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Contemporary Problems of Drug Abuse - II. Saturday Morning

David F. Musto

Michael R. Sonnenreich

Thomas E. Bryant

James Markham

Jaffe, Dr. Palmer, and Mr. Meserve for showing their interest in your education by coming here.

I would like now to call upon Karen Dickie, President of The Media Guild of East Lansing, Michigan, who will introduce what I consider to be one of the finest media presentations that I have ever seen on drug abuse.

> [At this point, The Media Guild, Inc., of East Lansing, Michigan, offered the multi-media presentation "Any Drug Education Program that Talks Only about Drugs Is at Best . . . a Waste."]

II. SATURDAY MORNING

A. An Historical Perspective on Legal and Medical Responses to Substance Use.

MR. LEVIN: Ladies and gentlemen, we are fortunate to have Dr. David F. Musto, Associate Professor of History and Psychiatry at Yale University, with us this morning. Dr. Musto will give us an historical perspective on legal and medical responses to substance use in the United States. Much of his remarks have been taken from his book, *The American Disease: Origins of Narcotic Control.*

Dr. Musto is an historical consultant to the Special Action Office of Drug Abuse Prevention and a consultant to the National Commission on Marihuana and Drug Abuse. He is also a Fellow at the Drug Abuse Council in Washington, D.C. It is my pleasure to introduce Dr. Musto.

DR. DAVID F. MUSTO: Thank you, Mr. Levin.

Americans have sought for more than a century to control, through legal means, substances, like morphine, which the medical profession has agreed were hazardous. The cooperation of the medical and legal professions in the regulation or prohibition of certain drugs — opium, cocaine, alcohol, heroin, and cannabis — sheds great light on the role of those institutions in channelling public concern or fear into practical action. Both professions reveal themselves as closely in step with the prevailing current national fear and quite capable of reinforcing and implementing what, in hindsight, may appear as a distortion of reality. For example, some of the past events in American drug control which may now appear inexplicable can be understood if they are placed in historical context. We must rediscover the powerful reasons for the legal profession's ingenuity with such stumbling blocks as Constitutional separation of federal and state powers and examine the medical profession's often more than occasional willingness to

offer conclusions regarding social policy wrapped in its prestige and authority. Those conclusions ostensibly arising from medical science may often be revealed as personal opinons — sincere, to be sure, — which were strongly influenced by the same social forces that were simultaneously molding general public opinion, that they seemed to doctors to be scientific truths.

First, I would like to give some examples of legal and medical cooperation regarding widespread fear of certain substances. Then I will consider some of the reasons why such seemingly anomalous events were considered to be in the best interests of the nation, and fully justified in the opinion of the professions' leaders at the time. An examination of the context in which laws were passed, or control decisions made, illuminates the larger question of social control of deviance of which the control of dangerous substances is a part. The examples provide an historical dimension for considering current recommendations for action.

First, let us consider what was for 50 years the chief characteristic of American drug control — the federal policy against addiction maintenance. In 1919, two crucial Supreme Court decisions — *U.S. v. Doremus*[5] and *Webb v. U.S.*[6] — made almost all forms of addiction maintenance illegal. In effect, the decisions took away the physician's right to decide whether an opiate user with no other ailment should or could be maintained in his addictive state. Indeed, the decisions made such practice a considerable hazard to the practitioner. Much obloquy has been heaped on this interpretation of the Harrison Act.[7] As decades have passed, the decisions' historical context has been forgotten and the action appears almost accidental. In recent years some lawyers have concluded that the Supreme Court was "tricked" into outlawing maintenance — perhaps by a cleverly worded appeal brief. It has also been charged that the medical profession was not concluded in 1919, that it was "the lawyers' fault" that we have such a serious problem with opiate abuse because simple users were made into criminals by uninformed court action. Other critics have regretted that if it were not for these decisions the United States would have had the benefit of the so-called British System — permitting physicians to use their own judgment regarding addiction maintenance. Since it was explicitly stated in the Rolleston Report of 1926, the British System is said to have held down addiction in Great Britain, or even to have drastically reduced the number of

5. 249 U.S. 86 (1919).
6. 249 U.S. 96 (1919).
7. Act of Dec. 17, 1914, ch. 1, 38 Stat. 785.

addicts. Since anti-maintenance is a long-standing, core element in the American attitude toward opiate use, it might be useful to inquire whether men not usually thought to be gullible, such as Justices Oliver Wendell Holmes and Louis Brandeis, were indeed tricked by cleverly worded appeals into supporting the outlawing of addiction maintenance.

Let us examine some actions by the medical profession regarding narcotic control which may appear equally indefensible. I draw your attention to the testimony of the AMA spokesman at the 1924 Congressional hearings on prohibiting heroin manufacture. Dr. Charles Richardson, the representative of the AMA's Board of Trustees' executive committee, appeared and told the House Committee that "heroin contains, physiologically, the double action of cocaine and morphia. It produces the excitation of cocaine, with the sedative action of morphia . . . . [It] dethrone[s] their moral responsibility. It gives them an exalted impression of their own importance, and criminals by using it obtain this result." It was stated that heroin did not just create crime as a result of the cost of the drug on the black-market, but that heroin had a positive stimulating effect toward crime, crime of most violent and senseless brutality. Dr. Dana Hubbard, another physician and Director of Public Health Education of New York City's Health Department declared, at the same hearing, that "the physiological effect of heroin is to benumb the inhibitors and make of moral cowards brutal, brainless men, without fear and without conscience. . . . The heroin question is not a medical one, as heroin addicts spring from sin and crime." It is safe to say that these statements were inaccurate and misleading, which is especially disturbing in light of the fact that one would expect the medical profession to be well informed.

Another example arises from the furor over cannabis in the 1930's. The vast majority of medical reports written then described cannabis as far more dangerous than is now assumed. Even those who questioned the generally believed connection between crime and the use of marihuana reported that marihuana, when smoked, released inhibitions to expressions of violence and sexual expression, particularly homosexual desires. Thus, clinical reports favored the strict control of marihuana, which was thought, among other things, to be a potent cause of insanity.

Another example of a leading medical authority supporting fearful and apparently inaccurate reports on drugs is Dr. Edward Huntington Williams. In a 1911 medical journal he described the effects of cocaine as being particularly appealing to Blacks, driving them to

senseless brutality against Whites in the South, and further reported that cocaine improved the marksmanship of users so that almost every shot hit home. As recently as 1965 Dr. Williams was described in a respected study of addiction as a "nationally known expert on narcotic addiction whose writings are still read with respect."

The foregoing are just a few examples of how the medical profession used the language and apparent objectivity of science to confirm already exaggerated fears — both about drugs and the groups that used them. Thus, with regard to fundamental aspects of dangerous substance control we have the legal profession described as either tricked or tricky, and the medical profession described as misleading and uninformed. In order to understand these severe condemnations must we posit evil intentions, or a conspiracy, or can we learn from these instances something about the usual role, then and now, of medical and legal institutions? It is clear that objectivity about dangers to society can be just as difficult for doctors and lawyers as anyone else: law and medicine are integral parts of total society and attempt to move with the rest of society, as harmoniously as it is possible.

