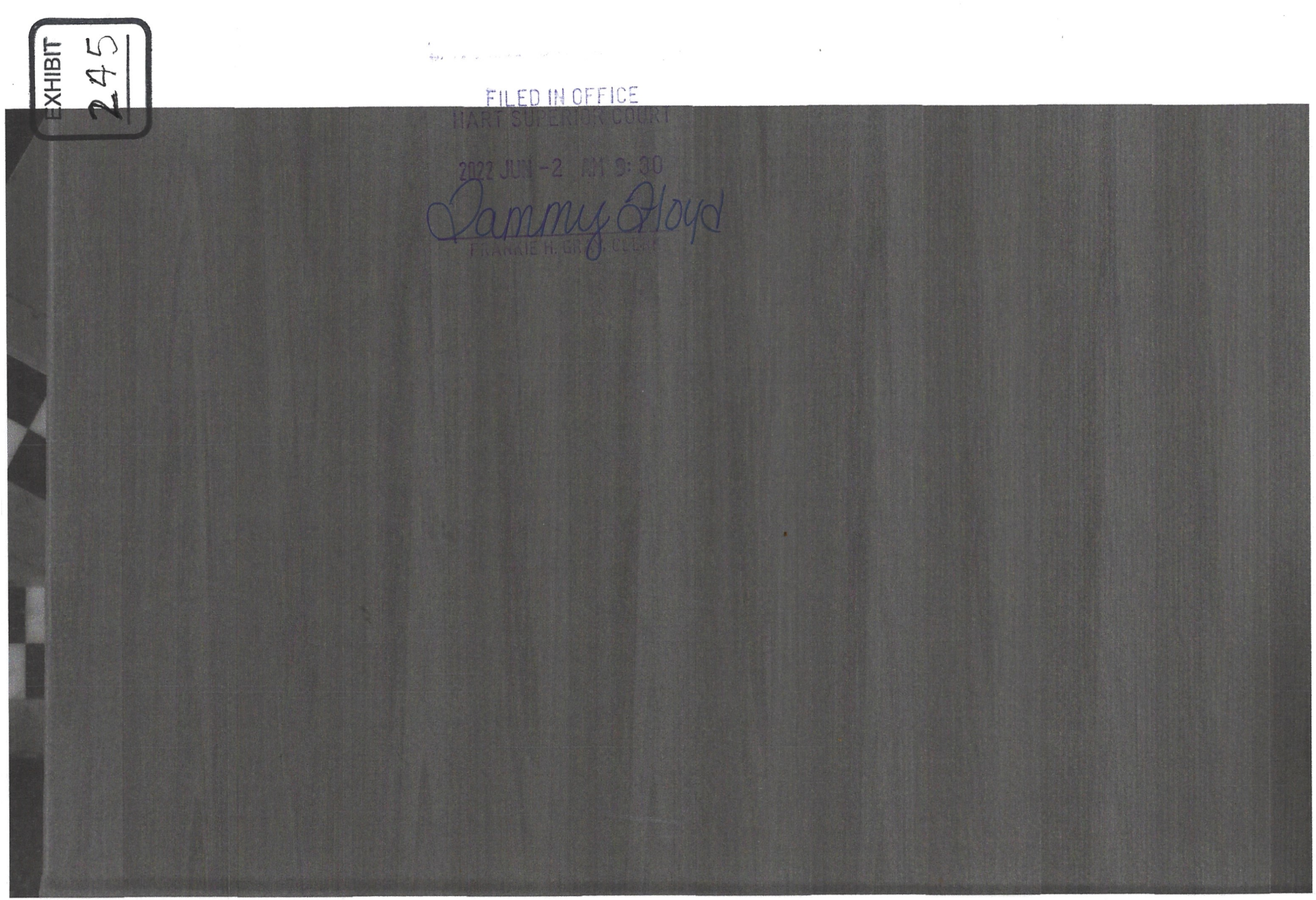

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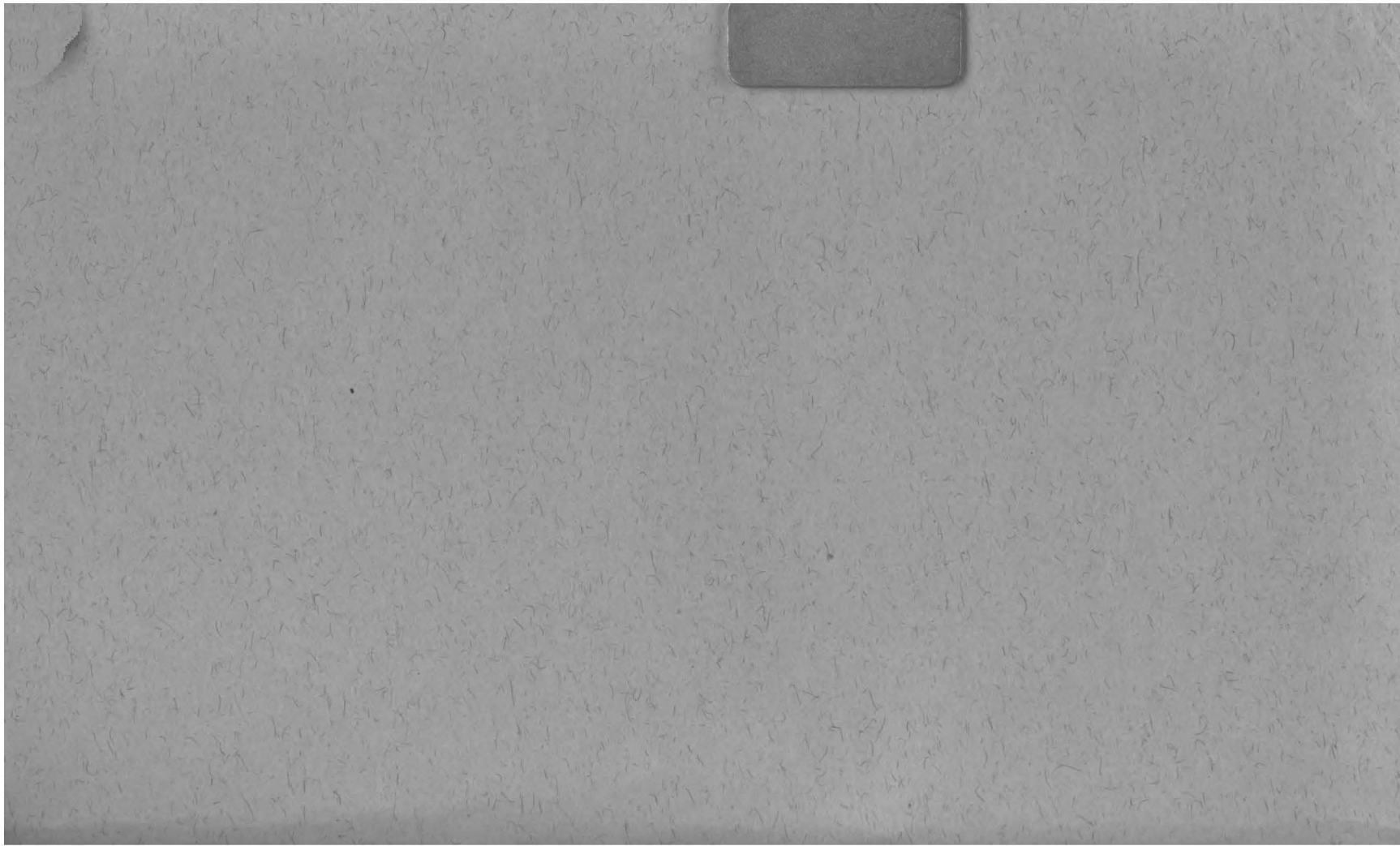

CONTROLLED DANGEROUS SUBSTANCES, NARCOTICS AND DRUG CONTROL LAWS

HEARINGS

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

SECOND SESSION

ON

LEGISLATION TO REGULATE CONTROLLED DANGEROUS SUBSTANCES AND AMEND NARCOTICS AND DRUG LAWS

JULY 20, 21, 22, 23, AND 27, 1970

Printed for the use of the Committee on Ways and Means

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CONTROLLED DANGEROUS SUBSTANCES, NARCOTICS AND DRUG CONTROL LAWS

MONDAY, JULY 20, 1970

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Today the Committee on Ways and Means is beginning public hearings on legislation to regulate and control dangerous substances and to amend the narcotics and drug laws. Among the bills pending before the committee are H.R. 17463 which was requested by the administration and is generally along the lines of the bill which passed the Senate and also H.R. 13742, a bill to protect the public health and safety by amending the narcotics and drug laws.

Without objection a copy of the press release announcing these hearings will be included in the record at this point along with copies of the bills heretofore mentioned.

(The press release, H.R. 17463, and H.R. 13742 follow:)

[Press release of Thursday, June 25, 1970]

CHAIRMAN WILBUR D. MILLS (D., ARK.), COMMITTEE ON WAYS AND MEANS, ANNOUNCES PUBLIC HEARINGS ON BILLS PENDING BEFORE THE COMMITTEE TO REGULATE CONTROLLED DANGEROUS SUBSTANCES AND AMEND NARCOTICS AND DRUG LAWS

Chairman Wilbur D. Mills (D., Ark.), Committee on Ways and Means, U.S. House of Representatives, today announced public hearings would be held by the Committee on bills presently pending before the Committee to regulate controlled dangerous substances and to amend the narcotics laws, beginning on Monday, July 20, 1970. Included among such pending bills is H.R. 17463, introduced by Chairman Mills and the ranking Republican Member of the Committee, the Honorable John W. Byrnes of Wisconsin, to regulate and establish fees for the importation and exportation of controlled dangerous substances, to amend the narcotic and drug laws, and for other purposes, which was requested by the Administration and is generally along the lines of the bill which passed the Senate; H.R. 13742, by Chairman Mills and Representative Byrnes; and other bills.

It will be recalled that some time ago Chairman Mills announced that upon completion of executive sessions on the subject of foreign trade, the next order of business of the Committee would be public hearings on the subject of narcotics control. It is expected that the Committee will complete its decisions on foreign trade by July 20, the date on which these hearings will begin.

The first witnesses to testify will be representatives of the Administration, to be followed by testimony from the interested public.

DETAILS FOR THE SUBMISSION OF REQUESTS

Cut-Off Date for Requests To Be Heard.—The cut-off date for requests to be heard is not later than the close of business Wednesday, July 15, 1970. The requests should be submitted to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, 1102 Longworth House Office Building, Washington, D.C. 20515. Witnesses will be advised as promptly as possible as to when they have been scheduled to appear. Once the witness has been advised of his date of appearance, it is not possible for this date to be changed. If the witness finds that he cannot appear on that day, he may wish to either substitute another spokesman in his stead or file a written statement for the record of the hearing in lieu of a personal appearance.

Coordination of Testimony.—In view of the limited time available to the Committee to conduct this hearing, it is requested that all persons and organizations with the same general interest designate one spokesman to represent them so as to conserve the time of the Committee and the other witnesses, prevent repetition and assure that all aspects of the proposals can be given appropriate attention.

The Committee will be pleased to receive from any interested organization or person a written statement for consideration for inclusion in the printed record of the hearing in lieu of a personal appearance. These statements will be given the same full consideration as though the statements had been presented in person. In such cases, a minimum of three (3) copies of the statement should be submitted by the close of business on Tuesday, July 28, 1970.

Necessity to Allocate Time.—Because of the Committee's very heavy legislative schedule which will limit the time available to the Committee in which to conduct this hearing, it will be necessary to allocate time to witnesses for the presentation of their direct oral testimony. If the witness wishes to present a long and detailed statement to the Committee, it will be necessary for him to confine his oral presentation to a summary of his views, while submitting a detailed written statement for the Committee Members' consideration and for inclusion in the record of the hearing.

Contents of Requests To Be Heard.—In order to eliminate repetitious testimony and to properly schedule witnesses, it will be necessary for the request to be heard to specify:

(1) The name, address, and capacity in which the witness will appear;

(2) The list of persons or organizations the witness represents and in the case of associations or organizations, their total membership and where possible a membership list.

(3) An indication of whether or not the witness at this time is supporting or opposing the proposal or proposals on which he desires to testify;

(4) The amount of time the witness desires in which to present his direct oral testimony or summary thereof (not including answers to questions of Committee Members); and

(5) A topical outline or summary of the comments and recommendations which the witness proposes to make.

If a prospective witness has already submitted a request to be heard on any of the subjects covered by this hearing, the *request should be re-submitted* furnishing the above information and otherwise conforming to the rules set forth for conducting this hearing.

Written Statements.—In the case of those persons who are scheduled to appear and testify, it is requested that 75 copies of their written statement be submitted 24 hours in advance of their scheduled appearance, if possible. If it is desired, an additional 75 copies may be submitted for distribution to the press and the interested public on the witness' date of appearance.

Persons submitting a minimum of three copies of written statements in lieu of a personal appearance may also, if they desire, submit an additional 75 copies of their statement for distribution to the Committee Members and the interested departmental and legislative staffs, pending the printing of the hearings, which will contain such written statements along with the oral testimony of those persons who appear in person. An additional 75 copies may be submitted for the press and the interested public, if it is so desired.

Format of All Written Statements.—To more usefully serve their purpose, *all* written statements (those for the purpose of a personal appearance and those submitted in lieu of a personal appearance) should contain—

(1) A summary of comments and recommendations; and

(2) Subject headings in the appropriate places of the statement itself.

charge of the controlled premises so consents in writing, no inspection authorized by this section shall extend to—

(a) financial data;

(b) sales data other than shipment data; or,

(c) pricing data.

FORFEITURES

SEC. 704. (a) The following shall be subject to forfeiture to the United States and no property right shall exist in them:

(1) all controlled dangerous substances which have been manufactured, distributed, dispensed or acquired in violation of the provisions of this Act;

(2) all raw materials, products and equipment of any kind which are used, or intended for use, in manufacturing, compounding, processing, delivering, importing, or exporting any controlled dangerous substance in violation of the provisions of this Act;

(3) all property which is used, or intended for use, as a container for property described in subsections (1) and (2);

(4) all conveyances including aircraft, vehicles, or vessels, which are used, or intended for use, to transport, or in any manner to facilitate the transportation, sale, receipt, possession, or concealment of property described in (1) or (2), except that:

(a) No conveyance used by any person as a common carrier in the transaction of business as a common carrier shall be forfeited under the provisions of this chapter unless it shall appear that the owner or other person in charge of such conveyance was a consenting party or privy to a violation of this Act; and,

(b) No conveyance shall be forfeited under the provisions of this section by reason of any act or omission established by the owner thereof to have been committed or omitted by any person other than such owner while such conveyance was unlawfully in the possession of a person other than the owner in violation of the criminal laws of the United States, or of any State; and

(5) all books, records, and research, including formulas, microfilm, tapes, and data which are used, or intended for use, in violation of this Act.

(b) Any property subject to forfeiture to the United States under this Act may be seized by the Attorney General upon process issued pursuant to the Supplemental Rules for Certain Admiralty and Maritime Claims by any district court of the United States having jurisdiction over the property except that seizure without such process may be made when—

(1) the seizure is incident to an arrest or a search under a search warrant or an inspection under an administrative inspection warrant;

(2) the property subject to seizure has been the subject of a prior judgment in favor of the United States in a criminal injunction or forfeiture proceeding under this Act;

(3) the Attorney General has probable cause to believe that the property is directly or indirectly dangerous to health or safety; or

(4) the Attorney General has probable cause to believe that the property has beeen used or intended to be used in violation of this Act.

In the event of seizure pursuant to paragraphs (3) and (4) of this subsection, proceedings under subsection (d) of this section shall be instituted promptly.

(c) Property taken or detained under this section shall not be repleviable, but shall be deemed to be in the custody of the Attorney General, subject only to the orders and decrees of the court or the official having jurisdiction thereof. Whenever property is seized under the provisions of this Act, the Attorney General may:

(1) place the property under seal;

(2) remove the property to a place designated by him; or

(3) require that the General Services Administration take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(d) All provisions of law relating to the seizure, summary, and judicial forfeiture, and condemnation of property for violation of the customs laws; the disposition of such property or the proceeds from the sale thereof; the remission or mitigation of such forfeitures; and the compromise of claims and the award of compensation to informers in respect of such forfeitures shall apply to seizures and forfeitures incurred, or alleged to have been incurred, under the provisions of this Act, insofar as applicable and not inconsistent with the provisions hereof: *Provided,* That such duties as are imposed upon the customs officer or any other person with respect to the seizure and forfeiture of property under the customs laws shall be performed with respect to seizures and forfeitures of property under this Act by such officers, agents, or other persons as may be authorized or designated for that purpose by the Attorney General, except to the extent that such duties arise from seizures and forfeitures effected by any customs officer.

(e) Whenever property is forfeited under this Act the Attorney General may—

(1) retain the property for official use;

(2) sell any forfeited property which is not required to be destroyed by law and which is not harmful to the public, provided that the proceeds be disposed of for payment of all proper expenses of the proceedings for forfeiture and sale including expenses of seizure, maintenance of custody, advertising and court costs;

(3) require that the General Services Administration take custody of the property and remove it for disposition in accordance with law; or

(4) forward it to the Bureau of Narcotics and Dangerous Drugs for disposition. Such disposition may include delivery for medical or scientific use to any Federal or State agency under regulations of the Attorney General.

(f) All substances listed in schedule I that are possessed, transferred, sold or offered for sale in violation of the provisions of this Act shall be deemed contraband and seized and summarily forfeited to the United States. Similarly, all substances listed in schedule I, which are seized or come into the possession of the Government, the owners of which are unknown, shall be deemed contraband and summarily forfeited to the United States.

(g) (1) All species of plants from which controlled substances in schedules I and II may be derived which have

been planted or cultivated in violation of this Act, or of which the owners or cultivators are unknown, or which are wild growths, may be seized and summarily forfeited to the United States.

(2) The failure, upon demand by the Attorney General, or his duly authorized agent, of the person in occupancy or in control of land or premises upon which such species of plants are growing or being stored, to produce an appropriate registration, or proof that he is the holder thereof, shall constitute authority for the seizure and forfeiture.

(3) The Attorney General, or his duly authorized agent, shall have authority to enter upon any lands, or into any dwelling pursuant to a search warrant, to cut, harvest, carry off, or destroy such plants.

INJUNCTIONS

SEC. 705. (a) The district courts of the United States and all courts exercising general jurisdiction in the territories and possessions of the United States shall have jurisdiction in proceedings in accordance with the Federal Rules of Civil Procedure to enjoin violations of this Act.

(b) In case of an alleged violation of an injunction or restraining order issued under this section, trial shall, upon demand of the accused, be by a jury in accordance with the Federal Rules of Civil Procedure.

ENFORCEMENT PROCEEDINGS

SEC. 706. Before any violation of this Act is reported by the Director of the Bureau of Narcotics and Dangerous Drugs to any United States attorney for institution of a criminal proceeding, the Director may require that the person against whom such proceeding is contemplated be given appropriate notice and an opportunity to present his views, either orally or in writing, with regard to such contemplated proceeding.

IMMUNITY AND PRIVILEGE

SEC. 707. Whenever in the judgment of the United States attorney the testimony of any witness, or the production of books, papers, or other evidence by any witness, in any case or proceeding before any grand jury or court of the United States with respect to violation of any provision of this Act, is necessary to the public interest, he, upon the approval of the Attorney General, shall make application to the court that the witness shall be instructed to testify or produce evidence subject to the provisions of this section, and upon order of the court such witness shall not be excused from testifying or from producing books, papers, or other evidence on the grounds that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture. But no such witness shall be

prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he is compelled, after having claimed his privilege against self-incrimination to testify or produce evidence, nor shall testimony so compelled be used as evidence in any criminal proceeding, except prosecution described in the next sentence, against him in any court. No witness shall be exempt under this section from prosecution for perjury or contempt committed while giving testimony or producing evidence under compulsion as provided in this section.

BURDEN OF PROOF; LIABILITIES

SEC. 708. (a) It shall not be necessary for the United States to negative any exemption or exception set forth in this Act in any complaint, information, indictment, or other pleading or in any trial, hearing, or other proceeding under this Act, and the burden of proof of any such exemption or exception shall be upon the person claiming its benefit.

(b) In the absence of proof that a person is the duly authorized holder of an appropriate registration or order form issued under this Act, he shall be presumed not to be the holder of such registration or form, and the burden of proof shall be upon him to rebut such presumption.

(c) The burden of establishing that a vehicle, vessel, or aircraft used in connection with the substances listed in schedule I of this Act was used in accordance with the

provisions of this Act shall be on the persons engaged in such use.

(d) No liability shall be imposed by virtue of this Act upon any duly authorized Federal officer engaged in the enforcement of this Act, or upon any duly authorized officer of any State, territory, political subdivision thereof, the District of Columbia, or any possession of the United States, who shall be engaged in the enforcement of any law or municipal ordinance relating to controlled dangerous substances.

PAYMENTS AND ADVANCES

SEC. 709. (a) The Attorney General is authorized to pay any person, from funds appropriated for the Bureau of Narcotics and Dangerous Drugs, for information concerning a violation of this Act, such sum or sums of money as he may deem appropriate, without reference to any moieties or rewards to which such person may otherwise be entitled by law.

(b) Moneys expended from appropriations of the Bureau of Narcotics and Dangerous Drugs for purchase of controlled dangerous substances and subsequently recovered shall be reimbursed to the current appropriation for the Bureau.

(c) The Attorney General is authorized to direct the

advance of funds by the Treasury Department in connection with the enforcement of this Act.

