that an addict does to himself, we can substantially reduce the harm the addict inflicts on society. At this time, there appear to be only two ways of having a substantial effect on the heroin crime cycle. The first alternative is to place addicts permanently in institutions. This is punishment for illness. The second alternative is to establish government controlled medical clinics where, if nothing else succeeds, heroin could be administered, not handed out, to confirmed heroin addicts on the educated, experienced judgment of physicians. This would substantially reduce crime, the role of the commercial peddler, and the likelihood of peddlers attempting to hook our youth.

CONCLUSION

The reader will perceive that we make no cut-and-dried recommendation. We have pointed up the problem and delineated the choices. We have done all we can if this Report opens up thoughtful debate.

MINORITY REPORT

We do not agree with the Report or recommendations of the Committee majority on DANGEROUS DRUGS AND NARCOTICS. We regret that the Committee issued an opinion and recommendations on this subject - a subject we believe deserving of more careful study and evaluation than the Committee gave to it. Our brief comments concerning the recommendations on marihuana illustrate our disagreement. We deem fallacious the Committee's argument that because there is a conflict of opinion as to whether the use and possession of a "small" amount of marihuana by adults and the sale of it to them is harmful to society, therefore the existing laws should be repealed and such use, possession and sale should be legalized.

To the contrary, we believe that just because there is such a sharp conflict of opinions on such a serious subject, the total reversal of the present laws without further study would be misleading and do disservice to the community. Based upon the small amount of evidence presented to the Committee, it appeared that there were two completely conflicting views. One view was that marihuana is not one of the causes of crime and violence nor does it lead to the use of addicting drugs, particularly heroin. The other point of view was exactly to the contrary. The proponents of neither point of view could point to any evidence by way of scientific study, research, available statistics or opinion

of so-called experts in the field which could in any way be deemed to be substantially in support of their particular point of view. We, the minority of the Committee, are not necessarily in agreement with the existing laws and procedures which may be too punitive with respect to adults who use or possess small amounts of marihuana. However, we cannot accept the principle that because present laws may be too harsh they should be repealed in their entirety as to the class of adults affected by the majority recommendation.

Such repeal at this time would suggest, despite any disclaimers, that the Committee after careful study recommends that society sanction the use of marihuana as medically and socially acceptable. We would then be making a positive educational statement about marihuana use which our study does not warrant. The minority believes that the entire problem deserves much more careful and considerable consideration than this Committee has given to the issues and that until more substantial evidence has been presented supporting the view that legalized use and possession of marihuana by adults will be relatively harmless, the recommendations of the Committee majority are misleading and should not be adopted.

That the conflict of views results in what the majority term a "Scotch (inconclusive) Verdict" does not necessarily justify the jump to the conclusion that existing laws should be repealed

and use and possession by adults should be legalized. Legalization should only follow the positive verdict of the scientific community that the bases upon which the laws are founded are proven to be wrong. Short of that proof, consideration should be given to moderation of the laws and changes in the procedures of handling drug abuse victims so that those laws will be helpful rather than punitive with respect to users. All of the laws relating to DANGEROUS DRUGS AND NARCOTICS are presently under intensive study in many places.

The following members of the Committee concur with the above:

* Alessandro Baccari
* Gene N. Connell
* Dr. Leon J. Epstein
** Reverend Albert R. Jonsen, S. J.
Samuel Ladar
* Lawrence R. Lawson
* William Osterloh
* Mrs. Becky Schettler
* Zeppelin W. Wong

* Dissenting only on marijuana section of Report.
** Not participating on heroin section of Report.

SUPPLEMENTAL MINORITY REPORT

In addition to my agreement with the minority report concerning marijuana, I should like to add the following supplementary comments:

For most persons, for most varieties of the substance generally used in this country, and for most situations, the occasional use of marijuana has not proven injurious. One simply cannot deny the fact, however, that for certain people, in certain situations, and in certain dosages, marijuana is indeed a harmful substance. There are ample data which demonstrate that there can be behavioral toxicity with marijuana which may include impaired thinking and judgment, slowed motor responses, and with potent material, psychotic reactions. As with LSD, opiates, amphetamines, and cocaine, the important and meaningful hazards are in the area of behavioral, rather than tissue, toxicity.

Although the recommendation for legalization of marijuana is certainly not an endorsement of its use, and this was clearly not the intention of those who have endorsed the majority report, many would at least interpret this as an endorsement. In the current complex society, where individual citizens do not possess the technical information or the machinery to reach an informed opinion about the hazards, risks and dangers relative to the toxicity of chemical agents, they increasingly look to their government for protection, whether in canned tuna, sugar substitutes, or other

substances. We must, therefore, beware of misleading many of the great majority of Americans who have not experimented with marijuana because they believe it to be unsafe in the light of current restrictions.

It is of importance, also, for one to be aware that experience in this country with marijuana is rather limited to about a five year period of its wide usage, and to relatively low dosages of weak material. We must not dismiss reports and studies from other countries because they are not consistent with our own data. More conclusive data should be obtained before recommending the changes suggested in the majority report, data which may need several more years to accumulate. This is important because should deleterious chronic effects appear after marijuana is legalized, it will be exceedingly difficult to reverse either the trend of wider usage or government policy. This would surely suggest caution in recommending the legalization of marijuana. Also suggestive of caution is the fact that there are data which suggest that the current extensive use of marijuana may be a fad which will ultimately go the way of other transient fads and premature legalization may interfere with this natural process.

There is frequently expressed conviction that marijuana restrictions tend to criminalize youth. It is a fact, however, that certain other laws such as parking, speeding, and other traffic laws, are very often violated and often both inconsistently and irrationally enforced. These traffic laws nevertheless serve a

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very useful social purpose. Marijuana restrictions probably act as a deterrant much as do the traffic laws, and both may well have desirable effects on the behavior of many individuals.

Certain aspects of the present marijuana laws do, however, appear unreasonable. This is particularly true for the severity of punishment for such offenses as the possession of small amounts of the substance. Among other questionable issues is that of the selective enforcement of laws concerning marijuana which results in far greater arrest frequency within certain age and socio economic groups. The net effect of such issues in the light of our present knowledge is not, however, sufficient at this time to recommend its legalization, as recommended in the majority report.

Submitted by: Leon J. Epstein, M. D.

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APPENDIX "A"

SAN FRANCISCO CRIME LABORATORY SERVICES PERFORMED:

A COMPARISON OF YEARS 1960, 1969 AND 1970

TYPE OF LABORATORY SERVICE	1960	1969	Change from 1960	1970	Change from 1960
1. CASTS (Moulage, silicone or plaster)	106	14	-92	8	-98
2. CHEMICAL AND PHYSICAL PROPERTIES					
A. Blood	182	72	-112	85	-97
B. Fibers	5	1	-4	2	-3
C. Glass	10	6	-4	1	-9
D. Miscellaneous	53	83	+30	5951 **	+5898
E. Paint	9	15	+6	17	+8
F. Powder residue	19	3	-16	6	-13
G. Stains	10	1	-9	--	--
H. Semen	170	95	-75	64	-106
I. Poisons & Narcotics	866	6103 *	+5237	6545*	+5679
3. DOCUMENTS					
A. Handwriting	320	39	-281	24	-296
B. Restoration	21	4	-17	6	-15
C. Typewriting	17	3	-14	--	--
D. Printing	10	9	-1	--	--
4. FINGERPRINTS					
A. Development					
(Powder)	2366	6933	+4567	7593	+5227
(Chemical)	241	96	-145	131	-110
(Photographic)	19	3	-16	1	-18
5. PALM OR SOLE					
A. Development	372	294	-78	61	-311
B. Comparison	90	122	+32	37	-53
6. FIREARMS					
A. Bullet or Case Exam.	32	97	+65	87	+55
B. Bullet comparison	61	99	+38	66	+5
C. Case comparison	26	46	+20	33	+7
D. Test patterns	1	1	--	4	+3
E. Test bullets fired	71	122	+51	88	+17
F. Weapon exam.	12	16	+4	32	+20

A-3

SAN FRANCISCO CRIME LABORATORY SERVICES PERFORMED:

A COMPARISON OF YEARS 1960, 1969 AND 1970, CONT.

TYPE OF LABORATORY SERVICE	1960	1969	Change from 1960	1970	Change from 1960
7. FLUORESCENT EXAMINATION	84	5	-79	--	--
8. MICROSCOPIC EXAMINATION					
A. Hair and fibers	19	14	-5	5	-14
B. Paints	16	4	-12	3	-13
C. Powder residue	26	1	-25	--	--
D. Stains (Blood & Semen)	389	130	-259	174	-215
E. Miscellaneous	12	2145	+2133	2746	+2734
F. Microcrystalline examination	715	2441	+1726	3427	+2712
9. PHOTOGRAPHY					
A. Special	216	162	-54	159	-57
B. Crime scene	326	404	+78	204	-122
10. SEROLOGICAL					
A. Precipitin	147	57	-90	85	-62
B. Blood group	110	32	-78	65	-45
11. SPECTROGRAPHIC	1	--		3	+2
12. SPECTROPHOTOMETRIC	81	338	+257	410	+329
13. TOOL MARK COMPARISONS	28	4	-24	7	-21
14. PHYSICAL MATCH	11	3	-8	5	-6

* Narcotics cases only.

** During 1970, physical examinations of narcotics were included for the first time.

APPENDIX "B"

AN ANALYSIS OF
THE EXISTING CALIFORNIA SYSTEM
OF INVOLUNTARY COMMITMENT
OF
NARCOTICS ADDICTS

A-5

"Is C.R.C. a Prison?"

"It is not a prison. Although it has the physical aspects of a prison for security, to prevent escapes and to keep illegal narcotics and drugs OUT of the institution, it is a '..... detention, treatment and rehabilitation facility' within the Department or Corrections."

"A person who escapes from CRC is charged with the felony of Escape, which carries a prison term of seven years."

California Department of
Corrections
"Orientation to California's
Civil Addict Program"

1. The Commitment*

In accordance with the emerging medical consensus that addiction is a "disease" and should be treated as such by the law, the California Legislature enacted in 1961 a program for the commitment of addicts who either volunteered for such treatment or were involuntarily committed for treatment by the courts. Part of this program consists of the California Rehabilitation Center in Corona, California, which is under the supervision of the Department of Corrections. This institution is commonly called "C.R.C."

The purpose of this program was stated in Section 3000 of the Welfare and Institution Code: "It is the intent of the Legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be

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*A comprehensive, and readable, analysis of the C.R.C. commitment procedure has been prepared by the Los Angeles Public Defender's Office. See Fischer, Narcotic Addiction Commitment: From In to Out, Office of the Public Defender for the County of Los Angeles, Room 402, Hall of Justice, Los Angeles, California, 90012. This analysis is cited below as "Narcotic Addiction Treatment."

treated for such condition and its underlying causes, and that such treatment shall be carried out for non-punitive purposes not only for the protection of the addict, or person in imminent danger of addiction, against himself, but also for the prevention of contamination of others and the protection of the public . . ." The Legislature obviously had the intent not merely to attempt to rehabilitate addicts, but also to detain those addicts who could not be "rehabilitated" so that they would not "contaminate" the rest of society.

There are two ways by which a narcotics addict can be sent to C.R.C. First, the law allows a commitment even though an arrest has not occurred. Thus, "anyone who believes that a person is addicted to the use of narcotics or by reason of repeated use of narcotics is in imminent danger of becoming addicted to their use or any person who believes himself to be addicted or about to become addicted" can go to the District Attorney and petition for a commitment.[1] Also, any peace officer or health officer who has reasonable cause to believe that a person is addicted to narcotics or is in danger of becoming addicted can take the suspected addict directly to a hospital, where commitment proceedings are begun nearly immediately.[2] After an examination by a physician,[3] and a full judicial

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[1] Sec. 3100.6 W. & I. Code.

[2] Sec. 3103.5 W. & I. Code.

[3] Secs. 3105, 3108 W. & I. Code.

hearing, which may include a jury trial,[4] the person may be committed to C.R.C.[5] This commitment procedure, which is undertaken without the arrest of a suspected addict, is used very rarely in San Francisco. Chief Assistant District Attorney, Walter H. Giubbini has explained,[6] "Our office very rarely gets requests for this kind of commitment procedure. Most of the time, we get parents who investigate the possibility of having a son or daughter committed, but, when we explain the procedure to them, they decide not to go ahead with legal proceedings and find another way to deal with the problem."

Thus, most commitments to C.R.C. occur after a defendant, in a criminal proceeding, has been convicted of a crime, often by entering a guilty plea.[7] Both misdemeanor[8] and felony defendants[9] may be committed after conviction, if they are eligible for the C.R.C. program.[10] In either case, "if it appears to the judge that the defendant may be addicted or by reason of repeated use of narcotics may be in imminent danger of becoming addicted to narcotics, he shall adjourn the

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[4] Sec. 3106.5 W. & I. Code.

[5] Sec. 3106.5 W. & I. Code.

[6] Telephone interview with Walter H. Giubbini, August 30, 1970.

[7] See, generally, Narcotic Addiction Treatment, supra, note 1, pp.26-49.

[8] Sec. 3050 W. & I. Code.

[9] Sec. 3051 W. & I. Code.

[10] Sec. 3052 W. & I. Code.

the proceedings or suspend the imposition of the sentence and order the district attorney to file a petition for commitment . . ."[11] After two physicians, appointed by the Court, have examined the defendant, there is a hearing before a judge.[12] If the judge orders the defendant committed to C.R.C., and if the defendant is dissatisfied with the commitment, he may file a written demand for a jury trial, and he must be given a full jury trial, on the issues of his addiction, within 30 days.

How, then, does the Court determine whether a defendant is "addicted" or is "in imminent danger of becoming addicted to narcotics?" The legal test was further defined by the California Supreme Court in People v. Victor, 62 C. 2d 280, 292, 42 Cal. Rptr. 199 (1965):[13]

> In creating a distinct category of persons who "by reasons of repeated use" of narcotics are in imminent danger of "becoming addicted" the legislature has in effect recognized the fundamental medical fact that narcotic addiction is not so much an event as as process... Certainly mere sampling or experimentation does not make an addict; but it could be a step in the process. Among the identifiable stages in this process may be listed the following: (1) introduction to and initial experimentation with the drug; (2) "joy popping" or occasional use to satisfy personal gratification or social pressures; (3) increasingly frequent

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[11] Sec. 3051 W. & I. Code

[12] Secs. 3050, 3051, 3108 W. & I. Code

[13] Although this language is dictum, the Court, following Victor, reached a square holding in People v. O'Neil, 62 C. 2d 748, 44 Cal. Rprt. 320 (1965).

use coincident with development of a growing degree of emotional dependence on the drug; (4) bodily reaction to such use by development of increasing physical tolerance; (5) temporary cessation (whether voluntary or not) of use of the drug, resulting in manifestation of physical dependence in the form of withdrawal symptoms; (6) realization by the user of the fact that it was his failure to maintain his intake of the drug that caused the withdrawal distress; (7) continuing use of the drug thereafter for the conscious and primary purpose of forestalling or alleviating withdrawal distress; and (8) concomitant side-effects, such as the tendency towards lowering of the user's anxiety threshold so that normal (non-addict) instances of nervousness or discomfort become misinterpreted as signs of an impending withdrawal experience and hence increase even further the user's recourse to and dependence on the drug.

* * * *

To recognize that addiction is more a process than an event is also to clarify the scope of the challenged category of persons "who by reason of repeated use of narcotics are in imminent danger of becoming addicted." On the one hand, and individual may not escape an inquiry into his addictive status merely by showing that he is not yet "hooked" in the strict sense of the word. On the other, to be brought within this category it is not enough that the individual be "addiction prone" or associate with addicts, or even have begun to experiment with drugs; he must have subjected himself to "repeated use of narcotics." (The) argument that "repeated use" can theoretically mean as few as twice is unreasonable when the phrase is seen in the context of the whole addiction process; for "At least several weeks of experience with a drug are usually necessary for the development of an addiction." (Citations omitted). Nor is it enough that the individual has thus "repeatedly used" narcotics, or even be "accustomed or habituated to their use, unless such repeated use or habituation has reached the point that he is in imminent danger -- in the common-sense meaning of that phrase discussed above -- of becoming emotionally or physically dependent on their use.

If a defendant has been declared an addict, or is in imminent danger of becoming an addict, he is then committed to C.R.C. for institutional treatment.[14] During 1967, the median period of commitment for men was 14 months before release.[15]

Inside the dormitory like buildings at Corona reside approximately 2,000 men. Another 800 or so male "patients" reside in a wing of the state prison at Tehachapi. An additional 300 or so women patients occupy the C.R.C. branch in Patton. 13% of these patients are from the San Francisco area; northern California patients for the most part are institutionalized at Tehachapi. Together, these three branches constitute the entire state-run narcotics rehabilitation center; capacity: nearly 3,700 "patients."

Within the walls of these institutions, patients are normally separated into 60-man units, each with its own counselling staff. Large group meetings are held daily, five days per week, and include all dormitory residents plus their staff. However, the basic therapy sessions and work details are based upon those 60-man living units.

Each day the patients are subjected to "encounter group" styled therapy sessions, work details, educational and job training, and

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[14] Secs. 3050, 3051 W. & I. Code. Until 1970, the patient was required to spend at least six months in the institution.

[15] Narcotic Addiction Treatment, supra, note 3, p. 64.

psychiatric counseling; all calculated to enable the patients to overcome their desire for narcotic like substances and to prepare them to lead useful lives outside the institution.

However, workers from within the institution admit that some of these programs are ineffective. One gave his synopsis of the job training programs. He characterized the vocational training which patients receive as "nothing which would develop into a first class job." Each patient receives a few hours per week of instruction in such fields as upholstery, drafting, baking, dry cleaning, landscape gardening, small appliance repair, hotel maintenance and secretarial work, among others; however, the Center makes no attempt to determine what types of jobs will be in demand in California in the next few years, and shape its vocational program accordingly. Therefore many persons find themselves "trained" for jobs in which there are no openings. Also, the worker offered reasons which have prevented the Center from offering vocational rehabilitation of a more skilled and perhaps more demanded variety: first, the patients do not remain at the Center for a long enough period of time to be able to train them adequately in more complex fields; second, patients frequently do not have the educational background with which to be able to cope with more advanced programs; thirdly, the Center does not have adequate funds. For whatever reason, patients who are released from the California Rehabilitation Center are rarely much better prepared to accept employment than when they entered.

Perhaps for this reason, the Center does not have any formalized job placement program, although there are a few "contacts" in the meatpacking industry and shipyards which sometimes employ qualified ex-addicts. If the patient has had prior welding or mechanics training it is often not difficult to place him in a job; however, most patients are left to find a job on their own after leaving the institution.

The job training problem would not be as acute if it were not for the fact that a majority of addicts are school "drop-outs" and often do not possess even the rudimentary qualifications for most employment, although C.R.C. staff categorize them as often having average or above average intelligence. Although many employers will not hire persons who do not have at least a high-school degree, a majority of the patients at the California Rehabilitation Center have dropped out of school prior to receiving this degree. The Center offers high-school courses to such patients, but often a patient is released before he can qualify for a degree.

2. Release on Outpatient Status

After an initial unspecified period of treatment and observation, C.R.C. may ask that the defendant be released on an out-patient basis if the defendant "has recovered from his addiction or imminent danger of addiction to such an extent" as to warrant release.[16] This request

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[16] Sec.3151 W. & I. Code. A defendant gets an automatic yearly review of his status at C.R.C. by parole authorities.

is made to the Narcotic Addict Evaluation Authority, which is analogous to a parole board.[17] The N.A.E.A. then supervises the defendant on an outpatient basis, receiving reports from special supervisors employed by the Department of Corrections.[18] The defendant must be closely supervised, and he is subjected to surprise testing for narcotics use while on outpatient status.[19] There are about 220 C.R.C. outpatients in San Francisco.

If the defendant makes it through two consecutive years of outpatient status, then the Director of Corrections (in practice, the C.R.C. authorities) may certify the defendant's success to the N.A.E.A.[20] Then, if that Authority agrees with the Director, the Authority can file a request with the Court for discharge from the C.R.C. program.[21] The Court has to discharge the defendant from the C.R.C. program, but the defendant is then sent back to the criminal court where he was originally convicted. There, the defendant may have his original charges dismissed,[22] or he may be put on

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[17] Sec. 3150 W. & I. Code. The N.A.E.A. replaced the Adult Authority, which supervised addicts until 1963.

[18] In San Francisco, these supervisors are employed by the Parole and Community Services Division of the Department of Corrections, 71-11th Street, San Francisco.

[19] Sec. 3152 W. & I. Code.

[20] This discharge procedure is governed by Sec. 3200 W. & I. Code. In 1970, the requisite period of successful out-patient status was reduced from three years to two years.

[21] Id.

[22] Pursuant to Sec. 1203.4 P.C.

probation, or he may be sentenced to jail or prison, with credit for time served while at C.R.C.[23] As a practical matter in San Francisco, defendants who have successfully made it through the C.R.C. program (including the 2-year outpatient requirement) may be put on probation, but they will not receive jail time.

If the defendant begins to use narcotics at any time that he is on outpatient status, or if he refuses to submit to nalline testing for addiction, the defendant may be sent back to C.R.C. by the Authority, for further institutional treatment.[24] In addition, "if at any time following receipt at the facility of a person committed pursuant to this article, the Director of Corrections concludes that the person, because of excessive criminality or for other relevant reasons, is not a fit subject for confinement or treatment ... he shall return the person to the court in which the case originated for such further proceedings on the criminal charges as that court may deem warranted."[25] It is simply not clear whether the court must give the defendant credit for time served at C.R.C. where the defendant has been sent back to the court as "unfit

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[23]Sec. 3200 W. & I. Code.

[24]Sec. 3151 W. & I. Code. In re Marks, 71 A.C. 33, 77 Cal. Rptr. 1 (1969).

[25]Sec. 3053 W. & I. Code.

for treatment."[26] The Committee staff has witnessed a number of cases in which a defendant, rejected from the C.R.C. program, was sentenced by the San Francisco Courts without credit for the time served.

Staff members at the Center consistently proclaim that the most important crisis an addict will face in his struggle to refrain from narcotics is within the few weeks immmediately after he is released from in-patient status. The patient finds himself released from the cloistered atmosphere of the institution and thrust into his "old environment" where he must again struggle to support himself and to ignore the drugs which are within easy access. Most rehabilitation personnel emphasize that it is at this juncture that the need for community support for such patients becomes acute; yet, it is at this very juncture that the California Rehabilitation Program's support is seriously deficient. After the State spends at least $3,300 per patient for institutional care at Corona, the State then gives the patient $46.55 at the gate and tells him to go home. The patient must buy his clothes and his transportation home out of the $46.55. What happens when a patient gets to San Francisco is described by Mr. Walter China, Assistant

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[26] Compare: People v. Reynoso, 64 C. 2d 432, 50 Cal. Rptr. 468 (1968), holding no right to time served, with People v. McCuiston, 246 C.A. 2d 799, 55 Cal. Rptr. 482 (1966) (distinguishing Reynoso).

Supervisor of the Parole and Community Services Division of the Department of Correction in San Francisco:[27]

> If a guy has a family and a job waiting for him here, then there is a good chance that he'll make it. But take a guy who has no family and has no job waiting for him. We call these cases "cold turkey" releases. By the time he gets to the city, his gate allowance is almost gone. We try to do whatever we can for him -- contact welfare, the Department of Human Resources. And in most cases, we can give him enough money to live for a couple of weeks. But his budget is so low that he invariably ends up in a cheap hotel, usually South-of-Market. They are not good hotels, and there is a lot of drug use in the area. Some guys manage to make it -- somehow. But most guys get discouraged pretty fast. Also, they know that they can get a good bed, without roaches, and good food at C.R.C. So they can solve all their problems by shooting up, because they will go back to C.R.C. and it is a better place than they have.

Mr. China estimates that not more than 20% of all San Francisco out-patients make it through the out-patient requirement (recently changed from 3 to 2 years) to discharge. It is fairly obvious that the State, by giving a C.R.C. out-patient $46.55 at the gate, is jeopardizing an investment in excess of $3,300.00 per year and the ultimate success of its rehabilitation program.

The success of the out-patient program is not merely jeopardized by the inadequate funds given to addicts upon release from the institution. Perhaps the more important short-coming of the program lies in its disregard for the emotional problems occasioned by a person's "re-entry" into society from an institution. The problems of re-entry from prisons has been amply described by ex-cons in recent literature;

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[27] Interview with Walter China, Assistant Supervisor, Parole and Community Services Division, Department of Corrections, San Francisco, May 4th, 1971.

the problems of re-entry from the California Rehabilitation Center are no different. Recent experiments with so-called "Halfway-Houses" where persons can learn to re-adapt to their environment in the presence of others who are going through the same process have shown that they may alleviate some of the stresses of re-adjustment. Privately-funded drug treatment facilities in the Bay Area, such as San Francisco's Walden House and Synanon, have long recognized the importance of community living -- where people can share their problems and where people force other people to be honest -- in their schemes of drug treatment. Ironically, the law has permitted the Department of Corrections to set up experimental half-way houses for C.R.C. patients since 1965. Section 3153 of the Welfare and Institutions Code as follows:

> The Director of Corrections is authorized to establish one or more half-way houses in large metropolitan areas as pilot projects in order to determine the effectiveness of such control on the addict's rehabilitation, particularly upon his release from the narcotic detention and treatment facility. Rules and regulations governing the operation of such half-way houses shall be established by the Director of Corrections and shall provide for control of the earnings of persons assigned to such half-way houses during their residence there, from which shall be deducted such charges for maintenance as the Director of Corrections may prescribe.

The California Rehabilitation Program utilizes two half-way houses in Los Angeles and one in San Diego; however, although there is a critical need for one in the San Francisco area, one has yet to be established here by the state.

3. Release from the Program

If a patient completes two full years of living in the community without having used drugs or having engaged in anti-social activities, he may be released permanently from the program.[28] If he resumes or seems in danger of resuming his narcotics habit, or engages in anti-social activity (unless it is serious enough to warrant his release from the program and his incarceration in prison), he will be returned to in-patient status for another series of months until, again, he seems qualified to release.[29] This revolving door procedure may continue up to the entire term of his commitment -- 7 years for one involuntarily committed, or 14 years if he is recommitted, or 10 years if the director of the program petitions the court for a three year extension of the original commitment.[30]

4. The Limitations of the C.R.C. Program

Why doesn't the C.R.C. program do even an adequate job for defendants in San Francisco who use addictive or dangerous drugs? There are a number or reasons:

(a) Limitation to Addictive Drugs

The C.R.C. program is limited by statute to defendants who are "addicted" or who are "in imminent danger" of addiction.[31] Consequently,

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[28] Sec. 3200 W. & I. Code

[29] Sec. 3151 W. & I. Code

[30] Sec. 3201 W. & I. Code

[31] Secs. 3050, 3051 W. & I. Code

the program does not provide treatment for defendants who are habitual users of dangerous non-addictive drugs -- mainly amphetamines and barbituates. Although some habitual users of these drugs may get treatment at either Napa or Atascadero, if they have been committed to these facilities for treatment of mental illness under either Sec. 1370 or Sec. 1026 of the Penal Code,[32] there are undeniably significant numbers of defendant in the city who are habitual users of these drugs and who end up in the county jail without treatment.

(b) Statutory Limitations[33]

Not all defendants who are addicts are eligible for the C.R.C. program. Indeed, Section 3052 of the Welfare and Institutions Code specifically excludes defendants who have been convicted (a) in the present offense, or (b) previously of certain offenses, many of which might be logically connected with drug use. For example, the statute excludes defendants convicted of robbery, first-degree burglary, pimping, pandering, and "any felonies involving bodily harm or attempt to inflict bodily harm."[34] However, "in unusual cases, wherein the interest of justice would best be served, the judge may, with the

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[32]Penal Code Section 1370 provides for commitment for treatment where a defendant is not capable of standing trial. Penal Code Section 1026 provides for treatment where a defendant has been found "not guilty by reason of insanity."

[33]Generally, see: Note, Statutory Ineligibility for Commitment of Narcotics Addicts, 19 Hast. L. J. 637 (1968).

[34]The statute also excludes defendants convicted of numerous violations of the Health and Safety Code. See Sec. 3052 W. & I. Code.

concurrence of the district attorney and defendant, order commitment notwithstanding Section 3052."[35] Although some of San Francisco's judges have exercised this discretion and have sent defendants to C.R.C. in spite of the defendant's ineligibility under Section 3052, they have seen most of these defendants sent back. The judges also know that C.R.C. has sole discretion whether to send a defendant back to court,[36] and C.R.C. itself has declared that it will not accept defendants who have:[37]

(a) a history of large volume narcotics or other drug sale beyond that necessary to support own addiction;

(b) a pattern of aggressive and violent behavior;

(c) a long and continuous history of criminal behavior, usually preceding addiction history, and particularly older men who have served several prison terms before; and

(d) a pattern of overt and provocative homosexuality.

One San Francisco Superior Court Judge said:

> There is no doubt that C.R.C.'s standards are quite restrictive. I can't blame them too much. It's a relatively new program, and they want to prove themselves. They know that they can't take too many risks. But it makes it tough on the Courts, because there is

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[35] Sec. 3051 W. & I. Code.

[36] Sec. 3053 W. & I. Code.

[37] C.R.C. Memorandum re: "Exclusionary Criteria, June 3, 1969," in Narcotic Addiction Treatment, supra, note 3, at p. 55.

> just no place to send a lot of people for decent treatment. I know that a defendant will be very lucky if he gets any treatment in state prison, but that is where the worst addicts -- the 30-year addicts -- go. And what about a homosexual? I simply can't send a homosexual any place where he will get institutional care for his drug problems.

(c) The "Imminent Danger" Test

The test for C.R.C. commitment, as announced by the California Supreme Court in People v. Victor, supra, indicates that "repeated use" of narcotics is not, in itself, sufficient to constitute addiction. Rather there must be an "imminent danger" of physical or emotional dependence. Most people who are concerned with so-called "drug-treatment" -- from doctors to social workers to streetworkers -- have come to realize that "treatment" for drug abuse is far from merely a medical problem. In most cases, medical care for heroin withdrawal, for bad trips, can be provided in a rather routine way. Thus, drug treatment workers know that their real problem is in figuring out ways to deal with why people take, and become dependent on, dangerous drugs. The problem with drug abuse rests in people's heads, not in their bodies.

It should not be surprising that "treatment" for drug use -- which ordinarily includes a variety of psychological techniques, ranging from individual psychiatric counseling to in-house community living, -- is far more successful where a drug user is still experimenting.[38] Yet

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[38]Interview with Josea Bly and Walter Littrell, Walden House, William Bathurst, Haight-Ashbury Drug Treatment Center.

this is precisely the stage of drug use which is, by Court rule, excluded from C.R.C. treatment. It is easy enough to understand why the Court ruled as it did. Given limited resources at C.R.C., it makes sense to limit C.R.C. services to those who really need intense institutional care. In addition, the Court was undoubtedly influenced by the fact that C.R.C. is an institution. Defendants cannot walk out. Thus, before a defendant is committed, and removed from society for a substantial period of time, there must be adequate evidence that his use of drugs is likely to pose a danger to society. Consequently, the problem is not with the Court-made standard for commitment; rather, the problem is that institutional confinement is not a good way of treating drug abuse at its earlier stages.

(d) Deficiencies in the Outpatient Program

The C.R.C. program relies heavily on its outpatient program, whereby defendants are released from C.R.C. to return to their places of residence.

Yet, as we have shown, this outpatient component of the C.R.C. program is ridiculously weak. The frugal release dole of $46.55 would cause problems enough in a society with full employment, for it is not easy for an ex-addict to get a job even when jobs are available. In these times of high unemployment, when even trained engineers and college graduates cannot find jobs, what chances are there for the ex-addict? One thing is clear: an ex-addict needs income to support

himself, if not a renewed habit. If he is ineligible for unemployment, for welfare, or for other state income, and if he cannot find a job, it is very likely that he will turn to a familiar and certain (albeit risky) source of income: pushing heroin.

5. The Failure of C.R.C. Rehabilitation

Dr. John Kramer, formerly Research Director at C.R.C., and Richard A. Bass who studied the performance of 121 addicts after the addicts left C.R.C., reported that "...while some people successfully complete three years of outpatient status (OPS),...most of the remainder do not and it appeared that they would spend about half of their rather long commitments within the institution."[39] These researchers tabulated that for every addict who successfully completes a three year outpatient period, four do not. Out of the nearly 9,000 individuals who had been committed to the program since its inception in 1961, only 300 had been discharged for having successfully completed the outpatient program by 1968.

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39 Kramer & Bass, Institutionalization Patterns Among Civilly Committed Addicts, 208 Jour. Am. Med. Assoc. 2297, 2300 (July, 1969).

Mr. ALIOTO. There were approximately 11,000 patients admitted to the San Francisco General Hospital alone for emergency psychiatric treatment of drug problems.

Senator HUGHES. In how many years, Mr. Mayor?

Mr. ALIOTO. In 3 years. Of this number, 17 percent were related to LSD, and that is falling off all the time. In other words, it was more 3 years ago than it is now, 48 percent were due to amphetamines, 27 percent were due to barbituates, and 8 percent were due to heroin. But the heroin curve is an upward curve, while the LSD curve is a downward curve.

San Francisco is identified in the minds of almost everybody in the world as the place where the drug cult started.

It is an observation that I have made myself over a number of years, that most things in the world, and I don't know why this is, but most things in the world, for good or evil, seem to originate in either San Francisco, Paris, or London. In New York, Senator, there is a certain expansion of these things.

Senator JAVITS. Once they are taken on in New York, they are established, really in business.

Mr. ALIOTO. But for some reason or other, they seem to originate in these particular cities. This is identified in the minds of so many people with Haight-Ashbury, but most of the people we are dealing with in Haight-Ashbury are not residents of San Francisco. They came there. There is a certain belief that we have looked at the problem more humanely, or more permissively, some would say.

We have tried to do something about this problem. We have private organizations and public organizations. We have funded the private ones. The Haight-Ashbury Clinic, cooperating with the Health Department and partially funded by the Health Department, reports that less than 7 percent of their drug abuse patients are under the age of 20.

Whereas, 54 percent are between the ages of 20 to 25; 35 percent are between the ages of 26 and 40; and one half of 1 percent over the age of 40. That is the age breakdown in the Haight-Ashbury Medical Clinic which has been in operation a long time.

Now, during the past 5 months, they treated just in this one clinic, 773 patients for heroin. We took a recent statistical count, and we have some very interesting facts to show you. They are deplorable, but interesting in terms of what we ought to do about it.

Out of the 773 heroin patients, 4 percent were under the age of 15; 54 percent were under the age of 19; 88 percent were under the age of 25; 97 percent were under the age of 30.

Now, the cost of their habit—we broke this down under minute examination, because it has some significance to some of the things I am going to suggest here in a moment—the cost of the habit was less than $50 a day for about half of the addicts, ranging from about $20 to $50.

The cost of the habit for 28 percent was between $50 and $100 per day; between $100 a day and $200 a day for 14 percent of the 773 patients; and over $200 a day for 1.5 percent.

Three habits of $400 per day were found and one had a habit of $630 per day.

Approximately 75 percent of those 773 patients, treated in the last 5 months in the Haight-Ashbury Clinic, were males and 75 percent were white.

Now, we have spent a lot of time and a lot of money in connection with doing something about this problem, and we have come to certain conclusions and I would like to share those conclusions with you.

With all of the faults of methadone—we know what they are, we heard them here just a moment ago, it is another drug, it is addictive, terrible withdrawal pains attached to it—with all of the faults of methadone, it is the best thing that is working.

But we have such a woefully small amount of money that is being spent on it, and right now it is all city money. The State started by giving us $100,000. We now have approximately 400 individuals who are being treated.

Senator JAVITS. How many?

Mr. ALIOTO. 400, not nearly enough, and it is costing us $400,000.

Senator JAVITS. What percentage do you figure that is of the heroin population of San Francisco?

Mr. ALIOTO. We think we have approximately 5,000 heroin addicts, and we are treating less than 10 percent. Each one costs us $1,000 a year to treat. That is city money. Nobody else is doing anything on that score, neither the State nor the Federal Government at the moment.

We think that about 90 percent of them have been returned either to their homes or to jobs, and that 90 percent of them are off other kinds of drugs, except methadone. We think it is very effective.

Now, we know, as I said, the feeling of a great number of people that this is just another drug, but the point is that it is a drug that we are giving to people.

We think that we ought to at least suggest to this committee that those of us who are trying to deal with this problem, those of us who are on the cutting edge of this problem, don't know enough about other experiments taking place in the world.

We know what the British have done with respect to actually administering heroin to heroin addicts. We know that they passed a Dangerous Drug Act back in 1920. It wasn't until about 1926 that the Rollston report worked out a procedure by which the physicians themselves simply dispensed the drug to addicts. There was no registration requirement in this period of time.

But during the 1950's the British began to get a little alarmed by the increase in heroin addicts. So in 1968, they took it away from the doctors entirely. There was too much of a feeling that many doctors were dispensing heroin for reasons that were not sufficient.

There was too much of a feeling that too many of the addicts were able to get more than the dose required by them and pushing it. So the British removed it from the hands of doctors, and special treatment centers were set up, and the registration requirements were effected.

Now, 3,000 registered in Great Britain, and they figured there was an increase of approximately twice as many as they had in the pre-registration period, and a great increase in non-British residents.

We have an aspect of this, too. As I say, most of the people in our Haight-Ashbury clinics are people who have come to San Francisco

because they think we are a little more humane with respect to treating the drug problem.

Should we come back here and recommend to the Congress that we ought to adopt the British system? We don't know any place where we can go where we can get something as authoritative as the Surgeon General's report on cigarettes, and this is one of the recommendations we want to make, that the Congress authorize a study of the British system, an authoritative study, that would give us some guidance in terms of what we ought to be doing.

We are doing the same thing with methadone. We are not dispensing heroin, we are dispensing methadone. We don't know, for example, whether on a Federal basis there ought to be heroin dispensed as well in those circumstances where methadone is not doing the job.

There are some cases, I have indicated 10 percent so far as we are concerned, which aren't panning out on methadone at all. But we just don't know in this situation.

Also, the suggestion comes to us that whatever is done in this connection ought to be federalized. We have a situation in welfare where people shopped around for whomever gave them the best deal on welfare. Not only did people shop around, but there were some officials in the country who were willing to provide one-way bus tickets to some of their residents to go to the place that gave them the best deal on welfare.

The big cities are paying more attention to it, but are not going to be taking on everybody from their State, and perhaps their region, who is coming in from the country towns. So there ought to be a federalization of things that are done, either by way of methadone or whatever other treatment might be arrived at.

So far as the British experiment is concerned, manifestly there is an overwhelming section of the public that regards it as obnoxious that the Government should be dispensing a dangerous drug.

Our crime commission refused to take a position on the British record because it came to the conclusion there wasn't a sufficient body of authoritative study on the British experiment, and it seemed to us dealing with the problem that there ought to be at least that.

Our crime committee pointed out that its medical evidence indicated that the taking of heroin does not induce crime. Rather, it results in a certain passivity. It is necessary to steal to help the habit along, to subsidize the habit, and they have made an estimate based on the study of our police records that it is necessary to steal four times the amount of the habit, and I have just given you some statistics on how much that habit costs.

Their estimates are that one must steal four or five times the amount of the habit in order to fence the stolen goods and receive an amount sufficient to sustain the habit.

The estimate in San Francisco of total thefts related to drugs is $45 million a year. That is more than our total police budget, which is approximately $35 million a year. They figure a 4-to-1 or a 5-to-1 ratio on the amount of property you have to steal in order to subsidize this habit.

Senator JAVITS. May I ask you a question at that point? Doesn't this epitomize the problem which is related to the testimony we just

had from the professional people in the field with respect to the, as yet inadequate professional basis for dealing with drug addiction?

Probably in a less civilized society, you would take all these people into custody and coop them up like wild animals, but we wouldn't do that. It is unthinkable.

So what else do we do? In other words, wouldn't you agree because you are in the civilian sector, as it were, that we really have to get a very high priority on this question of methadone treatment, because it may be a humane and civilized way to deal with an absolutely unacceptable risk to society, even while the researchers are trying to find out what is the best way to deal with heroin antagonist or some other really effective way to approach this problem?

Mr. ALIOTO. I couldn't agree with that more, Senator. There isn't any doubt that we have to make a basic commitment to this thing because of the enormous scope that it is now getting in our society. You know, all human knowledge is being multiplied every 10 years right now. It seems to me knowledge about drugs is being multiplied almost every 2 or 3 years. There is no reason to believe that as we work on methadone programs or that which appears to be working that somehow or other they aren't going to come up with vast experimentation being carried out now, and an awareness that we haven't had up to this point. This is no reason to believe they will get better drugs to handle the problem.

But until they do, I don't think we can afford to wait it out. Until they do, I think we have to make a more massive commitment to the methadone method. But that does cost $1,000 a year per person. Maybe in expanding the program we can work out those costs so they are a little less.

Senator JAVITS. What is the juxtaposition between it now and your average estimate per addict in the $45 million gross?

Mr. ALIOTO. If someone will very quickly divide 5,000 in $45 million. That is $9,000.

Senator JAVITS. Per addict?

Mr. ALIOTO. As against a thousand dollars each for treatment. So there isn't any question about where those equities are. We ought to be heavily in favor of methadone.

The feeling against methadone is almost a feeling that it is not right for the Government to dispense a drug. The British apparently are prepared to dispense the actual heroin because it eliminates the organized crime aspect of it, it eliminates the actual seller of it, it eliminates the profit from dealing in it.

We ought to be prepared to dispense a less harmful drug which we can manufacture synthetically and which appears to be working in 90 percent of the cases which we have investigated of the 400 that we have are being treated with methadone.

I am leaving with you this report on nonvictim crime. I don't think it is going to help the situation to legalize marijuana. Admittedly there isn't any doubt that marihuana for some people, taken in restricted quantities, is not harmful. There isn't any question about that. We have come to the conclusion, too, that the hysteria which believes that marihuana leads inevitably to harder drugs isn't true.

Nevertheless, people look to the Government for guidance about things that are dangerous, and there isn't any doubt that for some

people marijuana taken in certain dosages is a very dangerous thing, that is, can cause a certain change in personality. So we think that legalization would tend to multiply the number of users, under what is apparently a Government sanction.

The legalization, I think, of marijuana would imply a Government sanction to too many people who are not now using it. All we have on marihuana is a 5-year study, nothing more than that, just a 5-year study.

We know how long it took us to find out about cigarettes. It was more than 5 years. There is no reason to give any apparent Government sanction to marijuana unless we have had a lot more study as to what it is about, and furthermore, one of our distinguished psychiatrists, the man who has worked in Haight-Ashbury from the very beginning, perhaps the most experienced man in this area, has indicated that this might be a fad and premature legalization might interfere with this process.

That doesn't mean we should criminalize everybody who uses it, either. Just as a matter of law enforcement, we have decided we won't use precious police manpower to arrest marijuana users. We think marihuana arrests have been discriminatory, based on age and based on socioeconomic conditions.

Somewhere between the criminalization and legalization we think there can be an enlightened governmental policy that permits us to study it more and more—more than the 5-year period suggesting legalization.

But I want to run to another point. We are also very, very much interested in the British system and we would like to get some authoritative opinion of the Congress as to whether or not it is worth it, as to whether or not is is desirable, as to whether or not it is really working.

The British are only dealing with approximately 3,000 people, and I assume that there are ways of getting a real clinical report, something that, as I say, has the authority behind it such as the Surgeon General's report had with respect to cigarettes.

Let me conclude by summarizing that with respect to the bill itself, we don't think we are dealing with enough money. The Conference of Mayors proposes a billion dollars rather than $100 million that you are talking about for the 3-year period.

We want to emphasize that we think we can get the job done better if there is direct dealing between the Federal Government and the big cities. Finally, when we get to some large program like the dispensation of methadone, whatever else is developed in terms of drugs, that we consider federalization so that the big cities will not become a Mecca for those who think the cities are treating the problem more humanely.

One last point why federalization is important, and why federalization in terms of funding is important. There are many Federal programs that impose further burdens on the cities. We don't object to that. There is a problem in our city with respect to liberalization of the immigration policy of the Chinese. The effect of that policy has poured a number of people into our cities, from grandfather to grandson.

Nobody speaks the English language. The tendency is to congregate in Chinatown, where we already have a housing problem and an employment problem, and we are beginning to get a crime problem.

Even the opium habit of the older Chinese doesn't appear in this generation. There you have a diminution of habit within the older group, but you get it in the younger group because of the employment, housing, and just the bad neighborhood generally.

No compensation is being made to the city in terms of handling that problem. The same type of problem faces most major cities with respect to drugs. The Federal Government must play a greater role, so that existing drug problems in cities are not compounded.

I thank you very much for listening to our views on this subject matter. I have previously filed with the committee those statistics that I spoke about a little earlier, which I think have some significance in a city which I think tends to be more aware than some cities, with the possible exception of New York, about the problem that we are dealing with today.

Senator HUGHES. Thank you very much, Mayor Alioto.

I have a few questions I would like to ask you. You talk about the federalization of a program like methadone maintenance, or the distribution of methadone. What about requiring the cities to set up umbrella agencies through which all Federal funds must go, Federal or private, nonprofit, so that small groups can apply to those agencies for funding?

Say it is at city level control, but the applications would go at that level rather than all in here.

Mr. ALIOTO. We have a general coordinating agency that we have put under the leadership of our medical director, Dr. Curry, in which we have attempted to coordinate the public agencies and the private agencies as well. Private groups have in fact come to that central agency in connection with applying for grants both from private funds and public funds. I think that would be an excellent idea if that were set up in all the major cities.

Senator HUGHES. What do you think about establishing grant programs to which local groups themselves could apply? In other words, neighborhood grant programs such as in Harlem or in Haight-Ashbury, where groups of programs could apply for funding as a group to take care of a particular problem in a particular area of your city?

Mr. ALIOTO. Again, I think that is an excellent idea, and to some extent we are already doing a little bit of that. Within the coordination, with Dr. Curry, there is in fact a neighborhood council in the Haight-Ashbury involving both public and private organizations and we have attempted to coordinate them.

As a matter of fact, some of the little clinics and some of the little halfway houses and some of the things being proposed worked through that particular council. I think it is an excellent idea, because there are some people with a knack for getting applications approved, and some people with very worthy projects, with a knack for not getting them approved.

So I think any cooperation on a full community basis would be extremely helpful, Senator.

Senator HUGHES. Do you think, Mr. Mayor, that the funding levels that have been requested by the administration are anywhere near the level needed to meet the problem in the country in relationship with your own experience?

Mr. ALIOTO. No; in our experience, we think not. We think until we are able to make some real dent in this drug problem, we will be unable to make a dent on hard-core crime. San Francisco is one of the cities which has had a rather dramatic reduction, of 10 percent, in hard core crime, as it is defined on Federal levels, but none of us has made a dent in this particular area of drugs.

It is getting worse every day. Deaths from drugs have multiplied from about six, 3 years ago, to 45 in 1970.

I don't think that a commitment of anything at this point of less than a billion dollars is really making a commitment to the problem.

Senator HUGHES. Are you familiar with the California civil commitment law?

Mr. ALIOTO. No; I am not. Senator Moscone, who is going to be here later on may be helpful to you on that score. But you will find a full discussion on the matter of civil commitment in the report of nonvictim crimes that I am leaving with you. There are grave constitutional questions on civil commitment.

We, of course, do something like that in cases of those who have very serious mental illness, but short of civil commitment, a methadone-type program for example, permits the person to live at home. We don't think that civil commitment is going to be an answer until we have tried these other methods first that don't involve civil commitment.

Senator HUGHES. Is there any Federal funding going into that Haight-Ashbury funding that you were talking about?

Mr. ALIOTO. We have some in the Haight-Asbury, and I met with Mr. Leonard this morning of LEAA to ask him for a lot more in terms of discretionary funds.

Senator HUGHES. It is all LEAA money as far as you know?

Mr. ALIOTO. No, I think some of it is HEW money. But it is not enough. We aren't making a real commitment to this problem yet. We just aren't.

Senator HUGHES. What is your experience, then, with the community mental health centers with respect to this problem?

Mr. ALIOTO. It has been effective, but much more is needed with respect to dealing with heroin. There is a certain effectiveness in dealing with the problem medically, psychiatrically, psychologically, and every other way. We have to come back to the fact that nothing has worked as well as methadone.

Methadone not only gives the opportunity to get away from the heroin habit itself, and from the necessity to steal in order to finance it, but the personal contact involved in the administration of methadone helps in certain psychiatric services that we are able to perform.

Senator HUGHES. Mr. Mayor, did you testify before the National Marihuana Commission when they were in San Francisco?

Mr. ALIOTO. No. Some of our people did, but I did not. But you will find, as I say, a rather exhaustive report on the subject matter.

The peculiar thing about the marihuana report that was very controversial throughout the country is that everybody agrees with all of the steps that lead the committee, by a vote of 19 to 7, to recommend legalization. Everybody agrees with the steps, but disagrees with the conclusion.

I think the minority report of Dr. Leon Epstein, who is probably the most experienced man in the country as to why it should not be legalized is most persuasive.

Senator HUGHES. Thank you, Mr. Mayor. We appreciate your testimony.

Mr. ALIOTO. I appreciate the opportunity to be here.

(The prepared statement of Mayor Alioto follows:)

Office of the Mayor
San Francisco

JOSEPH L. ALIOTO

STATEMENT OF
MAYOR JOSEPH L. ALIOTO

before the

SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

67-226 O - 71 - 20

Mr. Chairman and members of the Committee. I am Joseph L. Alioto, Mayor of San Francisco. I appreciate this opportunity to discuss with you the growing menace of narcotics abuse in the United States.

I would like first to talk a bit about a friendly little farm town out in western Iowa that for many of us would typify the heartland of America. It's a proud, civic-minded agricultural community that is pretty much isolated from many of the big problems facing the big American cities.

This town has 2,216 good people who grow soybeans and corn and don't mind much that a lot of the motorists who buzz by on U.S. Highway 59 don't bother to stop off.

This town has only one theater, the King, and one department store, the Ben Franklin, but both are doing a lively business with the same steady patrons who shop down at the Second and Main business community on a pretty regular basis.

The kids enjoy their own youth center, The Attic, and show the expected reluctance about giving up their summer to return to school, even if their high school is brand new.

This year's crops are shaping up as the best in many seasons; the weather's great, and the Mayor has the budget in balance.

Somewhere far off down the horizon of Highway 59 are the big cities--40 miles to Sioux City, 100 to Omaha, 300 to Minneapolis--but no one really much cares because most everything they need they already have in town.

I'm sure by now, Senator Hughes, you have recognized the town I'm talking about.

It's Ida Grove, Iowa, your own home town.

It has something very much in common with my own big, bustling, metropolitan San Francisco.

It has a narcotics problem.

Certainly it's not much of a problem. But Mayor Anton Schau remembers that two years ago there wasn't any at all.

Now the slimy reach of narcotics has touched even Ida Grove, Iowa.