My own research into the evolution of American narcotic controls does not support the suspicion that these seeming aberrations are to be explained by any conspiracy theory, nor by the assertion that the legal and medical professions are simply self-aggrandizing. The better we understand how institutions, such as medicine and law, are part of the whole society and are only partly independent, the better we can interpret present events and guard against overvaluation of professional opinions. None of us can be free of social pressures and strong currents of popular opinion, and what may now appear reasonable may appear clearly one-sided or distorted to a later generation. Unfortunately, what may be our idiosyncratic beliefs and what counts as an advance over past beliefs is not easy to determine. But certainly we can be more critical of our basic assumptions and self-satisfied attitudes.

I will return now to the anti-maintenance decisions of the Supreme Court in 1919. By World War I, political, reform, and even medical leaders agreed that half of the American addicts, variously estimated in the millions, had been created by mercenary or poorly trained physicians. It is not surprising, then, that the Court's anti-maintenance formulation was seen by many frustrated and knowledgeable reformers as the only way — perhaps the last chance — to counteract the cause of half the "dope fiends" in the nation. Somehow, the federal govern-

ment had to control the doctors who hid behind their state licenses while selling dope or prescriptions and needlessly addicting patients. For a layman's view of the "dope doctor," and the fearful image of addiction among American families before the Harrison Act of 1914,[8] one can look to Eugene O'Neil's autobiographical drama *Long Day's Journey Into Night.* O'Neil portrays his mother's addiction at the hands of an incompetent doctor as the family's curse and horror. It was in this mood that many Americans wanted to obtain some control over physicians' judgment and practice.

By 1910 it was considered that the states had failed in their attempts to control doctors, druggists, and manufacturers. The problem facing constitutional lawyers was how to curb medical and pharmaceutical practice by *federal* law. The right to regulate medical practice was clearly reserved to the states — any infringement was bound to be vigorously contested in the courts. In effect the Supreme Court decisions of 1919 solved this dilemma by excluding addiction maintenance from the practice of medicine and therefore from the exclusive control of the states. To have permitted exceptions, that is, for the court to say that some doctors could maintain simple addicts but that the wrong type of doctor could not, would have been an obvious attempt to regulate the practice of medicine. As a consequence, the Supreme Court's imposition of control over the professional use of drugs had to have a rigid, dogmatic character in order to avoid the appearance of licensing the professions. Leaders of the medical and legal professions cooperated to control the group which was considered the prime cause of American addiction: the physicians. Legal ingenuity in overcoming constitutional restrictions and problems, and the determination among the medical profession's leadership that reform was an absolute necessity, led to this rigid formulation — a trade-off which was felt to be, on balance, worth the inconvenience and difficulties it caused. Here is what the President of the American Medical Association said a few months after the 1919 Supreme Court decisions:

> These laws are making it more and more burdensome for physicians using the narcotics legitimately, but that is a mere annoyance. The responsibility on the medical profession is becoming greater and greater to see to it that some action should be taken against a few renegade and depraved members of the profession who, joining with the criminal class, make it possible to continue the evil and illicit drug trade.

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8. *Id.*

What may appear as capricious or ill-informed was in fact a strenuous effort to control as effectively as then possible, a rise in addiction considered a national menace. Yet the Court's decision was close, five to four, with liberal members such as Holmes and Brandeis favoring expansion of federal powers to protect the public, while other court members, like the arch-conservative Justice McReynolds, believing that the extension of federal police powers into medical practice was simply and blatantly unconstitutional. The closeness of this landmark decision had a strong effect on the anti-narcotic enforcement style of the federal government until fairly recently. Federal anti-narcotic agencies had an extreme reluctance, one might say fear, to compromise publically on the question of maintenance lest they appear to be regulating medical practice. Maintenance was at times permitted through unofficial understandings between agents and physicians. Formal tolerance of narcotic maintenance clinics became an obvious threat to the federal interpretation of the Harrison Act.[9] The clinics could not publically and officially dispense narcotics, and still permit indictment of "dope doctors" for the same kind of action. Yet this was only one reason the clinics were closed; a second reason was that the clinics made narcotics available while the federal government's position had been, from at least 1906 onward, that the drugs should be made scarce and strictly limited to legitimate medical purposes, such as pain relief. Maintenance clinics seemed inconsistent with the campaign to seek international control of narcotics — for example, asking Turkey and Persia to plow under large crops of opium poppies, while simultaneously distributing narcotics from city health departments. Thus a harmonization of governmental efforts to curb drug availability helped doom the narcotic maintenance clinics.

A similar fate might await methadone programs. One major difference, however, is that the federal government has now, through the evolution of constitutional law, the accepted power to control prescribing dangerous drugs. As a result, the 1970 Comprehensive Drug Abuse and Prevention Act[10] based on the power to regulate interstate commerce, enables the federal government to revoke physicians' Controlled Substances Registration Certificates. If this extension of federal powers had been possible in 1919, it is likely the controls enforced thereafter might have been less rigid. In this way the contemporary interpretation of the Constitution profoundly affects the style of the control of dangerous substances — in accord, it should be

9. *Id.*

10. Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. 91-513, 84 Stat. 1236 (codified in scattered sections of 21, 42 U.S.C.).

added, with reputable medical opinion and popular attitudes toward drug use.

Examination of the health professions at the time when the fundamental drug control laws were enacted also brings an understanding of the motivation for and the form of the laws enacted. In the evolution of drug laws, the American medical profession, as it formally interacted with the government and the community, is shown to have been profoundly affected by the currents of public fear and concerns. One can conclude from the history of the medical profession's contribution to the various laws that a greater effort should be made to separate what is actually demonstrated in clinical research from the social implications of that research as interpreted by medical spokesmen. The danger to public policy formation arises from the appearance of scientific objectivity that may be given to what is actually a strongly felt social or political judgment. The medical and legal professions have often been as persuaded of the truth or significance of inaccurate and passionate judgments as everyone else.

To take a few examples, the Dr. Williams I quoted previously on the effects of cocaine on southern Blacks, was repeating a belief that was widespread before the First World War. Yet, there is evidence from the records of state mental hospitals and from the practice of Southern narcotic clinics that the baneful effect of cocaine on Blacks was neither particularly common nor the direct cause of violence. However, in the popular sentiment of the times cocaine was associated with Black hostility and, thus, indirectly contributed to massive repression of Black voting and other civil rights around the turn of the century. Cocaine became a convenient explanation for violent crimes or even open hostility by Blacks. Cocaine became a convenient explanation for racial and social tensions. This symbolic use of cocaine permitted a simple formula for social harmony. If cocaine were eliminated — and perhaps alcohol as well — you would have a docile and cooperative Black population. The attractiveness of such an explanation for trouble with a restless and exploited group is obvious. Blame is placed on an inert substance rather than complex and emotional factors.