TITLE VIII—MISCELLANEOUS

REPEALERS

SEC. 801. The laws specified in the following schedule are repealed except with respect to rights and duties which matured, penalties which were incurred, and proceedings which were begun before the effective date of this Act:

STATUTES AT LARGE

(a) Act of February 23, 1887 (ch. 210, secs. 1, 2, 24 Stat. 409), as amended (title 21, secs. 191–193).

(b) Act of February 9, 1909 (ch. 100, 35 Stat. 614), as amended (title 21, secs. 171, 173, 174–184, 185).

(c) Section 1 of the Act of March 28, 1928 (ch. 266, 45 Stat. 374), as amended (title 31, sec. 529a).

(d) Act of June 14, 1930 (ch. 488, sec. 6, 46 Stat. 587; title 21, sec. 173a).

(e) Act of June 14, 1930 (ch. 488, secs. 7, 8), as amended (title 21, secs. 197, 198).

(f) Act of July 3, 1930 (ch. 829, 46 Stat. 850; title 21, sec. 199).

(g) Section 6 of the Act of August 7, 1939 (ch. 566, 53 Stat. 1263; title 31, sec. 529g).

(h) Act of December 11, 1942 (ch. 720, 56 Stat. 1045), as amended (title 21, secs. 188–188n).

(i) Act of August 11, 1955 (ch. 800, secs. 1–3, 69 Stat. 684; title 21, secs. 198a–c).

(j) Section 15 of the Act of August 1, 1956 (ch. 852, 70 Stat. 910; title 48, sec. 1421m).

(k) Section 1 of the Act of July 18, 1956 (ch. 629, title I), as amended (title 21, sec. 184a).

(l) Act of April 22, 1960 (74 Stat. 55; title 21, secs. 501–517).

UNITED STATES CODE

(a) Title 18, sections 1401–1407.

(b) Title 18, section 3616.

(c) Title 26, sections 4701–4776.

(d) Title 26, sections 7237–7238.

(e) Title 26, section 7491.

CONFORMING AMENDMENTS

SEC. 802. (a) Section 1114 of title 18, United States Code, is amended by striking out "the Bureau of Narcotics" and inserting "the Bureau of Narcotics and Dangerous Drugs".

(b) Section 1952 of title 18 of the United States Code is amended by—

(1) inserting in subsection (b) (1) the words "other controlled dangerous substances," immediately following the word "narcotics".

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(2) striking subsection (c) and substituting the following new section:

"(c) Investigation of violations under this section involving liquor shall be conducted under the supervision of the Secretary of the Treasury.

(c) Section 4251(a) of title 18 of the United States Code is amended by striking out the words "section 4731 of the Internal Revenue Code of 1954, as amended," and substituting "the Controlled Narcotic Drug Act of 1969".

(d) Section 584 of the Act of June 17, 1930 (ch. 497, title IV, 46 Stat. 748), as amended by section 10 of the Act of July 1, 1944 (ch. 377, 58 Stat. 722), and section 9 of the Act of March 8, 1946 (ch. 81, 60 Stat. 39; title 19, sec. 1584), is amended by striking out the last sentence of the second paragraph and substituting the following new sentence: "The words 'opiate' and 'marihuana' as used in this paragraph shall have the same meaning as defined in the Controlled Narcotic Drug Act of 1969."

(e) Section 801(a) of the Federal Food, Drug, and Cosmetic Act (title 21, sec. 381(a)), as amended, is amended in the last sentence thereof by striking out "This paragraph" and substituting therefor "Clause (2) of the third sentence of this paragraph," and by striking out the words "section 2 of the Act of May 26, 1922, as amended

(U.S.C. 1934 edition, title 21, sec. 173)" and substituting "the Controlled Narcotic Drug Act of 1969".

(f) Section 4901(a) of title 26 of the United States Code is amended by deleting the words "4721 (narcotic drugs), or 4751 (marihuana)" and by inserting the word "or" before the number "4461".

(g) Section 4905(b) of title 26 of the United States Code is amended by deleting the words "narcotics, marihuana," and "4722, 4753".

(h) Section 6808 of title 26 of the United States Code is amended by striking out subsection (8) and renumbering subsections (9), (10), (11), (12), and (13), as (8), (9), (10), (11), and (12).

(i) Section 7012 of title 26 of the United States Code is amended by striking out subsections (a) and (b) and renumbering (c), (d), (e), (f), (g), (h), (i), and (j) as (a), (b), (c), (d), (e), (f), (g), and (h).

(j) Section 7103 of title 26 of the United States Code is amended by striking out subsection (d) (3) (D) and renumbering (E) and (F) as (D) and (E).

(k) Section 7326 of title 26 of the United States Code is amended by striking out subsection (b) and relettering (c) as (b).

(l) Section 7607 of title 26 of the United States Code

is amended by deleting all words prior to the word "officers" and by capitalizing the word "officer"; and by deleting in subsection (2) the words "section 4731" and "section 4761" and inserting in subsection (2) in lieu thereof the words "Controlled Narcotic Drug Act of 1969".

(m) Section 7651 of title 26 of the United States Code is amended by deleting the words "sections 4705(b), 4735, and 4762 (relating to taxes on narcotic drugs and marihuana)".

(n) Section 7655 of the United States Code is amended by deleting subsections (3) and (4).

(o) Section 7609 of the United States Code is amended by striking out subsections (a)(3) and (a)(4) and renumbering (5) and (6) as (3) and (4).

(p) Section 7641 of the United States Code is amended by striking out the words "opium suitable for smoking purposes,".

(q) Section 2901(a) of title 28 of the United States Code is amended by striking out the words "section 4731 of the Internal Revenue Code of 1954, as amended," and substituting "the Controlled Narcotic Drug Act of 1969".

(r) Section 3 of the Act of August 7, 1939 (ch. 566, 53 Stat. 1263; title 31, sec. 529d), is amended by striking out the words "or the Commissioner of Narcotics, as the case may be,".

(s) Section 4 of the Act of August 7, 1939 (ch. 566, 53 Stat. 1263; title 31, sec. 529e), is amended by striking out the words "or narcotics" and "or narcotic".

(t) Section 5 of the Act of August 7, 1939 (ch. 566, 53 Stat. 1263; title 31, sec. 529f) is amended by striking out the words "or narcotics".

(u) Section 308 (c) (2) of the Act of August 27, 1935 (ch. 740), as amended (49 Stat. 880; title 40, sec. 304 (m)), is amended by striking out the words "Narcotic Drugs Import and Export Act" and substituting "Controlled Narcotic Drug Act of 1969".

(v) Section 302 (a) of the Act of July 1, 1944 (ch. 373; title III), as amended (58 Stat. 692; title 42, sec. 242 (a)) is amended by striking out the words "Narcotic Drugs Import and Export Act" and substituting "Controlled Narcotic Drug Act of 1969".

(w) Section 301 (a) of the Act of November 8, 1966 (ch. 175, title III), as amended (80 Stat. 1444; title 42, sec. 3411) is amended by striking out the words "section 4731 of the Internal Revenue Code of 1954 and substituting "the Controlled Narcotic Drug Act of 1969".

(x) Section 1 (a) of the Act of July 15, 1954 (ch. 512), as amended (68 Stat. 484; title 46, sec. 239a) is amended by striking out the words "paragraph (a) of the first section of the Narcotic Drugs Import and Export Act, as

amended (21 U.S.C. 171 (a))" and substituting "the Controlled Narcotic Drug Act of 1969"; and by striking out the words "section 3238 (b) of the Internal Revenue Code" and substituting "the Controlled Narcotic Drug Act of 1969".

(y) Section 7 (d) of the Act of August 9, 1939 (ch. 618), as amended (53 Stat. 1292; title 49, sec. 787) is amended by striking out the words "Narcotic Drugs Import and Export Act, the internal revenue laws or any amendments thereof, or the regulations issued thereunder" and substituting "Controlled Narcotic Drug Act of 1969"; and striking out the words "Marihuana Tax Act of 1937 or the regulations issued thereunder" and substituting "Controlled Narcotic Drug Act of 1969".

PENDING PROCEEDINGS

SEC. 803. (a) Prosecutions for any violation of law occurring prior to the effective date of this Act shall not be affected by these repealers or amendments, or abated by reason thereof.

(b) Civil seizures or forfeitures and injunctive proceedings commenced prior to the effective date of this Act shall not be affected by the repealers or amendments, or abated by reason thereof.

(c) All administrative proceedings pending before the

Bureau of Narcotics and Dangerous Drugs on the effective date of this enactment shall be continued and brought to final determination in accord with laws and regulations in effect prior to the date of this enactment. Such drugs placed under control prior to enactment of this Act which are not listed within schedules I through IV shall automatically be controlled by the Attorney General and listed in the appropriate schedule.

(d) The provisions of this Act shall be applicable to violations of law, seizures and forfeiture, injunctive proceedings, administrative proceedings and investigations which occur following its effective dates.

CONTINUATION OF REGULATIONS

SEC. 804. Any orders, rules, and regulations which have been promulgated under any law affected by this Act and which are in effect on the day preceding enactment of this title shall continue in effect until modified, superseded, or repealed by the Attorney General.

SEVERABILITY

SEC. 805. If a provision of this Act is held invalid, all valid provisions that are severable shall remain in effect. If a provision of this Act is held invalid in one or more of its applications, the provision shall remain in effect in all its valid applications that are severable.

AUTHORIZATION OF APPROPRIATIONS

SEC. 806. There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this Act.

SAVING PROVISION

SEC. 807. Nothing in this Act, except this title and, to the extent of any inconsistency, section 309 of this Act, shall be construed as in any way affecting, modifying, repealing, or superseding the provisions of the Federal Food, Drug, and Cosmetic Act.

EFFECTIVE DATE

SEC. 808. This Act shall take effect on the one hundred and eightieth day following the date of its enactment.

The CHAIRMAN. There is a Presidential message on this subject which will also be included in the record at this point.

(The President's message referred to follows:)

[H. Doc. No. 91–138, 91st Cong., first sess.]

COMBATING DRUG ABUSE

To the Congress of the United States:

Within the last decade, the abuse of drugs has grown from essentially a local police problem into a serious national threat to the personal health and safety of millions of Americans.

A national awareness of the gravity of the situation is needed; a new urgency and concerted national policy are needed at the Federal level to begin to cope with this growing menace to the general welfare of the United States.

Between the years 1960 and 1967, juvenile arrests involving the use of drugs rose by almost 800 percent; half of those now being arrested for the illicit use of narcotics are under 21 years of age. New York City alone has records of some 40,000 heroin addicts, and the number rises between 7000 and 9000 a year. These official statistics are only the tip of an iceberg whose dimensions we can only surmise.

The number of narcotics addicts across the United States is now estimated to be in the hundreds of thousands. Another estimate is that several million American college students have at least experimented with marihuana, hashish, LSD, amphetamines, or barbiturates. It is doubtful that an American parent can send a son or daughter to college today without exposing the young man or woman to drug abuse. Parents must also be concerned about the availability and use of such drugs in our high schools and junior high schools.

The habit of the narcotics addict is not only a danger to himself, but a threat to the community where he lives. Narcotics have been cited as a primary cause of the enormous increase in street crimes over the last decade.

As the addict's tolerance for drugs increases, his demand for drugs rises, and the cost of his habit grows. It can easily reach hundreds of dollars a day. Since an underworld "fence" will give him only a fraction of the value of goods he steals, an addict can be forced to commit two or three burglaries a day to maintain his habit. Street robberies, prostitution, even the enticing of others into addiction to drugs—an addict will reduce himself to any offense, any degradation in order to acquire the drugs he craves.

However far the addict himself may fall, his offenses against himself and society do not compare with the inhumanity of these who make a living exploiting the weakness and desperation of their fellow men. Society has few judgments too severe, few penalties too harsh for the men who make their livelihood in the narcotics traffic.

It has been a common oversimplification to consider narcotics addiction, or drug abuse, to be a law enforcement problem alone. Effective control of illicit drugs requires the cooperation of many agencies of the Federal and local and State governments; it is beyond the province of any one of them alone. At the Federal level, the burden of the national effort must be carried by the Departments of Justice, Health, Education, and Welfare, and the Treasury. I am proposing ten specific steps as this Administration's initial counter-moves against this growing national problem.

I. FEDERAL LEGISLATION

To more effectively meet the narcotic and dangerous drug problems at the Federal level, the Attorney General is forwarding to the Congress a comprehensive legislative proposal to control these drugs. This measure will place in a single statute, a revised and modern plan for control. Current laws in this field are inadequate and outdated.

I consider the legislative proposal a fair, rational and necessary approach to the total drug problem. It will tighten the regulatory controls and protect the public against illicit diversion of many of these drugs from legitimate channels. It will insure greater accountability and better recordkeeping channels. It will give law enforcement stronger and better tools that are sorely needed so that those charged with enforcing these laws can do so more effectively. Further, this proposal creates a more flexible mechanism which will allow quicker con-

trol of new dangerous drugs before their misuse and abuse reach epidemic proportions. I urge the Congress to take favorable action on this bill.

In mid-May the Supreme Court struck down segments of the marihuana laws and called into question some of the basic foundations for the other existing drug statutes. I have also asked the Attorney General to submit an interim measure to correct the constitutional deficiencies of the Marihuana Tax Act as pointed out in the Supreme Court's recent decision. I urge Congress to act swiftly and favorably on the proposal to close the gap now existing in the Federal law and thereby give the Congress time to carefully examine the comprehensive drug control proposal.

II. STATE LEGISLATION

The Department of Justice is developing a model State Narcotics and Dangerous Drugs Act. This model law will be made available to the fifty State governments. This legislation is designed to improve State laws in dealing with this serious problem and to complement the comprehensive drug legislation being proposed to Congress at the national level. Together these proposals will provide an interlocking trellis of laws which will enable government at all levels to more effectively control the problem.

III. INTERNATIONAL COOPERATION

Most of the illicit narcotics and high-potency marihuana consumed in the United States is produced abroad and clandestinely imported. I have directed the Secretary of State and the Attorney General to explore new avenues of cooperation with foreign governments to stop the projection of this contraband at its source. The United States will cooperate with foreign governments working to eradicate the production of illicit drugs within their own frontiers. I have further authorized these Cabinet officers to formulate plans that will lead to meetings at the law enforcement level between the United States and foreign countries now involved in the drug traffic either as originators or avenues of transit.

IV. SUPPRESSION OF ILLEGAL IMPORTATION

Our efforts to eliminate these drugs at their point of origin will be coupled with new efforts to intercept them at their point of illegal entry into the United States. The Department of the Treasury, through the Bureau of Customs, is charged with enforcing the nation's smuggling laws. I have directed the Secretary of the Treasury to initiate a major new effort to guard the nation's borders and ports against the growing volume of narcotics from abroad. There is a recognized need for more men and facilities in the Bureau of Customs to carry out this directive. At my request, the Secretary of the Treasury has submitted a substantial program for increased manpower and facilities in the Bureau of Customs for this purpose which is under intensive review.

In the early days of this Administration, I requested that the Attorney General form an inter-departmental Task Force to conduct a comprehensive study of the problem of unlawful trafficking in narcotics and dangerous drugs. One purpose of the Task Force has been to examine the existing programs of law enforcement agencies concerned with the problem in an effort to improve their coordination and efficiency. I now want to report that this Task Force has completed its study and has a recommended plan of action, for immediate and long-term implementation, designed to substantially reduce the illicit trafficking in narcotics, marihuana and dangerous drugs across United States borders. To implement the recommended plan, I have directed the Attorney General to organize and place into immediate operation an "action task force" to undertake a frontal attack on the problem. There are high profits in the illicit market for those who smuggle narcotics and drugs into the United States; we intend to raise the risks and cost of engaging in this wretched traffic.

V. SUPPRESSION OF NATIONAL TRAFFICKING

Successful prosecution of an increased national effort against illicit drug trafficking will require not only new resources and men, but also a redeployment of existing personnel within the Department of Justice.

I have directed the Attorney General to create, within the Bureau of Narcotics and Dangerous Drugs, a number of special investigative units. These special forces will have the capacity to move quickly into any area in which intelligence indicates major criminal enterprises are engaged in the narcotics traffic. To carry out this directive, there will be a need for additional manpower

within the Bureau of Narcotics and Dangerous Drugs. The budgetary request for FY 1970 now pending before the Congress will initiate this program. Additional funds will be requested in FY 1971 to fully deploy the necessary special investigative units.

VI. EDUCATION

Proper evaluation and solution of the drug problem in this country has been severely handicapped by a dearth of scientific information on the subject—and the prevalence of ignorance and misinformation. Different "experts" deliver solemn judgments which are poles apart. As a result of these conflicting judgments, Americans seem to have divided themselves on the issue, along generational lines.

There are reasons for this lack of knowledge. First, widespread drug use is a comparatively recent phenomenon in the United States. Second, it frequently involves chemical formulations which are novel, or age-old drugs little used in this country until very recently. The volume of definitive medical data remains small—and what exists has not been broadly disseminated. This vacuum of knowledge—as was predictable—has been filled by rumors and rash judgments, often formed with a minimal experience with a particular drug, sometimes formed with no experience or knowledge at all.

The possible danger to the health or well-being of even a casual user of drugs is too serious to allow ignorance to prevail or for this information gap to remain open. The American people need to know what dangers and what risks are inherent in the use of the various kinds of drugs readily available in illegal markets today. I have therefore directed the Secretary of Health, Education, and Welfare, assisted by the Attorney General through the Bureau of Narcotics and Dangerous Drugs, to gather all authoritative information on the subject and to compile a balanced and objective educational program to bring the facts to every American—especially our young people.

With this information in hand, the overwhelming majority of students and young people can be trusted to make a prudent judgment as to their personal course of conduct.

VII. RESEARCH

In addition to gathering existing data, it is essential that we acquire new knowledge in the field. We must know more about both the short and long-range effects of the use of drugs being taken in such quantities by so many of our people. We need more study as well to find the key to releasing men from the bonds of dependency forged by any continued drug abuse.

The National Institute of Mental Health has primary responsibility in this area, and I am further directing the Secretary of Health, Education, and Welfare to expand existing efforts to acquire new knowledge and a broader understanding in this entire area.

VIII. REHABILITATAION

Considering the risks involved, including those of arrest and prosecution, the casual experimenter with drugs of any kind, must be considered at the very least, rash and foolish. But the psychologically dependent regular users and the physically addicted are genuinely sick people. While this sickness cannot excuse the crimes they commit, it does help to explain them. Society has an obligation both to itself and to these people to help them break the chains of their dependency.

Currently, a number of federal, state and private programs of rehabilitation are being operated. These programs utilize separately and together, psychiatry, psychology and "substitute drug" therapy. At this time, however, we are without adequate data to evaluate their full benefit. We need more experience with them and more knowledge. Therefore, I am directing the Secretary of Health, Education, and Welfare to provide every assistance to those pioneering in the field, and to sponsor and conduct research on the Federal level. This Department will act as a clearinghouse for the collection and dissemination of drug abuse data and experience in the area of rehabilitation.

I have further instructed the Attorney General to insure that all Federal prisoners, who have been identified as dependent upon drugs, be afforded the most up-to-date treatment available.

IX. TRAINING PROGRAM

The enforcement of narcotics laws require considerable expertise, and hence considerable training. The Bureau of Narcotics and Dangerous Drugs provides the bulk of this training in the Federal government. Its programs are extended to include not only its own personnel, but State and local police officers, forensic chemists, foreign nationals, college deans, campus security officers, and members of industry engaged in the legal distribution of drugs.

Last year special training in the field of narcotics and dangersous drug enforcement was provided for 2700 State and local law enforcement officials. In fiscal year 1969 we expanded the program an estimated 300 percent in order to train some 11,000 persons. During the current fiscal year we plan to redouble again that effort—to provide training to 22,000 State and local officers. The training of these experts must keep pace with the rise in the abuse of drugs, if we are ever to control it.

X. LOCAL LAW ENFORCEMENT CONFERENCES

The Attorney General intends to begin a series of conferences with law enforcement executives from the various States and concerned Federal officials. The purposes of these conferences will be several first, to obtain firsthand information, more accurate data, on the scope of the drug problem at that level; second, to discuss the specific areas where Federal assistance and aid can best be most useful; third, to exchange ideas and evaluate mutual policies. The end result we hope will be a more coordinated effort that will bring us visible progress for the first time in an alarming decade.

These then are the first ten steps in the national effort against narcotic marihuana and other dangerous drug abuse. Many steps are already underway. Many will depend upon the support of the Congress. I am asking, with this message, that you act swiftly and favorably on the legislative proposals that will soon be forthcoming, along with the budgetary requests required if our efforts are to be successful. I am confident that Congress shares with me the grave concern over this critical problem, and that Congress will do all that is necessary to mount and continue a new and effective Federal program aimed at eradicating this rising sickness in our land.

RICHARD NIXON.

THE WHITE HOUSE, *July 14, 1969.*

The CHAIRMAN. We will hear first today from the Honorable John N. Mitchell, the Attorney General, who will be followed this afternoon by the Secretary of the Treasury, the Honorable David M. Kennedy.

Tomorrow we will hear from Dr. Roger O. Egeberg, Assistant Secretary of HEW, and Dr. Bertram S. Brown, Director, National Institute of Mental Health.

Following the testimony of these administration officials, we will then receive testimony from the interested public.

Mr. Attorney General, we welcome you. We understand you have with you Messrs. John E. Ingersoll, Director, and Michael R. Sonnenreich, Deputy Chief Counsel, Bureau of Narcotics and Dangerous Drugs.

This is your first public appearance before the Ways and Means Committee. We are delighted to have you with us and we will be pleased to hear from you.