Until recently, people in the Ida Groves of America have too frequently viewed the narcotics problem as a mildly-shocking, big-city phenomenon somehow safely bottled up in places like our Haight-Ashbury in San Francisco or New York's Harlem or Detroit's Mack Avenue on the West Side.

Ida Grove's experience, as limited as it has been, should be a signal that we in the big cities are losing our fight, that America is losing this fight, that someday unfortunately Ida Grove may be just as much a battleground in this fight as San Francisco or New York or Detroit.

Maybe it already is.

Sheriff Don Gebers says he's had about a half-dozen drug cases in the last year. Suddenly there's a little marijuana, some pills, an occasional LSD trip showing up on his records. He knows there's been a few pushers coming through town lately.

Don Gebers' concern is starting to show. He's gone to the Justice Department for training in narcotics enforcement. He's started up drug education classes in Ida Grove's schools. He would like to start up his own narcotics unit because the State of Iowa's narcotics office is getting too busy to handle his calls until it's too late.

If it gets worse, Don Gebers is going to need help. We need it now.

We have more heroin addicts in San Francisco than Ida Grove has people.

Every week someone dies in Ida Grove. Every week some poor soul dies in San Francisco, too, not from a heart attack or a stroke, but rather from the savage slam of a heroin overdose or the fatal smack of too many "uppers" or "downers" to use the idiom of the street.

There are about 885 school-age children in all of Ida Grove. We'll arrest at least that many children in San Francisco for narcotics offenses this year.

Ida Grove's one hospital, Horn Memorial, serves an average of 80 patients a month--broken legs and kidney stones and water on the knee and all the usual human miseries.

That's about half the number of hard-core heroin addicts just one of our voluntary drug clinics in the Haight-Ashbury will see in the same time. Six of them will be children under the age of 15. Eighty-three of them will be 18 or under. Forty-two of them will be spending as much as $100 a day to support their habit.

Yes, I can put a scare into Ida Grove. So can the Mayor of any big city in the United States.

We can talk about the history of bloodshed that pervades the twilight world of the narcotics hustler.

We can talk about the thousand-yard stare in the eyes of a young boy "strung out" on "speed" or "acid".

We can talk about kids who have been hacked to death by their own companions under some wild narcotics-induced compulsion.

But what we have to talk about is what we are doing about it... or unfortunately what we're not able to do about it.

We in San Francisco need the legislation that is before this distinguished body. So does Ida Grove, Iowa.

We need it in the big cities to strangle this evil that threatens the lives of our children and the health of our communities.

We need a major commitment from the Congress, more actually than provided even in these excellent bills, of funds for the cities.

Instead of the $100 million provided under this legislation, over the first three years, we need $1 billion if we are to save many more thousands of youngsters from the terror of a shattered mind or the desperation of a life with no future.

We need this sort of a commitment if we are to save the Ida Groves of America from the rapidly spreading spectre of a generation of mindless young.

This commitment must come in the form of a coordinated Federal assault as proposed in the legislation before this committee. But we must have the money channeled directly to our cities where we know the nature of the problem and have already set into motion the machinery that, with proper funding, we believe can bring this problem under control.

My shopping list is big. So is our problem.

Maybe if I lick our drug problem in San Francisco and John Lindsay beats his in New York and Carl Stokes gets his under control in Cleveland and Ken Gibson cuts his down in Newark, maybe then Mayor Anton Schau in Ida Grove can breath a little easier.

Unless we do, it is as certain to reach out and strangle the Ida Groves of America as it is strangling our big cities.

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Senator HUGHES. The chairman asks if Senator Moscone is present. Welcome to the subcommittee.

You may proceed with your testimony as you desire.

STATEMENT OF HON. GEORGE MOSCONE, CALIFORNIA STATE SENATOR

Mr. MOSCONE. Thank you very much, Mr. Chairman, and I am sorry that I was delayed and apologize to you. I enjoyed very much hearing the brilliant testimony of the mayor of my city on one of the more important issues of our time. I hope my testimony can be equally enlightening.

Mr. Chairman, at a time when the attention of the Nation has been forcibly drawn to the growing tragedy of the widespread heroin addiction and a shocked citizenry cringes at the news of an alarming incidence of drug use among its Armed Forces, my testimony today may run counter to prevailing mood and public acceptability.

It is precisely because the general public is on the verge of hysteria over heroin that I wish to speak briefly about America's No. 1 drug abuse menace, alcohol.

I share the horror revealed in the statistics on the growing use of hard and addictive drugs among our young people. But I am reminded that drug abuse among their elders is of epidemic proportions, and growing.

Alcohol, as members of this committee are well aware, is pharmaceutically grouped with morphine, codeine, and heroin. As so dramatically revealed in previous hearings before this committee, abuse of alcohol extolls a cost to America's individuals and collective society that is infinite and nonmeasurable.

On a monetary scale more than $6 billion are lost annually to business, industry, and government because of addiction to alcohol. California, with 10 percent of the total population of the United States, is estimated to house one-sixth of the Nation's alcoholics.

My city of San Francisco has the dubious distinction of being ranked as the drinkingest city in the country. In a city of approximately 700,000 men, women, and children, it is estimated that approximately 75,000 are alcoholics. Deaths attributable to cirrhosis of the liver are four times the national average.

Of our 75,000 alcoholics only about 1,500 are the visible derelicts of our skid row, and they account for three-fourths of the 2,300 annual arrests for drunkenness.

As in other communities throughout America, our main body of alcoholics are submerged. They are known as "private" alcoholics. They are covered and condoned by a society that has been conditioned to accept drinking, even abusive, excessive drinking, as a way of life.

In California, State and local governments are not unaware of the magnitude of its addiction problem. Alcohol and its abuse accounts for one-half of all nontraffic arrests; one-third of all inmates in penal institutions; and one-half of all patients in our mental hospitals and community clinics. An untold number are frequent patients in private sanitariums.

In a report prepared for the State legislature in 1970, the State auditor general determined seven State agencies expended $70,083,000 on alcoholism programs the previous fiscal year.

Of that amount the State spent $53,276,000—and $4,390,000 came from county sources. The Federal Government's contribution was $11,417,000. Of that almost $11.5 million, almost $10 million was channeled through the department of social welfare for support of families where the head of the family is alcoholic.

Some $1,880,000 Federal dollars went to our department of rehabilitation, whose programs are designed toward vocational rehabilitation of alcoholics and their return to the work force. For 1970–71, the Federal share has been increased to $3,200,000.

Of particular significance to me is the absence of Federal funding support for the extensive alcoholic programs conducted in our nine State mental hospitals where 10,000 patients with alcohol-related diagnoses were admitted last year.

It is in these hospitals and in community clinics, supported by State and local funds, where the innovative approaches are being made to help addicts discover the underlying causes of their addiction and how to live full, productive lives without alcohol.

I need not tell this committee that there is no single approach, no single cure (if indeed there is a cure) for alcoholism. That is why there is such a need for continued project explorations into both the psysiological and psychological aspects of alcoholic behavior.

The Federal Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970 was an important first step toward proper Federal funding in the battle against alcoholism. But the dollar amount available to States cannot match the need. Of this, the committee is no doubt well aware.

In California, mental health programs and facilities lead a precarious existence. An economy-minded administration, with no particular commitment toward public monetary support of these programs, continues to underfund and understaff our State facilities. Administrative edict will close one of our State mental hospitals this year.

So it is necessary that we turn to the resources of the Federal Government to meet the demands of what is, in actuality, a national problem. Alcoholism, like cancer, recognizes no State boundaries.

Cancer, once unmentionable, has gained a measure of public respectability. It is now acceptable socially to suffer and die from cancer. It is not, however, socially acceptable to suffer from, or die from alcoholism. The alcoholic is still a social pariah.

Although recognized as a disease by the American Medical Association since 1956, many hospitals won't accept alcoholics without a prior diagnosis of "gastritis" or "nutritional deficiencies." This hypocrisy extends deeply into the medical profession.

In most cases, an honest alcoholic is refused group medical insurance coverage. He must lie to buy life insurance. His presence is discouraged by medical doctors and by many psychiatrists.

His problems are considered so formidable that it is no wonder that alcoholics remain submerged—if possible—in a society that approves the use of alcohol but scorns abuse.

The public is apparently willing to accept the reality of an epidemic of veneral disease, but closes its eyes to an ever-growing wave of alcoholism. And alcoholism is on the rise. In California, 1 in 12 adults is alcoholic by most definitions of the term. In 2 years, by 1973, we estimate that the incidence will increase to 1 in 9.

The menace of heroin and addiction to drugs is real and a threat to our national well-being. Everything in our power must be done, at all levels of government, to combat its use. At the same time I urge this committee not to lessen its priority in the battle against alcoholism.

I urge you to continue to force the threat of all drug abuse into the public's consciousness, to seek ever-expanding funding for treatment and education; and to trigger needed reforms in medical treatment and medical insurance coverage, both private and governmental.

Mr. Chairman, and Senator Javits, I want to particularly commend the chairman of this committee for the contributions he has made to this most serious problem. I am only sorry that my late father, who was an alcoholic at age 29, did not have the benefit of having this kind of an outspoken approach to this most serious problem. I dare say he would still be with us today.

Thank you very much, Mr. Chairman, and Senator.

Senator HUGHES. Thank you very much, Senator Moscone. I appreciate your willingness to come and your willingness to testify. I think you heard my question to the mayor about the civil commitment laws in California. Are you familiar with those laws, Senator?

Mr. MOSCONE. Yes; that act is something of which we have been reasonably proud for some years.

Senator HUGHES. How has it been working?

Mr. MOSCONE. Not as well as I would like. It ties in with my discussion of alcoholism, because for 2 years I have been trying to insert a program where alcoholics would be treated on the same basis as those who otherwise would be given an understanding that their problem is less than criminal.

The first thing I think California has to do is eliminate the concept that drunkeness is a crime. I think we emphasized a great deal the question that Senator Javits talked about earlier this morning, and that, of course, would be the use of methadone, and if I understood the trend of what the Senator was saying, it was that notwithstanding the mystery that still surrounds the use of methadone—and that, I understand to be whether methadone at the same time could cause addictions that might be equally a problem—that we have to push ahead in that area while we continue to discuss other questions of addiction.

So I think we have a lot of work to do yet, and while I wouldn't say that funding is the answer to all our problems—I feel we ought to have an understanding, that the lack of State commitment to the problem has impeded the progress that we should be expected to make.

Senator HUGHES. You mentioned the passing of the Alcoholism Act in 1970, and the fact that the funding is inadequate. As of today, there has been no funding of that program, by the Federal Government.

Mr. MOSCONE. That is about as inadequate as you can get.

Senator HUGHES. We just passed a bill in the Senate last week that provided $80 million under that particular piece of legislation. The House had already passed legislation that provided $25 million. So

hopefully there will be a startup fund, at least, but it is totally inadequate.

Senator Javits, do you have any questions?

Senator JAVITS. I just thank the Senator, because the drug abuse thing is so highly pinpointed, and the alcoholic issue is not nearly as pinpointed because as you say, it is submerged.

But it is very much more numerous, and though it may not cause as much crime of a deliberate kind, it certainly causes us infinitely more deprivation socially and economically. Our own governor in New York—I just called it to Senator Hughes' attention this morning—Governor Rockefeller is now picking up the ball and running with it strongly with a major State conference and program with respect to alcoholism, and I hope very much this may inspire other States to do the same.

Add to that a major Federal program and we may be able to make some great progress. It is very interesting, I point out, that drunkeness is one of the worst things the Soviet faces, and they talk about sweeping it under the rug. That is their obsession.

So it is an interesting thing that this is one they very much not only share, but probably far outstrip us in.

Mr. MOSCONE. That is the one race they can get ahead of us in.

Senator JAVITS. We don't take any pleasure in it, but it is an interesting comment.

I join our chairman in thanking you for your testimony on what, in terms of numbers, is probably a 10-to-1 problem in terms of narcotics addiction, or more.

Senator HUGHES. Thank you very much, Senator Javits. I believe, Senator Moscone, you placed in perspective this morning the total problem of drug addiction, because one of the problems we face in America in intelligently discussing drug dependence and narcotics addiction and the abuse of drugs and narcotics is the fact that we don't have a total picture of it.

It is very difficult to communicate to people younger than our own generation the problems related to their own experimentation and use of certain drugs and narcotics. This, the method of communication, in itself becomes a problem.

We have such total abuse of one drug, which is legal, and at the same time we have a crying out against experimentation with drugs which they consider no more harmful than the legal drug.

Your own expression is one of familiarity with this problem, and I want to thank you for your leadership in your own State in relationship to the problems we share at the Federal level. Thank you very much.

The committee is adjourned.

(Whereupon, at 12:05 p.m., the subcommittee adjourned, to reconvene for further hearing at 9:30 a.m., Wednesday, August 4, 1971.)

DRUG ABUSE, PREVENTION, TREATMENT, AND REHABILITATION, 1971

WEDNESDAY, AUGUST 4, 1971

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

The subcommittee met at 9:45 a.m., pursuant to recess, in room 4200, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes and Javits.

Also present: Senator Miller of Iowa.

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

Senator HUGHES. The Subcommittee on Alcoholism and Narcotics of the Senate Labor and Welfare Committee will come to order.

This morning our witness is Dr. Jerome Jaffe, acting director, Special Action Office on Drug Abuse Prevention. He is accompanied by Mr. Art Konopka, acting general counsel.

Gentlemen, I am not going to make an opening statement this morning in the interest of time. Dr. Jaffe, you may proceed with your statement as you desire.

STATEMENT OF JEROME H. JAFFE, M.D., ACTING DIRECTOR, SPECIAL ACTION OFFICE ON DRUG ABUSE PREVENTION, ACCOMPANIED BY KONOPKA, ACTING GENERAL COUNSEL, AND GEN. ROBERT G. GARD, JR., DIRECTOR OF DISCIPLINE AND DRUG POLICIES, DEPARTMENT OF THE ARMY

Dr. JAFFE. Mr. Chairman, in the interest of time I will skip some of the paragraphs in my full statement and submit the full statement for the record.

I am pleased to appear before this subcommittee to testify on behalf of S. 2097, the administration's bill to set up a Special Action Office for Drug Abuse Prevention. During the past 6 weeks I have been engaged in the development of a number of plans, programs, and policies pursuant to the Executive order establishing the Special Action Office on an interim basis pending statutory authorization. I have also visited Vietnam and have been working in close liaison with the Department of Defense in the development of its screening, detoxification, and treatment programs. I would like to discuss the President's proposal for a Special Action Office in terms of what has been done to date and the way that reflects on how the SAO would operate.

The Special Action Office is a mission office within the Executive Office of the President which will be equipped to develop, implement, coordinate, and evaluate a national strategy for drug abuse treatment, education, training, rehabilitation, and research. At present no one Federal agency has the requisite authority or responsibility for this task. In fact, some nine Federal agencies have responsibility for various parts of the non-law-enforcement aspect of drug abuse prevention.

However, even if the departmental reorganization were to take place immediately, there would still be a need for the Special Action Office, as certain programs of immediate interest—such as those in the Department of Defense and the Veterans' Administration—would be outside the scope of the proposed Department of Human Resources. We need a Special Action Office to function for 3 to 5 years to provide coherent policy and overall direction until such a time as the separate agencies can proceed in concert.

The Special Action Office is also intended to upgrade significantly the capacity of the total Government system to integrate and coordinate its respective responsibilities and I view my role as an innovator and an instigator in achieving a tightening up of this system.

Relevant to the implementation of any national treatment strategy, one of our first steps must be to develop an inventory of the treatment capacity of drug abuse programs in the United States. We understand that there are, at least nominally, some 12,000 drug abuse prevention programs across the country funded by Federal, State, local, and private sources.

What we must determine for each is the type of service or services offered, the extent of professional and paraprofessional staff available, the number of patients or clients currently served, the average cost of that service, and the marginal cost for additional treatment capacity.

We are aware of the fact that in the first year of operation programs may require considerable funding for small patient loads due to the absorption of many resources in the starting up of operations. However, programs with extensive operations tend to find that each year their cost of inpatient and outpatient care per patient-year and their incremental costs for additional patients typically decline.

The survey that will provide us with information on national treatment capacity has already been initiated. In fact, it is a study already contracted for by the National Clearinghouse for Drug Abuse Information which was modified so as to begin to provide us the data we need.

I intend to generate a sense of urgency throughout all elements of the drug abuse area on which we must rely. I recognize the delicate relationships which exists between supply and demand in the drug area, between the military and domestic environments, and between voluntary and law enforcement aspects of dealing with addicts. It is my plan that the new Special Action Office will become the central cohesive force around which closer and more effective relationships can be built.

The authorities developed in S. 2097 allow the Special Action Office to proceed immediately and with authority in the following ways:

First, the Special Action Office 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 coordinating mechanisms with them to insure a uniform coherent national policy on the programs for research, prevention, treatment, and rehabilitation. My office is developing 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.

Second, in addition to acquiring the policy control discussed immediately above, the Director of the SAO, 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 central to the Federal civilian drug abuse prevention program. They, therefore, represent the priority efforts over which the Special Action Office must exert its authority for direct management control.

The SAO authority is specifically intended to face up to the need for continuous evaluation of the success or failure of programs 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.

The Special Action Office is still in the early stage of its development and thus has not formulated the precise mechanisms by which budget and management control will 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. We believe there needs to be policies in each separate sphere—treatment, research, prevention, and education. We shall formulate these 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: Fiscal authority provides a necessary tool for integrating programs and implementing decisions on priorities. 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 to 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 for 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: By regular reporting mechanisms the Special Action Office would be kept currently informed of the status of actions being taken under various programs. The reporting requirement 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 the 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.

The authorities proposed by S. 2097 establish one central source for policy, information, and coordination through all the operating agencies: Federal, State, and local. This source has no vested interests, is temporary in nature, and will most likely operate no treatment programs of its own—though it may do so if that becomes necessary.

We feel that the most persuasive force for implementation of the policy formulated by this Office must be the reasonableness of that policy viewed in its overall context. The Office must have the flexibility to change policy as the conditions indicate and be able to speak specifically and immediately with authority to problems as they develop.

So that there can be assurance that the enunciated policy will be uniformly implemented—assurance both to the people and organizations who must deal with the Federal agencies and to the Nation as a whole—the Special Action Office is granted budgetary and management authorities over the key drug abuse prevention programs. With-

out this clear grant of authority to the Director, I feel it would be most difficult for him to make any assurance that his policies would be carried out and most difficult for him to insure coordination of even the Federal programs.

Anything less than this gathering of authorities would severely limit his ability to respond to emergency situations or particularly complex situations requiring various and multiple modes of treatment, or multiple modes of funding.

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. One of its goals 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 is 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 empirical as well as intellectual learning.

We are exploring the possibility of introducing 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 of this question. We are also considering the viability of secondary prevention—intervention into 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 response by trained teams before the phenomenon can spread or become firmly established. Perhaps someday in the not-too-distant future this possibility will exist for the communities of America.

These are 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 August 1 had tested 41,800 departing servicemen. Of these, 2,275 or 5.44 percent had urines positive 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 opiates 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 specially 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, we believe, 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 points 14–21 days before departure, and 2 days prior to departure (the screening process already in effect) and points in between.

The implication of this is that all servicemen will have remained drug free for 3 weeks prior to their 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 installed 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 sufficent manpower will exist onsite in Vietnam, and that facilities in the United States and Europe will be better able to provide adequate treatment for servicemen with drug-dependent 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.

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 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 most of the data we have requested on treatment, detoxification, and identification facilities. The same information is being developed for all 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.

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 more that will have a 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 civilian society. 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.

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In other testimony I have been 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.

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 combat 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 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 the administration's bill are viable and effective. We do 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 hope 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 S. 2097.

Thank you.

Senator HUGHES. Thank you very much, Dr. Jaffe. Does your colleague, Mr. Konopka, have any additional statement he would care to make?

Dr. JAFFE. No, sir.

Mr. KONOPKA. No, sir.

Senator HUGHES. Dr. Jaffe, your entire statement didn't mention S. 2217, a bill introduced jointly by myself and other Senators. Was this a deliberate omission, since you knew you were going to be testifying this morning on that particular bill as well as the administration's position?

Dr. JAFFE. Not at all, sir.

Senator HUGHES. Do you have any opinions?

Dr. JAFFE. I have read all those bills.

Senator HUGHES. You have forgotten all but the President's, then?

Dr. JAFFE. No, it was my impression that I was to testify on behalf of Senate bill 2097, but that I could answer questions and should answer questions on the other bills.

Senator HUGHES. It is the obligation of this committee to consider all of the bills that are presently before it. We would appreciate your comments, and will submit the entire bill to you and hope that you will give them to us in writing. I will ask you some questions with relation to it as we go along.

Dr. JAFFE. Certainly.

Senator HUGHES. Dr. Jaffe, in your prepared statement, if you would turn to it, about halfway down through the first long paragraph is a sentence starting, "So that there can be assurance." Do you find that?

Dr. JAFFE. Yes.

Senator HUGHES. "So that there can be assurance that the enunciated policy will be uniformly implemented—assurance both to the people and organizations who must deal with the Federal agencies and to the Nation as a whole—the Special Action Office is granted budgetary and management authorities over the key drug abuse prevention programs."

Now, if you will turn with me to page 14, at the beginning of the first complete paragraph, you say, "In other testimony I have been 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."

Here DOD is totally inexperienced at handling anything at all in this area. You say you shouldn't have any control over it, and you go to other agencies that have had experience and you must have control over them or you can't operate.

Can you reconcile that difference for me? It is an interesting question.

Dr. JAFFE. Yes, it is, and I appreciate the apparent inconsistency. The general feeling is that treatment within the military——

Senator HUGHES. Whose general feeling, Doctor, yours or someone else's?

Dr. JAFFE. It seems to be the consensus of opinion of the people I can query, and this is buttressed by some of my observations in Vietnam, that the treatment operations are so inextricably intertwined with command operations that budgetary control in and of itself without the authority to command the military, adds very little to one's capacity to implement policy.

It literally takes command decisions to implement drug abuse policy within the military and these policies have to be weighed against the other major, primary missions of the military.

For example, right now helicopters are used to move urine specimens from point to point. I think I would be reluctant to see us budget special helicopters for transporting urine.

Commanders with responsibility for that equipment make them available, and they have to program the availability of those capacities into their decisions and their other missions.

This seems to be an issue of the totally self-sufficient aspect of the military apparatus, both for its medical treatment and its combat responsibilities.

Senator HUGHES. Dr. Jaffe, what was the military doing when you first looked into the handling of the drug situation?

Dr. JAFFE. I looked over the steps that they had taken over the previous year. They included educational programs, the development on a command option basis of what were called amnesty programs. These were small areas where men could seek treatment, and there were a number of efforts to control the availability of drugs as well as efforts to communicate with troops about the issue of prevention.

To a large extent, we have seen the military in transition from a time when drug abuse was a court martial offense, to a time when there is recognition that drug dependence requires a less punitive response.

Senator HUGHES. Can you assure us that that is so in every service today?

Dr. JAFFE. With the kind of scientific reliability that I feel makes me feel comfortable, I cannot, sir. I can say to the best of my knowledge it is true as far as I have seen it in the Army, the Navy and the Air Force.

Senator HUGHES. How about the Marine Corps?

Dr. JAFFE. I saw none of their facilities. They have a very small fraction.

Senator HUGHES. Are they admitting yet they have a problem?

Dr. JAFFE. I believe so, sir. But to the best of my knowledge, the Marine Corps policy is precisely the same as that of the other departments within the Department of Defense.

They use Navy facilities for treatment, and the very appearance of the Marine in the Navy treatment facilities suggests that indeed they are following the policy. But, again, I am not sure how much assurance you want that this is actually being implemented.

I am certain that the Secretary of Defense and the Deputy Secretary, Mr. Packard, have made the amnesty concept apply to all services.

These is no question about what the policy is. I think your question addressed itself to "Can I give you my personal assurance that at the lowest levels that policy is being implemented?" and the answer is I can only tell you what the policy is and what I saw myself.

Senator HUGHES. Dr. Jaffe, are we still relaying information, from patient to doctor, to command personnel, law enforcement agencies and so on in the military?—Is the doctor-patient confidentiality relationship still being ignored?

Dr. JAFFE. No information on patients in treatment is being turned over to military authorities. We discussed this with people in the military intelligence and military police. I can ask, I think, General Gard here. Perhaps he could tell me whether that general policy has been implemented.

Senator HUGHES. General, can you respond to that?

General GARD. Senator, as far as the confidentiality between a patient and his doctor as he is undergoing treatment, the command has not the right to have the information revealed to other than medical authorities.

Now, I have talked to several military psychiatrists and asked them as a practical matter how they would handle this kind of problem.

If, in their view, they receive information from a patient in which his own safety or the safety of the command is in jeopardy, and it is

a judgmental matter on his part, he sometimes will reveal that information. I spoke last evening with one who discovered that parents, service parents, were abusing children and he felt in his view that the life of that child was at stake. He felt that he should reveal this information, even though it was given to him confidentially.

He was sued for it by the parent later, but he was exonerated in providing that.

I think the only fair way to answer your question is that you can't make a hard, fast rule about confidentiality, but it must be a judgmental matter.

Senator HUGHES. Dr. Jaffe is very aware of this particular problem. I understand you are setting up a task force to look into this. Is that right—to look into the confidentiality of patient records relative to treatment?

Dr. JAFFE. This is one of our major problems, the problem of confidentiality, against the issue of preventing certain abuses, for example, of the methadone matter. How do you prevent multiple registration unless you can identify the patients?

How do you get data on incidents and prevalence unless you have a way to identify people, not necessarily by name? The concern is, how can we see that confidentiality is protected as we gather information?

We are developing a task force to try to balance these issues. This has also come up with respect to our situation in handling servicemen. We do want them to know that treatment is available to them. If you take the names of people who have had treatment, even through medical channels, and we send them letters when they reach home as a sort of reminder that in case something goes wrong, we have facilities standing and waiting for them, are we not violating the relationship by sending them that letter?

These are very, very complex issues. You can decide that, "No, we won't write them a letter, because someone at home may open it," and the consequence of that may be that he feels no one cares.

I am not certain that these things can be resolved easily, and I will await the advice of the experts we will bring in to consider these matters.

Senator HUGHES. General, under article 64–10, September 18, 1949, are names of amnesty users turned over to the FBI?

General GARD. They are not, sir.

Senator HUGHES. That is no longer done?

General GARD. That is no longer done.

Senator HUGHES. Are you speaking ony for the Army?

General GARD. I am speaking only for the Army, sir, but as I understand it, the other services are following the same policy.

Senator HUGHES. What if the FBI requests such information?

General GARD. If it is simply a matter of a man having been identified as a drug user, I don't believe they would receive it, sir.

Senator HUGHES. On trafficking, for example?

General GARD. If a specific question comes up on trafficking as such, the current policy is that the criminal investigating division has specific information on trafficking will provide it.

Senator HUGHES. If I read this carefully and correctly in the statement, "And furthermore, the Navy can turn over to civil authorities

any information the exemption application gives them about his own possession and use of drugs, and while he may not be prosecuted for this in the service, he can be prosecuted for this by the civil authorities, whether in this country or in countries where we have status of forces agreements."

General GARD. I cannot address myself to that, sir. I was unaware of the Navy's policy.

Senator HUGHES. I have a lot of questions in relationship to this matter. I am going to pass most of them by because, Dr. Jaffe, you are very familiar with the question. I know that from your previous experience, and at least for the time being we are going to have to trust in your confidence and your ability to protect the interests of these men to the best of your ability.

I know you will.

Dr. JAFFE. Senator, I hope that when policies come to light that seem inconsistent with the major thrust of what we are attempting to do, I would hope that the Senate and others would bring these to my attention, because if that Navy policy is still in operation, this must be brought out.

Senator HUGHES. I don't know whether it is or not. It seems to be from the written record we have here, but things have been changing rapidly in DOD and the services.

Dr. JAFFE. We hope so.

Senator HUGHES. I hope you will continually review this to see that there is a uniform policy in the services and that, if possible, we can, to the extent of the ability we have, protect the confidentiality of patient records.

If you turn to your prepared statement where it starts, "If the test is negative, there is no delay, and the serviceman returns home. If positive, he remains in Vietnam at a specially 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."

Can you explain that "if needed" to me?

Dr. JAFFE. All of our information indicated that we had a number of people who were what we might call—we have no specific term—discretional, occasional users, the man who for whatever reasons elects to experiment with heroin, and elects to experiment too close to this period of testing. So the kind of people we might pick up with the kind of diagnostic procedures we are using are not necessarily all hard-core narcotics users, at least of the kind we have become familiar with here in the United States.

There may be a few persons who have used just once. It would be difficult to make a uniform policy for every single one on that basis, that is, that everyone would therefore require extensive treatment.

Further evaluation——

Senator HUGHES. Can you determine by urinalysis if a man has used heroin only once?

Dr. JAFFE. Of course; if he has used it close to the testing.

Senator HUGHES. He would need psychiatric help if he shot up within 3 days of returning home.

Dr. JAFFE. I am not sure whether it is psychiatric or educational. When someone knows he is going to be in for a period of observation, who elects to use drugs that close to a period of testing——

Senator HUGHES. For the first time?

Dr. JAFFE. Or even for the second time.

First of all, I think he may not realize that what he is taking is heroin and we are going to pick it up. Somebody may tell him it is something else. It may very well be that it is the first time because he feels, after he leaves, he won't have the opportunity again. I can't speak to the motivations of thousands of young men.

Senator HUGHES. It isn't necessary. My point is, in this 7 days you talk about, and what percentage of that 5.44 percent you mention, you are detecting are going to need extensive help beyond that?

Dr. JAFFE. I think as time goes on— and we are rapidly approaching that time—that the men coming into that situation are the ones who do need help. The 7 days is what we have accomplished in a matter of weeks. It was never viewed as an adequate response any more than first aid is viewed as an adequate response.

Senator HUGHES. That is what I am getting at. You don't consider this an adequate response?

Dr. JAFFE. Not at all, sir; and it was not intended to be. We are gearing up to provide a minimum. I think our commitment to the American people is a minimum of 4 weeks of drug-free behavior prior to discharge.

I think once you get beyond that into arbitrary periods of time, you begin to get people where further rigid treatment outside their home communities becomes counterproductive.

Meaningful activity is, I think, a keystone to overall rehabilitation, and that means we have to get people back to where they are involved in something meaningful. When it is time to be discharged, I think 4 weeks is sufficient for most of the men that we are looking at. I don't say that for every narcotics user, but we give them an option for what they are going to do with their lives. Some could certainly use more, and it is our obligation to develop civilian capacities so that those who want more, and those who can use more, can have it.

Senator HUGHES. Civilian capacity, or Veterans' Administration capacity?

Dr. JAFFE. In my own view, a man does not lose his citizenship by having served in the military.

Senator HUGHES. He has recently, almost.

Dr. JAFFE. We have a health care system in the VA that can be geared up rapidly to handle the problem. That doesn't mean that every man in the service with a drug problem will feel obliged to go to the Veterans' Administration.

I feel strongly that treatment close to where a man works, to where his family is, is in most respects the most effective kind of treatment, to the exent that it is possible to have a veterans' facility in every small community.

Senator HUGHES. Do you expect to pay for the treatment of those people to be treated close to home through contracting, and are you requesting enough funding to do that?

Dr. JAFFE. Ultimately we feel there has to be enough funding so that no drug user goes without treatment. The boundaries of this involve policymaking far beyond my office.

Senator HUGHES. It is not beyond your office to make the recommendations, however. That is what your office is for.

Dr. JAFFE. We will recommend that every citizen get treatment. What I am trying to clarify is that all of the bills I have seen include a specific statement that our office cannot, in fact, go contrary to the decisions of Congress on State and Federal matching situations, so that apparently there is going to be a need to continue to review the role of the local communities as well as the Federal Government.

Senator HUGHES. What has your experience been with that in Chicago?

Dr. JAFFE. I think in the beginning it is unrealistic to ask a group that has no support, that has sufficient resources and time to go out and develop the local support. At least in the beginning the Federal Government should take initiative to fund things that create a base from which community support can be developed. On the other hand, I feel that traditionally and at least for the near future, health care delivery systems involve local, State, and private components. I am not at all certain that it is either desirable or necessary that the Federal Government support all medical care for all people no matter where they are.

I don't consider myself an expert on that issue, but I have noted in all the bills that the matching requirements for participation of local groups have been included and cannot be deleted from the authorities, and I assume that the reason for this is that this kind of policymaking is reserved by Congress.

Senator HUGHES. Congress can change its mind on occasion.

Dr. JAFFE. I would hope in some of these instances Congress would review this.

Senator HUGHES. We are looking to you for a lot of guidance, Dr. Jaffe. Whether you like it or not, you are now the Nation's expert.

Dr. JAFFE. I don't pretend to be the Nation's expert on total budgetary policy. It may well be that the nature of this office will force me to develop a greater expertise in that area, but at the present time I consider myself knowledgeable primarily in the field most directly related to drug abuse.

Senator HUGHES. Let's go back to your program in Chicago. How many patients did you have there?

Dr. JAFFE. At what point in time?

Senator HUGHES. At any point in time you want to pick.

How many did you have the last calendar year, or the last fiscal year?

Dr. JAFFE. As of July 1 of this year when I formally gave up responsibility for that program, we had somewhat over 2,000 patients in continuous treatment at any given time.

Senator HUGHES. What was the budget?

Dr. JAFFE. The budget was a little over $2.5 million.

Senator HUGHES. $2.5 million for 2,000?

Dr. JAFFE. Yes, sir.

Senator HUGHES. Do you have a percentage of success in relationship to that expenditure?

Dr. JAFFE. Success is unfortunately too simple a word for a very complex issue. We did not use a single treatment approach nor did we treat a single subgroup in that population. To talk about success, we would have to talk about success along various continuums.

We measured success in at least five ways: In terms of lessened drug use, in decreased criminal activity, in increased employment, in terms of stability, and staying in contact with the program. We measured success in terms of human and interpersonal progress and family stability. The difficult aspect of this is that people do not progress uniformly along all those continuums.

Senator HUGHES. How many of those 2,000 are veterans?

Dr. JAFFE. We asked the question about veteran status only recently on a survey. The information that I've received, as of last week, revealed that somewhat over 60 Vietnam veterans are in treatment.

Senator HUGHES. Go ahead, Dr. Jaffe.

Dr. JAFFE. I can't say how many Vietnam veterans, for example, in total, had come in over the year. There were 60 at a given time.

We did not ask on our intake form about veteran status, as I recall, and therefore we had no way of capturing the data on it.

Senator HUGHES. Do you view the veteran addict population, this 5.44 percent, as being easier to treat than 2,000 people you have in Chicago?

Dr. JAFFE. In some ways I believe they will be, because——

Senator HUGHES. They are younger, they have been on it less time?

Dr. JAFFE. I think in a sense being younger has not in general proved to be a hopeful fact. It may make it more difficult on that basis.

On the other hand, they have—let me pause for a moment to point out that information coming in from Vietnam now indicates that a number of servicemen who are drug users were drug users before they entered the military.

Senator HUGHES. They were?

Dr. JAFFE. They were before they went in.

Senator HUGHES. That is what we have been saying for about a year and a half without anyone listening.

Dr. JAFFE. I was listening, sir.

Senator HUGHES. What are you doing to tighten up the screening process?

Dr. JAFFE. The Air Force has already initiated a process to screen people as they come into the service. To the best of my knowledge, as the urine testing capacity is geared up, the Army will do the same. This will give us some idea of what we are dealing with.

Senator HUGHES. The general looks like he would like to say something. I would like to give him the opportunity.

General GARD. Senator, when the people go to the Armed Forces entering and examining stations, the doctors there are supposed to do what they can to determine drug addiction. However, we are not in a position at these 74 facilities to provide the kind of urine screen, hang onto the people long enough to get the results, put them under medical observation and keep them for the period of time we think it is necessary to make that determination. Therefore, we have to do this by physical examination observation.

But as every soldier comes into one of the eight reception centers around the country now, he will receive, indeed we have already started

doing this—he is receiving a urinalysis screen. It is sent to one of three civilian agencies that can run the sample for us. If he turns out to be a confirmed positive, in the initial test and the confirmatory test that you and I have discussed before, he then will be placed under this medical observation and a determination then made as to whether or not he seems to be drug dependent.

Senator HUGHES. You are totally committed to this kind of a program in the Army, are you not?

General GARD. We are, sir.

Dr. JAFFE. We ought to make clear that, again, not all these young men are addicts in that sense. The thing that, in fact, seems to be hopeful about this situation is that the thing that perpetuates addiction in some measure at least in the civilian population is that people learned to use drugs among friendship groups. They use drugs and their friends use drugs, and when they try to stop, they lose their entire circle of acquaintances.

To have a friend, you have to associate with a man who is using the drug, and in a sense they become reinfected.

To the extent this is not true of this group that is using drugs, they may return to a situation where their friends may be drug users, and they will return to other life styles and may not return to drug use at all.

This, I hasten to state, is a hope. It is a hypothesis. It requires our testing of this situation. We will try to obtain that data by followup, and should it prove to be so, we will feed that information back into the system so that we can modify treatment and design it for this new kind of drug use.

Senator HUGHES. How many addicts did you estimate were in Chicago, Dr. Jaffe?

Dr. JAFFE. Our estimates were between 8,000 and 10,000. It varies. By the way, I think I may have left the impression that our treatment program treated only 2,000 people. It has a capacity for 2,000 people. In a program where you treat a variety of people, some of whom you treat for a matter of a month or two, some needing treatment continuously, you have a turnover.

We have treated in that period of time something over 4,000 people, and assuming treatment for some people lasts only a matter of months, it is possible in a center of that size to treat well over 2,000 people in a year because there is some turnover.

We don't think that someone who is a drug user is inevitably a drug user forever, that they don't have a capacity for change, that they can't be totally rehabilitated. We know of people who have been. They have gone to other parts of the country and are working in the mainstream of society.

So when we talk about a treatment capacity, we don't mean that is static. If it is a turnover of every 6 months, that facility can treat 4,000 in a year. The complex decisions that go into deciding on how the system has to be, one has to say, "What kinds of people are we to treat, at what period of time, and what is the turnover?"

We tried to do that as we geared up the Chicago program.

Senator HUGHES. How many people in Chicago generally, in your experience, have gone away after 4 weeks' treatment without any further help?

Dr. JAFFE. Well, a lot go away and there is no further help. The real issue is finding them to find out how well they did. We have to admit that many people feel after several weeks they are able to do well on their own.

Senator HUGHES. Do they usually?

Dr. JAFFE. Not usually, but surprisingly enough in some situations they do. These are atypical cases, but certainly because there are these atypical cases, we are hesitant to build some kind of a Procrustean bed which says everyone must stay 4 months or 6 months or 1 year.

Sometimes the healthiest thing a person can do after 4 weeks is to say that he never wants to associate with drug users again. Those people do best of all. I think our treatment systems have to reflect the needs for that variability.

Senator HUGHES. Of the 5.44 percent, Dr. Jaffe, if you could completely test all the men in Vietnam now, how many do you feel would be showing positive signs?

Do you think it would be double that if you could run a complete test on everyone there now?

Dr. JAFFE. As a matter of fact, they have attempted to do some complete random samples to get that. I would suppose that it would be somewhat higher than that, based on this. Suppose we estimated that of all of the men in Vietnam 5 percent could be regular users. There would be another group of occasional users.

Assuming they used once a week, if you did the test on any day, you would pick up one-seventh of them, assuming they didn't all use on Sunday. You have this kind of probablistic problem. It would be somewhat higher, but I doubt if it would be double that rate.

Again, I think it would depend on the day you picked and the tendency of the people to use on a particular day.

Senator HUGHES. Are you saying that a man can use heroin once a week and not become addicted?

Dr. JAFFE. I guess I am saying it because it has been seen, sir. It is not a common phenomenon, and I am not sure how long one can do that once a week and not ultimatley become a regular user.

We are told, and we have taken history from some people who say that; yes, that can occur.

Senator HUGHES. How do you feel about it as a professional? You have worked in it as long as anyone. Do you feel a man can use heroin once a week and get by?

This is the kind of information a lot of people in the country want to know, if they are thinking about experimenting.

Dr. JAFFE. Well, I would like to put it in its complete context, that——

Senator HUGHES. First, put it simply so I can understand it.

Dr. JAFFE. The answer is some people can.

Senator HUGHES. What, 1 out of 10,000 or 1 out of 5,000 or 1 out of 10?

Dr. JAFFE. Well, it is more than 1 out of 5,000. It certainly is fewer than 1 out of 10.

Senator HUGHES. But it is a high risk?

Dr. JAFFE. It is so high that there is a tendency on the part of people who are knowledgeable to take the simple position and say that you can never start and not become dependent. From a public infor-

mation point of view, I am not sure that does too much violence to truth. But if you pin me down in a scientific way and ask is it possible for a man to use heroin once a week for a period of weeks and then stop entirely without becoming dependent, I would probably have to say that from the surveys of people who have done this, "yes, it is possible."

It may be exceptional. We have a dilemma in public education. Can we tell people you can start, use it once and do it with impunity?

The fact is, the rare case can. Or should we, in fact, tell people it can never be done, that inevitably a single use leads inevitably to regular use, and thereby damage our credibility.

These are decisions that everybody makes in trying to communicate. Very often people don't take the time to hear the situation in its full complexity, but since we are taking the time here, I will try to give you as full an answer as I can.

Senator HUGHES. I have heard a lot of speculation about it, and so have you, and you have also treated a lot of patients who thought they could get by with using it once a week, haven't you?

Dr. JAFFE. Too many, sir.

Senator HUGHES. They wound up using it three times a day in the long run.

Dr. JAFFE. Yes.

Senator HUGHES. That is a pretty high-risk factor.

Dr. JAFFE. So high that I haven't felt bad in saying, "Don't even experiment with this drug."

Senator HUGHES. How do you view the 5.44 percent, and let's say you are correct as near as can be? It this an alarming figure, or is this something that America shouldn't be alarmed about? Is it an epidemic? What is it?

If it were some other illness and incidence were 5.44 percent in the Army, what would be your opinion?

Dr. JAFFE. It is certainly an epidemic.

Senator HUGHES. My concern has been very honestly that the estimates were 10 to 15 percent in Vietnam, and now they are down to, I think you said when you came back, 4.5 percent, and now 5.44 percent, and the tendency is to play down in the minds of the American people that we don't have much to worry about because the rate is only 5.44 percent.

Dr. JAFFE. Senator, I can only tell you that I have done everything I can in every opportunity I've had to speak publicly to avoid conveying that idea. We don't want to underplay or overplay this situation. Frankly, I have said in the past that if 5 percent of 200,000 men have a serious problem, this represents three or four times the treatment capacity of many major treatment systems.

This is a major problem.

On the other hand, I don't think we are well-served by conveying the idea that every man who has been to Vietnam is a potential or confirmed drug user. 95 percent of the men do not have drug problems. They are seeking employment, they are seeking acceptance back in the mainstream of society.

I don't think we need people looking at them as if every one of them is a heroin addict. It is important not to minimize—certainly I hope

that nothing I have ever said has indicated that 5 percent is anything less than a tremendously serious problem.

On the other hand, to talk about 15 percent of the men as addicted, meaning confirmed heroin addicts, cannot be supported by our information at this time.

Senator HUGHES. How many can be confirmed as experimenters in your opinion, by your information?

Dr. JAFFE. I can tell you some of the data we have.

First of all, a survey was conducted by using questionnaires among the men most likely to be drug users, young men below the rank of E–5. This survey was made in April and May and indicated that something over 10 percent were occasion users.

Senator HUGHES. That includes the 5.44?

Dr. JAFFE. Yes.

Senator HUGHES. In other words, another 4.5 percent or 5 percent.

Dr. JAFFE. Yes, of that group of occasional users, 5 percent were—on that survey—heavy users.

Now, what does that mean for the command in general? Remember, this was only the Army, and only men below the grade of E–5. Our data indicates that the officers and men above E–7 were rarely drug users. The kind of figure you would project over the entire command, you would have to dilute the information by the number of people in the officer corps.

Then our information indicated that neither the Navy nor the Air Force, because of their geographic locations and their activities, had the same percentage, and if you want to project it onto the entire command, you would have to further dilute that percentage of experiment.

Certainly we feel that the percentage of experimenters is going to be somewhat higher than the 5.4 percent that we have been getting. I doubt that it can be higher than 8 or 9 percent, but again, to say this without information is simply to lead to speculation.

We are trying to get that data in reasonably scientific effective ways. It probably will be several more weeks.

Senator HUGHES. The only thing we need is speculation on what we try to do in attempting to design, and fund legislation. We need the truth, and I am not implying to the American people that all the veterans that come out of Vietnam are affected. I do not want the people of America to get the opinion that 5.5 percent of them are heavy users of opiates. Opiate use is now a damned serious problem.

Dr. JAFFE. I don't know how I, as one developing a treatment capacity for that group of men, can say it more strongly.

Senator HUGHES. If you will turn to your prepared statement, and this may be just semantics, but I do want to question on it: "We are receiving on a regular basis from the command in Vietnam through the Department of Defense most of the data we have requested."

What are you not getting?

Dr. JAFFE. I omitted that——

Senator HUGHES. I noticed you omitted it.

Dr. JAFFE. What I was saying is that there are times when a scientist looks at things in retrospect and asks for data that nobody ever gathered, and I have occasionally done this to scientific colleagues.

You just requested that I give you information on the number of veterans in the Chicago program. We did not have the foresight in 1967 to put the question "Are you a veteran?" on our intake form.

You requested that data, and I in all honesty cannot give it to you. That is what it meant. We have asked questions that would be useful that cannot be anticipated.

Of that data that has been gathered, we have either gotten it or it is in the process of analysis to be turned over to us. Nothing has been withheld.

Senator HUGHES. Do you consider your working relationship with the Department of Defense to be perfectly satisfactory, that you are getting complete and full cooperation, and that they are following the advice you are giving them?

Dr. JAFFE. Fortunately, they don't follow all of it, because maybe they persuade me that it wasn't that good, and I appreciate that.

Senator HUGHES. Who knows more about it over there than you do?

Dr. JAFFE. They know an awful lot about how to run a military operation.

Senator HUGHES. They apparently have a lot to learn about narcotics addiction.

Dr. JAFFE. I hope we can teach them a lot, but, again, not everything that strikes us as being immediately possible turns out to be so, or even to be wise. I hope that people won't accept every single thing without questioning whether or not the policies that are going to be elaborated are sensible and reasonable.

When they are reasonable, I expect they will be implemented.

Senator HUGHES. The Chair wishes to welcome Senator Javits, who has been cooperative with the committee. We also have Senator Miller of my home State of Iowa, and Governor Ray of Iowa, who is going to be a witness a little later on when we get finished with you, Dr. Jaffe.

Senator Javits.

Senator JAVITS. Dr. Jaffe, it is my first opportunity to appear at a hearing at which you are testifying though I am a member of both of the committees before which you testified, and I welcome you. I would like to assure you of the fullest understanding and cooperation.

We may ask provocative, often nasty questions, but we are exactly on your side and we know you are on ours. So bear with us and we will bear with you.

I like the idea that you are on the job, and whatever may be the lacunae in your authority, as you have said many times, a person can stand all of those vacant places even if there is an abyss.

The first question I have, and I will not detain you very long, is precisely on that point. There are two authorities which apparently you do not reach, the Department of Defense and the Department of Justice.

You have already stated your view as to the Department of Defense. I am inclined to side with our chairman on that. I don't see any secrets, and I have served myself for years in the military, and I don't think they are all as secret as the people are led to believe.

But laying that aside, what about the Department of Justice? They are not only engaged in law enforcement and the intelligence of law enforcement but other factors which are critically important to your mission.

We know of a fellow who has been sentenced to 90 years in a given State because he had some marihuana in his possession. He had a long arrest record, and he has just been extradited from New York because we believe the Federal courts will see that he doesn't get 90 years. But nonetheless, that is the kind of place where Justice impinges on you.

The second point is that Justice also handles the education of law enforcement officers, and I would beg you, sir, to look into that carefully, because their responsibility could also be broken down. Maybe the President doesn't want you to have any supervision over John Mitchell's budget, and he is a great friend of mine and I can understand that, but perhaps there are aspects of the work which you ought to be deeply concerned about.

Dr. JAFFE. Actually we do have budgetary control over educational activities of the Department of Justice. We do have policymaking and budgetary authority within the programs in the Department of Justice that impinge on education and treatment.

Senator JAVITS. And also the education of the enforcement officials?

Dr. JAFFE. We would hope we can persuade the Department of Justice about the reasonableness of a uniform curriculum in certain areas for people who treat, and people who make policy and people who enforce laws. Understandably people like to run their own teaching programs. We would have no capacity to teach people to do investigative work or law enforcement work.

There is overlap, however, and where that can be fruitful, I would develop a single core curriculum where Justice people could interact with others getting involved in communication. I would hope that would come about. In every presentation we have made in our international training center we have included people from the Department of Justice in the hope that they would participate.

Senator JAVITS. Dr. Jaffe, you are relatively new to the Federal Government, and I hope you will forgive me if I say what I am about to say. I hope that in your relations with the Congress you will appreciate that we, too, have a few brains around here and a lot of experience, and you don't have to apologize for everything the administration does.

If its record is 75 percent, it is terrific. That leaves a lot of margin for error. So I suggest to you that you have a good, hard look at what is allegedly sacrosanct in every Department, Defense and Justice included, in order to see whether to carry out your mission you need to have greater authority than apparently you have over that particular aspect.

It doesn't have to be by the law or the record. It needs to be simply effective. I assure you, if your mission fails, there will be few people who will attend the wake. You and the country will be the likely ones that will do most of the grieving.

So I just beg you to bear those things in mind.

Dr. JAFFE. Senator, I believe there is in the bill a provision so that the President can transfer additional authority, budgetary authorities, under the special action office with the approval of the Congress.

Senator JAVITS. While you have got the President with you, use it. [Laughter.]

Just a few other questions, Dr. Jaffe.

First, one line of questioning and that is about the veteran. We have had an enormous problem with all kinds of treatment of the rate of recidivism, and the fact that so long as they are in treatment they are all right. The minute you let them out, the rate of return to drug addiction is extremely high.

Therefore, would you consider the possibility that the 21-day, or whatever short treatment is going to be given the veteran, is very likely to prove ineffective? I don't say "useless," but ineffective.

I realize many of them are superficial users and many are relatively new users and the atmosphere of Vietnam is different. But the experience has been that that is hardly likely to bail them out. So would you give consideration to what inducements could be given the veteran in coordination with the Federal Government, working with the States and localities, so that he is in a sense passed from hand to hand, he isn't just turned loose on the community when he is only technically drug free?

I especially mention that because in my own city we have a crime problem that is so tremendous, and a veteran knows how to use weapons, and has been raised in an atmosphere of violence anyhow, and there is great concern about that.

So could you make some recommendations, now or any other time, that would deal with rather a sense of continuity in the veteran being cast, as it were, from the military establishment to the civilian establishment, and some inducement to become drug free?

For example, it has been suggested that a trustee administer funds for him while in treatment so that he has a sense of economic well-being and so on. It also has been suggested that he might get a honorable discharge if he hasn't earned it in the forces, through the rehabilitation process, and again that is a very great incentive.