Heroin partly represented in its first encounter with American society not ethnic tension, but rather fear of a stage of life — adolescence. During and after World War I heroin characterized threats from — to use a favored expression of the times — "youthful debauchees," rebellious adolescents. It also served as a popular cause for the crime wave which was widely claimed to spread over the

nation after the First World War. For example, in 1925, the New York City Commissioner of Correction warned:

> Heroin . . . is the most insidious and crime-inspiring of all drugs. When we consider that the United States uses more of the powerful opiates than all the leading nations of Europe combined we begin to understand why there are more murders in a single American city than in all the countries of Western Europe. In my opinion no measure is too radical or severe that would prohibit the manufacture and sale of habit-forming drugs.

By such descriptions and beliefs, the drug became linked with cocaine's euphoric and stimulating effects. Thus the AMA spokesman before Congress related what would be a logical deduction from the popular image and explanation for heroin use, — but still he did not accurately describe its physiological effects which were known to research physicians in 1924. One gets the impression that the prohibition of heroin was thought so important to the public welfare that the medical profession should, out of public spirit, support the movement without quibbling over the pharmacological effects of the drug. Dr. Lawrence Kolb, Sr., who was then the Public Health Service's narcotics expert, tried to explain that heroin and morphine were essentially the same and did not physiologically stimulate violence. He said there was more violence in a gallon of alcohol than in a ton of opium. But no one was interested. Therefore, we can conclude that it is likely that a drug, if identified with a group that is the source of social fear, will have attributed to it the dangers said to come from the group; consequently the drug cannot be accurately evaluated in the political process once it becomes an essential part of common-sense explanation for a social problem. In such a situation, one might expect the influential medical profession to inject reality into the controversy, but too often, the profession, as well as everyone else, is caught up in the belief.

There is another observation worth noting. Medical and legal objections, such as those made by Dr. Kolb to extravagant descriptions of heroin, were simply ignored if other professionals testified in accordance with public fears. The fears of the public helped determine what was valid medical testimony. Only the most vigorous professional protest has had much chance of deflecting public pressure from simplistic and punitive solutions to complex social problems. And, of course, the power and threat of an aroused public is a warning to professional leaders — opposition to a popular explanation for social disorder can be politically unwise, or even fatal.

The linking of a drug to a social threat can be caused by growing racial or generational tension; it can be further inculcated through

determined and sustained propaganda campaigns. Such campaigns often reiterate and exaggerate popular impressions of drug dangers. Consider one of the most successful national campaigns — that conducted in the 1920's and into the 1930's by Admiral Richmond Pearson Hobson, a hero of the Spanish-American War and a former congressman. He was a vigorous proponent of prohibition and an eloquent platform speaker. I think there is no question that Admiral Hobson was sincere in his attempt to arouse America to the dangers of heroin and marihuana, but the overly fearful descriptions he employed and his wide acceptance by some of the most respected elements of society meant that the message he gave was harmful. For example, he considered heroin a direct stimulus to senseless violence and preached that one dose of heroin, even if unwittingly eaten in an adulterated ice cream cone, would be addicting. Hobson established national and international organizations to wage the campaign against heroin. During the 1920's he mobilized the radio, service clubs, congressional clout, educators, magazines, etc., to give an exaggerated and distorted vision of heroin's dangers. In the early 1930's he switched his primary concern to marihuana and faithfully spread blood-curdling horror stories about cannabis. Always, he believed that the best way to fight drug use was through propaganda campaigns which painted drugs as the ultimate in evil and degeneration.

Enactment of the Marihuana Tax Act of 1937[11] provides another example of the ways in which a drug came to be associated with an increasingly feared and repressed ethnic group. The Agriculture Department in 1920 had published a pamphlet urging Americans to grow cannabis as a profitable undertaking. The pamphlet provided, for example, all rules for planting marihuana. Yet as the 1920's progressed, immigrants from Mexico poured into the nation at the request of agricultural growers to harvest beets and other farm products, and tensions mounted in those communities where the Chicanos gathered. The custom of some Chicanos of growing and smoking cannabis ultimately was identified with troubles between Anglos and Chicanos. Former narcotics Commissioner Anslinger himself recalls that the pressure for a federal anti-marihuana law came from the areas of the nation in which Chicanos were considered a threat to the Anglo communities — that is, the American Southwest.

Supported by a combination of fearful medical opinion, ethnic tensions, and political pressure, the Marihuana Tax Act was passed.[12] But it was not easy to outlaw a weed. Therefore — and here is another

11. Act of Aug. 2, 1937, ch. 553, 50 Stat. 551.
12. *Id.*

example of legal ingenuity comparable to the Supreme Court's outlawing addiction maintenance — the Roosevelt administration proposed a law controlling marijuana. The administration did that, not by formally prohibiting it (which would be unconstitutional), but, by making it, like machine guns, subject to a transfer tax. Here again, the common opinion of the medical profession and the ingenuity of the legal profession collaborated to provide what appeared to be a public necessity: the reassurance that there was a national defense to a supposed drug danger. Marihuana became linked with Chicanos as smoking opium had been identified with the Chinese, cocaine with southern Blacks, and heroin with young criminals. Each social tension or prejudice could be explained by a drug, and vice versa. The result was, for all practical effects, total prohibition with extreme punitive measures. The regrettable result of directly and simply explaining social disorder and tension by the use of a partcular substance is that anger, fear, and frustration make unlikely both flexible regulation and reasonable punishments for use and sale. The punishments may become so severe that the probability of injustice to some poorly defended individual rises and the probability of consistent deterrence decreases.

There is, of course, no perfect way for society to work. Mistakes are inevitable and justice is never swift or sure enough. By examining and understanding the past, we can, at least, ask if the temptation to eliminate evil doers by horrendous punishments represents an accurate estimate of what is best for society in the short or long term or simply an expression of frustration.

Thank you, ladies and gentlemen.

B. Discussion of The Final Report of the National Commission on Marihuana and Drug Abuse.

MR. LEVIN: Ladies and gentlemen, the most comprehensive report ever made in the United States on the subject of drug abuse was presented to the President of the United States and the Congress of the United States two days ago. We are most honored to have Michael Sonnenreich, the man who prepared this report, the Executive Director of the National Commission on Marihuana and Drug Abuse, here to address us now.

MR. MICHAEL R. SONNENREICH: I thought we would talk about this report in generalities simply because I do not want to intone all 110 recommendations, and everybody in this room is in-

telligent enough to buy a copy from the Government Printing Office and read it himself if he is interested enough.