CONTROLLED DANGEROUS SUBSTANCES, NARCOTICS AND DRUG CONTROL LAWS

TUESDAY, JULY 21, 1970

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witnesses this morning are Dr. Egeberg and Dr. Brown who are appearing for the Department of Health, Education, and Welfare.

Gentleman, will you please come to the witness table?

Dr. Egeberg will make the first statement and then will be followed by Dr. Brown. We appreciate having both of you with us and we are most anxious to hear your testimony. We are glad to recognize you, Dr. Egeberg.

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. SIDNEY COHEN, ACTING HEAD, BUREAU OF NARCOTICS AND DRUG ABUSE, NATIONAL INSTITUTE OF MENTAL HEALTH; AND NANCY WOLFF, OFFICE OF LEGISLATIVE COUNSEL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. EGEBERG. Thank you, sir. May I introduce Dr. Sidney Cohen who is the Director of the Division of Narcotics and Drug Abuse in the National Institute of Mental Health.

The CHAIRMAN. We are glad to have you with us also.

Dr. EGEBERG. He was a resident of Los Angeles and a neighbor of mine.

The CHAIRMAN. Don't overlook the ladies.

Dr. EGEBERG. Miss Wolf is going to keep us honest. She is from the General Counsel's Office.

The CHAIRMAN. I am glad you brought her along.

Dr. EGEBERG. Perhaps I should not have admitted that.

The CHAIRMAN. We appreciate having all of you here and you are recognized.

Dr. EGEBERG. Mr. Chairman, and members of the committee:

I appreciate the opportunity to discuss with you today H.R. 13742

and H.R. 17463 and the vitally important problem with which they deal—the problem of insuring that man's ever-growing knowledge of the properties of drugs of all kinds will be put to constructive use only.

I need not tell this committee that the misuse of drugs through their diversion into unauthorized channels has created a serious public health problem of major proportions. The media has published figures that indicate large numbers of persons—anywhere from 70,000 to 150,000, depending on whose survey figures are used, are opiate addicts.

The numbers of Americans who experiment with or regularly use marihuana and other dangerous drugs are estimated in the millions.

What is worse, the blight of drug abuse is afflicting an ever-growing number of young people under 21—young people from every walk of life and type of environment. More precise incidence figures, to the extent of the information now available, can be supplied to the committee for the record. The important question is, what can we do about it?

The answer to the drug abuse problem is multifaceted and requires a heroic national effort in the area of prevention and education, treatment and rehabilitation and lastly, control of the dangerous substances themselves.

Most recently, the President announced the creation of the National Clearinghouse for Drug Abuse Information to give the public one central office to contact for help. The first year budget is almost $700,000.

Grants to provide increased support for construction and staffing of community-based treatment and rehabilitation facilities were also provided by this Congress through Public Law 91–211, the Community Mental Health Centers Amendents of 1970. This act also provides for a program of training of specialized personnel to work in these facilities as well as authority to support surveys and field trials aimed at evaluating adequacy of prevention and treatment programs.

It is now time to turn our attention to the problem of devising a sound and effective regulatory scheme of control—a scheme based on a realistic and scientifically valid appraisal of our various kinds of drug abuse problems.

As you know, Mr. Chairman, the basic framework of legal controls over the use and abuse of narcotics, marihuana, and other dangerous drugs is a triple structure composed of international commitments, State and local police measures, and Federal laws which interact with and reinforce the others.

There is another tripartite division of controls according to the type of substance to be controlled. The laws which govern narcotics, marihuana, and the "dangerous drugs" are not consistent at present. They are a veritable patchwork of inconsistent controls, showing little knowledge of differences in abuse liability and in legitimate medical value from one substance to another.

The two bills before you today are designed to change the ill founded and inappropriate classification of drugs and punishment of those who abuse them.

H.R. 13742, which you introduced at the request of the administration on September 11, 1969, deals only with narcotics and marihuana.

Since that time, you have sponsored omnibus legislation which would apply to other drugs of abuse as well, and which contains important additions and modifications, especially with respect to penalties and to HEW participation in decisionmaking.

It is this latter bill, H.R. 17463, which the department recommends be enacted. As indicated by Mr. Ingersoll's testimony yesterday, we are continuing to work closely with the Department of Justice and other concerned congressional committees to develop effective legislation.

The control and regulation of certain medically useful drugs are both necessary and desirable. These include the narcotics, sedatives, and stimulants that are employed in the practice of medicine.

It should not be assumed, however, that intensified regulatory activity alone will solve our serious problem of drug abuse. Reducing the leakage of these lawfully manufactured agents will be helpful, but the bulk of the problem lies elsewhere and this should be explicitly recognized.

Heroin accounts for more than 90 percent of all narcotic addiction in this country. No heroin whatsoever is manufactured or imported legally into this country. It is estimated that 2 or 3 tons of heroin will supply the needs of all addicts for a year. Consider the enormous difficulties of preventing the entry of that small quantity from being introduced into the United States by land, sea, or air.

Most of the marihuana and all of the hashish used is illicitly introduced into the United States. Lesser quantities of American marihuana are consumed from wild, low-grade material which do not enter into legitimate commercial channels.

None of the hallucinogens listed in section 202, schedule I(c) of H.R. 17463, are licit items of commerce. When they are abused, items like LSD are illegally manufactured or smuggled into the country.

The amphetamines are drugs with some medical usefulness. They can, however, also be very easily manufactured in unlicensed laboratories from precursors which are not controlled under H.R. 17463. Methamphetamine, the amphetamine known as speed, is made for intravenous injection exclusively in clandestine laboratories when it is used by the so-called speed freak.

It is remarkable what a strange assortment of chemicals, poisonous solvents, and dangerous plants will be sought out by those who, for one reason or another, cannot tolerate sober existence. I suspect that mind-distorting chemicals will always be with us no matter how well we enforce the provisions in this bill. Nevertheless efforts must be made to diminish the availability of these substances.

As an example of the facility with which the purveyors of mind-shaking chemicals can provide new products, two hallucinogens are known to the National Institute of Mental Health that are now being actively abused, and they are not listed in H.R. 17463. Their manufacture, sale, and distribution is not now and will not be illegal despite the fact that they are just as dangerous as many of the drugs listed in section 202, schedule I(c). I am referring to MDA (3,4-methylenedioxyamphetamine) and TMA (3,4,5-trimethoxyamphetamine).

It would be easy to add these drugs to the existing list of hallucinogenic substances and I recommend that we do so. But the basic problem would still remain unresolved for we have long series of active hallucinogens which could make their appearance at any time.

They include dipropyltryptamine (DPT), 6-hydroxydimethyltryptamine, 2,5-methoxy, 4-ethylamphetamine (DOET), 2,4,5-trimethoxyamphetamine (TMA-2), 2,3,6-trimethoxyamphetamine (TMA-5), 2,4,6-trimethoxyamphetamine (TMA-6), 2,4,5-methoxymethylenedioxyamphetamine (MMDA-2), 2,5-dimethoxy-3, 4-methylenedioxyamphetemine (DMMDA), 2,5-dimethoxyamphetamine (DMA) and many others.

The basic problem, of course, is that while external deterrents are needed, it is the internal deterrents which are crucial in solving this problem. When we have learned, through research and meticulous study, how to make drug taking irrelevant, then we will have begun to finally resolve the issue that concerns us here.

We are only beginning to learn how to develop attitudes in the very young which will make a be-drugged existence unnecessary and inappropriate. We have found that viable alternatives to drug taking are available for all age groups. These are not easily instilled, but some persons have been freed from chemical dependence by turning on to people and on to more genuine life experiences than the spurious drug experience. Some procedures have been learned which successfully deal with the chronic user who wants help.

It is in these areas of skillful prevention, of expert education, of devoted and innovative treatment that the definitive answer will be found. The problem, as we learn more about it, is not drugs; it is people. When people find suitable goals and values, drugs become meaningless and superfluous.

The determinations that have to be made in decisions to impose special controls on any drug must be based on scientific information on the nature of a given drug, its physiological and psychological effects, trends in its use among various segments of the population, its potential medical usefulness, and other factors in the province of health sciences, as well as practical questions of enforcement and the effect on organized crime.

We think the inclusion in H.R. 17463 of the requirement that the Attorney General seek in writing the advice of this Department and a committee of scientists before changing or modifying the schedules of controlled substances is a vitally important one.

You have my assurance, Mr. Chairman, that the Department will promptly and fully meet this responsibility so that the Attorney General will be able to base his determinations on the best possible scientific information we can provide.

As an example of the need for rapid input of information from the Secretary, a current example can be cited. We are all aware of the investigations which have been conducted during the past 5 years in which methadone maintenance is used in the treatment of certain heroin addicts. Methadone is in schedule II.

Recently, it has been found that alphaacetylmethadol can do as well as methadone for this purpose, and its effects last at least twice as long. If this finding is confirmed by additional studies, a difficult technical treatment problem will be overcome in that the patient will require three doses of medicine a week instead of seven. Alphaacetylmethadol might have to be shifted quickly from schedule I to schedule II since it is predictable that considerable therapeutic work will be done with it. When its medical usefulness is established, it will require

rescheduling. Its potential for abuse is even less than methadone's abuse potential.

We note with approval that the penalties for violations of the various strictures in the act have been considerably modified in H.R. 17463 along the lines developed and presented by the Department of Justice since the administration bills were first introduced. Mandatory minimum sentences for all drug violations, except in the case of the professional criminal whose traffic in drugs poses a real threat to society, have been abolished and the courts are given considerably greater flexibility in imposing sentence to make the punishment more nearly fit the crime.

Although the bill still classifies marihuana in schedule I for regulatory purposes, it establishes significantly lesser penalties for unlawful distribution of marihuana than for a similar offense involving narcotics drugs. We think this a very sound and useful distinction to make.

Perhaps I should say a few more words about marihuana and its active ingredient, delta-9-tetrahydrocannabinol (THC). Few drug-related topics trigger as intense emotional reactions as the proper controls for this ubiquitous substance.

The plant has been cultivated for its fiber since pre-Revolutionary days in the colonies. Introduced into this country around 1840 for medical purposes, its use as a medication reached a peak about the time of World War I and then gradually declined. Its use began to be regarded as a vice in 1927, when Louisiana passed the first restrictive law specifically directed toward marihuana use, and several other States followed suit.

Meanwhile, Federal narcotic enforcement officials who regarded marihuana as the "new" drug danger second to opiates in hazard (no clear scientific basis was ever given for this belief), asked for and received responsibility for its regulation at the Federal level, culminating in the Marihuana Tax Act of 1937.

Thus, marihuana became subject to almost the same controls as "hard" narcotics and it remains associated in the minds of a large segment of the public with more dangerous substances such as heroin, morphine, and other addicting drugs.

We know now that marihuana is not a narcotic, its use does not lead to physiological dependence under ordinary circumstances, and there is no proof that it predisposes an individual to go on to more potent and dangerous drugs. With respect to its short-term effects, marihuana can be described as a rather mild hallucinogenic drug.

What I have been talking about are the effects of short-term use. We are painfully aware of great gaps in our knowledge of the risks associated with regular and continuing long-term use of Marihuana. The National Institute of Mental Health is presently engaged in intensive research on all aspects of this problem.

The bill (H.R. 17463) before your committee today, in detailing the jurisdiction of the new Committee on Marihuana it would establish, clearly delineates the many unanswered questions to which we must have answers before we can take further socially and scientifically justified steps to change the control of marihuana.

Until these answers are in, I must point out to all the millions of Americans, young or old, who are experimenting with marihuana, that they are taking a significant risk in tampering with this substance.

Permit me to mention some of the advances in the field of cannabis, now that sufficient supplies of assayed marihuana and pure THC have become available to researchers.

1. We now know the first metabolic change that THC undergoes in the body. The chemical changes that accompany smoking marihuana are becoming better understood.

2. One of our contractors is, at last, able to detect extremely minute quantities of THC from smoked marihuana in body fluids.

3. A number of investigators have demonstrated a defect in very recent memory (the recall of events that happened moments ago) when average amounts of marihuana are smoked.

4. Studies of the genetic effects of THC and marihuana are underway, but no definite results can be reported at the time. It has been demonstrated that THC does cross the placenta.

5. Our planned studies with long-term users in countries where hashish consumption is traditional are underway.

6. Although we are receiving reports of acute marihuana panic and psychotic reactions, the number remains small in comparison to the total amount of marihuana consumed.

7. From the continuing survey reports that we receive, the general trend of marihuana indulgence seems to be on the increase. Experimentation is observed down to grade school levels and across all economic and social classes. The majority of marihuana users are "triers." They have smoked less than a dozen times and have no intention of indulging in the future.

A third of all users are occasional, "social" smokers. They will use marihuana intermittently when they regard the time and place as propitious. The remaining 5 to 10 percent are consistent, regular users, the "potheads."

It is this latter group that tend to go on to more potent hallucinogens, stimulants, and sedatives. In a few instantes they try opium and heroin, and some become addicted to these narcotics. On psychological studies the "potheads" are distinguishable from nonusers and infrequent users by their degree of emotional disturbance. They tend to have immature, inadequate, impulsive personality traits.

As I indicated, the Department is highly supportive of the mandate to the Committee on Marihuana established in this bill. I would just like to call your attention to the "Marihuana and Health Reporting Act", incorporated as title V of the recently passed "Hill-Burton Act" (P.L. 91–296) which, with respect to its reporting requirements particularly, overlaps the requirements of section 801(b) of this bill.

The "Marihuana and Health Reporting Act" designates the Secretary as the "authoritative source" for informing Congress about the health consequences of using marihuana to enable it to take further legislative and administrative action. In your bill this information is to come not from the Secretary but from an outside committee of experts selected jointly by the Secretary and the Attorney General.

The Reporting Act requires a preliminary report 90 days after enactment (on September 28, 1970), a first full report on January 31, 1971, and other reports annually on that date thereafter. H.R. 17463 asks for the same comprehensive report 2 years from the date of enactment on a one time basis.

I mentioned earlier the importance of research and education as part of the total comprehensive attack on the drug abuse problem.

H.R. 17463 recognizes the need for involvement in these activities by the Attorney General when such research or education is directly related to his law enforcement functions. The primary responsibility for comprehensive research into all medical, pharmacological, and social aspects of the use and abuse of drugs and the carrying out of information and educational programs to deter and prevent such abuse among our Nation's youth and other segments of the population remains with the Department of Health, Education, and Welfare.

The National Institute of Mental Health and this Department, as I have mentioned, are directing a comprehensive program of drug abuse and research and education.

We are recommending enactment of H.R. 17463, Mr. Chairman, because we feel that it represents significant progress in the achievement of effective and acceptable controls over the use and abuse of dangerous substances.

Dr. Brown and I will be happy to answer any questions you may have.

The CHAIRMAN. Dr. Brown, do you have a special statement?

Dr. BROWN. I have no special statement. Dr. Egeberg and I worked closely together on this statement and I will be glad to answer any questions.

The CHAIRMAN. We appreciate your fine statement. There are some words in your statement that I think I will have to go to a medical dictionary to understand fully.

Dr. EGEBERG. So will I.

The CHAIRMAN. Is that where I will find them or may we use an ordinary dictionary?

Dr. EGEBERG. You won't find many of those in a dictionary that is more than 6 months old.

The CHAIRMAN. Mr. Schneebeli.

Mr. SCHNEEBELI. Dr. Egeberg, on page 6 you refer to a long series of these hallucinogens. As they come onto the market, I assume the problem is one of whether to add them to the list of forbidden products.

Tell me how is this coordinated? As a product comes onto the market, how is it considered for being put on the list? Does the Attorney General ask your permission or ask your advice? Who calls it to the attention of the Attorney General?

Dr. EGEBERG. In the first place, if a request for a new drug comes to the agency of the Food and Drug Administration, and if they think it has hallucinogenic or habit-forming properties, they should notify both the Secretary and the Attorney General.

Mr. SCHNEEBELI. You say they should.

Dr. EGEBERG. It is in this proposed bill. Otherwise, the Secretary, if he feels some new attitudes have derived or if some new properties in drugs that are currently being used would make them appear to be habit forming or hallucinogenic and appropiate to come under control, he can recommend them to the Attorney General. The Attorney General does not have to take his recommendation because it has to be balanced against many social effects, its present popularity, the size of the import, and so on.

Mr. SCHNEEBELI. The pharmaceutical companies have to start with FDA.

Dr. EGEBERG. Yes, sir.

Mr. SCHNEEBELI. And they may suggest to you he may want to have them put on the restrictive list.

Dr. EGEBERG. Yes, sir.

Mr. SCHNEEBELI. Can this be done rather quickly?

Dr. EGEBERG. FDA is very sensitive to this and, I think, they would be very much alert to the possibilities. Many of these drugs are in categories. They change the numbers, but a lot of the names are quite similar and they would, I think, have their suspicions aroused rather early.

Mr. SCHNEEBELI. So the proposed legislation does implement it with procedures to cover it?

Dr. EGEBERG. To make it a living document.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. How is marihuana used for medical purposes?

Dr. EGEBERG. It used to be used as a sedative. Cannabis indica was in the pharmacopeia until recently. It supposedly has no useful medical purpose at the present time. I believe that somebody has raised a question of its having a good influence in lowering blood pressure.

But, otherwise, I don't know that it has any useful purpose.

Dr. COHEN. There are substances derived from THC which should be tested for blood pressure lowering effects as an antidepressant or as a sedative. These are variances of THC and not THC itself.

Mr. BROYHILL. In light of some of the statements you made about a lot of research yet to be done and about the lack of proof as to the ultimate harmful effects, I am wondering if we are not a little too severe in the proposed legislation about the simple possession of marihuana?

Dr. EGEBERG. Which way?

Mr. BROYHILL. Of course, it is quite severe now, and in the proposed legislation we would be lessening the penalty for simple possession of marihuana. In light of your lack of proof as to the harmful effects of marihuana and your statement that you had not completed your research in this regard, it would be questioned whether the penalty for simple possession, which is proposed, is still too great.

Dr. EGEBERG. As I understand the proposed penalty, and I think I will pass this to you, the first time it can be entirely erased if the judge wishes and will not appear in any record.

Dr. COHEN. The penalty for the first offense of simple possession is a misdemeanor, up to 1 year in jail or up to $1,000 fine. However, the judge has flexibility. If he imposes a sentence, it can be erased after 1 year.

So, there is no criminal record. In other words, the penalty in certain cases may be only a small fine if the judge feels this is a correct punishment.

Mr. BROYHILL. I have a question as to whether we should lower the penalty to that extent in light of what the doctor said. I think it is quite severe for just possession.

Dr. EGEBERG. At the present time, there is a mandatory minimum of 2 years which has caused judges to find that there was no real evidence that the man had it in his possession. This seems to denigrate the law.

Mr. BROYHILL. That is all I have, Mr. Chairman.

The CHAIRMAN. Mr. Conable.

Mr. CONABLE. I was under the impression, Doctor, that some hallucinogens are used to treat some types of schizophrenia, is that true?

Dr. BROWN. There have been some investigations as to whether they can be used for schizophrenia or alcoholism. They are not used as ordinary treatment, but that does highlight the use of these drugs in scientific investigation to find appropriate new uses for them. They are not regularly used for that purpose as of this time.

Mr. CONABLE. But marihuana or the derivatives are not among those used that way.

Dr. BROWN. The potential use would be the active use of marihuana for depression. This is being explored in other countries and may be an important outcome, although at this point, it is very much in the research arena.

Mr. CONABLE. We have been receiving some telegrams from doctors expressing concern about this legislation and saying that it represented a threat to their practice in some way. I wonder if there has been any direct contact between HEW and organized groups of doctors with respect to these allegations and if so, how serious they are. Is there a widespread feeling among the medical profession?

Dr. EGEBERG. I will start answering that. Doctors hate to be policed. I think for a long time they felt that if an agent of the Bureau of Narcotics should come into their office to count their pills it meant they were under suspicion and cheating. In a way this belief permeates the medical profession.

There has been the question of this slowing down the use of methadone as a substitute for heroin. We have discussed this with many representative groups from the medical profession. I am sure that both Dr. Brown and Dr. Cohen have discussed this.

Dr. BROWN. I think you will be hearing from witnesses who will express this point of view quite cogently and articulately. All I can answer at this point is, yes, there is widespread concern in the scientific community as well as the medical practitioner community. They consider these somewhat oppressive controls over their practices.

Mr. CONABLE. What is the major sticking point in this respect? Is it simply that the intrusion of the Justice Department into the field in what they consider to be a dangerous degree? They seem to be asking for HEW to continue to maintain its control, feeling this would be more along the lines of how drugs should be handled?

Dr. BROWN. The heart of the matter seems to be the feeling of wanting to be bossed by one's own kind. If it were indeed Dr. Egeberg or the Chief of the Division or the Surgeon General or the Secretary of HEW who were calling the tune on these things, they would feel somewhat more comfortable than having the Attorney General or a law enforcement organization do so.

As to the actual impact or implications of these legislative and administrative behaviors, I think they are open to serious discussion as to what is best. The feeling is one of anxiety and concern.

Mr. CONABLE. It has been alleged in the press there have been tensions between Justice and HEW about this bill. Of course, we in the legislative branch don't have any way of knowing what kind of negotiations and discussions you had and I don't want to put you on the spot, Dr. Egeberg, but I wonder if you could summarize these tensions or describe whether they actually exist.

Dr. EGEBERG. I would be glad to talk to this. I think we have had very friendly and cooperative meetings with Justice over a period of almost a year. While we have some points of what I would consider residual, slight differences, there is no doubt that the job of policing, the job of trying to cut down the amount of illicit traffic, the amount of people using the drug at the moment and perhaps for a long time is primarily in the sphere of influence of the Department of Justice.

