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ABSTRACT

Following Governor Milliken's address, Dr. Dana Farnsworth defines the problem in terms of who's involved, to what extent, and with which drugs. His presentation focuses primarily on the motives of affluent young people who experiment with or become dependent upon hallucinogens, marihuana and amphetamines. He deals extensively with the drastically changing psychological environment of adolescents, their resultant unhappiness with life and society, and the use of marihuana as a special symbol of this dissatisfaction. The relationship between the control of drug use, and the balance between the respective rights of society and the individual is explored. A case is made for more rational drug laws. Dr. Jerome Jaffe of the Illinois Department of Mental Health talks about solutions. Components of a strategy are listed, along with their underlying assumptions. He elaborates on the State of Illinois' response to compulsive drug users. The premises and principles of a multimodality pilot treatment program of the Illinois Narcotic Advisory Counsel are discussed. Reactions and discussions are included. (TL)

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The Piton

SPECIAL ISSUE

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Credits

The Honors College is pleased to cooperate with the several sponsoring agencies in reproducing the substance of *THE GOVERNOR'S CONFERENCE ON DRUG DEPENDENCE AND ABUSE*. The conference was held on the campus of Michigan State University on December 8, 1969.

The Honors College expresses its deep gratitude to:

THE OFFICE OF RESEARCH DEVELOPMENT and
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MICHIGAN

for their support, both financial and moral, in bringing the content of this conference to a wider audience.

GOVERNOR'S CONFERENCE ON DRUG DEPENDENCE AND ABUSE

MODERATOR:

Louis Rome, Executive Director
The Michigan Commission on Law Enforcement
and Criminal Justice

CONFERENCE SPONSORS:

Governor William G. Milliken
The Michigan Commission on Law Enforcement
and Criminal Justice
College of Human Medicine, Michigan State University
Continuing Education Service, Michigan State University

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

WILLIAM G. MILLIKEN
GOVERNOR

SPECIAL MESSAGE

I wish to take this opportunity to express my personal thanks to all those who participated in the Governor's Conference on Drug Dependence and Abuse held last December at Michigan State University. The fact that we had to use closed circuit television to allow over 600 people to view the conference indicated the tremendous interest in the drug problem in Michigan.

In response to this expression of public interest and concern, the Honors College at Michigan State has offered to devote an entire issue of its "Piton" to a report of the conference. With the assistance of the Michigan Commission on Law Enforcement and Criminal Justice, this issue of the "Piton" virtually reproduces the conference in total. For these efforts, I am most grateful.

If we first determine the facts about this danger and then use the facts to educate potential drug abusers, I am confident that we can reduce this danger and save thousands of people from the dismal consequences of drug dependence or addiction.

It is my urgent hope that the conference and this conference report will provide many of the badly needed facts about the drug abuse problem and its possible solutions.

William G. Milliken

Governor

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Ladies and Gentlemen in attendance at the Governor's Conference on Drug Abuse.

As Mr. Rome has indicated, this is not the first time that I have had the opportunity to speak at a Governor's Conference, but it is the first time that I have been called upon to introduce both the subject matter and the Governor. I am reminded of a remark attributed to Hubert Humphrey after the 1960 election when, as Senate Whip, he had been invited to the White House with other congressional leaders. He stated that he had hoped to eat all of his meals at the White House but was delighted, under the circumstances, to be invited for breakfast. He indicated that he was still part of the governmental process.

Honorable John B. Swainson, Circuit Court Judge for Wayne County, Detroit, Michigan

I am delighted to be invited to this Governor's Conference, but the subject of the conference is not so delightful. Both drug abuse and drug dependence have become a major public health problem in Michigan as they have in other areas of this country. It certainly is a problem not restricted to youth, but is particularly endemic to youth and is epidemic throughout the nation.

Consider, if you will, these facts:

1. *In 1968, the Federal Bureau of Narcotics and Dangerous Drugs ranked Michigan fifth in the United States for opiate drug arrests (very closely approaching Los Angeles).*

2. *Doctors and health and law enforcement officials say that there are between 3,000 and 4,000 KNOWN narcotics addicts in the City of Detroit alone. (There are estimated to be a total of 10,000 persons addicted to narcotics or dependent on dangerous drugs.)*

3. *During the period January through September, 1969, more than one-third of the drug arrests by the Detroit Police Department were of persons between 17 and 20 years of age.*

4. *The estimated cost of criminal activity necessary to provide Detroit opiate addicts with the money for their drug purchases may amount to more than $40,000,000.00 per year (4,000 addicts times $10,000.00 per year habits).*

5. *Narcotics and dangerous drugs, including alcohol, kill more people in the United States than all other chronic diseases combined. There is no question but that narcotics and dangerous drugs abuse is the number one cause of death for the 15-35 year age group.*

Now, in view of these facts, what has been done, what should be done and what can be done? (Interestingly, this problem has probably brought families closer together in a learning experience than any other single problem in this decade.)

EDUCATION: There is a tremendous demand for information about the broad spectrum of drug abuse and drug dependence. The information is desired by parents, teachers, police officials, judges, lawyers, administrators and yes, even youth.

TREATMENT FACILITIES: Presently there are no treatment facilities for drug-dependent persons in the State of Michigan. There are some fragmented programs with very limited application to the endemic and epidemic problem described. There is an acute need for in-patient treatment facilities. A Judge can do only one of two things today; place a narcotics offender on probation, or commit the person to one of our penal institutions.

RESEARCH: Suffice it to say that there is the greatest lack of information in the area of the long term effects of drug abuse than in any other area of inquiry. There is much research to be accomplished, and by the very nature of the subject, it is a most difficult subject in which to gain objective study.

RE-EXAMINATION OF STATUTE LAWS: Our present statute laws in regard to the illicit traffic in drugs, drug abuse and drug dependence, have not been effective in the past, are not now, and there is very little hope that they will be effective in the future. There is a desperate and compelling need for a re-examination of our present laws with a view towards providing treatment for drug dependent persons rather than only assessing criminal sanctions. For too long we have considered drug dependent persons as evil-doers, rather than as unstable persons suffering from a chronic illness.

Out of all of these facts there has emerged a four letter word -- a four letter word joined in by both the young and the older citizens -- and this word simply is *HELP*.

Our Governor has heard this appeal and by his appointment of a Special Committee on Drug Dependence and Abuse, by his consultation with the President and the Governors of other states on December 3, 1969, by his calling of this Governor's Conference on Drug Dependence and Abuse today, he has demonstrated his concern with this problem that has been described as "the most staggering public health problem facing this nation today."

It gives me a great deal of pleasure to introduce to this Conference a person who obviously needs no introduction, the Governor of the State of Michigan, The Honorable William Milliken.

Governor's Address

William G. Milliken

Ladies and Gentlemen:

It is a pleasure for me to welcome you to the Governor's Conference on Drug Dependence and Abuse.

The fact that we have had to use closed circuit television to allow everyone to participate in this conference indicates the tremendous interest in the drug problem in Michigan.

I want to extend a special welcome to the many legislators who are participating in this conference. The Legislature and I share the important responsibility of assuring an effective program to deal with this growing social menace. Our efforts to enact laws and to fund programs will have an important impact on drug abuse in Michigan.

There can be no doubt about the absolute urgency of the drug abuse problem. This was dramatically illustrated by a conference I attended recently in

Honorable William G. Milliken, Governor, State of Michigan

Washington called by President Nixon. The President, the Vice-President and several members of the cabinet met with 42 governors to discuss the drug problem that has become a fact of life -- if not a way of life -- for far too many of our citizens.

The President noted during his three-hour meeting on the drug abuse problem that one-third of all college students in the United States and sixteen percent of all the high school students either are users of marijuana now or have at least experimented with marijuana. I was shocked to learn that one-half of all the robberies in our nation's Capitol are committed by people addicted to drugs and that 100 people in New York died from an overdose of drugs in one week alone. The Justice Department noted that 76% of all of those arrested last year for possession of drugs were under 25 years of age. But, of course, the arrests represent only the tip of the iceberg of a problem that affects such a large segment of an entire generation that is seeing the end product of our pill culture.

I came from that conference, as I hope you will go from this conference, with an *extreme sense of urgency* and an *absolute determination* to do something about this grave problem.

We are fortunate to have an outstanding group of nationally known people in the field of narcotic and dangerous drug dependence and abuse participating in this conference. In the major presentations by Dr. Dana L. Farnsworth and Dr. Jerome H. Jaffee and in the panel discussions, you will have the opportunity to hear this broadly representative group of experts.

Before the first major speaker, I would like to comment further about my meeting with the President and the other governors.

It was made very clear at the meeting that drug abuse is a national and international problem. For example, several foreign countries serve as the source of illicit drugs, while traffic in illegal substances over state lines is a Federal crime.

The Federal government has an important role to play in enforcement and control of dangerous substances -- in education relating to the dangers of drugs and in the rehabilitation and treatment of addicts and drug-dependent persons.

This Governor's Conference will give you an opportunity to look broadly at a complex and challenging problem.

First, and perhaps most important, is the question of defining and delineating the drug dependence and abuse problem.

The issue of drug abuse, perhaps more than any other public issue, requires precision of definition and rational discussion by public officials and by the public. In seeking solutions, we must recognize that there is not one, but several problems.

In discussing these problems, it is important also to be aware of the fact that drug abuse is often only a symptom of some deep psychological problem in the individual.

The second broad area for our consideration today is an examination of possible solutions to these problems. This conference will not produce all the answers but it will, I hope, focus public attention on alternative programs that are being considered. Your discussions will, I am sure, bring out many different approaches to this vastly complex problem.

I hope this conference encourages debate and discussion that will help give Michigan a comprehensive program to deal with drug abuse.

In discussing possible solutions, it is important to mention several efforts that are now underway in Michigan:

First, I expect to receive the report of my Special Committee on Drug Dependence and Abuse soon. This broadly representative committee has been working for several months on a set of comprehensive recommendations for action.

Second, committees of both the House of Representatives and the Senate are working on legislation to improve Michigan's response to addiction and drug abuse.

Third, I have urged Congress to enact legislation creating a Presidential Commission on Marijuana. This Commission, if created, would provide the needed resources and expertise to establish the facts about marijuana use.

Fourth, a number of private and public agencies are continuing their efforts to develop and operate programs in this area.

I have strongly supported the efforts of Synanon in Detroit as one proven way for some addicts to overcome the habit that is robbing them of a meaningful life.

In all this, I think we should realize that the only meaningful solution must be an individual solution. The heroin addict, the young person slipping into dependency on marijuana, and the adult hooked on barbiturates, all must make difficult personal decisions if they want to return to a normal life free of drug dependence.

Our *laws,* our *public programs,* our *educational efforts,* and our *personal efforts* must be directed toward providing each addict with the support he needs to find his own way out.

While this Governor's Conference on Drug Dependence and Abuse will only provide a start, I hope it will make strides toward these objectives:

First, to win greater commitment on the part of law enforcement, health and education officials, and public and private agencies, to work cooperatively in developing effective programs.

Second, to create willingness on the part of young people to listen to the honest facts regarding the real dangers of excessive drug use.

Third, to build understanding among parents and other adults that scare stories and myths regarding narcotics and dangerous drugs are no longer an effective way to help young people decide whether or not to experiment with them.

Fourth, to win wide recognition that drug abuse is not simply a problem of a minority of misguided youth, but a danger that hangs over all ages and classes in modern society.

I would like to thank the Michigan Commission on Law Enforcement and Criminal Justice, the College of Human Medicine, and the Continuing Education Service of Michigan State University for co-sponsoring this program.

Mr. Louis Rome executive director of the Law Enforcement Commission, merits special thanks for the many hours the Commission staff spent arranging this event.

Finally, I would like to thank each of you for attending and for your interest in this problem.

Drug abuse poses a serious danger to the whole fabric of our society. If we first determine the facts about this danger and then use those facts to educate potential victims, I'm confident that working together we can remove this danger and save thousands of people from the dismal consequences of addiction.

Definition and Delineation of the Drug Dependence and Abuse Problem

Dana L. Farnsworth, M.D.

A crisis of morals and values confronts this nation, and shows itself in many forms. The idealism of the young, their critical spirit, and their impatience with anything less than full justice and equal opportunity for everyone are not only admirable but a source of optimism and hope for the future. Some of their methods of expressing their impatience, however, do not always lead to a realization of their aims -- they may, in fact, be self-defeating.

One of these unfortunate by-products of social upheaval is the pervasive and widespread use of drugs for non-medicinal purposes, coinciding with an overuse of many drugs which have a very important role in medicine. Under present circumstances, it is understandable that an observer would first come to the conclusion that drugs were the primary problem. Only after considerable thought does it become apparent that the basic problem is the psychological and emotional state of those who look to drugs for a solution to their problems and thus postpone or avoid sound approaches toward

Dana L. Farnsworth, M.D., Director, Harvard Health Services, Harvard University, Cambridge, Massachusetts

their resolution. Hence, any program of drug education must focus on the individuals who use drugs. "But until an individual can understand his drug need in terms of his own psychology, drug use for him will continue to be one of the symptoms that perpetuate its causes (3)."

Almost every class entering college today contains a higher percentage of students who have used illegal drugs than did the preceding one. The problem is spreading from colleges and high schools down to the junior high and even grade schools. The use of marijuana and amphetamines, especially, is escalating apparently beyond control. Thousands of young people are demonstrating lack of judgment concerning drugs -- they have some realization that these are dangerous substances, yet they take drugs anyway, risking their own health, their present and future mental functioning, the legal consequences if they are detected, and the further alienation from the adult world which drug use represents.

I should like particularly to direct your attention to an aspect of the drug problem which is very rarely discussed -- and whose omission indicates the depth of the misunderstanding. *Why* do we consider this such a serious problem? Why is our reaction so strong and so emotional? Even those of us who are professional people, presumably reasonably knowledgeable about the dangers of this world and the process of growing up in it, have reacted with shock, horror, and disbelief when learning that our children have been using drugs. Why does marijuana, especially, warrant a display of emotion more intense than that associated with most of the more dangerous drugs? Why are we getting so distraught?

An essential first step is to recognize that many persons have an immediate, emotional reaction to the word "drug": to some it means "narcotic," to others, "anything illegal that people smoke or inject or swallow," and to others simply any medicine prescribed by a doctor. These incomplete, emotionally charged meanings have confused the problem. A more comprehensive, workable definition is the following:

A drug is any chemical compound or non-infectious substance, other than food, which when taken into the body changes, in a chemical manner, the physical or mental state of that body.

This definition covers all of the above. It also covers alcohol and tobacco, which few adults think of as drugs but which are included in this category and which (as we shall see) are very much in the minds of young people when they talk about the drug problem.

In our society, the prevailing opinion is that drugs should be used only for medical purposes -- to correct some condition that is causing the body to function incorrectly -- and only under competent medical authority. A partial exception is that some drugs which do not have any great potential for danger are available without prescription, but in this case the "competent medical authority" is assumed to be the user himself. The two major exceptions to this rule are alcohol and tobacco, which our laws and social mores permit to be employed for purely social use. Other societies have at different times allowed various drugs to be used for social and religious purposes, and it is possible that in the future the use of other drugs will be permitted in our own society. But at present alcohol and tobacco are the only widely-used non-medical drugs that are legally permissible. And the essence of the "drug problem" is that more and more people are taking various drugs without medical supervision or for non-medical purposes.

I have said "people" rather than "young people" and added "without medical supervision," because the drug problem includes much more than young people taking drugs for non-medical reasons. They form only a part of the problem, and their part is derivative from the main problem -- the fact that we are a "pill-oriented," medicated society. Belief in the efficacy of curative drugs is part and parcel of modern medical care. Not only physical ailments, but psychological troubles also, are now being "solved" by pharmacology; tranquilizers, antidepressants, sedatives, stimulants, are all available to reverse undesired moods. It is not uncommon for many Americans to use up to six mind-altering drugs each day -- the caffeine in their morning coffee, nicotine in their cigarettes, diet pills, tranquilizers, alcohol, sleeping pills. There are drugs for every transient pain, every sniffle, every small bodily dysfunction. Both young people and adults are bombarded by advertising that displays the magical power of drugs. There is little necessity, they hear, for preventive measures, for endurance, for self-discipline, for more rational modes of living: any trouble that you get into, drugs can get you out of it. If your trouble is too deep for non-prescription medicine, go to your doctor, who has available the miraculous

pharmacopeia of modern medicine -- able to prolong life, instill happiness, and cure nearly all the ills of man.

With this background, it is easy to see how today's young people grow up with the general conviction that drugs can solve anything, given the right prescription and the right dosage. The idea of changing their physical or mental state by swallowing chemical substances is thus an essential part of their cultural orientation. This is where the "drug problem" starts, in this social acceptance of drugs; it is not essentially a rejection, but rather an affirmation, of early teaching and propaganda.

Obviously, a drug used under proper medical supervision can be of inestimable, life-saving value. And probably an occasional self-prescribed aspirin or antacid does little damage. But the very complexity and potency of modern drugs has led to the complications of undesired side-effects and the proliferation of drugs to ameliorate the side-effects of others. Many physicians feel that the case for drugs has been over-stated. They are a temptation to the physician: he finds it much easier to prescribe a drug to clear up a symptom than to spend time and effort, and possibly frustrate the patient, in trying to discover the cause. They are a temptation to the patient: he knows he can get relief without making the radical changes that may be necessary to root out the cause of discomfort or disease. And once they are in the hands of the patient, they present a temptation to him and his friends to take the problems of diagnosis and adjustment of dosage into their own hands -- to decide who needs them, and when, and how much.

Drug abuse, therefore, involves the problem of all persons who may use drugs in an improper manner. The drug abusers include physicians who prescribe dangerous drugs without full knowledge of their effects, or use a strong drug to correct a condition which would right itself in a few days, or allow a patient to take a drug indefinitely with no follow-up. They include housewives who become dependent on diet pills or tranquilizers. They include business and professional men who cannot get through the day without two martinis at lunch, or rely on amphetamines to get them through a difficult project. They include all the people who demand a broad-spectrum antibiotic every time they get a cold. Yet these people find it very hard to see their behavior as drug abuse; they often say, "I got this drug

legitimately, so how can my taking it involve abuse?" They are also the ones who may react the most emotionally when their child is discovered to be using drugs. It is important that we see the basic contradiction in thinking which this polarization manifests.