I would like to give you some idea of where we are and why the Commission has written the report in the manner it has. The most important thing that you should recognize about commission reports in general is that they are usually ahead of their time. Because commissions do not have the bureaucratic bias, they generally make statements that do not have general applicability for 3 to 5 years. However, the report officially exists, and one can agree or disagree with it as a matter of conscience. The important thing is that one read it and understand the process that is involved in its production.

As with other things, problems arise in this country when the public is told that it has a problem. We have not been told that we have an alcohol problem so we do not worry about alcohol. We have been told that we have a drug problem, so we now worry about drug abuse.

About four years ago we spent a total of some $66.4 million for the entire federal effort in the drug abuse area, including law enforcement, treatment, prevention, and education. That is the equivalent, for those who like to make comparisons, of approximately three and one-half F-14 fighter planes for the Navy. This year we have spent $796.3 million, and the budget estimates that have been submitted indicate that we will exceed the $1 billion mark. When we do so, we become, for want of a better term, a drug abuse industrial complex.

Real dilemmas become manifest when we start to look at this problem. We have had rapid funding with very little questioning of either basic assumptions or the definitions that define what we are talking about. Words like "addiction," "narcotics," and "drug abuse" are thrown around. These are terms which have, over the course of years, absolutely lost their meaning and have become social code words. They are not medical words. We really do not have a workable vocabulary in this area, especially since the words are used to connote nothing more than social disapproval. In fact, the term "drug abuse" now simply means something of which we socially disapprove. It is a term that fluctuates in harmony with the mores of society. Those who lived in the Mediterranean area around 1600 and smoked tobacco had their heads chopped off. That was drug abuse.

We have circumscribed those drugs the use of which we consider unacceptable. The Commission is asking, among other things, whether we drew our circle correctly. Are there other drugs that belong within the circle? Are there drugs that go without the circle,

such as alcohol and tobacco? Why did we draw the circle the way we did?

One of the reasons, I believe, that we drew the circle this way is because some drugs simply have been culturally accepted and others have not. Some are indigenous to the United States and others are not. Tobacco and alcohol have been with us for a long time. Sir Walter Raleigh is legendary. Alexis de Tocqueville wrote of the propensity of the American public to consume spirits over 100 years ago.

The problem is, though, that we keep talking about drugs. Until about the early 1900's that was fine because there were not too many drugs to worry about. However, with the growth and development of pharmacology and new drugs, the old terms lost meaning. Unfortunately, instead of losing meaning and disappearing from the vernacular, they changed into social words.

Consequently, the Commission wanted to eliminate words like "addiction," "narcotics," and "drug abuse" — words that cannot describe the problem we are looking at. We asked whether we were really looking at drugs.

The Commission feels we are not. The things that are important from our point of view as policymakers, not as lawyers or doctors, are the social risks and the social costs. If there are only minimal social costs due to some activity, or if the public risks are small, then, as policymakers, we have to ask ourselves whether we want to do anything about that activity.

We do not want to become involved with private health concerns. For example, we are not terribly interested if by smoking cigarettes your lung falls down to your kneecap. That is your problem, and the problem of your doctor and hospital and Blue Shield and Blue Cross. Those concerns are not determinative when deciding whether or not to utilize the government. Under our system there must be a justifiable reason for the government to become involved.

The first assumption that we critically examined is that there is a distinction to be made between a hard drug and a soft drug. Everyone has heard that heroin and the opiates are hard drugs, the usual explanation being that they are physically addictive. But, is physical addiction the major concern, and the one that escalates drug concern to the government?

One of our Commissioners is Dr. Maurice H. Seevers, Chairman of the Department of Pharmacology at the University of Michigan. Dr. Seevers is in charge of the monkey colony for the United

States government. For 40 years now, all psychoactive drugs that we have discovered or uncovered have been sent to Dr. Seevers, and he tests them on his monkeys. He has approximately 450 monkeys, some dogs, some cats, and one parrot. We have never determined why he has the parrot. Anyway, we put the monkeys in the cages, we put catheter tubes down into the monkeys' stomachs, and we give them a little light and a bar to press. We teach the monkey to hit the bar and everytime he hits the bar he gets a drug. If the monkey likes the drug, he hits the bar many times. This is recorded on a computer.

We let them have a good time for about 2 weeks; in other words, we give them free access to the drugs in order to see what kind of drug reinforcement there is and to plot their tolerance curve. After two weeks we take away the drug. The monkey goes over and he hits the bar — nothing; he hits the bar again — nothing. After a while, the monkey gives up.

The machine records up to 6,400 bar presses a day. With the physically dependent opiate drugs, the bar is pressed an average of 162 times a day before the monkey gives up. When dealing with the amphetamines, which are not physically addictive, the monkey bar pressed an average of 1,800 times a day. With cocaine, which is not physically addicting, the monkey pressed an average of 6,400 times a day.

Therefore, the old assumption that hard drugs are more deadly than soft drugs really means little. One thing we did discover with the monkeys using cocaine — and this is one of the reasons we are very concerned about this drug — is that, given free access, the monkeys will press the bar until they die. There are only two known drugs for which the monkeys will not press a second time unless forced — LSD and mescaline. They will press for other hallucinogenic drugs but not for those two, so maybe they know something that we do not.

So this assumption, differentiating between hard and soft drugs, is really subject to very serious questioning and raises the point of whether we should be concentrating on the drugs. Do we care what the drug is, or do we really care about the behavior that results from the drug's use? The Commission's feeling is that we should be concerned with the behavioral consequences resulting from use.

Another assumption that we examined is that the easiest way to deal with the problem is to eliminate the source of the drug. This is a very legitimate initial concern because if you are trying to

eliminate drugs, it should be done across the whole spectrum of concern. However, to think that you can eliminate drugs that are growing wild, such as coca leaf, opium, poppy, and cannabis, does not seem realistic. I recall, in particular, being up in northern Thailand in the Golden Triangle in a Maya village and trying to explain to a Maya chief, who could not even communicate with the tribe around the other hill, what New York City looks like. It was even more difficult to explain to him what heroin addiction or heroin dependence is. These people have been growing it for 400 years. There is no question we should do something about eliminating the source, but it must be a long-range strategy. In addition, restricting availability is only part of the problem because if the demand continues someone is going to discover a way to synthesize drugs that have nearly the same effects.

With respect to treatment and rehabilitation, there is an implicit assumption that people want to be helped. The Commission has some serious questions as to whether that is true across the entire spectrum of people that are heroin-dependent. Many people do not want to be helped and simply drop out of society as a means of escape. They drop out to alcohol; they drop out to heroin. One sees much cross-tolerance and cross-substitution between the two. The question centers upon the degree to which people want to drop out and their relative desire to get involved with what is commonly referred to as the "hustle." I think we may have to begin testing our approach to treatment and rehabilitation because it may not be true that everybody wants to go have a job and raise a family and cope with all the problems of middle class life.