Hopefully later on education will make it primarily a sphere of seeing that people get educated to the dangers of the drug.

The points where there have been differences and where you see the doctors worry is in the question of who is going to control the drugs used for research, and Justice has agreed that they will approve whatever the Department of Health, Education, and Welfare recommends on this score, unless they find that the person is a felon, has had a previous conviction of some kind for using drugs himself or has lied about something very obviously.

To my mind, this should satisfy those who are worried about restrictive influences on research.

May I say this is important. I am very glad to hear of that agreement because it is hard to get people started doing research on these very important issues. If we worry them about having somebody looking over their shoulder to see that they are counting every night, they might say they would rather go into something else.

But the fact remains that they have to be accountable for all of the things they are using, and I think this arrangement takes care of that.

This was arrived at yesterday really.

The other point is who should decide what drugs should be classified and how they should be classified.

At the present time, and according to this bill, this is to be decided by the Attorney General on the basis of recommendations received in writing from the Secretary of HEW as to what drugs should be classified and how they should be classified. This presupposes that they will speak to each other, understand each other, and probably cooperate. I feel that is a great likelihood.

Mr. CONABLE. Doctor, we understand about jurisdictional sensitivities here on the Ways and Means Committee. We even have some about this bill.

To summarize your position, it would be that you support this bill but feel it represents only part of the picture and that there must be something going hand in hand with it in the way of education and research that should be the jurisdiction of HEW and should contemplate the picture before we will have a rational drug control program; is that correct?

Dr. EGEBERG. Yes, I think this bill was written primarily with a view to formulating what the Department of Justice should do, to show their sphere of influence. There are others which have explained our responsibility through the Institute of Mental Health for prevention, education, treatment and so forth.

Mr. CONABLE. Looking ahead, what can we expect in the way of further legislation in this field, at least as recommendations from the administration?

Miss WOLFF. There is a good deal of legislation pending before the Congress now dealing with drug abuse education. HEW has presented testimony on some of these bills. Our position is that in this particular

area the Department's existing authority is adequate, and this is exemplified by numerous ongoing projects and activities which NIH, NIMH, and the Office of Education are conducting.

In the area of treatment and rehabilitation, the Congress recently has passed the Community Mental Health Centers Amendments of 1970. This act provides grant authority to increase support for construction, staffing, and training of specialized personnel for community-based treatment and rehabilitation centers which serve narcotic addicts and other drug dependent patients. I understand there is pending also some legislation which would add funds and expand the authority somewhat in this particular area.

In these two subject areas, drug abuse education and rehabilitation, I do not know of any specific additional legislative recommendations that the Department of HEW has made.

Mr. CONABLE. Thank you, Mr. Chairman. That is all.

The CHAIRMAN. Are there any further questions?

Mr. Bush.

Mr. BUSH. After these studies are going on, Dr. Egeberg, are you going to come out with one finding? Is there going to be a report on a certain date that everybody will have access to?

Dr. EGEBERG. On the marihuana?

Mr. BUSH. Yes, sir.

Dr. EGEBERG. According to the amendment that was added to the Hill-Burton bill, there would be a committee that would report and that would be appointed by the Secretary and it would give a preliminary report in 90 days on what the situation is. That is the current law, I am informed.

This report would then be given on the 31st of January, I believe, every year from then on.

H.R. 17463 provides that a committee appointed jointly by the Secretary and the Attorney General report in 2 years, with a one-time report, on the status of the research done to find out about marihuana.

So, in a sense there is some conflict, because, one report required under Hill-Burton is just the Secretary's responsibility, and H.R. 17463 says the Secretary and the Attorney General together will appoint a committee which will do this.

Mr. BUSH. Will the 2-year period give enough time to tell actual body effects? There are traces that memory is affected and traces of other things. Will 2 years give enough time?

The argument today is marihuana will not help you, it is perfectly OK, you drink, and so on. If these hints prove to be something more serious, can this be clearly established from a research point of view in 2 years?

Dr. EGEBERG. I would doubt it, but Dr. Cohen is right in that sphere.

Dr. COHEN. We believe that given 2 years of planned and funded research on marihuana—and we have a plan to explore this question and the very important question of the effects of the chronic use of marihuana—that in 2 years we can come up with a scientific answer to this question.

You may perhaps wonder how is it possible to know in 2 years what the chronic effects of marihuana are. What happens to the pothead after 20 years? Well, we can find this out in populations in other

countries that have been using the drug and study them in comparison with a group in that country that has not been using it. These studies are already contracted for and are beginning so that in 2 years we should be able to report to you some very significant evidence regarding a decision about the dangers of marihuana, if any, especially the long-term dangers, if any.

Mr. BUSH. What would you say to a 15-year-old kid today who asks why should I not use marihuana? How would you answer the question?

Dr. COHEN. First of all, I would point out the legal danger, the fact that it can put him into jail and second, I would point out that there are so many unknowns that he is indeed indulging in a fair amount of risk-taking if he is a consistent marihuana user.

Mr. BUSH. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any further questions?

Mr. LANDRUM. I would like to know why he would place his reply in the order he answered Mr. Bush. Why wouldn't he reverse them?

Dr. EGEBERG. It is a good question.

Dr. COHEN. Jail is here and now, whereas the harmful effects of marihuana may be in the distance. We know of many drugs that have been brought into our culture which appeared harmless. Yet, after long study, we find that this is not quite so.

The same may be true of marihuana. There are hints in the older literature which are not quite scientific that there is impairment if strong marihuana is used over a long period of time.

Mr. LANDRUM. It would occur to me that it would be much better for the psychological values and also for the moral and spiritual values of the child if you reversed the order of your reply, for the mere reason you say jail, incarceration, restraint is purely temporary, but the lasting effects of something like this that needs to be impressed upon a child's mind, in my judgment.

Dr. EGEBERG. Dr. Cohen must have a special significance attached to jail.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. I understand you are going to use statistics on this, and you already are planning contracts on this now, and this will be more or less a statistical research endeavor as to what might be the dangers of the use of marihuana.

Dr. BROWN. Mr. Broyhill, we have a broad set of research, an effort of approximately $2 million a year, about $800,000 a year in contracts for a variety of subjects and $1.3 million out in grants. We are studying a wide range of scientific aspects of marihuana, its short term effects, its pharmacology, what happens in body fluids as well as doing this kind of ingenious thing that Dr. Cohen spoke to about checking with populations which have used it to see what or what has not happened. This is the sort of effort that will yield information.

My own guess is in 2 years we will know a lot more but not enough. It is like any other common substance interacting from human beings. We will be much further ahead, but we would still need to know more.

Mr. BROYHILL. What has been done with respect to cigarette smoking? We have passed legislation requiring labeling and with respect to advertising over TV and we have had a program of information, but we have provided no penalty for the use of cigarettes. The Govern-

ment has made a determination that use of cigarettes and tobacco is hazardous to your health, but there is no scientific proof of that, is there?

Dr. BROWN. The feeling with cigarette smoking is there is good scientific evidence that it does have harmful effects on your health, the kind of scientific evidence we accept in medicine and pathology, science generally speaking. This does highlight the issue that having the facts as to harmfulness does not necessarily change people's behaviors and philosophers can put that in quite a colorful way.

I think the fact that people are the ones who indulge in these activities is our part of the problem that we are trying to understand so that the controls are not only external, such as availability, but rather more as Congressman Landrum was speaking, internal, not wanting to do this sort of harmful thing to yourself or not giving adequate reasons.

My own guess is that in those instances where we have found that the drug has harmful effects or have good evidence toward harmful effects the actual use does decline. This was the experience with LSD which was going up rapidly from 1961 to 1967 among the college students. There was a lot of publicity about whether it hurt the genes and chromosomes. Now the use in college of LSD seems to have declined quite markedly.

On the other hand, the information which is somewhat more uncertain concerning marihuana as to whether it is harmful or not has correlated with rapidly increasing use of marihuana by Americans, as you know.

Mr. BROYHILL. I am concerned about the feeling of uncertainty as to the harmful effects of marihuana. Would you say now from the information that you now have that marihuana is certainly more dangerous and hazardous than the use of tobacco? You have been working on tobacco for a long time.

Dr. BROWN. At this point, without just trying to run away from the question, I would say we don't know about marihuana as clearly as we do about tobacco and the effects of using it for 20 or 30 years. The hardest evidence against tobacco is that chronic use over a 20-year period, anywhere from 10 to 40, does lead to heart disease, emphysema and lung cancer.

At this point, I could not say that about marihuana, but we are launching an effort to see if analogous or similar things are true about marihuana.

As to short term effects, we do know that marihuana has an impact on memory loss. It does bring on a hallucinogenic state in some. There have been a certain amount of people who have acute panic or psychotic or anxiety reactions. It is a small number thought. You don't get this from a few puffs of cigarettes. You don't very often, if ever, get an acute psychotic or crazy reaction from smoking cigarettes.

This has happened in a small number of cases with marihuana.

Mr. BROYHILL. You seem to minimize the tendency for the use of marihuana to lead into more dangerous drug usage.

Dr. EGEBERG. Could I answer your question a little bit there.

It seems to me that smoking is a man's own business. What it may do to him, it does to him. Marihuana use particularly because it starts at such an early age is apt to make many people go off into a pleasant euphoria or other means of evading the reality at a time, 15, 16, 17,

18 years when they should be getting ready for life when they should be setting their aims when they should be deciding or wondering where they are going.

This I would say, is the tragedy to all of society with respect to the use of marihuana. As we have said, it would apply particularly to the very young.

I don't think there has been any proof ever that the use of marihuana leads to the use of heroin. Rather, some people who seek marihuana early seek it because they are the kind of people who want physical satisfaction and demand it above mental satisfaction. These people will go on from any kind of physical satisfaction to whatever one suits them most and they could get there through alcohol to heroin, they could get there from sex to heroin.

There are a lot of different ways to heroin and naturally some of them might get there through marihuana or speed or any number of other things to heroin.

Mr. BURKE. What is your explanation for the problem that we have today? Drugs have been around for thousands of years. In my lifetime the people with whom I have been associated dreaded any participation in this type of activity.

Why do you think there is such a permissive use of drugs today and why do you think some people look so lightly upon the use of marihuana?

Dr. EGEBERG. I think we are in a very permissive era. What developed this era, I don't know. I am sitting between two people interested in psychiatry, so I hate to point the finger at them, but there has been a feeling that to raise children appropriately one should not inhibit them. I have a feeling that that is part of it.

Another thing is that the useful and realistic chores no longer exist. The things that would keep you busy feeling that you were doing something that you either had to do or could see the need for such as bringing in the wood, mowing the lawn, taking out the trash or any other number of things that occupied people when I grew up no longer have much validity.

I think both of these play a part.

Then comes this feeling that we don't understand the younger generation. I think perhaps part of it is that they have had a lot more time to think than we were allowed and maybe their conclusions are justifiable. But with this they have taken on a new culture. They look on us as belonging to an alcohol culture and they like to think of themselves as belonging to a marihuana culture.

So, it becomes a very significant thing, way beyond the use of that and probably way beyond the effect it has on the many people who just smoke it occasionally.

Mr. BURKE. Thousands of years ago their was a communications gap between the young people and the old people. I think if you read history down through the years you will always find there was a thrust on the part of the young people to enter into the unknown fields, to become pioneers.

What I cannot understand is why the young people cannot understand the dangers in the field they are entering into in the use of drugs. Do you think our educators, the parents or the churches have failed. How do you think this condition has been brought about?

Is it the permissive society we are living in? Is it the encouragement of pseudointellectuals who were educated beyond their commonsense in encouraging youngsters to get into this field? How do you think all of this has been brought about?

Dr. EGEBERG. For one thing, there is more misinformation about all of the narcotics than there is about almost any other thing. One of the things that the National Institute of Mental Health is trying very hard to do, which I think perhaps Dr. Brown should speak about, is educating the public as to what the facts are.

Dr. BROWN. I think the question you ask, Mr. Burke, is a fair one, but it is a tough one—what brings about a condition or set of values of this sort?

Certainly there is no simple answer as to whether it is school, church, pseudo-intellectuals, permissive educators, et cetera. As a psychiatrist I feel like the messenger that brought the bad news. We did not bring the permissive society about, but we try to treat the consequences thereof.

I could not begin to answer the consequences of it because of the complexity of it.

Mr. BURKE. You said the treatment of the conditions as they exist, but I think we ought to be looking into the causes. What good does it do to have all kinds of psychiatrists and doctors and tranquilizers around if the cause is continuing to exist? This is like trying to put out a grass fire with a broom, but it keeps spreading and spreading and you just put the fire out in a few places but it keeps spreading with the wind into other areas.

What I am trying to get from you people is what do you believe are the causes? What are the things that have brought this about? Why do young people today take the attitude that it is a good thing for them to use drugs?

When we were youngsters we knew enough to stay away from it. When people told us not to go into the whirlpools or where the currents were strong, we used to accept their advice. Once in a while some young kid would go out there and get drowned.

Why is it the young people today are not paying any attention to what over thousands of years people have known? In places like China and Africa where they have used all kinds of drugs over the years, we can see the results of that use of drugs in those areas. Why should a country like the United States with our advances in science and education and everything else, why should we suddenly find ourselves with such a problem?

I know in some of the communities in my district youngsters in grade schools and high schools are using marihuana, and it is common knowledge. I listened to a broadcast last night where one of the people speaking was complaining about the fact that nobody could seem to apprehend those who were distributing the drugs all over and making it available to younger children.

What I would like to find out from you is about the causes. What do you believe are the causes? I know that psychiatrists and mental institutions are doing their best to straighten out these people after they get to that point, but what do you believe are the causes?

Dr. EGEBERG. I will give him time to think a second.

When I was little, often the man who had early sexual experience was looked up to by those who were slower as being quite a guy, and the fellow who smoked behind the barn was looked up to by the others. Both of these are not exactly things that one particularly admires. I think it is switched and I think there is a false looking up to the person who starts smoking marihuana at the age of 12 or 15. Instead of being considered to be what he really is, an emotional moron, he sort of becomes a hero.

That is part of a culture that has arisen. And how? I imagine there are many philosophers, psychologists, and others trying to find out.

Dr. BROWN. I just don't know. That is the reason I am hesitating with some genuine humility. I think there is at least one major dimension to the cause which has to do with the feeling of uncertainty towards the future and what the future will be like. Thus one turns inward to sort of experiencing things or having experimental experiences, if I can coin a phrase. In the "old days" one had a pattern or future in what one did. Much of our youth and some of the leadership, though, are so uncertain about the 1980's or 1990's or whether they will ever be there, they take a here-and-now experimental value.

I don't condone that, but this anxiety and concern for the future seems to be one of the root causes for the behavior. I would like to pass the buck to Dr. Cohen who has spent 20 or 30 years thinking about it on the fundamental level that you raised, Mr. Burke.

Dr. COHEN. You mentioned there has been a generation gap around since forever. Youth has always disagreed with their elders. Youth is also a time of risk-taking and I seem to recall going into speakeasies myself at a certain period.

In other words, I was doing deleterious things to myself some of which are being repeated now.

We have to consider that, but one important factor that Dr. Egeberg touched on is this matter of peer group—what is the gang doing, what is fashionable. Marihuana is definitely in these days. It is spreading down to the grammar school because the grammar school is mimicking what the college students are doing.

I would not be surprised but that when it gets down into the grammar school the college students will stop using it because it will be out and, although I have no good evidence to indicate that there is a leveling off of marihuana use, I think it will go through a cycle and someday we will see an end to it.

There are other reasons for this. The lack of purpose that was touched on, the lack of a future orientation, the affluence of our society are factors. All of these things and a lot more seem to combine to make this a drug-taking period of existence, and I hope it will go away.

Mr. BURKE. One of the answers given here is that the youth are concerned about the future. Of course, when you look back over the years, youth have always been concerned about the future. I think during the year 1929 when no one was working and youngsters did not have tuition to go to school, there were no jobs, there was unemployment everywhere. That was a bleak period in our history and yet, the young people at that time did not turn to drugs or alcohol or other things—some of them did, but not in the proportion that they are today.

I was wondering whether we are not missing something here in failing to do something here that we could do. There is a responsibility on the part of the press. There is a responsibility on the part of radio and television. I was reading an article about Great Britain, how the great emphasis has been put on the Beatles and they have held up as great heroes.

Whether or not our schools and our homes have just encouraged the permissiveness and the laxity all the way down the line, and while we are writing legislation here, is legislation going to be effective if the other areas are not reached into? Are we trying to hold back the tide by passing legislation and giving the false illusion that we are really attacking this problem when actually we are only scratching the surface.

I am wondering whether or not people in this great society of ours—everybody expresses concern, but they go about their work everyday and youngsters are using marihuana everyplace.

How can it be possible in a small community of say 5,000 or 10,000? How can marihuana be distributed in that community and yet nobody seems to know where it is coming from? How can it take place all over the country? How can school teachers allow their children to be in their class and not observe that something is happening to a child in that class. What are the schools and local communities doing and what are the local churches doing and what are the news media and what are the rest of the people who all have a sphere of influence doing?

Of course, a great tendency is to blame it on Washington. Everybody says the Federal Government is to blame. That is why I am asking you for the causes. I am sorry you haven't got the answers. I haven't, but I do see a lot of areas where people in this country could do something about it and not expect Uncle Sam to cure a problem that is permitted by the permissiveness, the obscenity and vulgarity, and all of the other ills of our society which are so well exhibited around the Nation.

You can't have all of these things and keep a stable society.

I am going to support this legislation, but I hope we can have some reasonable answers from some people.

Dr. EGEBERG. Dr. Cohen thinks he has part of one.

Dr. COHEN. I would like to respond to some of the thoughts you had, Mr. Burke, with two points.

One, a child brought up without limit-setting has been done a great disservice, because someone is going to set limits for him. If he does not learn them early, he is going to be in a bad shape later on. Then the police will set limits for him.

The other thought is that this society must develop new goals for this new world we are living in, appropriate goals, viable goals, goals which will attract the idealism of youth and this is the charge that you are referring to. This is what must be done in addition to passing this bill.

Mr. BURKE. Of course, we should set goals. When I was a little boy they used to have the board of education in the schools. When I talk about the board of education I don't mean the elected board or the appointed board. The principal of the school had a board hanging on the wall down there that was shaped like a paddle and he used it once in a while. I don't recall anyone really being injured by it. I don't

like physical violence, but I think the use of a little paddle now and then might encourage a little bit of discipline in our society.

Dr. COHEN. That is what I call limit setting.

The CHAIRMAN. Mr. Pettis.

Mr. PETTIS. Doctor, I would like to pursue one other aspect of this. I conclude that there is an increase in the use of mood-elevating or mood-controlling drugs through legal channels. It would appear doctors are prescribing these more and more.

Is this a desirable thing in your mind as an expert in this field?

Dr. BROWN. A question like that gets us into the very fundamentals of what the values are in our society in meeting life's daily problems. I am not talking about illness, but the slight feelings of blueness or depression we have or slight feelings of being overactive and whether or not the medical profession or the industry through advertising promotes the use of drugs for the control of mood.

You are right and we have some studies to show that the use of mood-altering drugs is increasing rapidly. We have a set of studies and are monitoring the situation to measure the size of this use of drugs in cooperation with the industry and the FDA.

Whether or not it is the way to handle life's problems is a question for all of us and we in part would value your opinion.

Mr. LANDRUM. Mr. Pettis, would you yield a moment?

Mr. PETTIS. I yield.

Mr. LANDRUM. I would like him to include a comment to expand your question to include what he thinks about the articles we have read recently about the prescription of pep pills or drugs to students to increase their learning powers.

Mr. PETTIS. This was going to be my next question.

To what extent are we getting into a chemical society where we alter our life patterns by artificial means?

Dr. BROWN. Between the two questions, I think we have highlighted something that did not exist per se 20 or 30 years ago. Along with the many other technological and social changes that are taking place, the chemical revolution, the availability of new and more diverse and "better chemicals" to alter behavior and mood and feeling and thinking is part of the environment that our children are living in even more so than ours.

By the time you reach adulthood your propensity to use or not use drugs is pretty well established, whereas our adolescents are growing up in a culture where the drugs are part of what they feel in the very fabric.

I think, however, the role of the medical profession is but one role. The role of the industry, the role of advertising is another. I listen to my car radio and I am told what I should do if I feel a little nervous with over-the-counter prescriptions and this is part of the chemical revolution or control for the improvement or modification of behavior.

Specifically concerning the use of drugs for learning in children, there has been some publicity on that and some misinformation. There is good medical evidence that some young hyperactive children who have minimal brain damage or some neurological brain damage, paradoxically are helped by pep pills. This is a well-known medical fact, rather than pepping them up, it calms them down.

If this is done indiscriminately for the wrong children without adequate or medical attention, it is no good.

Mr. PETTIS. One last question. Is it your opinion that many of these tranquilizers which are being used for people who have mental disturbances, particularly those who have been institutionalized, has enabled us to get by with fewer medical personnel than we used to have in those situations and maybe in our total society where we are running short of medical personnel?

Dr. BROWN. In the psychiatric or mental hospital field, the drugs have substituted for the doctors who were never there in the first place and have had some dramatic effects in helping out. There is no doubt that any sophisticated knowledgeable layman or physician who visits a ward prior to the tranquilizer age currently will see a dramatic difference as well as significant numbers of people becoming well enough to adjust and do well in the community.

I think it would be an extension of our medical practice rather than a substitute for our medical practice.

The issue the two of you have brought up, which is so terribly significant, is when the drug use is above the medical practice, and how we live our lives and what we take and what is advertised and promoted. That is an issue bigger than the medical aspect of it.

Mr. PETTIS. No further questions.