The non-medical drugs are also abused. Tobacco has been shown to be carcinogenic and to contribute to chronic lung and heart disease. It would probably not be legalized if suddenly introduced into our culture; but it has been so extensively used and become so important economically that attempts to limit its use have had to be extremely cautious and tentative. The dangers of, and economic loss from, acute and chronic alcoholism are much greater than those from any of the illegal drugs. But we permit these things to continue, because we have discovered (especially through the experience of Prohibition) that they are so integral a part of our society that though they may be harmful, trying to ban them produces more social evils than does their controlled use.

It is very difficult to view one's culture and one's attitudes objectively, but in this case it is of utmost importance that we try. Much of the drug problem -- and much of the other misunderstanding that makes up the "generation gap" -- comes from ourselves having one view of our society, and young people having another. Both are valid, if incomplete; and if we try to understand their point of view, and explain ourselves in such a way that *they* will understand *us*, there is at least a possibility of overcoming this dangerous gap in communication. No matter how good our educational and judicial programs are, they cannot solve the drug problem while young people continue to say:

> *"If my parents drink, why can't I use marijuana?"*
>
> *"Why is drug dependence any worse than being dependent on music, or on another person?"*
>
> *"You can't discuss drugs unless you have used them."*
>
> *"If we didn't have unfair laws, there wouldn't be any problem."*

Nor will there be any solution while parents think they have definitive

answers when they say:

> *"I hear that some of your friends are smoking marijuana, and I forbid you to see them again; I don't want you turning into a dope addict."*
>
> *"We drink alcohol because it's legal -- but marijuana isn't legal, and you have to obey the law."*
>
> *"Adults have more problems than children, that's why we take tranquilizers and sleeping pills."*
>
> *"If we put all the kids who take dope in jail, that will scare the rest of them enough so that the problem will solve itself."*
>
> *"I check my daughter's room every week to make sure she isn't hiding any drugs."*

In such a morass of miscomprehensions and false assumptions, it is no wonder that little satisfactory progress has been made. But if both young people and adults can understand the meanings that lie behind these questions and statements, there is hope of solving the problem through mutual understanding.

The drug most commonly abused, and most intimately connected with the "drug problem," is marijuana -- a plant with unjustified notoriety as the "killer weed" second only to heroin in its danger. Marijuana is actually a mild hallucinogen and intoxicant (in the dosages usually available in this country), and its most common effect is to produce drowsiness, a feeling of closeness and companionship, and euphoria with alteration of the perception of time and space. Because much of its effect depends on the mood of the person taking it, an individual who is disturbed or nervous may experience acute panic or depression, and cases are known where it has precipitated psychotic states in unstable persons. Isolated instances of marijuana use are usually not dangerous, however, and if the user does not continue taking the drug it is very unlikely that damage will result. There is much more danger to the user from the laws which classify marijuana use or possession in the same category as that of the hard-core narcotics.

Marijuana does not produce physical dependence, but it does produce psychological dependence when it is used regularly or used by persons with emotional problems who use the drug as a means of blotting out these problems. Its continued use has been associated with what has been called an "amotivational syndrome (4);" the user loses his ability to concentrate, to set and carry out realistic goals, and to communicate in the usual manner with other persons. He becomes more and more unable to cope with reality, endure frustration, or master new material. Persons whose original orientation had been towards conforming, achievement-oriented behavior tend to change to a state of careless drifting after long-term marijuana use.

We do not yet know whether long-term use affects the user's intellectual ability or causes organic damage. Probably the marijuana usually available in this country does not -- it is generally of a weak grade to begin with and is often further "cut" by dealers. Marijuana use does not increase sexual activity, cause criminal activity, or lead directly to the use of other drugs. Because it releases inhibitions, it may cause an unstable person to become violent, or a person from a culture where crime is endemic to join in criminal activity, but other drugs are much more implicated in these effects.

Although marijuana use has no cause-effect relationship with use of stronger drugs, they are connected in certain ways. Dealers are apt to encourage the use of stronger drugs which have a higher profit margin; persons with emotional problems may find that marijuana does not give them enough relief and turn to stronger drugs because of their greater power to mask reality; and persons who are introduced into the drug sub-culture are likely to experiment with whatever drugs are available. It must be admitted, however, that a person who does not start with one of the milder drugs is unlikely to become involved with the stronger ones.

I believe that marijuana *is* a dangerous drug, and that although more research is desperately needed if we are ever to find out the scientific facts about this drug, present evidence suggests that the drug can be harmful and that sound social policy would be to discourage its use by all reasonable methods until or unless future research proves that it is safe (2). The present laws, however, are so severe and so out of proportion to the harm caused by marijuana that they have been widely ignored or enforced

sporadically and discriminatorily. Rather than being basically punitive, laws ought to be used as instruments for learning and for education; they should be as mild as possible to achieve the result, but severe enough to indicate that the society means what it says. They ought also to be enforceable, otherwise they become a sham. I would suggest that the penalty for the first offense of using or possessing marijuana be a relatively mild one, and if the offense is not repeated that it not be made a part of the individual's permanent record. But if he repeats the offense, the penalty should be quite markedly increased, and if he again repeats it, the offense becomes a felony. Whatever the details of our revised drug laws, the penalties for each drug should be proportional to the ability of that drug to cause harm. And the main thrust should be not at the individual consumer, who as we shall see is not always a completely free agent; it should be at the distributor, who is the one who actually perpetuates the drug problem by making drugs so widely available.

Closely related to marijuana in their effects are various other hallucinogenic drugs: LSD, DMT, STP, mescaline, peyote, psilocybin. THC (the active ingredient in marijuana) and hashish (purified marijuana resin) are usually included with these stronger drugs, because although they are cannabis preparations they are much stronger than marijuana and probably more dangerous. All of these drugs have the potential for causing severe psychotic states, even in relatively stable individuals who have taken a single dose. The third of the intrinsically illegal drugs is heroin, the drug which for many years was representative of the entire drug problem. Previously, however, it was only a problem in urban areas among disadvantaged groups; with the escalation of the drug abuse problem heroin is becoming available in places where it was never a problem before. Drug dealers have been reported as urging young people to use heroin when marijuana is in short supply, even lowering prices drastically as a kind of "loss leader" salesmanship.

The drug abuse problem also involves various prescription drugs which are usually made available by diverting legitimate drug supplies into the black market. The ones most abused are the depressants (especially barbiturates, but also the various tranquilizers), narcotics and related synthetic analgesics, and stimulants. The stimulants -- amphetamine and methamphetamine, usually known as "speed" and most popular when taken intravenously -- have become an extremely serious problem. Their use leads to hyperactivity and

often to violence, malnutrition and infections from unsterile hypodermic needles are common, and the person who becomes dependent upon them has an estimated life span of only a few years if he continues the habit. The drugs cause constant stimulation of the central nervous system and eventually impair both mental and physical functioning. The adolescent who is determined to experiment will try mixtures of these various drugs (combinations of amphetamines with other drugs are particularly popular). He will also try whatever else is available: preparations containing codeine, morphine, opium, or antihistamines; heart stimulants; various volatile substances which give off intoxicating (and often poisonous) vapors; and even inert substances which acquire a brief popularity because others have suggested that they have bizarre effects.

To understand why drug use among adolescents is so widespread now, an awareness of the rapidly changing psychological environment of the young in present-day society is essential. Such an understanding is useful only if one sees the current scene as dynamic, constantly changing, and viewed by those in it with fine shades of emphasis that are often more subtle than an outside observer can comprehend at first glance.

Adolescence is the time when the young person starts the long task of achieving independence in place of dependence and individual identity in place of a borrowed or assigned identity, developing personal values, achieving meaningful social relationships outside his family, deciding on his life's work, and learning how to postpone immediate gratification in order to achieve long-term goals. It is natural for him to turn increasingly to peer groups for his companionship, to test the boundaries of authority and to experiment regarding his own place in society, and to desire to experience as much as possible in order that he may have as clear an idea as he can obtain of what choices are open to him in this world.

He lives, also, in a world which has exploded in technological skill but has had no corresponding increase in understanding of human needs. The old structural institutions of family, church, and community have lost much of their influence, and no way has been found yet to reestablish them or to create meaningful new social institutions. Publicity by the mass media spotlights the bizarre, the violent, and the psychopathological, until often they are taken as the norm. Adolescent purchasing power has increased and

restrictions have decreased. Permissive modes of childrearing have confused both young people and their parents as to what is expected of them. Because their parents gave them little responsibility, they do not know how to take it and are unwilling and afraid to assume any. A marked and dramatic change has overtaken what used to be considered acceptable in speech, manners, clothes, and in entertainment and communications media. Vigorous attacks on the "Puritan ethic," originally motivated by the very real defects and excesses of this point of view, have progressed to rejection of all its components, good and bad. Attitudes toward sexual morality have undergone radical changes, and in many groups behavior has changed as well. The trend toward immediate gratification of impulses has become stronger, and postponement of gratification is often considered futile.

Despite all this, young Americans have been able to establish new moral standards based on honesty and increased personal freedom. They want a meaningful part in a world which expresses high ideals but is mired in aggression, discrimination, economic imbalance, violence, depersonalization, and personal unhappiness. They have seen a dampening of the high hopes for quick granting of full civil and social rights to all citizens. And the continued involvement of our country in the Vietnam war and in a generally increased military posture has evoked drastic divisions among everyone in the nation. The transition period of adolescence seems to be unbearably drawn out; physically mature and socially relatively sophisticated, but with their education incomplete and no meaningful social role assigned to them, they feel trapped in a continued state of dependence from which they need to break out in one way or another. Yet there often seems to be no advantage to growing up, for maturity is seen only as a technological jungle and a series of superficial encounters with persons with whom one never has a chance to interact on a human level. They are not happy, and they are looking for ways out of their unhappiness.

The basic effect of drugs is to change the mental atmosphere in which people live and to help them escape from some form of mental pain -- unhappiness, loneliness, feelings of alienation, depression, and the inability to resolve personal or interpersonal conflicts. Marijuana is the drug which many young people feel is the perfect antidote to mental pain. Not only can it produce peacefulness, contentment, and euphoria at the time it is taken, but many people believe that even when the drug is no longer

chemically active it will have given certain lasting insights that will aid in solving problems and breaking through the psychological barriers that have prevented success in friendship or love. Narcotics, barbiturates, and alcohol, all of which are central nervous system depressants, cause an individual to forget his troubles for the moment. Paradoxically, so do the stimulants. They may cause nervousness and paranoid reactions, but they also make the individual stimulated and self-confident, and give him a surge of energy in which he may respond actively without worrying about himself or the consequences of his actions. The stronger hallucinogens, too, may be used as an escape from mental pain, or at least as a diversion from everyday troubles.

But the desire to escape from unhappiness is not sufficient explanation for the epidemic of drug use that has erupted in the past few years. Another important aspect is that drug use, after it became established in certain key areas of life important to young people, became a symbol of the things they were trying to accomplish and the manner in which they were trying to accomplish them -- peer group identification, adolescent rebellion, and the need to experiment.

Many persons have said that young people want marijuana legalized; others have said that the main reason they use marijuana is *because* it is illegal. Still others have pointed out that the other drugs in common use are not illegal, but although true this is not exactly the point at issue. Unauthorized possession of them often is illegal, so is being under their influence in public, and the whole aura of "drug use" evokes such a highly negative reaction that the actual technicalities of illegality are more or less beside the point. But marijuana use, because the laws against it are so specific and so irrationally severe, has become a symbol of a very great protest against society (and also one which the individual is very likely to get away with). More realistic marijuana laws would defuse the problem on two fronts: by substituting reason for emotion, they would make marijuana a less powerful symbol of that which society fears; and they would make possible the enforcement of laws and restore some of the respect which authority has lost.

Because drugs have acquired this symbolic status, they have also acquired a social currency and sometimes function as a "coming-of-age" rite. Group

identification and the sharing of experiences with friends are important for young people, especially in a world where they feel cut off from everyone except their peers. Peer group influence often leads even basically cheerful young people to think in a pessimistic manner, and may contribute to drug use by creating an atmosphere of hopelessness and negativism. When group identification and shared experience include initiation into drug use, even young people who ordinarily would not consider taking drugs find that the pressures on them to conform are immense. Only a few years ago, in the less complicated world of our adolescence, beer and cigarettes served very much the same purpose, and usually "going along with the group" had no more serious consequences than a bad stomach upset or chastisement by one's parents. Now, however, the symbols of maturity and rebellion are drugs which can lead to a felony conviction or to serious mental and physical illness. Many young people realize at least some of these facts, and often their decision to try drugs is not made lightly.

Along with rebellion and identification goes the desire to experiment. Young people are curious about unknown experiences, and they know that drugs have the capacity to produce many "different feelings." This desire to experiment is akin to other activities engaged in by adolescents and young adults, such as trying on new roles, life styles, and self-images. Often a person who is curious about drugs will try them once or twice and then stop after his curiosity has been satisfied. Even if he receives pleasure from the experience, he will decide that the manifold reasons for not taking drugs militate against further drug use. This is a strong argument for not over-reacting to a situation in which a young person is discovered to have experimented with drugs. It does not necessarily indicate character disorder or personality difficulties. Although such use is not to be dismissed without a thought, it may indicate nothing more than a simple desire to find out what all the commotion is about, and once he has obtained that knowledge the person concerned will have no more need to use drugs.

Experimentation also involves the element of risk. This is two-fold: the risk involved in possessing and using illegal substances, and the dangers inherent in the drugs themselves. Young people's understanding of the danger varies widely. Some seem to believe there is no danger; some acknowledge its presence but believe that they are strong enough to conquer it, brave enough to descend into a hallucinatory psychosis and return unscathed.

Others do realize that the drugs can cause damage but are so strongly motivated to use them that they consciously or unconsciously deny the danger. Such denial may lead to dangerous psychological complications. The risk-producing attributes of drugs are especially prized in that facing and conquering the challenge requires no physical exertion.

The "psychedelic," "mind-manifesting" qualities of the hallucinogenic drugs introduce another important dimension into the drug abuse problem. Many people feel that much of what is wrong in the world today could be improved if new areas in man's mind were opened up and new goals seen and adopted. Marijuana, LSD, and the related drugs, they feel (in all honesty and with what they think are sound reasons), will aid in creativity, give access to facets of the mind that usually remain hidden, and reveal new dimensions of universal truth. These people are searching for new values embracing heightened aesthetic response, subjectivity, introspection, self-knowledge and understanding of others, nonverbal experience, pleasure, and creativity.* And they feel either that these can be achieved only through drugs or that any other mode of achieving them is so long and arduous that drugs are a tempting short-cut.

No evidence has yet been demonstrated, however, that extensive use of drugs for self-realization, increased creativity, or attainment of mystical states of consciousness has been beneficial for more than a few isolated individuals. Certainly it has had effects on many individuals that are little short of disastrous. There is no doubt that many drug users are sincerely interested in achieving greater creativity; but creativity is generally regarded as including productivity. And what happens to people who become set in a pattern of drug use is that from then on nothing happens. The great philosophical theories are developed, but they are not recorded; the great paintings are

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* Persons familiar with adolescent culture will see many of these goals reflected in the musical and artistic forms, in experimental forms of communication, and in the interest in Oriental religions and philosophies, mysticism, and astrology.

envisioned, but no paint is applied to canvas; everything draws to a halt.

But one of the main reasons for the drug abuse problem is simply that drugs are so readily available. Once the idea of drug-taking became fashionable, a huge potential market was established, and the suppliers were quick to grasp their opportunity. This easy accessibility has meant that there is a deceptively easy answer to all the adolescent's problems right at hand. For a few dollars he can escape from his problems, defy society and authority, identify with his peer group, imagine he is discovering his true self, and enjoy the thrill of a dangerous and unknown experience, all at once. The mystique of "drugs can do anything" is present from the medically-oriented culture; the desire to escape from personal trouble and to revolt are often omnipresent; and the dangers are seen only as an additional challenge. Anyone who does not try drugs is apt to be considered by his peers as pathologically timid, or totally lacking in group orientation. In addition, rapid dissemination of information about new drugs and new forms and patterns of drug experimentation means that even in remote areas adolescents have available not only the drugs but also much information about them.

The control of drug use is intimately involved with the age-old problem of the appropriate balance between the rights of the individual and the right of society to keep intact the web of morality which enables it to survive (1). Those who stress the rights of the individual find one of the most famous expressions of their point of view in John Stuart Mill's essay *ON LIBERTY:* "...the only purpose for which power can rightly be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant..." At the other pole is the idea that people must be protected from harm, in this case the harm that drug use can cause.

The two main contentions made by the advocates of free drug use are that (a) such use is a purely private matter, not involving nor harming anyone else; (b) even if a particular drug causes harm to the user, that is his business and not society's. There would be a definite difference, in this point of view, between control of a drug that is taken quietly at home and control of a drug that causes a person to run wild in the streets and attack other people or destroy property. Considerable support would be given, even by liberals, for restriction of the second drug. It seems to me that our young people generally underestimate the danger to society that a drug-intoxicated person can be. A drug *may* be taken quietly at home, but

if there is free access to that drug there is no control over whether it is taken in an isolated setting or whether the user, despite prior intentions, will become a public hazard. Amphetamines, for example, have caused many instances of violence. Many of the other abused drugs cause drowsiness, slowed reflexes, and mental clouding. A person in this condition, driving a car or even trying to walk around in a crowded city, can be a menace to everyone around him.

Moreover, most persons have responsibilities to others -- wives or husbands, children, parents, those they work with -- and they are not free to do as they wish without any thought of these others. Drug use tends to reduce the responsibility of the individual and to undermine the inner discipline that directs him toward attainable and idealistic goals. In fact, hardly any action involves *only* the person who performs it -- everyone lives in direct or indirect interaction with other persons and with numerous social groups. Every time he encounters another person, even if only passing him on the street, a transient "society" is formed, a "social situation" comes into existence. Each of these momentary interactions changes the individual in some large or small way, and thereby changes the nature of each subsequent social interaction. Urban crowding and economic interdependence intensify the number of such interactions and the potential for good or ill in each.

When a young person says, "The society has no right to tell me what to do in my private life," he does not take into account these fundamental facts of human interaction. The society in which he lives, according to the philosophy generally subscribed to today, has the right to protect itself, to act in its own best interest, and to regulate the lives of its members in those areas where damage can result. Young people can see this in regard to laws designed to protect individual members of society against personal attack or loss of personal property, in laws regulating traffic and economic transactions, and in laws governing the structure of social units. They have been particularly able to see the legitimacy of the government's role in protecting and assisting the less advantaged members of the society. They must learn to see that their own acts of drug abuse can have a damaging effect on the rights of others.