We also tested our assumptions about education. The assumption is that if you give people information they will react in a rational manner to it. Experience has indicated otherwise. The education programs in the United States are presently somewhat haphazard because they have never been systematically evaluated. We are not certain whether the information dispersed is turning people off or on. It is a very difficult thing to analyze because it is only one factor among many variables. Yet we have pigeonholed the problem and now we are assuming that there is some way of dealing with it. The Commission has recommended that there be a moratorium on these kinds of programs until there has been some sort of rational analysis. Why spend the money if we do not know what the real results are? Remember that this drug abuse industrial complex is a business — a very real business. When $1 billion is spent at the federal level, and probably three times that

amount at the state level, you are in big business. There is a tendency for bureaucracies to follow Newton's Law of Physics, *i.e.*, that a body in motion tends to stay in motion. It is very difficult to stop a bureaucracy that is building momentum.

There is a tendency to institutionalize problems and one of the Commission's concerns is that we may be institutionalizing the drug problem as a continuing part of the American way of life. There is a premium placed on describing any problem in ever more and more grotesque terms because that will generate ever more and more federal spending.

It becomes a sort of chicken-egg situation with the end result that, in many instances, the system awards failure rather than success. If you take the entire heroin-dependent population of a city, work with them, treat them, and cure them, then you do not get funded the following year. Hence the tendency to institutionalize the program in order to be assured of federal funding.

As I said earlier, we are not as interested in drugs per se as we are in breaking the circle. Alcohol is doubtless part of the circle. There is a certain hypocrisy to speak of alcohol as food, of tobacco as a cash crop — so dubbed by the Department of Agriculture, and of all the other drugs as drugs. Therefore, it is best to begin analyzing this problem in terms of consequences rather than nomenclature.

When we talk about the social costs, we must consider both sides of the equation. We are worried about acute effects at the compulsive end of the scale — the drug-dependent person — because of the other factors involved, but we must also be concerned with the social costs of the institutional response to the problem. There are costs to instituting responses, whether they be methadone maintenance programs, law enforcement programs, or inspecting baggage at customs. These things must be weighed in the balance. You must recognize that there is a cost to each institutional response. Some of the costs of response may deal with the very cost of the problem identified. For example, the rate of crime certainly reflects property crimes committed by drug-dependent persons. However, just because you recognize that one institutional response may cause people to commit crimes because they cannot buy a drug legally does not automatically condemn the response. Other factors must be weighed.

When we decide to treat heroin-dependent people, we spend not only money, but we deplete a most important resource — the human beings in the medical and social work fields. That is a

finite resource and when they are placed in the drug dependence area, they are taken away from some other important area. This factor must be weighted in the equation to determine whether the response should be that great. Maybe we should have only 10 people instead of 20, and put 10 in mental retardation or 10 in cancer and things like that. It certainly is a subjective judgment — but it is one that must be made.

Drug use is not unique; it is symptomatic of a range of other things. The causal relationships are few. People use drugs for a variety of reasons, reasons which stem from other causes, such as boredom or poverty. It is easy to talk about getting somebody off heroin; the more important thing is restructuring him back into society, if he wants to come back. I really question whether we want to eliminate drug use. I think we will always have some degree of drug use and I also understand that when people say they want to eliminate drug use, they are not including alcohol and tobacco. Heaven forbid. I could not survive without my cigarettes. Rather, we want to restructure drug use so that it is responsible use. There are always going to be people who are going to use drugs no matter how concerned we are about it. The goal is to keep it down to an irreducible minimum. That has been the response of both the federal government and the states.

The ideal may be nice but the reality is in direct conflict with it. For some strange reason, in every society man has ever formed, he has managed to find the one thing that can turn him on — be it alcohol or a mushroom — and he has structured its use. But the point is that man does find it, and we have to accept it.

I am reminded of the fact that if I were to tell you today that unemployment in the United States is 4 per cent, everybody in this room would feel relieved because you have been told that 4 per cent is a rate that indicates as many people are employed as want to be employed. We would accept 4 per cent. If I told you unemployment was 10 per cent, you would all get very nervous and start hoarding your money and be very concerned about the problem.

I submit to you that perhaps we should be thinking about drug use and other social concerns in very much the same fashion. There is some percentage of our population that will become drug-dependent; the issue is whether this is a percentage of the population we can carry. Maybe we should start looking at the problem in terms of cost-benefit and restructure our responses. We are carrying 10 million alcoholics right now.

We have been concerned about all institutional responses dealing with the drug problem as a drug monolith. We do not talk about marihuana or heroin except when we want to have arguments; we talk about the drug problem. It is a code word used because we really do not look behind that drug monolith. What the Commission tried to do, since we were interested in behavior, was to find out what kind of behavior we were talking about. We divided it down into several gross categories, and focused upon motivation and frequency of use.

The largest such category of drug use is experimental use. This is not an unusual kind of behavior; in fact, we tell our youth to experiment and to be inquisitive. Most of us took some alcohol before legal age. A couple of us smoked cigarettes behind the barn. We engaged in all sorts of naughty but nice conduct. It is part of growing up. As we did, youth today also experiments with the forbidden, including drugs. This must be recognized in our institutional approach. It is highly unlikely that we will halt experimentation by our youth, and hence the response should be tailored toward trying to move that kind of curiosity and experimentation into more acceptable social channels.

The second area, social recreational use, is also widespread. People decide that they are going to use drugs, including alcohol, for social purposes. We all go to cocktail parties. If one were to ask what drugs have social recreational use in the United States today, the response would be alcohol, tobacco, and marihuana. But in comparison to marihuana, alcohol is used much more frequently. The patterns of marihuana use in the United States simply do not approach those of alcohol. The statistics also indicate that marihuana will not replace alcohol.

Those of you who have just left college are using alcohol more and using marihuana less. You have discovered alcohol as a great new drug. Our surveys showed that 45 per cent of our youth and 50 per cent of the adults who have used marihuana have used it in combination with alcohol, probably Boone's Farm Apple wine. I categorize marihuana as a recreational drug because, according to our national survey, at least 26 million Americans have used it at least once, and 13 million categorize themselves as present users.

We also note that marihuana use is very age-specific. The heaviest use is between the ages of 18 and 21 and it decreases sharply at about age 25. The saturation point is at college level — 69.9 per cent of the people in college have used marihuana. How-

ever, use is intermittent, less than once a month. It is not the kind of social lubricant that alcohol is, and there is serious doubt, given our cultural background, that it ever will be.

The third category is very perplexing; we call it circumstantial or situational drug use. Fundamentally, it is displayed by the athlete who takes his amphetamines or steroids to perform better and the truck driver who takes his amphetamines to stay alert. Drug use was very clearly situational in Vietnam — easy availability of a cheap drug, combined with the boredom and fright of the most vulnerable age group led to heavy use. Yet studies indicate that no more than 10 per cent of the soldiers there had ever used heroin and that there was a very high dropoff when they came back to the United States. Over 90 per cent never went back to heroin.