Those are only two suggestions. There may be others. I would appreciate any comments you have.

Dr. JAFFE. We are looking for incentives to motivate people to stay in treatment in general. I appreciate your comments on the need to pass people from hand to hand. In our program, for example, we did some research and instead of referring somebody who was taken in, we said, "Treatment is available for you." These people had waited several months to get into it.

We treated them a few days, and transferred them to another unit, for most people it was 14 blocks away; 75 percent of them never showed up.

We have been discussing with the Veterans' Administration and DOD ways to do precisely what you have just suggested, pass him from hand to hand, pick him up when he gets off the plane and so forth. I am not sure how far along these specific plans are.

Senator JAVITS. That is all right. You will work on that?

Dr. JAFFE. Yes.

Senator JAVITS. Please feel free, with the permission of the Chairman, to supplement this record in any way with details of what is being done.

I have one last question, and that is on methadone. I understand that you are rather partial to the methadone idea, and the question I would like to ask you is, what can you tell us about it, both morally and practically, as a man of great experience in the field?

Let me give you my reason. We are faced with a dreadful scourge upon society, and the balance is definitely in favor of society. Hence, the feeling of people like myself is, notwithstanding the uncertainties and the fact that methadone is itself an addicting drug, society simply demands an immediate curb on the danger, and the most humane curb that apparently we all know of is methadone. Yet many have appeared here, and will appear again, who object violently to its use or to heavy reliance upon it.

As you know, in New York we are about to go to 20,000, about a fifth of the addict population, if we can find the money and the means. Mayor Alioto here the other day said he simply had to do it.

Could you give us your best views?

Dr. JAFFE. Well, I think I have stated them many times in the past, starting back in 1966 when we began working with this drug, and my feeling is that methadone is a useful medical treatment for people who are heroin users who have relapsed in the past.

In many instances, and I want to emphasize that we don't view this as a panacea, suitable to every user, or even always successful with everybody for whom it is suitable, but that in many instances for many people it permits them to function as law-abiding, productive citizens.

Furthermore, many narcotics users find this an acceptable alternative life style that permits them to function, and that is what they want. I would take a strong position from a moral point of view, if there is a medicine that permits a man to function as a law-abiding, productive citizen, it is inapproprate that that medicine not be provided to him.

From the point of view of the medical aspects and the point of view of what we can reasonably expect, I think we should not be unrealistic about what we can expect. Many people will start on methadone. Not all will continue.

Some people, at least the majority who stay on treatment, will certainly show a dramatic drop in their use of illicit drugs. Even then, some will continue to use occasionally. That is the nature of the kind of problem we have.

There will be subtstantial drops in illegal activity, and there will be substantial increases in legal, legitimate employment. This has been the uniform opinion of most people working with me that have conducted programs.

In my view of methadone, there is some controversy about only one issue, and that is whether or not somebody placed on methadone should expect to remain, or be maintained on this medication indefinitely.

Now, I happen to belong to the school that feels that this may not be necessary for many, many people, that it is possible eventually to

withdraw from methadone and to maintain adjustment in society totally nondependent on anything—in other words, a total, full recovery.

We don't say that that will happen for most, or even many, but a significant percentage of people maintained on methadone for a period of months or years can at some point withdraw and maintain their stability in society.

There will be others, for whom methadone seems to be a mainstay, that each time they attempt to refrain from methadone, they relapse to heroin use. Those people should be entitled to remain on methadone for as long as it is needed to permit them to function.

People say, "I am partial to them." A doctor is partial to anything that helps his patient. He doesn't give them all the same medicine, but for those for which it is suitable, he tries to get it and treat those people appropriately.

I seem to be partial to methadone only in the presence of people who are violently antagonistic. When there are people who are overly confident about what we can accomplish, I am antagonistic to methadone, pointing out that there is a wider range of options. We are viewing a wide range of human problems in a very diverse population and we have to recognize the need for diverse responses.

We are not going to get any simple successes. There will be complex ways of evaluating as well.

Senator JAVITS. May we assume this will be the policy of your administration?

Dr. JAFFE. Yes, you may.

Senator JAVITS. We asked Dr. Duvall for an optimum budget to deal with narcotics addiction, the whole problem, as contrasted with the practicable budget, which the OMB must be asked for. He said they were no longer in a position to do it because you were now the head man.

We don't want to rush you, and it is a serious point, and you can take it up when you wish to. But can you tell us now or later when you can give us that optimum budget? We want something to work for. We may not be successful. We don't have to be limited by the OMB or the Government's budget in terms of working for something, but we don't want to work for something which has no rationality.

So we have a right, we think, to ask the executive department to give us what we can work for as an objective. We may not get it, but we want something to work for.

Dr. JAFFE. I think that we have to look at the total nonnarcotics using population and we have to develop both a treatment and prevention response. If we recognize that we only treat, we will continue to have new recruits into that system at the rate we are now getting them, and we are probably in a losing battle. But if we recognize the two things have to be viewed as a single problem, then we can begin to think in terms of a budget for the Nation.

But with respect to a Federal budget, I think we require, at least I would require, further counsel from Congress as to what we expect from communities, from States, from private philanthrophy, and even private patients. We have developed systems, and other people have, not only in Illinois, but in Oregon and in New York, that say that if a

man in fact, is able to become a law-abiding, productive citizen, it is not written in any special legislation that he is not permitted to purchase those services in the same way as if he had come more socially accepted medical disorder.

To that extent, people can pay when they can, but how much of that would be local and State versus Federal is an issue that I think is going to require further discussion. We could talk about how much the Nation needs, recognizing it will not all be Federal dollars.

Senator JAVITS. If you could let us know how much the Nation needs—and as I say, we are not trying to rush you—we will try to fill in the details.

Thank you very much, Doctor.

Senator HUGHES. Thank you, Senator Javits.

We have a rollcall vote which you may have heard, and I am going to have to recess the hearing while we go vote.

The question we would like answered, Dr. Jaffe, is one that includes the total expenditure. We will then decide what the split should be and where and how much. To give an example, we asked Dr. Wilson for a private professional judgment budget. He came up with an estimate of $1 billion in the next 5 years, disregarding priorities for money. In other words, he professionally was looking at the question as though we have an abundance of money and there was no fight on priorities or cash .

That was on alcoholism.

We asked him for the same thing in relation to drug abuse, which he agreed to provide and then you were appointed, and we had a letter from him saying he no longer could provide the estimate because you are now in charge.

Senator Javits is saying that now you have heard the phrase in heroin addiction, "a monkey on your back," and now you have it on yours. We want an estimate of money to be used in this country in all ways——

Senator JAVITS. Do you want it broken down by years?

Senator HUGHES. Any way you feel it is best to do it professionally, to gear up, over a period of 3 years or 5 years.

Dr. JAFFE. Can you give me some counsel? One of the problems, you see, is, as in any other situation, if you begin on a particular day to say, "We want to do this"——

Senator HUGHES. The efficiency depends on you.

Dr. JAFFE. I am not an economist, but if you want to bring in marginal kinds of resources that are not designed to do the job and cost five times as much as other kinds of resources then, yes, if you want that done——

Senator HUGHES. I am assuming you wouldn't even consider that as a project. If it is marginal and they are going to waste the money. I am not expecting you to want to fund that.

Senator JAVITS. Senator Hughes and I are agreed that we are not pressing you, but we want you to give us an objective to work for.

Senator HUGHES. Not much, that is. [Laughter.]

The committee is going to have to recess for approximately 15 minutes for a vote on the Senate floor.

Dr. Jaffe, I hate to retain you. What is your schedule?

Dr. JAFFE. My schedule is your schedule, sir.

Senator HUGHES. Then wait. [Laughter.]

(A brief recess was taken.)

Senator HUGHES. The subcommittee will come to order again please.

I wish to thank all of you for waiting, and I apologize for the fact that we have no control over the voting procedures around here, any more than anything else. As a result of that, we may be voting again in 10 minutes. I don't know.

But, Dr. Jaffe, thank you very much for waiting. I would like to turn to Senator Miller. Do you have a question or two, Jack?

Senator MILLER. Thank you, Mr. Chairman.

Dr. Jaffe, the last time you and I visited, about 2 weeks ago, I believe the statistics that we had from Vietnam showed around 3.5 percent out of 22,000 checked, and then just the last few days it indicated that there was a higher percentage on about 35,000 checked.

How do you account for that difference?

Dr. JAFFE. There are two reasons. The figure that we presented when we first came back based on 22,000 was 4.5 percent. The figure that we got when we approached the 39,000 mark was about 5.4 percent. They were cumulative totals, indicating that one of two things had happened. Either the percentage of positives was running higher than before or we were looking at a different sample.

It may be that earlier we were looking at a higher percentage of men from the Navy and Air Force, which have consistently had much lower rates, and that lately we have been seeing a higher proportion of younger Army dischargees.

As a matter of fact, in the last few days it went down to the 4.5-percent rate. So that we have cautioned people that we are not looking at the same groups day by day, that the cumulative figures will eventually be the most accurate, but they will fluctuate from week to week in any given week based on the kinds of people we are seeing.

The other thing we are doing is sharpening up the sensitivity of the system. For several weeks we were in the higher percentage by indicating that we were declaring a positive at a lower level. There was concern about this.

In any situation there is a fine gray area. So that contributed in part to it.

Senator MILLER. In response to one of the questions by the chairman, you indicated that the military apparently knows something that you don't, and that was very gracious of you to say so, but when I picked up a local newspaper here in the last few days and I find that in their testing system that there are abuses of the system, a lack of control of the system as a result of which, for example, urine samples of an addict may not show up because urine samples for a nonaddict are somehow or other put in place of his, I am wondering what you are doing to try to get that system tightened up.

Dr. JAFFE. The unfortunate thing about the way things are condensed in newspapers is that they don't accurately reflect what was said. And since I said it, I remember it rather vividly. What I said was that one of the reasons we cannot test with great reliability at points other than the collection points is that the problem of maintaining that control requires trained teams. Moreover, we must build specific kinds of facilities so that when a specimen is collected, it really

represents the specimen that is attached to the man that purports to give it.

That system has to be protected from the point of collection all the way through the laboratory if the results are to be meaningful. That takes time to gear up.

If we were to rush into a system of trying to get it, we would have perhaps information that was virtually worthless, because the people most likely to substitute other people's specimens or other kinds of specimens would be those people we most want to have providing accurate specimens.

It is not that the current system does that—that rarely happens, and I have been there, and it is fairly thorough—but we want that kind of thoroughness for the rest of the testing system so that these other things can't happen.

If we take a random sample of everyone wherever they are on a given day, you have to train people to go out and do things they are not very well trained to do. In those instances, these abuses can occur, and are difficult to prevent. What I was trying to say is that we can't do everything we would like to have tomorrow. Some things will take a couple of weeks.

So the record really wasn't an accurate report as to what was happening at the debarcation points. It was a statement of what would likely be the case if we rushed into it hurriedly.

Senator MILLER. I appreciate that response, and I would just add that it seems to me that not only do you need the system, but you need the discipline in the system. That seems to me where the military may have fallen down on the job, if you don't have that discipline as a result of which you have these instances that you referred to.

Dr. JAFFE. Well, of course, I can only speak for the two sites I saw. I thought they were disciplined and well organized. I think the difficulty is, of course, when you send people out to small bases, it is hard for a team of eight or 10 people supervised by an officer, to maintain that discipline.

Again, this is where I need the judgment of the military as to what we can expect as you proceed from central large bases, where you have the organization, to peripheral stations which only have a handful of men, but where the handful of men should be tested if you are going to get an appropriate sample, an appropriate random assessment, if you will, of what the situation is across the entire command.

Other testing sites are being built. The Air Force now has its own. Where there is a fixed base, you can do this and get reliable information. Where you don't have a fixed base, the problem is much more complex.

Senator MILLER. Thank you, Doctor.

Thank you, Mr. Chairman.

Senator HUGHES. Thank you, Senator Miller.

Dr. Jaffe, when will there be an organized national plan for the control of and eradication of heroin addiction?

Dr. JAFFE. The question catches me on the horns of a dilemma. If we were to be presumptuous enough the present plans without consultation with every person who really feels he knows the best way to do

it, I would be considered presumptuous and a number of other epithets that I don't want to go into.

Such plans of national import have to be developed in consultation with the best people we have. We had some preliminary things done by a group of people called together by the White House a while ago. There have been also a number of task forces. We can give you preliminary, broad strokes as to what the overall strategy will be, but without a real knowledge, I feel a policy of this Nation should be carried out with collaboration in each of the spheres, in Government, out of Government, and perhaps calling in people from other parts of the world for their expertise.

Senator HUGHES. Are you doing that?

Dr. JAFFE. We have called in persons, and in certain areas we also have task force reports, for example, how do we develop a national data base, how can be measure incidence of drug abuse, and we run into the problems of confidentiality. Yes, we have groups of experts and I am impressed with the quality of the people who are willing to lend their time to these tasks.

But certainly the issue of treatment would not be addressed by the same group of experts who would address themselves to the issue of epidemiology.

The issues of research are not necessarily overlapping with treatment. We need panels of people to formulate these things and ultimately to try to integrate these into an overall strategy.

Senator HUGHES. I repeat, has the President instructed you to do this?

Dr. JAFFE. The President has instructed me to develop policy, and I assume that he realizes that one would obtain the consultation of the best minds in the world to develop this policy.

Senator HUGHES. I mean specifically to draw up a plan with consultation with the best minds in the world to do it for the eradication of one of the greatest and most troubling problems we have in America today, and if not, do you intend to do it?

Dr. JAFFE. I think that is a responsibility of the Office, yes.

Senator HUGHES. It will take some time, as you have indicated, but it is in the background when you get geared up? I realize you are still moving.

Dr. JAFFE. Yes, sir.

Senator HUGHES. I am surprised you have had time to do anything, as much as you have had to travel since you have had the appointment, and as much time you have spent over here testifying about what you are doing. I am well aware of what is happening to you.

Dr. JAFFE. We are trying.

Senator HUGHES. I think you spend more time in the Congress than you do in your office.

Dr. JAFFE. I don't regret a moment I have spent here in the Congress. [Laughter.]

Senator HUGHES. When are you running for office? [Laughter.]

Dr. JAFFE. That is one of the things that I include in things not to do. [Laughter.]

Senator HUGHES. You are adapting fast.

I hope, and I am sure the committee hopes, that this will be a part, when you get to the point where you can begin your formulation, of total national policy. I hope that this sort of a plan will be what you will be shooting for, and I am sure you will be. I don't expect you to unveil such a plan now or what it would cost or how you could put it into effect, but it certainly should be one of the prime goals of our country, and I am assuming you will bear that major responsibility.

HEW testified Monday that the only legislation which the administration could support at this time was the President's bill, and that the remaining legislation was pending your review. Are you aware of that?

Dr. JAFFE. Well, ——

Senator HUGHES. As of now you are.

Dr. JAFFE. I am now aware of it. I think the issue is that there are numerous bills, not only pending, but numerous pieces of legislation that are already in effect.

One of the tasks of the office apparently will be to review all legislation to see where these things impinge on national policies and national strategies. I try in the time I have to read these bills.

Senator HUGHES. Who is staffing your office now, Dr. Jaffe? Is it HEW?

Dr. JAFFE. No, sir. We have our own staff. Some are detailed from various agencies.

Senator HUGHES. They told me the other day they were furnishing the staff for your office.

Dr. JAFFE. They did? [Laughter.]

Senator HUGHES. Yes. They said they were furnishing the staff for your office. Aren't they?

Dr. JAFFE. I shall review——

Senator HUGHES. There doesn't seem to be much communication, does there? If they seem to think they are staffing your office and you don't know, I wonder where they went. [Laughter.]

Dr. JAFFE. Some people from the Department of HEW have been detailed to us. For that we are grateful. To the best of my knowledge, they do not represent the overwhelming majority of the people who are working in the office. They have come from various agencies, ranging from NASA to, I guess, the Department of Labor and other units, and we have looked all through Government as well as outside Government for people who are able to participate in this task.

Certainly we have looked to HEW, but I wasn't aware that they felt that we had in a sense incorporated their staff into ours.

Senator HUGHES. Well, they certainly implied that. Maybe the Chair misunderstood it, but it was a pointed question a number of times about staffing procedures, and what their input was into your office, because the Chair and the committee are concerned about the input of HEW in the overall planning that you are doing.

Dr. JAFFE. Well, I have spoken to Dr. DuVall, I have been in communication with Secretary Richardson, we have talked to people in the Office of Education. I suppose that qualifies as input.

We have 21 people hired. We have 16 people who are on detail from various agencies, and some of these are from HEW. I think it would be fair to say that they have helped.

Senator HUGHES. Have you met them all yet?

Dr. JAFFE. I have met most of them, yes. I can't say that I know everybody by name at this point.

Senator HUGHES. That is difficult in any office.

There is a point of confusion at HEW. They seemed to imply that they were furnishing the complete staff at your office.

Dr. JAFFE. Perhaps they feel so understaffed that the loss of one or two people makes them feel grossly neglected.

Senator HUGHES. As I said, you are learning, Dr. Jaffe, rapidly. [Laughter.]

Could I ask you to have that staff to give us a section-by-section analysis of our bill, since there is no testimony on it this morning, and no testimony in your statement, and do that in writing please.

Dr. JAFFE. We can ask what staff we have to begin to prepare that.

Senator HUGHES. It is important to us, and you realize, that the Congress will recess in August and you will not. We want to take advantage of that period and have the analysis prepared so that when we get back in the first week of September we can have as much information from the professional judgment of you and your staff of the various bills that we must consider in this committee. The legislative process has got to begin immediately, and you can be helpful to us, by having your staff do that without taking the time to go through these other bills, some of which we don't have anyway.

My subcommittee staff will be in contact with your people, and I hope they can furnish us with that analysis, with the help of whoever thinks they are staffing you.

Dr. JAFFE. Yes, sir.

Senator HUGHES. It will be helpful to us.

(The following analysis was subsequently supplied for the record:)

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20506

October 6, 1971

EVALUATION OF S. 2217

We fully share the sense of urgency which underlies S. 2217 and are deeply appreciative of the interest which its sponsors have shown in the subject matter. Nevertheless, we object to its enactment for several reasons. First, S. 2217 confers inadequate authority on the Director. Second, even his moral authority is hopelessly compromised by overlapping functions conferred on HEW. Third, the assignment of law enforcement responsibilities to the Director would constitute a crippling handicap to the achievement of his primary mission. More detailed comments on each of these points follow:

Although the functions of the Director of the Office of Drug Abuse Prevention and Treatment in S. 2217 bear a formalistic resemblance to those proposed for the Director of the Special Action Office for Drug Abuse Prevention in S. 2097, there are significant differences. Under S. 2217, the Director would have no decisional authority and could in no event be held responsible or accountable for results. Section 6(a)(1) of S. 2097, on the other hand, unequivocally empowers the Director to "prescribe policies... and procedures for the administration and management of (drug abuse) programs and activities." The corresponding

section 203(a)(1) of S. 2217 does not contain language conferring policy responsibility on the Director. Moreover, in section 203(b) of S. 2217, there is the crucial omission of the phrase "Except as otherwise provided by the Director" preceding a provision to the effect that no federal officer is relieved of any responsibilities in the drug abuse field which he had on the date of enactment. The same provision occurs in S. 2097, but with the qualifying phrase. Without it, any officer of the Government from the cabinet level down who was not inclined to follow the recommendation of the Director could point to this section as a complete legal justification for a refusal to do so.

Such moral authority as the Director might have had under S. 2217 if that bill had ended with Title II is hopelessly compromised by the provisions of Title III creating, within HEW and subject to the authority of the Secretary of HEW, a National Institute on Drug Abuse and Drug Dependence. While the line authority of the Secretary and the Director of the Institute would presumably be confined to operations conducted by the Department itself, their responsibilities would obviously detract from those of the Director of the Office of Drug Abuse Prevention, and would seriously reduce the effectiveness of his role.

Finally, one of the tragic results of the development of the drug problem in America has been an almost total breakdown of confidence, at least in the drug abuse area, between the law enforcement community

on the one hand, and the medical and scientific community on the other. To maintain the Director's credibility in the latter community, it is absolutely essential that he not be regarded as a member of the former, a result which would surely follow were he to be given the type of law enforcement responsibilities vis-a-vis users and illicit suppliers which S. 2217 provides.

Quite apart from the question of its interference with the functions of the office to be created within the Executive Office of the President, the creation of a National Institute on Drug Abuse and Drug Dependence in the Public Health Service appears is unwise. We regard it as urgently important not to dissipate our limited resources of professional manpower in staffing a new bureaucratic structure which may upon analysis be found to be unnecessary or inconsistent with the policies and programs developed in the Executive Oddice of the President.

We also oppose the establishment at this time of a new categorical grant-in-aid program as proposed in Title IV. Even if some such program is ultimately determined to constitute an appropriate response, we believe it would be premature to establish it by legislation before its goals have been developed with reasonable specificity.

Similarly, we have serious reservations regarding the provisions of Titles VI, VII and VIII. In addition to our objections relating to the diffusion of responsibility for policy, we think it important that the reversal of the punitive aspects of past policies be carried out in a

way which does not inadvertently make drug abuse attractive by responding to it more favorably than other forms of illness or disability.

In response to the request for an estimate of the total cost of a comprehensive attack by the federal government on drug abuse, the primary mission of the Special Action Office is to develop an overall strategy and an integrated federal program incorporating individual agency responsibilities to deal with the demand side of the drug equation. We are now actively engaged in a review of individual agency programs and proposals recommended for inclusion in FY 1973 budget. Only when we have completed our review will we be in a position to estimate the budgetary impact.

Senator HUGHES. I have here probably enough questions to keep your staff busy the rest of the fall if I present them all to you in writing, and I have no intentions of allowing the committee staff to do that, so in your presence I am going to instruct the committee staff to get together, minority and majority, and decide on about the 15 or 20 most important questions that they feel have gone unanswered this morning and present them to Dr. Jaffe and his staff in writing for completion of the record this morning on these bills, and I am hopeful that you might have those back to us, if you could, by no later than the first of September, which should give you an adequate amount of time and leave us approximately a week, then, before we get back into gear again to analyze and consider that amount of information.

(The information referred to had not been received at date of printing.)

Senator HUGHES. Dr. Jaffe, I am going to conclude your section of the testimony this morning in the interest of time. I want to again state the confidence of myself and the committee not only in your ability, but in the way that you have taken on a job rapidly when you were thrust into it that was really, I think, one of the critical points facing our Nation. I think it has been an admirable job, and little confusion has resulted from it.

That certainly speaks highly of your capability and that of your staff, whoever they are. [Laughter.]

I do want to say that naturally we are going to be coming in contact with each other in the months ahead. We share a common hope and a common goal, and it will be our hope to supplement, support, implement, and furnish the legislative procedures that you will be working with. It is ultimately important to us that we get your viewpoints, and we are going to be forced to ask for them even though they differ from the administration's guidelines that are given to you.

We know you understand that. We hope you can give us a clear professional judgment for our guidance. It is evident that the Congress and the administration are not always in agreement, but they are not always in disagreement. There is much we have in common as a basis to work for in these bills.

I want to thank you and your staff for being here, and I hope they are getting paid from somewhere.

Dr. JAFFE. Thank you very much, Senator.

Senator HUGHES. The Chair next calls Governor Ray of the State of Iowa.

If we could diminish the confusion in the hearing room as rapidly as possible so we can get underway with the testimony please.

Governor Ray, on behalf of the committee and myself I certainly extend a warm welcome and thank you for your willingness to testify before the subcommittee this morning, and to simply state as an Iowan I am happy and proud to have you here with us, and also to say that you have the freedom of presentation of your statement however you would like to give it.

If you would care to read it, fine. If you would care to summarize it and talk orally, that would be fine.

STATEMENT OF HON. ROBERT D. RAY, GOVERNOR OF THE STATE OF IOWA

Governor RAY. Thank you, Senator Hughes. I appreciate your inviting me to appear before your subcommittee. I can tell you that HEW does not staff my office, first of all.

I would like to recognize the fact that you have long been interested in the problem that we are going to talk about today, and it pleases me that you and Senator Miller and many other members of the Senate are recognizing the subject of misuse of drugs as a very important matter, I believe one of the most farreaching, and as you said a moment ago, one of the most critical issues of our time.

Last Saturday the President of the United States visited our State. During his remarks President Nixon referred to Iowa as the "Heartland" of this Nation. Iowans do live in the heartland of this country. The State of Iowa is primarily known for its hard-working and independent people, its choice soil, productive agriculture and its healthy envirnoment. We have enjoyed a sense of community which has maintained some traditional values that have afforded us a good quality of life. Yet we have not escaped the increasing incidence of drug use and dependency, especially among our young people.

For a long time—far too long—most Iowans believed that those hooked on drugs lived in New York or California or some far-off place, but couldn't believe that the menace had invaded the heartland of our country, their homes, even their own families. It was commonly believed that the drug problem was one that festered in crowded and congested big cities and urban ghettos. While some continue to keep the shades pulled, Iowans are awakening to the realization that Iowa, like all other States, is not isolated from the rest of the world. The problem exists in our State and we must face it.

The drug scene is not limited to high population density areas. There is an increasing movement of drugs in our sparsely populated communities.

You have heard much testimony and I have no desire to merely repeat heart-rendering stories of tragedies that have occurred because of the misuse of drugs. We have all heard many of them, but I do want to mention one case that happened in my State that I think illustrates how drug abuse is not the basic problem, but is a symptom of deeper problems and of comunity problems.

An 11-year-old girl from an Iowa county seat town, high on drugs, slashed her wrists with a kitchen fork. Treated and released, she cut off a finger during another drug high. Again she was treated—for the injured finger—and again she leaned on the drug. Her third attempt in self-abuse resulted in the loss of an ear, sliced off with a knife.

After the last incident this youngster returned to her classroom in an attempt to find a place among her peers. She was met by her teacher who, in front of her fellow students, approached her and slapped her across the face saying, "We don't need people like you in this school. Now get out!"

An 11-year-old girl was maimed physically, but was scarred even deeper emotionally. Here is a tragic example of the utter failure of

and individual—in fact, society as a whole—to value human life. The cause? To say the cause was drugs is to kid ourselves. A symptom, yes, but the cause is much deeper, and we all have to share part of that responsibility.

When we talk about cause, we must realize that our young people are growing up in a swift-moving world where pressures mount, where competition is fierce, where instant communications absorb them in societal problems, where a feeling of disenchantment exists, and where our young people of nearly all ages are confronted with easily accessible drugs. In short, the long-range answer to this serious problem must encompass far more than the immediate problem of the use of drugs.

Drug abuse fits in the same basket of problems that made necessary current health, welfare, education, law enforcement, and rehabilitation programs. While we believe that Government alone cannot solve the riddle of drug abuse and dependency, it most certainly has a responsibility to deal with this individual and community condition through its many State and local governmental agencies.

One limitation, of course, is money. The Federal Government can be a great help in supporting local efforts by providing funds and expertise in technical assistance.

It has always been my personal belief that the best help in aiding a drug user is an understanding friend in whom the victim has confidence. It is people that make any program develop and operate successfully. In the case of drug programs, we found people, groups, organizations and governmental units all straining to actively involve themselves in combating drug abuse.

To harness this eagerness, desire and manpower so that their efforts would be channeled effectively called for positive direction, we moved to provide that direction by first enlisting the aid of a leading authority as the consultant to the Governor, and then convening one of the First Governor's Conferences on Drug Abuse. The purpose was to bring together the people whose official activities and concerns influence the social and legal life of our citizens. It was extremely important that programs would not spring up around our State that would merely inform and not educate—it was imperative that they be helpful—and not harmful.

This group of almost 400 people met with Federal representatives in an initial effort to establish cooperation and coordination for community-based programs encompassing (1) education, (2) treatment and rehabilitation, and (3) enforcement. This was the beginning of our three-pronged program.

Instead of creating a new agency or committee to direct Iowa's drug abuse program efforts, I thought it much wiser to utilize the existing agencies that had or should have full-time personnel working in this field. I felt it was necessary to avoid duplication and to avoid a big show with a lot of motion, but little action. By bringing together the expertise of existing agencies, it would be possible to have an effective council to direct our statewide activities.

Therefore, I created by executive order the Iowa State Drug Abuse Authority. This established a coordinating council, consisting of personnel from each of the State departments involved in this field, whose

prime responsibility was to work on drug abuse. They include the Department of Public Instruction, Department of Social Service, Office of Economic Opportunity, Department of Public Safety, Crime Commission, Office for Planning and Programing, Office of the Attorney General, Community Mental Health Centers, Department of Health, Division of Rehabilitation and Educational Services, and the Governor's Youth Coordinator. The council and its full-time director are charged with assisting and encouraging local programing in all aspects of drug abuse.

Our State program, therefore, is based upon local program development with local community participation, combined with coordinated efforts at other levels of government, business, and civic leadership.

It is my understanding that I was extended an invitation to appear here today to inform you of some of the activities that exist in a rural State for fighting the drug menace, and I am glad to be able to do that, because I think everyone needs to realize that the drug problem doesn't exist only in the urban areas, but in a rural State like ours as well. Counties, towns, and cities throughout Iowa have been and are developing approaches that are responsive to the needs of people in their own specific area. Briefly, stated, some of these efforts include:

"Rap centers" where youths can meet and talk with each other and with both professional and paraprofessional personnel that have been locally trained;

Crisis centers which are geared to emergency intervention;

Hot lines that serve as both a listening post and as a point of initial contact and entry for people needing help;

Education prevention efforts in the schools, and also in the homes where paraprofessionals get together with groups of parents and children for discussions;

Numerous private organizations, such as Young Lawyers, YMCA's, YWCA's, Kiwanians and others that are involved in efforts that range from programed information distribution through small group multidisciplinary presentations in schools, to meetings of parents whose children use drugs.

These items are merely an indication of efforts going on in various parts of Iowa. On a statewide basis we have:

Newly enacted Uniform Controlled Substances Act which makes it tougher on the pusher, but provides for rehabilitation of the user. This new statute also creates a closed regulatory system. We are computerizing our registration of doctors, hospitals, pharmacies, and others to facilitate effective control. In addition, we are developing a computerized monitoring system so that we can more closely watch and control the utilization of prescription drugs throughout the State;

Metropolitan narcotic enforcement, units which have been initiated in several sections of the State in order to more effectively utilize existing expertise and manpower;

A State Narcotics Enforcement Bureau which has been established in the Department of Public Safety and has been significantly expanded both in terms of manpower and resources.

Also we have been developing statewide training efforts for judges, lawyers, probation officers, corrections personnel, and others.

Our 27 mental health centers throughout the State offer outpatient counseling and care. Often the mental health center staff conducts paraprofessional training for volunteers who work in the community.

The four State mental health institutes provide inpatient care. In the fiscal year ending June 1970 there were 200 patients treated and released, as compared with 71 patients in 1970. The median age was 22, their median stay was 35 days. There are currently 58 persons in our four institutions.

Regional information centers exist as a distribution center for materials with a positive contribution to developing alternatives to the use of drugs.

An emergency treatment referral system is being operated which will allow any doctor in the State to call on a WATTS line and obtain specialized assistance in diagnosis and treatment matters.

Public and private hospitals, as well as physicians, throughout the State perform in and outpatient drug abuse treatment.

I have with me detailed information about the various efforts being made throughout the State that I would like to submit with my remarks.

Senator HUGHES. We will include it as part of the file of the subcommittee records.

Governor RAY. Thank you.

Local programing utilizing the efforts of local people developed with and coordinated into a statewide action plan designed around local needs, conditions and circumstances is an effective approach to attacking the drug abuse menace.

There is no simple solution, and I hardly need to tell you that. We have to try many, many things. Funds that are made available through the Federal Government should not be limited to narrowly designed plans that would prevent local planning and operation consistent with local means and priorities.

If money is forthcoming to aid the States and cities in their drug abuse battle, then it should be soon, for the problem continues and there is no way to defer it. I would hope that whatever approach your committee and Congress might take, it would be realistic enough to recognize the importance of local planning for local problems and would be on a Federal-State relationship so that the efforts of the different levels of government could be well coordinated. It should not be necessary to spoil genuinely succeeding programs in order to comply with stringent rules and regulations that would not conform to local needs.

I cannot help but believe that the coordination of Federal agencies as they are called upon engage in the fight against the misuse of drugs should be demanded as we have insisted upon it at the State level. Any Federal program should be flexible enough that States have not only the opportunity but a sufficient amount of time to be responsive to the availability of Federal funds. We have found on the State level that it is essential to have the coordinated effort of our law enforcement agencies with our educational efforts and health and social services. I would think such coordination would likewise be needed on the Federal level.

Thank you.

Senator HUGHES. Thank you very much, Governor Ray. Did you happen to bring with you anything in the relation to funds being spent in Iowa at the State level in this type of coordinated program?

Governor RAY. I think it is fair to say that we are not spending much in the way of Federal funds in this area of drug abuse control and prevention. We do have some, as I am sure you are aware, that come through our Department of Public Instruction for training of teachers. That has been used, and I think wisely so.

We do have some that comes through our Crime Commission, a small amount of that LEAA money that has been used in the area of drug abuse. But not a great amount, and most of our programs have been based upon what little money we could squeeze out of our State budget.

We asked the Executive Council for $40,000 last year. As you know, that doesn't go very far. This year we have a budget of $137,000, which will permit us to use about $70,000 for local programs. This basically is seed money, and the rest of it comes from county governments, some from city governments, and most of it from volunteers and contributions.

Senator HUGHES. In other words, the Federal funds other than LEAA are actually practically negligible in our State?

Governor RAY. I think it is fair to say that is a good way to put it.

Senator HUGHES. And our State is probably in the middle of the average population of States.

Governor RAY. We are still 29, right in the middle.

Senator HUGHES. Information that I am sure your people have as well as my own indicates that the problem has been growing rather consistently in the last 3 years in Iowa, and that heroin addiction, which 5 years ago was negligible, is now a problem of concern in the State, particularly in certain regions of the State.

Do you have any estimates as to how many heroin addicts you believe there are in the State of Iowa?

Governor RAY. First, may I introduce Mr. Paul Flynn, Senator, who is director of our Drug Abuse Authority in Iowa. We don't have the full figures on how many actually exist in our State, and I don't know that we ever will have accurate figures. It is estimated that we might have as many as 1,100 heroin addicts.

I could give you a few brief statistics that will bear out what you have just said.

We have the most recent figures from the mental health institutes, not that they are large numbers now, but I think they show a pattern. Those who are, or have been in one of our institutions for the use of opiate and derivatives were 11 in 1970 and are 44 now.

Now, I recognize that maybe the 11 did not include some who were classified as something else, but I think it does give you an indication that it has been on the increase. The others have increased also, but the heroin one is as serious as any that we know of, and we think this is significant, and we have to recognize that it is on the increase.

Senator HUGHES. The estimates you gave are lower than the ones that have been given to me, and they are just educated guesses, frankly, because there is no way to really know and put them together that I know of.

It was indicated to me when I was doing some surveys, and you and your directors were contacted, that there are as many as 500 heroin addicts in the Des Moines area alone, and it could be up to 1,000 in the Eastern Iowa area, and that it has been on a rampant increase in that area, more rapid that it has in the Des Moines area.

Governor RAY. I would accept that, because regardless of which figures we use——

Senator HUGHES. It may be high or low. I don't have any idea. The point I am making is that a State like ours, which is average in population, which really has no large metropolitan areas, with a well-dispersed population, does have an increasing problem with narcotics addiction and drug dependency and all the other things that go with it. One of the concerns and problems we have in legislating is trying to meet the needs of a major city like New York City, with 10 times the problem almost, of any other city in the country, and probably could utilize three times the money that is now allocated in total Federal budget alone and still allocate funds to meet the needs of States like our own and other States in the Union that have problems that are growing and can become disastrous for us.

This is the type of testimony which you have provided for us very well.

Senator Miller, do you have any questions?

Governor RAY. I might, if I may—excuse me, Senator—but I might add that this, of course, concerns us greatly because we know that the city of New York has this tremendous problem, and we know that it needs help, and we don't want to be in a positon of denying that.

At the same time, as you point out, we recognize that we have a growing problem, and with our sparsely populated area, we can, we believe, do something about the problem. We can reach it, and do it quickly now, much easier and much better than when it reaches epidemic proportions which we are talking about in some of the other areas like New York City.

Senator MILLER. Thank you, Mr. Chairman.

Governor Ray, I want to compliment you on a very fine statement. It is apparent that you and your staff in Des Moines have not been sitting idly by, that you have been working hard to develop an overall comprehensive program at all levels to cope with this serious problem.

I noticed on page 6 in the education, prevention and efforts in the schools, nothing was said about teachers, but do I not understand correctly that certainly at some of the local levels there are efforts being made through the police department, for example, or other paraprofessionals, to work with teachers so that teachers themselves will become familiar with problems which sometimes go unnoticed in their classrooms?

Governor RAY. Senator, I think this is one of the best ways to detect early the use and abuse of drugs, through the teachers in the classrooms, and we trained some 300 people in seminars last year to do this very thing. These people in turn trained over 2,000 who worked with over 28,000 of our youth.

As I mentioned, Federal funds were used to have some specialized training of some of our teachers and people in the Department of Public Instruction, which has been very helpful. One of the problems

is how do you spread out fast enough and far enough to do a very comprehensive and complete program. But we are moving in this direction, and I think it is very important.

Senator MILLER. One other thing. There was nothing that I detected in your statement that had to do with any programs that are being carried out in either the State or the private colleges. Do you know whether or not there are any programs that are being developed in some of our private colleges, or through the board of regents institutions, to help cope with the problem on the campuses?

Governor RAY. I know of no specialized program through the board of regents, Senator. We have used and have had advantage of some of the people on the college campuses, who have helped disseminate the information on a basis that we could consider educational, so that they know the harm and the danger and the risks if they want to imbibe in drugs, this type of thing. Of course, I think you have to assume that one of the best things we can do is make the information available to them on the basis they can understand well, and they have to make decisions, and they won't always make the right decisions.

But we sense in some areas on our college campuses, there might be a trend away from the use of drugs into other areas, and it seems to be slipping more into the younger years. This is very discouraging, I suppose, because it is becoming a bigger problem with the young people.

Yet, if it is, we must recognize that as the problem.

Senator MILLER. Probably the chairman is familiar with it, but there is a program at the University of Pennsylvania, which apparently has been very successful, and it is the kind that is adaptable to the so-called economy of a college campus, and I mention it so that possibly you could have your staff contact the University of Pennsylvania, because it certainly has proven effective there. I recognize that we are still feeling our way on how to tackle this problem almost everywhere, but certainly we understand that there is a problem on many of the campuses, and that we want to do something about it within the framework of the traditional college campus environment. And I think that this is another area that we might give a little more attention to, and if we have a good precedent, it might be well to look into it.

So I mention it merely for your information so that you might draw a little help from it.

Governor RAY. We are happy to have the suggestion, and I can tell you that we will follow up and see what that program is and see if it can be adapted in our State.

Senator MILLER. Thank you.

Thank you, Mr. Chairman.

Senator HUGHES. Thank you, Senator Miller.

Governor Ray, I am sure you have been given a copy of our bill, and your director has at least had a chance to look at it superficially, if not to analyze it carefully.

Under this bill, the State of Iowa would receive $200,000 for the development of treatment and rehabilitation and prevention programs; and additional programs within States can be funded provided they come within the State plan required if the State gets the development funds.

The only requirement in the bill is to provide reasonable assurance that Federal funds made available during this period will be used to supplement local and State funds, and so forth, and that they would not supplant State and local funds.

In other words, in this formula grant program, the States would receive that amount of money with just assurance that you were not simply going to wipe out your State and local efforts and use this money to supplant it.

Is this type of a program or formula grant, with $200,000 that this would authorize, if appropriated—is that anywhere near sufficient to cope with the problem in the State of Iowa?

Governor RAY. I would say, first of all, that $200,000 would be of great help. I would question whether or not we could have the overall program we would like to have.

We wanted to move more rapidly in the direction of treatment and rehabilitation, and at one time we were moving to set up in one of our mental health institutions a special program that really could be used as a pilot project and could be used to train other people for other facilities. But we found that they already were pushing their budget and they had no money, and there was no money to shift into that program to actually start this comprehensive program within the institutions.

So it we had additional funds, Senator, I think I could assure you that it wouldn't supplant anything that is already being done. It could very wisely be used in this area, and it is an area that takes money.

You cannot have a treatment and rehabilitation program without money. So I think this would be one way in which the States could benefit from Federal funds for a program, a very specific program, without binding us so tightly that we couldn't have flexibility to use it wisely.

Senator HUGHES. It would also be a project grant provision under the bill, Governor, that would allow for additional funding to come into the State under a project section of the bill rather than the formula approach, which would be at the State level.

I think what we are talking about in a State the size of ours is the need and the understanding of the Federal Government to know that our problems in proportion to our population are as serious to us as the problems of any other segment of this country, and they are as devastating to our segments of society as they are devastating in other sections of the country; and though we have fewer people, the concentration of those problems is just as serious to us as it is to them; and we need an overall scope of a bill in legislation that does provide funding, opportunity, and structure for project grants and formula grants to States such as ours for the development, the attack, the prevention, the treatment, the rehabilitation, institutional services that are absolutely essential.

With that I am sure you agree.

Governor RAY. I certainly do, and I am a very firm believer in Federal revenue sharing, as I am sure you know.

I do believe that there is room for the other ways in which Federal funds can be used, categorical grants and block grants, where it is necessary to have that type of financing.

I might draw an analogy between what perhaps you are talking about and the Crime Commission money, which we have found has been used rather effectively in most cases.

Now, there are always those things that crop up that we have to correct, but basically, with the freedom of movement, even though the money had to be used in a very specific general area, we could do many things that I am sure we could never have done if the money had come to us in specific, categorical programs.

If the money to be allowed for drug abuse programs, as you are suggesting, but not to the extent that we have no room to wiggle, then I think we could very effectively put to use those funds in many different areas.

Senator HUGHES. Governor, thank you very much. I, too, want to commend you on your statement. I believe you have drawn together in the State of Iowa through the governmental agencies and by your own direction by executive order a total capability of facing the problem in our State, if we go ahead at the Federal level with the necessary programs and funding for you to attack the problems locally.

It is common knowledge that every State in the Union has financial problems today. There are no States without them. They have all got their backs against the wall and are struggling for revenues on a priority basis to put in areas of great need. I think you have demonstrated that you are a Governor utilizing to the best of his ability the existing agencies on a priority basis to try and focus on the problem and to initiate those programs, and I compliment you for it.

Governor RAY. Thank you very much, Senator.

Senator HUGHES. Thank you very much for coming to testify.

The Chair calls Mr. Graham Finney. He is the commissioner of the Addiction Services Agency of the city of New York.

Mr. Finney, I thank you for being so patient this morning, and it is good to see you again. We welcome you before the subcommittee. You may proceed with your testimony as you desire.

STATEMENT OF GRAHAM S. FINNEY, COMMISSIONER, ADDICTION SERVICES AGENCY, NEW YORK, N.Y.

Mr. FINNEY. You have my written testimony. Let me try to encapsulate some of the points.

Senator HUGHES. All right. We will incorporate your full statement into the record following your testimony.

You may proceed as you wish.

Mr. FINNEY. Thank you very much.

Drug addiction is properly labeled an issue of survival for America today, such is its current impact on the fabric of our society. It is a grave indicator of ill health, hopelessness, and evasion of reality among growing numbers of Americans.

Speaking for New York City, I am able to make that statement, for we have the unenviable distinction of possessing some 100,000 heroin addicts, perhaps 50 percent of the Nation's problem. In addition, we are host to many times that number of drug abusers who use a variety of amphetamines, barbiturates, and other dangerous drugs for nontherapeutic purposes. This population knows no geographic, economic, ethnic, nor institutional limitations.

The city of New York, through my agency which was established by Mayor John V. Lindsay in 1968, currently budgets $90.9 million toward treatment, rehabilitation, and prevention of drug abuse. Of this amount $5.94 million is Federal funds. Another $2.55 million comes to the city via the model cities program. The balance, more than 90 percent of the total, represents city and State funds which cannot be stretched further even though efforts to curb and cure addiction are this city's No. 1 priority at the present time.

Despite this effort, which has required an immense energy to mount and manage, New York City still reaches only a small percentage of its estimated addict population.

There are numerous indicators of unmet demand:

Addicts continue to apply for welfare in growing numbers, roughly 1,000 new applicants per month.

About 8,000 unsolicited names are on the waiting list for methadone maintenance programs.

Some 200 individuals are being detoxified each week in our prison system where perhaps 50 percent of the total detained population has a severe drug problem.

Youth constantly seek entry into drug-free programs offering hope and rehabilitation.

Almost 3,000 veterans are returned to New York City each month with an estimated 300 of them likely carriers of dangerous drug habits.

There are, in short, no indicators that we are solving the problem despite herculean efforts to do so. The age of the typical drug abuser grows steadily younger and, increasingly, drugs invade the elementary school.

More than 1,200 narcotics-related deaths occurred last year in New York City and may well be repeated this year. Narcotics deaths remain the largest single cause of death in the 15- to 35-year-old age group in our city. Arrests and dope seizures soar, yet the price of drugs gets cheaper. The indiscriminate polydrug user grows in number. The addicted veteran comes marching home to New York City, which has no need for such reinforcements.

Given this picture, New York City, laying aside whatever comments it might be tempted to make about the belatedness of the Federal effort or the special tragedy of the veteran addict who has made addiction at last a national issue, can only welcome a new Federal initiative.

With respect to pending legislation, I think I can be most helpful to you by doing two things. First, by sharing some of the experience in New York City in trying to build a comprehensive response to the drug problem across agency and functional lines. Second, by projecting how our needs might be served best by your actions at the Federal level, performance criteria for legislation, as it were.

New York City endorses the concept of a single agency responsible for directing Federal activities in the drug rehabilitation, prevention, and research fields. This agency should have purview over all such programs under the auspices of the following Federal agencies: the Departments of Defense, State, Justice, Housing and Urban Development, Treasury, Labor, and Health, Education, and Welfare, the Civil Service Commission, the Veterans' Administration, and the Office of Economic Opportunity.

I see no reason to exclude completely any portion of the Federal Government from this involvement. Drug problems crosscut virtually all systems, whatever level of government. My own agency deals constantly with the social service, criminal justice, health services, and educational systems, among others. Any successful strategy will involve all these elements from the outset.

Only one system, law enforcement, might be excluded as a full component of a new agency. There are reasons for this. First, enforcement of narcotics laws frequently go hand-in-hand with activities serving broader objectives of public policy as, for example, with the Bureau of Customs. Law enforcement is thus exercised in a very complex set of legal and administrative relationships that defy complete integration, at least in the short run.

We do feel strongly, however, that the new agency should be empowered to develop truly meaningful evaluative and performance activity related to narcotics.

We are very mindful that perhaps the fundamental decision in mounting any national drug program will be to effect the distribution of resources between treatment, research and prevention, on one hand, and enforcement, on the other.

In our opinion, the cutting edge of any national strategy, as it is on the local level, must be to reduce the current pool of addicts and to restrict the future contagion by successful prevention work.

We suggest, for this reason, that the great bulk of new funding should be applied to research, prevention and rehabilitation programs.

We urge strict congressional review of this fundamental allocation. We expect a strong administrative justification based upon sound data and performance measurement.

A Federal response of maximum benefit to the city of New York must yield a high degree of flexibility in the utilization of funds made available in conformance with an annually updated comprehensive plan stating local goals and objectives.

We are already preparing such a plan to meet the State's and our own local requirements. We feel that such a statement, a workable program concept, should be considered a prerequisite to future Federal funding.

Any approach must respect the different starting points among the participating cities and States. To be workable, the Federal program should insist that each locality demonstrate a multimodal approach, that it include the basis for broad-scale community and professional participation, that it document linkages with all Federal systems previously named, and that it conform to basic standards governing administrative and fiscal capability.

We would oppose any provision that prevents the city of New York from dealing directly, as we do now, with Federal agencies responsible for funding drug programs.

We would oppose any provision that attempted to confine programs to one or two approaches. Our situation clearly requires a multifaceted approach. For example, while we would favor utilization of community mental health centers as one focus for Federal drug funds, we would strongly resist having this be the exclusive mode of local operation. There must be no provision that penalizes already existing operations which can demonstrate their effectiveness.

We support a distribution formula for treatment funds that reflects need as documented by incidence of drug abuse. We would expect the Federal Government to hold us to a similar intracity allocation. The definition of measures of need should be an early output of any performance measurement system created by the new agency.

A basic interest we have regarding any new Federal office is whether it will permit this city to be served by a one-stop point of contact as opposed to the hit or miss collection of program sponsors with which we now deal. Let me illustrate our concern.

Recently we have sought funding for a systematic network of ambulatory detoxification facilities. In doing so we have dealt with three different agencies—the Office of Economic Opportunity, the National Institute of Mental Health and Model Cities. Each has its own guidelines, each has its own procedures, each has its own review and approval cycles. We have had great difficulty, therefore, in mounting a comprehensive and consistent program.

The new agency should, in our opinion, be able to assess our overall proposal and greatly reduce the administrative frictions we have faced. We would appreciate some clarification of Federal intentions to rectify this problem as soon as possible.

We have several other concerns about local Federal working relationships with which this subcommittee should be familiar. One illustrates the close connection between Federal treatment and enforcement activities that can have profound local consequences. Recently a proprietary methadone clinic was closed in our city by the combined efforts of the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs.

While we welcomed this action, while we hope that in the future more, intensive inspection activities will accompany treatment activities and while we feel that any new agency should have a role in coordinating such enforcement, we would point out that no Federal agency assumed any responsibility for the ongoing treatment of those involved in the program when it closed.

It fell to the city of New York to develop emergency referral procedures to protect against that failure to respond and led to additional local expenditures in doing so.

Recently food stamps have been cut off summarily to those in treatment in residential drug-free communities within New York City. The use of food stamps had been an important adjunct to the funding of these programs and to the development of a sound therapeutic approach. It should be easy to distinguish between this use and alleged misuse of food stamps in other communal settings housing unrelated individuals. We urge reversal of this order as inconsistent with a new Federal initiative.

We strongly question the 3-year timeframe of the administration's bill. A suggestion that there may be an early solution to the drug problem is totally unfounded. Based upon past experience, we suggest that a Federal management information system will be lucky if it is functioning smoothly by the end of the 3-year period.

Necessary basic research will only be underway within this period. There should be no false expectations about easy solutions in this field, the same way that there are no false expectations in the field of cancer

or heart research, which are equally primitive in their prospects for finding solutions.

We do believe, however, that a review of activities launched under whatever legislation is eventually passed after 3 years is sensible and should be welcomed by the Congress.

We see far too little emphasis being placed upon the need for a tremendous increase in research funds in the drug abuse field. The provisions of S. 2217 are most clearly addressed to this concern. Recently we had to tap scarce city funds in order to launch much-needed research in the development of drug antagonists.

Our limited money should be spent in treatment and prevention activities and not in basic research which is of national concern and should be federally supported. I make a strong plea, therefore, for the rapid expansion of biological, sociological, and other research in the drug abuse field in order to tap the tremendous amount of medical and other interest which has been generated recently.