Even when they have understood this, however, they are still apt to fall back on point (b): even if a particular drug causes harm to the user, it is none of society's business. We do not agree. But too often we have

expressed our disagreement in moralistic terms, e.g., "Society has the right to prevent you from doing something that is evil." This argument merely perpetuates the lack of communication, because a great many of today's young people do not consider this a moral matter and automatically see a red flag when the ideas of "good" and "evil" are raised. It will help if they understand that certain reactions left over from the days when society was more religiously oriented and a stricter morality prevailed are still consciously or unconsciously assumed by many persons. It will be even more helpful to examine the assumptions behind the following two statements:

(1) Society has the right to protect itself from loss incurred by diminished productivity of its members.

(2) Society has the right to protect an individual from harm which he may inflict on himself.

The first point assumes the basic idea that our cultural system believes all persons to be valuable and, indeed, necessary to the society. The society is only acting for its own self-preservation when it attempts to ensure that all persons will fulfill their potential and legislates against practices such as drug abuse which tend to lessen productivity. Young people may point out that other cultures have been able to tolerate use of cannabis preparations and narcotics; they should learn that these countries have had a very real problem with lost motivation and social decay but could tolerate this because very little was expected in the first place of those persons who became drug dependent. We cannot afford to waste human resources.

Young people may argue back that they have an "inalienable right" as human beings to determine their own fate and to limit their productivity, even destroy themselves, if they wish, and that their human rights supersede the rights of the society. It is no use to argue here that we are "right" and they are "wrong," for these are questions of value which lend themselves to discussion, not to scientific proof. But we should at least be able to enter into dialogue not over "rights" and "obligations" but about the nature of the society and to what a person's "humanness" entitles him. It will help, in this case, if we remember that adolescents are often very unsure of their position in society, their goals, and their rights, and that they feel fanatical about clinging to the few they do feel they possess. If we remember, also, that orientation towards these value questions can and does

change, it is quite possible that we may learn from them new ideas about human and social values.

Similarly, the society assumes certain rights of control because it knows that many persons do not know the correct way of handling dangerous substances. In some cases, simple age is considered sufficient proof that a person has learned enough to handle a particular potential danger, as in the purchase and use of alcoholic beverages. In other cases, particular ability must be demonstrated (licensing to operate a motor vehicle) or ability and intention to use properly (permission to purchase a gun, where both knowledge of gun operation and proof of being a law abiding citizen are necessary). In regard to drugs, the society has decided that the only persons with sufficient knowledge to ensure safe use are physicians. An individual may think that he has such knowledge, but many times the best of intentions break down. Man is weaker than he wishes to think himself. We have never had such an array of powerful psychoactive drugs available before, so we have no specific knowledge of what would happen if they were available without limitation or restriction to all who wanted them. But all our past experience indicates that the increased drug dependence would be striking, and the tragedy for society would be immense.

Both we, and the young persons with whom we are attempting to communicate, assume that the basic values involved are *freedom* and *responsibility*. Where we differ is in the means of achieving them. Young people are often inclined to think that if the other factors are working in his favor, a man is basically inclined to be responsible; but this is not always so. And often they have been unable to see the ambiguities in the idea of freedom. Freedom is not license; it is not doing anything you want; it does not include the right to interfere with other people's freedom. If you assume your own right to freedom, you must also see that other people have that right too, and that conflict can and does occur.

Maximum freedom depends on finding those minimal restraints on individual freedom which are necessary to ensure freedom for everybody -- as the Harvard Law School graduation ceremony calls them, "the wise restraints that make men free." It involves thoughtfulness, caring, being other-people-centered rather than self-centered, controlling impulsive action which may have untoward consequences. A free person must be one who has learned to predict what the consequences of his action may be. Such prediction and

regard for consequences are also necessary criteria for mental health, because the person unable to carry out these functions is likely to be suffering from a character disorder which makes him unable to see the effects of his actions on other persons.

One freedom which is often overlooked is freedom of choice -- the ability to use all available facts and all one's faculties in arriving at a decision. The protection of this freedom is an important function of the society. When a young person is just coming to the point where he makes basic choices about his own identity, his relationship to others, and his methods of problem-solving, it is vital that he have all his faculties and know the full range of possibilities. Drug use may destroy freedom of choice before it is ever exercised and may prevent many potentialities from ever emerging. A pattern of retreat from problem-solving and decision-making into a conflict-free world of drug use is especially dangerous when established early in life, because it cuts off all other possibilities. This is why we are especially concerned with drug abuse occurring among younger and younger groups.

Understanding the problem of social control still does not, however, answer all the questions related to why our society permits such free use of alcohol and tobacco but severely restricts the use of a drug such as marijuana.

We must grant at the outset that this is not altogether a question which legislators have sat down and analyzed rationally. Young people are probably correct when they say, "Marijuana is no more dangerous than alcohol;" we do not yet know what the effects of long-term marijuana use are. But when they continue that statement by saying, "If you legalize alcohol, why not legalize marijuana?" a different idea is introduced. A more logical corollary to that is not *legalize marijuana* but *prohibit alcohol*. But that has been tried, and we (even better than they) know what the result was in social disruption and gain in power for organized crime. For better or worse, American voters made it clear that they considered alcohol a social beverage and chose to let State and local laws, rather than Federal, determine the mode of its use. It is a drug which most Americans feel is a legitimate part of their own, or others', social life.

Marijuana, on the other hand, was introduced to the American people, in legislation passed in 1929 and 1937, as being a narcotic. It is not a narcotic, but many people still think it is; many of the laws still consider

it a narcotic and assess the same penalties for use or possession as are borne by heroin. An extraordinary cluster of emotional associations have grown up around this relatively mild drug, until many people, when they hear the word "marijuana," automatically think "dope addict!" or "dirty long-haired people defying society." Certainly adults need to be educated concerning the relative dangers of the various drugs just as much as do young people. But young people must realize that cultures differ; there are socially acceptable drugs and those which are not socially acceptable. The argument that if alcohol is allowed marijuana should be also does not take into account the fact that most people feel that alcohol *does* have a legitimate place in the society and that marijuana *does not*.

What, then, is the answer to the drug dependence and abuse problem? We shall encounter possible solutions in Dr. Jaffee's paper (p.), but there are two general points that I would like to raise for your consideration. One is that the essential task is one of education -- education of young people about the reasons for drug-taking and about the effects and dangers of drugs, and education also of adults, who perhaps know even fewer of the facts than do young people and who need especially to examine their own attitudes and to understand their own reactions better. This will have the practical effect of defusing the problem emotionally, and can make possible the passage of more rational drug laws and a more widespread awareness that drug abuse is a symptom, not a self-defined condition. The second is that we must begin to understand what our young people are saying, the meaning behind their words and actions. We must convey to them a new sense of their being needed and of having a necessary place in this world; only if we do, will we give them an incentive to face reality and accept the challenges of the modern world and of their own maturity.

This can only be accomplished if we do not react in fear and irrationality, for this will only provoke fear and irrationality in others. President Roosevelt's famous statement, "the only thing we have to fear is fear itself," has much relevance in our present crisis.

1. Angell, R. C., *FREE SOCIETY AND MORAL CRISIS*. Ann Arbor: University of Michigan Press, 1959, pp. 220-232.

2. Council on Mental Health, "Marijuana in Society," *JAMA* 204:13 (June 24, 1968), pp. 91, 92.

3. Larner J., "The College Drug Scene," *ATLANTIC MONTHLY* 216:5 (November, 1965), pp. 127-134.

4. McGlothlin, W. H., and West, L. J., "The Marijuana Problem: An Overview," *AM. JOUR. PSYCHIAT.* 125:3 (September, 1968), p. 128.

Reaction Panel

Moderator: Herbert A. Raskin, M.D.

Maurice H. Seevers, Ph.D.

Permit me to congratulate Dr. Farnsworth on his masterful job of presenting and analyzing the polar positions of youth and the establishment relating to the use of psychoactive drugs.

As one raised in the protestant ethic, who has been attempting to sprinkle truth in the pathway of youth and studying the effects of narcotics and other psychoactive drugs on monkeys and man for 45 years, my membership in the anti-drug establishment must be clearly apparent. This long conditioning makes me believe strongly that the most important heritage one generation can contribute to the next, is the desire and capacity to distinguish truth from falsehood, and fact from fiction. Obviously this means the older generation must know facts and the younger generation must listen if social perspective rather than individual bias is to guide the destiny of this nation.

Allow me to present some facts about three drug abuse epidemics which I have

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been permitted to follow on the scenes of the action. I use the term epidemic advisedly since in all instances these three episodes represent increase of abuse of a new substance, or substances, which is superimposed upon other drug abuse problems which are endemic in the population.

EPIDEMIC I. The world's greatest and most rapidly fulminating epidemic of drug abuse occurred in Japan during the ten year period 1948 to 1958. During World War II Japan made extensive use of methamphetamine in industry to counteract fatigue during the long working hours needed to increase war time production. For several post-war years these drugs were sold freely over the counter in Japan. Use became widespread and drug production increased rapidly. The Government, alarmed at the rising crime rate associated with methamphetamine abuse, first put the drugs on prescription and later classed them as dangerous drugs unavailable legally. Illegal manufacture, smuggling, and diversion of legal supplies resulted. The epidemic reached its peak in 1954 with an estimated two million users in a population of ninety million. Of this group 600,000 were estimated to be heavy users, half of these by intravenous injection. The rise in crimes against the person, usually low in Japan, paralleled the increase in drug use.

In 1954, 55,600 persons were arrested for drug crimes in Japan. The Government instituted drastic regulatory measures, completely banning this class of drugs even for medical purposes without a special license which was very difficult to obtain. Legal sanctions in proportion to the degree of involvement were imposed: 3 to 6 months imprisonment for illicit possession of small quantities -- 1 to 2 years for minor peddling -- 2 to 4 years for trading in illicit drugs -- and up to 10 years for illegal manufacture and large scale smuggling. Large-scale educational programs were instituted by the Government with the active and positive cooperation of the communications media.

By 1958 the arrest figure had dropped to 271 and the epidemic was over. Since then abuse of stimulants in Japan is insignificant.

In the early sixties the abuse of heroin smuggled from the mainland began to skyrocket in Japan reaching a peak in 1964. Using the same strict control measures as with the amphetamines, this epidemic was quashed in two years.

I spent October of this year in Japan and was distressed to find that there have been twenty-five thousand protective arrests of teenage lacquer thinner

sniffers in the Tokyo-Yokahama area this year, with two hundred deaths. Since the government obviously cannot control all volatile solvents without closing paint stores, gasoline stations and the like, this presents a tough control problem. Possibly it will permit an accurate evaluation of the effectiveness of the world's best educational program on drug abuse in the presence of high drug availability.

LESSON - Degree of addiction paralleled drug availability and was controlled by concerted Government action, sensible laws, an efficient police and judiciary system, and a cooperative and intelligent communications media.

EPIDEMIC II. Sweden has always been plagued with endemic alcoholism. Prior to World War II, abuse of other psychoactive drugs was at a very low level. In 1949, only a few dozen amphetaminists were known in a small bohemian group, mostly by oral use. By 1954, it was estimated that there were two hundred intravenous amphetaminists in Stockholm; by 1960, about one thousand. At this time restrictive regulations were placed upon physicians' prescriptions.

In 1965, Doctor Nils Bejerot, psychiatrist at the Karolinska Hospital, commenced an investigation of all persons taken into custody at police headquarters in Stockholm. By the spring of 1968, three years later, thirty-five thousand arrestees had been examined for injection marks. Bejerot was thus able to follow the development of the epidemic as reflected in the arrest population. In 1965, in this population, every fifth Swedish man was an intravenous abuser. By 1966, every fourth; by 1967, every third; by 1968, thirty-nine percent. Among women arrested between 1965 to 1968, the percentage figures were thirty-three, thirty-six, fifty-three, and sixty-four percent, respectively. Criminality of all types increased rapidly during these four years.

This dramatic increase in addiction ran parallel to a period of intensive propaganda by the sociologists for a liberal drug policy and a brief attempt to put this policy into practice in the form of large-scale prescription of dangerous drugs to addicts. One physician alone during this period, 1965 to 1967, prescribed at a rapidly accelerating rate six hundred thousand doses of opiates, and four million doses of central stimulants to an average of about 80 patients. The addicts received at the beginning an average of one thousand doses each per month; after six months, two thousand doses; and after two years, three thousand doses per month. Much of this went into the black market.

In November 1968, I was privileged to participate in a Symposium empanelled by the Swedish Government, to review the problems related to the abuse of the central stimulants. Two months later, on January 1, 1969, the Swedish Government instituted a complete legal ban on medical uses of central stimulants, except by special license, permitted to only a few physicians. During the six months period prior to the ban, Bejerot treated seventy-one acute florid, amphetamine psychoses in his own psychiatric practice. In the six months period following the ban, he saw one.

LESSON - Addiction and crime rate follow liberal government drug policy leading to easy drug availability. Control by concerted government policy and action.

EPIDEMIC III. I am reluctant to dignify the present marijuana problem in the United States as a major epidemic because the use of marijuana in this country does not, with but few exceptions, represent the potential social effects of chronic use of this drug in its most potent forms. In any case it is more like an epidemic of "boils" than of cholera or some other virulent disease. As Doctor Farnsworth has pointed out, its classification in 1939, in the same category as narcotics and subject to the same legal sanctions, was most unfortunate and is badly in need of correction.

Marijuana had no significance as an intoxicant in the United States prior to 1900 when it was introduced into the southern fringe states from Mexico. It took thirty-five years to spread into the major metropolitan areas and reached a point where it became the concern of the government. It came to a crisis in the late thirties because of the publicity given to marijuana purveyance by peddlers to school children and the public clamor for control. With little scientific or medical study, and less foresight, the Marijuana Tax Act patterned on opium control laws was enacted.

The lack of appeal of marijuana to the American public as a psychoactive drug is indicated by the following facts. It took nearly 70 years to reach its present state of use. Most current use is of the corksmelling variety, that is, more placebo than pharmacological effect. Many experimenters, disillusioned with the effects of the first few trials give it up. Others tolerate it because it is the thing to do. A minority try something with a better "kick." Very few become chronic users comparable to the general pattern of abuse in the Muslim and Hindu worlds where the concentrated resin,

hashish, is smoked in pipes as a major activity designed to maintain a continuous state of intoxication as with the chronic alcoholic. And with about the same results.

The statements of some of our national leaders in the drug and health field that future research with marijuana and the THC isomers is needed to come to a decision concerning its deleterious effects or to establish a basis for control, or lack of it, are so out of perspective that they might be amusing if they were not so serious.

No major nation in the world permits the legal use of cannabis except a few Indian states and its legal status in these is being phased out. In Egypt, chronic hashish users represent three percent of the population. In Afghanistan, an estimated eight percent of the population use it chronically even though it is against both canon and civil law. Even the most disadvantaged countries (or better, *especially* the most disadvantaged countries) recognize the chronic hashish user (like the chronic alcoholic) as a serious burden on an already dragging economy, since hashishins are not only unproductive but they must be supported, or as the case with the bhang-using* religious medicants in India, allowed to die in the gutters of Calcutta and other large cities.

What conceivable research on marijuana, or Delta 9 THC, could alter the experience of a thousand years of use by hundreds of millions of persons, or modify the uniform condemnation of all of the world's nations? Even my good friend Dana Farnsworth has apparently stepped into the booby trap which is used by extremists at both poles. One says we do not know anything about the harmful effects of marijuana, so legalize it. The other, we should not relax our punitive laws "until or unless future research proves it to be safe."

Even today we have not adduced proof of *specific* harmful effects of chronic heroin or morphine intoxication on health, although there are probably twenty thousand references in the literature since 1804.

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*Refers to the leaves and flowering tips of hemp: cannabis.

Many advocates of legalizing marijuana base their principal argument on the statement that marijuana is no worse than alcohol. For the unenlightened this may lead to the inference that the establishment is happy with the five to six million alcoholics in the U.S. simply because alcoholism is a socially accepted endemic addiction. *After all, alcoholism only represents the fourth largest health hazard in the nation.* Advocates also constantly reiterate that marijuana is weak stuff and as currently used in the U.S. it represents no significant public hazard. The same statement was made about 3.2% beer nearly forty years ago. The United States tried the experiment of legalizing a specific dosage form in the hope that hard liquor would go away. But who wants 3.2% beer when he can get whiskey? And who would want "grass" if he could get "hash?"

A reason for legalizing marijuana that I would find logical or acceptable, I have yet to hear advocated. The United States is the only nation in the world which could afford to support a significant increase in its already rapidly mounting non-contributory fraction of the population. With just 3% of the population as chronic alcoholics, another probably 2 to 3% of addicts to all other psychoactive drugs, why should we worry. At most, this is only 5% of the population. Add another 2 to 3% on hashish, and it would still be less than 10% of the population incapacitated by drugs.

If we can go to the moon, we can certainly support a sizeable population of hashishins with only a slight tax increase.

I am greatly pleased that President Nixon through the Governors is planning strong measures to educate the American public about drug abuse. But I am greatly concerned about how this is done, by whom, and what the public will be told. Some misinformed idealists would lead us to believe that education, slum clearance, better understanding between youth and the establishment, less punitive laws and the like, will make drug abuse disappear. I wish I could share this idealism. It is getting somewhat tiresome to listen to the "instant" experts who tell us that this will permit us to shove the problem under the rug. Before you believe this, listen to the following facts.

It is estimated that at least 1% (about 2500) of physicians are addicted to narcotics in the United States. European investigators find a similar situation there. Assuming that there are 250,000 narcotic addicts in the United States, this would represent about a ten-fold greater prevalence in this

profession than in the general population. A similar but less-well documented situation exists in the other health professions. Why? Just one reason. The drugs are easily available. It is clear that information about drugs and high standards of education are poor protection against abuse, even with medical training, in the presence of easy availability. No negative personality traits appear to be required in users if the drug is available. It would be difficult to say that members of the health professions have deviating personalities. In fact, they seem to be about average people, even if somewhat dull. Even extremely favorable social conditions do not protect from addiction if drugs are readily available.