The fourth category is intensified use, best characterized by the social drinker, the happy housewife in suburbia who pops her barbiturates, and the executive who has graduated from Digel to Librium. This is not a total lifestyle, but it becomes a large part of the lifestyle. Drugs are used to cope with stress and anxiety. That use represents the beginning of drug dependence.

Obviously, the last category is compulsive drug use, which is best characterized by the skid row alcoholic or the heroin-dependent person.

I want to raise one more point, which I think is important and is of personal concern to me. This country has dealt with drugs under three different legal approaches. We operate on a punitive premise, a therapeutic premise, and a preventive premise.

The punitive premise is very clear; you are told not to do something, you exercise your free choice and do it, and you are punished. Despite all the eumphemisms you can think of, we punish you whether you like it or not because it is part of our nature. The punitive premise has been applied in the drug area, and, as long as one can control his actions, there is some legal validity to that premise.

There is another premise called the therapeutic approach, which combines the legal and medical professions. In 1962 when the Supreme Court said, in *Robinson*,[13] that heroin-dependence (they said addiction) is an illness, it gave the impetus to the rise of the therapeutic premise which is paternalistic. This civil commitment has always been treated as a diversion from the criminal justice system, and we are concerned because this civil paternalistic approach has not been adequately safeguarded. If the therapeutic premise is to cure people, they can be kept under treatment forever because it may be

13. Robinson v. California, 370 U.S. 660 (1962).

impossible to cure them of heroin-dependence. We must consider the rights of those who are in treatment programs.

The Supreme Court evidenced its concern in 1972 in *Jackson v. Indiana*[14] when it wondered why anybody was challenging the civil commitment laws. We presently have 194,000 people in federal, state, and local jails and we have 428,000 people committed to mental institutions. The main question concerns the rights of those people, and I think both the lawyers and the doctors in this group will become involved in this important area.

The last area is the preventive premise about which you hear so much. It generally takes the phraseology, "Let's sweep the streets clean, pick them up, put them on an island, and float it out into the Pacific." The preventive premise makes great sense when you talk about communicable diseases like bubonic plague and smallpox; we recognize that nobody chooses to get bubonic plague. Therefore, if someone comes to this country with bubonic plague, the law can reach out, grab him, and quarantine him.

But do not get fooled with medical terms when speaking of drugs. You hear the words "epidemic" and "contagion." It is a contagion, but not a medical contagion. The transmission of drugs is not by bacteria and microbes; it is by thought. We cannot prevent the communication of ideas. We may not like the ideas; we may want to alter the message so that we do not have a spread in drug use, but the point is, that we do not exercise a legal premise to implement such a change.

I guarantee that if I walk into this room and stick a needle in my arm and shoot heroin into my veins and then run up to you and rub up and down your body, you will not get the disease — unless you want to. By the same token, if I come with bubonic plague, stay away from me.

This really is no joking matter. I think this is a very important thing that both doctors and lawyers have to realize. Do not get caught up in words without examining them. We are not talking about a medical disease, but first amendment issues — the communication of ideas. I think we should spend money and devote effort, but do not forget the larger social issues involved.

I believe that we lost sight of it during World War II in the famous decision wherein certain Japanese citizens were picked up and put in detention centers for fear they might create sabotage against the United States.[15] I believe that was a constitutional abberration,

14. 406 U.S. 715 (1972).
15. Korimatsu v. United States, 323 U.S. 214 (1944).

and I think the members of the Supreme Court that decided that case have said so in subsequent years. So, please, use words and terms carefully and do not extend them improperly.

Thank you.

C. Reactions to the Report.

MR. LEVIN: Before Mr. Sonnenreich answers any questions you may have, a panel comprised of some of the most knowledgable press people in the country will give reactions to the Commission Report. The panel will be chaired by Dr. Thomas Bryant, who is President of the Drug Abuse Council in Washington, D.C.

DR. THOMAS E. BRYANT: In Washington we refer to Mr. Sonnenreich as a breath of fresh air, as the irreverent Mr. Sonnenreich, and this morning we know him as a very thoughtful Mr. Sonnenreich.

To react to both Mr. Sonnenreich's presentation and to the report itself, we have assembled a panel of knowledgeable, experienced individuals — not necessarily drug experts, but people experienced in analyzing the processes, forces, trends, and idiosyncracies at work in our society in the broad area of how public attitudes, policies, and governmental responses evolve.

First, allow me to introduce Mr. James Markham. Mr. Markham is a reporter for *The New York Times*. He was a Rhodes Scholar at Balliol College and spent some time with the Associated Press in South Asia and West Africa. He has been specializing in covering drug abuse and the drug scene for *The New York Times* for the past couple of years.

Next is Mr. Jonathan Leff. Mr. Leff is a staff member and now Director of Special Publications for the Consumers Union and for *Consumer Reports*.

Mr. Leff is the Consumers Union staff member most directly involved with the preparation of the book, *Licit and Illicit Drugs; The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana — Including Caffeine, Nicotine, and Alcohol,* by Edward M. Brecher and the Editors of *Consumer Reports,* which was published in November. I imagine many of you have heard of it, if you have not read it. It is a singularly important document.

Next is Mr. Sander Vanocur. I think Mr. Vanocur is well known to most of us. He spent a number of years at NBC Television after having spent a few years in the news reporting business. During the last couple of years he was at the National Public Affairs Center

for Television — the public affairs programming center for Public Television. Presently, he is consultant to the Center for the Study of Democratic Institutions in Santa Barbara, California.

Finally, we have Mr. Robert Hughes, who is the Chief of Metromedia Radio's Washington News Bureau and the News Director of Station WASH-FM, the Metromedia Station serving the Nation's Capitol. Mr. Hughes won the Associated Press Award for outstanding in-depth reporting in 1972 for the documentary, *Magic in The Music,* a study of the FCC's controversial order on drug lyrics in popular music.

Mr. Sonnenreich has spoken to you and outlined some of his concerns in the preparation of the report. I thought we would initially get reactions from these four distinguished panelists and then give you a chance to ask some questions of Mr. Sonnenreich as well as the members of the panel. We will move first to Mr. Markham.

MR. JAMES MARKHAM: The beauty of this Marihuana Commission Report (and I think it is a very excellent one) is that it keeps alive a necessary tension between two approaches to addiction that have been dominant at various times in various places and quarters in this country. One is the medical approach which assumes that if you can do something about the man's drug problem — remove the drug from him — you have cured his problems and society's related problems. The opposite is the criminal approach which is a combination of what one would call the punitive and interventionist approaches. This has been the culturally dominant approach throughout this century and is still the most attractive one in political circles. I think Governor Rockefeller's recent wisdom on locking up violent addicts is typical of this approach and may represent the drift of the political-public, unenlightened sector of our nation. Fortunately, however, a significant number of people are now tending to drift toward the medical model. I think this is apotheosized in one sense by the Consumers Union; the Consumers Union report embodies the most intelligent form, but it too is subject to fault when it criticizes the medical approach.