No delays can be tolerated in the processing of whatever legislation emanates from the Congress. We ask that you do not complicate the machinery further. We ask that we not be caught in a moratorium as a superstructure is created and as old agencies drift to the new auspices. We must not lose momentum as a product of reorganization.

We strongly support the idea of a single non-Federal share requirement across Federal agencies for all new funds destined for a single locality. We urge 100 percent Federal funding of basic research and all innovative treatment programs.

We would borrow a leaf from the NIMH practice and suggest that 3- to 5-year funding of all treatment and rehabilitation projects be authorized. Particularly in programs which are community-based, there is a tremendous friction and time loss in the constant renegotiation of 1-year projects which clearly cannot show a product in the course of a single year.

We urge Federal support for vocational retraining and the breakdown of discriminatory patterns which affect the employment of the former addict. We urge the extension of the efforts to the U.S. Civil Service Commission as we in our own city are attempting to break down remaining barriers that exist within city government itself.

With regard to the veteran, we urge the Congress to consider the following points in framing any new legislation:

1. Full Federal financial responsibility for the costs of rehabilitation of returning servicemen and veterans.

2. The immediate need and the short time available for mounting large-scale rehabilitation services for veterans.

3. The consequent importance of utilizing the tested resources of civilian-based agencies through Federal purchase of service agreements with such organizations, as well as providing services through the Veterans' Administration directly.

4. The good sense of developing new treatment forms that respect the special circumstances and needs of the returning serviceman.

5. The importance of providing a review mechanism for converting dishonorable, bad conduct, and less than honorable discharges for men whose addiction occurred while on active duty. Without the prospect for such conversions, motivation to conquer drug addiction will be undercut badly.

We even suggest that the leadership of individual Senators be used to give support to the development of a national citizens' effort in the drug abuse field which would be analogous to the American Cancer Society or the American Heart Association, which have accomplished so much in building unity among efforts around the Nation in these fields, and which is needed to watchdog and to give continuing support in the drug field. Nothing such as this now exists.

The drug field has suffered from self-destructive, internal fights. As a byproduct to the Federal initiative, I urge your support for a national effort that will be supportive of the goals reached in the new legislation.

We suggest that an early effort be made by the new agency to package model legislation and model drug programs for use in those cities, counties, and small towns which are just becoming involved in the drug scene, and which can benefit from those of us who have been in the business and have learned many lessons. There is no time to reinvent the wheel in this field. Federal technical assistance is thus of high priority and should be offered in the very near future.

Much discussion has been made about the level of funding which should be offered by the Federal Government in year one of an expanded effort. For your benefit, may I summarize our immediate requirements and our immediate capacity to utilize funds along this line in line with constraints on buildup and in line with a strict focus on rehablitation, prevention, research and development.

These proposals which total $21 million are listed on table I, which follows. Mayor Lindsay has already stated on an annual level he would prefer to see something like a level of $1 billion as the annual mark in the early days of such an operation. I can add that our early indices of need show that in our "ready-to-go" plans that we feel can mount in the short run, we will have a continuing need for buildup as we can absorb, and therefore our urgent request is for a funding level far in excess of that which has been urged by the administration.

The projects we are discussing are such things as expansion of the methadone maintenance program, expansion of drug-free community-based rehabilitation, detoxification services, research and development, training and education, job development, training and supportive work for former addicts, and veterans programs.

(Table I follows:)

TABLE I

PROPOSALS FOR FEDERAL FUNDING

1. Expansion of Methadone Maintenance Program		$5.0 million
2. Expansion of Drug-Free Community-Based Rehabilitation		3.0 million
3. Detoxification Services (ambulatory narcotics detoxification, barbiturate detoxification)		5.3 million
4. Research and Development		1.2 million
Drug Antagonists	$500,000	
Methadone leading to Abstinence	500,000	
Evaluation of the Therapeutic Community	200,000	
5 Training and Education		1.0 million
Training Institute	750,00	
Multi-Media Community Education Program	250,000	
6. Job Development, Training and Supportive Work for Former Addicts		.5 million
7. Veterans Programs		5.0 million
TOTAL		$21.0 million

Mr. FINNEY. Congressional leadership is required not only to reach a very quick verdict on an emergency program to combat drug abuse, but also in building sensible approaches in the fields of housing, poverty, education, job training, and other areas which are part and parcel to the solution of drug problems.

As I say, in my city I hope mine will be the agency which disappears first. Short of a miracle, this will not unfortunately occur in the next 3 years. But at the time we are setting up an agency to bring about the eventual eradication of drug abuse, let's keep it in mind that we are involved in an issue that is the scourge of American society right now and requires a very comprehensive effort that extends beyond the drug abuse field per se.

Thank you.

Senator HUGHES. Thank you very much, Commissioner Finney.

I think your setting forth the needs and the setting forth of the legislation needed to meet these needs is well done. I think you said in your statement, but I would like to ask again, how many addicts are being maintained on methadone, on maintenance programs, not just withdrawal?

Mr. FINNEY. The figure is between 9,000 and 10,000 at the present time, out of a figure of about 22,000 in treatment in the city as a whole.

Senator HUGHES. What is the annual cost on maintenance?

Mr. FINNEY. Our best estimate at the present time—and we are now beginning to see that cost goes down as volume is increased, is about $1,700 a year. That is not only, of course, for the methadone treatment, but the ancillary services which we think are very important, counseling, marriage counseling, and so forth.

Senator HUGHES. What is the success of getting jobs for addicts or ex-addicts?

Mr. FINNEY. It is complicated by the state of the economy. We are finding some very welcomed interest on the part of private industry in employment of former addicts, but there is no question that, outside of the addiction field itself, which is containing many of them in very useful roles, that the market is very depressed and there is discrimination and intolerance.

Senator HUGHES. Do you have budgetary control over what is being done in New York City?

Mr. FINNEY. Not totally at this point. Let me simply say that we are en route toward that. Virtually all treatment rehabilitation, research and development activities now fall within my budget and I exercise supervisory control. There are a few remnant pieces that have not been pulled in. There is no question that the agency gives advice and directs decisions in this area. However, we work in very close concert with a council which the mayor himself chairs and which gives us very direct access to the chief executive on these problems, which is a very key and important part of our operating relationships.

Senator HUGHES. Did you hear the testimony of Dr. Jaffe?

Mr. FINNEY. I came in, I suspect, about one-third through the testimony.

Senator HUGHES. You heard his testimony then relating to the 30-day period for the veteran.

Mr. FINNEY. Yes, I did.

Senator HUGHES. The veterans coming back to New York City, your estimate was about 300 a month could be addicted coming into New York City right now.

Mr. FINNEY. We are rather convinced that we do not have, and I share Dr. Jaffe's concern about hard data in this entire field—we don't have accurate figures. We are doing a census, as he has been doing, on this. We are as concerned about the numbers that are already with us, I might add, as those who are yet to return from Vietnam, and we find in many of our programs substantial percentages of veterans, and we are afraid that there are equally substantial percentages on the streets of New York.

That is one reason we very much favor efforts to corral them through Federal assistance and offer rehabilitation.

Another point I would like to make is the importance we place upon trying, after successful participation in the program, to address the problem of their discharge, which we have discovered to be the worst deterrent of all in dealing with the returning veterans in having him obtain employment. I wanted to make that very clear in my testimony.

Senator HUGHES. As I understand your testimony, you believe there should be a complete review, and if addiction is the primary reason for the discharge of under less than honorable conditions, you feel that should be changed?

Mr. FINNEY. Yes; providing that the chap has gone through and shown evidence of successful participation and treatment.

Senator HUGHES. Do you think 4 weeks' treatment for a heroin addict is going to do much for him?

Mr. FINNEY. I think it can do not very much for the typical heroin addict we know in New York City, no. I think it can be a very useful——

Senator HUGHES. You know a lot of veterans in New York City. What do you think 4 weeks will do for them?

Mr. FINNEY. I think in that period one can successfully diagnose, counsel, offer some assistance. For the hard-core addict, our experience is the need for a continuing long-term relationship, be it in a methadone program or be it in a drug-free program. I am afraid that our cycle of treatment is far more extensive than one month in any program.

Senator HUGHES. How do you estimate a cycle of treatment to be successful, or modestly successful of a man addicted in Vietnam, screened out, sent back, and he comes back to New York City? What do you think you are going to have to do with him? You are going to get him.

Mr. FINNEY. Yes; we are working now and hope to have ready by the first of September a comprehensive plan of how we wish to deal with it. Clearly, as my testimony indicated, we would like to develop a capacity in New York City, a combination of primarily civilian-based programs, to deal with the chap over a sufficient period of time.

Senator HUGHES. Of course, your testimony indicated you feel this is a total Federal responsibility.

Mr. FINNEY. Yes; we do.

Senator HUGHES. As far as paying for it and assisting you in doing it, you don't feel that is a city responsibility?

Mr. FINNEY. No; we don't. We feel that this is a special category where Federal assistance is marked, where there is an obligation to that returning veteran.

Senator HUGHES. Do you think as a city, for every veteran that comes back to you addicted that you have to pick up and maintain and give service for, that you ought to be reimbursed for the expenditures for that veteran if the addiction was service-connected?

Mr. FINNEY. That would be our position, yes.

Senator HUGHES. Do you think there is any capability in the Armed Forces to do this?

Mr. FINNEY. I am not really in a position, having not visited Vietnam, to comment on that, I think. The points I would make are, again, that we already have too many veterans, as indicated in several programs.

Senator HUGHES. How many do you estimate you have in New York City?

Mr. FINNEY. I can give a few indicators. I can't give you a good total, but we have taken samples in the Tombs, which you visited with the subcommittee that day, and find that 5 or 10 percent, and we are doing another probe there. The closing of the proprietary methadone clinic I mentioned indicated 14 percent veterans and active servicemen.

Senator HUGHES. In other words, you think that you have 10,000 veterans in New York City at this time?

Mr. FINNEY. No, I don't think the figure would be that high. It is 10 percent of the returning population, which is running about 3,000. From returnees of that volume over the last 2 years.

Senator HUGHES. That is 3,600 a year?

Mr. FINNEY. It could be that high at the present time and last year, that is correct. We think we should plan for that level of population. We honestly don't know how many there are, and there is no way to recover that information. We are aware we are receiving returning veterans from other parts of the United States because we are, alas, a Mecca for this.

Senator HUGHES. You are a source of supply, and they go there to "live."

Mr. FINNEY. That is right. This is where they can be assimilated and absorbed without notice.

Senator HUGHES. Are you developing any sort of a working relationship between the Veterans' Administration and the Defense Department now?

Mr. FINNEY. Yes, sir. I have a fulltime Veterans Affairs Coordinator charged with developing a comprehensive plan for the city of New York by September 1. Our plans would hope to include the opening of a referral center on or about that date for the exclusive use of veterans.

We are dealing with the local Veterans' Administration and have made contacts in this development with Federal officials as well.

Senator HUGHES. Based on your experience in New York City and the problems you have, would you be in a position to give this committee a professional judgment budget for the country?

Mr. FINNEY. I have not tried my hand at that.

Senator HUGHES. How would you like to try?

Mr. FINNEY. Sure, we'll take a whack at it. It would be not without some parochial involvements, because we have half the problems.

Senator HUGHES. You are working with the biggest problem in the world in New York City.

Mr. FINNEY. That is right.

Senator HUGHES. And you have the widest range of experience and probably expertise and records of failure, problems that go with it, and everything else, and if you could, Commissioner, give us the benefit of your opinions also in a professional judgment budget for our consideration in the committee along with the other estimates we will be getting. It could indeed be very helpful to us in how we face this problem.

Mr. FINNEY. We will do so.

Senator HUGHES. If you have that sort of capacity, I know the Chair, and I am sure Senator Javits and other members of the committee, would deeply appreciate it.

Mr. FINNEY. We will try to do that.

(The information referred to had not yet been received at time this hearing went to press.)

Senator HUGHES. I want to commend you. Based on our experience with the subcommittee in New York and sitting with the coordinating council of the mayor, I think you have drawn together the best capability in a large city, the best capability of focusing on all the problems that exist in a metropolitan area that I have witnessed in the country.

You still have a problem that is still out of control, and you are fighting for solutions in every way you can. I am convinced that you are doing the best you can to begin to cope with that problem, and certainly that is tremendously important to all of us.

Without that, we will never succeed.

Mr. FINNEY. I think the best way we can present to our own people in New York City and the Nation as a whole is a very candid statement that we do have a problem of epidemic proportion. I do like to make the analogy to the unsolved mysteries of cancer, heart disease, and mental illness in general, because I think the public grasps the difficulties and the investment level that would be required to cope with those matters.

Somehow we have allowed ourselves, and it is a good American characteristic, to think we can come up with an instant answer to this one. My own experience, which comes out of a background other than medicine—urban problems in general—is that we are not only confronted with profound medical mysteries, but we are also in this one deeply imbedded into the whole value system of this country.

That is what makes it such a profound question of national importance.

Thank God we recognize it.

Senator HUGHES. I have enough experience, not with heroin addiction, but with alcoholism, to know the attitude and the way people view a problem such as this, or an illness such as this. I read last night a letter from a group of fine people who are producing a textbook on alcoholism, who asked me if they could use my picture more or less as a specimen of an alcoholic, to demonstrate to the people of America that I conquered alcoholism and that others might, too. No mention of the fact that it is a disease or that is was a recovery.

It was simply, "You overcome it" by a matter of exercise of will, I suppose, rather than any expertise in relationship with the recovery process that goes into addiction.

That displays to me that even the people writing the textbooks have a total misunderstanding even today, and yet they are going to be presenting their ideas to college professors and teachers throughout the country in one of the textbooks to use for the future.

My God, what is going to happen? We can maintain and continue these prejudices and these attitudes.

In relation to heroin, it is even worse. You ask someone to hire a heroin addict and they almost jump through the wall. Yet we say, "Find them jobs."

You are hiring them for the city, I suppose, as many as you can. Because we in government have to furnish the example. We in the Federal Government ought to be hiring heroin addicts, recovered addicts, to prove to industry that they are available, they are maintainable, and that they can fit into the structure of society and work.

If we haven't the capacity as a government to do that, how in the hell can we expect industry to do it?

I shouldn't be preaching to you, because I know we share common feelings.

Mr. FINNEY. You might be interested, Senator, in knowing that one small project we think is significant in New York City which is being run by the Vera Institute of Justice is a messenger service where people out of drug programs are developing close connections with a number of major industries in the city, which is another way to break down some of these stereotypes.

One small piece of Federal assistance that we have just received is a grant from OEO, which has been our largest benefactor in the past, to assist us to break some of these barriers down further.

Senator HUGHES. Commissioner, in conclusion, I am well aware of the concern that you have and that the people in the city have for the tremendous problem you are faced with. I know that you are completely overwhelmed at the present time by everything that you have massed and drawn together in that city to try to cope with this problem. I was expecting to see for myself as chairman of the committee many of the things we saw in New York City, but I was extremely shocked the 2 days we were there for hearings at the ready availability of heroin in the streets and the inability to cope with the treatment programs and the absence of simple things like toilet tissue in wards where people are being treated because there are no funds to provide toilet tissue or washcloths. That is in America an impossibly degrading situation.

I am hopeful that we can succeed now with the national focus of attention on this to forget any politics related to it and look to the epidemic of a tragic illness that is eating the guts right out of America.

Thank you very much.

Mr. FINNEY. Thank you, sir, very much.

(The prepared statement of Mr. Finney follows:)

The City of New York

ADDICTION SERVICES AGENCY
HUMAN RESOURCES ADMINISTRATION
71 WORTH STREET, NEW YORK, N. Y. 10013
Telephone: 433-2020
GRAHAM S. FINNEY, *Commissioner*

TESTIMONY OF GRAHAM S. FINNEY, COMMISSIONER OF THE ADDICTION SERVICES AGENCY OF THE CITY OF NEW YORK, BEFORE THE SUB-COMMITTEE ON ALCOHOLISM AND NARCOTICS OF THE U.S. SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE, WEDNESDAY, AUGUST 4, 1971, WASHINGTON, D.C.

Thank you for the opportunity to testify before this subcommittee on legislation now pending before the Congress that will bring about a renewed Federal approach to the issue of drug abuse and addiction in the United States.

Drug addiction is properly labeled an issue of survival for America today, such is its current impact on the fabric of our society. It is a grave indicator of ill health, hopelessness and evasion of reality among growing numbers of Americans.

Speaking for New York City, I am able to make that statement for we have the unenviable distinction of possessing some 100,000 heroin addicts -- perhaps 50 percent of the nation's problem.

In addition, we are host to many times that number of drug abusers who use a variety of amphetamines, barbiturates and other dangerous drugs for non-therapeutic purposes. This population knows no geographic, economic, ethnic nor institutional limitations.

As members of this subcommittee experienced in New York City a little more than a month ago, however, the corrosive impact of drug abuse is unquestionably greatest in those neighborhoods that are the poorest and the blackest and where other indicators of social pathology abound: poor housing, inadequate education, lack of jobs and high criminal activity.

The City of New York, through my agency which was established by Mayor John V. Lindsay in 1968, currently budgets $90.9 million toward treatment, rehabilitation and prevention of drug abuse.

Of this amount, $5.94 million is Federal funds. Another $2.55 million comes to the City via the Model Cities program.

The balance, more than 90 percent of the total, represents City and State funds which cannot be stretched further even though efforts to curb and cure addiction are this City's number one priority at the present time.

Despite this effort, which has required an immense energy to mount and manage, New York City still reaches only a small percentage of its estimated addict population. Twenty thousand narcotics addicts and drug abusers are in treatment in all modalities out of a total population more than five times that number.

There are numerous indicators of unmet demand:

*Addicts continue to apply for welfare in growing numbers, roughly 1000 new applicants per month.

* Eight thousand unsolicited names are on the waiting list for methadone maintenance programs.

*Two hundred individuals are being detoxified each week in our prison system where perhaps 50 percent of the total detained population has a severe drug problem.

*Youth constantly seek entry into drug-free programs offering hope and rehabilitation.

*Three thousand veterans are returned to New York City each month with an estimated 300 of them likely carriers of dangerous drug habits.

There are, in short, no indicators that we are solving the problem despite herculean efforts to do so. The age of the typical drug abuser grows steadily younger and, increasingly, drugs invade the elementary school.

More than 1200 narcotics-related deaths occurred last year in New York City and may well be repeated this year. Narcotics deaths remain the largest single cause of death in the 15 to 35-year-old age group in our City. Arrests and dope seizures soar yet the price of drugs gets cheaper. The indiscriminate poly-drug user grows in number. The addicted veteran comes marching home to New York City, which has no need for such reinforcements.

Given this picture, New York City, laying aside whatever comments it might be tempted to make about the belatedness of the Federal effort or the special tragedy of the veteran-addict who has made addiction at last a national issue, can only welcome a new Federal initiative.

It pledges to work tirelessly with the new officials who will command the enlarged operations and to continue to work with current officials in the wide variety of Federal agencies now offering assistance.

With respect to pending legislation, I think I can be most helpful to you by doing two things. First, by sharing some of our experience in New York City in trying to build a comprehensive response to the drug problem across agency and functional lines. Second, by projecting how our needs might be served best by your actions at the Federal level.

New York City endorses the concept of a single agency responsible for directing Federal activities in the drug rehabilitation, prevention and research fields. This agency should have purview over all such programs under the auspices of the following Federal agencies: the Departments of Defense, State, Justice, Housing and Urban Development, Treasury, Labor, and Health, Education and Welfare; the Civil Service Commission; the Veterans Administration; and the Office of Economic Opportunity.

I see no reason to exclude completely any portion of the Federal Government from this involvement. Drug problems cross cut virtually all systems, whatever level of government. My own agency deals constantly with the social service, criminal justice, health services and educational systems, among others. Any successful strategy will involve all these elements from the outset.

Only one system, law enforcement, might be excluded as a full component of a new agency. There are reasons for this. First, enforcement of narcotics laws frequently go hand-in-hand with activities serving broader objectives of public policy, as, for example, with the Bureau of Customs. Law enforcement is thus exercised in a very complex set of legal and administrative relationships that defy complete integration, at least in the short run.

We do feel strongly, however, that the new agency should be empowered to develop truly meaningful evaluative and performance activity related to narcotics.

We are very mindful that perhaps the fundamental decision in mounting any national drug program will be to effect the distribution of resources between treatment, research and prevention on one hand, and enforcement on the other.

In our opinion, the cutting edge of any national strategy, as it is on the local level, must be to reduce the current pool of addicts and to restrict the future contagion by successful prevention work.

We suggest, for this reason, that the great bulk of new funding should be applied to research, prevention and rehabilitation programs.

We urge strict congressional review of this fundamental allocation. We expect a strong administrative justification based upon sound data and performance measurement.

A Federal response of maximum benefit to the City of New York must yield a high degree of flexibility in the utilization of funds made available in conformance with an annually updated comprehensive plan stating local goals and objectives.

We are already preparing such a plan to meet the State's and our own local requirements. We feel that such a statement (a workable program concept) should be considered a prerequisite to future Federal funding.

Any approach must respect the different starting points among the participating cities and states. To be workable, the Federal program should insist that each locality demonstrate a multi-modal approach; that it include the basis for broad-scale community and prcfessional participation; that it document linkages with all Federal systems previously named; and that it conform to basic standards governing administrative and fiscal capability.

We would oppose any provision that prevents the City of New York from dealing directly, as we do now, with Federal agencies responsible for funding drug programs.

We would oppose any provision that attempted to confine programs to one or two approaches. Our situation clearly requires a multi-faceted approach.

For example, while we would favor utilization of community mental health centers as one focus for Federal drug funds, we would strongly resist having this be the exclusive mode of local operation. There must be no provision that penalizes already existing operations which can demonstrate their effectiveness.

We support a distribution formula for treatment funds that reflects need as documented by incidence of drug abuse. We would expect the Federal Government to hold us to a similar intra-city allocation. The definition of measures of need should be an early output of any performance measurement system created by the new agency.

A basic interest we have regarding any new Federal office is whether it will permit this City to be served by a one-stop point of contact as opposed to the hit or miss collection of program sponsors with which we now deal. Let me illustrate our concern.

Recently, we have sought funding for a systematic network of ambulatory detoxification facilities. In doing so, we have dealt with three different agencies, the Office of Economic Opportunity, the National Institute of Mental Health and Model Cities. Each has its own guidelines, each has its won procedures, each has its own review and approval cycles. We have had great difficulty, therefore, in mounting a comprehensive and consistent program.

The new agency should, in our opinion, be able to assess our overall proposal and greatly reduce the administrative friction we have faced. We would appreciate some clarification of Federal intentions to rectify this problem as soon as possible.

We have several other concerns about local Federal working relationships with which this subcommittee should be familiar.

One illustrates the close connection between Federal treatment and enforcement activities that can have profound local consequences. Recently, a proprietary methadone clinic was closed in our City by the combined efforts of the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs.

While we welcomed this action, while we hope that in the future more, intensive inspection activities will accompany treatment activities, and while we feel that any new agency should have a role in coordinating such enforcement, we would point out that no Federal agency assumed any responsibility for the ongoing treatment of those involved in the program when it closed.

It fell to the City of New York to develop emergency referral procedures to protect against that failure to respond and led to additional local expenditures in doing so.

Recently food stamps have been cut off summarily to those in treatment in residential drug-free communities within New York City. The use of food stamps had been an important adjunct to the funding of these programs and to the development of a sound therapeutic approach.

It should be easy to distinguish between this use and alleged misuse of food stamps in other communal settings housing unrelated individuals. We urge reversal of this order as inconsistent with a new Federal initiative.

We strongly question the three-year time-frame of the Administration's bill. A suggestion that there may be an early solution to the drug problem is totally unfounded. Based upon past experience, we suggest that a Federal management information system will be lucky if it is functioning smoothly by the end of the three-year period.

Necessary basic research will only be underway within this period. There should be no false expectations about easy solutions in this field, the same way that there are no false expectations in the field of cancer or heart research, which are equally primitive in their prospects for finding solutions.

We do believe, however, that a review of activities launched under whatever legislation is eventallly passed after three years is sensible and should be welcomed by the Congress.

We see far too little emphasis being placed upon the need for a tremendous increase in research funds in the drug-abuse field. The provisions of S.2217 are most clearly addressed to this concern. Recently we had to tap scarce City funds in order to launch much needed research in the development of drug antagonists.

Our limited money should be spent in treatment and prevention activities and not in basic research which is of national concern and should be Federally supported. I make a strong plea, therefore, for the rapid expansion of biological, sociological and other research in the drug-abuse field in order to tap the tremendous amount of medical and other interest which has been generated recently.

No delays can be tolerated in the processing of whatever legislation emanates from the Congress. We ask that you do not complicate the machinery further. We ask that we not be caught in moratorium as a superstructure is created and as old agencies drift to new auspices. We must not lose momentum as a product of reorganization.

We strongly support the idea of a single non-Federal share requirement across Federal agencies for all new funds destined for a single locality. We urge 100 percent Federal funding of basic research and all innovative treatment programs.

We would borrow a leaf from the NIMH practice and suggest that three-to-five-year funding of all treatment and rehabilitation projects be authorized. Particularly in programs which are community based, there is a tremendous friction and time-loss in the constant renegotiation of one-year projects which clearly cannot show a product in the course of a single year.

We urge Federal support for vocational retraining and the breakdown of discriminatory patterns which affect the employment of the former addict. We urge the extension of the efforts to the United States Civil Service Commission as we in our own City are attempting to break down remaining barriers that exist within City government itself.

With regard to the veteran, we urge the Congress to consider the following points in framing any new legislation:

*Full Federal financial responsibility for the costs of rehabilitation of returning servicemen and veterans.

*The immediate need and the short time available for mounting large-scale rehabilitation services for veterans.

*The consequent importance of utilizing the tested resources of civilian-based agencies through Federal purchase of service agreements with such organizations, as well as providing services through the Veterans Administration directly.

*The good sense of developing new treatment forms that respect the special circumstances and needs of the returning serviceman.

*The importance of providing a review mechanism for converting dishonorable, bad conduct and less than honorable discharges for men whose addiction occurred while on active duty. Without the prospect for such conversions, motivation to conquer drug addiction will be undercut badly.

We suggest that the leadership of individual senators be used to give support to the development of a national citizens' effort in the drug-abuse field which would be analogous to the American Cancer Society or the American Heart Association, which have accomplished so much in building unity among efforts around the nation in these fields, and which is needed to watchdog and to give continuing support in the drug field. Nothing such as this now exists.

The drug field has suffered from self-destructive, internal fights. As a by-product to the Federal initiative, I urge your support for a national effort that will be supportive of the goals reached in the new legislation.

We suggest that an early effort be made by the new agency to package model legislation and model drug programs for use in those cities, counties and small towns which are just becoming involved in the drug scene, and which can benefit from those of us who have been in the business and have learned many lessons. There is no time to reinvent the wheel in this field. Federal technical assistance is thus of high priority and should be offered in the very near future.

Much discussion has been made about the level of funding which should be offered by the Federal Government in Year One of an expanded effort. For your benefit, may I summarize our immediate requirements and our immediate capacity to utilize funds along this line.

These proposals which total $21 million are listed in Table I, which follows.

TABLE I

PROPOSALS FOR FEDERAL FUNDING

1. Expansion of Methadone Maintenance Program		$5.0 million
2. Expansion of Drug-Free Community-Based Rehabilitation		3.0 million
3. Detoxification Services (ambulatory narcotics detoxification, barbiturate detoxification)		5.3 million
4. Research and Development		1.2 million
Drug Antagonists	$500,000	
Methadone leading to Abstinence	500,000	
Evaluation of the Therapeutic Community	200,000	
5 Training and Education		1.0 million
Training Institute	750,00	
Multi-Media Community Education Program	250,000	
6. Job Development, Training and Supportive Work for Former Addicts		.5 million
7. Veterans Programs		5.0 million
TOTAL		$21.0 million

The question here is whether we can afford not to undertake a vigorous and substantially increased effort in the field of drugs. The question further is whether we do not need also to increase our commitments to the solutions of the problems which under-lie drug abuse.

Congressional leadership is required not only to reach a very quick verdict on an emergency program to combat drug abuse but also in building sensible approaches in the fields of housing, poverty, education, job training, and other areas which are part and parcel to the solution of drug problems.

As I say in my City, I hope mine will be the agency which disappears first. Short of a miracle, this will not, unfortunately, occur in the next three years. But let us take as our clear goal the eventual eradication of the Federal agency which we today would form and, with it, the drug scourge which threatens the very fabric of American society at the present time.

Thank you.

Senator HUGHES. The Chair calls Dr. Edward Leibson, who is executive director of NARCO, Detroit, Mich.

Dr. Leibson, I am deeply appreciative of the fact that you stuck it out. I apologize for the lateness of the hour, but we were just unable to get through.

Dr. LEIBSON. I hope you are not too hungry.

Senator HUGHES. You may proceed with your testimony.

STATEMENT OF EDWARD LEIBSON, EXECUTIVE DIRECTOR, NARCOTICS ADDICTION REHABILITATION COORDINATING ORGANIZATION

Dr. LEIBSON. Thank you, Mr. Chairman and members of the committee, for the opportunity to appear before the Senate Subcommittee on Alcoholism and Narcotics.

The subject of drug abuse has become a concern bordering on near hysteria. Individuals vested with public authority and responsibility are seeking solutions for problems which have not been clearly identified. It is precisely this lack of direction which underscores the heavy responsibility that rests upon the shoulders of this subcommittee and the Congress of the United States. I am certain that this subcommittee is interested in the development of legislation which will assure the reduction and amelioration of this critical social problem.

We have been aware for some time that drug abuse has been growing across the Nation and, more particularly, in the metropolitan areas in our Nation. The Detroit metropolitan area has not escaped this blight. We have experienced an increase in the identified abuse with a wide range of drug substances at a frightening pace.

In 1968 there were 357 newly identified opiate addicts in the city of Detroit in a total of 1,054 who had been recorded by the Detroit Board of Health. In 1970, 1,442 new opiate addicts were reported in a total of 2,437 board of health-notified addicts. This is an increase of over 400 percent in the newly identified opiate addicts in the Detroit metropolitan area. That is, to add to the totals already existing.

A fact that is obscured by these figures is that the percent of new addicts falls largely in the age range between 17 and 24; 96 percent of the new, known opiate addicts falls in that age category, and a half of those fall in the age range between 17 and 20. We have a situation in our metropolitan area where over 400 young persons under 16 were arrested and investigated for narcotics activities by the Detroit Police Department in 1970.

In all, nearly 11,000 people in Detroit and Wayne County have been called to the attention of law enforcement officers as a result of their violations of the State narcotics laws. It appears clear that if this number of persons were afflicted with a contagious disease, that the health authorities would declare a state of emergency.

In the words of the chairman of this subcommittee, Senator Hughes, at the annual meeting of NARCO in Detroit on June 19, 1971:

> We have long had a moralistic, unforgiving attitude toward the sickness that makes people abuse dangerous chemical substances. If drug abuse had been a bacterial disease, we would have it well under control by this time—as we quelled polio and tuberculosis. But in our universally drug-oriented society, we have this hangup on chemical addiction and dependence. And now the hangup has us hung up.

I think to this point I have belabored the obvious. The honorable members of this subcommittee are well aware of the extent of the problem. Perhaps you don't know specific numbers and this is an important consideration. We ought to know the extent of the problem, but we know the problem exists.

The response that is necessary in every metropolitan area in our Nation is a comprehensive assault upon this as a public health and mental health concern. To further illustrate the concern evidenced by the executive branch, the President, upon the occasion of the establishment of a Special Action Office for Drug Abuse Prevention, said:

> We must now candidly recognize that the deliberate procedures embodied in present efforts to control drug abuse are not sufficient in themselves. The problem has assumed the dimensions of a national emergency.

A recommendation was made that $7 million be made available for a comprehensive treatment and rehabilitation program for the State of New Hampshire.

The following excerpt appeared in the Narcotics Control Digest on page 12 of the July 1971 issue:

> Sen. *Birch Bayh* (D-Ind.) today urged the Nixon Administration's new drug abuse director to adopt and fund New Hampshire's proposed drug control plan as a pilot project for the nation. In a letter to Dr. *Jerome Jaffe*, Director-Designate of the White House Office on Drug Abuse Prevention, Bayh said the state plan was "well conceived" and should serve "as a model to the Nation." The rehabilitation unit of the New Hampshire plan would provide a network of community-based homes to help drug addicts, including out-patient units and day centers.

To initiate such a program in the metropolitan area of Detroit it is necessary to consider expenditures in excess of $25 million per year. That is solely for Detroit and Wayne County. This figure is based upon the general cost of treating and rehabilitating those addicted who have identified themselves as desiring help.

To reach out to the remaining addicts who have not come forward for assistance, but for whom assistance will be required shortly, would require the expenditure of a like amount. These figures are based on an average per-patient cost experienced in most programs in the metropolitan area of Detroit regardless of the treatment procedure employed.

At present there are 75 programs in the Wayne County area and 46 programs in Macomb and Oakland Counties. The three counties make up the tricounty area. Many of these agencies are voluntary, such as our own, or receive modest amounts of money from local governmental bodies.

The Federal expenditures that are available and are being used in the Detroit metropolitan area include Department of Justice funds under the Narcotic Addiction Rehabilitation Act of 1966, National Institute of Mental Health funds under the Comprehensive Mental Health Centers Act, parts D and E, Department of Education funds under the Drug Abuse Education Act of 1970, Office of Economic Opportunity funds under the Economic Opportunity Act of 1964, section 222(a)(9), Department of Justice funds under the Manpower Development and Training Act of 1962, Department of Housing and Urban Development funds under the Public Health Service Act, and Veterans' Administration funds under title 38 of the United States

Code, Veterans' Administration for a total of $3,199,721. These totals do not include moneys made available through the State resources and the city of Detroit resources.

I have taken great pains to indicate something about the nature of the problem in our metropolitan area, the potential cost to our society, and the amount that currently is being invested in this problem in the metropolitan area of Detroit. Detroit is a case study; one in which there is high incidence of drug abuse of all varieties, and six Federal agencies which have been brought to bear upon this problem.

Our organization, NARCO (Narcotics Addiction Rehabilitation Coordination Organization), has had the privilege of providing consultation to the Detroit-Wayne County Community Mental Health Services Board. This board was established by the State of Michigan Public Act 54 of 1963, called the Community Mental Health Services Act, to provide comprehensive mental health services in Detroit and Wayne County. It follows the pattern of legislation adopted by the 88th Congress of the United States, which served during the John F. Kennedy administration and through its foresight established these mental health centers throughout the Nation.

The mental health board requested NARCO to fulfill a contract responsibility between the Governor's office of drug abuse and that board to develop a comprehensive plan for drug abuse control. This comprehensive plan of drug abuse control has become a portion of the State plan for Michigan.

In order to develop this plan it was necessary to develop a council of individuals providing drug abuse control services in Detroit and Wayne County. It has become evident through the process of planning that a great need exists, not only in the metropolitan area of Detroit, but in other States throughout the Nation for cooperative planning and service delivery.

We have found that as a result of funding from Federal, local, and private sources, that there is some overlapping, unnecessary duplication, a vying for power influence, and greater responsibility on the part of some programs. While large numbers of individuals cannot obtain service in the metropolitan area, we have clinics and programs which overlap service areas. The difference between the clientele from which they might draw has more to do with program selection criteria than location.

We feel that many of the problems associated with drug abuse have their origins in the community. Insofar as it is possible, comprehensive service to treat and rehabilitate the former drug user should be in the community where he is confronted daily by the temptation to slip back into the cycle of substance abuse.

I might say parenthetically that I think this is also a lesson that the military should learn, that the confrontation of the drug abuse problem has to be in the community. Overlapping programs hardly contribute to this goal.

Shortly after the President announced the Executive Office of the President would include a Special Action Office for Drug Abuse Prevention, I carried on correspondence with Congressman Broomfield, of Michigan. Specifically I requested information with regard to which agencies would be subject to the financial and policymaking control of the Director of the Special Action Office for Drug Abuse Prevention. He returned the following information:

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20506

16 July 1971

Honorable William S. Broomfield
House of Representatives
Washington, D. C. 20515

Dear Congressman Broomfield:

This responds to your request of July 12, 1971, for information responsive to the question raised by your constituent, Mr. Edward Leibson. Mr. Leibson asks what agencies would be subject to the financial and policy-making control of the Director of the Special Action Office for Drug Abuse Prevention pursuant to Sec. 5(c)(1) of HR 9264. There follows a list of the authorities and the responsible agencies:

Authority	Responsible Agency
The Narcotic Addiction Rehabilitation Act of 1966	HEW Justice
Community Mental Health Centers Act, Part D & E	HEW
Comprehensive Drug Abuse Prevention & Control Act of 1970, Title I & Sec. 502(a) (1)	HEW Justice
The Drug Abuse Education Act of 1970	HEW
Economic Opportunity Act of 1964, Sec. 222(a) (9)	OEO
Omnibus Crime Control & Safe Streets Act of 1968, Sec. 306(a) (2)	Justice

The Manpower Development & Training Act of 1962	HEW Justice
The Public Health Service Act	HEW
Title 38 of U.S. Code Veterans Administration	VA

Thank you for your interest in this program.

Sincerely,

Arthur F. Konopka

Arthur F. Konopka
Acting Director of
Congressional Affairs

Dr. LEIBSON. In reality the funding of specific programs still rests with the agency responsible and the Special Action Office for Drug Abuse Prevention, administered by Dr. Jerome Jaffe, has a coordinating function. Coordination implies voluntary association.

One of those Departments for which he has no responsibility is the Department of Defense, apparently a department for which he must spend some time, as evidenced by his recent tour of Vietnam. Because I see strong parallels with what has taken place in the metropolitan areas of Detroit and the concerns that are being evidenced in Congress about the lack of responsibility and the development of cooperation, it is my feeling that cooperation will evolve and responsibility will be forthcoming under the guidance of the agencies which hold the purse strings.

We have had occasion in our seeking to evolve a plan for Detroit and Wayne County to request certain types of information from local programs. Those programs have been reticent about sharing information and planning resources without control over their individual dollars. To put it bluntly, some of the program directors have said, "We will cooperate when you control our funding resources."

I believe that Dr. Jerome Jaffe and the Special Action Office for Drug Abuse Prevention will find itself in a similar position. Coordination, planning, the insistence upon continuity of care can only be vested in a single funding agency.

A series of bills have been introduced to provide the necessary teeth for the coordination efforts of the administration. It is my feeling that Senate bill 2217, introduced by Mr. Hughes, for himself and by Mr. Javits, Mr. Muskie and Mr. Williams, carries the greatest promise of attaining the ends which we all desire. Those ends are to blunt the epidemic growth of drug abuse and dependency in the United States.

The creation of a National Institute on Drug Abuse and Dependence insures a comprehensive program that relates to not only Federal coordination, but action. It provides the teeth necessary for disjointed efforts to come together in all segments of the social institutions which are confronted by this problem.

The requirement that State plans be developed speaks to the need for programs to be evolved in the community. I would encourage, in such a measure, the inclusion of community groups to assist in the development of the State plan. Where State plans exist, they should be reviewed to determine whether they might conform to Federal requirements.

Unfortunately, I am afraid the crisis may be transitory, but the problem will long be with us. We may be able to blunt the crisis proportions, but I don't think we are going to make it disappear. It is for this reason that I think an institute makes sense. A crisis response to the problems of drug abuse may alter the shameful increase of drug dependence among our youth, but it will not eradicate the problem from our Nation. Because this eradication is not probable, we need such an institute.

I would also like to comment on Senate bill 2097. This bill carries many of the same initial requirements for coordination and concentration, but does not go far enough in terms of actual program devel-

opment. The fact that it does not call for a series of State plans or the creation of a national institute on drug abuse prevention and treatment demonstrates this point.

Senate bill 2146, in the same way, is a partial effort to expand the requirements of the Community Mental Health Centers Act. There is evidence to indicate that these efforts toward developing comprehensive mental health services have fallen short of current needs in the mental health field. To add another requirement may distort the program development of mental health facilities.

Senate bill 2155 is a bill which provides a mechanism for cooperation between existing programs, but does not insure the necessary fiscal control for program development and direction.

In the Detroit metropolitan area there is one staff member assigned to five States with the responsibility for the development of drug abuse control programs, the monitoring of those programs, and ultimately the evaluation. This staff member is a member of the Narcotics Addiction Rehabilitation Branch of the Department of Health, Education, and Welfare. He carries responsibilities at the present time for monitoring and reviewing programs developed under the Community Mental Health Centers Act, the Narcotic Addiction Rehabilitation Act of 1966 and the Comprehensive Drug Abuse Prevention and Control Act of 1970.

A good deal more Federal dollars are being invested in Detroit by the Office of Economic Opportunity in the area of drug abuse treatment and rehabilitation than are being invested by the other three agencies combined—that is, Narcotic Addiction Rehabilitation Act, Community Mental Health Centers Act and the Comprehensive Drug Abuse Prevention and Control Act.

We are not certain as to what kind of monitor has been established for the Office of Economic Opportunity program. I think the point again is quite clear that in order to determine whether or not these programs will run effectively. efficiently and have made a significant impact on the reduction of drug dependency might best be determined through a single agency, adequately staffed.

Detroit, Wayne County, and the southeastern metropolitan areas of Michigan remain high among the metropolitan areas in the incidence of drug abuse. Federal money will be invested to try and stem the growing problem of drug dependency. There is great need for responsible Government cooperation and action. The action of the U.S. Congress on these measures which you are considering can go a long way toward insuring that every victim of drug dependency gets the maximum help.

I would urge that you look favorably upon Senate bill 2217, report it out of committee, move for its adoption, and enact it into law.

I sincerely appreciate the opportunity to express my views before this committee.

Senator HUGHES. Doctor, thank you very much for a very comprehensive and, I think, a very helpful piece of testimony this morning.

I notice in your next to last page, you say you received three times as much money from OEO as from other agencies of Government. Are you aware that the administration fought the funding of any funds for narcotics addiction in OEO?

Dr. LEIBSON. Yes, I am aware of that, and I am aware there is a contract currently being offered for an outside evaluation of the OEO programs.

But it speaks to the nature of the problem. OEO develops community target areas in the Detroit area, and these areas may overlap some existing programs. For example, we are in receipt of some information that an NIMH grant will be offered to the southwest part of the city of Detroit. OEO already has a program in a portion of that area.

What happens is that we get a tendency for the clientele to be creamed, and the poorest risks falling to the agency which has to take them. So there is a selectivity process involved in which programs acquire a predetermined level of responseability and success probability.

We have a similar kind of thing in operation in our model neighborhood program. It has received a grant matched by HUD funds. Their program overlaps the city program. They seem to get the better risk people on the basis of their selection procedures. The city can't make that kind of selection process.

We brought all these people together in this Drug Executive Council in the city of Detroit and they sit around the table to share in planning, but in reality to share in dividing up whatever State funds come down the pike.

Senator HUGHES. Would you support legislation which created a city agency or a city supervisory agency to whom the applications would be made?

Dr. LEIBSON. I would not. I would prefer to see the State held responsible for this. I think that there is a real problem in the metropolitan area of Detroit with divided allegiances. I think with the OEO, the model neighborhood and the city itself vying with each other, that it would make more sense in the drug abuse area to make this a State responsibility.

Senator HUGHES. What is the number of heroin addicts in the Detroit area?

Dr. LEIBSON. I would have to say that our estimates are not very well founded. We have a number of indicators. I would say the minimum we would be able to project would be 6,000, and the maximum that we would be knowledgeable about and would want to have help would be 12,000, somewhere between 6,000 and 12,000 heroin users.

There are currently nearly 3.000 people in private and public programs being treated, principally with the methadone modality. We have heavily invested in a single modality. When we look at the therapeutic community there are fewer than 50 people in the Detroit area involved in the therapeutic community. That means a very heavy investment in one modality.

I have heard Dr. Jaffe say it is poor medicine to use only one treatment approach for this problem.

Senator HUGHES. Do you subscribe to that, that it is?

Dr. LEIBSON. Yes; I think we have to have options based on what the individual needs.

An LEAA project in the northwest of Detroit has a youth detoxification house. Most of the young people who present themselves are suffering from malnutrition and the needle habit rather than drug dependence, and if they were then addicted to methadone, I think we would be perpetrating a crime upon them.

Senator HUGHES. Do you have an extensive problem in the rest of Michigan outside the Detroit metropolitan area?

Dr. LEIBSON. Yes; there are spots throughout the State where there is an intensive problem, in Lansing, in Flint, in the Saint Joe area. It is not peculiar solely to the Detroit area, though I would say the preponderance of it is in the Detroit area.

Senator HUGHES. How long has NARCO been in existence?

Dr. LEIBSON. Since 1969. It was founded by Justice John B. Swainson, former Governor and Justice of the Michigan Supreme Court. We have been interested in four principal goals and have chosen to focus only on the treatment aspect as it relates to your bill, but we are interested in education, treatment, research and reevaluation of the laws.

I might say in that regard Justice Swainson appeared before your subcommittee and sought release of a public service health hospital to the State as a treatment facility. In November this last year, largely I think because of the efforts of our organization in a petition campaign, that facility was turned over to the State and is currently treating 500 drug dependent persons, again principally with methadone.

Senator HUGHES. You have mentioned very clearly and more concisely than any other witnesses, the interagency and intergroup fights that go on—my experience with these with regard to alcoholism was that the greatest problem we had was the different groups and modalities fighting each other, because they all professed to have the only way to achieve success. They did more harm in fighting each other.

I went through this years ago when I was Governor of my own State; I mention it because you seem to be going through the same thing with relation to drug dependence. Have you come up with any solutions or suggestion you feel can handle or cope with this problem?

Dr. LEIBSON. No, I have not.

Senator HUGHES. Funding is what you seem to point out.

Dr. LEIBSON. I think that is about the only thing that a great many of the people assembled will listen to. If they feel somebody is responsible for the dollars and that they have to accord to them some sort of evaluation—that is another thing that floors me about the amount of expenditures we are making for the programs. There is no evaluation screen associated with them.

We don't know what programs are going to be successful with what kind of people. We are investing in treatment because it is needed, and because there is a crisis, however, there should be that evaluation component.

Dr. Jaffee is a strong believer in that, and I hope he has enough horsepower to do the job of evaluating as well, because he knows that business quite well. We have a number of people in our area who got their grounding in his program in Chicago.

Senator HUGHES. The factors that you mention are keenly important for the future, and as you point out, as Commissioner Finney pointed out and a number of the other people pointed out, there seems to be some opinion circulating in this country today that this crisis is a cyclical crisis, and that it will disappear in a couple of years.

You pointed out, I think, very ably that in your opinion professionally it isn't going to go away, that the crisis segment of it may go away, but a high incidence of drug dependence and abuse will continue for a long time.

Commissioner Finney pointed out that in their opinion in New York City it is going to go on for years and years and years. I hope that in relationship with this that we continue to face these problems as an ongoing, you know, part of our lifetime, that we are going to have to find solutions to find the problem as well as the addiction and education.

I think you pointed that out in your testimony, too, that we are not really attacking that part of the problem at all as of yet.

Do you have the capacity to give us a professional judgment budget of needs?

Dr. LEIBSON. For the total United States?

Senator HUGHES. Yes.

Dr. LEIBSON. I would have great difficulty in arriving at such a figure.

Senator HUGHES. Can you give it to us for the State of Michigan?

Dr. LEIBSON. No, I cannot. I can give it to you for the Detroit-Wayne County metropolitan area. I know that——

Senator HUGHES. Even that would be helpful to us, if you could give us a professional judgment budget on the needs there.

Dr. LEIBSON. I would say with the programs that are currently ready to be evolved and the staff that is available, that an expenditure of $5 million this year would be appropriate.

However, I would hasten to add that it is not the reverse kind of thing, in that startup costs here are probably going to be less than the long-range costs in that there are not enough people around who know what to do with the money to be able to carry out adequate programs.

Given the opportunity to really involve some competent people, then I would say the expenditures would have to border between $25 million and $50 million for the Detroit metropolitan area alone.

Senator HUGHES. A minimum of $25 million for an ongoing program.

Do you think with the assurance of proper funding you can attract the proper professional personnel into the field?

Dr. LEIBSON. I don't think there is any question about it. The transitory nature of the programs, and the fact that the funding comes after the program is supposed to have started, and some sort of data is supposed to be assembled by the end of the funding date precludes a lot of people from being interested in these kinds of programs.

I recall Dr. Jaffe again, when he initiated his program in Chicago, had to fight for his money, and it really takes that kind of person right now to get into this program, somebody who believes in what he is

doing and is willing to fight for the money. That is what we are seeing in the Detroit metropolitan area, not always the most competent people coming forward.

Senator HUGHES. What is the population of the Detroit metropolitan area?

Dr. LEIBSON. The city of Detroit is 1.8 million. I don't know what the population of Detroit and the Tri-County area would be.

Senator HUGHES. Is it around 3 million, do you believe?

Dr. LEIBSON. I believe so.

Senator HUGHES. You would estimate you have a maximum of about 12,000 heroin addicts?

Dr. LEIBSON. Yes.

Senator HUGHES. Are we doing anything about any of the other drug problems?

Dr. LEIBSON. Yes; but it is modest and mostly community-oriented. There is some discussion about it, and it is supposed to be part of the State plan.

Senator HUGHES. Do you pay any attention to marihuana any more?

Dr. LEIBSON. I have paid attention to some of the people who are making studies of this, and I would have to defer any questions related to that to the person who serves as our scientific adviser. That is Dr. Raskin.

Senator HUGHES. I find from witnesses around the country that few people are paying attention to it any more. They have forgotten marihuana and are concentrating on heroin, and think they are wasting their time trying to do anything about it.

What are you doing in Detroit?

Dr. LEIBSON. We have had discussions with traffic magistrates—Michigan, by the way, still has a very ancient act on the books in which possession of quantities of marihuana for a sale or delivery or gift still carries minimum mandatory 20-year to life sentences.

Senator HUGHES. Good grief!

Dr. LEIBSON. We have been supporting a bill which parallels the Comprehensive Drug Abuse Act of 1970 passed by the Congress of the States. I sat on a special committee appointed by the Governor to review legislation and we recommended the adoption of this uniform act as a model in the State of Michigan. It passed the House of Representatives by a vote of 77 to 20 and has been bottlenecked in the Senate Judiciary Committee in the State of Michigan for about 3 months.

We have been trying to pry it out of there.

Senator HUGHES. You mean some kid giving a friend marihuana could get a 20-year sentence?

Dr. LEIBSON. That is right.

Senator HUGHES. Do any other States still have that kind of a law?

Dr. LEIBSON. A few.

Senator HUGHES. I thought most of that had been eliminated in the past year.

Dr. LEIBSON. It has not. The State of Michigan is still reluctant to move on that. We still have a big argument about it. The county prosecutors and the State Association of Sheriffs are advocating that it must be a felony because of the search and seizure provisions of the

law. They feel they cannot have adequate support for their involvement with street traffic, and we have, of course, been very interested.

We have the support of some of the large city prosecutors who indicate their support for this new legislation. I don't care whether it is one ounce or two ounces, possession being viewed as prima facie evidence is intent to deliver. There ought to be some sort of decent cutoff, because we are just criminalizing young people.