Clearly all of the evidence, and I have presented only a sample, leads to the firm and unequivocal conclusion that social reform and education, although of utmost importance, must be considered to be reinforcing rather than the primary goal of drug abuse control. The only way to success is to prevent the first drug trial. This cannot be accomplished by rationalization, reward, threat, fear, coercion, or even severe punishment, if the drug is easily available.

Larry Alan Bear

I am only going to take a couple of minutes because I think by and large people who comment on somebody's speech or commentary are really wasting a good deal of time. I would like to exert my efforts by raising some questions with the people in the audience.

I think Dr. Seevers is right. I think the traffic control of drugs is important. The problem, however, appears to be that while we have been talking about traffic control we haven't been doing too well. We've been talking about traffic control for about 40 or 50 years but we must talk about some other things too. Drug abuse will probably never disappear. We have been trying to eliminate murder since Adam and Eve and we haven't been successful. We want to get things down to a tolerable level if we can and that's the best we can hope for. Dr. Farnsworth suggested that the basic problem is the psychological and emotional state of those who look to drugs for the solution to their problems and thus postpone or avoid sound approaches to the resolution of those problems. I think that's true, and a good many other things Dr. Farnsworth said are true and appropriate. But it seems to me that that is

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only one half of the battle and I raise the question whether or not we might also add this sentence: "The basic problem is the psychological and emotional state of those who seek to do something about the drug problem." The prevailing drug ambience is, and Dr. Farnsworth mentioned this, the notion that there is a drug to solve any problem. We express that in the adult generation by such terms as: "there must be an easier way." Young people relate more honestly to the drug scene than we do. If it's true that the prevailing drug ambience is the reason why so many people destructively act out with drugs rather than some other way, then it only highlights the basic questions: "Why do so many people destructively act out in *any* way?" and "What is the social malaise that produces the symptoms?"

Dr. Farnsworth also said: "Freedom involves thoughtfulness, caring, being other people-centered rather than self-centered, and controlling impulsive action which may have untold consequences." I also believe that is true; it is one of many apt definitions of freedom. I imagine that it applies just as well to adults who are questioning the behavior of the young as it does to young people. I would suggest that when we talk about drug abuse, which is a kind of behavior, that we are in fact talking about attitudes and about values. And when we question attitudes and values, I suppose we must question our own as well as those of the people who are misusing drugs.

Let me give you just two brief examples of what I consider to be a very basic problem in this field. In New York City, we have a program which relates to community development or prevention and education and we involve almost two and a half thousand people in these prevention programs. Recently, I was invited to speak at a local high school located in a white middle-class neighborhood in New York City. Prior to agreeing to speak there, I had sent some trained community-development people out to survey the neighborhood to see what the people thought about the drug problem. We found that all the community leaders, whether they were Rotary Club people or political people, denied that there was any drug problem at all in the area. We spoke with the priests and the rabbis and the ministers and they all said that there was a problem in the area but not in their particular congregations. In fact, we could not find anyone who was willing to admit to a drub problem except the young people whose attitude, I guess, is summed up best by that of a young lady in her early twenties who said that things were so bad in the community that even the Brownies were on the nod.

In any event, the result of five thousand flyers advertising my appearance was that a couple of hundred people showed up at the high school, but they really showed up to hear a local political leader who was giving a speech. When the politician left everyone in the audience left with him except some 50 people down front who hadn't come to talk about drugs either; they had come to boo. At the right there were 10 or 12 young people, I'd say between the ages of 14 to 17, and we spoke about soft drugs and the problems of soft drugs. After about an hour, one of the few adults remaining in the hall became excited and said that this was the first time he'd become aware of this problem of soft drugs and he was very concerned. It seemed to him a terrible shame that there was no way for older people to communicate with young people because young people wouldn't talk openly about their problems; that if only they would, something could be done. At this point, one of the youngsters got up and said to me, "It was worth coming to hear you but I want to tell you, Commissioner, that your problem is not with us, your problem is with *them*; please note all those empty seats out there representing all the people who really weren't sufficiently concerned about the problem to come."

Clearly these young people were in trouble with drugs. It is what we call "flagging." They were saying that they wanted help but were unable to say it straight out. So what really happened was that they came to get help and all the parents walked out on them.

The real problem facing us is who is committed to do something about this problem. We sponsored a three day session on drugs as part of our in-school educational program in New York City and we attracted fifty teachers and fifty student leaders -- most of them negative leaders -- and some twenty or thirty community people. The whole group spent three days in what was called *attitudinal skills training,* an attempt to talk to each other about problems. The first teacher to get up, who happened to be a parent, stated that he felt that the most serious problem in that area, a marginal poverty area, was that the kids weren't given enough to do, that there were not enough social clubs, boys' clubs, girls' clubs, pool tables, ping-pong tables, etc. As a consequence, there wasn't enough activity in the area for the kids, which was one of the reasons why they turned to drugs. One of the youngsters said -- and the language was a little different from what I'm using -- that wasn't the problem. The truth was that they were there at the meeting -- just like they have always been at meetings -- to really talk honestly and openly, and it wasn't any good to buy-off people with boys' clubs, girls' clubs or social clubs. It's a question of commitment. If you want to deal with attitudes and values, there has to be a commitment.

Turning now to a discussion about law enforcement and traffic control let me say, as an individual whose been on the firing line in the City in the Western world which has the largest city drug problem, New York City, that I know how much it means to have drugs freely available. I couldn't agree more with the suggestion that was made here: if we can't control traffic in drugs, no program is going to do any good. But let me tell you that if you had the greatest traffic control program in the world and cut down eighty percent or seventy percent on all the traffic coming into this country, and that's *all* you did, you would do more than raise the crime rate by raising the prices of drugs. Such a control program must go hand-in-hand with programming. As someone who has three and a half thousand people under his care involved with the drug problem every day, every week and every month, I think it is essential that we have control law and that we have law enforcement. However, I want to tell you, and I don't mean to be in any way derogatory to my host, that trying to resolve this problem by setting up penalties of 20 years to life in prison is atrocious and destructive. I think that other ways have to be worked out if we are ever to come to any really meaningful solution.

I would like to sum up by saying that we must have an *understanding* of the proper role of law enforcement and drug traffic control. We must make a meaningful and real *commitment* to the development and support of rehabilitation programs and we must initiate community development programs for basic change.

Edward Mileff, Ed.D.

Let me say first that I think what struck me most about Dr. Farnsworth's remarks was the fact that this problem of drug abuse is infinitely more complex than most of us in this room recognized even a half dozen years ago. Some of us have been interested in it, or in one aspect of it for some time, but as we become better informed, so we realize that there are dimensions to the problem that perhaps we hadn't thought too much about before. The problem is literally bigger than all of us and, moreover, it is difficult to define, and to delineate. I think all of us see *parts* of the drug abuse problem more often than we see the *whole*. However, I think the effort in trying to see the whole -- trying to grasp it and understand it -- that effort is going to help all of us do a better job with our particular responsibilities.

I want to emphasize that I don't believe education is the answer to the drug abuse problem. It is an important approach to the problem and to the

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individual but it is not going to solve the problem; it's not a panacea or a cure-all. Sometimes we don't have other recourses so we rely on education with the expectation that this is the ultimate answer; it is not! As a matter of fact, there are some people who are threatened by the educational approach. An analogy I might use is the problem of hunger and malnutrition in this country. You can educate people about nutrition all you want but if people are hungry they aren't going to be too receptive. We can use education as a preventive technique but there are many people who are already hung-up on drugs and the questions I ask myself as an educator are: "What do we do with these people?" "How do we approach rehabilitating them?" These people are a part of the total problem. I don't deal with them day-to-day, for the most part, but we do have drug users in the schools and those users are getting younger and younger as was noted by Dr. Farnsworth.

I see this conference as an effort to mobilize our resources to combat the hazards of drug use and drug abuse. I might say that I'm just as worried about drug *use* as I am about drug *abuse*.

As was implied this morning, we are living in a drug oriented society, so I don't think that we can suggest, let alone state, that it is just drug *abuse* which is evil. I think that sometime in the future we are going to have to "turn the corner" in our whole outlook toward the use and reliance on drugs. I'm a little shook up when I hear a funny guy like Stan Freberg giving a commercial on radio, as I did driving up from Detroit yesterday, on the use of Compose. This is an over-the-counter preparation that can be bought without a prescription. The paid commercial for Compose is legal and yet it disturbs me. It disturbs me more perhaps than the use of marijuana by an individual who is at least legally responsible in terms of his age.

This widespread dependence on drugs is a problem of concern in this country. I think that we are going to have to have an increased participation by all levels of government in dealing with the distribution, the sale, and the advertising of all drugs. I think regulatory agencies such as the Federal Trade Commission, which has stepped into the smoking and health controversy, can and should be helpful. I think the Federal Communications Commission should do more. I believe the drug industry is becoming more responsive to the problem by recognizing the wide ramifications of the problem and accepting some responsibilities for it; yet the industry people have vested commercial interests. So it is a very, very touchy and complex problem.

I would like to ask the question whether the problem of drugs used *legally* by prescription or otherwise is more serious in this country than the use of the so-called *illegal* drugs such as marijuana, LSD, or the opiates. Can we, or should we, gear our educational efforts to *all* people, focusing our attention on youth, but at the same time considering adult use of as many as a half dozen drugs daily?

We must have comprehensive educational programs in the schools, beginning in elementary school, dealing with the safe use of a variety of chemical preparations. This has been a part of safety education for many, many years to prevent accidental poisoning and this is where formal drug abuse education begins. Of course, it begins informally in the home long before that time. This program is going to have to extend not only into our public schools but into our adult lives as well. This means that teachers must have more extensive preparation for dealing with the problem, because as far as the problem of drug use and abuse is concerned, teachers are really lay persons. They are not experts on drugs, and in order that they learn about the use and abuse of drugs, a massive program of pre-service and in-service training for teachers is required. While it is true that some students are better informed than their teachers about drugs, there is also a great deal of misunderstanding among students about the hazards of drug use and abuse. Some teachers are inadequately trained and insecure about dealing with the subject, and yet we recognize that we all have a responsibility in this regard as educators. I am not talking just about health educators. I am talking about all teachers whatever their subject matter area because this problem does cut across all disciplines. Recently, the Michigan Legislature passed an act that dealt with critical health issues, one of which was the problem of drug use and abuse. This is an important first step. It may be a small part of the total solution -- at least it is a recognition of the problem and an overt effort to correct it in schools better than we have in the past.

Jean Paul Smith, Ph.D.

I'd like to make a few remarks about the nature of the drug problem and I hope that this will, in some way, amplify some of the things that Dr. Farnsworth has said. I do this because it is nice to be in a hurry; it is nice to have a great deal of social concern but it is even better to know where you're going, so that your hurry has some beneficial effect.

The *nature* of the problem, as I see it, is the critical issue. What type of a problem are we facing? This definition itself will support certain courses of action. We can say, off-hand, if we look at statistics rather casually, that somewhere around sixty to seventy percent of young people in the costal regions, at least in certain areas of California, have experimented with illicit exotic drugs. Perhaps fewer have experimented with categories other than grass, but this number appears to be increasing. We can also say that most of those who do experiment do not go on to use drugs actively in a day-to-day fashion. One conclusion we can draw from these two rather simple facts is that perhaps the *extent* of drug use and abuse is

Jean Paul Smith, Ph.D., Associate Project Director, Institute for the Study of Human Problems, Stanford University, Stanford, California

not the critical feature in evaluating the nature of the problem. Those figures by themselves are rather stark and, without some type of perspective, we are at a loss to use them wisely. We can say that experimentation with drugs is rapidly reaching the point where they are being used in this experimental fashion almost as frequently as alcohol is being used.

The foregoing has some rather subtle implications, all of which I'm not aware of at the present time, but it does mean that you cannot treat this problem in the way it has been treated in the past. We've been cut off from our past whether we like it or not. People say, in the Bay area, which has been noted for its wisdom in this regard, that if you want to have a link with the past, put your hand on your belly button, it may get you there. There's a bit of content in that as well as form and that means we have taken a radical step in some direction. I'm not sure in which direction it is away from our past, but we're going to have to look at the problems rather differently.

If we leave the problem of drug experimentation and look at the size of the population of persons that we might loosely call drug dependent, assuming we can define that, we find that we really are quite ignorant. We don't have health statistics for drug dependent people. We don't have a system of social or health indicators to serve us very well in this area. We can rely on arrest statistics but that procedure is comparable to talking about human sexual problems and using as an indicator the study of prostitutes. Somehow or other, this leaves me a little cold. The above may be a rather interesting comparison but it is lousy science.

At this point, if we look at the nature of the problem, we see two primary attempts to reach a resolution without knowing what the problem is. First, we have devised severe penalties for persons who experiment with or use illicit drugs. That doesn't seem to be working; so our immediate reaction, after we go through a period of alarm and intense concern and hysteria, is to legalize. We say that our attempted solution has not worked so we throw the whole thing down the drain and legalize the use of drugs and solve the problem. This is a mess, a terrible mess, and frankly a number of us contribute to it by saying we have two solutions available: (1) more laws (instead of having twenty years to life minimum mandatory, let's flog people before we give them a minimum mandatory and that may solve the problem) or (2) fewer laws (let everybody have what they want). It's a disgrace! It's a disgrace to our ability to think creatively about complex social problems.

The alternative rationales are several. Instead of legalizing or taking a punitive approach to the user, we have at least four or five steps in the middle that are rather practical solutions and we can't say whether they will work; the only thing we can say is that they are different from those we are now using and perhaps we will have a little less social baggage that is undesirable if we try some of these. We could have seizure of drugs without criminal proceedings; we could have civil penalties; or we could have misdemeanors with records wiped out. All of these are in the middle and could be used flexibly. The attempt to use mandatory penalties to solve a problem like this is grotesque and simply barbaric. If it worked, even for some people, there might be an argument for it. However, it hasn't worked. The major problem underneath this is that we have devoted practically none of our resources to intensive study of the whole area of drug abuse in a way that ties together the critical features.

We can predict rather well how a new rifle will operate in a certain fashion, in a given kind of platoon and in a given combat area, because we spend millions of dollars to find answers. Systems analysis, including social factors, is a present possibility and there is absolutely no reason why we can't start devoting some of our resources to this kind of analysis. We can look at drug abuse as a sort of internal pollution that is quite equivalent to external pollution. We all breathe stinking air, and we all use the products advertised on television. Why don't we put the two together and determine what effect they do have on us. Why can't we look at pollution and man's own self-selection in pollution as a problem that can be defined by systems analysis and look at the consequences. I'm not suggesting this as a practical solution but it is a way of jogging our thinking and getting something started. *Consequences* are the key factors that we have that we have not considered, preferring to express our moral views, our values and our intrinsic concepts of what drugs are. Our society is gradually and painfully moving from an intrinsic view of drugs as "good" or "bad" to a functional view, i.e. under certain circumstances drugs have certain consequences and thus have a greater or lesser desirability for society. I'd like to close at this point by repeating that it's nice to be in a hurry but it's also nice to know where we are going.

Michael Gieszer

My reactions to Dr. Farnsworth's speech are rather blase because the speech was totally irrelevant to most of the things that I am doing. However, in the nature of academic freedom, I would like to make some comments. Dr. Farnsworth may have raised some new ideas for some of the people here but many people who have been dealing with drug problems and trying to bring this whole area of drug use and abuse to society's attention, have been saying these things for years and nobody has been listening. This is traditional with society; social problems get recognized only when doctors, lawyers, and politicians admit they exist. Many people have been working with the drug problem and many people have been talking about it, but until the politicians say the problem is there, then it's not there.

I have ambivalent feelings about what Dr. Farnsworth has said because there is some truth in what he says and there is a hidden agenda and there are some half-truths and there are some outright lies, in my opinion. I'll give you an example. Young people in this country are perfectly aware of the drug problem, in many ways. The traditional helping institutions haven't responded. We have found other ways of dealing with the problem.

Michael Gieszer, Undergraduate Assistant in Student Activities, Office of the Dean of Students; Michigan State University

One way is a service like ours and there are various services like ours around this country run by young people simply because traditional agencies are unresponsive to the problem. Dr. Farnsworth made it clear that the drug problem is also faced by the middle class. However, there is a hidden agenda in that statement. Most of the older people don't consider the use of amphetamines, barbiturates, alcohol, and whatever else they take, as drug abuse and so it becomes a problem of moral superiority in the interaction between older people and younger people. "Our dependency is not a problem, yours is" -- and I think we ought to realize what kind of hypocrisy that is. At least young people realize what kind of hypocrisy that is.

Other comments Dr. Farnsworth made lead me to wonder whether he has ever been on the streets with young people, because he never even mentioned our major problem. Our major problem is with street drugs which are impure drugs. We don't know what we're getting in those drugs; things that are supposed to be LSD are anywhere from 70 to 80 percent methamphetamine, strychnine, arsenic, and possess any number of contaminants. The importance of this is that I really question whether Dr. Farnsworth's observations of people whom he has seen in his health center can be classed as responses to a pure drug. Can he diagnose a psychotic break as a response to marijuana or mescaline when he doesn't even know if that was the drug that was taken? That's another hassle that relates to the dull issue of society, you know, not providing adequate funds to have these drugs researched adequately to know what the responses are so that we would know whether that was in fact the response to a pure drug or a drug that contained some foreign substance.

I agree with Dr. Farnsworth's statement that there are many individual problems involved with young people using drugs. There's a problem, in my mind, with young people who are willing to ingest foreign substances when they don't know how they will react in their bodies. I think, however, that's an individual problem. To some extent there are a lot of individual problems that are facilitated by the taking of drugs, but I think it is patently absurd to continue to blame this problem solely on the individual. Part of it is the individual but part of it is also the social milieu in which we exist. The traditional cop-out in the society that young people see is that anything that we respond to is a product of our individual pathology rather than an indication that society may be messed up.

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I respond with hostility to the whole idea of legal repression because my experience is that it's really a cop-out; it's a cop-out for a lot of things. Law and order is a cop-out. The kind of legal repression that some people are advocating prevents young people from going to helping institutions and getting the care they need because they are so paranoid about being busted and being put in jail for twenty years. And that's a real problem that we see every day with the people who come to us. They can't get into institutions because of that fear of legal repression. And another thing is that legal repression is directed at young people and young pushers. Nobody is talking about the problem of organized crime -- at least I didn't hear that -- organized crime which is so heavily involved in pushing heavy narcotics, especially in inner cities which have a host of other illegal acts which contribute to the drug problem. Nobody is throwing the law and order theme over such acts as police pay-offs, or the organized crime syndicate which makes two and a half million dollars off a pound of heroin. Nobody is making a very big issue about the medical doctors who dispense amphetamines and barbiturates, not because they have any medicinal value but because the doctors want to be nice to their patients. Not much is said about the pharmacists who continue to stock preparations such as Freeon and Nyquil and Scope and Contact and turtle wax and cough syrups on their shelves that are killing my brothers and sisters in the streets. This is really a big cop-out to put this whole thing on young people. Nobody has asked the pharmacists to take a lot of that garbage off the shelves because that would mean a loss in profit to them.