Mr. ULLMAN. Dr. Egeberg, we have here, it seems to me, a series of problems that we try to treat as one problem. I am concerned about this legislation for that reason.

Certainly there is this problem of a chemical society, but as you have indicated, drugs can be a very useful tool. I certainly think there are times when drugs should be prescribed for a certain kind of child to accomplish a certain purpose. We are going to do that and I don't think there is any question about it.

But then we have the other problem of people just taking drugs for escape. This is not anything new. Since we have had wine and alcohol of any kind this has been part of the picture.

Right now the spotlight is on marihuana primarily because it is where the young people are and it is the "in" thing.

Do you think it is proper that we should lump marihuana into the same package with all other drugs under one set of rules in our law?

Dr. EGEBERG. We have separated both in the amendment to Hill-Burton and in this bill in saying it deserves particular, rapid and intensive study over the next few years so that we can clarify our thinking by having better knowledge about it.

If you are thinking of marihuana, it is in the same group with many other things like barbiturates. If you are talking about all four categories, barbiturates which do have a very useful thing, but which are also abused very, very much as are other substances which we know have a useful effect where as so far we are not aware definitely of any useful effect from marihuana.

I would say until we know more about it, it should be in one of the four categories of substances that we are thinking about or discussing.

Mr. ULLMAN. Of course, what we do around here when we don't have an answer to a problem we study it some more and that looks about like what we are proposing to do here.

Sometimes I am led to believe that marihuana is more a psychological thing than a real thing. When you take a certain amount of alcohol, you know it is going to go into your blood-stream and produce a certain result, varying in individuals, but for any individual it would be predictable.

Marihuana is, on the other hand, an indefinite thing. I have talked to people who have raised it during the war and smoked it and said it had no effect on them whatsoever. There is no standard marihuana. Some people raise it in their backyard. How much is psychology and how much is real?

I have talked to other people who say if you are in a group, you can begin to feel something because it is a psychological thing, but you can snap out of it right now which you can't do with alcohol.

To what extent is that a factor in the use of marihuana?

Dr. EGEBERG. I think I will refer to the psychiatrist for that.

Dr. BROWN. In hearing these stories, I think you have picked up a very interesting aspect of marihuana, and that is the experienced marihuana smoker often seems to need less rather than more. He does not build up tolerance. The reasons for this are subtle and interesting. It has to do with learning a reaction, feeling high or well, rather than the actual chemical or needing less chemical because he has learned how to go into this state.

I think the concern I have with the way you present it is to say that the psychology or feeling high or mania or different would be based just on psychology and not physiology. They sort of link together so closely it is hard to put your finger on one or the other.

It is well known with alcohol that you can take a drink or two and get pretty high, which has little to do with your alcoholic content. It has to do with the mood being set, being with friends and colleagues.

At other times, you will drink a minimal amount because your blood level would be higher. So, the interplay of psychology and physiology is a very intriguing and interesting one.

Marihuana does have this aspect that Dr. Cohen spoke to, that it is often smoked in peer groups and there is a lot of sensitivity to what you should feel. It may have more to do with that social or peer group pressure than actually the effect of the chemical in marihuana.

Mr. ULLMAN. Let's make a specific example—driving under the influence. We, of course, know driving under the influence of alcohol is a very real thing. You can test it. You can pretty well know whether a person has control of his facilities or has not. You never read about an automobile driver under the influence of marihuana. Why is that?

Dr. BROWN. I think because we have just not gotten around to it or tested it. We are doing a specific project in that area to see what the effect of marihuana is on the physiological function such as braking, alertness, et cetera. It has not just become part of our social patterns rather than it not being relevant.

I think also the marihuana smoking is done in a way that it is less common to take a ride in a car afterwards, although I am sure it happens. Also the officer would be less alert except that the person looks drunk, does not have any alcohol, and perhaps does not think of marihuana testing. This is why some of our pharmacological research is important. We are just beginning to have the first breakthrough and

being able to see traces of marihuana in the bloodstream which 3, 4, 5 years from now may be used in a similar way to testing driving under the influence.

I think we do know it has effects on behavior such as driving, and hope to be able to document it similar to alcohol.

Mr. ULLMAN. You have no evidence now.

Mr. BROWN. Let me ask Dr. Cohen who has been supervising specific projects in this area.

Mr. ULLMAN. If this can be smoked in cigarettes, why don't people who have hang ups take the marihuana cigarette and smoke it when they get in a car? What is it about this that you have to do it in a circle, in a dark room and you don't do it by yourself? What is the psychology involved?

Dr. COHEN. There are some people who use marihuana alone and while driving. The reason why you see very few reports of driving while potted is that we have no commercial test today like we do for alcohol for determining blood levels of marihuana. This, as Dr. Brown said, will come in a few years, but we don't have it today. So, we can't prove that a man is driving under the influence of marihuana today.

Mr. ULLMAN. What about in the case of crime. We have evidence that a lot of crimes are committed by people who are under the influence of something.

Is there something about marihuana that would give one the courage or the desire to commit a crime?

Dr. BROWN. This is an important question and I think that, as you hinted earlier, people don't take marihuana and get into a car and drive. Most of the marihuana smoking would be in social group settings rather than in the course of daily activities as it so often is with alcohol where a person has a cocktail at lunch, goes out in the evening and uses the car for transportation.

Marihuana is more often used in the company of others, but with considerably less of the sociability and gregariousness you see in alcohol. Alcohol is so widely used, but if you do look at the statistics for people who are caught and convicted in criminal behavior, I think you will find alcohol related very high, perhaps surprisingly high.

Mr. ULLMAN. Much higher than drugs?

Dr. BROWN. Much higher than drugs and I think low or minimal with marihuana. The marihuana taking leads more to a private, thoughtful, special experience in your head rather than an active getting out, doing something that you have not been able to do because you have not had the courage or the foolishness.

Mr. ULLMAN. Here again, we have real evidence that a lot of crime is caused by the hard drug users because it becomes costly and they have to get the money. It is just something they have to have. This is not true with marihuana; is it?

Dr. BROWN. You are correct; it is not true. It is true that in order to have $20 to $100 for heroin there is a very high order of criminal activity among the heroin addicts.

Mr. ULLMAN. Here again, we come to distinctions. I know Congressman Pepper and the committee decided that the use of marihuana did lead to hard drugs, but you said here this morning that there is no evidence, as far as you are concerned, that the use of marihuana does lead to hard drugs; is that right?

Dr. COHEN. Only in the case of the heavy marihuana user is there a tendency to go on to other more dangerous drugs. Some potheads are inclined, according to our surveys, to go on to amphetamines, barbiturates, LSD, and a few to heroin, but the pothead represents 5 to 10 percent of all marihuana users.

Mr. ULLMAN. Have existing laws inhibited research in this area?

Dr. COHEN. There is increasing marihuana research. We supply marihuana and THC to researchers and each year, for the past 5 years, there have been increasing numbers of studies so that, although marihuana research is difficult to do, there is quite a procedure. You need tax stamps, and you have to submit a protocol to a combined FDA–NIMH committee. Research in this field is increasing now.

Mr. ULLMAN. The laws have inhibited it?

Dr. COHEN. Yes; it has made it difficult.

Dr. EGEBERG. Also, there was a lack of interest on the part of the research community. I was on a Presidential commission looking into the whole drug question about 10 years ago, and it was difficult to get people interested without the difficulties of filling out papers.

Mr. ULLMAN. In order to really tackle this problem we have to answer the statements and the thinking of the young people. I just have not detected here real answers to the things that they are saying. I think that Mr. Burke and others in their questioning were trying to find out what makes them do it.

But what we need to do, I think, is get some people who use it here and get their arguments which I have heard many times. Many of them would sound really reasonable.

I remember just a few years back every kid smoked. He had to smoke cigarettes. It was not too long ago you sat around a table and if you didn't smoke you were an oddball.

Today the situation has changed. I wonder to what extent the kids in grade school, in place of having a cigarette and getting a cigarette habit, are doing this. In other words, to what extent are these things mutually exclusive?

Are they doing less cigarette smoking and less drinking if they go to marihuana? Or, in a permissive society, if they go to marihuana, are they likely to do the other things, too.

Do you have answers to that?

Dr. COHEN. According to our studies, there is no decrease in cigarette smoking among marihuana users. There may be some decrease in alcohol consumption among some marihuana users, although I know of others who use both at the same time.

Mr. ULLMAN. In other words, this is not a mutual exclusive thing as far as you are concerned?

Dr. COHEN. No; the statistics for tobacco and marihuana show that just as much tobacco is used by marihuana users and nonusers. There may be a slight decrease in alcohol consumption.

Mr. ULLMAN. Again, and we do not have the answers here today, but I would really like to see as a part of this record a series of statements by marihuana users and scientific answers to those statements because they can make a very convincing argument that the use of marihuana is not a hazard to society.

Dr. COHEN. Mr. Ullman, we have a publication called "Answers to The Most Frequently Asked Questions About Drugs," including a section on marihuana. We attempt to take these questions and deal

with them as honestly and as scientifically as we can, and we will be glad to submit that for the record. (See p. 297.)

Mr. ULLMAN. I would say again, that one of the fallacies in this whole procedure is we are trying to deal with a whole series of different kinds of problems under one set of concepts. I think there has been too little distinguishing between the issues involved in different circumstances and with different drugs.

Until we really understand that, I do not think we can really tackle the problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Vanik.

Mr. VANIK. Dr. Egeberg, first of all, let me say your agency and the agency that is headed by Dr. Brown, I think particularly, have the gravest responsibility confronting any group in America today because you have this tremendous problem and you have the know-how and the skill to apply to it.

What attracts my attention in your statement is this sentence: "When people find out suitable goals and values, drugs can become meaningless and superfluous."

This seems to indicate, does it not, that drugs are sort of a medicine of despair. I appreciate the statements that distinguish one drug from another and so on, but what does the family do that has a problem with a child who may be disturbed or upset or unconventional or nonconforming or filled with some despair because of failure to measure up to family expectations? What doors are open? What books are there that say do this or do that?

Yes; see a psychiatrist, if you can, if he can be found. Where are the places where these young people can find solutions to their problems?

Dr. EGEBERG. In the first place, if the problem is evident, naturally, the first place to begin would be to have a talk within the family. By the time it is evident it is often much more helpful to get a neutral figure, possibly an authoritarian figure which could be from the church, it could, perhaps, most likely be the family physician. It could be someone in a YMCA or Scout group who can talk without all of the habits and relationships that the family has had in the past.

Part of the problem can be answered by just giving proper information if one speaks early enough. After that one may need the help one can find in the many clinics that the National Institute of Mental Health has helped to set up which will tackle this problem or others.

Mr. VANIK. What sort of place would there be where a young person on his own volition might walk in and say, "I feel the need for a medicine of despair and I am here." Where could that person go? What door is there here that is open?

Dr. COHEN. There are the Community Mental Health Centers that deal with the problems of dangerous drugs.

Mr. VANIK. What happens there? They are probably told to go see a psychiatrist, are they not?

Dr. COHEN. You are right. The facilities do not extend as far as the need.

Mr. VANIK. They get a book on drugs and if you have any further need for help, "Come and see us," but they don't really provide any services, do they?

Dr. COHEN. Yes, there is a service capability, but I would be the first to admit to you that it does not meet the need. The need has come upon us so quickly that we have not caught up with it.

Mr. VANIK. How do you feel about these groups of young people who gather together? Do they help each other?

Dr. COHEN. I think so.

Mr. VANIK. Isn't it time we recognize in these groups that they make of their own, they may be solving some of their own problems on their own. At least they have a sympathetic exchange if they are gathered together with people who share a despair and a shared despair is probably easier to handle than a privately held despair.

Isn't there something to that?

Dr. COHEN. I think these rap sessions are very valuable because one young person will listen to another young person.

Mr. VANIK. Particularly when the other young person also has a problem.

Dr. COHEN. That is true. We know of groups where they have been extremely helpful.

I would like to mention one other resource that is springing up almost spontaneously, although we are trying to help; namely, the use of ex-drug users to help people who are attempting to turn off.

Mr. VANIK. Comparable to Alcoholics Anonymous.

Dr. COHEN. Yes, sir.

Mr. VANIK. Doesn't society discourage these people from gathering? Isn't there a tendency on the part of social groups and police authorities to discourage the gathering together of these young people rather than their meeting together? What about that?

Dr. BROWN. Mr. Vanik, you are putting your finger on a terribly critical point about where do you go as a young adolescent, anywhere from 13 to young adult, when you are despaired, discouraged, alienated. We know the medical or psychiatric setting does not quite meet the answer. The truth of the matter is that we have no good organized settings that you can go for that purpose. There are some churches where the minister or the leader has rather intuitively and on his own created a youth group where you can come to discuss.

Mr. VANIK. He gets in the paper sometimes.

Dr. BROWN. When a spontaneous physician does this who has been experienced with this problem, we run into the fact that there are these new peer groups which are formed and are on the constructive, creative side and they are looked upon with suspicion by the older group.

This can be a creative and new social form to meet a desperate need.

Mr. VANIK. Isn't it time we developed some technicians who are not psychiatrists, who do not have the capability of psychiatrists but who could, under direction, provide a great service to a great many people who have no access to psychiatrist reasons because of the scarcity of psychiatrists and the scarcity of services.

Should we not be building up a reservoir of technicians with some capability in this area so they could assist these people?

Dr. BROWN. Yes.

Mr. VANIK. My next question is this: Isn't it possible for the development of a publicly-funded place of refuge for disturbed young people, many of whom are going to drugs as a substitute for success

Dr. EGEBERG. We have learned one thing and that is we had better be sure of the facts when we talk to the young. That is the reason for stressing the research aspects in the next 2 years.

At the present time, if a young fellow, a 15-year-old asks "What is the difference between what marihuana will do to me if I use it over a period of years and if I use alcohol?" I don't think we have the scientific evidence to say what the difference is.

So, we have to say there are very possible dangers. We have to say that it can make you forget or it can make you evade life now when it is so important for you to face it.

That, I think, we can say, but we can't say it is going to do certain things to your brain with any assurance, and if we say otherwise, they can sense that we are speaking off the top of our head. I think we do more harm. That is why I think it is extremely important that within the next few years and as quickly as possible we list what marihuana can do to people or is likely to do to people and have some statistical evidence as to how long you have to use it or how many people will be affected.

It took a long, long time to get that information on cigarettes. I think it took two decades. You can probably add to what I have said.

Dr. COHEN. I would like to underline the fact that especially the pothead, the person who makes a career of marihuana use is doing a great disservice to himself. He is interposing a chemical between the very things that make him grow and mature; namely, the frustrations of life. This I think is a real harm that any drug can do including marihuana and including alcohol, when used in that way.

Mr. GILBERT. Now you have interjected with the use of marihuana-alcohol, yet, we don't say that the use of alcohol is a crime. On the other hand, you say the use of marihuana is a crime.

How do you explain that?

Dr. COHEN. We are getting close to the core of the problem. Alcohol and tobacco are culturally accepted and have been for innumerable generations and we can't forget that fact. We tried to do something about our terrific alcohol problem and failed miserably because it was part of society.

Now the question becomes then should marihuana become part of society before we have the answers? Should we accept it and then find out later that it causes A, B, C, and D which we only have presumptions about now.

Mr. GILBERT. We say it is a crime to use marihuana, and there have been some very severe sentences to some of our young people for the use of marihuana. Yet, some of the best people of our society, the most intelligent such as yourself say you don't have the answers to the problem, and you say it may be potentially harmful to them both physically and mentally.

Then you say to them you have a choice now which you can make whether you are willing to take this risk or not. But why should society turn around and say to this individual who wants to take the risk, you are going to go to jail because you are using this product and yet you put it in the same category as smoking and the same category as drinking.

Dr. COHEN. Merely, and this is not logical, it is not part of our culture. Therefore, it is taboo. We are faced with this hard fact that for 30-odd years it has been a crime to do this thing.

in life by conventional standards? Should we pick up some old facility that is surplus and turn it over or utilize it for the thousands of young people who have the need for a place to get strength?

Dr. EGEBERG. Could I answer this in terms of Los Angeles, sir?

In Los Angeles there was a great deal of marihuana used in East Los Angeles. There was a fair amount of heroin used. This is a community of primarily Mexican Americans. It has its counterpart in other parts of Los Angeles. But a group of young people there came to us—I worked for the Department of Charities and later I was the dean of a school that was in that area. They said, "We can take them off heroin. We have ex-addicts who can take them off marihuana, speed and so on. We can't get them off barbiturates because sometimes they die when we take them off of that and we need your help."

We managed to make available 10, 20, then 40 beds in one of the country hospitals, far enough away from here so there was a different atmosphere. These beds are constantly full. There is a feeling in the community that both the youth and the older people want to do something about it.

This was generated entirely in the community. They just came to us for help which we were very happy that we could give them.

I think if you can get something generated in the community, be sensitive to it and then help it, you have done the first five or six steps, as opposed to if you go to the community and try to start something.

Mr. VANIK. They need a place that is not a prison or a hospital, a place where lives can be readjusted.

Is your agency, under present law, authorized to provide such places demonstration grants to help? Have you made any effort to perhaps pick up some excess Federal property, and obsolete military establishment that can be utilized to provide a place or refuge and a place for readjustment?

Dr. COHEN. We have a capability to provide for innovative demonstration projects of the sort that you mention, although we have not taken over any battleships yet. There is one project that I can think of immediately in New Jersey that has occupied an old Army camp and is converted into a facility for the treatment of the hard drug user.

The marihuana user does not often appear there, but the speedfreak and the heroin addict is cared for in that facility.

Mr. VANIK. I am talking about the disenchanted young people. You have to reach them before they get into that category. I wonder what we do about this grave huge body of people who are filled with despair and disenchantment about our times and what we are doing.

Dr. BROWN. We can give you the bureaucratic answer which is we have the authority to do this. I have had occasion to offer informal consultation to youth councils across the country, trying to set up something like this, and they run smack into the difficulties of what kind of informal agreements can you make with the police.

This is the kind of a real problem they have. Who will be the sanctioning or authoritarian figure who will sponsor such a group? What other legal responsibilities are there since you run into runaways in situations like this.

I think it is a case where the people we are dealing with have such a variety of problems, legal, parental, social, as well as this drug aspect, which in perspective is but one dimension.

We do not have an organized approach to this very large need of our times.

Mr. CONABLE. Would the gentleman yield at this point?

Mr. VANIK. Yes, I would be happy to.

Mr. CONABLE. In New York State, we have done some work in this area. In my district there is a Job Corps camp built at great expense to the Government. It was closed within a year, also by the Federal Government. It was then turned over to the State of New York for a drug rehabilitation center. I must say we are having our problems with it, but there is progress being made. It is quite an isolated facility and apparently there are other facilities of this sort that are available that if there is an aggressive State government interested in it, it can work out the arrangement with the Federal Government for some interesting rehabilitative work.

Mr. VANIK. I am glad to hear that. I just want to say before I finish my questioning that I do hope among the documents and the publications that you develop that you develop one that gives advice, when your child is disturbed or you are concerned about your child, as to what can you do. I think everybody is aware of the minister, the priest, the doctor, the psychiatrist. It is beyond all that. It is what you do after you have exhausted all of the standard cliche remedies or suggestions.

I think most of the problems of most people go beyond that. They don't know what to do. There are very few places they can go. The psychiatric services that are available are very limited to persons in the lower economic status. There may be better services available to those who can afford to pay, but even among those who can afford to pay there are very few places and very few services that are available to help.

It seems to me that we are rejecting these people. We are forcing these people to solve their own problems—I hope they are.

It seems to me this is certainly a time for extensive demonstration, for extensive clinical research, and this other aspect of the drug problem which I think will do far more to solve the real problem than all of the laws we can write here today.

Thank you.

Mr. GILBERT. I have listened with great interest to your testimony about marihuana. It appears to me there is a great deal of confusion in the area, that the research is incomplete and I would suspect that this leads to a great deal of confusion in the minds of the public and in particular to the users or potential users of marihuana.

You were quite direct in response to a question with respect to the use of cigarettes and you ticked off very rapidly one, two, three, heart disease and lung disease and what the future would be for somebody that was a consistent user.

But yet in response to the question, I believe, of Congressman Bush, who asked about a 15-year-old inquiring about the use of marihuana, you said, "Well, it is a crime."

Well, I don't think that is a satisfactory answer because the 16-, 17-, and 18-year-olders know it is a crime. But what I think is the nut of the problem is what the medical result of the use of marihuana is. Or, what is the effect on the mental processes of the use of marihuana? I wish you gentlemen would address yourselves specifically to these two areas so the record might be complete.

Dr. EGEBERG. I think this became a cause celebre of the earlier Bureau of Narcotics. They suddenly decided that marihuana led to heroin and while they later could not prove that marihuana in and of itself was so bad, they clung to the fact that marihuana was the road to heroin and that they went together.

This has been built up and we have to unbuild it. To do that, we have to tear it down. To do that, we need a few more facts, many more facts than we have now. We want these. We think that the punishment has been completely unrelated to any crime. This was one of the things I personally felt violently about when I first came into this job that I hold and I think it helped open this subject.

We feel that this bill is a very good step in the right direction. Remember that this bill is more for the Department of Justice to help delineate their responsibilities and their relationship to us. We have through the Institute of Mental Health and through their mental health clinics and bills which support them, ways of approaching this problem both in prevention and in treatment.

But we still need a little more information on marihuana before we can go to our children and say categorically what we could say to them 5 or 6 years ago about smoking.

Mr. GILBERT. Is marihuana "marihuana" or are there different classes?