The state continues to function in that fashion. I am hopeful that at the conclusion of this session of the Michigan State Senate that they will pass this piece of legislation. We have the support of all of the professional people with the exception of law enforcement.

Senator HUGHES. That brings to light a very important point, I think, in our national program where we see, and Dr. Jaffe is the national coordinator, where the Department of Justice is one agency he has very little coordinating ability with.

Dr. LEIBSON. Again, I heartily endorse your position on this. He must have responsibility and a heavy investment in the kind of education programs that go on in the Department of Justice.

Senator HUGHES. Without this we are going to have two lines of policy going out into the country as policy and programing.

Dr. LEIBSON. That is correct, and I think that is what has brought us in a very large way to the situation we find ourselves facing in this nation today. We have the view of whether they should be punitive or treatment-oriented. It is a confusion that continues to exist in this country.

Senator HUGHES. Dr. Leibson, I want to thank you very much for your willingness to come down and testify this morning, and I want to compliment you with what you have done with NARCO in the State of Michigan.

As you know, I have been aware of it and interested in what you are doing there for a long time. I think you have shown the initiative and courage to bring to light in your State a problem and focus attention on it and demand services and facilities be brought about.

Without you, Detroit and the State and the Nation would be in a lot more serious position than we are in today. I have shared some of the minor frustrations with you. I certainly am deeply appreciative for working with your group and your people and especially yourself.

Thank you for being with us this morning.

(Whereupon, at 1:35 p.m. the subcommittee recessed, to reconvene at 9:30 a.m. of the following day, Thursday, August 5, 1971.)

DRUG ABUSE, PREVENTION, TREATMENT, AND REHABILITATION, 1971

THURSDAY, AUGUST 5, 1971

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

The subcommittee met at 9:30 a.m., pursuant to call, in room 4200, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes, Javits, and Schweiker.

Committee staff members present: Wade Clarke, counsel, and Jay B. Cutler, minority counsel.

Senator JAVITS (presiding pro tempore). The subcommittee will come to order.

Our first witness this morning is Mr. James Spillane, chief of personnel development needs branch, of the Office of Education.

Mr. Spillane, do you have a written statement?

STATEMENT OF JAMES SPILLANE, CHIEF OF PERSONNEL DEVELOPMENT NEEDS BRANCH, OF THE OFFICE OF EDUCATION

Mr. SPILLANE. I think a statement was submitted on Monday, Senator, by Dr. DuVal.

Senator JAVITS. Are you going to rely on Dr. DuVal's statement?

Mr. SPILLANE. I have a copy of it, sir. I am sorry. I thought it had been made available.

Senator JAVITS. The chairman of the subcommittee regrets to state that he is engaged in handling an amendment on the Senate floor, and I have agreed to chair this hearing until 10 o'clock.

Mr. Spillane, would you proceed?

Mr. SPILLANE. I quote from the Christian Science Monitor, August 19, 1970:

"Most of the drug education is missed. If it is unsophisticated, young people laugh. Scare tactics have even tempted some youngsters to try drugs, but out of trial and error, more sensible and profound approaches may be emerging."

Senator JAVITS. Would you push the microphone a little closer to you?

Mr. SPILLANE. Yes.

One of the more sensible and profound approaches emerging was the direct result of President Nixon's expression of concern with the

epidemic proportions of the drug abuse crisis and his March 11, 1969, announcement of several new drug abuse programs. At that time, he stated, "There is no greater priority in this administration than to see that children and the public learn the facts about drugs in the right way and for the right purpose."

The Office of Education, at that time, was directed to initiate a $4.2 million 2-year school-based drug education and training program on a national scale. Within the Office of Education, responsibility for administering the national drug education training program was given to the Bureau of Educational Personnel Development.

The bulk of the $4.2 million expended over the period of fiscal years 1970 and 1971, went to State departments of education for the training of educational personnel. The remainder was allotted to four regionally located universities for training programs for teams of personnel from the States and to the National Action Committee. The National Action Committee was formed to provide leadership, technical assistance, and aid in program planning, development, monitoring, and evaluation and is a cross section of well known expert consultants, educators, young people, and State officials.

The national drug education training program is helping to produce a knowledgeable cadre of teachers and other school related personnel as well as young people and community leaders to help solve the drug problem. It is estimated that as a result of the program, more than 1 million people nationwide will receive training. This is to be accomplished by the multiplier effect which trains teams to train other teams.

The States and territories sent 325 persons in teams for a month of intensive training at the four regional universities. These teams will in turn train an estimated 110,000 persons in State sponsored workshops. The 110,000 working in teams of school personnel, community people, and youth will conduct local school community workshops.

As a result of the program, a drug education coordinator has been named in each State, who is responsible for planning and implementation of projects. State and local contributions have been substantial and have helped to extend the influence of the program. It has made the States aware of the drug problem, and has brought about in many instances, cooperation for the first time between State education, mental health, and other agencies.

The Drug Abuse Education Act of 1970 (Public Law 91–527), which was signed into law by President Nixon on December 3, 1970, provides additional authority over a 3-year period for drug education and prevention programs.

During 1971, $6 million was appropriated for OE to carry out the provisions of the act. With these funds, the State department of education programs are being continued and new pilot projects at colleges and universities have been initiated under section III of the act. Twenty-six community projects are being funded on a pilot basis under section IV. In addition, a project to train educational personnel in Department of Defense schools for American dependents in Europe is being supported. Continued support is also being given to the awareness house training project which has been funded since fiscal year 1969. This project trains selected former addicts as coun-

selors to work with youth, their parents, the school, and the community.

Finally, the National Action Committee with a heavy emphasis on technical assistance to and evaluation of funded projects is being continued.

Under section III, 20 pilot college and university based drug education projects are being supported. These are engaging in a variety of activities aimed at pooling the resources of college students, faculty, and administration, and the community in which the college exists, in an effort to alleviate the drug abuse problem in the areas concerned. All the projects were student initiated and primary responsibility for program management and implementation remains in students' hands. This is in accord with the USOE basic program principle which stresses heavy youth involvement in all drug education projects.

Specifically, the college projects provide such diverse drug abuse prevention services to students and persons in the surrounding community as hotlines, rap centers, individual and group counseling, peer group leadership training, drug education seminars, and speaker panels for drug education presentations to schools and various community groups and organizations. Throughout all program activities, a multidisciplinary approach to drug education is emphasized.

Although students and young people maintain basic responsibility, each project attempts to include a variety of persons representing a wide range of attitudes, life styles, and values both on its staff and in the target groups it serves.

The act authorizes community-oriented drug education programs for the benefit of interested and concerned parents, young persons, community leaders and other individuals and groups within a community. Twenty-six such projects are being supported.

Since the act calls for a comprehensive approach, the projects will involve a variety of community agencies and groups—schools, law enforcement agencies, religious organizations, civic groups, service organizations, community agencies, parents and youth groups—in a concentrated cooperative effort within a given community.

An important byproduct of such an effort, as communities have discovered, is the value of getting many elements of a community together, in some cases for the first time. By really sitting down around the table, working through the problems—communication is often one of them—and finding ways to solve them, they are discovering that the effort itself is rewarding.

While the major emphasis will be placed upon prevention of drug use and abuse and the treatment of causes rather than symptoms, some services such as hot lines, free clinics, crash pads and counseling will be provided for youth. In many instances, these are not being funded by OE, but are byproducts of this new comprehensive approach. In addition, seminars, workshops, dropin houses, community action groups and peer group leadership programs are variously components of the projects. Emphasis is placed also on providing education for adults.

In addition to Drug Abuse Education Act moneys, 11 drug education projects are being funded through $1.3 million in grants under title III of the Elementary and Secondary Act of 1965. These projects

have been initiated by local school districts, but with heavy community involvement.

Although funded by title III, they are being administered by the Drug Education Branch in the Bureau of Educational Personnel Development in tandem with the other community-based projects authorized under section IV of Public Law 91–527.

The first years of the Drug Abuse Education Act must be considered developmental in nature. The Office is seeking ways to meet the problems which cause drug abuse in communities and in schools. Therefore, a limited number of pilot projects in selected sites are being supported and will be carefully evaluated. Plans are to support as many as possible of the current projects with fiscal year 1972.

However, their continued support will be contingent upon satisfactory performance.

On the basis of experience gained thus far, it seems, however, that ways must be found in 1972 to help as many communities as possible to help themselves by providing them with the basic skills and information needed to mount drug abuse prevention programs.

This may well be an important force in shaping the fiscal year 1972 program.

Of utmost importance in the next year's program will be the capability of the office to provide technical assistance to communities, school districts, colleges and universities and State departments of education. This will be accomplished primarily through a greatly expanded national action committee.

Senator JAVITS. Now, Mr. Spillane, you got $4.2 million for the program in fiscal 1970–71, is that right?

Mr. SPILLANE. That is true, sir.

Senator JAVITS. Now, in fiscal 1971–72, have you actually voted the $6 million, or is that in some stage of the appropriation process?

Mr. SPILLANE. We have the $6 million. We have the appropriation in hand.

Senator JAVITS. Is the President asking for more and, if so, where?

Mr. SPILLANE. I was under the impression he was asking for $10 million more, which is included in the $155 million supplemental request.

Senator JAVITS. In the supplemental. And $10 million would be for education?

Mr. SPILLANE. Right, for education.

Senator JAVITS. Do you handle the whole Federal program for Drug Abuse Education?

Mr. SPILLANE. Our Bureau handles the bulk of the Office of Education's efforts.

Senator JAVITS. What other efforts are there, do you know?

Mr. SPILLANE. There is money under Public Law 91–513, the Comprehensive Drug Control Act of 1970.

Senator JAVITS. That is earmarked for education?

Mr. SPILLANE. For community education projects. It is administered by the NIMH.

Senator JAVITS. What other programs are there?

Mr. SPILLANE. Under title I of the Higher Education Act of 1965 small grants may be made available to institutions of higher educa-

tion for community education projects among which may be drug education projects. There have also been several projects for curriculum development, under the Bureau of Elementary and Secondary Education. I have already mentioned the school/community drug education projects administered under title III of the Elementary and Secondary Education Act.

Senator JAVITS. Who handles the other programs in the Office of Education?

Mr. SPILLANE. The particular Bureaus involved. We do work closely with each other. They are the Bureau of Higher Education and the Bureau of Elementary and Secondary Education.

Senator JAVITS. How much is involved in those?

Mr. SPILLANE. The Bureau of Higher Education spent $100,310. The projects in BESE have amounted to $1.3 million for the projects under title III ESEA.

Senator JAVITS. Do you know the extent of the NIMH program?

Mr. SPILLANE. It was $1.3 million in 1971. This year it is in the neighborhood of $6 million.

Senator JAVITS. How do you coordinate your education program with their's?

Mr. SPILLANE. With NIMH?

One thing we do is involve one another in our proposal review. They help us review our proposals. I am on the proposal review committee on drug education for NIMH. We are trying as much as possible to try to avoid overlap. NIMH can also support research. We don't have a research capability.

Senator JAVITS. Are there any programs in the Bureau of Narcotics and Dangerous Drugs?

Mr. SPILLANE. Yes, there are community education programs in the Bureau of Narcotics and Dangerous Drugs, relating to law enforcement.

Senator JAVITS. How do you coordinate with that?

Mr. SPILLANE. Again, we are in the process of setting up a system whereby we can share program information with one another to get the benefit of each other's experience and to benefit from constructive reactions.

Senator JAVITS. You have set up a program? Is anything actually going on about it?

Mr. SPILLANE. Yes. There is a subcommittee—one of several set up under the original White House ad hoc Committee on Drug Abuse—for school and college based programs, which involves the Office of Education, BNDD, NIMH, SRS, and others in the field. It has the objective of sharing program information in an attempt to avoid overlap. We also think the individual agencies can benefit from the experience of others.

Senator JAVITS. You left the Bureau out of our list.

Mr. SPILLANE. That was an oversight.

Senator JAVITS. What about the Department of Agriculture, the 4–H, and other rural activities?

Mr. SPILLANE. We are working with groups representing young people. That is, we have contact with them, but we don't have any direct contact with the Department of Agriculture.

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Senator JAVITS. What contact have you established with Dr. Jaffe, who testified here yesterday, and who is the coordinator?

Mr. SPILLANE. Our contact so far with Dr. Jaffe has been informal.

Senator JAVITS. He is going to be your boss, isn't he?

Mr. SPILLANE. As I understand it he will have a good deal of responsibility for overall policy and for decisions regarding the allocation of program funds.

Senator JAVITS. That hasn't caught up with you yet?

Mr. SPILLANE. We haven't had a chance yet to have a formal arrangement.

Senator JAVITS. What about the Department of Defense, what is happening there with youth?

Mr. SPILLANE. We have set up a training program for educational personnel in the schools in Europe in cooperation with the Department of Defense. And, again, the Department of Defense is on our subcommittee for school and college-based programs and through that, we find out what each other is doing. The only direct intervention we have had so far has been in setting up the training program for their personnel in Europe.

Senator JAVITS. Do you have any idea how big their program is?

Mr. SPILLANE. I don't have the actual figures. I would assume it is fairly substantial.

Senator JAVITS. I am informed that the $100 million a year is being spent for education in this field, of which you only have 6 percent. Can you confirm or deny that figure?

Mr. SPILLANE. I can confirm that we had $6 million for fiscal year 1971.

Senator JAVITS. Don't you think that is a pretty poor way to run a railroad?

Mr. SPILLANE. I think I would have to agree.

Senator JAVITS. Coming back to your own situation, you have a little supplement, I see, to your testimony, out of the Elementary and Secondary Education Act.

Is that right?

Mr. SPILLANE. Yes; they are being supported by ESEA this year, but next year in fiscal 1972 they will be continued under funds from the Drug Abuse Education Act, Public Law 91–527.

Senator JAVITS. You will be at least supervising them?

Mr. SPILLANE. That is right.

Senator JAVITS. The request, even for your limited share of this acivity, has been enormously greater than the appropriation, hasn't it?

Mr. SPILLANE. That is right.

Senator JAVITS. According to our record, community funding requests come to $55 million and college funding requests come to $15 million.

Is that correct?

Mr. SPILLANE. Correct.

Senator JAVITS. Making a total of $70 million, of which you granted $2.8 million.

Mr. SPILLANE. Correct, for new programs. That is right.

Senator JAVITS. Have you undertaken any process of evaluation of the community and college funding requests?

Mr. SPILLANE. Of the requests? We are in the process now of analyzing these requests.

Senator JAVITS. In other words, you are not yet in a position to tell us what, if you had the money, would qualify legitimately for assistance?

Mr. SPILLANE. No, but we could be in a position very soon to tell you something about that. Because, I have a group of people working on the project right now.

Senator JAVITS. May the record show that on June 4, I asked you these questions—not you, but the Secretary. Without objection, a copy of my letter will be included in the record.

(The information referred to above appears on p. 402.)

Senator JAVITS. You will reply to that, I assume?

Mr. SPILLANE. I certainly will.

Senator JAVITS. I ask, without objection, that your reply be included in the record as part of the testimony.

Mr. SPILLANE. It will be supplied, sir.

(The information referred to appears on pp. 403–406.)

Senator JAVITS. In this respect, my letter too, you will note, I complain strongly about the fact that in the worst afflicted drug abuse area in the United States by far, to wit, New York City, only two applications were funded out of 40.

Can you give us any explanation for that?

Mr. SPILLANE. We could, as you know, we could have put the entire amount of money in New York City and still not even have scratched the surface. I think, I indicated in my statement, that our intention in the first 2 or 3 years of the act is to proceed developmentally, in other words, to support a limited number of pilot projects to see if we can learn something from these projects that might be replicable on a nationwide basis.

Community projects for example have been set up in a variety of geographic areas to serve various socioeconomic and ethnic groups.

We are hoping to learn in the community projects, something about the process of how the community organizes itself.

Senator JAVITS. Are you providing this money right now on an experimental basis, the way you think you could learn the most; is that right?

Mr. SPILLANE. The reviewers who read the proposals were given a very, very strong directive to pull out from among those 700 proposals—and this was a very difficult job—those they thought would have the most potential for models. And in so doing, we also wanted to make sure that we had as many different situations covered in these eventual models as possible.

Senator JAVITS. Doesn't it sound almost ridiculous to you that the place that has 40 percent of the addicts, can only produce 5 percent of the pilot projects?

Mr. SPILLANE. I can certainly recognize the disparity there, obviously.

Senator JAVITS. Was any instruction given to these evaluators to proceed on a regional sectional basis, just divided up the money that way?

Mr. SPILLANE. No; there is no division like that. It is simply a charge to pull out the best they could find.

Senator JAVITS. I know, in your statement, you say that it is estimated that as a result—on page 2—that as a result of the multiplier effect, more than 1 million people over the Nation will receive training. When will that be?

Mr. SPILLANE. By June of 1972, after the first 2 years of our State education agency projects.

Senator JAVITS. June of 1972 is less than a year away; how many have received training up to now?

Mr. SPILLANE. As of June 1 approximately 120,000 people had received training, but you have to remember that the multiplier effect works through a variety of levels.

Senator JAVITS. You think it will work that fast, so that you are going to train 10 times as many in the next 10 months as you did in the preceding 14 months?

Mr. SPILLANE. We are confident that this will be the case, Senator.

Senator JAVITS. Is this a hope, or is there any realistic estimate of the situation?

You understand, Mr. Spillane, I am not getting after you. I am sure you are doing a very competent job, but I think our country needs to have a little of a prod applied to it in this matter. I am trying to get the facts from you. You are the administrator.

Mr. SPILLANE. It looks as if we will certainly be able to train that many people by 1972. We have generated a good deal of activity in the States through this program and we have no reason to assume that the momentum will be stopped.

Senator JAVITS. Of this 120,000 people that you think you have trained so far, what has their training consisted of?

What have they got?

Mr. SPILLANE. Again, Senator, it varies from State to State. It may vary from a 2-week intensive workshop in one State, to a week in another to a day a week over an extended period of time in another State. It depends on the resources of the State and how well they are able to carry out the multiplier effect.

Senator JAVITS. None of them are more than 2 weeks?

Mr. SPILLANE. For the most part that is probably the case, Senator.

Senator JAVITS. And, you think that is adequate?

Mr. SPILLANE. Insofar as resources are available, it has to be adequate right now, Senator.

Senator JAVITS. Can you tell us, or can you give us any estimate, either now or supply it later, as to the amount which you consider the optimum requirement for use in this field in order to really do the job you should do?

Mr. SPILLANE. May I supply that later, because there are a lot of things that have to be taken into consideration to get what would be a realistic figure.

(The information referred to appears on pp. 403–406.)

Senator JAVITS. Also, would you make clear in that what part of that work is yours, and what part of the cost estimates are yours, and

what part is the work and cost estimates of other departments in Government.

Mr. SPILLANE. You want an overall optimal estimate involving all the agencies?

Senator JAVITS. Yes, as well as, your own.

Mr. SPILLANE. Right.

(The information referred to appears on pp. 403–406.)

Senator JAVITS. This is essentially a preventive proposition, and it doesn't deal with care or treatment.

Mr. SPILLANE. That is correct.

Senator JAVITS. It is prevention?

Mr. SPILLANE. That is correct.

Senator JAVITS. You have told us that there is $10 million in the supplemental for education. Didn't you have to make some estimates in that respect for the budget people?

Mr. SPILLANE. No, we did not, Senator. I could, off the top of my head, make some estimates, but we were not instructed to do that.

Senator JAVITS. You say, you did not make any estimates?

Mr. SPILLANE. No, we did not.

Senator JAVITS. Do you know whether anybody did as a basis for it?

Mr. SPILLANE. This I just don't know.

Senator JAVITS. But, you didn't, is that right, the Office of Education was not called on to supply any data or figures?

Mr. SPILLANE. I was not called on to supply any data, and I am not aware that anybody else in the office was.

Senator JAVITS. You are the man in charge?

Mr. SPILLANE. If anybody was instructed to do it, it should have been my responsibility.

Senator JAVITS. You have the figures for 1971–72. How much of that will be for ongoing programs, and how much for new programs?

Mr. SPILLANE. Well, the $2–2.2 million—will be for ongoing programs, that is, continuation of State grant programs and the awareness house program. The rest are for new college-based programs, community programs, a national action committee, the effort overseas with the Department of Defense and administrative expenses.

Senator JAVITS. What is your estimate of the percentage of funding you need to be able to fill in the college-based program?

Mr. SPILLANE. Well, with 20 college-based programs, and a total of at least 2,000 or 2,500 instructions of higher education and junior colleges, it is just a drop in the bucket.

Senator JAVITS. It is just a drop in the bucket. It is really almost infinitesimal.

Mr. SPILLANE. I must repeat that we are trying to find out ways of tackling the problem, and proceeding in a developmental way during the early years of the act.

Senator JAVITS. So, really, what you are doing is finding out the best way in which to give preventive education in this field.

Mr. SPILLANE. All of our projects will be subjected to a very heavy evaluation during the next 2 years.

Senator JAVITS. Thank you, Mr. Spillane.

Any questions, Senator Schweiker?

Thank you very much.

(The following material was subsequently supplied for the record:)

United States Senate

WASHINGTON, D.C. 20510

June 4, 1971

Dear Mr. Secretary:

Thank you for sending me a list of the grantees under the Drug Abuse Education Act of 1970 (P.L. 91-527), I am deeply disturbed that only two programs were funded in the State of New York and no projects were awarded in depressed communities. I believe this is a tragic response to a narcotic plague that terrorizes New York -- substantiated by the 65 applications by different communities in the State of New York and the more than 40 applications from colleges in the State of New York to establish projects under this program.

When there are community funding requests of more than $55 million, and college funding requests for proposals of almost $15 million, and grants in response to these requests of only $2.8 million as compared to total requests of $70 million, I believe this demonstrates a complete and utter lack of commitment to the problem at the Federal level.

In view of this indication of need by the communities throughout the United States, I would appreciate your views on the level of funding you believe could be effectively utilized for drug abuse prevention programs.

With best wishes,

Sincerely,

/s/

Jacob K. Javits

Honorable Elliott Richardson
Secretary of Health, Education,
and Welfare
Washington, D.C.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

October 5, 1971

MEMORANDUM

TO: Miss Olsen

FROM: James M. Spillane

SUBJECT: The Attached

My apologies for this delay and I won't bother you with the gruesome story. What the Senator asked is being done by the President's Special Action Office for Drug Abuse Prevention. Agencies are therefore unwilling, and rightly so, to provide information except through SAODAP. The attached can only reflect my estimate of the situation in the Office of Education and with that I can't come up with an optimum figure since we are embarking on new program directions in 1972 and must feel our way. I hope the document will provide the Senator with an answer (insofar as one is possible at this time) to his June 5 letter as well as the data (again with qualifications) he requested in the August 25 hearings.

OPTIMUM FUNDING FOR FEDERAL DRUG EDUCATION PROGRAMS

According to the Special Action Office for Drug Abuse Prevention two agencies administer the bulk of the Federal drug abuse prevention programs. They are the National Institute of Mental Health and the U.S. Office of Education both of which are located in the Department of Health, Education, and Welfare. The NIMH funding level for education projects for Fiscal Year 1972 is $6.8 million. The Office of Education has an appropriation of $13,024,000. Additionally the Bureau of Narcotics and Dangerous Drugs has an education budget of $850,000 for Fiscal Year 1972 and the Model Cities budget earmarked for education, approximately $200,000.

There is therefore a total of approximately $21 million earmarked for drug education in Fiscal Year 1972.

In the first year of the Drug Abuse Education Act the Office of Education was literally deluged with proposals. A total of $75,000,000 was requested in the 900 applications for support which were received. With funds available in Fiscal Year 1971 only 47 projects could be supported.

While the appropriation for Fiscal Year 1972 for the Office of Education Drug Education Program is $13 million, the increase will barely begin to satisfy the mounting need in communities for drug education capability.

There is a desperate need in communities across the country for expertise in the form of trained leadership in this area. It is becoming more and

more apparent to the Office of Education that if a community is to meet successfully the challenge of drug abuse it must have a trained group of leaders capable of acting as catalysts, providing the expertise needed to help plan, direct and implement community-based drug prevention programs.

In attempting to respond to the needs of as many communities as possible with available funds, the Office of Education proposes to follow new program directions in 1972. The new program is the Help Communities Help Themselves Program.

Under this program the Office will set up ongoing training facilities with built-in follow-up technical assistance for a minimum of 400-500 community teams of 5-6 persons per team. These facilities will serve an additional 700 teams (3500-4000 individuals) in Fiscal Year 1973. Specific plans for Fiscal Year 1973 will be based on careful on-going evaluation of the 1972 experience.

Under this new program small grants (a maximum of $5,000) will be awarded to communities to assist them in developing the capacity to provide comprehensive preventive drug education programs. The grants will be used specifically to support the training of a team of five or six individuals for two weeks at a regional training and support center.

Thus, while ongoing projects initiated in 1971 will receive continued support in 1972, the Office does not intend to fund new projects in a limited number of communities. Rather it will provide to as many communities

as possible the trained leadership capable of responding to their drug problems. In view of the great need throughout the country the universe is theoretically the number of communities in the United States. Therefore it is very difficult to determine the optimum level of funding needed to accomplish the job.

A possible benchmark may be provided by the response from the field to the new program directions. Application for support under the Help Communities Help Themselves Program will be due by a December 1, 1971 deadline. The Office should be in a better position at that time to assess the willingness of communities to participate in this new effort.

The Special Action Office for Drug Abuse Prevention is in the process of assessing national needs across the board in the drug abuse area. As the office to head the whole drug abuse effort in the Federal Government, it is working closely with all concerned Departments and will be in the best position to provide realistic data on agency needs and capabilities.

Senator JAVITS. The Chair wishes to announce that the chairmanship will from now on be in the hands of Senator Schweiker of Pennsylvania, and I would like to join him, but I have to go to a meeting of the Foreign Relations Committee.

Senator Humphrey, our very distinguished colleague, will be the next witness.

Senator SCHWEIKER (presiding pro tempore). Senator Humphrey, we are delighted to welcome you to our committee. And, we are delighted to hear you testify.

STATEMENT OF HON. HUBERT H. HUMPHREY, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator HUMPHREY. Thank you, very much, Senator.

First, may I compliment this committee on its initiative in the field of alcoholism and drug abuse, and your distinguished subcommittee chairman, Senator Hughes, has made a very enviable record. It is a record that has commanded the attention and respect of the Nation; and each member of this subcommittee has shown a tremendous interest in the topic which is before us.

I can't think of any more serious problem that confronts our country, at least in terms of anxiety and fears, than the matter of drug addiction, the illicit traffic in drugs, and the many dangers that this problem holds for vast numbers of our citizens.

May I first of all, Mr. Chairman, just say a word in reference to the legislative proposal S. 2217, that was introduced, I believe, on the date of June 30, 1971. This bill was introduced by Senator Hughes for himself and Senator Javits, Senator Muskie and Senator Williams. I have studied the text of this bill and the very brief analysis which is provided in the letter of transmittal, and I wish very much to commend the authors. It is a comprehensive piece of proposed legislation. The authors have, I think, sensed the dimensions of the problem and have placed their emphasis upon the treatment and care of those who are the victims of narcotics. At the same time, they have proposed important measures for improving the enforcement procedures against illict traffic in drugs.

Senator SCHWEIKER. I want to say, if I may interrupt, that we appreciate your comments. I share your view, with respect to the work that Senator Hughes is doing. Regretfully, as stated before, he has to be on the Senate floor to offer an amendment, and he can't be here to hear your testimony. I know he appreciates your fine comments about his work. I certainly concur.

Senator HUMPHREY. Thank you, Senator. I think one of the most refreshing and reassuring aspects of all this work is the great interest that all Senators have in it, particularly, the members of this subcommittee. I am confident that out of the discussion and the testimony with a variety of legislative proposals that have been submitted to you, that we will come out with a very constructive piece of legislation.

On this point I want to repeat what I said with reference to another subject matter—namely, revenue sharing—that I testified on before another committee. I don't think it is so important whose name is on the bill. I think what is important is that we come to some understand-

ing, that the pride of authorship is secondary to the quality of the legislation.

The President has a proposal before us; I have a bill before this subcommittee; the chairman of the subcommittee, I think, has an extraordinarily fine bill; and I am confident that within the principles outlined in these pieces of proposed legislation, that this committee will come out with a bill that will be literally a landmark piece of legislation, because we have to. We don't have any other choice. We simply have to meet the situation that is before us.

I have some prepared testimony, Mr. Chairman, and I am going to read it, and I will hopefully not take too much of your time.

Senator SCHWEIKER. Take as much time as you want.

Senator HUMPHREY. Thank you, Senator. I appreciate the opportunity to appear before this subcommitee and to testify on my proposals to help in the battle against drug abuse. I want my testimony to be viewed as the proposals of one Senator, recognizing their limitations and hoping that the committee will see their merit as may be appropriate.

I commend the chairman for the lead he has taken in the Senate in calling attention to drug abuse and problems of alcoholism. I know that I need not repeat all the horrible details of the drug menace. My appearance before your committee is to add my personal thoughts on the problem and recommend new methods of broadening the fight against illicit drug use.

My bill is known as S. 2155, which I introduced on June 24, a bill to establish a Drug Cure and Control Authority and to coordinate Federal agency programs relating to drug abuse, treatment, education, rehabilitation, and law enforcement.

I have a second proposal for establishing new drug centers at community mental health centers. This is bill S. 2146, to require community mental health centers and hospitals and other facilities of the Public Health Service to provide rehabilitation and treatment for drug addicts and persons with drug abuse and other drug dependency problems.

I am attempting through my drug cure and control authority bill and my proposal for new drug centers at community mental health centers to expand and strengthen provisions of other legislation before the Senate.

During the past several months, the American public has been presented with some shocking disclosures concerning drug abuse. The latest disclosures were headlines and announcements in scores of the Nation's newspapers and on television and radio, boldly alerting the public to drug abuse among U.S. soldiers in Vietnam. The headlines read something like this:

"Armed Forces Must be Cleansed—Drugs Undermine U.S. Security;" "Heroin Makes Vietnam War More Terrible."

Shortly after the American public was told that many of their sons in Vietnam and in other areas were becoming drug addicts, the administration woke up and decided this country was behind in the fight against drug abuse. And I might add, not only the administration, but a number of us in the Congress. It took a situation as shocking as the

GI's in Vietnam and elsewhere using heroin to alert this country to the spreading worldwide problem of drugs.

We have heard the situation described as a crisis and reaching epidemic proportions.

The President in his June 17 message on drugs said:

> We must now candidly recognize that the deliberate procedures embodied in present efforts to control drug abuse are not sufficient in themselves. The problem has assumed the dimensions of a national emergency * * *

With these words, the President called for the creation of a special action office to spearhead the drug abuse attack, immediately focusing attention on clearing up the problem of drug addiction among U.S. soldiers in Vietnam.

I am sure the Senate and the Congress will respond in a decisive manner to help combat the drug menace.

Unfortunately, what the President proposes as a special action office fails, I believe, to create the total cooperation and coordination of all branches of government dealing with the many areas of drug education, rehabilitation, treatment, research, and law enforcement.

I see in the bill of Senator Hughes and others a much more comprehensive attack.

The people are demanding now that Congress take strong measures to combat the drug problem. They want an all-out attack on this dangerous and crime breeding menace.

There are at least a dozen Federal agencies or departments with some jurisdiction in the drug field.

As the scope and dimension of the drug traffic has grown, there has been all too little cooperation and coordination by Federal and State agencies in a concerted effort to diminish the drug threat.

It is obvious that the continued growth of drug abuse means we are still not doing an effective job in attempting to curb the problem.

It is also very unfortunate that we have to wait for a crisis to act.

To solve problems today, all agencies of Government need to participate and cooperate with other branches of Government and the citizenry.

There must be depth to our programs and well publicized information on them to solve problems. I am sure the people think the solutions are available. I might add, I don't think the solutions are easy by any stretch of the imagination. The public is correct to note that the country has a Bureau of Narcotics and Dangerous Drugs and a Bureau of Customs which it believes are working to combat the drug problem.

But the problem, I find, is that so many people at the Federal level, at the State level and at the township and village level, don't know that there is a program or programs to offer help whether it is for rehabilitation and education or law enforcement against drug use.

May I add, at this point, that the problem of drug use which 10 years ago was essentially a metropolitan problem, and generally with people of lower income, or a handful of people who were just living it up on high income, today has spread throughout the country. It is to be found in rural communities, in junior high schools, in grade schools, it is to be found in factories, in corporations. It has permeated

the entire social structure, and it is amazing that with all of this, there is so little real understanding of the services that are available to be of assistance.

Our programs are hidden off in the library or in the archives. They really aren't made available to the total public.

It is not good enough to say the programs are there. They have to be in a real sense publicized until the people know they are there.

The Federal Government is like a supermarket with the lights off and with no labels on the products. A person goes around reaching for a cure and hoping he'll find it.

My proposal for a Drug Cure and Control Authority, along with other proposals before this committee, takes into account this problem of blurred vision by the administration and the Federal Government.

To be candid about it, it isn't just this administration, it has been going on for years. We just haven't faced up to the problem.

I am proposing that two panels of Federal agency advisers be established to give the President recommendations on ways to eliminate or diminish the drug menace.

Federal officials who now head various divisions dealing with drug related programs would be included on the panels.

The purpose of these panels would be for public exposure and coordination of ideas and programs. The effect of this plan should be a "one-action" program to inform, conduct research, and act on illicit drug use.

Under my proposal, the public would be fully apprised of the progress of the drug fight by five public representatives on each of two advisory panels. These appointments would be made by the President and confirmed by the Senate.

It would be necessary for these panels to meet regularly and to make known their progress and programs.

With such a council of advisors—a sort of cabinet or national security organization—the director of the new Drug Cure and Control Authority can publicly seek White House support for major projects.

The first panel or advisory group would consist of officials from drug cure, rehabilitation and education offices from the Veterans' Administration, the Department of Defense, the Office of Economic Opportunity, the Social and Rehabilitation Service, and other agencies.

The second panel would consist of law enforcement officials from the Bureau of Narcotics and Dangerous Drugs, the Justice Department, including the FBI, and even the CIA. Each panel of advisers would have a full-time deputy administrator to follow through on recommendations and proposals.

Mr. Chairman, I believe this means that the FBI is to take on these new responsibilities. I think the CIA, the customs bureau, the State and local law enforcement agencies, and many other agencies need to be brought together in a concerted program.

I believe that, if the CIA can ferret out subversives, it can help find the drug smuggler abroad. If the FBI can find saboteurs, it can find the pushers and put them out of business.

If drug abuse is public enemy No. 1, then all our law enforcement resources should be made available to halt the menace.

I would also, respectfully, suggest that a great deal of effort has to be made with State and local authorities to equip police and local enforcement agencies to deal with this kind of problem. This isn't like dealing with the common burglar, or safecrackers, or people who commit assault and battery. This requires a particular kind of training and a particular kind of expertise. And I believe that it is going to take a substantial amount of effort, as well as resources, on the part of the Federal Government in cooperation with local and State government to get this job underway.

Drug pushers and those who use drugs must know that pressure is being mounted to halt the use of drugs.

Law enforcement agencies must adopt programs aimed at a greater degree of coordination in their surveillance of drug traffickers. The pushers must be made to realize that there is pressure to arrest them, and apprehend them, and to punish them.

Mr. Chairman, I am somewhat familiar with local police organizations. I have worked closely with the International Association of Chiefs of Police. During my service as Vice President, I worked closely with local officials, and I think one of the great needs in the field of law enforcement, and I apply it now, particularly to this problem, is a much closer coordination at the State level of all Federal, State, and local law enforcement agencies.

In community after community, there is a kind of separatism. There are your State police, your sheriff's office, your local police. There is the Federal Bureau of Investigation from the Justice Department, the customs officers, the Narcotics Bureau. These frequently, while socially in touch with each other, do not come up with what you might call a total enforcement program.

I called for, and I still do, for what I call Councils of Civil Peace, in which in each State, a sort of master program for law enforcement activities is designed, coordinating Federal, State, and local efforts. This proposal was the result of a considerable amount of on-the-spot study. No matter how much talk people give you about coordination, it is just not there.

Frequently, the police services of our country are on different radio frequencies, so they can't even communicate. Oftentimes, there is no information center, and there is too often, even a kind of separation that dissipates the public resources.

An intensive law enforcement program—one involving the combined efforts of customs agents, the FBI, Federal Narcotics agents and special agents from States attorneys general offices and police departments—can mount a coordinated attack on the drug traffic.

I don't believe that this will stop it, but I believe it can reduce it.

Now, let's examine the administration's program.

Under the President's proposal, there is no direction given to law enforcement programs. In fact, the President's message specifically omits law enforcement.

"The Special Action Office," the President said, "would not be directly concerned with problems of reducing drug supply or with the law enforcement aspects of abuse control."

Unless the President is planning to send the Congress, and he may well be, a new message or come up with something spectacular in the

way of a new law enforcement program, I am led to believe his effort meets but part of the problem.

Obviously, current law enforcement efforts are not succeeding.

Second, the President's proposal makes no mention of coordination between Department of Defense drug programs and those within other Federal agencies.

Unless there is a broad exchange of ideas and views, it is entirely possible that one department or agency will not receive the benefit of the experience of others.

The advisory panels I have proposed are a necessary vehicle toward coordination of drug programs. Senator Hughes has also included a national advisory panel in his proposal.

The advisory panels would in effect be collection agencies and conduits of information on drug cure and control programs.

My proposal establishes a permanent Drug Cure and Control Authority as an independent agency in the executive branch. This structure would underscore the importance of the job that needs to be done.

Drug addiction, I am sorry to say, probably won't be a temporary problem. I am fearful that we will be treating this problem for years to come. Therefore, we must create and authorize a long-term program under a unified direction.

For too long, we have been giving lip service to the problem and asking individual agencies or departments to come up with what I would call, just piecemeal solutions. The solutions we have received have come in bits and pieces.

The administration currently is concentrating its interest on drugs in the military.

I have some training as a pharmacist. I don't claim to know much about modern pharmacy, but as a pharmacist, I do not believe the Department of Defense fully recognizes the contributions pharmacists could make in drug education.

I have seen no evidence by the administration and the military of putting to use the many college-educated pharmacists in the armed services as drug educators.

I recently asked the Department of Defense for information on this specific area. I received information on the number of registered pharmacists in the military who are part of the Medical Service Corps of the Army and Navy and of the Biomedical Sciences Corps. As a group, I was told, they contribute to the programs of combating drug abuse through their responsibility for the accountability and control of narcotics, dangerous drugs, and all other medications subject to abuse.

However, there is no available information on the pharmacist as a drug educator—a man who can talk the language of his peers and offer advice against using addictive drugs.

As a matter of fact, Mr. Chairman, just a couple of days ago, I placed in the Congressional Record evidence from the Department of Defense where trained pharmacists are in the Engineering Corps. Of course, that is not unusual for the military.

Senator SCHWEIKER. That is rather normal, I would say.

Senator HUMPHREY. Where trained pharmacists are off doing clerical work. These are men who have had professional experience, and they ought to be used where they are needed.

I cite this particular situation, because it is just one small area that a panel of experts can begin looking at and seek means for adopting a program for pharmacists as drug abuse educators.

I recently received a letter from a constituent of mine, who is a pharmacist and now serving as a pilot in Vietnam. Another was serving as a mechanic for helicopters.

The first young man, Capt. Edward E. Kamolz, reported to my office that he believes "the utilization of pharmacists in drug abuse education programs could prove highly beneficial to the military services in view of the extensive programs now underway."

I would hope this committee might make a further indepth inquiry in reference to the use of these professional personnel in the armed services. It isn't good enough, Mr. Chairman, to say that when a doctor gives a prescription that you as a pharmacist merely fill it, or that you are in control of seeing how many of the particular narcotics or barbiturates are put out to the patient. That is only part of it. Frankly, that can be done by any professional.

Senator SCHWEIKER. Let me respond to that. Both Senator Hughes and I, in addition to being members of this committee, are members of the Senate Armed Services Committee. I think, Senator Humphrey, that this is an excellent suggestion. I assure you that we will push it on this committee. And we will pursue the matter on the Armed Services Committee as well. I think it is a gold mine of unused talent which can fit quickly into any kind of massive program.

Senator HUMPHREY. Thank you very much, Senator.

May I further suggest that when these men are out of the service, we ought to have a special recruitment program to include men of competence in the Veterans' Administration and in the drug rehabilitation service, because they will have had training and knowledge in the area, particularly, if they are used at the military level first.

I want to emphasize that we are not just talking about Vietnam. I think, Mr. Chairman, most respectfully, that this has been given so much attention that we have forgotten the problems of drug use and abuse in Europe. I have had considerable information, as every other Senator has, I am sure, of the flow of the opium products, and particularly of heroin, in our Armed Forces in Germany, out of Turkey through the different ports of entry, and into the services in other parts of the world.

I just wanted the record clear that this is not just Vietnam we are talking about. I suppose in many ways what is happening in the military is pretty much a picture of what is happening in our society.

Senator SCHWEIKER. Very much so. I would like to emphasize that point.

Senator HUMPHREY. We tend to pick out the military.

Now, a word about community mental health centers.

While the administration seeks to play catchup with a new coordinated drug plan, it apparently has overlooked a vital program at the most elemental level—the community mental health centers.

Community mental health centers have offered some drug rehabilitation treatment in the past. But we need to give much greater attention to expanding this resource.

Because of the President's lack of attention to this area, I am recommending $160 million for staffing grants at community mental health centers to provide needed treatment and rehabilitation programs for drug addicts and other persons with drug abuse and drug dependence problems.

Reportedly, one of the greatest obstacles to a permanent cure for the drug addict is his inability to achieve psychological divorce from a drug once withdrawal procedures have run their course.

I think we have to admit that cure from hard drugs is a very, very difficult assignment. Some people have said it is almost impossible. But where you get at least indications of a cure for a drug addict, there are serious psychological problems that remain. This is why I believe there is a special need for this further drug abuse rehabilitation resource.

A recent report on drugs said that:

> There are countless thousands of cases where the physical addiction has been broken by withdrawal only to find the addict returning to drugs once he is back in an old and familiar environment.

Community mental health centers may be—I say may be—one of our best hopes for quickly establishing effective drug rehabilitation programs. But they need much greater support. This is the other end of the line, so to speak, Mr. Chairman. In addition to treatment and enforcement, you have to have a continuity of rehabilitation and counseling, and the community health center, I think, offers that.

In fiscal year 1971, the community mental health centers had a staffing and operational budget of $90.1 million. The administration's budget request for the next fiscal year asks for only $15 million more. The increase will go toward supporting an estimated 42 new centers. None of this money is for expansion of any drug treatment operations at the centers.

The total budget allocates to special staffing under the narcotics addict treatment program of the community mental health centers only $14.6 million. All of this money will be required for continuation of current projects relating to drug treatment.

As of April 30, 1971, the 23 drug treatment centers at community mental health centers had treated more than 8,000 patients. Because of the widespread use of drugs, such treatment hardly makes a dent in assisting the tens of thousands or more persons now efflicted.

Might I say that, as the education programs proceed through voluntary agencies, through the medical association, through a host of instrumentalities, both public and private, there will be a greater awareness of the possibility of this kind of care and treatment, and I would predict that the community mental health centers would be really overworked and overtaxed if the education programs are anywhere near effective.

I believe the budget request is also too low for special projects under Public Law 91–513, which provides for the treatment of drug addicts at community mental health centers in areas where there is a high rate of drug use.

The current budget of the Nixon administration asks $9 million for detoxification, institutional services, and after-care services. However, this amount will only maintain the treatment at 1971 levels.

Of the $9 million in special project moneys, $4 million worth of projects are being transferred from the Office of Economic Opportunity to the community mental health centers. Therefore, there is no real gain in funds.

It is my judgment that the community mental health program, if suitably strengthened, could prove a most effective instrument in helping combat the drug problem.

The centers, in addition to treating residents of a community, could also be contracted to take in servicemen and veterans. This problem is particularly serious where the veterans hospitals are removed from the residence of the veteran. The same conditions would apply to the Public Health Service clinics and hospitals.

The community mental health centers represent a unique model in the delivery of mental health services. They can reach those in need of treatment much more quickly than the traditional mental health institutions.

The centers already have established working rapport with the leading segments of the community—educators, clergy, physicians, psychiatrists, and other community leaders.

These are all elements which must be brought together to fight drug abuse.

Mr. Chairman, I want to thank the committee for listening to me. These proposals that I offer are simply my own ideas. I don't claim any expert knowledge in this field, but I do think that this committee has a golden opportunity which I know that it is going to take charge of and bring to the Congress a very important piece of legislation.

Senator SCHWEIKER. Thank you, Senator Humphrey, for a very fine statement. I think you have made some very excellent points. I would like to pursue a couple of them. I see there is a rollcall on, so we will recess shortly.

But I would like to ask one or two questions. Based on your experence as Vice President and also your extensive legislative experience, do you believe a special action office, such as presently proposed can be really effective without a budgetary and physical management authority to cut across some of the lines and problems, redtapewise, that you mentioned in your testimony?

Senator HUMPHREY. I do not. I think, if you are going to set up a special action office by whatever title, you have to provide the tools to do the job. Senator, I had the opportunity as Vice President to do what they call coordination work between agencies. I want to tell you something. You cannot have effective coordination until you have authority. A Vice President has a unique role to play. He has lots of responsibility, and no authority, and I can recall instances where I was asked to coordinate, and frankly, the departments would look upon me as an uninvited outsider. When that happened, I would go to the President, who did have the authority.

The President must give the special office tools; first of all, give an Executive order that says you are going to be the coordinating agency; and second, you must have a budget and the sufficient personnel. You

have to have the authority and the tools to do the job, Senator, or it is just another bit of window dressing.

Senator SCHWEIKER. Along with that, your bill envisions giving a triple A priority to the whole problem. I gather from reading your bill and hearing your testimony that this is your objective. And it is our objective. I don't think you can do a job unless you are willing to do that.

Senator HUMPHREY. I would agree, and several of these bills give prominence to this task, providing the full backing of statutory law as well as presidential initiative.

Senator SCHWEIKER. We have been conducting investigations into a number of cities and have been looking into the aspect of using community mental health centers, which logically and facilitywise would be good. One of the problems is that the addict doesn't relate very much to a community mental health center.

When we were touring Harlem in New York, we asked someone there why he didn't use the mental health facilities that were available. He replied, "There's nothing wrong with my head. I just shoot dope."

I don't say this can't be done, but we have to have some kind of a rapport between whatever branch we use and the addict. It was obvious that they stand almost gunshy in the traditional establishment approach. This is part of our problem.

Senator HUMPHREY. Yes, I think there is merit to that comment, Senator. I do think there is a problem there. I would say, it is less a problem, possibly, in areas outside of the major cities.

We have community health centers, for example, in some of the smaller communities, the towns of 50,000, 20,000, and so on, or less.

Senator SCHWEIKER. There might be a way of changing the approach that the health center uses in the inner city to channel it in a different way from its normal pattern.

Senator HUMPHREY. And to staff it in a different way, plus the community education program that continuously impresses the individual that this is the place to go. There still is the problem, as we all know, even with the dope addict or drug addict to try to remove himself from treatment and contact with what he might call "the regular society," so to speak, or the establishment.

It requires, first of all, a good deal of personal counseling, and to get that individual to understand that there is professional help on a highly personalized basis at whatever center he goes to, whether it is a hospital or whether it is a community health center.

I think, too, that those community health centers should be tied in much more closely with the medical and hospital situation in his community. I think they should be looked upon as sort of adjuncts to it.

Senator SCHWEIKER. At this point, we will recess the hearing and call our witness after the vote.

Senator Hughes' amendment is now up for a vote.

I do want to say, again, Senator Humphrey, I think your bill is a very constructive one and I know the committee will be very receptive to your ideas and approach. We certainly want to commend you for developing such a positive, creative way of solving this problem.

Senator HUMPHREY. I want to commend you. I am not trying to make this a mutual admiration society, but I do know that this subcommittee has shown some initiative which really stands out in this Congress. And I can tell you that as we all know from our correspondence and from our visits back home, that this isn't a problem only for blacks in Harlem any more or for the poor; it is a problem that deeply concerns middle and upper income families as well. I can tell you right out in rural Minnesota, we have serious problems. Right in small towns. It is a profound shock to the parents and to the community. What we have got to devise here is a program that is not looked upon as if it is for a kind of special situation. This is for a general situation which afflicts a vast amount of our public, and I believe, Senator, that we have to look a long way down the road.

I think it is going to get worse before it gets better.

Senator SCHWEIKER. Thanks again, and we appreciate it very much. We will recess now until the vote on Senator Hughes' amendment.

Senator HUMPHREY. Thank you.

Senator SCHWEIKER. Thank you.

(A brief recess was taken.)

Senator HUGHES (presiding). The Chair calls Dr. Gardner, Director, Division of Neuropharmacological Drug Products, Bureau of Drugs, Food and Drug Administration.

Thank you for waiting, Doctor. I understand it is your intention to summarize your statement. We will include the statement in the record as though given in full.

STATEMENT OF DR. ELMER GARDNER, DIRECTOR, DIVISION OF NEUROPHARMACOLOGICAL DRUG PRODUCTS, BUREAU OF DRUGS, FOOD AND DRUG ADMINISTRATION

Dr. GARDNER. I will read a slightly revised version of the FDA statement that was submitted with Dr. DuVal's statement.

This will concentrate mainly on the Food and Drug Administration's experience with the supervision of methadone programs.

The use of methadone for maintenance treatment of heroin addiction was formally recognized as a new indication for methadone when programs were asked to submit investigational new drug applications in early 1970, and with publication of proposed guidelines in the Federal Register in June of 1970.

Prior to that time, there had been only two investigator teams using methadone in this manner, and there had been considerable question about whether this use would require an investigational new drug application.

Since early 1970 the FDA and, more recently, the Bureau of Narcotics and Dangerous Drugs (BNDD), have approved about 275 sponsors for methadone maintenance programs, representing approximately 300 individual treatment units throughout the country.

Senator HUGHES. How many was that?

Dr. GARDNER. 300.

Some sponsors, particularly the National Institute of Mental Health and the Veterans' Administration, monitor 20 or more programs and plan to increase their numbers in the near future.

Since publication of the April 2, 1971, regulations in the Federal Register, each applicant for a methadone maintenance program has been inspected by BNDD and must receive approval by that agency and the FDA. Prior to that time, they had merely to submit an application and could start their program in 30 days, without prior inspection.

Subsequent to the initiation of the inspection program, every program has been asked to correct any major deficiencies in their protocol before they can initiate their program or correct deficiencies in an ongoing program to provide better control.

We have not approved any applications unless the sponsor can conduct an adequate study of this treatment modality, and thus, with the more complex studies that are now required, there have been few private practitioners who have been granted IND's for methadone maintenance.

Our Drug Abuse Advisory Committee met on June 30 of this year and provided criteria for the approval of a new drug application for methadone maintenance, generally following the guidelines that had been published in the April 2, 1971, publication.

A new drug application was submitted by E. Lilly Co. on June 28, 1971, and is now under review by our agency. The summary of that review will be sent to the committee members by August 23, and the committee will advise the agency regarding this application in their next meeting on September 15.