The danger is that we approach this drug problem bristling a bit. Liberals, as "right-thinking people," tend to have negative preconceptions about the criminal model. We are repulsed by the proponents and by the essential reprehensibleness of the criminal approach and, hence, lurch left into the medical solution, which, again, in its simplest form is maintenance — if you cannot remove the drug from him, give it to him and let him be.

I would submit, using the Marihuana Commission as a touchstone, that we have to get beyond the drugs to the people using them and the reasons why. We should not let the drugs themselves obfuscate how we react to the problem.

I think there will be, in certain quarters of this country (like Charles River), people who will find the Marihuana Commission report a timid document. This group will doubtless believe that the Commission lacked the guts to go the whole way and propose abolishing the crime of possession. The Commission wrestled with anguish. If you read the pertinent section, you will see that it is partially a copout because the Commission came to the conclusion that possession laws have no real functional utility, but have, rather, a kind of symbolic value — society does not want to legitimize the possession of heroin. That is a decision that society can indeed make. The Commission, however, made a different decision about marijuana. Yet, there will still be people who find it a copout.

I do not know the internal politics of the Commission but my generous instinct is to think that it was not afraid of public indignation, but, rather, made an intelligent decision to retain the tension between the medical and criminal approaches.

The junkie in America belongs neither to the ABA nor the AMA. He is somewhere in between. Lawyers especially love to seize on the medical model since it is so beautifully logical. The addict's problem is his drug. Give him the drug and you are finished with the problem. But it may be — and this is especially true in heroin addicton — that the problems the man brought to drug-taking have a lot more to do with the behavior to which we so object.

Neither of the professions that you represent (and I think this is terribly important), as Dr. Musto indicated, have performed totally admirably in this area. They have been making the same mistakes as the general population. If you keep alive in yourself that unwillingness to have certainty in this field thrust upon you either as oppression or benign, paternalistic compassion — this poor man is taking drugs — if you can remain skeptical of both those poles that will be a contribution.

DR. BRYANT: Thank you, Jim. Next, we want to hear from Mr. Leff, the Director of Special Publications for the Consumers Union. Mr. Leff was intimately involved with the publication of the book, *Licit and Illicit Drugs.*

MR. JONATHAN LEFF: I would first recall, having been involved in a general introduction of experts, Carl Sandburg's definition of an expert — a damned fool a long way from home.

Overall, I would applaud the Commission's efforts to turn policies and attitudes toward more constructive approaches in this subject area. In comparing the Commission's report inevitably as I must with the Consumers Union's report, *Licit and Illicit Drugs,* I find the Commission shares a good deal of our philosophy but that we do differ in certain very important areas.

The Commission report states that the use of illicit drugs, particularly marihuana, increased dramatically during the 1960's despite draconian penalties. I would suggest that this has occurred at least in part because of the draconian penalties and the accompanying policies that have followed. We believe that prohibition does not work — alcohol prohibition did not work and, as the country has been learning since 1914, the time of the Harrison Act,[16] heroin prohibition does not work either. Prohibition simply raises prices, thus attracting more entrepreneurs to the drug market. If the drug is addicting and the price escalation is carried to outrageous extremes, as in the case of heroin, addicts resort to crime to finance their purchases at a tragic cost, not only in dollars, but in community disruption and personal destruction. Prohibition also transforms the market from relatively bland substances to more hazardous concentrates which are more readily smuggled and marketed — from opium smoking to heroin mainlining, from coca leaves to cocaine, and from marihuana to hashish. Prohibition opens the door to adulterated and contaminated drugs. Worst of all, excessive reliance on prohibition laws and enforcement lulls the country, decade after decade, into a false confidence that nothing more needs to be done except to pass yet another law, to hire a few hundred more narcotics agents, or to give license to break down doors without knocking first.

I think one of the most significant contributions of the Commission report is to be found on page 84 in Table 229 — *Percentage Change in Student Use of Drugs, 1969 to 1972.* During that period of concentrated effort by the Administration in the drug field, the report indicates that, among young people who tried various types of drugs at least once, opiate use rose 218 per cent among junior high school students, 5 per cent among senior high school students, and 18 per cent among college students. The use of LSD and other hallucinogens rose 50 per cent among junior high school students, 133 per cent among senior high school students, and 133 per cent among college students. The use of marihuana rose 60 per cent among junior high school students, and so on. I need not continue the roll call

16. Act of Dec. 17, 1914, ch. 1, 38 Stat. 785.

since it can be found in the report. It is a shocking testament to the efficacy of the present system.

The Commission report makes much of the ostensible need to discard certain terms, including the word "addiction." In its place, the report turns to the terms "heroin-dependent," "compulsive use," "drug-dependent" and, occasionally "severe dependence." Later, in at least two places "drug dependence" is categorized as an illness of the spirit for which the Commission says, "As in the case of other social maladjustments, there are no quick solutions." We find little but confusion to be gained by such euphemisms or by such mysticisms. We have found the terms "addicting" and "addiction" to be precise, adequate, and useful.

There appear to be three basic attributes to an addicting drug: physical dependence with a withdrawal syndrome when the drug is abruptly discontinued; tolerance so that the effects gradually disappear if the same dose is taken repeatedly; and craving during abstinence with a tendency to resume drug-seeking behavior. That last, the matter of craving, does not appear to have impressed the Commission very much. Yet it is well known that long after withdrawal the addict will experience, from time to time, waves of anxiety, depression, and craving. The response ultimately, except in very very few cases, is to return to the drug. Mr. Sonnenreich said today, "Getting someone off heroin is no great feat." I would add: Keeping him off is the problem.

Whatever the causation of addiction — whether it be psychological, sociological, or biochemical — we believe this about heroin as an addicting drug — and I quote from *Licit and Illicit Drugs:*

> The time has come to recognize what should have been obvious since 1914 — that heroin is a drug most users go right on using despite the threat of imprisonment, despite actual imprisonment for years, despite repeated "cures" and long-term residence in rehabilitation centers, and despite the risks of disease and even death. Heroin is a drug for which addicts will prostitute themselves. It is also a drug to which most addicts return despite a sincere desire to "stay clean," a firm resolve to stay clean, an overwhelming effort to stay clean — and even a success (sometimes enforced by confinement) in staying clean for weeks, months, or years. This is what is meant by the statement that heroin is an addicting drug.
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> Almost all heroin addicts, it is true, do stop taking heroin from time to time. But almost all subsequently relapse. . . . By publicizing the few conspicuous exceptions — the handful of successful ex-heroin addicts — and by assuming that others need

only follow in their footsteps, harm is done in at least three tragic ways:

(1) Another generation of young people is persuaded that heroin addiction is temporary. They are falsely assured that the worst that can happen to them if they get hooked on heroin is that they may have to spend a year or two in a drug treatment center, or, better yet, in a therapeutic community like Synanon or Daytop — after which they will emerge, heads high, as certified ex-addicts [I would add maybe they will be invited to lecture to your high school students in assembly about how easy or hard it is to become an ex-addict.].