Dr. EGEBERG. It is the final chemical that does the trick to the smoking of leaves of marihuana raised in this country. Hashish and cannabinols are different aspects of marihuana. One is stems and everything ground up and compressed and another is a gum. They get the gum from the opium. Marihuana growing in different countries apparently has different potencies and now that they have been able to isolate the ingredient that causes the biological action, they can compare all of these with each other.

I would say that all of these come from marihuana. Their potency probably varies hundreds of fold.

Mr. GILBERT. Would you say, Doctor, that the smoking of marihuana, say, immediately at the time it is cut in Mexico to the time it reaches a college campus there is quite a difference in the potency of the marihuana?

Dr. EGEBERG. I don't know.

Dr. COHEN. Marihuana increases slightly in potency when it is dried, but after drying it starts losing potency and after a year or two has lost a considerable amount of its THC.

Mr. GILBERT. I heard or read some testimony to the effect that when the marihuana is first cut in Mexico, it is quite potent and devastating upon the individual. Then by the time it goes through its devious route and it finally reaches the ultimate user that there is quite a difference because of the fact that it is drying out, that the climatic conditions are not the same and for whatever myriad of reasons; there is a change in the potency of the marihuana.

What concerns me is that when we talk about marihuana and we don't know the effects of it, is it the ultimate user on the college campus, say, who smokes this marihuana at the stage where perhaps it is not as potent can turn around with great impunity and say, "Gentlemen, it really does not have any effect on me." Because it really does not have any effect on him and as the doctor said, it is a mental sort of condition and he is getting high kicks through some vicarious sort of thrill.

Do we have any statistics about that and how do we place it in the final perspective?

Dr. BROWN. The joints arriving on a campus have a 0.1 to 0.5 percent THC, depending on where it was grown, et cetera. This is why we had to start growing our own under our own auspices at NIMH so we could provide investigators with known quantities and known amounts. Without this kind of control you can't do any kind of sensible factfinding.

Indeed, it is true what you mention that quite often the home grown marihuana, pot, in our Midwest is so weak that people smoke it and decide there is no effect at all and they are correct. Often they will then run into a very powerful marihuana and have a psychotic reaction and be all surprised. So, this language of uniformity is quite accurate as you describe it.

Mr. GILBERT. Would that be more or less at taking booze which is 60 percent and they take a shot of booze that is 150 percent and and they see a difference?

Dr. BROWN. The difference is between diluted beer and Southern Comfort.

Dr. EGEBERG. You can tell the difference between 20 proof and 60 proof.

Mr. GILBERT. We are not speaking as experts, of course.

I thank you for your testimony here this morning, but I am as deeply concerned about the problem now as I was before and I am equally as confused. I think we have to supply these answers and very rapidly to our people so that they do realize that marihuana has an effect upon them, and having teenage children I am very, very concerned about it from the reports that I get from my own children and in speaking with their friends and just the general material that you would read in the newspapers.

I think the bill may be one thing, but I think the research is of vital importance, and I commend you gentlemen and I hope you can solve the problem a lot more rapidly.

The CHAIRMAN. Since there are no further questions, Dr. Egeberg, and those at the table with you, let me again thank you for your very fine testimony and for taking the time to come to the committee to deliver it.

(The appropriate parts of the publication entitled "Answers to the Most Frequently Asked Questions About Drug Abuse," follow:)

A Federal Source Book:

ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS ABOUT DRUG ABUSE

GENERAL QUESTIONS ABOUT DRUG ABUSE

WHAT IS A DRUG?

A drug is a substance that has an effect upon the body or mind. This publication deals only with those drugs that have a potential for abuse because of their mind-altering capability.

WHAT IS DRUG DEPENDENCE?

Drug dependence is a state of psychological or physical dependence, or both, which results from chronic, periodic, or continuous use. Many kinds of drug dependence exists: they all have specific problems associated with them.

Not everyone who uses a mind-altering chemical becomes dependent upon it. Alcohol is one common example of this point. The majority of persons who drink do not harm themselves or those around them. However, more than five million Americans are dependent upon alcohol.

WHAT IS HABITUATION?

Habituation is the *psychological* desire to repeat the use of a drug intermittently or continuously because of emotional reasons. Escape from tension, dulling of reality, euphoria (being "high") are some of the reasons why drugs come to be used habitually.

WHAT IS ADDICTION?

Addiction is *physical* dependence upon a drug. Its scientific definition includes the development of tolerance and withdrawal. As a person develops tolerance he requires larger and larger amounts of the drug to produce the same effect. When use of the addicting drug is stopped abruptly, the period of withdrawal is characterized by such distressing symptoms as vomiting and convulsions. A compulsion to repeat the use of the addicting drug is understandable because the drug temporarily solves one's problems and keeps the withdrawal symptoms away.

Drugs other than narcotics can become addicting. Some people have acquired an addiction to sedatives and certain tranquilizers. Stimulants in very large doses are addictive.

Whether the person is physically addicted or abuses drugs for psychological reasons, he is dependent upon drugs. Drug dependence of any kind is a serious problem for the individual and society.

ARE ALL DRUGS HARMFUL?

Every drug is harmful when taken in excess. Some drugs can also be harmful if taken in dangerous combinations or hypersensitive people in minute or ordinary amounts.

The fact that certain drugs can produce enormously beneficial results has produced the false notion that pills will solve all problems. Society must develop a new respect for all drugs. Drugs that affect the mind can have subtle or obvious side effects. These can be immediate or may become evident only after long continuous use.

WHY ARE DRUGS BEING ABUSED THESE DAYS?

Drug abuse is not a new phenomenon. Varying forms of drug abuse have been present for years in the United States and other countries. There are many reasons for the current epidemic of drug misuse. Very broadly, drug abuse can be described as an effort by individuals to feel different than they do. Many drugs temporarily allow their users to evade frustrations, to lessen depression and feelings of alienation, or to escape from themselves. Such misuse of drugs, of course, does not produce any improvement in the problems of the individual or society. Rather, it is a flight from problems.

Some of these factors in the great "turn on" of recent years are:

(1) The widespread belief that "medicines" can magically solve problems.

(2) The numbers of young people who are dissatisfied or disillusioned, or who have lost faith in the prevailing social system.

(3) The tendency of persons with psychological problems to seek easy solutions with chemicals.

(4) The easy access to drugs of various sorts.

(5) The development of an affluent society that can afford drugs.

(6) The statements of proselytizers who proclaim the "goodness" of drugs.

WHAT IS MEANT BY A DRUG CULTURE?

A drug culture or subculture is a group of people whose lives are committed to drugs. The members of any subculture may congregate in a particular geographic area, such as the Haight-Ashbury district in San Francisco.

Marihuana is almost invariably smoked in such communities, but hallucinogens, sedatives, stimulants and narcotics are also used. It has been demonstrated that these subcultures are transient in nature; only a minority of the members remain for more than a year.

WHERE ARE MOST DRUG USERS LOCATED?

The location of users varies with the drugs in question. Until recently, almost all heroin use was confined to males in urban ghettos. Now this pattern is changing. A few young people in suburban areas use heroin. Marihuana formerly was seen primarily in disadvantaged areas, in certain Mexican-American communities, and in some groups of jazz musicians and similar persons. Today, marihuana smokers and users of hallucinogens are found among middle and upper class young people and other groups. Barbiturates and amphetamines were once abused primarily by middle and upper class adults. Now, many youngsters of all classes are misusing them. The important thing to keep in mind is that drug use patterns are changing rapidly in the United States.

WHY DO DEPENDENCY PRODUCING DRUGS HAVE SUCH A WIDE RANGE OF EFFECTS UPON DIFFERENT USERS?

The effects of mind-altering substances are related to the expectations of the user, the setting in which the use takes place, and the potency of the drug. Mind-altering substances can have vastly different effects upon different people because such drugs release individual underlying personality traits that are ordinarily covered up. Internal controls are diminished or eliminated; one person may become angry, another amorous, a third happy, others disoriented, confused, or depressed, and so on.

Even the same person taking the same dose of a drug on a subsequent occasion may have an entirely different response. As self-control is lost, the person reacts to suggests from people around him and the setting in which the drug is taken. These factors can markedly alter the drug's effects.

DO DRUG ABUSERS TAKE MORE THAN ONE DRUG AT A TIME?

People who abuse one drug tend to take all sorts of drugs. Some of them say they are looking for a new "high." Some will take any drug to get outside themselves. Some play chemical roulette by taking everything, including unidentified pills.

WHAT ABOUT "PATENT MEDICINES"?

Certain over-the-counter medicines have been taken in excess and have been used to "turn on." Certain cough syrups and the stay-awake and go-to-sleep preparations are sold without prescription and may cause dependence. Paregoric (camphorated tincture of opium), which is available in some states without a prescription, is also being abused.

Another way in which patent medicines may contribute to the drug abuse problem is their manner of advertisement in the mass media. Children and adolescents hearing such commercials may become conditioned to believe that taking drugs for minor emotional difficulties is all right. To promote the belief that taking a drug will deal with the difficulties of everyday life is undesirable.

WHY DO AFFLUENT PEOPLE BECOME INVOLVED IN DRUG USAGE?

At one time we thought that if we could eliminate poverty, drug abuse would fade away. This notion was obviously erroneous. In a world where changes are rapid and yesterday's faiths and values may erode, affluence allows the time and finances to support drug excesses. Loss of goals and drive can be a by-product of affluence. When a person no longer needs to work in order to eat and clothe himself, he may develop problems of leisure. If he has no viable goals, no motivation or drive to create, to study or to help others, he may become bored or alienated, and vulnerable to the temptation of using chemical substitutes for productive living.

CAN THE EFFECTS OF DRUG ABUSE BE PASSED ON TO THE UNBORN?

Some babies born to heroin-addicted mothers have shown withdrawal symptoms. Not enough is known about the genetic effects of other drugs. Taking drugs without careful medical supervision during pregnancy is extremely risky.

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WHAT IS WRONG WITH TAKING ANY DRUG I WANT AS LONG AS I DO NOT HURT ANYONE ELSE BY DOING SO?

Society has duties to the individual, and the individual has certain responsibilities to the society in which he lives. A responsible social system provides its citizens with information about the dangers facing them, including the possible dangers of drugs. When a drug has both a harmful and a beneficial potential, regulations about the manner in which the drug is used should be formulated.

It is difficult for an individual to do something to himself that has consequences upon himself alone. Inevitably, the act will have an impact on those who are close to him and those who are dependent upon him. To "drop out" via drugs means that the person becomes dependent upon the social structure for a variety of services and supplies. Someone has to pay the bill.

WHERE DOES ONE GO IF HE IS BECOMING OR IS DEPENDENT UPON DRUGS?

If the user wants help, one's family, a friend, physician, or minister could be asked to help find the best resource in the community. The family doctor, mental health professionals, or school counselors should be among the first to be contacted. Some community self-help groups are effective. Many community mental health centers have special drug abuse units; all centers should be able to provide services or referral to an appropriate resource.

WHAT CAN A PARENT DO TO HELP A CHILD WHO IS ABUSING DANGEROUS DRUGS OR NARCOTICS?

Talk about it and try to understand why this behavior is taking place. Ideally, a relevant alternative to drug misuse can be figured out. Increased family interest and involvement in the child's daily activities will help. Professional advice may be desirable. Some communities have programs run by ex-users.

When the youngster is intent upon continuing his drug taking, the problem is much more difficult. Solutions must be individualized. In some instances, it may be desirable to point out that the family cannot be expected to support the drug-taking activity. Psychotherapy may be necessary, but it usually is not successful if the patient is resistant to change. Arbitrary restriction of the youngster may or may not work. If he runs away or is apprehended in some illegal act, he should know that the family will support and help him as soon as he decides to alter his destructive pattern of drug taking and antisocial behavior.

WHAT ARE THE BEST COUNSELING PROCEDURES TO USE FOR DRUG ABUSERS?

In general, the counselor whose approach is punitive is unlikely to succeed. Channels of communication must be opened, and the patient must acquire some measure of trust in the counselor. By listening to the drug abuser's story, the counselor should not give the impression that he is condoning the behavior because he is listening without judging. He must try to understand what the drug means to the patient, and then determine what non-drug alternatives are available.

Group therapy is often successful. Many treatment programs are very effectively using ex-abusers as part of their counseling staffs. Naturally, the skill of the therapist is an important element in achieving success, but the most important factor is the desire of the user to stop using.

IS IT POSSIBLE TO OBTAIN MEDICAL HELP WITHOUT INCURRING LEGAL PENALTIES?

A certified physician or psychologist can generally assure patients that discussion of drug abuse problems will be kept confidential. Practically all enforcement agencies cooperate with the person who wants help.

WHAT MORE CAN BE DONE TO CURB THE MISUSE OF LEGALLY OBTAINED DRUGS?

The family medicine chest may be a source of initial drug trials by children. It should not be used as a stockpile of drugs that are no longer needed. Physicians and pharmacists must carefully watch the renewal of prescriptions of drugs that can cause dependence. The patient should be warned about using such drugs exactly as prescribed.

All manufacture, transportation and distribution of large quantities of drugs in legal commerce should be controlled by adequate safeguards. Large amounts of stimulants and sedatives are being diverted into illegal channels by theft and fraudulent orders.

WHAT SORT OF PROGRAM COULD MAKE A REAL IMPACT ON OUR DRUG ABUSE PROBLEM?

1. Society should judge adults who misuse liquor or drugs by the same standards it judges young people. A double standard produces a credibility gap.
2. Children should not be continually exposed to the idea that the stresses of daily life require chemical relief.
3. Factual information about drugs should be stressed rather than attempts to frighten people.
4. Respect for all chemicals, especially mind-altering chemicals, should be instilled in people at an early age.
5. Efforts to detect all manufacturers and large scale traffickers of illicit drugs should increase.
6. Further research in prevention, education and treatment techniques should be carried out.

WHAT CAN ONE DO TO HELP PREVENT THE SPREAD OF DRUG MISUSE?

There are a number of things an individual can do:

1. He can set a good example by not abusing drugs himself. Since he can expect his children to model their drug-taking behavior after his, he can either refrain from drinking socially accepted alcoholic beverages, or drink in moderation.
2. He can learn as many facts as possible about drugs so that he will understand the problem and be equipped to discuss it in a reasonable manner.
3. If he learns that someone is peddling drugs, he should notify the authorities. It is the responsibility of both the individual and the community to keep the dealers out.
4. He should do what he can to assist anyone wanting help for a drug problem while awaiting additional aid from a trained person or a treatment facility.
5. Most important of all, he can strive to meet the ideals of parenthood, trying to rear his children so that they are neither deprived of affection nor spoiled. He should have a set of realistic expectations for them. He should give his children responsibilities according to their capabilities, and not overprotect them from the difficulties they will encounter. A parent should be able to talk frankly to his children, and they to him.

Questions About Marihuana

WHAT IS MARIHUANA?

Marihuana is Indian hemp (*Cannabis sativa*). The parts with the highest tetrahydrocannabinol (THC) content are the flowering tops of the plant. The leaves have a smaller amount. The stalks and seeds have little or none. THC is believed to be the active ingredient in marihuana. Many other compounds are present in marihuana, but they do not produce the mental effects of the drug.

DOES MARIHUANA VARY IN STRENGTH?

Yes. Some marihuana may produce no effect whatsoever. A small amount of strong marihuana may produce marked effects. The THC content of the plant determines its mid-altering activity, and this varies from none to more than 2 percent THC. Because THC is somewhat unstable, its content in marihuana decreases as time passes.

The plant that grows wild in the United States is low in THC content compared to cultivated marihuana, or the Mexican, Lebanese, or Indian varieties. Climate, soil conditions, the time of harvesting and other factors determine the potency.

WHAT IS HASHISH?

Hashish (hash) is the dark brown resin that is collected from the tops of potent *Cannabis sativa*. It is at least five times stronger than marihuana. Since it is stronger, the effect on the user is naturally more intense, and the possibility of side effects is greater.

IS MARIHUANA AN ADDICTING DRUG?

Marihuana does not lead to physical dependence. Therefore, it cannot be considered addicting. Chronic users become psychologically dependent upon the effects of marihuana. Thus, it is classified as habituating. The fact that a drug is not addicting has little relationship to its potential for harm, since dependence, whether psychological or physical, is a serious matter.

IS MARIHUANA A STIMULANT OR A DEPRESSANT?

Because it affects the individual's self control, the effects of marihuana vary so widely that it can be either a stimulant or a depressant. THC is a strong hallucinogen with some sedative properties. Occasionally, a person intoxicated with marihuana will become stimulated and overactive.

HOW IS MARIHUANA USED?

In this country, it is generally smoked in self-rolled cigarettes called "joints." It is also smoked in ordinary pipes or water pipes. Marihuana and hashish can also be added to foods or drinks.

WHAT ARE THE IMMEDIATE PHYSICAL EFFECTS OF SMOKING A MARIHUANA CIGARETTE?

Reddening of the whites of the eyes, an increased heart rate, and a cough due to the irritating effect of the smoke on the lungs are the most frequent and consistent physical effects. Hunger or sleepiness are reported by some individuals.

HOW LONG DO THE EFFECTS OF MARIHUANA LAST?

This depends upon the dose and the person. A few inhalations of strong marihuana can intoxicate a person for several hours. Weak marihuana will produce maximal effects for a short period of time. When a large amount is swallowed, the effects start later but persist longer than when the same quantity is smoked.

HOW DOES MARIHUANA WORK IN THE BRAIN?

This is not known. Studies attempting to clarify the question are underway.

DOES THE INDIVIDUAL'S TOLERANCE TO MARIHUANA VARY WITH REPEATED USE?

The development of tolerance to marihuana does not occur. Some people speak of "reverse tolerance." By that they mean that a person may require less marihuana in order to reach a specific "high." This is basically a matter of learning how to smoke the drug, and of learning what effects to look for.

DO HEAVY USERS SUFFER PHYSICAL WITHDRAWAL SYMPTOMS LIKE THE NARCOTIC ADDICT?

No. Sudden withdrawal may provoke restlessness and anxiety in a few persons who daily smoke large amounts of hashish, but true withdrawal symptoms as seen in the heroin addict do not develop.

WHAT ARE THE LONG-TERM PHYSICAL EFFECTS OF EXTENDED MARIHUANA USE?

These are not precisely known. Extensive scientific research is underway to answer this most important question.

WHAT ARE THE PSYCHOLOGICAL EFFECTS OF MARIHUANA?

The psychological effects of marihuana are variable. They include distortions of hearing, vision and sense of time. Thought becomes dream-like. The belief that one is thinking better is not unusual. Performance may be hampered or unchanged. Illusions (misinterpretation of sensations) are often reported, but hallucination (experiencing non-existent sensations) and delusions (false beliefs) are rare. Unfounded suspicion may occur, and this may be accompanied by anxiety. More often the feeling is one of a passive euphoria or "high." The individual tends to withdraw into himself. Occasionally, uncontrollable laughter or crying may occur.

WHAT KINDS OF EMOTIONAL PROBLEMS CAN THE MARIHUANA USER HAVE?

Anxiety reactions and panic states have been noted. Accidents have occurred due to impaired judgment and time-space distortions. The user, especially if he is inexperienced, may become excessively suspicious of people and take action that leads to injury. A toxic psychosis consisting of mental confusion, loss of contact with reality, and memory disturbances has been recorded.

The effects of prolonged use are not scientifically known. In those countries where *cannabis* use has been traditional, excessive amounts are claimed to induce loss of motivation, apathy, memory difficulties and loss of mental acuity. Reports of psychotic breakdowns from the extended use of marihuana are frequently found in the medical literature of the Near and Middle East, but these require further scientific investigation.

DOES THE HEAVY USE OF MARIHUANA AFFECT THE PERSONALITY DEVELOPMENT OF THE YOUNG PERSON?

It can. By making marihuana use a career, the young person avoids normal life stresses and the problems that are an intrinsic part of growing up. He therefore misses the opportunity to mature to his full physical and mental potential. In addition, the developing personality is known to be susceptible to the effects of all mind-altering substances.

DOES MARIHUANA LEAD TO INCREASED SEXUAL ACTIVITY?

Marihuana has no known aphrodisiac property. At various times in the past, both promiscuity and impotence have been attributed to the use of marihuana without scientific basis for either allegation.

WHY DO PEOPLE CONTINUE TO USE MARIHUANA?

The consistent user, the "pothead," is likely to be emotionally disturbed, according to many studies of this group. He is using the drug to treat his personality problems.

HOW MUCH MARIHUANA IS BEING USED IN THIS COUNTRY?

The use of marihuana is increasing. In a recent nationwide survey, 4 percent of those queried responded affirmatively to the question, "Have you ever used marihuana?" That would mean that more than 8 million people have tried the drug. Twelve percent of the young people indicated that they have tried it. Exact statistics are difficult to obtain because of the legal penalties.

In college surveys, two-thirds of those who said that they had tried the drug did so less than a dozen times. Another quarter are occasional users, and the rest—less than 10 percent—may be considered daily or heavy users.

WHY ARE SO MANY ADOLESCENTS EXPERIMENTING WITH MARIHUANA NOW?

In part this is because marihuana is "in." Peer group pressures have led many to try "pot." Some use it as an act of defiance. Some are curious. While most adolescents do not continue using the drug, 5 to 10 percent become heavy, daily users.

HOW ARE TEENAGERS INTRODUCED TO MARIHUANA?

In general, adolescence are introduced to marihuana by others in their group. There is little evidence to confirm the belief that "pushers" need to "turn on" a novice. His "friends" do it for him.

Heavy marihuana users may go on to more dangerous drugs as a result of group pressures or of their own volition. Occasionally, a "pusher" will persuade the buyer to try a more dangerous drug.

HOW DOES MARIHUANA GET ONTO THE BLACK MARKET?