The committee had decided in their June 30 meeting that efficacy for methadone maintenance would be demonstrated by blocking of heroin craving; this means that an addict would remain free of heroin as shown by urine testing for opiates. This pharmacological efficacy could be supported by social indicators such as job performance, reduced criminal activity, participation in group therapy, and so forth. But these indicators would not be necessary to prove efficacy.

From our review of the new drug application, it is quite likely that the new drug application does support efficacy with these criteria, and barring deficiencies in the data collection or the design of the studies, the NDA, or new drug application might well be approved sometime in September or not long thereafter.

The Advisory Committee expressed concern in their meeting about the control of methadone programs and promoted the concept of a licensing procedure which would restrict methadone maintenance to select programs scattered geographically throughout the country. The committee also approved a change in the labeling for the use of methadone and heroin withdrawal programs. Essentially, this labeling change would limit withdrawal or detoxification treatment to a maximum of 3 weeks, and caution against repeat withdrawal in less than a month's time after the initial detoxification.

This labeling would provide much stronger enforcement authority for the Bureau of Narcotics and Dangerous Drugs in their control of practitioners who conduct maintenance programs under the quise of conducting detoxification or withdrawal.

If a new drug application for methadone maintenance is approved, some consideration must still be given to the manufacturers and approximately 20 distributors of methadone for its use as an analgesic and antitussive.

Production for these indications could be sharply curtailed to prevent diversion from these production sources into illicit channels which might be fostered by the maintenance programs.

Two other companies have IND's for other methadone formulations. One company is investigating a concentrate which would be difficult, if not impossible, to inject, and another company has started clinical testing of a tablet which is similar to the Lilly tablet.

Another company has initiated testing of a methadone-naloxone preparation. Naloxone, a narcotic antagonist with minimal addicting properties, requires a large oral dose. It can be given orally with methadone and have no effect. However, if the same amount were given intravenously, it would block the methadone euphoria, and thus the combination would preclude the intravenous use of methadone.

A long-acting derivative of methadone is also under investigation. It may be effective for roughly 48 hours to 72 hours, and if so, this would allow the addict to attend a program two to three times weekly. Thus, it would not be necessary to give large amounts of the drug at each visit or continue daily visits.

Several investigators have expressed their intention to use this drug, and this might eventually replace methadone.

The other blocking agents such as cyclazocine do not seem likely to replace methadone.

The Food and Drug Administration, using district office inspectors, currently is completing inspections of several programs which have been thought to be inadequate, and approximately 30 programs selected at random. By next week, as a result of these inpections, the 5th program will have been terminated.

In all instances, any termination action has been coordinated with BNDD and with many of the local authorities.

Other methadone programs have cooperated in each instance in which a program has been terminated to continue treatment of the addicts from the terminated programs.

Eventually, inspection of all methadone programs will be conducted by BNDD and the FDA.

Twelve programs in addition to the five that have been terminated have voluntarily discontinued their IND's; approximately 50 are currently under review for IND approval.

Finally, most programs have responded to our request for a 6-month progress report, and tabulations from these reports are now being prepared. A preliminary tabulation suggests that about 50 percent of the applicants in the methadone programs are accepted for treatment, and of these 50 percent, another 30 percent drop out of treatment within 6 months time.

There are approximately 25,000 addicts now under methadone maintenance treatment; we hope to have some more data soon from these reports.

Thank you, Mr. Chairman.

Senator HUGHES. Thank you very much, Dr. Gardner.

Isn't it true that methadone doesn't have any effect whatsoever on psychological dependence on heroin?

Dr. GARDNER. Yes; that is true. It affects just the craving. Whether there is some effect on psychological dependency, in addition, is difficult to evaluate.

Senator HUGHES. If this is true, I can't understand how we are going to affect the psychlogical dependency behind the heroin addiction simply by methadone maintenance?

Dr. GARDNER. I don't believe anyone thinks in terms of just using methadone. Most of the programs have a variety of other therapeutic efforts being conducted at the same time. In fact, part of our inspection consists of looking for just this. All of the protocols have indicated that they would have counseling or vocational rehabilitation or some ther kind of therapeutic effort.

Senator HUGHES. In other words, you think you need a comprehensive program in addition to methadone maintenance or withdrawal?

Dr. GARDNER. Yes; that is correct.

Senator HUGHES. You said you had approximately 300 treatment units now abroad in the country, operating under 275 licensing grants; is that correct?

Dr. GARDNER. That is right, sir.

Senator HUGHES. How much do you intend to expand this in light of the President's new advocacy of this sort of program?

Dr. GARDNER. Under the investigational status, we wouldn't be expanding this very much. There are almost enough programs to help us evaluate this as a treatment method, and this is the purpose of the investigational status.

Senator HUGHES. What is your goal on it, a year, 2 years, 5 years, or until you think the results are sound enough to warrant a decision?

Dr. GARDNER. We must wait until somebody submits an NDA and we obtain the data to show whether this is efficacious and safe. This type of data is submitted in the new drug application by one of the companies. This is how we eventually decide whether a drug should be marketed or not.

Senator HUGHES. Are you working with Dr. Jaffe on these new programs?

Dr. GARDNER. I have discussed this with him and other members of his staff on at least a few occasions.

Senator HUGHES. How broadly is methadone being used in withdrawal of our soldiers in Vietnam?

Dr. GARDNER. I don't know.

Senator HUGHES. You don't have anything to do with licensing of that?

Dr. GARDNER. No; we don't.

Senator HUGHES. What authority are they operating under, if the drug isn't proven, and you haven't approved it for use. How can they use it?

Dr. GARDNER. I can't answer that, Mr. Chairman.

Senator HUGHES. You can't answer that? Do you have an obligation to stop it if they are using it, then, under Federal law?

If anyone else were using it, you would be out there to end it right now, wouldn't you?

Dr. GARDNER. Yes; we would have to stop the shipment of the drug.

Senator HUGHES. I have been under the impression, and maybe the Chair is wrong, but I have been under the impression that there is wide usage of methadone right now in the Army for withdrawal, and that the VA is doing likewise. Have you licensed the VA?

Dr. GARDNER. Yes; the VA does have an IND.

Senator HUGHES. How many units are they operating?

Dr. GARDNER. They have had 13 and have submitted about another 25 applications just recently.

Perhaps that is what you are referring to.

Senator HUGHES. I am referreing to the procedure in Vietnam to be used on return from Vietnam of the so-called 5.44 percent of Veterans there who come up with a positive test in urinalysis, and the President's stated program of not returning those men to the United States, or at least to their homes, until they have been treated.

Are we going to use a cold turkey withdrawing system, are we going to use methadone withdrawal, some other form of narcotic withdrawal, and if so, aren't you supervising it?

Dr. GARDNER. I assume we would. If this is under some jurisdiction other than the Veterans Administration, they would submit an IND. When a licensing procedure is established, this would be under somebody else's jurisdiction.

Senator HUGHES. When did you say you expect that new licensing procedure to come up?

In September, was it?

Dr. GARDNER. The approval of the new drug application would be in September. If there is to be a licensing procedure, that might require legislation.

Senator HUGHES. Do you expect you will be able to approve it on the basis of what you know now?

Dr. GARDNER. I think that is fairly likely from what we have seen.

Senator HUGHES. Do you think that on the basis of controlled clinics, that we are going to be able to maintain this broadly in the States as most people working with this particular heroin problem think?

Dr. GARDNER I think that is a difficult problem.

Senator HUGHES. If the heroin addict has to travel 20 miles from one side of town to the other to get methadone, he just isn't going, is he?

Dr. GARDNER. We know of many that do, but obviously, many would not. The difficulty is how many programs have to be established to provide easy access for most of the addicts. Presumably, a large proportion of addicts are in the metropolitan centers, and that would help limit the program somewhat. If a large number of programs have to be established, then illicit traffic would be very difficult to prevent. This is one of the major problems—not only approval of this treatment modality, but widespread use, and the kind of control procedures that must be established.

Senator HUGHES. How long has methodone maintenance treatment of heroin addicts been practiced?

Dr. GARDNER. This dates back to late 1963.

Senator HUGHES. Is this Dole's work?

Dr. GARDNER. Dr. Dole's work and Dr. Jaffe's. Most of the others started at the end of 1969 and 1970.

Senator HUGHES. From this work dating back to 1963, don't you have enough evidence relating to controlled circumstance to relate to now?

Dr. GARDNER. That is the data submitted in the new drug application. We have to wait until somebody submits that and says they want to market it before we can do anything.

Senator HUGHES. Is the official position of your agency now that methadone is either unsafe or ineffective?

Dr. GARDNER. No; I think we haven't had a chance to look at all the data that has been submitted yet. This data involves at least two major programs, and that does give us quite a bit of information about the long-term use of methadone. We still would probably want more information about it over the course of the next few years, but that wouldn't necessarily preclude approval of the new drug application.

Senator HUGHES. Dr. Cole's testimony before this subcommittee indicates that methadone exhibits no evidence of toxicity under proper doses, that it causes no allergies, no liver or bone damage. He claims when the patient had no serious health problem to begin with, the health of all his methadone patients has actually improved while on maintenance treatment. He also finds that it is effective in that it stops heroin use by a majority of the patients.

Do you have any response to that?

Dr. GARDNER. Yes; first of all, I think he is basing at least some of what he is saying strictly on the results from his program. This involves, perhaps a thousand addicts who have been in treatment over a period of a year or two.

The effects on some of the organs has been studied in a much smaller number of patients.

Our experience with most drugs, particularly for chronic use, indicates that a much larger number of people must be followed over a much longer period of time to detect toxic effects. Obviously, we can't wait forever, but we generally do need larger numbers than that.

In speaking of efficacy, when he says that the majority are helped, he is talking about those who have stayed in treatment, and only 50 percent who apply to the program even enter treatment.

Senator HUGHES. Why?

Dr. GARDNER. That is one of the things we would like to answer.

Senator HUGHES. Isn't it because they are restricted?

Because they are not allowed to?

Dr. GARDNER. Do you mean to even enter treatment?

Senator HUGHES. The waiting list is so long that the application simply keeps these men piled up on the streets for years.

Dr. GARDNER. That may be part of it. It is a difficult thing to know. The important thing would be to know which addicts are staying in treatment compared with the overall addict population, to know whether a selected population is receiving treatment.

Senator HUGHES. Doctor, isn't efficacy based only on those who are taking the drug?

Dr. GARDNER. That is right.

Senator HUGHES. So what relationship does that have to the efficacy of the drug whether they got into the program or not?

Dr. GARDNER. That has no relationship. I was responding to your statement about Dr. Dole's program.

Senator HUGHES. What is the evidence of toxicity of heroin?

Dr. GARDNER. There really isn't and good evidence from long-term use. It has notbeen studied. Methadone, in short-term use has been studied.

Senator HUGHES. There have been no studies made of heroin maintenance programs? They haven't had any real research study into that?

Dr. GARDNER. No.

Senator HUGHES. Into the effect on the patients?

Are you contemplating, or do you have any research available on heroin maintenance?

Dr. GARDNER. No; there has been one group interested in this, but nobody has started that type of investigation.

Senator HUGHES. Do you have an opinion as to whether this is a worthy investigation or not?

Dr. GARDNER. No, I don't, other than that it will be another major problem in control.

Senator HUGHES. They are already getting the heroin, it is a question of whether they get it from a doctor or from a pusher, isn't that right? And if you could get a controlled community of heroin addicts, as you were trying to get a controlled community under methadone maintenance, could they also be studied?

Dr. GARDNER. Certainly.

Senator HUGHES. In a research capacity?

Dr. GARDNER. Yes.

Senator HUGHES. None of this is being done now in Kentucky, to your knowledge?

Dr. GARDNER. Not to my knowledge.

Senator HUGHES. What are we trying to prove there? The center has been there for a long time, with a lot of doctors working.

Dr. GARDNER. I know they are studying a number of narcotic-blocking agents, and analgesics which don't have addicting properties.

Senator HUGHES. How many narcotics has FDA approved for manufacture and prescriptions in the last 5 years—any new ones?

Dr. GARDNER. Just one major substance that comes to mind offhand. I would have to check on that. I am thinking mainly of Talwin, which is not under schedule at the moment. There is none that I know of that have been put under schedule.

Senator HUGHES. How many, if we drop out the "narcotic" label and get down to the "drugs" label. How many have you approved in the last 5 years?

Dr. GARDNER. Drugs in what area?

Senator HUGHES. Amphetamines, barbiturates, and classifications like that. Do you have any recall on that?

Dr. GARDNER. No; except there would be a large number. There would be a particularly large number if we include the stimulants, hypnotics, and sedatives.

Senator HUGHES. Would you consider the mainlining of amphetamines as dangerous as mainlining heroin?

Dr. GARDNER. Yes, I would; at least as dangerous.

Senator HUGHES. What have we been doing to control amphetamines, dispensation, and usage?

Dr. GARDNER. We have recommended that these drugs be placed under schedule 2 of the Drug Abuse Act, thereby controlling the production of these as well as the prescription.

Senator HUGHES. Is that in the process now, Doctor, under the new law?

Dr. GARDNER. Yes, it is.

Senator HUGHES. For the shipment and distribution and procedures of manufacture and so on. What was it, 2 years ago that we passed the law, or a year and a half? I have forgotten.

Dr. GARDNER. That law was passed in October 1970. Probably there will be a number of revisions made under the schedules of that law. The first has been the amphetamines.

Senator HUGHES. Your guidelines with relationship to methadone set extensive criteria that say that a patient cannot abuse alcohol or other drugs?

Dr. GARDNER. We recommend looking at that, but it doesn't say that is an absolute, that they can't. There are a number of items in the guidelines that are strictly suggestions.

Senator HUGHES. The point I am getting at is, what does the fact that the patient may drink too much when he is on methadone have to do with the drug itself?

Dr. GARDNER. This is not a primary factor in the evaluation of the drug, but it is a secondary aspect of it. If you are giving a drug that may relieve one kind of addiction, it is important to know whether this replaces one form of addiction for another.

Senator HUGHES. Alcohol is legal, you know, and people are abusing it every day of the week all over the world. Do you consider that better than heroin addiction?

Dr. GARDNER. No.

Senator HUGHES. If you transfer a man from heroin to alcohol, do you figure you have gained anything?

Dr. GARDNER. It depends on a number of factors.

Senator HUGHES. He wouldn't steal as much, that is one thing.

Dr. GARDNER. No, sir; but in the evaluation of any drug, there are many things to look at other than its absolute pharmacological effect. It doesn't necessarily say this is an effective drug or not, but it is valuable to know this.

Senator HUGHES. Is there any claim that you know of by anyone that methadone controls the psychology of dependence on drugs?

I thought all it did was physiologically block the euphoria of heroin. Am I wrong in that?

Dr. GARDNER. It blocks the euphoria and it has been claimed that it affects the craving for heroin.

Senator HUGHES. The physical craving, but there has been no claim that if a person has what I call an addictive personality, it would be on alcohol or amphetamines or something else, that by using methadone to block the heroin use that you are going to have any effect on the rest of that.

Dr. GARDNER. Not at the moment. Those claims vary from time to time, and originally, this was proposed. I don't think that is the general opinion now. It is very difficult to separate the strict physiological from the psychological dependency and know which is which. If some-

body has a craving, for example, it is difficult to know how much of it is physiological and how much is psychological.

Senator HUGHES. Let's say that methadone succeeds with heroin and nothing else, it has absolutely no effect on whether a man uses alcohol or some other form of drug in relationship to some sort of psychological dependency. Is it still worth the effort?

Dr. GARDNER. I think so. I think it is all we have at the moment that has shown any possible efficacy and would lend itself to any large scale use. The problem is that it is an addicting drug and it can be abused if it is used intravenously. This will present problems in control. But it is the best we have.

Senator HUGHES. Do you think the present narcotics problem in America is a cyclical one that will dissipate in a matter of a few years?

Dr. GARDNER. I really couldn't answer that, Mr. Chairman. I think the addiction problem may well change from one drug to another, as it has to some degree in the past. Whether the extent of it is going to remain the same depends on many factors, part of which are economic as well as social.

Senator HUGHES. Has there ever been a period in our history when our young people turned to a narcotic like heroin before in the numbers they are today, that you know of?

Dr. GARDNER. No; but it is difficult to judge. Certainly, opiates were abused considerably, and we don't really have good evidence for that. It wasn't just among the young people.

Senator HUGHES. There was a period after World War I, wasn't there, when opiate use went up extensively?

Dr. GARDNER. Yes; it was used a great deal in the last century, but we don't really know how much.

Senator HUGHES. We don't have enough facts to look at on that.

Dr. GARDNER. No.

Senator HUGHES. The reason I asked the question is that I have seen statements that these things travel in cycles, and that we are at the peak of the cycle, and that leaves the implication that if we don't do anything, it will go away. That is the point of my questioning. Are you laboring under that impression?

Dr. GARDNER. No.

Senator HUGHES. Good; that is what I am wondering, whether we are waiting for this thing to go away, or whether we are going to use everything we can.

Dr. GARDNER. I think we must look at the economic aspects of the drug abuse scene. It is different from the use of opiates, for instance, in the last century. That is a major factor.

Senator HUGHES. We have had indications from Dr. Dole, that the guidelines for methadone are much more comprehensive than those for other drugs. Is that true?

Dr. GARDNER. Yes, they are. There is more detail. Methadone is under the guidelines for other drug studies, but its guidelines for maintenance treatment are spelled out in more detail.

Senator HUGHES. On Tuesday, apparently, your agency told the subcommittee staff that there were similarly comprehensible guidelines for other drugs, and they also indicated to the staff they would submit those guidelines to us for comparison. But you indicate that you believe

that the methadone guidelines are more comprehensive than the other drugs as you remember them.

Dr. GARDNER. I think so.

Senator HUGHES. Could you submit for us the guidelines in relationship to other drugs and methadone so that we can use them as a comparison?

Dr. GARDNER. Yes.

(The information referred to follows:)

Investigational Use of Methadone

Methadone is currently under study for the maintenance treatment of narcotic addiction. It has been an effective analgesic since it was synthesized at the end of World War II. Although for more than a decade it has been known that low oral doses of methadone would allay withdrawal symptoms, not until 1963 was it first observed that large oral doses could block the euphoric effects of even high doses of other opiates or synthetic narcotics. Thus, the current widespread interest in methadone for the maintenance treatment of heroin addicts.

Methadone is a marketed drug that has been approved through the new drug procedures for three specific uses: as an analgesic, an antitussive, and for treatment of withdrawal symptoms in heroin addiction. The last refers to the short-term treatment of the acute symptoms resulting from the withdrawal of heroin from those who have become physiologically dependent.

Maintenance treatment of heroin addiction with methadone is investigational because substantial evidence of its safety and effectiveness for this use is not yet available. The law defines "substantial evidence" as meaning evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug. Although there are studies which suggest that methadone maintenance may be effective for some heroin addicts over a period of at least months, and perhaps a few years, we have no good body of data or well-controlled studies that meet the required criteria.

We are only now beginning to obtain the kind of information which may eventually permit us to define the place of this drug in the treatment of heroin addiction.

Because it was available on prescription, the use of methadone for maintenance therapy became quite widespread following the early reports of success.

In order to collect the type of scientific data needed to support approval of a new use of a drug, it was necessary that the maintenance programs follow protocols, including recordkeeping, that could yield such data. Investigational studies of methadone present problems not encountered in studies with other types of drugs because it is an addicting narcotic with a proven capacity for abuse.

Therefore, to protect the community from the hazards of diversion and abuse, and to assure the development of valid data, guidelines

for methadone maintenance studies were developed through the cooperation of the National Institute of Mental Health, the Bureau of Narcotics and Dangerous Drugs, and the Food and Drug Administration. These guidelines were published in the Federal Register on April 2, 1971. Prior approval of both the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs, Department of Justice, is required before such studies may be initiated.

Heroin addicts do not constitute a homogeneous population and proper treatment requires that we have some knowledge about which addicts may benefit from this treatment approach in contrast to other therapy.

Some investigators have reported that 70 to 80 percent of treated addicts are rehabilitated as judged by reduction in criminal activity, improvement in employment status, or schooling. Most of these reports, however, have not given adequate consideration to the bias produced by patient selection. Some idea of the difficulty of interpreting such studies can be gained from a most recent evaluation of one of the best known programs. Although the program had a very broad criteria for admission, more applicants were not admitted to the study then were admitted.

In general, those patients admitted to the study and remaining in treatment, when compared to the overall heroin addict population, tended to be older, more often white, and in better health. This group, which had an improved employment status and reduced criminality, was not representative of the total heroin addict population. Therefore, this study, as well as others reported to date, cannot be used to generalize the results to the entire addict population.

Whether those not accepted for treatment would have fared as well as those accepted is unanswered. Reports have not provided the kind of data that enables better patient selection.

Also, data are needed to distinguish the role played by the drug itself from the role played by the psychological, social, and occupational rehabilitative efforts in such programs; a marked proliferation of programs may produce many in which only the drug is used and no rehabilitation is provided.

Methadone maintenance treatment may be a valuable therapy in reducing heroin addiction, but we believe it is wise to proceed cautiously in moving toward its general prescription use for this purpose. We need better evidence to determine the safety of this treatment. It is well to bear in mind that methadone maintenance treatment represents substituting methadone addiction for heroin addiction and does not represent the absence of drug addiction. One of the

hazards of methadone treatment is that young drug users who are not physiologically dependent on heroin might become addicted to methadone as a result of treatment. Another hazard stems from the possibility of death if a nonaddict takes the usual maintenance dose of methadone intravenously or because of the additive effect, if an addict "shoots" methadone while still taking heroin. We do not wish to have a potentially valuable therapy discredited because of its misuse by some practitioners while its efficacy is being evaluated.

We now have approximately 250 Investigational New Drug Exemption (IND) numbers assigned to sponsors representing some 275 methadone treatment programs. Of these, 185 programs are institutional programs; the remainder private.

At present, no application is being approved unless the program can study an adequate number of patients to yield meaningful data regarding the safety and efficacy of methadone.

We have requested six-month status reports from these programs instead of the customary annual reports, in order to obtain adequate data as soon as possible.

We expect our recently published regulations to serve as a valuable tool in insuring compliance with existing requirements. In this regard, we have recently undertaken a program for the inspection of all methadone maintenance studies. By mid-July, we will have completed inspection of an initial 40 to 50 programs throughout the country, selected on the basis of various criteria.

In addition to achieving correction of any deficiencies, we hope to stimulate improved practices and better data collecting procedures. In these inspections, whenever possible, medical officers from our Bureau of Drugs will accompany District field inspectors. All of this will be done in close cooperation with the Bureau of Narcotics and Dangerous Drugs, which in addition has its own program for surveillance of the methadone studies.

Results of these inspections have demonstrated that some programs must be terminated. FDA has already terminated five programs, and twelve have voluntarily discontinued their programs following inspections by FDA and BNDD.

When necessary, a sponsor will be given a time limit to correct deficiencies or face loss of his investigational status. However, before a program is terminated, we will contact local health departments, medical societies, and other approved methadone maintenance programs in an effort to insure that continuing treatment for the addicts is available. A letter has been sent to all State and local drug program officials notifying them of our inspection program.

In addition to review by our own personnel, we have appointed a committee of outside experts to assist in evaluating data as it accumulates, as well as other aspects of the ongoing programs. The committee will also be called on to assist in reviewing any new drug applications for methadone maintenance.

67-226 O - 71 - 28

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION
ROCKVILLE, MARYLAND 20852

SEP 28 1971

Honorable Harold E. Hughes
Chairman, Subcommittee on Alcoholism
and Narcotics
Committee on Labor and Public Welfare
United States Senate
Washington, D.C. 20510

Dear Senator Hughes:

This is in response to a request made at the Subcommittee August 5, 1971 hearing on S. 2217 and related bills.

Elmer Gardner, M.D., who represented the Food and Drug Administration at the hearing, was asked to furnish the Subcommittee with information as to how the guidelines for methadone studies compare with guidelines relating to the study of other investigational new drugs.

The Investigational Drug Regulations (copy attached) are the only formal "guidelines" which apply to investigational drugs other than methadone. The major difference between other investigational drugs and methadone is that in the case of methadone we have specified in detail (by regulation) the protocol that we believe investigators should use.

We do not have standard protocols for other investigational drugs although we do make recommendations on protocols submitted to us by firms and investigators.

We are, however, developing guidelines in cooperation with industry and our Neuropharmacology Advisory Committee for clinical studies by drug classes. These include guidelines for antipsychotic, antidepressant, psychotropic and antianxiety drugs. They are more general in that they cover classes of drugs and, of course, do not specify details such as required laboratory tests, dosages, etc. These guidelines are still under consideration and have not as yet been finalized.

If we can be of further assistance, please let us know.

Sincerely yours,

M. J. Ryan, Director
Office of Legislative Services

2 Enclosures

INVESTIGATIONAL DRUG REGULATIONS

UNDER THE KEFAUVER-HARRIS DRUG AMENDMENTS OF 1962

(SECTION REPRINTED FROM THE MANUAL OF NEW DRUG REGULATIONS,
CODE OF FEDERAL REGULATIONS - PART 130)

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FOOD AND DRUG ADMINISTRATION

AUGUST 1963

Amendment published in Federal Register:
* August 14, 1970; 35 F.R. 12891

PART 130--NEW DRUG REGULATIONS--Page 3
Remove old page 3 and insert this new page in your reprint.

1/ **§ 130.3 New drugs for investigational use in human beings; exemptions from section 505(a).**

(a) A shipment or other delivery of a new drug shall be exempt from section 505(a) of the act if all the following conditions are met:

(1) The label of such drug bears the statement "Caution: New drug—Limited by Federal (or United States) law to investigational use."

* (2) The person claiming the exemption has filed with the Food and Drug Administration a completed and signed "Notice of Claimed Investigational Exemption for a New Drug" in triplicate, with the information shown below in form FD-1571; and not less than 30 days have elapsed following the date of receipt of the notice by the Food and Drug Administration; and the Food and Drug Administration has not, prior to expiration of such 30-day interval, requested that the sponsor continue to withhold or to restrict use of the drug in human subjects. The 30-day delay requirement may be waived by the Food and Drug Administration upon a showing of good reason for such waiver. *

Form FD 1571

Department of Health, Education, and Welfare, Food and Drug Administration

Notice of Claimed Investigational Exemption for a New Drug

Name of sponsor ----------
Address ----------

Name of investigational drug ----------

To the Secretary of Health, Education, and Welfare,
For the Commissioner of Food and Drugs,
Washington 25, D.C.

Dear Sir:

The sponsor, ----------, submits this notice of claimed investigational exemption for a new drug under the provisions of section 505(i) of the Federal Food, Drug, and Cosmetic Act and § 130.3 of Title 21 of the Code of Federal Regulations.

Attached hereto are:

1. The best available descriptive name of the drug, including to the extent known the chemical name and structure of any new-drug substance, and a statement of how it is to be administered. (If the drug has only a code name, enough information should be supplied to identify the drug.)

2. Complete list of components of the drug, including any reasonable alternates for inactive components.

3. Complete statement of quantitative composition of drug, including reasonable variations that may be expected during the investigational stage.

4. Description of source and preparation of any new-drug substances used as components, including the name and address of each supplier or processor, other than the sponsor, of each new-drug substance.

5. A statement of the methods, facilities, and controls used for the manufacturing, processing, and packing of the new drug to establish and maintain appropriate standards of identity, strength, quality, and purity as needed for safety and to give significance to clinical investigations made with the drug.

6. A statement covering all information available to the sponsor derived from preclinical investigations and any clinical studies and experience with the drug as follows:

a. Adequate information about the preclinical investigations, including studies made on laboratory animals, on the basis of which the sponsor has concluded that it is reasonably safe to initiate clinical investigations with the drug: Such information should include identification of the person who conducted each investigation; identification and qualifications of the individuals who evaluated the results and concluded that it is reasonably safe to initiate clinical investigations with the drug and a statement of where the investigations were conducted and where the records are available for inspection; and enough details about the investigations to permit scientific review. The preclinical investigations shall not be considered adequate to justify clinical testing unless they give proper attention to the conditions of the proposed clinical testing. When this information, the outline of the plan of clinical pharmacology, or any progress report on the clinical pharmacology, indicates a need for full review of the preclinical data before a clinical trial is undertaken, the Department will notify the sponsor to submit the complete preclinical data and to withhold clinical trials until the review is completed and the sponsor notified. The Food and Drug Administration will be prepared to confer with the sponsor concerning this action.

b. If the drug has been marketed commercially or investigated (e.g. outside the United States), complete information about such distribution or investigation shall be submitted, along with a complete bibliography of any publications about the drug.

c. If the drug is a combination of previously investigated or marketed drugs, an adequate summary of preexisting information from preclinical and clinical investigations and experience with its components, including all reports available to the sponsor suggesting side-effects, contraindications, and ineffectiveness in use of such components: Such summary should include an adequate bibliography of publications about the components and may incorporate by reference any information concerning such components previously submitted by the sponsor to the Food and Drug Administration. Include a statement of the expected pharmacological effects of the combination.

1/ NOTE: Order of the Commissioner of Food and Drugs published at 28 F.R. 183, Jan. 8, 1963, provides as follows:

"That, § 130.3 (28 F.R. 179) shall not apply to radioactive new drugs, until further notice, provided the radioactive new drugs for investigational use are being shipped in complete conformity with the regulations issued by the Atomic Energy Commission."

Amendment published in Federal Register:
* March 17, 1971; 36 F.R. 5037

PART 130--NEW DRUG REGULATIONS--Page 4
Remove old page 4 and insert this new page in your reprint.

7. A copy (one in each of the three copies of the notice) of all informational material, including label and labeling, which is to be supplied to each investigator: This shall include an accurate description of the prior investigations and experience and their results pertinent to the safety and possible usefulness of the drug under the conditions of the investigation. It shall not represent that the safety or usefulness of the drug has been established for the purposes to be investigated. It shall describe all relevant hazards, contraindications, side effects, and precautions suggested by prior investigations and experience with the drug under investigation and related drugs for the information of clinical investigators.

8. The scientific training and experience considered appropriate by the sponsor to qualify the investigators as suitable experts to investigate the safety of the drug, bearing in mind what is known about the pharmacological action of the drug and the phase of the investigational program that is to be undertaken.

9. The names and a summary of the training and experience of each investigator and of the individual charged with monitoring the progress of the investigation and evaluating the evidence of safety and effectiveness of the drug as it is received from the investigators, together with a statement that the sponsor has obtained from each investigator a completed and signed form, as provided in subparagraph (12) or (18) of this paragraph, and that the investigator is qualified by scientific training and experience as an appropriate expert to undertake the phase of the investigation outlined in section 10 of the "Notice of claimed investigational exemption for a new drug." (In crucial situations, phase 3 investigators may be added and this form supplemented by rapid communication methods, and the signed form FD 1573 shall be obtained promptly thereafter.)

* 10. An outline of any phase or phases of the planned investigations and a description of the institutional review committee, as follows:

*

a. Clinical pharmacology. This is ordinarily divided into two phases: Phase 1 starts when the new drug is first introduced into man—only animal and in vitro data are available—with the purpose of determining human toxicity, metabolism, absorption, elimination, and other pharmacological action, preferred route of administration, and safe dosage range; phase 2 covers the initial trials on a limited number of patients for specific disease control or prophylaxis purposes. A general outline of these phases shall be submitted, identifying the investigator or investigators, the hospitals or research facilities where the clinical pharmacology will be undertaken, any expert committees or panels to be utilized, the maximum number of subjects to be involved, and the estimated duration of these early phases of investigation. Modification of the experimental design on the basis of experience gained need be reported only in the progress reports on these early phases, or in the development of the plan for the clinical trial, phase 3. The first two phases may overlap and, when indicated, may require additional animal data before these phases can be completed or phase 3 can be undertaken. Such animal tests shall be designed to take into account the expected duration of administration of the drug to human beings, the age groups and physical status, as for example, infants, pregnant women, premenopausal women, of those human beings to whom the drug may be administered, unless this has already been done in the original animal studies.

b. *Clinical trial.* This phase 3 provides the assessment of the drug's safety and effectiveness and optimum dosage schedules in the diagnosis, treatment, or prophylaxis of groups of subjects involving a given disease or condition. A reasonable protocol is developed on the basis of the facts accumulated in the earlier phases, including completed and submitted animal studies. This phase is conducted by separate groups following the same protocol (with reasonable variations and alternatives permitted by the plan) to produce well-controlled clinical data. For this phase, the following data shall be submitted:

i. The names and addresses of the investigators. (Additional investigators may be added.)

ii. The specific nature of the investigations to be conducted, together with information or case report forms to show the scope and detail of the planned clinical observations and the clinical laboratory tests to be made and reported.

iii. The approximate number of subjects (a reasonable range of subjects is permissible and additions may be made), and criteria proposed for subject selection by age, sex, and condition.

iv. The estimated duration of the clinical trial and the intervals, not exceeding 1 year, at which progress reports showing the results of the investigations will be submitted to the Food and Drug Administration.

Amendment published in Federal Register:
* March 17, 1971; 36 F.R. 5037

PART 130--NEW DRUG REGULATIONS--Page 5
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(The notice of claimed investigational exemption may be limited to any one or more phases, provided the outline of the additional phase or phases is submitted before such additional phases begin. This does not preclude continuing a subject on the drug from phase 2 to phase 3 without interruption while the plan for phase 3 is being developed.)

Ordinarily, a plan for clinical trial will not be regarded as reasonable unless, among other things, it provides for more than one independent competent investigator to maintain adequate case histories of an adequate number of subjects, designed to record observations and permit evaluation of any and all discernible effects attributable to the drug in each individual treated, and comparable records on any individuals employed as controls. These records shall be individual records for each subject maintained to include adequate information pertaining to each, including age, sex, conditions treated, dosage, frequency of administration of the drug, results of all relevant clinical observations and laboratory examinations made, adequate information concerning any other treatment given and a full statement of any adverse effects and useful results observed, together with an opinion as to whether such effects or results are attributable to the drug under investigation.

* c. *Institutional review committee.* If the phases of clinical study as described under 10a and b above are conducted on institutionalized subjects or are conducted by an individual affiliated with an institution which agrees to assume responsibility for the study, assurance must be given that an institutional review committee is responsible for initial and continuing review and approval of the proposed clinical study. The membership must be comprised of sufficient members of varying background, that is, lawyers, clergymen, or laymen as well as scientists, to assure complete and adequate review of the research project. The membership must possess not only broad competence to comprehend the nature of the project, but also other competencies necessary to judge the acceptability of the project or activity in terms of institutional regulations, relevant law, standards of professional practice, and community acceptance. Assurance must be presented that neither the sponsor nor the investigator has participated in selection of committee members; that the review committee does not allow participation in its review and conclusions by any individual involved in the conduct of the research activity under review (except to provide information to the committee); that the investigator will report to the committee for review any emergent problems, serious adverse reactions, or proposed procedural changes which may affect the status of the investigation and that no such change will be made without committee approval except where necessary to eliminate apparent immediate hazards; that reviews of the study will be conducted by the review committee at intervals appropriate to the degree of risk, but not exceeding 1 year, to assure that the research project is being conducted in compliance with the committee's understanding and recommendations; that the review committee is provided all the information on the research project necessary for its complete review of the project; and that the review committee maintains adequate documentation of its activities and develops adequate procedures for reporting its findings to the institution. The documents maintained by the committee are to include the names and qualifications of committee members, records of information provided to subjects in obtaining informed consent, committee discussion on substantive issues and their resolution, committee recommendations, and dated reports of successive reviews as they are performed. Copies of all documents are to be retained for a period of 3 years past the completion or discontinuance of the study and are to be made available upon request to duly authorized representatives of the Food and Drug Administration. (Favorable recommendations by the committee are subject to further appropriate review and rejection by institution officials. Unfavorable recommendations, restrictions, or conditions may not be overruled by the institution officials.) Procedures for the organization and operation of institutional review committees are contained in guidelines issued pursuant to Chapter 140 of the Grants Administration Manual of the U.S. Department of Health, Education, and Welfare, available from the U.S. Government Printing Office. It is recommended that these guidelines be followed in establishing institutional review committees and that the committees function according to the procedures described therein. A signing of the Form FD-1571 will be regarded as providing the above necessary assurances. If the institution, however, has on file with the Department of Health, Education, and Welfare, Division of Research Grants, National Institutes of Health, an "accepted general assurance," and the same committee is to review the proposed study using the same procedures, this is acceptable in lieu of the above assurances and a statement to this effect should be provided with the signed FD-1571. (In addition to sponsor's continuing responsibility to monitor the study, the Food and Drug Administration will undertake investigations in institutions periodically to determine whether the committees are operating in accord with the assurances given by the sponsor.) *

11. A statement that the sponsor will notify the Food and Drug Administration if the investigation is discontinued, and the reason therefor.

12. A statement that the sponsor will notify each investigator if a new-drug application is approved, or if the investigation is discontinued.

13. If the drug is to be sold, a full explanation why sale is required and should not be regarded as the commercialization of a new drug for which an application is not approved.

14. A statement that the sponsor assures that clinical studies in humans will not be initiated prior to 30 days after the date of receipt of the notice by the Food and Drug Administration and that he will continue to withhold or to restrict clinical studies if requested to do so by the Food and Drug Administration prior to the expiration of such 30 days. If such request is made, the sponsor will be provided specific information as to the deficiencies and will be afforded a conference on request. The 30-day delay may be waived by the Food and Drug Administration upon a showing of good reason for such waiver; * and for investigations sub- *

Amendment published in Federal Register:
* March 17, 1971; 36 F.R. 5037

ject to institutional review committee approval as described in item 10c above, an additional statement assuring that the investigation will not be initiated prior to approval of the study by such committee.

Very truly yours,

(Sponsor)

Per ---

(Indicate authority)

(This notice may be amended or supplemented from time to time on the basis of the experience gained with the new drug Progress reports may be used to update the notice.)

Provided, however, That where a new drug limited to investigational use is proposed for shipment to a foreign country and the circumstances are such that the submission of the "Notice of Claimed Investigational Exemption for a New Drug" (Form FD 1571) is not feasible, the Commissioner may authorize the shipment of the drug if he receives, through the U.S. Department of State, a formal request to allow such shipment from the government of the country to which the drug is proposed to be shipped. This request should specify that said government has adequate information about the drug and its proposed use and is satisfied that the drug may legally be used by the intended consignee in that country.

(3) Each shipment or delivery is made in accordance with the commitments in the "Notice of claimed investigational exemption for a new drug."

(4) The sponsor maintains adequate records showing the investigator to whom shipped, date, quantity, and batch or code mark of each such shipment and delivery, until 2 years after a new-drug application is approved for the drug; or, if an application is not approved, until 2 years after shipment and delivery of the drug for investigational use is discontinued and the Food and Drug Administration has been so notified. Upon the request of a scientifically trained and properly authorized employee of the Department at reasonable times, the sponsor makes the records referred to in this subparagraph and in subparagraph (2) of this paragraph available for inspection, and upon written request submits such records or copies of them to the Food and Drug Administration.

(5) The sponsor monitors the progress of the investigations and currently evaluates the evidence relating to the safety and effectiveness of the drug as it is obtained from the investigators. Accurate progress reports of the investigations and significant findings, together with any significant changes in the informational material supplied to investigators, shall be submitted to the Food and Drug Administration at reasonable intervals, not exceeding 1 year. All reports of the investigation shall be retained until 2 years after a new-drug application is approved for the drug; or, if an application is not approved, until 2 years after shipment and delivery of the drug for investigational use is discontinued and the Food and Drug Administration so notified. Upon request of a scientifically trained and properly authorized employee of the Department, at reasonable times, these reports shall be made available for inspection, and on written request copies of these reports shall be submitted to the Food and Drug Administration.

(6) The sponsor shall promptly investigate and report to the Food and Drug Administration and to all investigators any findings associated with use of the drug that may suggest significant hazards, contraindications, side-effects, and precautions pertinent to the safety of the drug. If the finding is alarming, it shall be reported immediately and the clinical investigation discontinued until the finding is adequately evaluated and a decision reached that it is safe to proceed.

Amendment published in Federal Register:
* March 17, 1971; 36 F.R. 5037

PART 130--NEW DRUG REGULATIONS--Page 6
Remove old page 6 and insert this new page in your reprint.

(7) If the investigations adduce facts showing that there is substantial doubt that they may be continued safely in relation to the drug's potential therapeutic effects, the sponsor shall promptly discontinue the investigation, notify all investigators and the Food and Drug Administration, recall all stocks of the drug outstanding, and furnish the Food and Drug Administration with a full report of the reason for discontinuing the investigation. The Food and Drug Administration will be prepared to confer with the sponsor on the need to discontinue the investigation.

(8) The sponsor shall discontinue shipments or deliveries of the new drug to any investigator who has repeatedly or deliberately failed to maintain or make available his records or reports of his investigations.

(9) The sponsor shall not unduly prolong distribution of the drug for investigational use but shall submit an application for the drug pursuant to section 505(b) of the act (or give reasons for not submitting such application, or a statement that the investigation has been discontinued and the reasons therefor):

(i) With reasonable promptness after finding that the results of such investigation appear to establish the safety and effectiveness of the drug; or

(ii) Within 60 days after receipt of a written request for such an application from the Commissioner.

(10) Neither the sponsor nor any person acting for or on behalf of the sponsor shall disseminate any promotional material representing that the drug being distributed interstate for investigational use is safe or useful for the purposes for which it is under investigation. This regulation is not intended to restrict the full exchange of scientific information concerning the drug, including dissemination of scientific findings in scientific or lay communications media; its sole intent is to restrict promotional claims of safety or effectiveness by the sponsor while the drug is under investigation to establish its safety or effectiveness.

(11) The sponsor shall not commercially distribute nor test-market the drug until a new-drug application is approved pursuant to section 505(b) of the the act.

(12) The sponsor shall obtain from each investigator involved in clinical pharmacology a signed statement in the following form:

Form FD 1572

Department of Health, Education, and Welfare, Food and Drug Administration

Statement of Investigator (Clinical Pharmacology)

Name of investigator _____
Date _____
Name of drug _____
To supplier of the drug:
Name _____
Address _____

Dear Sir:

The undersigned, _____, submits this statement as required by section 505(1) of the Federal Food, Drug, and Cosmetic Act and § 130.3 of Title 21 of Code of Federal Regulations as a condition for receiving and conducting clinical pharmacology with a new drug limited by Federal (or United States) law to investigational use.

1. A statement of the education and training that qualifies me for clinical pharmacology.

2. The name and address of the medical school, hospital, or other research facility where the clinical pharmacology will be conducted.

* 3. If the experimental project is to be conducted on institutionalized subjects or is conducted by an individual affiliated with an institution which agrees to assume responsibility for the study, assurance must be given that an institutional review committee is responsible for initial and continuing review and approval of the proposed clinical study. The membership must be comprised of sufficient members of varying background, that is, lawyers, clergymen, or laymen as well as scientists, to assure complete and adequate review of the research project. The membership must possess not only broad competence to comprehend the nature of the project, but also other competencies necessary to judge the acceptability of the project or activity in terms of institutional regulations, relevant law, standards of professional practice, and community acceptance. Assurance must be presented that the investigator has not participated in the selection of committee members; that the review committee does not allow participation in its review and conclusions by any individual involved in the conduct of the research activity under review (except to provide information to the committee); that the investigator will report to the committee for review any emergent problems, serious adverse reactions, or proposed procedural changes which may affect the status of the investigation and that no such change will be made without committee approval except where necessary to eliminate apparent immediate hazards; that reviews of the study will be conducted by the review committee at intervals appropriate to the degree of risk, but not exceeding 1 year, to assure that the research project is being conducted in compliance with the committee's understanding and recommendations; that the review committee is provided all the information on the research project necessary for its complete review of the project; and that the review committee maintains adequate documentation of its activities and develops adequate procedures for reporting its findings to the institution The documents maintained by the committee are to include the names and qualifications of committee members, records of information provided to subjects in obtaining informed consent, committee discussion on substantive issues and their resolution, committee recommendations, and dated reports of suc- *

(4) If the Commissioner determines after the unreliable data submitted by the investigator are eliminated from consideration that the data remaining are inadequate to support a conclusion that it is reasonably safe to continue the investigation, he will notify the sponsor and provide him with an opportunity for a conference and an informal hearing in accordance with paragraph (d) of this section. If an imminent hazard to the public health exists, however, he shall terminate the exemption forthwith and notify the sponsor of the termination. In such event the Commissioner, on request, will afford the sponsor an opportunity for an informal hearing on the question of whether the exemption should be reinstated.

(5) If the Commissioner determines after the unreliable data submitted by the investigator are eliminated from consideration that the data remaining are such that a new-drug application would not have been approved, he will proceed to withdraw approval of the application in accordance with section 505(e) of the act.

(6) An investigator who has been determined to be ineligible may be reinstated as eligible to receive investigational-use drugs when the Commissioner determines that he has presented adequate assurance that he will employ such drugs solely in compliance with the exempting regulations in this section for investigational-use drugs.

(d) If the Commissioner of Food and Drugs finds that:

(1) The submitted "Notice of claimed investigational exemption for a new drug" contains an untrue statement of a material fact or omits material information required by said notice; or

(2) The results of prior investigations made with the drug are inadequate to support a conclusion that it is reasonably safe to initiate or continue the intended clinical investigations with the drug; or

(3) There is substantial evidence to show that the drug is unsafe for the purposes and in the manner for which it is offered for investigational use; or

(4) There is convincing evidence that the drug is ineffective for the purposes for which it is offered for investigational use; or

(5) The methods, facilities, and controls used for the manufacturing, processing, and packing of the investigational drug are inadequate to establish and maintain appropriate standards of identity, strength, quality, and purity as needed for safety and to give significance to clinical investigations made with the drug; or

(6) The plan for clinical investigations of the drugs described under section 10 of the "Notice of claimed investigational exemption for a new drug" is not a reasonable plan in whole or in part, solely for a bona fide scientific investigation to determine whether or not the drug is safe and effective for use; or

(7) The clinical investigations are not being conducted in accordance with the plan submitted in the "Notice of claimed investigational exemption for a new drug"; or

(8) The drug is not intended solely for investigational use, since it is being or is to be sold or otherwise distributed for commercial purposes not justified by the requirements of the investigation; or

(9) The labeling or other informational material submitted for the drug as required by section 7 of the "Notice of claimed investigational exemption for a new drug" or any other labeling of the drug disseminated within the United States by or on behalf of the sponsor fails to contain an accurate description of prior investigations or experience and their results pertinent to the safety and possible usefulness of the drug, including all relevant hazards, contraindications, side-effects, and precautions; or any promotional material disseminated within the United States by or on behalf of the sponsor contains any representation or suggestion that the drug is safe or that its usefulness has been established for the purposes for which it is offered for investigations; or

(10) The sponsor fails to submit accurate reports of the progress of the investigations with significant findings at intervals not exceeding 1 year; or

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* March 17, 1971; 36 F.R. 5037

* cessive reviews as they are performed. Copies of all documents are to be retained for a period of 3 years past the completion or discontinuance of the study and are to be made available upon request to duly authorized representatives of the Food and Drug Administration. (Favorable recommendations by the committee are subject to further appropriate review and rejection by institution officials. Unfavorable recommendations, restrictions, or conditions may not be overruled by the institution officials.) Procedures for the organization and operation of institutional review committees are contained in guidelines issued pursuant to Chapter 140 of the Grants Administration Manual of the U.S. Department of Health, Education, and Welfare, available from the U.S. Government Printing Office. It is recommended that these guidelines be followed in establishing institutional review committees and that the committees function according to the procedures described therein. A signing of the Form FD-1572 will be regarded as providing the above necessary assurance; however, if the institution has on file with the Department of Health, Education, and Welfare, Division of Research Grants, National Institutes of Health, an "accepted general assurance," and the same committee is to review the proposed study using the same procedures, this is acceptable in lieu of the above assurances and a statement to this effect should be provided with the signed FD-1572. (In addition to sponsor's continuing responsibility to monitor the study, the Food and Drug Administration will undertake investigations in institutions periodically to determine whether the committees are operating in accord with the assurances given by the sponsor.) *

4. The estimated duration of the project, and the maximum number of subjects that will be involved.

* 5. A general outline of the project to be undertaken (modification is permitted on the basis of experience gained, without advance submission of amendments to the general outline, but with the approval of the review committee and upon notification of the sponsor). *

6. The undersigned understands that the following conditions generally applicable to new drugs for investigational use govern his receipt and use of this investigational drug:

a. The sponsor is required to supply the investigator with full information concerning the preclinical investigation that justifies clinical pharmacology.

b. The investigator is required to maintain adequate records of the disposition of all receipts of the drug, including dates, quantity, and use by subjects, and if the clinical pharmacology is suspended or terminated to return to the sponsor any unused supply of the drug.

c. The investigator is required to prepare and maintain adequate case histories designed to record all observations and other data pertinent to the clinical pharmacology.

d. The investigator is required to furnish his reports to the sponsor who is responsible for collecting and evaluating the results, and presenting progress reports to the Food and Drug Administration at appropriate intervals, not exceeding 1 year. Any adverse effect which may reasonably be regarded as caused by, or is probably caused by, the new drug shall be reported to the sponsor promptly; and if the adverse effect is alarming it shall be reported immediately. An adequate report of the clinical pharmacology should be furnished to the sponsor shortly after completion.

e. The investigator shall maintain the records of disposition of the drug and the case reports described above for a period of 2 years following the date the new-drug application is approved for the drug; or if no application is to be filed or is approved until 2 years after the investigation is discontinued and the Food and Drug Administration so notified. Upon the request of a scientifically trained and specifically authorized employee of the Department, at reasonable times, the investigator will make such records available for inspection and copying. The names of the subjects need not be divulged unless the records of the particular subjects require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual studies or do not represent actual results obtained.

f. The investigator certifies that the drug will be administered only to subjects under his personal supervision or under the supervision of the following investigators responsible to him, _____, and that the drug will not be supplied to any other investigator or to any clinic for administration to subjects.

g. The investigator certifies that he will inform any patients or any persons used as controls, or their representatives, that drugs are being used for investigational purposes, and will obtain the consent of the subjects, or their representatives, except where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects.

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* March 17, 1971; 36 F.R. 5037

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h. The investigator is required to assure the sponsor that for investigations involving institutionalized subjects the studies will not be initiated until the institutional review committee has reviewed and approved the study. (The organization and procedure requirements for such a committee should be explained to the investigator by the sponsor as set forth in Form FD-1571, division 10, unit c.)

Very truly yours,

_____
(Name of investigator)

_____
(Address)

_____

(13) The sponsor shall obtain from each investigator involved in clinical trials a signed statement in the following form:

Form FD 1573

Department of Health, Education, and Welfare, Food and Drug Administration

Statement of Investigator

Name of investigator _____
Date _____
Name of drug _____
To supplier of drug:
Name _____
Address _____

Dear Sir:

The undersigned, _____, submits this statement as required by section 505(i) of the Federal Food, Drug, and Cosmetic Act and § 130.3 of Title 21 of the Code of Federal Regulations as a condition for receiving and conducting clinical investigations with a new drug limited by Federal (or United States) law to investigational use.