A lot ot these things add up in young people's minds to the question, "How sincere are you adults about all my problems?" Is your answer to repress young people rather than to make some sincere commitment among yourselves? I'm not really this self-righteous usually, I'm just paranoid.

The last point I would like to make is that the whole legal hassle doesn't allow adequate research on a lot of these drugs and I think that more research is vitally important so that we can begin to deal more effectively with the problem. We are forced to deal in a rather sporatic, random way with the bad trips we get. Drugs are continuing to flow on the market at a rapid rate; there may be ten or twelve new drugs on the streets by next week and nobody is researching them. The doctors in this community, even if we can get young people in to see them, have no way of knowing how to treat them. I see that as a real problem.

Discussion

QUESTION. *Why do people take drugs?*

SMITH. *I could go through a list of apparent social-psychological factors involved in drug use and discuss those factors which appear to support continued use after experimentation has gone on, but that would be paying homage to our credentials rather than to the simple fact that drugs are fun for a lot of people. I suspect that there is a very valuable purpose served in the use of any drug in our society and that function is to produce very quick and real relaxation. I know that in flying around the country, many people can't wait for the first drink, and sometimes I feel the same way because it helps me to relax. The aspect of this that intrigues me is that we have never tried to find out how much of a contribution drugs make to our society. Perhaps alcohol is a boon to our society. Perhaps it has great contributions to make, especially as there are more and more of us with less and less personal space. This same thing may be true of marijuana -- I don't know. The problem is we haven't looked at both sides and tried to make intelligent balanced estimates of the consequences and how rewarding those consequences are for our society.*

BEAR. *I'm sometimes a little confused by a word like "rewarding." I do not know what "rewarding" means. In New York City there are somewhere between fifty-five and one hundred thousand heroin addicts. I have yet to find one who found the use of drugs rewarding in any positive sense. There are a whole lot of reasons why people shoot dope, but one of them, aside from the initial euphoria, is to ward off something worse. Addicts use many rationalizations such as, "If the man stayed off my back it would not be so bad," or "If my kids didn't carry on, it wouldn't be so bad," and I can shoot dope and be happy, but they don't and they aren't." I think that is true of a lot of dope users. I don't think it can be said that people who continue to take drugs take them because they are rewarding in*

any positive sense; this may be true for some, but certainly not in most cases.

QUESTION. *Since the use of heroin is an expensive drug, how do you account for the high use of heroin in poverty areas?*

BEAR. *I think that the price of heroin is more or less irrelevant, frankly, to the central problem. I don't think that people in the ghetto take heroin because of any chemical need. I think that the problem lies both in the conditions outside the individual and the conditions inside the individual's head, not inside his belly. I think people take drugs because that way of life is better than another with which they don't want to cope or with which they can't cope and I doubt the price matters very much. I think that heroin is part of an exploitation process but only one part; money is taken out of the ghetto in many other ways. If you were able to eliminate costly drugs and allowed the numbers racket and a lot of other rackets to remain, a flow of money would continue to stream out of the ghetto at an incredible rate in terms of how little money there is supposedly there.*

QUESTION. *Would Dr. Smith elaborate on the four solutions to the drug problem which he proposed as fitting between the two extremes?*

SMITH. *The extremes that I talked about earlier were (1) the extreme punitive measures for possession and (2) extreme permissiveness for distribution and use of drugs. What I am suggesting is that both of these extremes are going to get us into serious trouble. If we look at the steps that are intermediate to these two extremes, we may find solutions that we can live with as a society. Instead of legalizing pot, to which I am very much opposed we could adopt non-punitive laws on possession. We could bar advertising, but refrain from sending a person to prison for possession. The next step could be that the drug would be confiscated by an authorized agent of the government; an executive seizure authority. The next step beyond that could be a civil penalty, comparable to a traffic ticket tied to a structure of fines. The next level would be something like a misdemeanor and would carry an additional legal penalty. What I am suggesting is that the debate should not be between the extremes, but should be centered on these intermediate steps that are far more practical because they*

could be tied to socially-oriented treatments. Unless we start paying attention to certain aspects of social psychology we are going to continue to be unsuccessful in solving the problem.

QUESTION. I would like to explore the use of hospitalization as a method of control. Do you feel that a person should be self-committed or committed by the courts in order to have proper medical attention?

BEAR. We have to understand that involuntary commitment is not treatment. It doesn't do much good to put a sign on a building with bars that says "hospital" when the building with bars is just another jail. However, if the commitment is really nothing more than establishing a kind of environment where you can provide meaningful treatment, that involuntary commitment might, in fact, work. In other words, if a person is sick and needs help and the help is provided, I am not terribly concerned if he gets there by means of involuntary or by voluntary procedures, but I am desperatly concerned about the substitution of involuntary commitment for treatment.

QUESTION. Mr. Mileff mentioned that education in itself was not the answer. For those of us who are not in clinical areas, but who are in the educational systems, what is the answer?

MILEFF. I hope I suggested that if education was not the answer, it was an important part of the answer. I think it's important that we not proceed with the assumption that education is a form of immunization. It's just possible that the problem isn't what is being taught but rather who is teaching. The question is how much credibility the school system has with the majority of young people. We have had great success with drug education programs run by young people, but many youth are distrustful of the adult community. The fact is that the majority of adults have already lost that credibility with the young, not necessarily because of who you are but what you represent in the school system or what you represent to the student in terms of authority figures.

QUESTION. Judging from what I have heard so far, the use and the abuse of drugs is really not the disease but the symptom and therefore I take it that the disease must be society itself. I come from a community where five years ago we had one case involving drug use and now we have

three hundred. This raises the question, "What has happened to society in the last five years or ten years?"

GIESZER. The first thing that's happened to this generation is television. A lot of the contradictions in our society are brought out very clearly by television which invades our lives very personally. To most of you television is a form of entertainment, to many of us it is a way of life in terms of how we view it and what it means to us. I think that there's been a growing awareness in young people which has been fostered through the use of media such as underground newspapers, television programming through NET, and things like that. The whole problem of the educational system is based on the manipulation of us as opposed to any kind of humanistic behavioral intervention. I think that the Vietnam war has had a significant impact. To me the war and drug problems are very gut level issues and we haven't gotten down to this level. All of your people are very comfortably sitting here and listening to this problem when I know Larry (Bear) could tell you what it's like to be in Harlem with people who are emaciated and dying on the streets. Not once did Dr. Farnsworth say how he felt about young people; he never said we feel, we feel; he said I think, I think. As a result, we have lost a lot of the meaningful inaction that we could have had from some of the older people who are willing to accept us. We could have learned to grow from them but we have turned away.

Possible Solutions to the Drug Dependence and Abuse Problem

Jerome H. Jaffe, M.D.

In many respects much of our difficulty in dealing with the consumption of chemicals by people stems from the way in which we phrase our questions. Let us, for example, consider the title of this presentation which, as you will see, was not precisely of my choosing: *POSSIBLE SOLUTIONS TO THE DRUG DEPENDENCE AND ABUSE PROBLEM*. The title implies that there is *a problem*. Yet Dr. Farnsworth has clearly shown that there are really a number of distinct problems that are only indirectly related.

The problems of the adults who smoke too much or get a bit "too high" at cocktail parties are different in their implications from the problems of college and high school students experimenting with marijuana or LSD, and both of these are distinct not only from each other, but also from the problems of the skid row alcoholic or the compulsive heroin user; and these are in turn different from those of individuals who are taking excessive amounts of prescribed medications for pain or other psychic distress.

Jerome H. Jaffe, M. D., Director, Drug Abuse Programs, Illinois Department of Mental Health, Chicago, Illinois.

This is not to say that there are no common factors. Dr. Farnsworth has eloquently described the ways in which our culture tends to support both the use of pharmacological solutions to human discomfort (discomforts often as trivial as minor episodes of insomnia or drowsiness). Our culture also supports the notion of pharmacological lubrication of the social machinery; any casual viewing of television advertisements for beer or cigarettes will illustrate the way in which drugs are made to seem a necessary part of happy human interaction.

Obviously, one possible move that would have some impact on all of the many distinct drug abuse problems would be a major reexamination of the role of the advertising and mass media in normalizing if not fostering drug use. Such a reexamination falls into the area of public education -- to which I will later return. At present I would like to focus on the elements of a more general strategy of which education is only one facet.

In elaborating such a strategy I must make certain assumptions. First, I must assume that our culture, for better or for worse, has accepted the idea of recreational pharmacology. In other words, we approve of the use of some drugs, not to cure disease or ease pain, but merely because in certain situations the drug effect is pleasurable. At present we include among the recreational agents only alcohol, caffeine, and the pharmacologically active substances found in tobacco. But it is the principle (not the specific agent) that is important. The principle implies that over a period of time -- years or hundreds of years -- we may add to or delete substances from the roster. Hopefully we will do so in a rational way, after carefully weighing both the risks and potential advantages. For example, at present we seem to be moving toward a gradual phasing out of tobacco as a recreational substance because of the association between its prolonged use and cardio-vascular, pulmonary, and neoplastic diseases. We also may be moving toward the addition to the roster of a new substance -- cannabis, or marijuana. Whether we know enough about the long term effects of cannabis is certainly an issue for serious debate. My point here is that the roster of recreational substances has never been fixed or immutable, and additions and deletions from the roster of socially sanctioned recreational substances are to be expected. Because they are recreational, they are eventually surrounded with rituals and symbols, and the process of either addition or subtraction will always be difficult and painful. Nevertheless, one element in any overall approach to the problems of abuse will be the

development of a greater understanding of this process of change. If we can understand the process of change we may be able to minimize the social cost of any specific change. For example, it has only been over the last 75 years that many countries (including this one) have sought to delete opium from the roster of recreational drugs. Prior to that time opium for medicines *or for smoking* was available at the local grocery store. The disadvantages of opium smoking or eating were many and serious. It was entirely appropriate to bring about a change. Yet the process of change resulted in new problems which also had serious consequences. In various parts of the world the new problems varied with the methods used to effect the change. In this country, we failed to appreciate the intensity and persistence of the dependence on opiates. By making no provision for those individuals already dependent on opiates to obtain legitimate supplies under adequate supervision, we inadvertently sowed the seeds of an illicit trade that has persisted to this day. I suspect that we are wiser now and if, for example, it becomes appropriate to entirely prohibit the use of tobacco we would not be as insensitive to the problems of those already dependent.

Let me return now to the concept of an overall strategy. I have assumed that some recreational drugs will continue to be used in order to proceed to the next assumption: that some pharmacological substances equally capable of yielding pleasure or tension relief in social situations will be viewed as inappropriate, too dangerous, or otherwise unacceptable for use. They will be, in short, forbidden. If history teaches us anything it teaches us that drugs, like ideas, once born never die. Cocaine, recognized as a drug with serious abuse potential a decade before the turn of this century, was brought under federal and state regulation more than 50 years ago; it has had only minimal use in medicine for the past 20 years. Nevertheless, it is available illegally for recreational uses in every large metropolitan area of the United States. Thus, we should assume that the drugs in use of which we do not approve will nevertheless remain available. As long as there is a demand someone will take the risks necessary to try to reap the profits that the demand creates. Good law enforcement can go far in reducing availability, but I seriously doubt that availability of forbidden drugs can be reduced to zero. Yet it is also true that availability and use of any particular drug rise together. Once we are certain that the use of a particular agent should be minimized, the first steps in an overall strategy are those directed toward reducing and controlling its availability. This is the job primarily of law enforcement agencies. Their problems in

this area are immense, and I am sure that Mr. Finlator will elaborate further on this element.

The other components in an overall strategy are the procedures to be used with the individuals who use or become dependent on prohibited substances, and the techniques of preventing those who have not yet done so from joining the ranks of the drug dependent. The specifics of treatment and prevention will vary with the specific drug or class of drugs in question, and the characteristics of the populations using each drug.

Dr. Farnsworth's presentation focused primarily on the motives of affluent young people who are experimenting with, and in some cases becoming dependent upon, hallucinogenics, marijuana, and amphetamines. Nevertheless, I would like to select another drug abuse problem -- that of the compulsive narcotics user -- to illustrate not only the complexities but also the possibilities of achieving real progress toward problem resolution.

How does a State or a community respond to this situation? I would like to present the response of the State of Illinois as an illustration.

BACKGROUND

Two years ago, there were virtually no public treatment facilities for narcotics users in the entire State of Illinois. Therefore, in planning it was necessary to consider not only what kinds of treatment programs would be best suited to the needs of a given community, but what kinds of programs could be made operational with the financial, physical, and human resources that could be made available in the foreseeable future. It was immediately apparent that any attempt to develop within a single two-year funding period a program that could deal with all of Illinois' estimated 6,000 known narcotics users and its unknown numbers of barbiturate and amphetamine users would necessitate the kind of crash effort that is usually wasteful and often merely shifts already scarce personnel from one activity to another. The history of such crash programs is usually characterized by large scale activity long before the value of *any* activity is demonstrated, and, just as disheartening, an inability to reduce the level of activity if and when careful evaluation indicates that some aspects of the program are of doubtful value.

After considering the conflicting claims and counterclaims about the effectiveness of treatment programs in operation in other places throughout the country, the Illinois Narcotic Advisory Council (a commission created by the Illinois Legislature in 1965) proposed a program based on an explicit set of premises and principles. I was fortunate enough to be asked to serve as chief consultant to the Council.

PRINCIPLES AND PREMISES

These premises and principles are as follows:

First, the problem of narcotics abuse is only one band in the spectrum of drug abuse, and perhaps from a social viewpoint, not the most significant band. However, because of the social conditions surrounding the use of narcotics and the high-morbidity, mortality, and criminality associated with the compulsive narcotics user, it seemed appropriate for Illinois to begin with treatment programs focusing on the treatment of narcotics users.

Second, the narcotics-using population is a heterogenous one. Those who make up this population have different reasons for initiating drug use, exhibit different patterns of drug use, relapse for different reasons, and have widely differing experiences as a result of their narcotics-using behavior. Such a heterogenous group may require a number of distinct treatment, rehabilitative, and resocialization approaches. Treatment cannot be considered the exclusive domain of any profession or philosophical persuasion.

Third, at present there is no reliable way to determine in advance what types of narcotics users will respond best to what kinds of treatment, and it is necessary to develop a method for predicting treatment response.

Fourth, the *goals of treatment* must be clearly defined before any meaningful inferences can be made concerning the *outcome* of treatment approaches. In defining the goals of treatment, the INAC rejected the concept that abstinence from narcotics must be the sole or even the most important criterion of successful treatment. Instead it adopted the concept of a hierarchy of goals, applicable to any treatment approach.

Ideally, a treatment program should attempt to help all compulsive narcotics users become emotionally mature, law abiding, productive non-drug-using members of society who require no additional medical or social support to maintain this ideal status. But, this is *an ideal* set of goals, a set which society does not expect any other group with medical or psychiatric disabilities to meet. For example, we do not expect middle-aged people with mild congestive heart failure to become marathon runners; we do not even insist that, after some arbitrary period of treatment, they abstain from digitalis, diuretics, and visits to the doctor. The INAC took the position that compulsive drug use should also be thought of as a chronic disorder, in many cases requiring continued or intermittent treatment over a period of years. It followed, then, that while all treatment programs should attempt to help every individual reach all the components of the ideal set of goals, any evaluation of the overall effectiveness of any specific treatment must take into consideration that different programs tend to place their emphasis on different goals.

Fifth, these goals can be arranged into a hierarchy with some goals considered more important than others. However, any such hierarchical arrangement will be somewhat arbitrary. Nevertheless, the INAC felt that as a public agency operating in a large Midwestern state, it should at least make its own arbitrary hierarchy explicit.

Thus, in the program which evolved, the minimum expectation was that all patients who are treated will become law abiding citizens -- even if they do not become productive, mature, or even drug-free. At the next level patients would be law abiding and also gainfully employed, even though they may require continued psychological and medical support and may even use illicit drugs from time to time. Close to the ideal is the stage where patients are law abiding and productive, and do not use illicit drugs, even though they may require either continued medical or psycho-social treatment.

The INAC was aware, even while arranging these behaviors hierarchically, that they are actually often quite independent, and that some individuals may show behavior at the "upper" levels of the hierarchy without exhibiting the behavior at the "lowest" levels. For example, some patients may stop using illegal drugs and work at legitimate jobs and require no medical treatment, but continue nevertheless to engage in illegal activities; others may not use drugs nor engage in illegal activity, but may require

prolonged or semi-permanent residence in a therapeutic community. In addition, some treatment approaches may be more effective in helping patients achieve one goal than another.

Sixth, programs receiving public support must be prepared to demonstrate objectively just how much the public (including the drug using population) is getting for its money. Closely related to this last proposition is the view that large programs for any given community should be built on the basis of objective data from smaller programs specifically designed to permit extrapolation to large populations within that community. Programs which, after adequate trials, do not achieve any substantial movement toward any of the goals described should be abandoned no matter how attractive they may appear to be in theory. The more costly the program in terms of the cost per person achieving particular goals, the more rapidly it should be evaluated, since each day of operation of an ineffective program drains resources from those treatment approaches which are potentially more effective.