Although truckload lots are sometimes detected, most marihuana smuggling and sales are small-time operations of a few pounds or less. Organized criminal syndicates have not been involved to date. About 80 percent of the marihuana comes in from Mexico. The rest is acquired locally. Hashish is made in the Near East and is smuggled into the U.S. Young people themselves account for most acquisition and sales, according to the Bureau of Narcotics and Dangerous Drugs.

WHAT IS THE RELATIONSHIP BETWEEN MARIHUANA AND CRIMINAL OR VIOLENT BEHAVIOR?

Any drug that loosens self-control may contribute to criminal behavior. Persons under the influence of marihuana tend to be passive, although some crimes have been committed by persons while they were "high." The personality of the user is as important as the type of drug in determining whether chemical substances lead to criminal or violent behavior.

CAN ONE SMOKE A LITTLE MARIHUANA, EQUIVALENT TO A DRINK OF ALCOHOL, AND NOT BECOME INTOXICATED?

Some people familiar with the drug are able to control its effects to permit only a feeling of relaxation. However, the usual intent of the user is to become "stoned." As a rule, either no effect or an intoxicating effect is obtained from the use of marihuana.

IS MARIHUANA LESS HARMFUL THAN ALCOHOL?

The results of intoxication by both drugs can be harmful.

We know that alcohol is a dangerous drug physically, psychologically or socially for millions of people. There is no firm evidence that marihuana would be less harmful if used consistently. In countries where alcohol is forbidden by religious taboo, skid rows based on marihuana exist. The "rumhead" and the "pothead" are both unenviable creatures.

IF ALCOHOL IS LEGAL, WHY NOT MARIHUANA?

It would seem more logical to deal with our millions of alcoholics than to add another mind-altering chemical to our existing problem. Whether another intoxicant should be accepted into the culture is the question.

Only during the past 3 years has the sophisticated, scientific study of marihuana been underway. It would seem prudent to await the results of ongoing and planned studies before treating marihuana as we do alcohol.

DOES MARIHUANA HAVE ANY MEDICAL USES?

Marihuana has no approved medical use in the U.S. Some researchers are attempting to determine whether THC may have appetite-enhancing, anticonvulsant, or antidepressant capabilities.

WHAT RESEARCH IS BEING DONE ON MARIHUANA?

A considerable amount of research with marihuana and THC is underway or planned. These investigations will help provide answers to many questions about the drug.

With the recent availability of synthetic THC and the ability to determine the amount of THC in marihuana, it is now feasible to know the exact quality of the substance being studied. This permits precise analysis that was not possible before in such ways as the following:

1. An examination of the changes that occur in the body when marihuana is smoked, as well as the observation of the metabolic changes that take place in THC.
2. The labelling of THC with radioactive material in order to learn the distribution and excretion of the drug.
3. The effect of marihuana on the chemical components of the brain and other tissues.
4. A testing of the acute and chronic toxicity of marihuana.
5. Research to discover the physiological and psychological changes in man caused by varying doses of marihuana. This ranges from studying brain-wave patterns to testing a subject's ability to perform complex tasks.
6. An examination of the effects of THC and other marihuana components upon chromosomes.

To determine the effects of the long-term use of marihuana more accurately, negotiations are now underway with qualified scientists in countries where the use of the drug has been customary for years. Groups of long-term, daily users will be compared with matched groups of nonusers. The results of physical and psychological examinations will be studied for the two groups.

IS THERE ANYTHING IN MARIHUANA THAT LEADS TO THE USE OF OTHER DRUGS?

There is nothing in marihuana itself that produces a need to use other drugs. Most marihuana smokers do not progress to stronger substances. Some do. Surveys supported by the National Institute of Mental Health show that the "pothead" does tend to experiment with other drugs. Hashish is frequently tried, and large numbers of "potheads" later use strong hallucinogens, amphetamines, and, occasionally, barbiturates. Some try opium and heroin.

In one college survey, 1 percent of the "potheads" became addicted to opium heroin. In surveys of heroin addicts, 85 percent had previously tried marihuana, but a still larger percentage had used alcohol before heroin.

It appears that the person who becomes seriously overinvolved with any drug is likely to have the emotional need to seek other kinds of drugs and to try them repetitively.

QUESTIONS ABOUT HALLUCINOGENS

WHAT ARE HALLUCINOGENS?

Hallucinogens (also called psychedelics) are drugs capable of provoking changes of sensation, thinking, self-awareness and emotion. Alterations of time and space perception, illusions, hallucinations and delusions may be either minimal or overwhelming depending on the dose. The results are very variable; a "high" or a "bad trip" ("freakout" or "bummer") may occur in the same person on different occasions.

LSD is the most potent and best-studied hallucinogen. Besides LSD, a large number of synthetic and natural hallucinogens are known. Mescaline from the peyote cactus, psilocybin from the Mexican mushroom, morning glory seeds, DMT, STP, MDA and dozens of others are known and abused. Along with its active component THC, marihuana is medically classified as an hallucinogen.

IS IT TRUE THAT ANY DRUG WILL MAKE YOU HALLUCINATE IF TAKEN IN SUFFICIENT AMOUNTS?

Many drugs will cause a delirium, accompanied by hallucinations and delusions, when taken by people who are hypersensitive to them. Extraordinarily large amounts of certain drugs may also produce hallucinations. However, the mind-altering drugs are much more likely to induce hallucinations because of their direct action on the brain-cells.

WHAT IS LSD?

Lysergic acid comes from ergot, the fungus that spoils rye grain. It was first converted in 1938 to lysergic acid diethylamide (LSD) by the Swiss chemist, Albert Hoffman, who accidentally discovered its mind-altering properties in 1943.

WHAT ARE THE IMMEDIATE PHYSICAL EFFECTS OF LSD?

A person who has consumed LSD will have dilated pupils, a flushed face, perhaps a rise in temperature and heartbeat, a slight increase in blood pressure, and a feeling of being chilly. A rare convulsion has been noted. These effects disappear as the action of the drug subsides.

WHAT IS THE LSD STATE LIKE?

The LSD state varies greatly according to the dosage, the personality of the user and the conditions under which the drug is taken. Basically it causes changes in sensation. Vision is most markedly altered. Changes in depth perception and the meaning of the perceived object are most frequently described. Illusions and hallucinations can occur. Thinking may become pictorial and reverie states are common. Delusions are expressed. The sense of time and of self are strangely altered. Strong emotions may range from bliss to horror, sometimes within a single experience. Sensations may "crossover," that is, music may be seen or color heard. The individual is suggestible and, especially under high doses, loses his ability to discriminate and evaluate his experience.

WHAT IS A "GOOD TRIP"? A "BAD TRIP"?

In the parlance of the LSD user, the "good trip" consists of pleasant imagery and emotional feelings. The "bad trip" or "bummer" is the opposite. Perceived images are terrifying and the emotional state is one of dread and horror.

WHAT ARE SOME OF THE MORE HARMFUL EFFECTS OF LSD?

During the LSD state, the loss of control can cause panic reactions or feelings of grandeur. Both have led to injury or death when the panic or the paranoia was acted upon.

The prolonged reactions consist of anxiety and depressive states, or psychotic breaks with reality which may last from a few days to years.

WHAT IS A "FLASHBACK"?

A "flashback" is a recurrence of some of the features of the LSD state days or months after the last dose. It can be invoked by physical or psychological stress, or by medications such as antihistamines, or by marihuana.

Those individuals who have used LSD infrequently rarely report flashbacks; intensive use seems to produce them more frequently. Often a flashback occurring without apparent cause can induce anxiety and concren that one is going mad. This can result in considerable fear and depression and has been known to culminate in suicide.

CAN LSD DAMAGE CHROMOSOMES?

A number of reputable scientists have reported chromosomal fragmentation in connection with LSD exposure in the test tube, in animals, and in man. A similar number of equally capable scientists have been unable to confirm these findings. The question whether LSD itself can induce congenital abnormalities remains unresolved. Further work is continuing and will clarify this question.

IS THERE ANY EVIDENCE THAT HEAVY LSD USE CAUSES BRAIN CELL CHANGES?

In experiments designed to answer this question, some changes in mental functions have been detected in heavy users, but they are not present in all cases.

Heavy users of LSD sometimes develop impaired memory and attention span, mental confusion, and difficulty with abstract thinking. These signs of organic brain changes may be subtle or pronounced. It is not known whether these alterations persist or whether they are reversbile if the use of LSD is discontinued.

ARE PEOPLE MORE CREATIVE UNDER OR AFTER LSD?

People who have taken LSD feel more creative. Whether they actually are or not is difficult to determine. In studies done to compare individuals' creative capabilities before and after LSD experiences, it was found that no significant changes had occurred. Creativity might conceivably be enhanced in a few instances, but it is diminished in others because LSD may reduce the motivation to work and execute creative ideas.

IS THE LSD STATE LIKE THE MYSTICAL STATE?

The transcendental or mystical state includes feelings of wonder or ecstasy, a sense of perceiving beauty, the absence of rational thought, a sense of discovering great meaning. Many of these phenomena can be mimicked by the LSD state, which is why it has been called a "religious" drug. The LSD-induced mystical state differs as significantly from the natural one as an artificial pearl from the real thing.

DO YOU REALLY GET TO KNOW YOURSELF AFTER LSD?

The *illusion* that one obtains insights about one's personality and behavior while under LSD may occur. From an analysis of these "insights" and of subsequent behavior, it is doubtful that true insights happen with any regularity.

WHY WOULD ANYBODY TRY A DRUG LIKE LSD?

People give many reasons for trying LSD, ranging from curiosity to a desire to "know oneself." The overwhelming majority of people take the drug for the "high"—to feel better. This may be because they are unable to deal with life's frustrations, or feel alienated. If the LSD state were not accompanied by a "high," it would never have become popular.

WHAT PERCENTAGE OF STUDENTS HAVE TRIED LSD?

Most surveys indicate that about 4 percent of college students have tried LSD at least once. This figure has remained relatively stable for the past three years. However, numbers of high school and junior high school students are known to have tried this drug recently.

IS THE USE OF LSD INCREASING?

The use of LSD has levelled off and may be decreasing. Although some very young people are turning to LSD, a number of the older users are discontinuing its use. This shift is probably due to the growing knowledge of the side effects, the "flashbacks," the possibility of chromosomal changes, or imply because the users finally have come to recognize the illusory nature of the LSD experience.

WHAT HAVE WE LEARNED FROM LSD?

LSD is the most potent of all hallucinogenic substances used by man. A minute amount reaching the brain produces striking effects on mental functioning.

From research with LSD we have gained much basic information about the nature of brain cell transmission, and how distortion of the chemical mediators of transmission can result in disruptive mental functioning. Experiments that have sought to find a use for this unusual chemical have been inconclusive. It has been tried for the severe alcoholic, in certain character disorders, in childhood autism and as an aid to psychotherapy. At present no medical usefulness has been found.

IS MUCH RESEARCH GOING ON USING LSD?

More than 300 investigators have been given supplies of this drug through the National Institute of Mental Health to carry out research in the past three years. Considerable important work is continuing.

WHAT IS THE SOURCE OF ILLICIT LSD?

Almost invariably, illicit LSD comes from clandestine laboratories or is smuggled in from abroad. The precursors, lysergic acid and lysergic acid amide, can be converted into lysergic acid diethylamide (LSD) by a proficient chemist who has a reasonably well-equipped laboratory.

When obtained from illicit sources, the quality of LSD varies. Some LSD is fairly pure; other samples contain impurities and adulterants. The amount contained in each capsule or tablet usually differs greatly from the amount claimed by the "pusher." The user has no way of knowing the quality or the quantity of his LSD.

QUESTIONS ABOUT STIMULANTS

WHAT IS A STIMULANT?

Stimulants are drugs, usually amphetamines, which increase alertness, reduce hunger and provide a feeling of well being. Their medical uses include the suppression of appetite and the reduction of fatigue or mild depression.

Many stimulants are know, including: cocaine, amphetamine (Benzedrine "bennies"), dextroamphetamine (Dexedrine "dexies") and methamphetamine (Methedrine). The latter drug is commonly called "speed" or "crystal." Stimulants are also known as "uppers" or "pep pills."

HOW DO AMPHETAMINES WORK?

According to current research findings, amphetamines increase the availability of noradrenaline at the nerve cell connections. This is particularly true in areas of the brain associated with vigilance, heart action, and mood. Excessive stimulation of these brain cells is normal under emergency life conditions, but when it is prolonged by amphetamines, undesirable secondary changes develop.

HOW ARE STIMULANTS TAKEN?

Usually stimulants are taken by mouth in the form of capsules or tablets. Crystal methamphetamine and cocaine can be inhaled or "snorted" through the nose.

They can also be injected into veins, in which case the effects are immediate and more intense.

HOW MANY PEOPLE ARE ABUSING AMEPHETAMINES?

The exact number of amphetamine abusers is unknown, but the abuse of very large quantities of amphetamines is increasing. The drug-using subcultures, such as Haight-Ashbury in San Francisco, are now essentially "speed" subcultures. The abuse of amphetamines in weight-reducing pills is also on the rise. Approximately 10 billion amphetamine pills are legitimately manufactured every year, and a large amount of these will be diverted into illegal channels. Many illicit laboratories that manufacture stimulants have been discovered and seized.

WHAT ARE THE VARIOUS TYPES OF STIMULANT ABUSE?

There is the occasional user who takes the drug to exert himself beyond his physiological limits. He may want to stay awake to drive, excel in an athletic contest, or cram for an examination. This type of abuse rarely leads to difficulties, but it may. Instances of death during athletic contests have been traced to amphetamine use.

A second type of abuse is taking 75–100 mg. per day (the average dose is 15–30 mg.) for long periods of time. These individuals are drug-dependent.

A relatively new type of abuse involves the injection of massive doses intravenously once or a dozen times a day. This produces practically the same effects as cocaine. These users are referred to as "speed freaks."

WHAT EFFECTS DO AMPHETAMINES HAVE?

In ordinary amounts the amphetamines provide a transient sense of alertness and well being. Hunger is diminished, and short-term performance may be enhanced in the fatigued person.

When amphetamines are taken intravenously in large amounts, an ecstatic "high" occurs which decreases over a few hours. Re-injection is then necessary to reproduce the stimulation. This cycle can go on for days until the person is physically exhausted. Shakiness, itching, muscle pains, and tension states are common. Collapse and death have occurred.

Upon withdrawal the "speed freak" feels terribly depressed and lethargic. Re-injection of amphetamines relieves these symptoms. Since tolerance to high doses develops and withdrawal symptoms occur, large amounts of amphetamines are considered physically addicting. Small amounts are psychologically habituating.

WHAT ARE THE PHYSICAL COMPLICATIONS OF AMPHETAMINE ABUSE?

In addition to those diseases which accompany the unsterile injection of material into the body, the excessive amounts of amphetamines can cause certain medical problems. Liver damage may result from the enormous quantities being taken. Brain damage from such quantities has been demonstrated in animals. Abnormal rhythms of the heart have occurred, and a marked increase in blood pressure is well known.

Neglect of personal hygiene can lead to skin infections or dental decay. Drastic weight loss, and malnutrition and vitamin deficiencies are part of the list of adverse physical complications.

WHAT ARE THE PSYCHIATRIC COMPLICATIONS OF AMPHETAMINE ABUSE?

While under the influence of large amounts of amphetamines, the individual may become overactive, irritable, talkative, suspicious and sometimes violent. He reacts impulsively. This combination can lead to belligerent or homicidal behavior.

There is a deterioration of all social, familial and moral values. Like the heroin addict, the "speed freak" will do anything to obtain his supplies.

The paranoid psychotic state can last long beyond the period of drug activity and resembles paranoid schizophrenia.

WHAT CAN BE DONE ABOUT THE "SPEED" PROBLEM?

The elimination of the large-scale illicit supplies and better controls over legitimate production are part of the answer. In addition, the consequences and

complications must be made known as widely as possible. The user needs skilled treatment. It is likely that only the very disturbed person will become involved in the "speed" scene if the known effects of taking the drug are properly disseminated.

ARE THERE ANY SPECIAL DIFFICULTIES IN THE TREATMENT OF STIMULANT ABUSERS?

The "speed freak" is a difficult patient to rehabilitate. Although he may want to stop using the drug, his "high" is so intense that he is attracted to the enormous euphoria that he obtains from the chemical. Persons who seem to have broken the speed habit often relapse.

Treatment may require the close support of the user's friends and family, plus medical and psychological help. In some cases, closed-ward hospitalization may be necessary. One of the more successful forms of treatment is group therapy in which ex-users interact with "speed freaks." Those who have come through the "speed" scene are trusted, and their counsel is likely to be accepted by the person who wants to stop his destructive use of the drug.

WHY HAS SWEDEN VIRTUALLY ABOLISHED THE MEDICAL USE OF AMPHETAMINES?

Sweden has a major problem with the amphetamine-like substance, phenmetrazine (Preludin). It was introduced as a "safe" weight reducing pill, but for the past 10 years its illicit use has been increasing. It is estimated that about 10,000 people (Sweden has a population of 8 million) use large amounts of this drug, most of it by intravenous injection.

At present only those few cases which are approved by a special commission can be legally treated with amphetamines. Despite this cutoff of legitimate supplies, the problem continues. Illegal laboratories still provide the material, and much is brought in from other countries where it is readily available.

Questions About Sedatives

WHAT ARE SEDATIVES AND TRANQUILIZERS?

Sedatives induce sleep. When taken in small doses they reduce daytime tension and anxiety. The barbiturates constitute the largest group of sedatives. When used without close supervision, the possibility of taking increased amounts and becoming dependent are present. In street parlance, the sedatives are also called "goof balls," "sleepers," and "downers."

The tranquilizers are drugs that calm, relax and diminish anxiety. Like sedatives, they may cause drowsiness. Tranquilizers that are used to treat serious mental disorders are not dependency producing. It is tranquilizers like meprobamate (Miltown, Equinil) to which dependence can be developed.

ARE SEDATIVES PHYSICALLY ADDICTING?

Yes. Tolerance to the effects of barbiturates develops and withdrawal effects occur when the drug is stopped. A strong desire to continue taking the drug is present after a few weeks on large amounts. Addiction to 50 or more sleeping pills a day has been reported.

ARE BARBITURATES THE ONLY GROUP OF SEDATIVES WITH DANGER OF ADDICTION?

No. Other addicting sedatives include glutethimide (Doriden), chloral hydrate and many others. Everything that is said about the barbiturates can be applied to the non-barbiturate sedatives.

WHO ARE THE ABUSERS OF BARBITURATES?

People who have difficulty dealing with anxiety, or who have troubles with insomnia may become overinvolved with sedatives or tranquilizers and come to depend on them.

Barbiturates are taken by some heroin users either to supplement the heroin or substitute for it.

People under excessive stress, or those who cannot tolerate ordinary stress, are vulnerable. A few years ago sedatives were drugs of abuse for adults. Now they are being consumed more and more frequently by teenagers and preteenagers.

Persons who take amphetamines and become jittery might also take barbiturates to ease their tension.

WHAT ARE THE MEDICAL USES FOR SEDATIVES?

In addition to inducing sleep and relaxing tensions, barbiturates are used for psychosomatic conditions such as high blood pressure and peptic ulcers. One barbiturate, phenobarbital, is useful as an anticonvulsant.

WHAT HAPPENS IF A BARBITURATE ABUSER SUDDENLY STOPS TAKING THE DRUG?

If the barbiturate dependence is severe, sudden discontinuance of the drug can be dangerous. A severe withdrawal state resembles delirium tremens. The patient is sweaty, fearful, sleepless and tremulous. He is restless, agitated, and may suffer convulsions. In addition, he may see things that aren't there and have delusional, confused thoughts. The amount of barbiturates must be slowly decreased; the patient requires considerable medical and nursing support.

Sudden barbiturate withdrawal is an acute medical emergency requiring hospitalization and intensive care.

ARE SEDATIVES TAKEN IN LARGE QUANTITIES DANGEROUS?

Yes. The most common mode of suicide with drugs is with sleeping pills. Accidental deaths due to taking a larger number than intended are not uncommon. In the latter instance, the person takes one or two pills at bedtime, falls asleep and then awakens. Not remembering that he has taken his sleeping medicine, he takes some more. If this is repeated a few times during the night a poisonous overdose may be consumed.

DO PEOPLE FALL ASLEEP WHEN THEY TAKE LARGE AMOUNTS OF SEDATIVES CONTINUALLY?

Ordinarily they go into a coma. If they are tolerant to large amounts, they may remain awake and appear intoxicated. Speech and movements may be uncoordinated. Skilled tasks are performed sluggishly and without precision. Judgment and perception are impaired. Confusion, slurred speech, irritability, and an unsteady gait are often seen in chronic users.

HOW CAN ONE BREAK A LARGE SEDATIVE "HABIT"?

This should be done with the help of a physician. Sometimes hospitalization is necessary. Gradual reduction is safer than abrupt discontinuance.

IS IT TRUE THAT SOME PEOPLE ABUSE SEDATIVES AND STIMULANTS SIMULTANEOUSLY?

Yes. Although the two types of drugs have opposite actions, some individuals become dependent upon the combinations. It might be imagined that an "upper" would completely neutralize a "downer," but this is not so. A desirable feeling is obtained, and large numbers of such combinations may be swallowed habitually.

IS IT TRUE THAT THE COMBINATION OF SLEEPING PILLS AND ALCOHOL IS DANGEROUS?

Yes. Taken together, less than lethal doses of alcohol and sleeping pills may be fatal. The person who is drunk may take a few barbiturate capsules and not survive. Barbiturates when taken with narcotics, anesthetics, and tranquilizers may also be fatal.