1. The following is a statement of my education and experience:

a. Colleges, universities, and medical or other professional schools attended, with dates of attendance, degrees, and dates degrees were awarded.

b. Postgraduate medical or other professional training: Dates, names of institutions, and nature of training.

c. Teaching or research experience: Dates, institutions, brief description of experience.

d. Experience in medical practice or other professional experience: Dates, institutional affiliations, nature of practice, or other professional experience.

e. Representative list of pertinent medical or other scientific publications: Titles of articles, names of publications and volume, page number, and date.

(If this information has previously been submitted to the sponsor, it may be referred to and any additions made to bring it up to date.)

* 2a. If the investigation is to be conducted on institutionalized subjects or is conducted by an individual affiliated with an institution which agrees to assume responsibility for the study, assurance must be given that an institutional review committee is responsible for initial and continuing review and approval of the proposed clinical study. The membership must be comprised of sufficient members of varying background, that is, lawyers, clergymen, or laymen as well as scientists, to assure complete and adequate review of the research project. The membership must possess not only broad competence to comprehend the nature of the project, but also other competencies necessary to judge the acceptability of the project or activity in terms of institutional regulations, relevant law, standards of professional practice and community acceptance. Assurance must be presented that the investigator has not participated in the selection of committee members; that the review committee does not allow participation in its review and conclusions by any individual involved in the conduct of the research activity under review (except to provide information to the committee) that the investigator will report to the committee for review any emergent problems, serious adverse reactions, or proposed procedural changes which may affect the status of the investigation and that no such change will be made without committee approval except where necessary to eliminate apparent immediate hazards; that reviews of the study will be conducted by the review committee at intervals appropriate to the degree of risk, but not exceeding 1 year, to assure that the research project is being conducted in compliance with the committee's understanding and recommendations; that the review committee is provided all the information on the research project necessary for its complete review of the project; and that the review committee maintains adequate documentation of its activities and develops adequate procedures for reporting its findings to the institution. The documents maintained by the committee are to include the names and qualifications of committee members, records of information provided to subjects in obtaining informed consent, committee discussion on substantive issues and their resolution, committee recommendations, and dated reports of successive reviews as they are performed. Copies of all documents are to be retained for a period of 3 years past the completion or discontinuance of the study and are to be made available upon request to duly authorized representatives of the Food and Drug Administration. (Favorable recommendations by the committee are subject to further appropriate review and rejection by institution officials. Unfavorable recommendations, restrictions, or conditions may not be overruled by the institution officials.) Procedures for the organization and operation of institutional review committees are contained in guidelines issued pursuant to Chapter 140 of the Grants Administration Manual of the U.S. Department of Health, Education, and Welfare, available from the U.S. Government Printing Office. It is recommended that these guidelines be followed in establishing institutional review committees and that the committees function according to the procedures described therein. A signing of the Form FD-1573 will be regarded as providing the above necessary assurances; however, if the institution has on file with the Department of Health, Education, and Welfare, Division of Research Grants, National Institutes of Health, and "accepted general assurance," and the same committee is to review the proposed study using the same procedures, this is acceptable in lieu of the above assurances and a statement to this effect should be provided with the signed FD-1573. (In addition to sponsor's continuing responsibility to monitor the study, the Food and Drug Administration will undertake investigations in institutions periodically to determine whether the committees are operating in accord with the assurances given by the sponsor.) *

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* b. A description of any clinical laboratory facilities that will be used. (If this information has been submitted to the sponsor and reported by him on Form FD-1571, reference to the previous submission will be adequate). *

3. The investigational drug will be used by the undersigned or under his supervision in accordance with the plan of investigation described, as follows: (Outline the plan of investigation, including approximation of the number of subjects to be treated with the drug and the number to be employed as controls, if any; clinical uses to be investigated; characteristics of subjects by age, sex, and condition; the kind of clinical observations and laboratory tests to be undertaken prior to, during, and after administration of the drug; the estimated duration of the investigation; and a description or copies of report forms to be used to maintain an adequate record of the observations and tests results obtained. This plan may include reasonable alternates and variations, and should be supplemented or amended when any significant change in direction or scope of the investigation is undertaken.)

4. The undersigned understands that the following conditions, generally applicable to new drugs for investigational use, govern his receipt and use of this investigational drug:

a. The sponsor is required to supply the investigator with full information concerning the preclinical investigations that justify clinical trials, together with fully informative material describing any prior investigations and experience and any possible hazards, contraindications, side-effects, and precautions to be taken into account in the course of the investigation.

b. The investigator is required to maintain adequate records of the disposition of all receipts of the drug, including dates, quantities, and use by subjects, and if the investigation is terminated to return to the sponsor any unused supply of the drug.

c. The investigator is required to prepare and maintain adequate and accurate case histories designed to record all observations and other data pertinent to the investigation on each individual treated with the drug or employed as a control in the investigation.

d. The investigator is required to furnish his reports to the sponsor of the drug who is responsible for collecting and evaluating the results obtained by various investigators. The sponsor is required to present progress reports to the Food and Drug Administration at appropriate intervals not exceeding 1 year. Any adverse effect that may reasonably be regarded as caused by, or probably caused by, the new drug shall be reported to the sponsor promptly, and if the adverse effect is alarming, it shall be reported immediately. An adequate report of the investigation should be furnished to the sponsor shortly after completion of the investigation.

e. The investigator shall maintain the records of disposition of the drug and the case histories described above for a period of 2 years following the date a new-drug application is approved for the drug; or if the application is not approved, until 2 years after the investigation is discontinued. Upon the request of a scientifically trained and properly authorized employee of the Department, at reasonable times, the investigator will make such records available for inspection and copying. The subjects' names need not be divulged unless the records of particular individuals require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual cases studied, or do not represent actual results obtained.

f. The investigator certifies that the drug will be administered only to subjects under his personal supervision or under the supervision of the following investigators responsible to him, ----------, and that the drug will not be supplied to any other investigator or to any clinic for administration to subjects.

g. The investigator certifies that he will inform any subjects, including subjects used as controls, or their representatives, that drugs are being used for investigational purposes, and will obtain the consent of the subjects, or their representatives, except where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects.

* h. The investigator is required to assure the sponsor that for investigations involving institutionalized subjects, the studies will not be initiated until the institutional review committee has reviewed and approved the study. (The organization and procedure requirements for such a committee should be explained to the investigator by the sponsor as set forth in form FD-1571, division 10, unit c.) *

Very truly yours,

(Name of investigator)

(Address)

(This form should be supplemented or amended from time to time if new subjects are added or if significant changes are made in the plan of investigation.)

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* August 14, 1970; 35 F.R. 12891

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(b) A shipment or other delivery of a new drug that is being imported or is offered for importation into the United States shall be exempt from the requirements of section 505(a) of the act if the following conditions are complied with:

(1) The label of such drug bears the statement "Caution: New drug—Limited by Federal (or United States) law to investigational use"; and

(2) The importer of all such shipments or deliveries is an agent of the foreign exporter residing in the United States or the ultimate consignee, which person has prior to such shipments and deliveries completed and submitted signed copies to the Food and Drug Administration of the "Notice of claimed investigational exemption for a new drug"; and acts as the sponsor of the clinical investigation to assure compliance with the conditions prescribed by paragraph (a) of this section; or

(3) The drug is shipped directly to a scientific institution with adequate facilities and qualified personnel to conduct clinical pharmacology and is intended solely for such use in such institutions and a "Notice of claimed investigational exemption for a new drug" covering this activity has been filed.

(4) Not less than 30 days have elapsed following the date of receipt of the notice by the Food and Drug Administration; and the Food and Drug Administration has not, prior to expiration of such 30-day interval, requested that the sponsor continue to withhold or to restrict use of the drug in human subjects. The 30-day delay requirement may be waived by the Food and Drug Administration upon a showing of good reason for such waiver.

(c) (1) Whenever the Food and Drug Administration has information indicating that an investigator has repeatedly or deliberately failed to comply with the conditions of these exempting regulations outlined in Form FD-1572 or FD-1573 (set forth in paragraph (a) (12) and (13) of this section), or has submitted to the sponsor of the investigation false information in his Form FD-1572 or FD-1573 or in any required report, the Director of the Bureau of Medicine will furnish the investigator written notice of the matter complained of in general terms and offer him an opportunity to explain the matter in an informal conference and/or in writing. If an explanation is offered but not accepted by the Bureau of Medicine, the Commissioner will provide the investigator an opportunity for an informal hearing on the question of whether the investigator is entitled to receive investigational-use drugs, if the hearing is requested within 10 days after receipt of notification that the explanation is not acceptable.

(2) After evaluating all available information, including any explanation and assurance presented by the investigator, if the Commissioner determines that the investigator has repeatedly or deliberately failed to comply with the conditions of the exempting regulations in this section or has repeatedly or deliberately submitted false information to the sponsor of an investigation and has failed to furnish adequate assurance that the conditions of the exemption will be met, the Commissioner will notify the investigator and the sponsor of any investigation in which he has been named as a participant that the investigator is not entitled to receive investigational-use drugs with a statement of the basis for such determination.

(3) Each "Notice of Claimed Investigational Exemption for a New Drug" (Form FD-1571 set forth in paragraph (a)(2) of this section) and each approved new-drug application containing data reported by an investigator who has been determined to be ineligible to receive investigational-use drugs will be examined to determine whether he has submitted unreliable data that are essential to the continuation of the investigation or essential to the approval of any new-drug application.

(4) If the Commissioner determines after the unreliable data submitted by the investigator are eliminated from consideration that the data remaining are inadequate to support a conclusion that it is reasonably safe to continue the investigation, he will notify the sponsor and provide him with an opportunity for a conference and an informal hearing in accordance with paragraph (d) of this section. If an imminent hazard to the public health exists, however, he shall terminate the exemption forthwith and notify the sponsor of the termination. In such event the Commissioner, on request, will afford the sponsor an opportunity for an informal hearing on the question of whether the exemption should be reinstated.

(5) If the Commissioner determines after the unreliable data submitted by the investigator are eliminated from consideration that the data remaining are such that a new-drug application would not have been approved, he will proceed to withdraw approval of the application in accordance with section 505(e) of the act.

(6) An investigator who has been determined to be ineligible may be reinstated as eligible to receive investigational-use drugs when the Commissioner determines that he has presented adequate assurance that he will employ such drugs solely in compliance with the exempting regulations in this section for investigational-use drugs.

(d) If the Commissioner of Food and Drugs finds that:

(1) The submitted "Notice of claimed investigational exemption for a new drug" contains an untrue statement of a material fact or omits material information required by said notice; or

(2) The results of prior investigations made with the drug are inadequate to support a conclusion that it is reasonably safe to initiate or continue the intended clinical investigations with the drug; or

(3) There is substantial evidence to show that the drug is unsafe for the purposes and in the manner for which it is offered for investigational use; or

(4) There is convincing evidence that the drug is ineffective for the purposes for which it is offered for investigational use; or

(5) The methods, facilities, and controls used for the manufacturing, processing, and packing of the investigational drug are inadequate to establish and maintain appropriate standards of identity, strength, quality, and purity as needed for safety and to give significance to clinical investigations made with the drug; or

(6) The plan for clinical investigations of the drugs described under section 10 of the "Notice of claimed investigational exemption for a new drug" is not a reasonable plan in whole or in part, solely for a bona fide scientific investigation to determine whether or not the drug is safe and effective for use; or

(7) The clinical investigations are not being conducted in accordance with the plan submitted in the "Notice of claimed investigational exemption for a new drug"; or

(8) The drug is not intended solely for investigational use, since it is being or is to be sold or otherwise distributed for commercial purposes not justified by the requirements of the investigation; or

(9) The labeling or other informational material submitted for the drug as required by section 7 of the "Notice of claimed investigational exemption for a new drug" or any other labeling of the drug disseminated within the United States by or on behalf of the sponsor fails to contain an accurate description of prior investigations or experience and their results pertinent to the safety and possible usefulness of the drug, including all relevant hazards, contraindications, side-effects, and precautions; or any promotional material disseminated within the United States by or on behalf of the sponsor contains any representation or suggestion that the drug is safe or that its usefulness has been established for the purposes for which it is offered for investigations; or

(10) The sponsor fails to submit accurate reports of the progress of the investigations with significant findings at intervals not exceeding 1 year; or

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* August 14, 1970; 35 F.R. 12891

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(11) The sponsor fails promptly to investigate and inform the Food and Drug Administration and all investigators of newly found serious or potentially serious hazards, contraindications, side-effects, and precautions pertinent to the safety of the new drug;

he shall notify the sponsor and invite his immediate correction or explanation. A conference will be arranged with the Bureau of Medicine if requested. If the Bureau of Medicine does not accept the explanation and/or the correction submitted by the sponsor, the Commissioner will provide the sponsor an opportunity for an informal hearing on the question of whether his exemption should be terminated, if the hearing is requested within 10 days after receipt of notification that the explanation or correction is not acceptable. After evaluating all the available information including any explanation and/or correction submitted by the sponsor, if the Commissioner determines that the exemption should be terminated he shall notify the sponsor of the termination of the exemption and the sponsor shall recall unused supplies of the drug. If at any time the Commissioner concludes that continuation of the investigation presents an imminent hazard to the public health, he shall terminate the exemption forthwith and notify the sponsor of the termination. The Commissioner will inform the sponsor that the exemption is subject to reinstatement on the basis of additional submissions that eliminate such hazard(s) and will afford the sponsor an opportunity for an informal hearing, on request, on the question of whether the exemption should be reinstated. The sponsor shall recall the unused supplies of the drug upon notification of the termination.

(e) Where drugs were under clinical trial on man on or after August 10, 1962, the sponsor shall, within 30 days after these regulations become effective, submit a list of such investigational drugs, and within 120 days after such effective date shall submit to the Food and Drug Administration the completed "Notice of claimed investigational exemption for a new drug" or a new-drug application. Failure to do so shall automatically terminate the exemption. If any such clinical trials have been discontinued, the sponsor is requested to submit a statement of why the investigation was discontinued.

(f) [Reserved]

*(g) A "Notice of Claimed Investigational Exemption for a New Drug" which pertains to a product subject to the licensing provisions of the Public Health Service Act of July 1, 1944 (58 Stat. 682, as amended; 42 U.S.C. 201 et seq.), should be submitted initially to the Division of Biologics Standards, National Institutes of Health, Public Health Service, rather than to the Commissioner of Food and Drugs. Also, amendments of or supplements to such notice, and progress reports, consultations, or other communications with regard to the investigation, should be directed to the Division of Biologics Standards, which monitors the development of biological products subject to license under section 351 of the Public Health Service Act. A sponsor for a "Notice of Claimed Investigational Exemption for a New Drug" pertaining to such biologic should substitute in reading this § 130.3 the unit "Division of Biologics Standards" for "Food and Drug Administration" and the person "Director, Division of Biologics Standards" for "Commissioner" or "Commissioner, Food and Drug Administration," wherever they appear. *

(h) Any requirement by this section for the submission of information or data that has been submitted previously may be incorporated by reference.

NOTE: Order of the Commissioner of Food and Drugs published at 28 F.R. 183, Jan. 8, 1963, provides as follows:

"That, § 130.3 (28 F.R. 179) shall not apply to radioactive new drugs, until further notice, provided the radioactive new drugs for investigational use are being shipped in complete conformity with the regulations issued by the Atomic Energy Commission."

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* March 24, 1966; 31 F.R. 4891 Insert this new page in your reprint.

*** § 130.3a New drugs for investigational use in animals; exemptions from section 505(a).**

(a) *New drugs for tests in vitro and in laboratory research animals.* (1) A shipment or other delivery of a new drug intended solely for tests in vitro or in animals used only for laboratory research purposes shall be exempt from section 505(a) of the act if it is labeled as follows:

Caution—Contains a new drug for investigational use only in laboratory research animals, or for tests in vitro. Not for use in humans.

(2) The person or firm shipping new drugs for tests in vitro or in animals used only for laboratory research purposes under this exemption shall use due diligence to assure that the consignee is regularly engaged in conducting such tests and that the shipment of the new drug will actually be used for tests in vitro or in animals used only for laboratory research.

(3) The person who introduced such shipment or who delivered the drug for introduction into interstate commerce shall maintain adequate records showing the name and post office address of the expert to whom the drug is shipped, date, quantity, and batch or code mark of each shipment and delivery for a period of 2 years after such shipment and delivery. Upon the request of a properly authorized employee of the Department at reasonable times, he shall make such records available for inspection and copying.

(4) The exemption allowed in this paragraph shall not apply to any new drug intended for in vitro use in the regular course of diagnosing or treating disease, including antibacterial sensitivity discs impregnated with any new drug or drugs, which discs are intended for use in determining susceptibility of micro-organisms to the new drug or drugs.

(b) *New drugs for clinical investigation in animals.* A shipment or other delivery of a new drug intended for clinical investigational use in animals shall be exempt from section 505(a) of the act if all the following conditions are met:

(1) The label shall bear the statements:

Caution—Contains a new drug for use only in investigational animals in clinical trials. Not for use in humans.

Edible products of investigational animals are not to be used for food unless authorization has been granted by the U.S. Food and Drug Administration or by the U.S. Department of Agriculture.

In the case of containers too small or otherwise unable to accommodate a label with sufficient space to bear the caution statements required by paragraphs (a) or (b) of this section, the statements may be included on the carton label and other labeling on or within the package from which the drug is to be dispensed.

(2) The person or firm shipping the new drug shall use due diligence to assure that the drug will actually be used for tests in animals and not in humans.

(3) The person who introduced such shipment or who delivered the drug for introduction into interstate commerce shall maintain adequate records showing the name and post office address of the investigator to whom the drug is shipped, date, quantity, and batch or code mark of each shipment and delivery for a period of 2 years after such shipment and delivery. Upon the request of a properly authorized employee of the Department at reasonable times such records shall be made available for inspection and copying.

(4) Prior to the shipment of the drug for clinical tests in animals, the sponsor of the investigation shall submit in triplicate to the Food and Drug Administration a signed statement containing the following information:

(i) The identity of the drug.

(ii) All labeling and other pertinent information to be supplied to the investigators.

(iii) The name and address of each clinical investigator.

(iv) The approximate number of animals to be treated (or if not available, the amount of drug to be shipped).

(v) If the drug is given to food-producing animals, the statement or a supplemental statement shall contain the following additional information:

(a) A commitment that the edible products from such animals shall not be used for food without prior authorization in accordance with § 121.75 of this chapter.

(b) Approximate dates of the beginning and end of the experiment or series of experiments.

(c) The maximum daily dose(s) to be administered to a given species, the size of animal, maximum duration of administration, method(s) of administration, and proposed withdrawal time, if any.

(5) Authorization for use of edible products derived from a treated food-producing animal may be granted under the provisions of this section and § 121.75 of this chapter when the following specified conditions are met, except that in the case of an animal administered any unlicensed experimental veterinary biological product regulated under the viruses, serums, toxins statute (21 U.S.C., Chapter V, sec. 151 et seq.) the product shall be exempt from the requirements of this section and § 121.75 when U.S. Department of Agriculture approval has been obtained as provided in § 103.2 of Title 9, Code of Federal Regulations. Conditional authorization may be *

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* granted in advance of identification of the name(s) and address(es) of the clinical investigator(s) as required by subparagraph (4)(iii) of this paragraph. Information required for authorization shall include, in addition to all other requirements of this section, the following:

(i) Data to show that consumption of food derived from animals treated at the maximum levels with the minimum withdrawal periods, if any, specified in accordance with subparagraph (4)(v)(c) of this paragraph, will not be inconsistent with the public health; or

(ii) Data to show that food derived from animals treated at the maximum levels and with the minimum withdrawal periods, if any, specified in accordance with subparagraph (4)(v)(c) of this paragraph, does not contain drug residues or metabolites.

(iii) The name and location of the packing plant where the animals will be processed, except that this requirement may be waived, on request, by the terms of the authorization.

Authorizations granted under this subparagraph do not exempt investigational animals and their products from compliance with other applicable inspection requirements.

(6) On written request of the Food and Drug Administration, the sponsor shall submit any additional information in his possession with respect to the investigation deemed necessary to facilitate a determination of whether there are grounds in the interest of public health for terminating the exemption.

(7) The sponsor shall assure himself that the drug is shipped only to investigators who:

(i) Are qualified by scientific training and/or experience to evaluate the safety and/or effectiveness of the drug.

(ii) Shall maintain complete records of the investigations.

(iii) Shall furnish adequate and timely reports of the investigation to the sponsor.

(8) The sponsor:

(i) Shall retain all reports received from investigators for 2 years after the termination of the investigation or approval of a new-drug application and make such reports available to a duly authorized employee of the Department for inspection at all reasonable times.

(ii) Shall provide for current monitoring of the investigation by a person qualified by scientific training and experience to evaluate information obtained from the investigation, and shall promptly investigate and report to the Food and Drug Administration and to all investigators any findings, associated with use of the drug that may suggest significant hazards pertinent to the safety of the drug.

(iii) Shall not unduly prolong distribution of the drug for investigational use.

(iv) Shall not, nor shall any person acting for or on behalf of the sponsor, represent that the drug is safe or effective for the purposes for which it is under investigation. This requirement is not intended to restrict the full exchange of scientific information.

(v) Shall not commercially distribute nor test-market the drug until a new-drug application is approved pursuant to section 505(c) of the act.

(9) If the shipment or other delivery of the new drug is imported or offered for importation into the United States for clinical investigational use in animals, it shall also meet the following conditions:

(i) The importer of all such shipments or deliveries is an agent of the foreign exporter residing in the United States or the ultimate consignee, which person has, prior to such shipments and deliveries, informed the Food and Drug Administration of his intention to import the new drug as sponsor in compliance with the conditions prescribed in this subdivision; or

(ii) The drug is shipped directly to a scientific institution with adequate facilities and qualified personnel to conduct laboratory or clinical investigations and is intended solely for use in such institutions and which institution has submitted a statement as sponsor of the investigation.

(10) Where drugs were under clinical trial on or after the effective date of this section, the sponsor shall, within 120 days after such effective date, submit to the Food and Drug Administration the signed statement described in subparagraph (4) of this paragraph or a statement explaining why the investigation has been discontinued.

(c) *Termination of exemption.* If the Commissioner of Food and Drugs finds that:

(1) The sponsor of the investigation has failed to comply with any of the conditions for the exemption established under this section; or

(2) The continuance of the investigation is unsafe or otherwise contrary to the public interest or the drug is used for purposes other than bona fide scientific investigation; He shall notify the sponsor and invite his immediate correction. A conference will be arranged if requested. If the conditions of the exemption are not immediately met, the Commissioner shall notify the sponsor of the termination of the exemption and the sponsor shall recall or have destroyed the unused supplies of the drug.

(d) *Statements and requests.* Statements of clinical investigations and requests for authorization to use investigational animals and their products for food should be addressed to the Food and Drug Administration, Bureau of Veterinary Medicine, Washington, D.C., 20204. *

Amendment published in Federal Register: * March 24, 1966; 31 F.R. 4891
PART 130--NEW DRUG REGULATIONS--
Insert this new page in your reprint.

(For convenience, this reprint of § 121.75 is appended to the reprint of § 130.3a)

§ 121.75 Exemption for investigational use and procedure for obtaining authorization to market edible products from experimental animals.

A food additive, including one that is a new drug or antibiotic, or foods containing such a food additive, intended for investigational use by qualified experts shall be exempt from the requirements of section 409 of the act under the following conditions:

(a) If intended for investigational use in vitro or with laboratory research animals, it bears a label which states prominently, in addition to other information required by the act:

Caution—Contains a new food additive (or new drug, or antibiotic) for investigational use only in laboratory research animals, or for tests in vitro. Not for use in humans.

(b) If intended for clinical investigational use in animals other than laboratory research animals, and the edible products of the animals are to be marketed as food, permission for the marketing of the edible products as food has been requested by the sponsor, and authorization has been granted by the Food and Drug Administration in accordance with §130.3a of this chapter, or by the Department of Agriculture in accordance with § 309.20 of Title 9, Code of Federal Regulations, and it bears a label which states prominently, in addition to other information required by the act, the following:

Caution—Contains a new food additive (or new drug, or antibiotic) for use only in investigational animals in clinical trials. Not for use in humans.

Edible products of investigational animals are not to be used for food unless authorization has been granted by the U.S. Food and Drug Administration or by the U.S. Department of Agriculture.

(§ 130.44)

Amendment published in Federal Register: PART 130--NEW DRUG REGULATIONS--Page 22.12
* April 2, 1971; 36 F.R. 6075 Insert this new page in your reprint.

*

§ 130.44 Conditions for investigational use of methadone for maintenance programs for narcotic addicts.

(a) There is widespread interest in the use of methadone for the maintenance treatment of narcotic addicts. Though methadone is a marketed drug approved through the new-drug procedures for specific indications, its use in the maintenance treatment of narcotic addicts is an investigational use for which substantial evidence of long-term safety and effectiveness is not yet available under the Federal Food, Drug, and Cosmetic Act standards for the general marketability of new drugs. In addition, methadone is a controlled narcotic subject to the provisions of the Harrison Narcotic Act and has been shown to have significant potential for abuse. In order to assure that the public interest is adequately protected, and in view of the uniqueness of this method of treatment, it is necessary that a methadone maintenance program be closely monitored to prevent diversion of the drug into illicit channels and to assure the development of scientifically useful data. Accordingly, the Food and Drug Administration and the Bureau of Narcotic and Dangerous Drugs conclude that prior to the use of methadone in the maintenance treatment of narcotic addicts, advance approval of both agencies is required. The approval will be based on a review of a Notice of Claimed Investigational Exemption for a New Drug submitted to the Food and Drug Administration and reviewed concurrently by the Food and Drug Administration for scientific merit and by the Bureau of Narcotics and Dangerous Drugs for drug control requirements.

(b) No person may sell, deliver, or otherwise dispose of methadone for use in the maintenance treatment of narcotic addicts until a study providing for such use has had the advance approval of the Commissioner of Food and Drugs on the basis of a Notice of Claimed Investigational Exemption for a New Drug justifying such studies.

(c) An abbreviated Notice of Claimed Investigational Exemption for a New Drug shall be submitted in four copies to the U.S. Food and Drug Administration, 5600 Fishers Lane, Rockville, Md. 20852. Forms entitled "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotic Addicts," suitable for such a submission may be obtained from the above address. The submission should be signed by the person in charge of the maintenance program who will be regarded as the responsible party and sponsor for the exemption. (If the sponsor is a manufacturer or distributor of the drug, the regulations as outlined in § 130.3 should be followed, except where the guidelines set forth below in this section are appropriate.) The notice shall contain the following: *

Amendment published in Federal Register: \pril 2, 1971; 36 F.R. 6075

Insert this new page in your reprint.

* (1) Name of sponsor, address, and date and the name of the investigational drug, which is methadone.

(2) A description of the form in which the drug is purchased (for example, bulk powder or tablet or other oral dosage form), the name and address of the manufacturer or supplier, and a statement that the drug meets the requirements of the United States Pharmacopeia or the National Formulary if recognized therein. If it is in an oral form designed to minimize its potential for abuse, and is not recognized in the U.S.P. or N.F., assurance that the drug meets adequate specifications for its intended use should be provided. This information may be obtained from the manufacturer. If bulk powder is used, a statement detailing how it is to be formulated, the name and qualifications of the person formulating the dosage form, and the address of where the formulating will take place if it is to take place at any location other than the principal address of the sponsor.

(3) The name, address, and a summary of the scientific training and experience of each investigator, and all other professional personnel having major responsibility in the research and rehabilitative effort, and individuals charged with monitoring the progress of the investigation and evaluating the safety and effectiveness of the drug if the monitor is other than a physician-sponsor. An investigator, other than a physician-sponsor (and investigators immediately responsible to a physician-sponsor and named in his submission) who has signed a form FD-1571 or the form entitled "Notice of Claimed Investigational Exemption for Methadone for Use in Maintenance Treatment of Narcotic Addicts," is required to sign a form FD-1573, obtainable from the Food and Drug Administration.

(4) A description of the facilities available to the sponsor to perform the required tests including the name of any hospital, institution, or clinical laboratory facility to be employed in connection with the investigation.

(5) A statement regarding the number of subjects to be included in the program.

(6) A statement of the protocol. The following is an acceptable protocol; however, it is not to be construed that this protocol must be adhered to in order to obtain clearance by the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs. This protocol is intended primarily as a guide for investigators who wish guidance in what said agencies consider acceptable. Investigators who wish to do so may submit modifications of this protocol or other protocols; these will be judged on their merits. *

(§ 130.44)

Amendment published in Federal Register: PART 130--NEW DRUG REGULATIONS--Page 22.14
* April 2, 1971; 36 F.R. 6075 Insert this new page in your reprint.

* PROTOCOL

A. *Objectives.* 1. To evaluate the safety of long term methadone administration at varying dosage.

2. To evaluate the efficacy of oral methadone per se in decreasing the craving for other narcotic drugs and in minimizing their euphoriant effect.

3. To evaluate the efficacy of methadone as a pharmacological moiety in facilitating social rehabilitation of narcotic addicts.

4. To determine which addicts are capable of returning to an enduring drug-free state.

B. *Admission criteria.* 1. Documented history of physiological dependence on one or more opiate drugs, the duration of which is to be stated.

2. Confirmed history of one or more failures of treatment for their physiological dependence on opiates.

3. Evidence of current physiological dependence on opiates.

An exception to the third criterion (current physiological dependence on opiates) is allowable in exceptional circumstances for certain subjects for whom methadone maintenance may be initiated a short time prior to or upon release from an institution. This procedure should be justified on the basis of a history of previous relapses. In these circumstances, appropriate descriptions of the facilities, procedures, and qualifications of the personnel of the institution are to be included in the application filed by the sponsor.

Subjects who wish to do so may be transferred from one approved program to another.

C. *Patients requiring special consideration*—1. *Pregnant patients.* Safe use of methadone in pregnancy has not been established. There is limited documented clinical experience with pregnant patients treated with methadone, and animal reproduction studies have not been done. It is therefore preferable that pregnant patients be hospitalized and withdrawn from narcotics. If such a course is not feasible, pregnant patients may be included provided the patient is informed of the possible hazard. To minimize the risk of physiological dependence of the new born, or other complications, pregnant women should be maintained on minimal dosage. The investigator should promptly report to the Food and Drug Administration the condition of each infant born to a mother in a methadone maintenance program.

2. *Patients with serious physical illness.* Patients with serious concomitant physical illness are to be included in methadone maintenance program only when comprehensive medical care is available. Such patients require careful observation for any adverse effects of methadone and interactions with other medications. The investigator should promptly report adverse effects and evidence of interactions to the Food and Drug Administration.

3. *Psychotic patients.* Psychotic patients may be included in methadone maintenance programs when adequate psychiatric consultation and care is available. Administration of concomitant psychotropic agents requires careful observation for possible drug interaction. Such occurrences should be promptly reported.

Investigators who intend to include in their programs patients in categories 1, 2, and/or 3 above should so state in their protocols and should give assurance of appropriate precautions.

4. *Patients less than 18 years of age.* It is imperative that adolescents be afforded the benefit of other treatment modalities whenever possible and that those with minimal histories of physiological dependence be excluded from methadone maintenance programs. Investigators who wish to include adolescents in the program are therefore required to submit special protocols for this purpose. These protocols should state in detail the number of such patients to be treated, the alternative treatment methods available, the criteria for selection, the screening procedures, and the ancillary procedures to be employed.

D. *Admission evaluation.* 1. Recorded history to include age, sex, history of arrests and convictions, educational level, employment history, and past and present history of drug abuse of all types.

2. Medical history of significant illnesses.

3. History of prior psychiatric evaluation and/or treatment.

4. Assessment of the degree of physical dependence on and psychic craving for narcotics and other drugs, and evaluation of the attitudes toward and motivations for participation in the program.

5. Formal psychiatric examination in subjects with a prior history of psychiatric treatment and in those in whom there is a question of psychosis and/or competence to give informed consent.

6. Physical examination.

7. Chest X-ray.

8. Laboratory examinations to include complete blood count, routine urinalysis, liver function studies (including SGOT, alkaline phosphatase, and total protein and albumin globulin ratio), blood urea nitrogen, and serologic test for syphilis.

E. *Procedure*—1. *Dosage and administration.* The methadone is to be administered in an oral form so formulated as to minimize misuse by parenteral injection. The initial dosage is to be low; for example, 20 milligrams per day. Subsequently, the dosage is to be adjusted individually, as tolerated and as required, up to 160 milligrams per day. In exceptional cases, investigators may find it essential to exceed this dosage to obtain the intended effect. If such cases are encountered, the initial protocol or an amended protocol should include the maximum dosage to be administered, the number of patients for whom such dosage is required, and a description of the considerations leading to such dosage levels. The methadone is to be administered under the close supervision of the investigator or responsible persons designated by him. Initially, the subject is to receive the medication under observation each day. After demonstrating adherence to the program, the subject may be permitted twice weekly observed medication intake with no more than a 3-day supply routinely allowed in his possession. Additional medication may be provided in exceptional circumstances, such as illness, family crisis, or necessary travel, where hardship would result from requiring the customary observed medication intake for the specific period in question.

2. *Urinalysis.* Urine collection is to be supervised; urine specimens are to be analyzed for methadone, morphine, quinine, cocaine, barbiturates, and amphetamines; urine specimens are to be pooled or selected randomly for analysis at intervals not exceeding 1 week.

3. *Rehabilitative measures.* Rehabilitative measures as indicated may include individual and/or group psychotherapy, counseling, vocational guidance, and job and educational placement. *

Amendment published in Federal Register: * April 2, 1971; 36 F.R. 6075

* 4. *Abnormalities.* There shall be adequate investigation and appropriate management (including necessary referral and consultation) of any abnormalities detected on the basis of history, physical examination, or laboratory examination at the time of admission to the program or subsequently, including evaluation and treatment of intercurrent physical illness with observation for complications which might result from methadone.

5. *Repeated examinations.* Physical examination, chest X-ray, and laboratory examinations conducted at the time of admission are to be repeated annually.

6. *Discontinuation and followup.* Consideration is to be given to discontinuing the drug for participants who have maintained satisfactory adjustment over an extended period of time. In such cases, followup evaluation is to be obtained periodically.

7. *Records.* Adequate records are to be kept for each participant on each aspect of the treatment program, including adverse reactions and the treatment thereof.

F. *Other special procedures.* Within the limitations of personnel, facilities, and funding available and in the interest of increasing knowledge of the safety and efficacy of the drug itself, the following procedures are suggested as worthwhile, to be carried out at baseline and periodically in randomly selected subjects: EKG, EEG, measures of respiratory, cardiovascular, and renal function, psychological test battery, and simulated driving performance.

G. *Voluntary and involuntary terminations.* Subjects who have demonstrated continued frequent abuse of narcotics or other drugs, alcoholism, criminal activity, or persistent failure to adhere to the requirements of the program are ordinarily to be terminated and their records should reflect that they are treatment failures. If they are continued indefinitely in the program, the reasons for so doing should be stated in the protocol.

H. *Results.* 1. Evaluation of the safety of the drug administered over prolonged periods of time is to be based on results of physical examination, laboratory examinations, adverse reactions, and results of special procedures when these have been carried out.

2. Evaluation of effectiveness or rehabilitation is to be based on such criteria as:

a. Arrest records.

b. Extent of alcohol abuse.

c. Extent of drug abuse.

d. Occupational adjustment verified by employers or records of earnings.

e. Social adjustment verified whenever possible by family members or other reliable persons.

f. Withdrawal from methadone and achievement of an enduring drug-free status.

3. Evaluations are to be recorded at predetermined intervals; for example, monthly for the first 3 months, at 6 months, and at 6-month intervals thereafter.

I. *Evaluation group.* Whenever possible, a locally oriented independent evaluation committee of professionally trained and qualified persons not directly involved in the project nor organized by the sponsor will inspect facilities, interview personnel and selected patients, and review individuals' records and the periodic analysis of the data.

(d) The sponsor shall assure that adequate and accurate records are kept of all observations and other data pertinent to the investigation on each individual treated. The sponsor shall make the records available for inspection by authorized agents of the Food and Drug Administration. The Bureau of Narcotics and Dangerous Drugs is also authorized to inspect these records under the Harrison Narcotic Act.

(e) The sponsor is required to maintain adequate records showing the dates, quantity, and batch or code marks of the drug used. These records must be retained for the duration of the investigation.

(f) The sponsor shall monitor the progress of the investigations and evaluate the evidence relating to the safety and effectiveness of the drug. Accurate progress reports of the investigation and significant findings shall be submitted to the Food and Drug Administration at intervals not exceeding periods of 1 year. All reports of the investigation shall be retained for the duration of the investigation.

(g) The sponsor shall promptly notify the Food and Drug Administration of any findings associated with the use of the drug that may suggest significant hazards, contraindications, side effects, and precautions pertinent to the safety of the drug.

(h) The physician-sponsor or individual investigators in admitting addicts to the investigational treatment program are required to give to the addict an accurate description of the limitations as well as the possible benefits which the addict may derive from the program.

(i) The physician-sponsor or each individual investigator of this program shall certify that the drug will be used and administered only to subjects under his personal supervision or under the supervision of personnel directly responsible to him; a statement to this effect shall be included in the notice. The signing of the form "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotics Addicts" by a physician-sponsor or the form FD-1573 by an investigator will satisfy this requirement.

(j) The physician-sponsor or each individual investigator shall certify that all participants will be informed that drugs are being used for investigational purposes, and will obtain the informed consent of the subjects and shall include a statement to this effect in the notice. The signing of the forms as indicated in paragraph (i) of this section will satisfy this requirement.

(k) Failure to conform to the protocol for which approval has been received from the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs will be a basis for termination of the claimed investigational exemption.

(l) The sponsor of a "Notice of Claimed Investigational Exemption for a New Drug" already on file with the Food and Drug Administration should review and amend his submission to bring it into accord with the acceptable protocol where appropriate within 60 days after the effective date of this section. All differences in his protocol from the suggested protocol should be justified.

(m) Provisions under the Harrison Narcotic Act enforced by the Department of Justice are applicable to this use of methadone *

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* August 14, 1970; 35 F.R. 12891

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(11) The sponsor fails promptly to investigate and inform the Food and Drug Administration and all investigators of newly found serious or potentially serious hazards, contraindications, side-effects, and precautions pertinent to the safety of the new drug;

he shall notify the sponsor and invite his immediate correction or explanation. A conference will be arranged with the Bureau of Medicine if requested. If the Bureau of Medicine does not accept the explanation and/or the correction submitted by the sponsor, the Commissioner will provide the sponsor an opportunity for an informal hearing on the question of whether his exemption should be terminated, if the hearing is requested within 10 days after receipt of notification that the explanation or correction is not acceptable. After evaluating all the available information including any explanation and/or correction submitted by the sponsor, if the Commissioner determines that the exemption should be terminated he shall notify the sponsor of the termination of the exemption and the sponsor shall recall unused supplies of the drug. If at any time the Commissioner concludes that continuation of the investigation presents an imminent hazard to the public health, he shall terminate the exemption forthwith and notify the sponsor of the termination. The Commissioner will inform the sponsor that the exemption is subject to reinstatement on the basis of additional submissions that eliminate such hazard(s) and will afford the sponsor an opportunity for an informal hearing, on request, on the question of whether the exemption should be reinstated. The sponsor shall recall the unused supplies of the drug upon notification of the termination.

(e) Where drugs were under clinical trial on man on or after August 10, 1962, the sponsor shall, within 30 days after these regulations become effective, submit a list of such investigational drugs, and within 120 days after such effective date shall submit to the Food and Drug Administration the completed "Notice of claimed investigational exemption for a new drug" or a new-drug application. Failure to do so shall automatically terminate the exemption. If any such clinical trials have been discontinued, the sponsor is requested to submit a statement of why the investigation was discontinued.

(f) [Reserved]

*(g) A "Notice of Claimed Investigational Exemption for a New Drug" which pertains to a product subject to the licensing provisions of the Public Health Service Act of July 1, 1944 (58 Stat. 682, as amended; 42 U.S.C. 201 et seq.), should be submitted initially to the Division of Biologics Standards, National Institutes of Health, Public Health Service, rather than to the Commissioner of Food and Drugs. Also, amendments of or supplements to such notice, and progress reports, consultations, or other communications with regard to the investigation, should be directed to the Division of Biologics Standards, which monitors the development of biological products subject to license under section 351 of the Public Health Service Act. A sponsor for a "Notice of Claimed Investigational Exemption for a New Drug" pertaining to such biologic should substitute in reading this § 130.3 the unit "Division of Biologics Standards" for "Food and Drug Administration" and the person "Director, Division of Biologics Standards" for "Commissioner" or "Commissioner, Food and Drug Administration," wherever they appear. *

(h) Any requirement by this section for the submission of information or data that has been submitted previously may be incorporated by reference.

NOTE: Order of the Commissioner of Food and Drugs published at 28 F.R. 183, Jan. 8, 1963, provides as follows:

"That, § 130.3 (28 F.R. 179) shall not apply to radioactive new drugs, until further notice, provided the radioactive new drugs for investigational use are being shipped in complete conformity with the regulations issued by the Atomic Energy Commission."

Amendment published in Federal Register: PART 130—NEW DRUG REGULATIONS—Page 10.1
* March 24, 1966; 31 F.R. 4891 Insert this new page in your reprint.

*** § 130.3a New drugs for investigational use in animals; exemptions from section 505(a).**

(a) *New drugs for tests in vitro and in laboratory research animals.* (1) A shipment or other delivery of a new drug intended solely for tests in vitro or in animals used only for laboratory research purposes shall be exempt from section 505(a) of the act if it is labeled as follows:

Caution—Contains a new drug for investigational use only in laboratory research animals, or for tests in vitro. Not for use in humans.

(2) The person or firm shipping new drugs for tests in vitro or in animals used only for laboratory research purposes under this exemption shall use due diligence to assure that the consignee is regularly engaged in conducting such tests and that the shipment of the new drug will actually be used for tests in vitro or in animals used only for laboratory research.

(3) The person who introduced such shipment or who delivered the drug for introduction into interstate commerce shall maintain adequate records showing the name and post office address of the expert to whom the drug is shipped, date, quantity, and batch or code mark of each shipment and delivery for a period of 2 years after such shipment and delivery. Upon the request of a properly authorized employee of the Department at reasonable times, he shall make such records available for inspection and copying.

(4) The exemption allowed in this paragraph shall not apply to any new drug intended for in vitro use in the regular course of diagnosing or treating disease, including antibacterial sensitivity discs impregnated with any new drug or drugs, which discs are intended for use in determining susceptibility of micro-organisms to the new drug or drugs.

(b) *New drugs for clinical investigation in animals.* A shipment or other delivery of a new drug intended for clinical investigational use in animals shall be exempt from section 505(a) of the act if all the following conditions are met:

(1) The label shall bear the statements:

Caution—Contains a new drug for use only in investigational animals in clinical trials. Not for use in humans.

Edible products of investigational animals are not to be used for food unless authorization has been granted by the U.S. Food and Drug Administration or by the U.S. Department of Agriculture.

In the case of containers too small or otherwise unable to accommodate a label with sufficient space to bear the caution statements required by paragraphs (a) or (b) of this section, the statements may be included on the carton label and other labeling on or within the package from which the drug is to be dispensed.

(2) The person or firm shipping the new drug shall use due diligence to assure that the drug will actually be used for tests in animals and not in humans.

(3) The person who introduced such shipment or who delivered the drug for introduction into interstate commerce shall maintain adequate records showing the name and post office address of the investigator to whom the drug is shipped, date, quantity, and batch or code mark of each shipment and delivery for a period of 2 years after such shipment and delivery. Upon the request of a properly authorized employee of the Department at reasonable times such records shall be made available for inspection and copying.

(4) Prior to the shipment of the drug for clinical tests in animals, the sponsor of the investigation shall submit in triplicate to the Food and Drug Administration a signed statement containing the following information:

(i) The identity of the drug.

(ii) All labeling and other pertinent information to be supplied to the investigators.

(iii) The name and address of each clinical investigator.

(iv) The approximate number of animals to be treated (or if not available, the amount of drug to be shipped).

(v) If the drug is given to food-producing animals, the statement or a supplemental statement shall contain the following additional information:

(a) A commitment that the edible products from such animals shall not be used for food without prior authorization in accordance with § 121.75 of this chapter.

(b) Approximate dates of the beginning and end of the experiment or series of experiments.

(c) The maximum daily dose(s) to be administered to a given species, the size of animal, maximum duration of administration, method(s) of administration, and proposed withdrawal time, if any.

(5) Authorization for use of edible products derived from a treated food-producing animal may be granted under the provisions of this section and § 121.75 of this chapter when the following specified conditions are met, except that in the case of an animal administered any unlicensed experimental veterinary biological product regulated under the viruses, serums, toxins statute (21 U.S.C., Chapter V, sec. 151 et seq.) the product shall be exempt from the requirements of this section and § 121.75 when U.S. Department of Agriculture approval has been obtained as provided in § 103.2 of Title 9, Code of Federal Regulations. Conditional authorization may be *

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★ granted in advance of identification of the name(s) and address(es) of the clinical investigator(s) as required by subparagraph (4)(iii) of this paragraph. Information required for authorization shall include, in addition to all other requirements of this section, the following:

(i) Data to show that consumption of food derived from animals treated at the maximum levels with the minimum withdrawal periods, if any, specified in accordance with subparagraph (4)(v)(c) of this paragraph, will not be inconsistent with the public health; or

(ii) Data to show that food derived from animals treated at the maximum levels and with the minimum withdrawal periods, if any, specified in accordance with subparagraph (4)(v)(c) of this paragraph, does not contain drug residues or metabolites.

(iii) The name and location of the packing plant where the animals will be processed, except that this requirement may be waived, on request, by the terms of the authorization.

Authorizations granted under this subparagraph do not exempt investigational animals and their products from compliance with other applicable inspection requirements.

(6) On written request of the Food and Drug Administration, the sponsor shall submit any additional information in his possession with respect to the investigation deemed necessary to facilitate a determination of whether there are grounds in the interest of public health for terminating the exemption.

(7) The sponsor shall assure himself that the drug is shipped only to investigators who:

(i) Are qualified by scientific training and/or experience to evaluate the safety and/or effectiveness of the drug.

(ii) Shall maintain complete records of the investigations.

(iii) Shall furnish adequate and timely reports of the investigation to the sponsor.

(8) The sponsor:

(i) Shall retain all reports received from investigators for 2 years after the termination of the investigation or approval of a new-drug application and make such reports available to a duly authorized employee of the Department for inspection at all reasonable times.

(ii) Shall provide for current monitoring of the investigation by a person qualified by scientific training and experience to evaluate information obtained from the investigation, and shall promptly investigate and report to the Food and Drug Administration and to all investigators any findings associated with use of the drug that may suggest significant hazards pertinent to the safety of the drug.

(iii) Shall not unduly prolong distribution of the drug for investigational use.

(iv) Shall not, nor shall any person acting for or on behalf of the sponsor, represent that the drug is safe or effective for the purposes for which it is under investigation. This requirement is not intended to restrict the full exchange of scientific information.

(v) Shall not commercially distribute nor test-market the drug until a new-drug application is approved pursuant to section 505(c) of the act.

(9) If the shipment or other delivery of the new drug is imported or offered for importation into the United States for clinical investigational use in animals, it shall also meet the following conditions:

(i) The importer of all such shipments or deliveries is an agent of the foreign exporter residing in the United States or the ultimate consignee, which person has, prior to such shipments and deliveries, informed the Food and Drug Administration of his intention to import the new drug as sponsor in compliance with the conditions prescribed in this subdivision; or

(ii) The drug is shipped directly to a scientific institution with adequate facilities and qualified personnel to conduct laboratory or clinical investigations and is intended solely for use in such institutions and which institution has submitted a statement as sponsor of the investigation.

(10) Where drugs were under clinical trial on or after the effective date of this section, the sponsor shall, within 120 days after such effective date, submit to the Food and Drug Administration the signed statement described in subparagraph (4) of this paragraph or a statement explaining why the investigation has been discontinued.

(c) *Termination of exemption.* If the Commissioner of Food and Drugs finds that:

(1) The sponsor of the investigation has failed to comply with any of the conditions for the exemption established under this section; or

(2) The continuance of the investigation is unsafe or otherwise contrary to the public interest or the drug is used for purposes other than bona fide scientific investigation; He shall notify the sponsor and invite his immediate correction. A conference will be arranged if requested. If the conditions of the exemption are not immediately met, the Commissioner shall notify the sponsor of the termination of the exemption and the sponsor shall recall or have destroyed the unused supplies of the drug.

(d) *Statements and requests.* Statements of clinical investigations and requests for authorization to use investigational animals and their products for food should be addressed to the Food and Drug Administration, Bureau of Veterinary Medicine, Washington, D.C., 20204. ★

Amendment published in Federal Register: PART 130--NEW DRUG REGULATIONS--
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(For convenience, this reprint of § 121.75 is appended to the reprint of § 130.3a)

§ 121.75 Exemption for investigational use and procedure for obtaining authorization to market edible products from experimental animals.

A food additive, including one that is a new drug or antibiotic, or foods containing such a food additive, intended for investigational use by qualified experts shall be exempt from the requirements of section 409 of the act under the following conditions:

(a) If intended for investigational use in vitro or with laboratory research animals, it bears a label which states prominently, in addition to other information required by the act:

Caution—Contains a new food additive (or new drug, or antibiotic) for investigational use only in laboratory research animals, or for tests in vitro. Not for use in humans.

(b) If intended for clinical investigational use in animals other than laboratory research animals, and the edible products of the animals are to be marketed as food, permission for the marketing of the edible products as food has been requested by the sponsor, and authorization has been granted by the Food and Drug Administration in accordance with §130.3a of this chapter, or by the Department of Agriculture in accordance with § 309.20 of Title 9, Code of Federal Regulations, and it bears a label which states prominently, in addition to other information required by the act, the following:

Caution—Contains a new food additive (or new drug, or antibiotic) for use only in investigational animals in clinical trials. Not for use in humans.

Edible products of investigational animals are not to be used for food unless authorization has been granted by the U.S. Food and Drug Administration or by the U.S. Department of Agriculture.

(§ 130.44)

Amendment published in Federal Register: PART 130--NEW DRUG REGULATIONS--Page 22.12
* April 2, 1971; 36 F.R. 6075 Insert this new page in your reprint.

* **§ 130.44 Conditions for investigational use of methadone for maintenance programs for narcotic addicts.**

(a) There is widespread interest in the use of methadone for the maintenance treatment of narcotic addicts. Though methadone is a marketed drug approved through the new-drug procedures for specific indications, its use in the maintenance treatment of narcotic addicts is an investigational use for which substantial evidence of long-term safety and effectiveness is not yet available under the Federal Food, Drug, and Cosmetic Act standards for the general marketability of new drugs. In addition, methadone is a controlled narcotic subject to the provisions of the Harrison Narcotic Act and has been shown to have significant potential for abuse. In order to assure that the public interest is adequately protected, and in view of the uniqueness of this method of treatment, it is necessary that a methadone maintenance program be closely monitored to prevent diversion of the drug into illicit channels and to assure the development of scientifically useful data. Accordingly, the Food and Drug Administration and the Bureau of Narcotic and Dangerous Drugs conclude that prior to the use of methadone in the maintenance treatment of narcotic addicts, advance approval of both agencies is required. The approval will be based on a review of a Notice of Claimed Investigational Exemption for a New Drug submitted to the Food and Drug Administration and reviewed concurrently by the Food and Drug Administration for scientific merit and by the Bureau of Narcotics and Dangerous Drugs for drug control requirements.