A MULTI-MODALITY PILOT PROGRAM

Much of what the INAC could rationally recommend was directly derived from the foregoing premises and principles and their corollaries. For example, given the principle of population heterogeneity, the likelihood that different types of drug users would require different kinds of treatment, and the absence of detailed knowledge of he typology and demography of the narcotics using population of the State, it would have been irrational to propose large scale programs using any one specific kind of treatment approach even if money and human resources had not been limiting factors. Therefore, the INAC recommended the development of a "multi-modality pilot program" designed to focus on a limited geographic area in Chicago with a relatively high prevalence of narcotics use (based on police arrest records). The word "pilot" implied that the structure should be *flexible* enough to be disassembled entirely should none of the specific treatment approaches prove helpful, yet *sturdy* enough to provide a framework on which a full state-wide program could be built if any or all of the components proved to be valuable. Since it was not possible to know in advance which of the several treatment modalities used elsewhere in the country would be most effective with this as yet unstudied Chicago population, the INAC recommended that the pilot program develop and carefully evaluate several distinct modalities, i.e., a multi-modality approach. As a minimum, the

specific modalities or treatments to be developed, evaluated, and compared to each other were:

1. *Standard periods of hospitalization for withdrawal followed by group therapy in the community -- narcotic antagonists such as cyclazocine were to be evaluated in this context.*

2. *The use of oral methadone in the context of a rehabilitative program.*

3. *Residence in therapeutic communities such as Synanon or Daytop Village.*

The use of narcotic-antagonists such as cyclazocine, is the most recent development in the continuing effort to find more effective treatment for narcotics addiction. Cyclazocine is not a narcotic itself, does not produce physical dependence of the morphine type, and is not "liked" by narcotics users; but it can prevent heroin, morphine, and other narcotics from reaching the sites in the nervous system where they have their actions. As a result, a patient taking eyclazocine regularly cannot feel the effects of the usual dose of narcotics. Furthermore, as long as he takes cyclazocine regularly he can take narcotics several times a day and will not become physically dependent because the narcotic never actually gets to its site of action. Cyclazocine can be used in treatment in several ways. First, since it prevents patients from becoming physically dependent, it makes it possible for them to work or to participate in rehabilitation programs even if they never get to the point of total abstinence from narcotics. In addition, there are theoretical grounds for believing that just as conditioning may play a role in the development of compulsive drug use, patients taking cyclazocine who use narcotics and feel no effect will "decondition" themselves, so that eventually even the cyclazocine can be discontinued. Obviously, cyclazocine in and of itself cannot change an individual's well established patterns of associating with other drug users nor his antisocial behavior, nor can it give him vocational skills or hope for a better way of life. To be effective, it must be used in the context of a broad program of social rehabilitation. Over the past three years, cyclazocine has been given clinical trials by several groups of investigators. Work now is in progress to attempt to develop narcotic antagonists that will be longer acting than cyclazocine and will also be free of its undesirable side effects. At present, we can only state that

the number of patients who have been treated with narcotic antagonists in a comprehensive program is still too small to decide how much the drug adds to the effectiveness of the overall program. Nevertheless, researchers using cyclazocine and other antagonists are cautiously hopeful.

The methadone maintenance approach is predicated on the proposition that any medication that permits a compulsive narcotics user to become a law-abiding, productive member of society should be considered as a therapeutic technique. If the medication is a narcotic it need not be eliminated from consideration, since the goal of treatment is socially acceptable behavior, rather than abstinence *per se*. It has been shown that when given daily, in high dosage, methadone produces at least two effects: it relieves the persistent "drug hunger" that often plagues the former narcotics user following withdrawal and, it induces a marked tolerance to opiate-like drugs, including methadone itself. As a result of this tolerance, the patient treated with methadone cannot feel the effects of other narcotics such as heroin, nor does he feel any significant effects of the methadone. Methadone maintenance has been criticized as the "substitution of one habit for another," implying that all habits are equally deleterious. This implication is supported neither by common sense nor by the observation that more than two-thirds of the 750 former heroin users treated in the Dole-Nyswander methadone maintenance research program are now either working or going to school, and that the amount of known anti-social behavior in this group is remarkably low. Methadone maintenance has also been called "legalized euphoria." If the criticism were accurate it would be merely a moralistic objection to a valuable treatment technique. However, such a criticism bears no relationship to the clinical state of the patients, who cannot be distinguished from normal controls with any of the standard techniques employed to detect euphoria in other clinical situations.

It is important to distinguish between the use of oral methadone maintenance as a rehabilitative technique and the current British practice of prescribing narcotics to addicts. With methadone, the dose of the drug and frequency of administration is determined entirely by the physician. Intensive efforts are made to direct the patient's energies, previously given over to the problems and mystique of the "junkie" subculture, into productive channels. Almost as important, the technique of dispensing all methadone in fruit juice makes it virtually impossible to use the drug intravenously, and in terms of the effect on behavior, differences in the

route of administration cannot be flippantly dismissed by the simplistic assertion that a narcotic is a narcotic no matter how it is used. By contrast, in the British situation the addict is given a prescription for a narcotic, often unaccompanied by any effort toward rehabilitation. The prescription is usually for heroin, and the addict is free to administer the drug to himself by whatever route and with whatever frequency he chooses.

In New York City, the methadone maintenance approach is now being used with almost 2,000 former heroin users. In other parts of the country other investigators are studying modifications of the original Dole-Nyswander procedures to determine if the costs can be lowered, the flexibility of approach increased, or the risk of illicit redistribution of methadone reduced.

Considerable progress has been made in all three of these areas. In our Chicago project we have demonstrated that the majority of heroin users can be transferred directly from heroin to oral methadone on an ambulatory basis. By eliminating the six-week hospitalization phase originally employed by Dole and Nyswander, we have not only been able to dramatically reduce the cost of this treatment, but we have also eliminated a major bottleneck in bringing new patients into treatment.

More recently we have been working with drugs related to methadone but whose durations of action are considerably longer. We have demonstrated that patients do equally well on methadone once a day or the related drug given only three times a week. Clearly, it is easier to make a satisfactory vocational adjustment if it is necessary to come to a clinic only three times a week rather than six to seven times a week.

Self-help programs such as Synanon, Daytop Villages, Phoenix Houses, and Gateway Houses (a network of therapeutic communities established in Chicago in July of 1968) are run almost entirely by rehabilitated ex-addicts or by ex-addicts working in close collaboration with a professional staff. They usually entail several years of residence in a therapeutic community. Experience demonstrates that many former compulsive drug users are able to remain drug free and to function productively so long as they remain in residence. This is certainly a worthwhile achievement, even if it falls short of the ideal of totally independent function in the

community at large. Of all the approaches now under evaluation, however, this one may be best suited to yield that elusive, ideal, long-term goal of drug free, productive behavior, without the need of continued medical or psychological treatment. It is also worth emphasizing that unlike the pharmacological approaches described for the treatment of narcotics use which are not relevant for the treatment of barbiturate or amphetamine abuse, the therapeutic community concept is equally applicable to all forms of drug abuse.

There was considerable discussion about the development of a civil commitment or a supervisory-deterrent system, but Illinois finally took the position that until the community could provide treatment for all those who wanted to be treated, it would not be appropriate to spend public resources to develop treatments for those who were not seeking treatment.

It was recognized that proposing the simultaneous development of several major treatment programs was a formidable undertaking, but after considering the difficulties experienced by other states where competition between autonomous single modality programs has often led to inefficient reduplication of effort, barriers to the movement of patients from one program to another and vituperous public attacks by the proponents of one program on the motives of the proponents of another, Illinois elected at least to attempt to develop the multi-modality approach. It was hoped to demonstrate that placing all modalities within a single administrative structure would eliminate duplication, facilitate patient movement, and permit a uniform and objective evaluation.

CURRENT STATUS

The State of Illinois-University of Chicago collaborative program became operational in January of 1968 when a single patient began to receive methadone on an ambulatory basis. At that time there were about six staff members and its total operating space was a six-room apartment lent to it by the Department of Psychiatry of the University of Chicago. As each of the projected units became operational (the hospital withdrawal unit in June, 1968, the first short-term methadone unit in May, the first Gateway House unit in July, research and administrative offices in September, and the first half-way house unit in December), it became progressively more feasible to implement the research design previously described. Obviously,

random assignment could not be initiated until all treatments were operative and would not be meaningful until all were operating at optimal effectiveness. A three-way random assignment became fully operational in December of 1968. Currently (December, 1969) the treatment program consists of a number of cooperating and coordinated clinical units:

1. *Four methadone outpatient facilities.*

2. *Therapeutic communities (two) operated by Gateway Houses Foundation, Inc. (an Illinois non-profit corporation).*

3. *A halfway house -- crises center in the community for detoxified patients -- some of whom are taking the narcotic antagonist, cyclazocine.*

4. *A multi-modality training and residential facility at the Tinley Park Mental Health Center.*

This system permits the program to obtain some measure of the acceptability of the various treatment approaches and to attempt to correlate treatment acceptance with a number of characteristics of the patients seeking treatment. Such estimates of treatment acceptability are important in planning new facilities in other parts of the community. Programs in which 90% of the patients in a given community refuse to participate may have markedly limited value even if they are relatively effective in rehabilitating the 10% who accept the treatment.

PROGRAM EVALUATION

What this program emphasizes as the most critical considerations for establishing pilot programs for the treatment of drug abuse is the continual monitoring of the efficacy of treatment and the feedback of this information into the clinical process, so that as a result, the clinical process can be continuously modified.

Each week after entering a treatment unit, every patient fills out a standardized questionnaire covering the following areas: housing, living arrangements, employment, earnings, antisocial activity, arrests, drug and

alcohol use, and types of program activities utilized. In addition, the treatment units obtain from each patient a urine specimen at least twice a week. Using thin-layer chromatography, the specimens are examined for opiates, quinine, amphetamines and barbiturates. Some units are now using breathometers to check on excessive use of alcohol. Reports from each patient's counselor, the medical unit and the legal unit are also fed into a central location. Computer programs are now under development which will merge, store, and print out this information with a short enough "turn around time" (e.g., three days) for maximum utilization in the care of patients and in the modification of the clinical procedures. Systematic organization of computer print outs permit program and clinical directors to review the entire patient population weekly. Such "online feedback" helps us to spot small troubles in our decentralized network before they become big ones.

RESULTS TO DATE

By early in December, 1969, more than 1,500 narcotics users have made contact with the program on a voluntary basis. Over 1,000 individuals have received some form of treatment, more than 580 are still actively engaged in treatment in one of the units, and about 10 narcotics users are entering treatment each week.

The program takes the position that there can be no single statement about the success of any particular approach. There can only be a statement about what kinds of individuals are moved more effectively toward which goals by which treatments and at what cost over a given time base.

We have also given some thought to the concept of prevention of narcotics use. In order to prevent a disease we must know the process. Addiction spreads from user to user. In this sense each time we effectively treat a user we reduce the probability of contagion in the community. Educational programs may be of value for the prevention of heroin use, but I cannot say that I am satisfied with any programs now available. Furthermore, I think it is irrational to assume either that all elements of the population are equally at risk, or that all susceptible individuals will respond to the same educational approach. In Chicago we have conducted epidemiological studies indicating that in one part of the city there are

virtually no young heroin users. The problem is confined to a large group of people in their 30's and 40's whose use began when they were teenagers between 1949 and 1955. In another part of the city heroin use among young adults and teenagers is a growning problem, with new users entering the population every day. Obviously preventive efforts, whether through educational programs in schools or community efforts to find alternative ways of channeling the behavior of the young people are desperately needed in one area, but might be wasted in another. I mention this merely to illustrate that even education and prevention should be based on a knowledge of the process in question.

I have spent most of my time talking about the approach to a treatment system for heroin addiction, and I have only touched lightly on the issue of the prevention of heroin addiction.

It was my aim to use the heroin problem to present a model -- a model which avoids unfounded assumptions but proceeds to test assumptions before they are incorporated into large scale operations. If I have conveyed the idea that effective programs are not wished into existence, that they can be developed only by a process that explicitly articulates program goals and carefully evaluates program operations to determine whether these goals are reached, then I will have accomplished my purpose.

As far as I am concerned, programs for prevention of heroin addiction are not exempt from these rules. I have heard many proposals for large scale education programs and other activities that would seem to have face validity. Nevertheless, I remain skeptical. To deserve more than a pilot status, goals must be articulated and operations so designed that objective estimates of effectiveness can be made.

With respect to other varieties of drug abuse such as the use of amphetamines, the basic model requires little change. It seems safest to assume that the population will be heterogeneous, that there will be more than one motive for amphetamine use, and many varied patterns.

At present we know very little about the basic physiological and biochemical changes induced by chronic amphetamine use, we have no demonstrably effective psychopharmacological therapies, and while some amphetamine users

have benefited from residence in therapeutic communities, it is not at all clear that the dynamics of communities originally evolved to benefit the heroin user are best suited to change the behavior of the new "speed" generation. We do not even know the natural course of the amphetamine- or psychedelic-use syndrome. Is it a transient phenomenon lasting a few months or a year, or is it more like the compulsive heroin-using syndrome which resembles a chronic relapsing disease? What is the contagion process; who "turns on" whom? These are a few of the questions that researchers are now asking. Hopefully, useful answers will be forthcoming.

I began with the notion that useful answers can come only from well thought out questions. Yet we often forget that the use of answers requires human effort and economic resources. All too often we have discovered how to treat or prevent many human diseases only to wait decades for these advances to be made available to the general population. Implementation of new technology implies planning, training of human beings, and the reordering of priorities to free up the necessary economic resources. From personal experience I know how time consuming and complex good planning can be. Like the foundations on which tall buildings are built, at first it appears that the builders are only digging holes. If the plans are good a useful structure should follow the digging.

I have described some problems where there are new procedures now available for implementation and other problems where precise questions have yet to be asked. I would like to end by suggesting that all who have the responsibility for developing community response to drug abuse problems ask themselves the following question, *WHAT ARE WE DOING NOW TO IMPLEMENT THOSE PROCEDURES THAT ARE DEMONSTRABLY EFFECTIVE AND WHAT ARE WE DOING NOW TO BE READY TO USE NEW SOLUTIONS AS THEY BECOME AVAILABLE?*

Reaction Panel

Moderator: Herbert A. Raskin M.D.

John Finlator

I would like to compliment Dr. Jaffe on his program in Illinois. I hear a lot of very fine things emanating from that program and I would like to say that at least they are trying and trying desperately to have a very effective program of rehabilitation; I only wish that a number of others of us across the country would try as hard. I think he has done a very fine job and I agree with most of his remarks. I think that some of his assumptions were good ones. I agree that law enforcement and rehabilitation should go hand in hand; in fact, I would love to see it happen that way. Rehabilitation rather than law enforcement is the real answer, but that is going to be difficult to accomplish because two different types of people are involved, the criminal element and the man who needs rehabilitation and help. We are quite interested, of course, in methodology in the maintenance program that Dr. Jaffe spoke about. Some clinics are doing an outstanding job, some are doing a pretty sloppy job, some prescribe indiscriminately, some are being robbed, and some are allowing methadone to get into the street.

John Finlator, Deputy Director, Bureau of Narcotics and Dangerous Drugs, U.S. Department of Justice, Washington, D.C.

We still don't know a great deal about methadone; we are particularly ignorant about the long term effect. We begin to see a lot of methadone in the streets in certain parts of the country and we found some illegal, clandestine laboratories manufacturing the drug, but that is a relatively small problem. Methadone maintenance could be a successful one, even though the individual becomes dependent on methadone much as some people who must take insulin all their lives. This seems preferable to being addicted to heroin.

Dr. Jaffe said that, in his community at least, heroin seems to be confined to certain parts of the city, but we find that the opposite is true. Our fourteen regional offices report that heroin is now appearing in the affluent neighborhoods, particularly among high school students. We do not find it so prevalent among the college population; they seem to give it a wide berth. However heroin is certainly increasing in popularity with high school students and, in some larger cities, even with junior high school students. Illegal sales of cocaine have now exceeded heroin, thus creating a new problem.

We are here to suggest some solutions and everybody is supposedly an expert in this business. Well, I am not an expert, but I see certain things from where I sit that bother me. I see two problems with the drug abuse question. I see the older people with one drug abuse problem and I see the younger people, particularly the teenagers, with another and distinct problem. The one that is getting the attention of course, is the drug problem related to young people because we like to talk about them more in the media and more among ourselves. As someone has already said, we can sit comfortably in our chairs in a room like this and talk about the problems of the young but it is very difficult to talk about our own problems.

One of the solutions, as I see it, would be education. I do not really know what that means, but certainly there must be some sort of exchange of information between us about drugs and drug abuse. We find ourselves in a time when young people, particularly junior high and high school students, know more about drugs than their parents, teachers, or their religious leaders, or almost anyone in that dirty word called *The Establishment*. It is true that their information may be mis-information, or bad information, or street information, or information from the market places, but they have *more* information about drugs than you do and they know it, and you know that they know it.

This is a pretty damnable situation for us to be in. There was a time when we would say, "I do not talk about drugs to young people, it might encourage them to use them." That philosophy lasted through the thirties and the forties and fifties and then suddenly in the sixties we find a generation of young people who know much more about drugs than their parents, or their teachers, or their religious leaders (I am not talking about their doctors, of course). We need education in the schools and for the parents and the public. Parents have turned out to be an uninformed group in many respects because they close their eyes to the drug abuse problem. We need an educational program in the school system at the very lowest level; I would say certainly at the elementary school level, if not before that. If we think that we are going to re-educate teenagers at the high school or college level we can forget it; we are not. I think we have a great chance to educate young people in the decade of the seventies if we could start very early and talk with them about drugs in the context of respect for and understanding of drugs, using scientific truths if we can get them.

We can at least talk with young people about drugs and this is what we have not done. A young man comes in today and he has "pot" written in his book and his old man nearly goes crazy. If the boy says, "I went to a pot party last night," his father either runs him out of the house or slaps him, and that is mostly the kind of reaction kids have gotten instead of understanding. No wonder these young people are telling us that they are bugging out. There has been a great apathy in the school system and on school boards about drug education today. As one man said, "It is all right to go over to the other county with your education program. Charlie has a drug abuse problem, I do not have one over here," so neither one of them will do anything about it.

Number two -- rehabilitation. I think that at least at the federal level, we have done a very poor job in the rehabilitation program. It will take programs like a number of the private ones that are going on today, with some of the state programs and local communities getting involved in a cooperative rehabilitation program. Some of the programs that depend upon ex-addicts have done well and they are helping people. Some of us have not done as well, for instance, Narrund. In the first twenty-four months of Narrund, no more than twenty-one people were admitted under that program.

I think we need more scientific information. We need scientific information on LSD, we need scientific information on marijuana, we must be able to tell the kids what the long-term effects are and what the short-term effects are. Whenever I talk to a group of college kids, and that is quite often, that is the first question, "When are you going to give us the scientific facts?" We do not have them and it is very difficult to talk to these kids.