QUESTIONS ABOUT NARCOTICS

WHAT IS A NARCOTIC

A narcotic is a drug that relieves pain and induces sleep. The narcotics, or opiates, include opium and its active components, such as morphine. They also include heroin, which is morphine chemically altered to make it about six times stronger. Narcotics also include a series of synthetic chemicals that have a morphine-like action.

WHICH NARCOTICS ARE SIGNIFCANTLY ABUSED?

Heroin accounts for 90 percent of the narcotic addiction problem. It is not used in medicine, and all heroin in the U.S. is smuggled into the country. Morphine, methadone, and meperidine are used medically and are infrequently seen on the black market. Paregoric and cough syrups containing codeine are also abused.

IS NARCOTICS ADDICTION INCREASING?

As of December 31, 1968, the Bureau of Narcotics and Dangerous Drugs reported 64,011 narcotic addicts in the United States. This is an increase of 2,000 (3 percent) over the previous year. These figures include only those addicts who have been reported to the Bureau. The reporting system is voluntary on the part of the reporting agency and, as such, is not all inclusive. The New York State Narcotic Control Commission reports about 60,000 narcotic addicts in New York alone. The heroin abuse problem has been increasing since World War II and it continue to increase. Perhaps the most realistic estimate of the number of opiate addicts in the country is between 100,00 and 200,000.

WHY DO PEOPLE TAKE OPIATES?

People in physical or psychological pain may turn to heroin for relief, especially if their ability to endure distress is low. Many are introduced to the drug by "friends." Some youngsters mimic the behavior of grownups who are addicted. Certain addicts derive gratification from turning others on.

Many believe, "It can't happen to me." They think they can use heroin occasionally and not get hooked. These are often weekend "joy poppers." A good number of these individuals end up addicted.

Young males from minority groups who live in central city areas are most likely to become addicts. There is evidence that some middle-class youngsters in the drug-using communities have begun to abuse heroin. A small number of doctors and nurses who have the drugs available have become addicted.

WHAT DOES THE HEROIN ADDICT LOOK LIKE?

He may appear normal. Some of the acute symptoms associated with heroin are sniffling, flushing, drowsiness and constipation. Very contracted pupils are typical of opiate use. Some addicts may have an unhealthy appearance because of poor food intake and personal neglect, Venereal disease among female addicts is not uncommon.

Heroin addicts appear at hospitals with blood infections, hepatitis, symptoms of overdose and, more rarely, lockjaw.

Fresh needle marks and "tracks" (discoloration along the course of veins in the arms and legs) are detectable during an examination.

A sample of the addict's urine will reveal heroin or quinine. Barbiturate and amphetamine abuse can also be detected by urine testing.

CAN A PERSON FUNCTION WHILE ON NARCOTICS?

If the person is tolerant to an opiate he can usually function satisfactorily. This assumes that he is on a constant dosage level, and that his body's reaction to the drug is minimal. It merely keeps him comfortable.

This ability to perform, stay awake and alert after being kept on a maintenance level has been demonstrated with the methadone maintenance treatment. An occasional person will be drowsy.

WHAT IS IT LIKE TO TAKE A SHOT OF HEROIN?

Generally, there is a feeling of relaxation and of being "high." This is accompanied by an "awayness" or pleasant, dreamlike state.

As tolerance develops, the "high" is generally lost. The addict then requires heroin to avoid the withdrawal sickness. In other words, at this point he is using heroin to feel normal.

WHAT ARE THE PHYSICAL DANGERS OF ADDICTION?

The physical complications are many and some are life endangering. An overdose, resulting in death, occurs when someone has lost or never developed toler-

ance because he was using very diluted heroin. If, by chance, he obtains pure heroin, he may die moments after injection.

Infections from unsterile solutions, syringes, and needles cause many bacterial diseases. Viral hepatitis can be epidemic among addicts. Skin abscesses, inflammation of the veins and congestion of the lungs are further complications. Venereal diseases, tuberculosis and pneumonia are not uncommon.

The life expectancy of the addict is much lower than that of the non-addict. Addicts of both sexes are less fertile, and infants born of addict mothers may suffer withdrawal symptoms.

WHAT ARE WITHDRAWAL SYMPTOMS LIKE?

When addiction exists, stopping the drug provokes withdrawal sickness some 12 to 16 hours after the last injection. The addict yawns, shakes, sweats, his nose and eyes run, and he vomits. Muscle aches and jerks ("kicking the habit") occur along with abdominal pain and diarrhea. Chills and backache are frequent.

Hallucinations and delusions can develop, and these are usually terrifying. An injection of an opiate brings about immediate relief.

WHAT ARE THE PSYCHIATRIC COMPLICATIONS OF NARCOTIC ADDICTION?

The life of the narcotic addict is deplorable. His waking existence is centered around obtaining money to buy heroin ("hustling"), making a connection with a pusher ("copping"), and trying to avoid withdrawal.

The activities that an addict will resort to in order to obtain heroin are harmful to himself and those around him. He may steal from his loved ones, double-cross his best friend, or pander his wife. It is obvious that a career of heroin addiction must lead to personality decay and seriously impair emotional maturation.

IS THERE AN ADDICTIVE PERSONALITY?

It has been demonstrated that anyone can become addicted if he takes opiates regularly for a few weeks. Even animals can become addicted. However, certain kinds of people are more likely to become involved with heroin than others under similar life situations. These individuals have a low frustration tolerance and great dependency neeeds. Impulsive, immature, inadequate individuals are likely candidates. Many are "now" oriented, seeking the immediate "high" without regard to future consequences. Some have a character disorder that permit deviant behavior without guilt feelings.

Should a reasonably mature, stable person become addicted, the prospects of his rehabilitation are much better than those of the immature, unstable addict.

WHAT TREATMENT PROCEDURES ARE AVAILABLE TO THE HEROIN ADDICT?

"Once an addict, always an addict" is simply untrue. Many treatment procedures are possible for the heroin user. Ex-addict self-help groups have been useful for some. Others have benefitted from methadone maintenance. This consists of the substitution of methadone, a narcotic, under close supervision. If the patient on methadone takes heroin he will notice no effect from it because of cross tolerance. Another approach uses cyclazocine, a narcotic antagonist, not a narcotic. If heroin is taken after cyclazocine, no effect is noted.

Taking the addict off heroin is not too difficult, but keeping him off is. He usually needs counselling, job training and other rehabilitative efforts. The Federal Government and some States have civil commitment and voluntary rehabilitation programs. Many more narcotic addict rehabilitation centers are coming into existence at the community level. At these centers the addict seeking help can be given all the rehabilitation assistance he needs.

IS THERE A RELATIONSHIP BETWEEN HEROIN AND CRIME?

Many addicts had criminal records before they became addicted. Nevertheless, a direct relationship between the addicted person and criminal activity does exist because of the need for large sums of money in order to support his "habit." Shoplifting, pimping, prostitution, peddling heroin, and car theft are some of the crimes to which the addict resorts. When he is feeling symptoms of withdrawal, he may commit more violent crimes in order to obtain his drug.

Addicts who are sufficiently affluent to buy heroin will not commit criminal acts. The opiate state is one of passivity rather than aggression.

WHAT ARE THE ORGANIZED CRIME ELEMENTS THAT DEAL IN NARCOTICS AND DANGEROUS DRUGS?

Trafficking in heroin is usually undertaken by the organized criminal elements based in major metropolitan areas throughout the country. These organizations have the manpower, financial ability, and international connections with which to procure and successfully smuggle large quantities of heroin into the United States from France and other countries. To a lesser extent, numerous individuals and independent groups smuggle illicitly produced Mexican heroin in small quantities across the Mexican border.

WHAT IS THE QUALITY OF HEROIN BOUGHT ON THE STREET?

Heroin is invariably diluted with milk sugar, quinine, or other materials. Capsules or cellophane "bags" which may vary from 0 to 10 percent heroin are sold to users for $2 to $10. The material is unsterile. Some of the heroin has been "cut" so much that the addict has a "needle habit," not a heroin "habit." A "needle habit" is one in which the user obtains gratification from hustling for narcotics and injecting himself with the material even thought it contains little or no heroin.

WHAT ABOUT THE "BRITISH SYSTEM" OF DEALING WITH HEROIN ADDICTION?

Until recently, English heroin addicts were able to obtain heroin by prescription after registering with a physician. During the past decade, however, the number of known heroin addicts rose from a few hundred to several thousand. The number of known addicts under 20 years of age increased from one in 1960 to 1,016 in 1969. (These figures are regarded as underestimates, since many addicts do not come to official attention.)

As a result of this increase, the "system" was changed in 1968. British physicians can no longer prescribe heroin. Instead, rehabilitation centers have been established for the treatment of drug addicts. In cases where total abstinence is not possible for an addict, some heroin or methadone may be prescribed. The British system is considered a failure and has been modified to meet the increasing problem of addiction. However, it has largely prevented the involvement of organized criminal elements in heroin traffic. At present, the illicit traffic consists of addicts selling their supplies to others.

Questions About Other Substances of Abuse

MODEL AIRPLANE GLUE, GASOLINE, PAINT THINNER AND OTHER VOLATILE SOLVENTS HAVE BEEN REPORTED AS ABUSABLE SUBSTANCES. WHAT ARE THEIR EFFECTS

These substances, which were obviously never meant to be taken by man, contain a variety of chemicals, some quite dangerous. Others are toxic only when used over long periods. They provide a clouded mental state that can develop into a coma. Temporary blindness has been reported. Death is known to occur when the solvent is inhaled without sufficient oxygen as, for example, when the individual loses consciousness and his mouth and nose fall into the plastic bag containing the solvents. Damage to bone marrow, kidneys and lungs has been described in autopsy reports.

CAN NUTMEG BE ABUSED?

If large amounts of nutmeg or mace are taken, they can induce a drunken, confused state. This requires a substantial quantity, which can irritate the kidneys. Abuse has been reported in immature adolescents, and in prisoners who have access to these spices while working in prison kitchens.

WHAT IS KNOWN ABOUT BELLADONNA AND JIMSON WEED ABUSE?

A large number of wild plants can cause delirium or death, depending upon the amount ingested. They include belladonna and Jimson weed (stramonium) which grow in many parts of the country. They have long been used as intoxicants; they were the constituents of the witches' brews of earlier days. The notion that witches flew on broomsticks was the result of the hallucinations of those under the influence of these powerful plants.

Dryness of the mouth and skin, a high fever and dilated pupils are characteristic of these weeds.

Asthmador is a drug that contains a combination of belladonna and stramonium and is prescribed as an asthma remedy. It, too, has been occasionally misused.

Drug Glossary

Acid: LSD, LSD–25 (lysergic acid diethylamide).
Acidhead: Frequent user of LSD.
Bag: Packet of drugs.
Ball: Absorption of stimulants and cocaine via genitalia.
Bang: Injection of drugs.
Barbs: Barbiturates.
Bennies: Benzedrine, an amphetamine.
Bindle: Packet of narcotics.
Blank: Extremely low-grade narcotics.
Blast: Strong effect from a drug.
Blue angels: Amytal, a barbiturate.
Blue velvet: Paregoric (camphorated tincture of opium) and Pyribenzamine (an antihistamine) mixed and injected.
Bombita: Amphetamine injection, sometimes taken with heroin.
Bread: Money.
Bum trip: Bad experience with psychedelics.
Bummer: Bad experience with psychedelics.
Busted: Arrested.
Buttons: The sections of the peyote cactus.
Cap: Capsule.
Chipping: Taking narcotics occasionally.
Coasting: Under the influence of drugs.
Cokie: Cocaine addict.
Cold turkey: Sudden withdrawal of narcotics (from the gooseflesh, which resembles the skin of a cold plucked turkey).
Coming down: Recovering from a trip.
Connection: Drug supplier.
Cop: To obtain heroin.
Cop out: Quit, take off, confess, defect, inform.
Crash: The effects of stopping the use of amphetamines.
Crash pad: Place where the user withdraws from amphetamines.
Crystal: Methedrine, an amphetamine.
Cubehead: Frequent user of LSD.
Cut: Dilute drugs by adding milk sugar or another inert substance.
Dealer: Drug supplier.
Deck: Packet of narcotics.
Dexies: Dexedrine, an amphetamine.
Dime bag: $10 package of narcotics.
Dirty: Possessing drugs, liable to arrest if searched.
Dollies: Dolophine (also known as methadone), a synthetic narcotic.
Doper: Person who uses drugs regularly.
Downers: Sedatives, alcohol, tranquilizers, and narcotics.
Drop: Swallow a drug.
Dummy: Purchase which did not contain narcotics.
Dynamite: High-grade heroin.
Fix: Injection of narcotics.
Flash: The initial feeling after injecting.
Flip: Become psychotic.
Floating: Under the influence of drugs.
Freakout: Bad experience with psychedelics; also a chemical high.
Fuzz: The police.
Gage: Marihuana.
Good trip: Happy experience with psychedelics.
Goofballs: Sleeping pills.
Grass: Marihuana.
H: Heroin.
Hard narcotics: Opiates, such as heroin and morphine.
Hard stuff: Heroin.
Hash: Hashish, the resin of Cannabis.

Hay : Marihuana.
Head : Person dependent on drugs.
Hearts : Dexedrine tablets (from the shape).
Heat : The police.
High : Under the influence of drugs.
Holding : Having drugs in one's possession.
Hooked : Addicted.
Hophead : Narcotics addict.
Horse : Heroin.
Hustle : Activities involved in obtaining money to buy heroin.
Hustler : Prostitute.
Hype : Narcotics addict.
Joint : Marihuana cigarette.
Jolly beans : Pep pills.
Joy-pop : Inject narcotics irregularly.
Junkie : Narcotics addict.
Kick the habit : Stop using narcotics (from the withdrawal leg muscle twitches).
Layout : Equipment for injecting drug.
Lemonade : Poor heroin.
M : Morphine.
Mainline : Inject drugs into a vein.
Maintaining : Keeping at a certain level of drug effect.
(The) Man : The police.
Manicure : Remove the dirt, seeds, and stems from marihuana.
Mesc : Mescaline, the alkaloid in peyote.
Meth : Methamphetamine (also known as Methedrine, Desoxyn).
Methhead : Habitual user of methamphetamine.
Mikes : Micrograms (millionths of a gram).
Narco : Narcotics detective.
Nickle bag : $5 packet of drugs.
O. D. : Overdose of narcotics.
On the nod : Sleepy from narcotics.
Panic : Shortage of narcotics on the market.
Pillhead : Heavy user of pills, barbiturates or amphetamines or both.
Pop : Inject drugs.
Pot : Marihuana.
Pothead : Heavy marihuana user.
Purple hearts : Dexamyl, a combination of Dexedrine and Amytal (from the shape and color).
Pusher : Drug peddler.
Quill : A matchbook cover for sniffing Methedrine, cocaine, or heroin.
Rainbows : Tuinal (Amytal and Seconal), a barbiturate combination in a blue and red capsule.
Red devils : Seconal, a barbiturate.
Reefer : Marihuana cigarette.
Reentry : Return from a trip.
Roach : Marihuana butt.
Roach holder : Device for holding the butt of a marihuana cigarette.
Run : An amphetamine binge.
Satch cotton : Cotton used to strain drugs before injection ; may be used again if supplies are gone.
Scag : Heroin.
Score : Make a purchase of drugs.
Shooting gallery : Place where addicts inject.
Skin popping : Injecting drugs under the skin.
Smack : Heroin.
Smoke : Wood alcohol.
Snorting : Inhaling drugs.
Snow : Cocaine.
Speed : Methedrine, an amphetamine.
Speedball : An injection of a stimulant and a depressant, originally heroin and cocaine.
Speedfreak : Habitual user of speed.
Stash : Supply of drugs in a secure place.
Stick : Marihuana cigarette.
Stoolie : Informer.
Strung out : Addicted.

Tracks: Scars along veins after many injections.
Tripping out: High on psychedelics.
Turned on: Under the influence of drugs.
Turps: Elixir of Terpin Hydrate with Codeine, a cough syrup.
25: LSD (from its orginal designation, LSD–25).
Uppers: Stimulants, cocaine, and psychedelics.
Weed: Marihuana.
Works: Equipment for injecting drugs.
Yellow jacket: Nembutal, a barbiturate.
Yen sleep: A drowsy, restless state during the withdrawal period.

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The CHAIRMAN. Without objection, the committee will recess until 2 o'clock this afternoon.

(Whereupon, at 12:10 p.m., the committee recessed to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Martha Griffiths presiding.)

Mrs. GRIFFITHS. This committee will come to order.

We are very happy to have you here, Congressman Pepper. You may proceed as you wish.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Thank you very much, Madam Chairman and members of the committee.

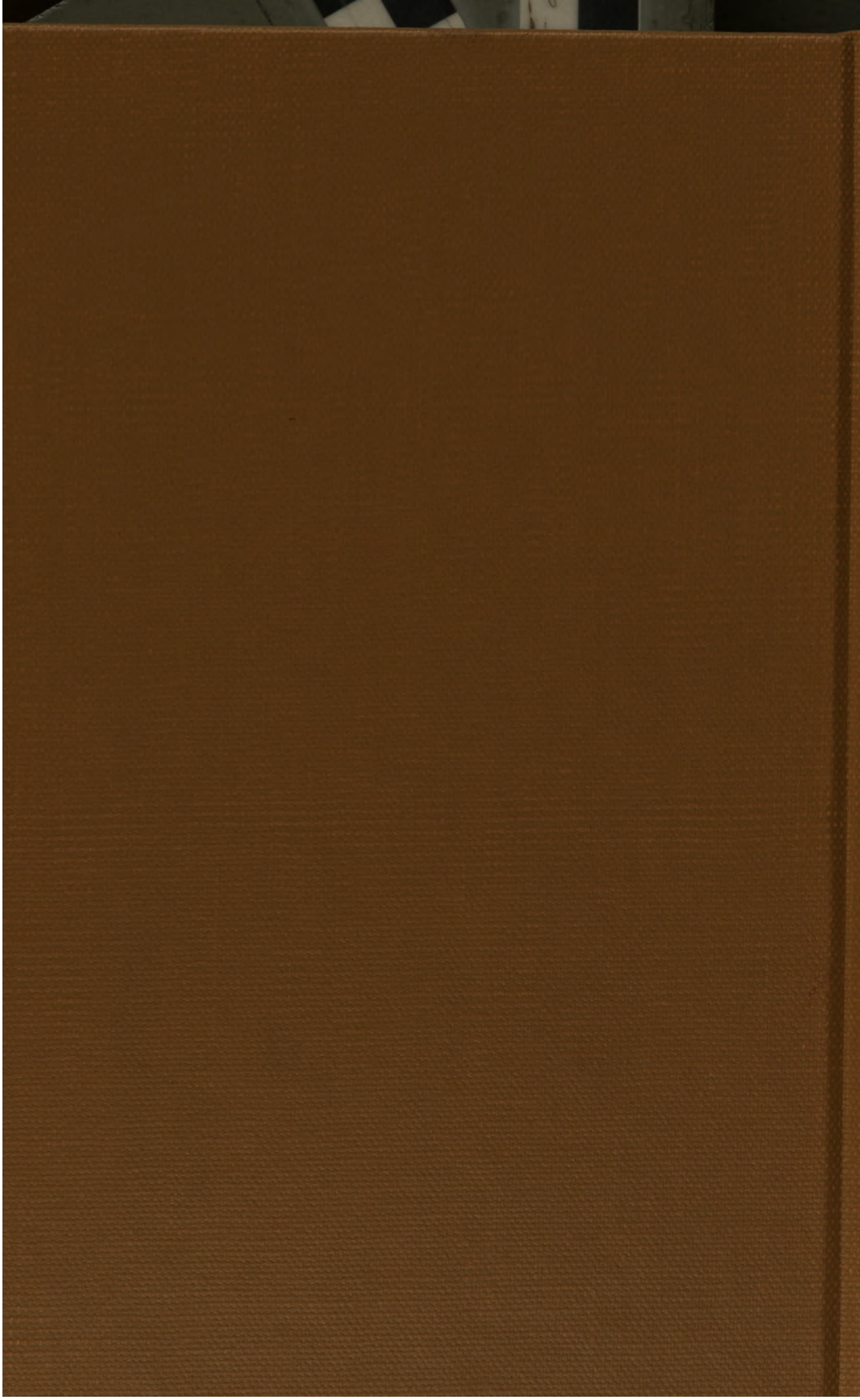
I thank you particularly for the opportunity and privilege to appear before your distinguished committee this afternoon.

On behalf of the Select Committee on Crime, I wish to say that we generally support the purposes and aims of H.R. 17463, introduced by your distinguished chairman, Mr. Mills, and the ranking Republican member of this committee, Mr. Byrnes.

As you perhaps know, in addition to holding hearings here on the Hill on a number of subjects, our committee has held a number of hearings in cities around the country. We have held hearings in Boston, Omaha, and Lincoln, Nebr., San Francisco, Columbia, S.C., Miami, Baltimore, New York City, and just last week for 2 days in Philadelphia, Pa.

Two weeks ago, several of my colleagues and I visited correctional institutions in five different States. In every city and correctional facility that we visited, it was conclusively shown with two exceptions, that the drug problem has grown in epidemic proportions within the last 2 to 3 years. Those two exceptions are San Francisco and New York City. San Francisco has been combating the dangerous drug problem for over 5 years. New York City, unfortunately, enjoys the distinction of being the heroin consumption and distribution capital of the world and has been for some time.

It is my understanding that dangerous drugs and most of the hallucinogens are not in principal consideration before the committee at this time. On March 2 of this year, I appeared before the Subcommittee on Public Health and Welfare of the Committee on Interstate



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