(b) No person may sell, deliver, or otherwise dispose of methadone for use in the maintenance treatment of narcotic addicts until a study providing for such use has had the advance approval of the Commissioner of Food and Drugs on the basis of a Notice of Claimed Investigational Exemption for a New Drug justifying such studies.

(c) An abbreviated Notice of Claimed Investigational Exemption for a New Drug shall be submitted in four copies to the U.S. Food and Drug Administration, 5600 Fishers Lane, Rockville, Md. 20852. Forms entitled "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotic Addicts," suitable for such a submission may be obtained from the above address. The submission should be signed by the person in charge of the maintenance program who will be regarded as the responsible party and sponsor for the exemption. (If the sponsor is a manufacturer or distributor of the drug, the regulations as outlined in § 130.3 should be followed, except where the guidelines set forth below in this section are appropriate.) The notice shall contain the following: *

(§ 130.44)

Amendment published in Federal Register: April 2, 1971; 36 F.R. 6075

Insert this new page in your reprint.

* (1) Name of sponsor, address, and date and the name of the investigational drug, which is methadone.

(2) A description of the form in which the drug is purchased (for example, bulk powder or tablet or other oral dosage form), the name and address of the manufacturer or supplier, and a statement that the drug meets the requirements of the United States Pharmacopeia or the National Formulary if recognized therein. If it is in an oral form designed to minimize its potential for abuse, and is not recognized in the U.S.P. or N.F., assurance that the drug meets adequate specifications for its intended use should be provided. This information may be obtained from the manufacturer. If bulk powder is used, a statement detailing how it is to be formulated, the name and qualifications of the person formulating the dosage form, and the address of where the formulating will take place if it is to take place at any location other than the principal address of the sponsor.

(3) The name, address, and a summary of the scientific training and experience of each investigator, and all other professional personnel having major responsibility in the research and rehabilitative effort, and individuals charged with monitoring the progress of the investigation and evaluating the safety and effectiveness of the drug if the monitor is other than a physician-sponsor. An investigator, other than a physician-sponsor (and investigators immediately responsible to a physician-sponsor and named in his submission) who has signed a form FD-1571 or the form entitled "Notice of Claimed Investigational Exemption for Methadone for Use in Maintenance Treatment of Narcotic Addicts," is required to sign a form FD-1573, obtainable from the Food and Drug Administration.

(4) A description of the facilities available to the sponsor to perform the required tests including the name of any hospital, institution, or clinical laboratory facility to be employed in connection with the investigation.

(5) A statement regarding the number of subjects to be included in the program.

(6) A statement of the protocol. The following is an acceptable protocol; however, it is not to be construed that this protocol must be adhered to in order to obtain clearance by the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs. This protocol is intended primarily as a guide for investigators who wish guidance in what said agencies consider acceptable. Investigators who wish to do so may submit modifications of this protocol or other protocols; these will be judged on their merits. *

(§ 130.44)

Amendment published in Federal Register: * April 2, 1971; 36 F.R. 6075

Insert this new page in your reprint.

* PROTOCOL

A. *Objectives.* 1. To evaluate the safety of long term methadone administration at varying dosage.

2. To evaluate the efficacy of oral methadone per se in decreasing the craving for other narcotic drugs and in minimizing their euphoriant effect.

3. To evaluate the efficacy of methadone as a pharmacological moiety in facilitating social rehabilitation of narcotic addicts.

4. To determine which addicts are capable of returning to an enduring drug-free state.

B. *Admission criteria.* 1. Documented history of physiological dependence on one or more opiate drugs, the duration of which is to be stated.

2. Confirmed history of one or more failures of treatment for their physiological dependence on opiates.

3. Evidence of current physiological dependence on opiates.

An exception to the third criterion (current physiological dependence on opiates) is allowable in exceptional circumstances for certain subjects for whom methadone maintenance may be initiated a short time prior to or upon release from an institution. This procedure should be justified on the basis of a history of previous relapses. In these circumstances, appropriate descriptions of the facilities, procedures, and qualifications of the personnel of the institution are to be included in the application filed by the sponsor.

Subjects who wish to do so may be transferred from one approved program to another.

C. *Patients requiring special consideration*—1. *Pregnant patients.* Safe use of methadone in pregnancy has not been established. There is limited documented clinical experience with pregnant patients treated with methadone, and animal reproduction studies have not been done. It is therefore preferable that pregnant patients be hospitalized and withdrawn from narcotics. If such a course is not feasible, pregnant patients may be included provided the patient is informed of the possible hazard. To minimize the risk of physiological dependence of the new born, or other complications, pregnant women should be maintained on minimal dosage. The investigator should promptly report to the Food and Drug Administration the condition of each infant born to a mother in a methadone maintenance program.

2. *Patients with serious physical illness.* Patients with serious concomitant physical illness are to be included in methadone maintenance program only when comprehensive medical care is available. Such patients require careful observation for any adverse effects of methadone and interactions with other medications. The investigator should promptly report adverse effects and evidence of interactions to the Food and Drug Administration.

3. *Psychotic patients.* Psychotic patients may be included in methadone maintenance programs when adequate psychiatric consultation and care is available. Administration of concomitant psychotropic agents requires careful observation for possible drug interaction. Such occurrences should be promptly reported.

Investigators who intend to include in their programs patients in categories 1, 2, and/or 3 above should so state in their protocols and should give assurance of appropriate precautions.

4. *Patients less than 18 years of age.* It is imperative that adolescents be afforded the benefit of other treatment modalities whenever possible and that those with minimal histories of physiological dependence be excluded from methadone maintenance programs. Investigators who wish to include adolescents in the program are therefore required to submit special protocols for this purpose. These protocols should state in detail the number of such patients to be treated, the alternative treatment methods available, the criteria for selection, the screening procedures, and the ancillary procedures to be employed.

D. *Admission evaluation.* 1. Recorded history to include age, sex, history of arrests and convictions, educational level, employment history, and past and present history of drug abuse of all types.

2. Medical history of significant illnesses.

3. History of prior psychiatric evaluation and/or treatment.

4. Assessment of the degree of physical dependence on and psychic craving for narcotics and other drugs, and evaluation of the attitudes toward and motivations for participation in the program.

5. Formal psychiatric examination in subjects with a prior history of psychiatric treatment and in those in whom there is a question of psychosis and/or competence to give informed consent.

6. Physical examination.

7. Chest X-ray.

8. Laboratory examinations to include complete blood count, routine urinalysis, liver function studies (including SGOT, alkaline phosphatase, and total protein and albumin globulin ratio), blood urea nitrogen, and serologic test for syphilis.

E. *Procedure*—1. *Dosage and administration.* The methadone is to be administered in an oral form so formulated as to minimize misuse by parenteral injection. The initial dosage is to be low; for example, 20 milligrams per day. Subsequently, the dosage is to be adjusted individually, as tolerated and as required, up to 160 milligrams per day. In exceptional cases, investigators may find it essential to exceed this dosage to obtain the intended effect. If such cases are encountered, the initial protocol or an amended protocol should include the maximum dosage to be administered, the number of patients for whom such dosage is required, and a description of the considerations leading to such dosage levels. The methadone is to be administered under the close supervision of the investigator or responsible persons designated by him. Initially, the subject is to receive the medication under observation each day. After demonstrating adherence to the program, the subject may be permitted twice weekly observed medication intake with no more than a 3-day supply routinely allowed in his possession. Additional medication may be provided in exceptional circumstances, such as illness, family crisis, or necessary travel, where hardship would result from requiring the customary observed medication intake for the specific period in question.

2. *Urinalysis.* Urine collection is to be supervised; urine specimens are to be analyzed for methadone, morphine, quinine, cocaine, barbiturates, and amphetamines; urine specimens are to be pooled or selected randomly for analysis at intervals not exceeding 1 week.

3. *Rehabilitative measures.* Rehabilitative measures as indicated may include individual and/or group psychotherapy, counseling, vocational guidance, and job and educational placement. *

* 4. *Abnormalities.* There shall be adequate investigation and appropriate management (including necessary referral and consultation) of any abnormalities detected on the basis of history, physical examination, or laboratory examination at the time of admission to the program or subsequently, including evaluation and treatment of intercurrent physical illness with observation for complications which might result from methadone.

5. *Repeated examinations.* Physical examination, chest X-ray, and laboratory examinations conducted at the time of admission are to be repeated annually.

6. *Discontinuation and followup.* Consideration is to be given to discontinuing the drug for participants who have maintained satisfactory adjustment over an extended period of time. In such cases, followup evaluation is to be obtained periodically.

7. *Records.* Adequate records are to be kept for each participant on each aspect of the treatment program, including adverse reactions and the treatment thereof.

F. *Other special procedures.* Within the limitations of personnel, facilities, and funding available and in the interest of increasing knowledge of the safety and efficacy of the drug itself, the following procedures are suggested as worthwhile, to be carried out at baseline and periodically in randomly selected subjects: EKG, EEG, measures of respiratory, cardiovascular, and renal function, psychological test battery, and simulated driving performance.

G. *Voluntary and involuntary terminations.* Subjects who have demonstrated continued frequent abuse of narcotics or other drugs, alcoholism, criminal activity, or persistent failure to adhere to the requirements of the program are ordinarily to be terminated and their records should reflect that they are treatment failures. If they are continued indefinitely in the program, the reasons for so doing should be stated in the protocol.

H. *Results.* 1. Evaluation of the safety of the drug administered over prolonged periods of time is to be based on results of physical examination, laboratory examinations, adverse reactions, and results of special procedures when these have been carried out.

2. Evaluation of effectiveness or rehabilitation is to be based on such criteria as:

a. Arrest records.

b. Extent of alcohol abuse.

c. Extent of drug abuse.

d. Occupational adjustment verified by employers or records of earnings.

e. Social adjustment verified whenever possible by family members or other reliable persons.

f. Withdrawal from methadone and achievement of an enduring drug-free status.

3. Evaluations are to be recorded at predetermined intervals; for example, monthly for the first 3 months, at 6 months, and at 6-month intervals thereafter.

I. *Evaluation group.* Whenever possible, a locally oriented independent evaluation committee of professionally trained and qualified persons not directly involved in the project nor organized by the sponsor will inspect facilities, interview personnel and selected patients, and review individuals' records and the periodic analysis of the data.

(d) The sponsor shall assure that adequate and accurate records are kept of all observations and other data pertinent to the investigation on each individual treated. The sponsor shall make the records available for inspection by authorized agents of the Food and Drug Administration. The Bureau of Narcotics and Dangerous Drugs is also authorized to inspect these records under the Harrison Narcotic Act.

(e) The sponsor is required to maintain adequate records showing the dates, quantity, and batch or code marks of the drug used. These records must be retained for the duration of the investigation.

(f) The sponsor shall monitor the progress of the investigations and evaluate the evidence relating to the safety and effectiveness of the drug. Accurate progress reports of the investigation and significant findings shall be submitted to the Food and Drug Administration at intervals not exceeding periods of 1 year. All reports of the investigation shall be retained for the duration of the investigation.

(g) The sponsor shall promptly notify the Food and Drug Administration of any findings associated with the use of the drug that may suggest significant hazards, contraindications, side effects, and precautions pertinent to the safety of the drug.

(h) The physician-sponsor or individual investigators in admitting addicts to the investigational treatment program are required to give to the addict an accurate description of the limitations as well as the possible benefits which the addict may derive from the program.

(i) The physician-sponsor or each individual investigator of this program shall certify that the drug will be used and administered only to subjects under his personal supervision or under the supervision of personnel directly responsible to him; a statement to this effect shall be included in the notice. The signing of the form "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotics Addicts" by a physician-sponsor or the form FD-1573 by an investigator will satisfy this requirement.

(j) The physician-sponsor or each individual investigator shall certify that all participants will be informed that drugs are being used for investigational purposes, and will obtain the informed consent of the subjects and shall include a statement to this effect in the notice. The signing of the forms as indicated in paragraph (i) of this section will satisfy this requirement.

(k) Failure to conform to the protocol for which approval has been received from the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs will be a basis for termination of the claimed investigational exemption.

(l) The sponsor of a "Notice of Claimed Investigational Exemption for a New Drug" already on file with the Food and Drug Administration should review and amend his submission to bring it into accord with the acceptable protocol where appropriate within 60 days after the effective date of this section. All differences in his protocol from the suggested protocol should be justified.

(m) Provisions under the Harrison Narcotic Act enforced by the Department of Justice are applicable to this use of methadone *

(Reprinted from Federal Register of April 2, 1971; 36 F.R. 6075)

Title 21—FOOD AND DRUGS

Chapter I—Food and Drug Administration, Department of Health, Education, and Welfare

SUBCHAPTER C—DRUGS

PART 130—NEW DRUGS

Conditions for Investigational Use of Methadone for Maintenance Programs for Narcotic Addicts

A notice was published in the FEDERAL REGISTER of June 11, 1970 (35 F.R. 9014), proposing establishment (21 CFR 130.44) of acceptable guidelines for programs for the investigation of methadone in the maintenance treatment of narcotic addicts. The guidelines of the Bureau of Narcotics and Dangerous Drugs, Department of Justice, were also proposed June 11, 1970 (35 F.R. 9015).

In response, a substantial number of comments were received from the medical community through the American Medical Association, Student American Medical Association, American Psychiatric Association, National Academy of Sciences-National Research Council, known authorities in the treatment of drug addiction, and from individuals and municipalities currently operating methadone maintenance programs.

The majority of the comments are in the form of objections to provisions of the protocol and the regulation, as follows:

1. The criteria in the protocol for the exclusion of subjects from the studies: Pregnancy, psychosis, serious physical diseases, and persons less than 18 years of age.

2. The requirement in the protocol that no more than a 3-day supply be given to a subject at one time.

3. The necessity for making records available to the Food and Drug Administration and to the Bureau of Narcotics and Dangerous Drugs and the lack of a guarantee of confidentiality of patient records.

4. The requirement that one of the objectives of the studies be a return to the drug-free state.

5. The requirement that the dosage level be limited to 160 milligrams per day.

6. The necessity of obtaining prior approval from the Bureau of Narcotics and Dangerous Drugs.

7. The requirements for weekly urine analysis and other laboratory tests and examinations.

8. The classification of the use of methadone in the maintenance treatment of narcotic addicts as an investigational use.

9. The regulation being overly restrictive and not in the best interest of the public.

The Commissioner of Food and Drugs, having considered the comments and having met with representatives of interested groups, associations, and individuals for further discussion, finds that:

1. The majority of the comments are a result of interested persons interpreting the proposal as restricting investigators to the suggested protocol. This is a misinterpretation since the protocol is intended only as a guide to assist the profession, municipalites, organizations, and other groups who are interested in sponsoring programs for the investigation of methadone in the maintenance treatment of narcotic addicts. It is not intended that every methadone program be confined to the limits of this protocol. Modification of the protocol and completely different protocols will be accepted, provided they can be justified by the sponsor. Modifications and completely different protocols consistent with public welfare and safety will be approved.

2. Since the suggested protocol is intended as an aid to those who wish to sponsor programs for the investigation of methadone in the maintenance treatment of narcotic addicts, it is recognized that it would be to the benefit of the Food and Drug Administration, the Bureau of Narcotics and Dangerous Drugs, and the sponsors of the investigations to have a suggested protocol that would be acceptable to the majority of sponsors while satisfying the requirements of the two aforementioned agencies. Accordingly, the following revisions have been made in the regulation as adopted below:

a. The provision of the protocol "Criteria for exclusion from the program" has been changed to "Patients requiring special consideration." Pregnancy, psychosis, serious physical disease, and being less than 18 years of age are not reasons for automatic eliminations from a program but are conditions that merit special considerations which are detailed.

b. A provision has been added to the protocol to permit the investigator to exceed the dosage of 160 milligrams per day when the investigator finds it essential to do so and describes the considerations leading to such dosage levels in his protocol.

c. The requirement for laboratory examinations at 6-month intervals has been changed to 1-year intervals.

d. The objectives of the study have been clarified.

3. The remaining comments concerning the protocol and not mentioned above deal primarily with problems that can be met by submission of a modified protocol to be judged on individual merit.

4. Regarding the objection that the recordkeeping requirements and the necessity for making records available to the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs could violate the confidential relationship between the patient and the physician: The Federal Food, Drug, and Cosmetic Act provides for promulgating regulations that require the sponsor of the drug investigations to maintain adequate records and that these records be made available to authorized personnel of the Food and Drug Administration. These records must be adequate in the event that followup on adverse reaction information requires identification of the patient. The Bureau of Narcotics and Dangerous Drugs is authorized to have access to these records under the Harrison Narcotic Act.

5. Methadone used in the maintenance treatment of narcotic addicts is an investigational use drug because, despite recent research gains, there remains inadequate evidence of long-term safety and of long-term effectiveness for this use to permit general marketability of methadone for maintenance treatment under the Federal Food, Drug, and Cosmetic Act standards for new drugs.

6. It is necessary that prior approval for methadone maintenance programs be obtained from the Bureau of Narcotics and Dangerous Drugs as well as the Food and Drug Administration because of this drug's potential for abuse. The Bureau of Narcotics and Dangerous Drugs' approval will be based on the existence of adequate control procedures to prevent diversion of the drug into illicit channels. Since the applications will be submitted only to the Food and Drug Administration and reviewed simultaneously by the two agencies, the inconvenience to the sponsor and the delay of approval will be minimal.

Therefore, pursuant to provisions of the Federal Food, Drug, and Cosmetic Act (secs. 505, 701(a), 52 Stat. 1052–53, as amended, 1055; 21 U.S.C. 355, 371(a)) and under authority delegated to the Commissioner (21 CFR 2.120), the following new section is added to Part 130:

§ 130.44 Conditions for investigational use of methadone for maintenance programs for narcotic addicts.

(a) There is widespread interest in the use of methadone for the maintenance treatment of narcotic addicts. Though methadone is a marketed drug approved through the new-drug procedures for specific indications, its use in the maintenance treatment of narcotic addicts is an investigational use for which substantial evidence of long-term safety and effectiveness is not yet available under the Federal Food, Drug, and Cosmetic Act standards for the general marketability of new drugs. In addition, methadone is a controlled narcotic subject to the provisions of the Harrison Narcotic Act and has been shown to have significant potential for abuse. In order to assure that the public interest is adequately protected, and in view of the uniqueness of this method of treatment, it is necessary that a methadone maintenance program be closely monitored to prevent diversion of the drug into illicit channels and to assure the development of scientifically useful data. Accordingly, the Food and Drug Administration and the Bureau of Narcotic and Dangerous Drugs conclude that prior to the use of methadone in the maintenance treatment of narcotic addicts, advance approval of both agencies is required. The approval will be based on a review of a Notice of Claimed Investigational Exemption for

a New Drug submitted to the Food and Drug Administration and reviewed concurrently by the Food and Drug Administration for scientific merit and by the Bureau of Narcotics and Dangerous Drugs for drug control requirements.

(b) No person may sell, deliver, or otherwise dispose of methadone for use in the maintenance treatment of narcotic addicts until a study providing for such use has had the advance approval of the Commissioner of Food and Drugs on the basis of a Notice of Claimed Investigational Exemption for a New Drug justifying such studies.

(c) An abbreviated Notice of Claimed Investigational Exemption for a New Drug shall be submitted in four copies to the U.S. Food and Drug Administration, 5600 Fishers Lane, Rockville, Md. 20852. Forms entitled "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotic Addicts," suitable for such a submission may be obtained from the above address. The submission should be signed by the person in charge of the maintenance program who will be regarded as the responsible party and sponsor for the exemption. (If the sponsor is a manufacturer or distributor of the drug, the regulations as outlined in § 130.3 should be followed, except where the guidelines set forth below in this section are appropriate.) The notice shall contain the following:

(1) Name of sponsor, address, and date and the name of the investigational drug, which is methadone.

(2) A description of the form in which the drug is purchased (for example, bulk powder or tablet or other oral dosage form), the name and address of the manufacturer or supplier, and a statement that the drug meets the requirements of the United States Pharmacopeia or the National Formulary if recognized therein. If it is in an oral form designed to minimize its potential for abuse, and is not recognized in the U.S.P. or N.F., assurance that the drug meets adequate specifications for its intended use should be provided. This information may be obtained from the manufacturer. If bulk powder is used, a statement detailing how it is to be formulated, the name and qualifications of the person formulating the dosage form, and the address of where the formulating will take place if it is to take place at any location other than the principal address of the sponsor.

(3) The name, address, and a summary of the scientific training and experience of each investigator, and all other professional personnel having major responsibility in the research and rehabilitative effort, and individuals charged with monitoring the progress of the investigation and evaluating the safety and effectiveness of the drug if the monitor is other than a physician-sponsor. An investigator, other than a physician-sponsor (and investigators immediately responsible to a physician-sponsor and named in his submission) who has signed a form FD–1571 or the form entitled "Notice of Claimed Investigational Exemption for Methadone for Use in Maintenance Treatment of Narcotic Addicts," is required to sign a form FD–1573, obtainable from the Food and Drug Administration.

(4) A description of the facilities available to the sponsor to perform the required tests including the name of any hospital, institution, or clinical laboratory facility to be employed in connection with the investigation.

(5) A statement regarding the number of subjects to be included in the program.

(6) A statement of the protocol. The following is an acceptable protocol; however, it is not to be construed that this protocol must be adhered to in order to obtain clearance by the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs. This protocol is intended primarily as a guide for investigators who wish guidance in what said agencies consider acceptable. Investigators who wish to do so may submit modifications of this protocol or other protocols; these will be judged on their merits.

PROTOCOL

A. *Objectives.* 1. To evaluate the safety of long term methadone administration at varying dosage.

2. To evaluate the efficacy of oral methadone per se in decreasing the craving for other narcotic drugs and in minimizing their euphoriant effect.

3. To evaluate the efficacy of methadone as a pharmacological moiety in facilitating social rehabilitation of narcotic addicts.

4. To determine which addicts are capable of returning to an enduring drug-free state.

B. *Admission criteria.* 1. Documented history of physiological dependence on one or more opiate drugs, the duration of which is to be stated.

2. Confirmed history of one or more failures of treatment for their physiological dependence on opiates.

3. Evidence of current physiological dependence on opiates..

An exception to the third criterion (current physiological dependence on opiates) is allowable in exceptional circumstances for certain subjects for whom methadone maintenance may be initiated a short time prior to or upon release from an institution. This procedure should be justified on the basis of a history of previous relapses. In these circumstances, appropriate descriptions of the facilities, procedures, and qualifications of the personnel of the institution are to be included in the application filed by the sponsor.

Subjects who wish to do so may be transferred from one approved program to another.

C. *Patients requiring special consideration*—1. *Pregnant patients.* Safe use of methadone in pregnancy has not been established. There is limited documented clinical experience with pregnant patients treated with methadone, and animal reproduction studies have not been done. It is therefore preferable that pregnant patients be hospitalized and withdrawn from narcotics. If such a course is not feasible, pregnant patients may be included provided the patient is informed of the possible hazard. To minimize the risk of physiological dependence of the new born, or other complications, pregnant women should be maintained on minimal dosage. The investigator should promptly report to the Food and Drug Administration the condition of each infant born to a mother in a methadone maintenance program.

2. *Patients with serious physical illness.* Patients with serious concomitant physical illness are to be included in methadone maintenance program only when comprehensive medical care is available. Such patients require careful observation for any adverse effects of methadone and interactions with other medications. The investigator should promptly report adverse effects and evidence of interactions to the Food and Drug Administration.

3. *Psychotic patients.* Psychotic patients may be included in methadone maintenance programs when adequate psychiatric consultation and care is available. Administration of concomitant psychotropic agents requires careful observation for possible drug interaction. Such occurrences should be promptly reported.

Investigators who intend to include in their programs patients in categories 1, 2, and/or 3 above should so state in their protocols and should give assurance of appropriate precautions.

4. *Patients less than 18 years of age.* It is imperative that adolescents be afforded the benefit of other treatment modalities whenever possible and that those with minimal histories of physiological dependence be excluded from methadone maintenance programs. Investigators who wish to include adolescents in the program are therefore required to submit special protocols for this purpose. These protocols should state in detail the number of such patients to be treated, the alternative treatment methods available, the criteria for selection, the screening procedures, and the ancillary procedures to be employed.

D. *Admission evaluation.* 1. Recorded history to include age, sex, history of arrests and convictions, educational level, employment history, and past and present history of drug abuse of all types.

2. Medical history of significant illnesses.

3. History of prior psychiatric evaluation and/or treatment.

4. Assessment of the degree of physical dependence on and psychic craving for narcotics and other drugs, and evaluation of the attitudes toward and motivations for participation in the program.

5. Formal psychiatric examination in subjects with a prior history of psychiatric treatment and in those in whom there is a question of psychosis and/or competence to give informed consent.

6. Physical examination.

7. Chest X-ray.

8. Laboratory examinations to include complete blood count, routine urinalysis, liver function studies (including SGOT, alkaline phosphatase, and total protein and albumin globulin ratio), blood urea nitrogen, and serologic test for syphilis.

E. *Procedure*—1. *Dosage and administration.* The methadone is to be administered in an oral form so formulated as to minimize misuse by parenteral injection. The initial dosage is to be low; for example, 20 milligrams per day. Subsequently, the dosage is to be adjusted individually, as tolerated and as required, up to 160 milligrams per day. In exceptional cases, investigators may find it essential to exceed this dosage to obtain the intended effect. If such cases are encountered, the initial protocol or an amended protocol should include the maximum dosage to be administered, the number of patients for whom such dosage is required, and a description of the considerations leading to such dosage levels. The methadone is to be administered under the close supervision of the investigator or responsible persons designated by him. Initially, the subject is to receive the medication under observation each day. After demonstrating adherence to the program, the subject may be permitted twice weekly observed medication intake with no more than a 3-day supply routinely allowed in his possession. Additional medication may

be provided in exceptional circumstances, such as illness, family crisis, or necessary travel, where hardship would result from requiring the customary observed medication intake for the specific period in question.

2. *Urinalysis.* Urine collection is to be supervised; urine specimens are to be analyzed for methadone, morphine, quinine, cocaine, barbiturates, and amphetamines; urine specimens are to be pooled or selected randomly for analysis at intervals not exceeding 1 week.

3. *Rehabilitative measures.* Rehabilitative measures as indicated may include individual and/or group psychotherapy, counseling, vocational guidance, and job and educational placement.

4. *Abnormalities.* There shall be adequate investigation and appropriate management (including necessary referral and consultation) of any abnormalities detected on the basis of history, physical examination, or laboratory examination at the time of admission to the program or subsequently, including evaluation and treatment of intercurrent physical illness with observation for complications which might result from methadone.

5. *Repeated examinations.* Physical examination, chest X-ray, and laboratory examinations conducted at the time of admission are to be repeated annually.

6. *Discontinuation and followup.* Consideration is to be given to discontinuing the drug for participants who have maintained satisfactory adjustment over an extended period of time. In such cases, followup evaluation is to be obtained periodically.

7. *Records.* Adequate records are to be kept for each participant on each aspect of the treatment program, including adverse reactions and the treatment thereof.

F. *Other special procedures.* Within the limitations of personnel, facilities, and funding available and in the interest of increasing knowledge of the safety and efficacy of the drug itself, the following procedures are suggested as worthwhile, to be carried out at baseline and periodically in randomly selected subjects: EKG, EEG, measures of respiratory, cardiovascular, and renal function, psychological test battery, and simulated driving performance.

G. *Voluntary and involuntary terminations.* Subjects who have demonstrated continued frequent abuse of narcotics or other drugs, alcoholism, criminal activity, or persistent failure to adhere to the requirements of the program are ordinarily to be terminated and their records should reflect that they are treatment failures. If they are continued indefinitely in the program, the reasons for so doing should be stated in the protocol.

H. *Results.* 1. Evaluation of the safety of the drug administered over prolonged periods of time is to be based on results of physical examination, laboratory examinations, adverse reactions, and results of special procedures when these have been carried out.

2. Evaluation of effectiveness or rehabilitation is to be based on such criteria as:

a. Arrest records.

b. Extent of alcohol abuse.

c. Extent of drug abuse.

d. Occupational adjustment verified by employers or records of earnings.

e. Social adjustment verified whenever possible by family members or other reliable persons.

f. Withdrawal from methadone and achievement of an enduring drug-free status.

3. Evaluations are to be recorded at predetermined intervals; for example, monthly for the first 3 months, at 6 months, and at 6-month intervals thereafter.

I. *Evaluation group.* Whenever possible, a locally oriented independent evaluation committee of professionally trained and qualified persons not directly involved in the project nor organized by the sponsor will inspect facilities, interview personnel and selected patients, and review individuals' records and the periodic analysis of the data.

(d) The sponsor shall assure that adequate and accurate records are kept of all observations and other data pertinent to the investigation on each individual treated. The sponsor shall make the records available for inspection by authorized agents of the Food and Drug Administration. The Bureau of Narcotics and Dangerous Drugs is also authorized to inspect these records under the Harrison Narcotic Act.

(e) The sponsor is required to maintain adequate records showing the dates, quantity, and batch or code marks of the drug used. These records must be retained for the duration of the investigation.

(f) The sponsor shall monitor the progress of the investigations and evaluate the evidence relating to the safety and effectiveness of the drug. Accurate progress reports of the investigation and significant findings shall be submitted to the Food and Drug Administration at intervals not exceeding periods of 1 year. All reports of the investigation shall be retained for the duration of the investigation.

(g) The sponsor shall promptly notify the Food and Drug Administration of any findings associated with the use of the drug that may suggest significant hazards, contraindications, side effects, and precautions pertinent to the safety of the drug.

(h) The physician-sponsor or individual investigators in admitting addicts to the investigational treatment program are required to give to the addict an accurate description of the limitations as well as the possible benefits which the addict may derive from the program.

(i) The physician-sponsor or each individual investigator of this program shall certify that the drug will be used and administered only to subjects under his personal supervision or under the supervision of personnel directly responsible to him; a statement to this effect shall be included in the notice. The signing of the form "Notice of Claimed Investigational Exemption for Methadone for Use in the Maintenance Treatment of Narcotics Addicts" by a physician-sponsor or the form FD–1573 by an investigator will satisfy this requirement.

(j) The physician-sponsor or each individual investigator shall certify that all participants will be informed that drugs are being used for investigational purposes, and will obtain the informed consent of the subjects and shall include a statement to this effect in the notice. The signing of the forms as indicated in paragraph (i) of this section will satisfy this requirement.

(k) Failure to conform to the protocol for which approval has been received from the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs will be a basis for termination of the claimed investigational exemption.

(l) The sponsor of a "Notice of Claimed Investigational Exemption for a New Drug" already on file with the Food and Drug Administration should review and amend his submission to bring it into accord with the acceptable protocol where appropriate within 60 days after the effective date of this section. All differences in his protocol from the suggested protocol should be justified.

(m) Provisions under the Harrison Narcotic Act enforced by the Department of Justice are applicable to this use of methadone.

Effective date. This order is effective upon publication in the FEDERAL REGISTER (4–2–71).

(Secs. 505, 701(a), 52 Stat. 1052–53, as amended, 1055; 21 U.S.C. 355, 371(a))

Dated: March 25, 1971.

CHARLES C. EDWARDS,
Commissioner of Food and Drugs.

(Reprinted from Federal Register of April 2, 1971; 36 F.R. 6081)

Title 26—INTERNAL REVENUE

Chapter I—Internal Revenue Service, Department of the Treasury

SUBCHAPTER A—INCOME TAX

[T.D. 7100]

[Treasury Decision 7076]

PART 151—REGULATORY TAXES ON NARCOTIC DRUGS

Administering and Dispensing Requirements

On June 11, 1970, there was published in the FEDERAL REGISTER, 35 F.R. 9015, 9016, a notice of proposed rule making amending §151.411 of Title 26 of the Code of Federal Regulations in order to make clear the conditions upon which practitioners may administer or dispense narcotic drugs in the course of conducting clinical investigations in the development of methadone maintenance rehabilitation programs. Essentially, the proposal would require that practitioners obtain approval prior to the initiation of such an investigation by submission of a Notice of Claimed Investigational Exemption for a New Drug to the Food and Drug Administration which would then be reviewed concurrently by that agency for scientific merit and by the Bureau of Narcotics and Dangerous Drugs for drug control requirements.

This proposal was published in conjunction with a notice of proposed rule making published by the Commissioner of Food and Drugs for addition of a new section to Part 130 of Title 21 of the Code of Federal Regulations. Among other matters this notice contained acceptable criteria and guidelines agreed upon by the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs for the conduct of clinical investigations of this nature. Since the original publication of both of these notices, two extensions of 30 days each have been granted for the receipt of additional written comments. After extensive review of the written comments received, both agencies have agreed upon certain alterations in the proposed criteria and guidelines which are designed to facilitate further research and to accommodate the diverse needs and interests of the scientific community. These changes have been effected by appropriate modification of the new section to be added to Part 130 of Title 21 of the Code of Federal Regulations published elsewhere in this issue of the FEDERAL REGISTER. Inasmuch as the bulk of comments received concern the criteria and guidelines appearing originally in that proposal, no modifications of the proposed amendment to § 151.411 of Title 26 of the Code of Federal Regulations as published on June 11, 1970, have been undertaken.

As previously set forth, it is recognized that the investigational use of methadone, a class "A" narcotic drug requiring the prolonged maintenance of narcotic dependence as part of a total rehabilitation effort, has shown promise in the management and rehabilitation of selected narcotic addicts. In addition, it is a drug which has been shown to have a significant potential for abuse. The amendment which follows is designed to clarify the conditions under which it may be used for the specific investigational purpose indicated until such time as the results of present and future clinical investigations may indicate the necessity for reevaluation of current uses and control mechanisms. It does not authorize the prescribing of narcotic drugs for any such purpose, see 26 CFR 151.392. Moreover, it does not affect any other uses of narcotic drugs, or waive any requirements concerning the control, security, use, transfer, or distribution of narcotic drugs imposed by other Federal narcotic laws or regulations. The amendment shall become effective as of the date of this publication; however, those practitioners currently engaged in the operation of a bona fide clinical investigation shall have a period of 60 days in which to submit or resubmit a Notice of Claimed Investigational Exemption for approval.

Accordingly, under the authority previously cited in the notice of proposed rule making published in the FEDERAL REGISTER on June 11, 1970, 35 F.R. 9015, 9016, the word "'Dispensing" preceding § 151.411 of Part 151 of Title 26 of the Code of Federal Regulations is hereby deleted and § 151.411 is amended to read as follows:

§ 151.411 Administering and dispensing.

(a) Practitioners may administer or dispense narcotic drugs to bona fide patients pursuant to the legitimate practice of their profession without prescriptions or order forms.

(b) The administering or dispensing of narcotic drugs to narcotic drug dependent persons for the purpose of continuing their dependence upon such drugs in the course of conducting an authorized clinical investigation in the development of a narcotic addict rehabilitation program shall be deemed to fall within the meaning of the term "in the course of professional practice" in sections 4704(b)(2) and 4705(c)(1) of title 26 of the United States Code: *Provided*, That approval is obtained prior to the initiation of such a program by submission of a Notice of Claimed Investigational Exemption for a New Drug to the Food and Drug Administration which will be reviewed concurrently by the Food and Drug Administration for scientific merit and by the Bureau of Narcotics and Dangerous Drugs for drug control requirements; and provided further that the clinical investigation thereafter accords with such approval; see 21 CFR 130.44. The prescribing of narcotic drugs is not authorized for any such purposes.

Effective date. This Treasury decision shall be effective when published in the FEDERAL REGISTER (4–2–71).

Dated: March 25, 1971.

[SEAL] JOHN E. INGERSOLL,
Director, Bureau of Narcotics and Dangerous Drugs, Department of Justice.

RANDOLPH W. THROWER,
Commissioner, Internal Revenue Service, Department of of the Treasury.

Approved: March 25, 1971.

EDWIN S. COHEN,
Assistant Secretary of the Treasury.

Senator HUGHES. Also, the staff requested written examples of regulations imposing social criteria on drugs other than methadone.

Dr. GARDNER. To my knowledge, again, there are no similar criteria spelled out in any of the regulations for other drugs.

Social criteria are, again, considered in the evaluation of many drugs, just as in considering the efficacy of any drug, several factors are considered, some of which are more primary than others.

Senator HUGHES. But there is nothing written down in relationship to that?

Dr. GARDNER. No, just in the proposed guidelines for methadone.

Senator HUGHES. Pardon?

Dr. GARDNER. Just in the proposed guidelines in methadone.

Senator HUGHES. You are writing them down in methadone, but you don't write them down in other drugs?

Dr. GARDNER. We haven't in the past.

Senator HUGHES. Why do you consider methadone much more dangerous than other drugs? Can you tell me that? Apparently, you do. You are writing these criteria, when you don't write them in the case of other drugs. You are saying that private physicians shouldn't administer it, when private physicians administer every narcotic that you can think of. Without this type of control, too, or regulations.

Why in this instance, do you pick out methadone and say, they shouldn't do this with methadone?

Dr. GARDNER. I am sorry, Mr. Chairman, they don't do what with methadone?

Senator HUGHES. They shouldn't administer it as private physicians.

Dr. GARDNER. There are private physicians administering it. I have said that we cannot utilize studies unless the person can conduct an adequate study of the drug. We are only allowing programs that can provide further data that will be of value, probable in special programs.

Senator HUGHES. The staff wonders, in relationship to allowing a private physician to use methadone, do you require that they provide additional services other than the drug and rehabilitation services and social services and counseling?

Dr. GARDNER. At least counseling or psychothearapy, or some form of other service.

Senator HUGHES. What relationship does that have to the drug itself? What does it have to do with the drug itself and the efficacy of the drug?

Dr. GARDNER. It is part of an overall program. People have used the drug and have, again, claimed that its use——

Senator HUGHES. Apparently, the agency fears, and the BNDD fears, and what the subcommittee is trying to get at, is that there is danger of methadone abuse in the country, that it would be disseminated broadly, get in the black market, be an addictive narcotic which could spread widely in the United States. Is this correct?

Dr. GARDNER. That is one fear, yes.

Senator HUGHES. Is that the reason you are trying to hang on to all the special comprehensive things in this particular use that you don't use in other narcotics and drugs?

Dr. GARDNER. I think that has been one of the reasons, but not all of them.

Senator HUGHES. What are the other reasons?

Dr. GARDNER. I think one of the reasons has been that when this first started, many people considered that this didn't have to be investigated further. They were going to carry out strictly treatment programs without really studying it. Thus, much of the reason for proposing these guidelines was to indicate some of the parameters that might be looked at in evaluating the use of methadone in the context of an overall drug abuse program.

Another reason was the large number of investigators, many more than is often the case, wanting to use this drug for study or treatment. This poses a difficult problem of control, in contrast to most of the drugs that are investigated.

Senator HUGHES. I think, doctor, and I might take Senator Javits' name and my own in vain here, that we sort of feel we are antagonists in this field with you. We are trying to find out why, with the heroin epidemic the size it is in the country, and the only thing we know that has a real effect on it, that can stop people from craving heroin, keep them from stealing $250 to $300 a day to feed that habit, why is this considered more dangerous than allowing the heroin epidemic to continue?

Dr. GARDNER. I don't think we are antagonists.

Senator HUGHES. I feel you are setting up so many restrictions and inhibitions against the use of methadone, that we are never going to reach 10 percent of the heroin addicts in this country that we might reach, because you feel it is so extremely dangerous. I can't see that additional danger from my viewpoint, and I am trying to understand it. Can you enlighten me on your view?

Dr. GARDNER. Yes; we are not trying to limit the program. We don't have the ability to market a drug until somebody says that they want to market it and can provide the evidence for evaluating the safety and the effectiveness of the drug.

Up until this time, until one company submitted a new drug application, this drug has been under an investigational status.

While the drug is under investigational status, it signifies that we do not have all of the data available to us for a thorough evaluation. It becomes incumbent upon us not to allow an unlimited number of programs or practitioners to use the drug.

Senator HUGHES. We have had some bad programs, we are both aware of that.

Dr. GARDNER. Yes.

Senator HUGHES. Some have been very bad, very poorly controlled, and methadone got abroad in the streets, and I agree with you on that.

Dr. GARDNER. While it is under investigational status, we do have to exercise some control over any drug.

As to the possible danger from wide distribution of the drug, that is something that must be considered by a number of agencies, advisers, et cetera.

Senator HUGHES. Is it easy to manufacture, is it easy to produce?

Dr. GARDNER. Yes; it is.

Senator HUGHES. Is the formula so well known that it can be done in illicit laboratories?

Dr. GARDNER. Not as easy as——

Senator HUGHES. LSD, for example?

Dr. GARDNER. Not as easy as that, but it could be manufactured widely. We have, even in the investigational stages, seen considerable abuse of this. Once the drug does become used in a large number of programs, that is something to be taken into consideration. But that is not really why the drug hasn't been marketed yet. No one had submitted a new drug application.

Senator HUGHES. You think it will be marketed soon?

Dr. GARDNER. Yes.

Senator HUGHES. Apparently, you furnished the President's people their information when he made his statement in his report to the Nation that at this time, the evidence indicates that methadone is a useful tool, and that that tool ought to be available to those who must do the work.

I am assuming they get their supply of information from your resources in order to pull the statement together.

I don't want to beat this thing to death. I don't like to see another wide distribution of another dangerous narcotic that lends itself easily to abuse in our society. But we all know that heroin addiction is just tearing us apart, and there is a risk involved in it. I have reached the point where I think a calculated risk in the use of methadone is in the best interests of the country. I think that is, really, that is our feeling, that that is what is occurring at the present time. The major thing people are attempting to work out is how to permit this with the best controls possible.

The staff, particularly, is hung up, and I am, too, a little bit, and maybe you can help us out, on why you require supportive services with methadone and you don't with other mood drugs and mind altering drugs?

Dr. GARDNER. It has not been detailed in any guidelines yet, but, as a matter of fact, the evaluation of all the psychotropic drugs consider either supportive service or other kinds of criteria, in viewing the efficacy of the drugs.

Senator HUGHES. Are you telling us that the same thing goes into the new drug, but it is not spelled out as it is with relationship to methadone?

Dr. GARDNER. That is right.

Senator HUGHES. Why don't you spell it out, then, if you feel it is absolutely essential that all these supportive services go along with it? If you are going to get to the roots of addiction and the personality problems that equate to the addiction, I agree there have to be additional services.

Dr. GARDNER. That varies from one drug to the other. We are in the process of publishing guidelines for the use of most classes of drugs and the mood drug guidelines would be very similar to methadone.

Senator HUGHES. We are getting a lot of flack from doctors who either are using or want to use methadone about the fact that there is a lot more stringent application of this sort of thing to methadone than to other mood drugs.

Dr. GARDNER. There have been probably more investigators, more doctors, using this drug in its investigational form than with many drugs. Rather than being restrictive, we have been less restrictive to date than we have been with many drugs. We usually do not have this many investigators evaluating a drug.

Senator HUGHES. We have a vote. The hearing is closed.

Thank you, doctor.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record:

(The information referred to follows:)

NC
CMHC

National Council
of
Community Mental Health Centers

Statement of the National Council of
Community Mental Health Centers Submitted for the
Record of Hearings Held by the Subcommittee on
Alcoholism and Narcotics on Various Drug Proposals
August 5, 1971

The National Council supports S 2146, requiring community mental health centers to provide treatment and rehabilitation programs for drug addicts and other persons with drug abuse and other drug dependence problems, and we support also those similar provisions of S 2217 (Part D), the Federal Drug Abuse and Drug Dependence Prevention, Treatment and Rehabilitation Act of 1971, providing for an expanded drug treatment and rehabilitation program in community mental health centers.

Community mental health centers are uniquely eauipped to reach and treat drug abusers in the community. Mental health centers represent the most effective and advanced vehicle in the nation today for providing community health care. With over 300 centers now fully operational, they could begin to provide drug treatment to a large segment of the population within a very short space of time.

The close working relationship most CMHCs have with community agencies in their catchment areas (schools, social agencies, vocational rehabilitation units, etc.) makes the mental health center a particularly appropriate organization for drug abuse treatment. Members in every corner of the community generally have easy access to the center, and the center to them.

322 Georgetown Building Phone: (202) 337-0991 2233 Wisconsin Avenue, N.W., Washington, D.C. 20007

Although many centers now do offer narcotic addiction treatment programs, the program as a whole has made little progress with the overall problem because of a lack of funding. Centers which are federally funded are required to provide certain services, but a drug abuse treatment program is not one of them. Thus, if they do provide a drug program they either must skimp on required services or find the funds somewhere else. One of the sources of funds for drug programs is Part D of the Community Mental Health Centers Act, but at last count only about a half-dozen center drug programs had been approved under that provision and none has been funded.

We therefore support the central intent of S 2146 and Part D of S 2217, and at the same time we recognize the important coordinating role of the Special Action Office proposed under S 2097. All centers have the potential capacity to provide drug abuse services - given the funds and the time to tool up.

We do have some concerns, however.

The principal one is that there be proper funding. We do not think it would be fair to centers to require them to offer drug programs and then provide them with no more funds than they are presently getting. If that turned out to be the case, the drug program would understandably not be a meaningful one. We suggest that this requirement not be implemented unless additional funds are actually available.

Drug abuse treatment and rehabilitation is expensive. We cannot give you an accurate average cost estimate, since costs vary widely depending on the size of the addict population in the catchment area served and on the type of treatment offered. Based on those programs the centers are now operating we can say that CMHCs located in areas with a high concentration of addicts may require as much as $500,000 per 100,000 catchment area population. Those centers with fewer addicts to serve will obviously require

less, possibly around $200,000 per 100,000 population. Taken as a whole, the mental health centers serve a population of nearly 50 million. Funds required for drug abuse programs in all existing centers, then, would probably be somewhere between $100 and $200 million annually. We think the $160 million authorized in S 2146 is a realistic figure.

The National Council is concerned, however, that this kind of money will not be appropriated, or if it is, that the commitment will not be sustained in future years.

We would like to draw your attention to the provision [subsection c(1)] of S 2146 which relieves a center from the necessity of providing a drug abuse treatment program if the need for such a program "is not of such magnitude to warrant the provision of such a program by the center." We would prefer to have the Secretary given more discretion over which, and how many, centers need not fulfill this requirement. It is possible that while a center is not providing a drug treatment program, the community is nevertheless adequately served by some other service. Also, such expanded discretion would make it possible to concentrate funds where the need is really acute.

Another concern is that by the time this legislation is enacted, the requirement that all centers have drug abuse treatment programs operating by July 1, 1972 may not allow sufficient lead time. We suggest that the starting date be set at one year from the date of enactment.

We also support the provision of S 2146 that requires CMHCs to contract with other government agencies to provide drug treatment and rehabilitation services for persons for whom those agencies are responsible. This is an appropriate and sensible use of resources.

The concept of a Special Office of Drug Abuse Prevention in the Executive Office of the President is, in our opinion, appropriate considering the magnitude of the problem. Moreover, we heartily support the appoint-

ment of Dr. Jerome Jaffe, whose competence and record of achievement in the field of drug abuse are well known to us. The drug abuse problem is so complex that coordination and phasing of all program efforts is essential. Any provision that restricts the capacity of the Special Office to function effectively in that role needs to be evaluated most carefully.

We recognize that there is some measure of conflict of intent between the provisions of S 2146 and S 2097. We do not presume to propose the specific form of a compromise among them. We do, however, suggest that efforts be made to reconcile such conflicts and hope that the resulting legislation will achieve these effects:

1. enable CMHCs to play a significant and appropriate role in treatment and rehabilitation;
2. provide additonal funds needed to deliver such services;
3. provide the flexibility and authority required by the proposed Special Action Office to carry out its essential coordinating role.

We would like to say, in conclusion, that our concern over the impact of these various bills stems mainly form the fact that there seems to us to be a lack of support within the Executive Branch for the CMHC program. This is evidenced by the failure of the Administration to request sufficient staffing funds in the fiscal 1972 budget to expand the program, or even to maintain it at its current level. The present practice of OMB to allow the funding only of those centers which have previously received federal construction grants, while at the same time no money has been requested for the construction program for the last two years, represents a real threat to the centers program.

In short, we heartily support the intent of S 2146, at the same time acknowledging the need to reconcile it with S 2097.

American Psychiatric Association

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August 16, 1971

The Honorable Harold Hughes
Chairman
Subcommittee on Alcoholism and Narcotics
Committee on Labor and Public Welfare
1327 New Senate Office Building
Washington, D.C. 20510

Dear Senator Hughes:

The American Psychiatric Association, which represents 19,000 of the 25,000 practicing psychiatrists in the United States, wishes to support the essentials of your latest piece of legislation dealing with drug abuse, "The Federal Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act of 1971" (S. 2217).

Our Association views your bill as a concerted attempt to establish a multi-pronged national attack on the problem of drug abuse and dependence, encompassing a number of instrumentalities to accomplish this purpose. As you recall, we also supported the "Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970" which you sponsored, and which we regard as quite similar in many ways to your bill on drug abuse.

It would be redundant at this time to go into the diverse reasons why drug abuse and dependence constitute a severe threat to our society, a fact that is generally accepted by a growing number of the American people, and we do agree with your statement that the problem presents elements of extreme urgency.

We do consider it essential that the various instrumentalities set up by the bill, i.e. the Office of Drug Abuse Prevention and Treatment in the Office of the President, the government agencies presently involved in drug abuse control, the newly proposed National Institute on Drug Abuse and Drug Dependence, the new grant programs for assistance to state and local communities, and the Independent National Advisory

Council on Drug Abuse and Drug Dependence, work together in a state of coordinated harmony toward the achievement of a thoroughly effective program. Nevertheless, the American Psychiatric Association views the Special Action Office of the President as necessary to facilitate the coordination and implementation of the various programs and not a monolithic device to unilaterally direct efforts on the local and national levels.

We support your recommendation to expand the role of the community mental health center in the treatment of drug abuse and drug dependence. These centers are operational and represent a logical modality for treatment facilities, provided they are adequately funded and staffed to accomplish their augmented goals.

The wide provisions which you make for veterans' treatment, to make veterans' facilities available to all of our returning servicemen despite the nature of their discharge status, and the special programs you propose for Federal civilian employees, are all commendable efforts which we heartily endorse.

The Model and Experimental Prevention, Treatment and Research Program of your bill is, of course, viewed as a matter of the greatest importance and priority because of the wide gaps in knowledge which exist in the area of drug abuse.

The American Psychiatric Association stands ready to be of whatever assistance it can by offering its knowledge in this field through our specialized task forces and committees on drug abuse. We wish you a rapid passage of the bill.

With very best personal regards, I am

Sincerely yours,

Ewald W. Busse

Ewald W. Busse, M.D.
President

Senator HUGHES. I wish to thank all of those who actively participated in the hearings along with those unable to attend but submitted statements and letters voicing their concern and opinions.

(Whereupon, at 11:50 a.m., the subcommittee adjourned, subject to the call of the Chair.)

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