Finally -- law enforcement. Certainly we need law enforcement, but we need a better understanding of law enforcement and what it should do. Take, for instance, the rise of 778% in the arrest of young people under the age of eighteen, in the period from 1960 to 1967. We need a better understanding of law enforcement, what it can do, what it should do. But let me say one thing in favor of law enforcement personnel -- they want to do their job. I sometines think that they have done a better job in the drug abuse area than the scientific world, or the educational world, or the parents, or the general public. And this is wrong. All across the country, in many communities, the only authority that people can get to talk to them about the drug abuse problem is policemen.

Helen H. Nowlis, Ph.D.

It is always very difficult for me because of my involvement in all aspects of this problem to pick out two or three things to emphasize in the short time available. And since I am supposed to be reacting to Dr. Jaffe's paper, I think I will let that be my guide and perhaps in the question and answer period I will have an opportunity to rove a little more freely. There were two things in Dr. Jaffe's paper that I could not agree with more. I would like to take them from the rehabilitation area and put them into the education area. The first thing that I want to emphasize is his point that we are not dealing with a simple, homogenous group of people who use drugs. As he puts it, treatments must vary with the individual case. As we move into the education area, this is probably one of the most important things that we should remember. It is very easy to deal in stereotypes. And it is easy to label people, or drugs or behavior and then assume that the label makes them all the same. If we are going to have any effective attempt at education, it must be tailored to what we know about the people whom we are attempting to educate.

Helen H. Nowlis, Ph.D., Research Consultant for Student Affairs, University of Rochester, Rochester, New York

The other thing that I would like to pick up and emphasize, and for which I want to commend him, is his plea for explicit articulation of goals. I would like to take it beyond goals, even to making explicit the many implicit assumptions that are floating around in all aspects of this problem. Let me use just one example. I think that one of the most important things we need to do is to examine the many implicit assumptions that are hidden in the way that we state the problem. I think until we do this, the many professions, the many disciplines, the many different people who are looking at this problem are going to talk past each other and argue about symbols and symptoms, not about basic issues. Let me just give you an example. If you look at the variety of ways in which the so-called drug problem has been stated, you find that they fall somewhat on a continuum and the continuum tends to go from the traditional to the innovative and from the simplistic to the complex.

On the simplistic end we have the implicit assumption that *drugs* as pharmacological agents, are the problem. If you make this assumption, than all kinds of things follow in terms of the laws you make or in terms of any education or rehabilitation programs. This gets us into a great deal of trouble because by and large we are still operating on what might be called a medieval magic potion notion of drugs. The idea that somehow or other drugs have within themselves the power to do something and that they do the same thing to all people gets us into a great deal of difficulty because it does not correspond in any way with modern scientific knowledge of what drugs are and how they act.

If you move a little bit along the continuum, you find a whole group of statements which have the implicit assumption that the real problem is *people* and some psychologists and some psychiatrists begin to talk about the dependent personality of people that risk taking drugs. I believe this view also tends to over-simplify and over-generalize. This, combined with the tendency to operate on stereotypes, creates more problems than it solves.

If you move farther along on the continuum, you have a whole group of statements which have an implicit assumption that the problem involves *groups* of people. We begin to talk about "the addict," or "the college student," or "the high school student" and again we fall into the trap of over-generalization.

As we move farther out on the continuum we find a group of statements that have within them the implicit assumption that the problem is really the problem of *society*; that society has its problems and drug abuse is just one response to these problems.

If we move all the way to the other end of the continuum we find a number of anthropologists and sociologists who state that the problem really is society's *attitude* toward certain drugs. We all tend to use as an explanation, or to assume in our statement of the problem, whatever it is we are prepared to do in order to deal with the problem. Consequently, as I see it, one of the most important things, and some of us are trying to do this on a national level, is to put aside some of our prejudices and some of our personal or professional investment and gather together people with a variety of points of view, making all kinds of implicit assumptions, and put those assumptions out on the table for discussion. I think we must talk with each other and this includes young people, law enforcement officers, legislators, all the education disciplines, and other people who are concerned with and want to do something about this problem. As long as each one of us has his own particular point of view or his own particular prescription and as long as we spend our time arguing about whether or not this is right, I don't think we are going to get anywhere.

The National Coordinating Council on Drug Abuse Education and Information in Washington, a very new organization, is trying to put this into practice. It is a group composed of representatives from eighty-nine different professional and service endorcement groups. Everybody is in the act and we're trying desperately to get a dialogue going so that all of us can contribute our insights, our skills, and our understanding to a problem which (a) is very complex and the more we try to simplify it the more complex it becomes and (b) impinges on almost every discipline, almost every profession, almost every person. So my plea is first for an interdisciplinary approach, for each of us to be willing to have our assumptions brought to the surface and examined, and then for a cooperative effort which we accept at the outset will not be a neat package, will not be a simple solution, and incidentally, will probably not be a very inexpensive solution.

Edward A. Wolfson, M.D.

Let me just start this reaction with two statements which, I hope, will give some historical perspective. "The drug habit is gaining ground amongst our professional men, our weary women, clerks, former liquor drunkards; all our classes from the highest to the lowest are yearly increasing their consumption of the drug." And, "The events of the last few years have unquestionably added greatly to their number." Now this wasn't made last year, or a month ago or even at this conference. The first statement appeared in *HARPERS* in May of 1867 and the second, a year later. They both refer to the Civil War and the use of opium, the soldier's disease of the nineteenth century. The words are familiar, they are similar to what one hears today. Perhaps we should be very thankful that the soldier's disease of today is marijuana rather than heroin -- clearly a step forward. Now what about possible solutions? What I am about to say may be flowery but I believe the problem requires a total commitment from all of us. It is a total commitment for society not only for the people in this room. It includes the educators and it includes the physicians who unfortunately have not been

Edward A. Wolfson, M.D., Director, Division of Drug Abuse, New Jersey College of Medicine and Denistry, East Orange, New Jersey

educated to this problem in the past. Educational programs are terribly important but they will be unsuccessful unless the educational system has a way of handling the problem. Education has to provide two things: (1) it has to provide the knowledge necessary to identify the problem and (2) it has to know how to deal with it. I submit that most school systems do not have a way of dealing with the problem. We must have a system that is fair and reasonable, constructive, honest, and not punitive. We should, of course, allow student participation within the system. Our present "no system" is so much worse than any system we could devise.

Whatever the system, we must provide confidential and meaningful counseling. When we can get the school speaker, he is either an unknowledgeable physician, an ex-addict, a moralist or worse -- some zealot or biased person with a personal charisma, and then as the cartoon goes, "that's all, folks, we stop right there." As Dr. Farnsworth put it we do have some responsibility to try to understand the adolescent. I feel that adult education with a humanistic approach might allow adults and parents to understand for the first time just what these youngsters are talking about. We have a drug oriented society right now, and perhaps we should look into the mirror. We have bandied about the word "education;" it is a useful word. We say that we must be truthful, that we must be scientific, and that we must dispense facts -- I think that most of us agree. The point is that Dr. Jaffe is one of the few people who is trying to bring a scientific approach to this complex problem which has social, economic, political, religious, moral, and medical ramifications. Only by setting specific goals and hypotheses and then by testing these goals and hypotheses can we ever hope to get somewhere with the problem.

With regard to education, let me suggest it isn't only a question of educating the youngsters, it is also a question of educating the teachers and the physicians. At our medical college we have a Division of Drug Abuse which is charged with not only running a drug program for the City of Newark but with working with the medical students at the New Jersey College of Medicine to try, for the first time we think, to let the medical students know what is going on in the drug world. On the question of what to do with the teachers, I think this one day seminar, or a two day workshop, or a movie, or one lecture is not the answer. I think we need very intensive two or three week courses where adults will be exposed to the history of drugs,

divergent views of all types, legal problems, different drug categories, chemical and pharmacological effects, mechanisms of action, toxicity and epidemiology.

We also need more research. To return to Dr. Jaffe's theme, and he is to be congratulated on this multi-modality approach, we must evaluate and re-evaluate programs that are now in use in rehabilitating drug abusers. We must realize that since there is no stereotype addict, as has been suggested by some theorists, it is therefore not surprising that no one approach will work for all. What we require is a critical, independent evaluation. In Dr. Jaffe's program this is being done by the hypotheses that he himself sets up within the program and continually evaluates. Another approach is that, depending upon the community, there can be an extramural evaluation of many different programs that may be going on in any one particular area. Each program as you know inevitably (and somewhat justifiably perhaps) develops an emotionally proprietory interest in its own techniques and its own program. Unfortunately, this introduces a bias which makes valid self-assessment rather difficult. Therefore we must develop some objective system of evaluation.

In our particular set-up in Newark we have what we think is a unique situation in the sense that we have six different treatment programs, each offering a different modality of treatment, affiliated with the Division of Drug Abuse in the medical college. Each do their own thing. We have a detoxification set-up and we have a system of referral to those programs. We have a narcotics registry and each affiliated program may receive monies through NIMH as an affiliate, but to be eligible they must allow an independent evaluation of their procedures. We do not have any facts or figures on this so I certainly can't give you any results. In summary, I think it is a total society commitment; revamping the educational system to incorporate a curriculum change; teacher training; understanding our youth; and research and evaluation so that the public monies can be spent properly.

Tod H. Mikuriya, M.D.

Unfortunately, Dr. Farnsworth's suggestion of lesser criminal penalties for initial marijuana convictions but significantly more severe punishments for subsequent pot arrests would serve only to encourage persecution of the user by the courts. Such ideas are not only utterly unrealistic, but totally void of scientific bases or moral consistency.

At one point in his paper he asserts that deterrent sanctions should be somehow commensurate with toxicity of the drug. If this would be the case, people would only sniff condescendingly at aspirin, caffeine or marijuana use, make the use of barbiturates, opiates, tobacco and LSD a misdemeanor, with alcohol and amphetamine use treated as felonious crimes.

It would seem on the basis of what is already known about marijuana, that control rather than prohibition is the only scientific, humane and feasible answer. If the current information gap between our contemporary medical

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leaders and medical authorities of the past were bridged by a more thorough study of what is known, we would not be in our current pickle.

The medical community used to know much more about cannabis than it knows today. Since marijuana used to be medically prescribed for all manner of diverse maladies, principally as a sedative and hypnotic, physicians were quite familiar with its effects and side effects. Predictably, when the use of marijuana for medical purposes declined as the synthetic analgesics and sedatives were popularized after their discovery around the turn of the century, knowledge of its effects dwindled as well. Knowledge of a subject, like a muscle, atrophies when it is not used. Contemporary medicine is suffering from amnesia in the case of cannabis.

Marijuana (cannabis, hemp, kif, or ganja) is a non-toxic, water insoluble resinous material with low liability for abuse or serious side effects. Side effects are chiefly cortical or sub-cortical in nature and are closely dose-related. As with any drug there are occasional cases of hypersensitivity or intolerance.

The smoking of marijuana, while adding an admittedly undesirable source of lung irritation, is probably less noxious to the body than the smoking of nicotine cigarettes in quantities encountered in general use. Since relatively few inhalations of marijuana are required to achieve desired effects, the stronger the smoked preparation, the less lung irritation would be incurred because of the fewer puffs needed for desired psychic effects.

This then brings us to another bugbear in the pot prohibitionists' apologetics; the stronger the preparation the greater the danger. The common comparison made is between weak North American grass and hashish. Because onset of the effects by the smoked route are from three to five minutes, the experienced user is easily able to adjust his dose by abstaining or taking another puff when the pipe or "joint" is offered. Today the young person must learn to hold his pot much as the older people learned to handle their booze.

Marijuana is also a safe drug because results of the taking of an overdose are often unpleasant. Perceptual distortion (especially time), loss of memory, and fear or paranoia are predictable effects in a manner that

appears to be closely dose-related. Recent descriptions of so called psychotic reactions may be either precepitation of anxiety attacks or unearthing of latent schizophrenia, but are usually cases of simple overdose with accompanying anxiety in unexperienced users. These reactions have been described innumerable times in both lay and medical literature.

While much has been made of adverse reactions to cannabis, a recent survey of 90,733 admissions to the Los Angeles County Hospital, University of Southern California Medical Center between July 1, 1966, and June 30, 1967, revealed only three admissions could be directly attributed to marijuana. In these cases there were other significant mitigating factors to explain reasons for admission.

This observation corroborates similar findings by numerous earlier studies and commissions starting with the Indian Hemp Drugs Commission Report of 1893 and 1894. This seven man commission spent two years traveling throughout India where marijuana use is rife, taking testimony of a total of 1,193 witnesses, both professional and non professional. Collateral animal experiments were also performed along with scrutinization of court and mental hospital records for possible adverse effects of marijuana. Part of their conclusion stated:

> *Viewing the subject generally, it may be added that the moderate use of these drugs is the rule and the excessive use is comparatively exceptional. The moderate use practically produces no ill effects. In all but the most exceptional cases, the injury from habitual moderate use is not appreciable. The excessive use may certainly be accepted as very injurious, though it must be admitted that in many excessive consumers the injury is not clearly marked. The injury done by the excessive use is, however, confined almost exclusively to the consumer himself; the effect on society is rarely appreciable. It has been the most striking feature of this inquiry to find how little the effects of hemp drugs have obtruded themselves on observation. The large number of witnesses of all classes who professed never to have seen these effects, the vague statements made by many who professed to have observed them, and the very few witnesses who could so recall a case as to give any definite account of it, and the manner in which a large proportion of these cases broke down in the first attempt to examine them, are facts which*

combined to show most clearly how little injury society has hitherto sustained from hemp drugs.

The U.S. Army in the thirties was interested in the possible deleterious effects of marijuana use on soldiers stationed in the Panama Canal Zone. It was their observation that:

Delinquencies due to marijuana smoking which result in trial by military court are negligible in number when compared with delinquencies resulting from the use of alcoholic drinks which also may be classed as stimulants and intoxicants.

In response to the federal legislative overkill of the 1937 Marijuana Tax Act by the federal government, Mayor Fiorello LaGuardia in New York City set up a comprehensive study of marijuana concluding:

I am glad that the sociological, psychological, and medical ills, commonly attributed to marijuana have been found to be exaggerated insofar as the City of New York is concerned.

As late as 1967 the President's task force on narcotics and drug abuse stated:

Basically research has been almost non-existent, probably because the principle active ingredient in marijuana has only recently been isolated and synthesized. Yet the Commission believes that enough information exists to warrant careful study of our marijuana laws and the propositions on which they are based.

I must say that I agree with these preceding conclusions rather than those asserted by Dr. Farnsworth in his presentation and also in those expressed through the American Medical Association-National Academy of Science-National Research Council position paper. This statement was based on only limited experience with isolated adverse reactions occurring in questionable and poorly controlled experimental circumstances that were not properly reported so as to rule out other possible factors in the so-called psychotic episodes. Dr. Farnsworth in his *ad hoc* efforts to solicit cases of adverse reactions within the Harvard Student Health Center Psychiatric

Service during the Fall of 1967, after having testified to the dangerous nature of marijuana at the Oteri marijuana test case, were notably unsuccessful considering the high rate of student use of marijuana at that fine university.

While Dr. Farnsworth proposes escalating harassment of the marijuana user in order to "protect" him from himself, (a domestic social search and destroy operation) the Indian Hemp Drugs Commission concluded that controlled, supervised and protected use by the cannabis devotee was the only feasible and just solution.

Since the drug problems are more broadly of a political and philosophical nature than narrow questions of pharmacology, it is apropos that we review just what that great philosopher of government, John Stuart Mill, had to say about the right of the individual and proper role of government.

> *That there is, or there ought to be, some space in human existence thus entrenched around law which no one who professes the smallest regard to human freedom or dignity will call in question: The point to be determined is where the limit should be placed; how large a province of human life this reserved territory should include. I apprehend that it ought to include all that part of which concerns the life, whether inward or outward of the individual, and does not effect the interest of others or affects them only through the moral influence of example. With respect to the domain of the inward consciousness, the thoughts and feelings and as much of external conduct as is personal only, involving no consequences, none at least of a painful or injurious kind, to other people, I hold that it is allowable in all, and in the more thoughtful and cultivated often a duty, to assert and promulgate with all the force they are capable of, their opinion of what is good or bad, admirable or contemptable, but not to compel others to conform to that opinion, whether the force used is that of extra legal coercion, or exerts itself by means of the law. Even in those portions of conduct which do affect the interest of others, the onus of making out a case always lies on the defenders of legal prohibitions. It is not merely a constructive or presumptive injury to others which will justify the inference of law with individual freedom. To be prevented from what one is inclined*

> *to, or from acting contrary to ones own judgment of what is desirable, is not only always irksome, but always tends, in this PRO TANTO, to starve the development of some portion of the bodily or mental faculties, either sensitive or active; and, unless the conscience of the individual goes freely with the legal restraint, it partakes either in a great or small degree of the degradation of slavery. Scarcely any degree of utility short of absolute necessity will justify a prohibitory regulation, unless it can also be made to recommend itself to the general conscience; unless persons of ordinary good intentions believe already, or can be induced to believe, that the thing prohibited is the thing which they ought not wish to do.*
> (from Mill's *POLITICAL ECONOMY)*

Using these criteria for evaluating and controlling human behavior, it would appear that Dr. Farnsworth in his support of maintaining even lesser criminal penalties for the use of marijuana than now exist, is rather inconsistent with principles of democracy in which we all profess to believe.

Marijuana use in America has become like prohibition -- in that some 12 million are smoking pot and the police of the 188 million other Americans are trying to prevent them from doing so. Despite vigorous efforts of society to regulate by deterrent legal sanctions, they have obviously sadly failed. The use continues to escalate. In fact marijuana may now be assumed to be a permanent part of American Society. Since all who try and continue to use pot find it enjoyable, and many more people are trying it all the time, I think we may correctly assume that marijuana use is here to stay.

The time has passed when prohibition of marijuana should have been repealed, as we are experiencing a condition of minority group abuse in the good old tradition of the Spanish Inquisition, the Salem witch trials, and the national sickness centering around Senator Joseph McCarthy in the early 50's.

"The horse has been let out of the barn." It will do no good to attempt to lock the door behind it. We must face up to the fact that marijuana use will be here on a continuing basis and institutions existing for the protection of public health and safety must respond appropriately to this new situation.

Dr. Farnsworth's suggestion to make marijuana offenses misdemeanors will only encourage judges to act in vindictive and punitive ways to continue the persecution of this unorganized minority thus further inflaming and polarizing a situation which requires rational responses and sound psychological and social approaches to the problem. This current prohibition of marijuana can no longer be justified nor tolerated, and the only approach is to provide just, fair, and effective controls by means similar to those used to regulate alcoholic beverages or nicotine preparations. I might add, however, that I would not like to see advertising or other inducements for using pot, especially in material for children below the age of reading.

When talking with the chief counsel for the New York Narcotic Addiction Program, I proposed such an idea and to my amazement he felt that this would be quite unworkable. I was amazed, not because he opposed the idea which on first impression may appear to be quite a radical solution to the problem, but because he felt that if the regulation of cannabis products were turned over to a regulatory agency similar to alcohol or nicotine control, that it would quickly cause widespread corruption within these agencies. Somehow that seemed to me a rather cynical "non-excuse" for keeping the situation the way that it is, but more seriously, a sign of a basic disbelief in the ability of government to function in an appropriate manner.

In conclusion: We must maintain faith in a democratic institution's ability to show capability of responding appropriately to social change. If we do not take these steps to adjust governmental functions by means of leadership education, we may look forward to further polarization and inflamation of problems surrounding drug abuse.

Behavior of those individuals and agencies responsible for public health and safety has shown, up until now, a notable lack in leadership. Hopefully we may look forward to more appropriate and relevant responses as they become more educated concerning actual versus imagined liabilities incurred in the use of marijuana and other illicit mind-altering drugs.

Randall Bushman

In relation to Dr. Jaffe's speech, I'm very happy to see this much "encountering" going on at the scientific level toward solutions to the drug problem. However, I personally define the problem as a *human* problem. Human beings have many needs, one of which is to be just a human being. When you have people standing up and saying, "Let's talk about the problem," how many of these young people out there would really like to identify themselves with the problem? They say, "I'm not a problem, I'm a human being." And when I talk with someone at the Crisis Center or the Listening Ear, I don't say, "Let's talk about your problem." That's not the way to deal with this. I feel we're talking about *people* whatever their age. When an adult with whatever problems he has, stands there and accuses the young people of having a problem, it does not facilitate communication. This is mainly the question I would like to address.

When I was arrested I can very happily say my parents approached me with the attitude that I was a person that they wanted to understand. They asked

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me questions with the idea that they would listen to the answers, which is not always the case. The delineation of the problem -- is it a legal problem, is it a medical problem, is it a moral problem -- is secondary. We are talking about *people*, the environment they live in and the other people they relate to or try to relate to. When you've got an environment so oppressive that the individual either can't relate, or an environment that provides no rewards, then the person will seek whatever crutch he can find. He could become a religious fanatic in the same sense that he could become a drug addict. There is something that he needs or there is something that he is looking for, that is not being provided. And when someone comes in and takes away his drugs, thereby "solving" the problem by removing the supply, that is no solution to him; his needs are still there. If we can't think about what people need in their relation to each other and to live on this earth, we are never going to solve the problem.

I think it's extremely gratifying to hear everybody addressing themselves in what, not too many years ago, was extremely unusual to hear, and this was the focus of any type of theraputic program that was person-oriented. The pharmacological effects of the drug do not constitute the essence of the processes that are going on in the individual that causes him to reach out to a particular chemical substance.

Discussion

QUESTION. *Mr. Finlator, would you like to reply to Dr. Mikuriya's thesis relating to law enforcement aspects of controlling marijuana?*

FINLATOR. *It is a good paper. Dr. Mikuriya has done a lot of thinking and he represents a certain segment of our society that feels very strongly the need to change our thinking about marijuana. He talks about free use of marijuana, but he does suggest that we put it under some control as we do alcohol. There's a great deal of similar thinking that's been going on, not only among people like the good doctor, but even in the halls of Congress and in our State Legislature. Law makers, both at the state level and the federal level, had a problem thrust upon them during the sixties with which they are not yet able to cope. They are trying to cope with it by consolidating into one unit what had been two different drug-related bureaus -- the Bureau of Narcotics in the Treasury Department and the Bureau of Drug Abuse Control in the Food and Drug Administration.*

Let us turn to a better understanding of the penalty structure concerning marijuana. Those of you who wish to have the support free and the legal use of marijuana should talk to your legislators because it is not people like us who have anything to do with it. We can only make certain proposals and we are making what we consider a rather progressive one this time. We propose that, for a first offense, possession should be a misdemeanor. But the judge has the right of first offender treatment and he can drop the charge if he feels this is a justified action. In this case, the next offense would become a misdemeanor, and the third one would be a felony. We are collecting criticism from all over the country because of the permissiveness of that proposal. My prediction is that it will pass; it looks to us like the right kind of a move.

We have had a rise of seven hundred and seventy-eight per cent in arrests

of drug offenders from 1960 to 1967, and most of them did not go to trial. So we have a pendulum-type problem. At the one extreme we have people who demand the free use of marijuana and, at the other, those who say it's a very, very dangerous substance and possession should be classed as a felony. That is where we stand, at least at the federal level.

QUESTION. How can legislators influence the education programs in elementary schools and secondary schools toward honest and open discussion with young people about the reasons for taking drugs? Does not our educational system need urgent change to remove the emphasis on content and replace it with an emphasis on meaningful interaction with young people?

NOWLIS. I think that we have a variety of assumptions implicit in our definition of (a) the goal of education and (b) the process of education. And I would remind you of the situation in which we found ourselves with relation to alcohol education over the past twenty years, and currently in the area of sex education. What is the purpose of education? Is it the support of the status quo or is it the search for truth and learning to use the best information possible in order to seek answers to complex problems? In most cases I'm afraid that whenever we approach any of these controversial problems we essentially want to maintain the status quo. We want to tell it the way we see it and in this age where communication, mobility, technology, and scientific information is mushrooming so fast that it boggles the mind, we find that our young people are not where we are. In terms of practicalities, my prescription for someone to successfully participate in drug education is someone who understands, feels with or for, likes and respects young people as well as being informed in all aspects of this complex problem. Whenever someone like this emerges, the cry of the administration is, "But you don't have time to teach your courses anymore." In other words, if you have a knowledgeable, honest friend and counselor he is absolutely beseiged.

FINLATOR. I would like to point out that we must spend more public money on the problem or we are not going to get anywhere with it. All you have to do is look at the money your city or your state or your county or federal government is spending in this area and find that it is pitifully small. We talk about it, we say that it's terrible, that it's the third

most perplexing problem we have today, but we spend very little money in that area.

NOWLIS. But I think we must deserve the money. I think we must set the goals. We must discuss, argue and go through all the processes of understanding which will enable us to arrive at those goals and then I think, with our heads held high, we can get the money. I think we have been too vague. We say we are going to educate. For what? How?

WOLFSON. This comes down to the total commitment which we need from legislators as well as from physicians, educators, etc. I first heard that the drug problem was really not a drug problem but rather a people problem, from Dr. Nowlis; I believe it. And if you do believe it, it is a new ball game and our entire educational efforts must be directed toward that new perspective. It means teaching about drugs in a proper perspective of life -- teaching respect for drugs, using the broad sense of drug definition and starting right from kindergarten.

MIKURIYA. I would like to point out a possible difficulty with making the initial crime of possession of marijuana a misdemeanor. This would shift cases from already clogged superior courts to lower court levels, thereby encouraging further arrests and further clogging up of the court system. I think this would also cause mis-deployment and abuse of the police who would have even less time to prosecute real crime that constitutes a threat to public health and safety.

QUESTION. What cost can we anticipate for an effective program providing for treatment facilities, education and research? Are we talking about five hundred thousand, or five million or fifty million?

BEAR. That is a hard question to answer because it depends a lot on where you start. As a broad example, let me say that in New York City, in two and one half years we have built fifty-six facilities and we have treated fifteen hundred hard core addicts. We also deal with something over two thousand young people who are not abusing hard drugs but who are taking soft drugs and consequently are in trouble with their families, teachers, and so forth. This adds up to from three and a half to four thousand people in fifty-six facilities with approximately five different kinds of programs.

The total annual cost is approximately ten to eleven million dollars.

QUESTION. Dr. Nowlis do you envision a need for a Coordinating Counsel on Drug Abuse Education and Information on a state-wide level as well as the national level and with a concomitant affiliation between the national and state agencies?

NOWLIS. Yes. We hope to stimulate not a mirror image of ourselves but a thoughtful group at the state level which will affiliate and work with us. In fact there will be a letter going out to the governors within the next couple of weeks suggesting that they designate some group with which we could work.

QUESTION. I wonder if any of the panel members know of any research on the long term effects, if any, of glue sniffing? I also wonder why there hasn't been more extensive research on drugs of all sorts.

BEAR. One comment on the glue sniffing. One thing we found in the City of New York is that glue sniffing by black children seems to produce sickle cell anemia. Sickle cell anemia is a blood disease which has a much higher incidence in this race as compared with others. Researchers want to sit down and plan a study very carefully in advance before starting research. I am much in favor of that but I do not know of anybody who has tried to follow drug users over a long period of time. We sometimes preclude getting into some of these long-range studies because we can't define the knotty problems in a sufficient degree of specificity.

QUESTION. Would someone expand on the suggestion that marijuana should be legalized?

NOWLIS. This is a very complex problem and I find that in order to think about it clearly I have to separate it into two problems. One problem is; should marijuana be controlled? and the other problem is; how should it be controlled? What is at stake here is a problem which we have not yet begun to face, and that is social control in an increasingly large, complex, and concentrated society. We tend to respond to this challenge merely by doing more and more of what we have always done. I think we have reached the stage now where more and more of what we have always done is

going to create more problems than it solves. So I would like to not get involved in whether or not marijuana is safe or dangerous but rather to look at whether it should be controlled and how. Once you begin to do this and separate it from all our opinions, beliefs, fears, etc., about the drug, then you come to many of the things that Dr. Smith has recommended in his paper. I think that there are many problems associated with making marijuana free and available, but I object strenuously to the use of criminal sanctions to control its use. I think if we get ourselves out of that bind and then begin to think creatively about how we control behavior in our society without doing more damage than the illness, then we may come up with some creative ideas.

QUESTION. Why can't we approach the drug problem as we approach polio and give every child, every person, a preventive pill or injection?

NOWLIS. I think that this is perhaps an example of the kind of trouble we get into when we invoke too orthodox a medical model. I just don't see the parallel with polio. Polio is caused by a microorganism which has been identified and a vaccine developed. I think that we have to accept the fact that drug addiction is not caused by the drug, it has to do with the person and reasons he uses the drug. The primary question is to identify the meaning and the function and the significance of drugs to him as an individual, psychologically and socially defined. We have overworked the disease model where we have at least the possibility of identifying a single cause which is simple and describable and then proceed to a way to deal with the cause. The drug problem is in no way analogous.

Summation

Hubert G. Locke

A summation, either at the conclusion of legal arguments in a trial or at the end of a conference on drug abuse, should properly represent a recapitulation of what has already transpired, not the introduction of new arguments or evidence into the proceedings. I have never heard a summation yet, however, either in a courtroom or a conference, which did not violate both these structures, and as I do not wish to depart from tradition, permit me just to make a few closing comments which may or may not bear upon what you have heard today and which I hope will add, in a small way, to the sense of criticalness and urgency underlying this important discussion.

I think we are just beginning to see how many of our society's most critical dilemmas are rooted in the society itself and why all the simplistic, hysterical answers we continually hear for resolving these dilemmas are

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nothing more than that -- simplistic and hysterical. A major work on crime and law enforcement has just been published, entitled *Our Criminal Society* (E. M. Schur), in which the author makes the bold and radical observation: "We have to face up to the possibility that what we do *not* need (at least as a first priority item) is greater dedication to and funding of the 'war against crime' . . . What is much more badly needed is a substantial shifting of anti-crime energy and money away from specialized enforcement schemes and crash programs, and into basic long term efforts at amelioration of the general socio-economic ills of our society." And today we have heard distinguished and knowledgeable experts on the critical issue of drug abuse tell us that drug use is, in one very real sense, the outcome of the very drug-oriented, drug dependent society that we have created and which advertising and common practice commonly affirm and encourage. This is why the chorus of voices who shout "Unhandcuff the police and we can stop crime!" or "Lock up all addicts and we will stop the drug traffic!" are so terribly and dangerously wrong. Terribly wrong because they propose the wrong answer in the first place and dangerous, because as long as that sentiment prevails, we will not in this nation take the intelligent, sensible steps that have to be taken to resolve these dilemmas.

But precisely because we have listened to men who by training, research and experience, are able to dissect this difficult issue for us, it ought simultaneously to help us overcome that extraordinary capacity for indifference which now monumentally characterizes the American people. We move in this nation, it seems to me, between hand-wringing and shoulder-shrugging; either our dilemmas and crises are all-consuming or else they are of no widespread concern. And that I submit is precisely where we are on the issue of drug abuse. Either people tend to climb the walls about it or else accept it as just further proof of the fact that the world is going -- I'm tempted to say, to pot -- perhaps to hell in a handbasket would be more appropriate -- and are content to do little or nothing about it until and unless the issue comes home to roost in their own backyards.

I say this, in spite of this tremendous manifestation of sober, citizen-concern represented by your participation in this conference, for the following reasons, and here I would like to bring home what is a problem to our own state and our own local communities:

First, like most states, Michigan is one which tolerates indiscriminate and, in Dr. Farnsworth's language, "unnaturally severe" drug abuse laws. Admittedly, the problem is confused by overlapping legislation at the state and federal level, but the fact remains that we have not gotten through to our parent-teacher groups, church organizations, service clubs and a host of similar vehicles for creating public policy; we have not petitioned or pressured our elected officials at the state or federal level for the kind of intelligent change in drug abuse legislation that would permit both government and the public to deal with this issue with greater sensibleness and sensitivity.

Second, in Wayne County, the most populous area of the State and accordingly, the area where the drug abuse problem is numerically the most serious, the medical experts tell us there simply is no rehabilitative treatment program offering in-patient medical care for addicts under the age of 18. For that segment of the population, therefore, which represents possibly the largest number of victims of drug abuse and certainly represents the age group in which initial use of drugs begins, we have no in-patient medical program to offer.

Third, the staff of Lafayette Clinic in Wayne County, which this fall launched a methadone treatment program, reports that since the program was launched, it has received over 300 applications from heroin addicts requesting admission to the program. Currently, Lafayette Clinic can handle only 10 persons in its methadone program because of a shortage of beds and personnel.

Fourth, while there is no one cure that works for all addicted persons, there is general agreement among persons knowledgeable in the drug abuse field that Synanon which, at the risk of over-simplication, represents for drug users what Alcoholics Anonymous represents for alcoholics and the Seventh Slip Foundation represents for ex-convicts -- Synanon has provided rehabilitation and hope for significant numbers of drug users. We have had a Synanon facility in Detroit for some five years now, and that facility almost had to close its doors last month because it could not raise $40,000.00 for operating expenses. Synanon may yet close in Detroit if a permanent facility and permanent funding cannot be secured for its work.

Fifth, finally, the debate continues to rage over the old Marine Hospital on Detroit's east side which has been closed by the federal government, and which has been proposed by Judge Swainson as an excellent 150-bed facility for in-patient care for drug users, but which still stands idle, ensnared in governmental bureaucracy and red tape.

It is for reasons such as these that I suggest a basic lack of seriousness and commitment on the part of the American public to move toward sound, workable answers to the dilemma of drug abuse.

While I am about it, I would be less than candid if I did not also take note of two additional facts: (1) the sale of narcotics and dangerous drugs has long been a common practice in the slums and core centers of our cities, and (2) the widespread citizen alarm and concern has been almost directly and chronologically related to the discovery that the use of dangerous drugs is increasingly a habit not only for the poor but the middle-class and wealthy as well, and not only in the slums but also in the suburbs. What I wish to suggest, and I have no desire to be cryptic about it, ladies and gentlemen, is that we have a weird way of arriving at and setting our priorities in this country. Accordingly, while I am cynical about our motives in many instances, I join with you in the hope that what we are finally witnessing is the emergence of an enlightened national resolve to bring some sensible resolution to this controversial issue.

As to the methods for achieving this, we should note that there is an uncommon reliance on education in this nation as curative for every social, physical, or economic ill we confront. We have the idea in America that we can educate away the evils of racial prejudice, reckless driving habits, children born out of wedlock, and now drug usage. It is a basic fallacy to think there is any correlation between education and enlightenment -- that if people know something is bad for them, they will avoid it. Education has had little impact on cigarette smoking and on using safety belts, and it is questionable how much it will help here. Our panelists this morning, moreover, together with Drs. Farnsworth and Jaffe, have quite properly pointed to the contradiction involved in wanting, on the one hand, to educate youngsters against dangers of drug use and *not* wanting, on the other hand, to do anything about the manufacturing and advertising policies of companies which promote, support, and enhance a drug-oriented society.

It means that unless we tackle this problem at some very unpopular levels, there is little hope that we will do anything but escalate the number of conferences we hold. We need:

1. tight governmental control over sources and distribution processes of both legal and illegal drugs;

2. serious attention to and resolution of basic social problems which create or give rise to the need for drug dependency and a host of other human difficulties;

3. greater efforts in providing effective rehabilitation programs for addicts; (Dr. Jaffe has examined several alternatives here.)

4. strengthening the ability of law enforcement agencies and personnel to deal more effectively with suppliers at the very highest, syndicated level where *real* crime in society is taking place.

I omit educational programs on the premise that the major problem with public education today lies in the fact that every time we identify a national crisis, we revise our school curricula. If there are too many traffic accidents, we put in driver training; if there are too many babies born without benefit of matrimony, we put in sex education; if there are too many drug addicts, we put in programs to discourage the use of drugs. If schools could ever get to the task of educating wholesome, knowledgeable, sensible, mature, creative young people, we might find much less of a need or a temptation to take drugs on their part.

Finally, there are conferences and then there are conferences. Conferences at the state and federal level have, on occasion, been the instruments of drastic change in public policy and governmental perspective; they have provided an impetus for mobilization of citizen concern and for substantive new directions in public and private programs, investment of funds, and personnel. But conferences can also be an excuse to get away from the desk, an opportunity to kill a day hearing speeches in which we may or may not really be interested and to go home impressed that what we thought was a serious problem is really approaching a national disaster. I am

very hopeful that this day has been well spent. We can certainly thank the Governor and his staff both for their initiative and for the exciting array of expertise they have brought to us. But whether this Conference has been worthwhile will be seen in the next few months and in the next year and thereafter -- in what happens in this State's legislature, courts, and especially in community groups, and in the development of community attitudes. I am inclined to be optimistic. But we shall see.