(2) Hundreds of millions of dollars are wasted on vast "treatment programs" that almost totally fail to curb subsequent heroin use by addicts, while more pressing methods are skimped on.

(3) Law-enforcement resources are wasted on futile efforts to keep heroin away from heroin addicts instead of concentrating on the essential task: keeping heroin away from non-addicts.

There is one major exception to the rule that most heroin addicts go right on using heroin or returning to heroin. The heroin addict can comfortably do without his drug if supplied with a related drug, such as methadone. Unlike heroin, it can be effectively taken orally rather than by injection. One of its other advantages is that it need be taken only once a day instead of several times. Like heroin, it has very little effect on either mind or body if taken regularly. Most important, methadone is legal and it is cheap.

I would applaud the Commission's support of methadone maintenance as, and I quote, "the most significant form of drug treatment available," but I would suggest that in its understandable concern for the methadone patient the Commission has failed to recognize an equally important potential for methadone maintenance. I refer to the sharp curtailment of the heroin black market. Methadone is not a panacea, but since it is legal and cheap, it can free the heroin addict from his or her life of crime and from the other disastrous consequences of the heroin black market.

The heroin black market must be abolished and the only way it can be abolished is by eliminating the demands for black market heroin. Contrary to the Commission, we believe that methadone maintenance can and does make a significant reduction in drug-related crime.

On the central issue of narcotic addiction, accordingly, Consumers Union recommends: (1) that the United States' policies and practices be promptly revised to ensure that no narcotics addict need get his drug from the black market; (2) that methadone maintenance

be promptly made available under medical auspices to every narcotics addict who applies for it; and (3) that other forms of narcotic maintenance, including opium, morphine, and heroin maintenance, be made available along with methadone maintenance under medical auspices on a carefully planned experimental basis.

The third of these recommendations — that experimental opium, morphine, and heroin as well as methadone be made available to addicts — is based, in part, on the unassailable fact that an addict is personally far better off on legal, low-cost, medicinally pure narcotics than he is on exorbitantly priced, dangerously adulterated, and contaminated black market heroin. Similarly, society is better off when addicts receive their drugs legally at low cost or free of charge.

Our recommendation for experimental opium, morphine, and heroin maintenance programs is not based on any confidence that they will prove superior to maintenance on methadone. All of the data so far indicates that methadone is very nearly the ideal maintenance drug. The ready availability of an excellent maintenance drug — and there are some 85,000 narcotics addicts on methadone maintenance in the United States today — is not a sound reason, however, for abandoning the search for an even better one. Even if in the end the trials of opium, morphine, and heroin maintenance merely buttress the conclusion that methadone is the drug of choice, the research will have served a useful purpose since oral methadone has so far only proved its worth in competition with black market heroin. The next challenge oral methadone should be required to meet is a carefully controlled comparison with legal opium, morphine, heroin, injectable methadone, and perhaps with other drugs. The tests should be designed to determine, once and for all, whether the heroin molecule itself or the mystique surrounding it makes the difference.

We should examine the British experience with narcotics. Great Britain and the United States began with essentially the same base a century ago when opiates were generally available. Through the years the two countries' problems were essentially the same until the United States turned in the direction of the Harrison Act[17] and the repression that followed. The British continued treating narcotic addiction as a medical problem. Indeed in the early 1920's they sent a Dr. Harry Campbell here to study American methods. He returned to England aghast, saying, in effect: "My God, they treat their narcotics addicts as criminals over there. Let's keep our present system."

Our understanding of the British experience does not square with that which appears in the Commission report. One statement

17. *Id.*

made is that in 1968, after a significant increase in the number of drug-dependent persons in Great Britain, the British practice changed. It is our understanding that the increase actually followed the institution of closer renotification of addicts and reflects understandable duplication. In the years that followed, the number dropped significantly. The report also states that a system was created which permits maintenance doses to be distributed only through government-authorized clinics. It is our understanding that if you want heroin you must go to a clinic, but that if you are willing to accept methadone, you can get it from a physician. This reflects an effort by the British Government to turn the narcotics addict in Great Britain toward methadone.

As of the end of 1971 — I do not know the precise figures — there were approximately 1,555 narcotics addicts registered with the Home Office in the United Kingdom. According to the head of the Home Office, there are very few additional hidden addicts, those who deal solely in the black market. There are a few square blocks of New York City where you can find 2,000 addicts.

The Commission report suggests that a significant reason for the British success, and our inability to adopt their approach, is that the British population really is not like ours. At the same time, however, the report makes an occasional reference to the success of certain approaches of the Japanese. I would suggest the Japanese population is not like ours, either.

In addition, I would touch briefly on what we call the Kentucky experience. All during the 1920's and 1930's and down into the 1940's, there were numerous narcotics addicts in Kentucky who were receiving their drugs from doctors illegally. The narcotics officers knew about this and did nothing because these addicts did not cause trouble.

We do not agree with the Commission's decision on nicotine. The report states: "The word 'addict' was commonly used to describe the tobacco habit despite the absence of significant drug abuse behavior arising from its use." There are similar references to the fact that nicotine is not an addicting drug, not a drug-dependent drug as the Commission describes it. In *Licit and Illicit Drugs,* we describe tobacco as one of the most physiologically damaging substances used by man, and we go on to say that "since nicotine is one of the most perniciously addicting drugs in common use, most tobacco users are hooked and, in effect, locked to the damaging effects of tobacco." Dr. M. A. H. Russell of the Addiction Research Unit of the Institute of Psychiatry in London, which now has added nicotine addiction to its studies, put

it this way: "If it were not for the nicotine in tobacco smoke, people would be little more inclined to smoke cigarettes than they are to blow bubbles or light sparklers."

I see that my time has run out. Obviously, I could go on and on. Thank you.

DR. BRYANT: I think you see that Mr. Leff could go on and on. There is an awful lot in the Consumers Union book as a result of their extensive research and careful analysis.

Let us move on to Mr. Vanocur.

MR. SANDER VANOCUR: The chief virtue of the Commission's report is its modesty. I am not sure that Mr. Sonnenreich thinks of himself as a modest person. Kenneth Galbraith says that modesty is a highly overrated virtue. But to somebody who has been trying to wander around in this darkness for a few years, always learning more and less at the same time, I think the document is useful for saying how little we know about the problem. It strikes me that one of the great problems we have in this society is knowing really so little. How so many of our leaders can act with such certainty about the drug problem with such little knowledge is beyond my understanding.

Mr. Sonnenreich talked about the description of the problem in ever more grotesque terms — a complex that is growing in the drug field. I have had a recurring fantasy for years about collusion between the military-industrial complex of the Soviet Union and the United States. They meet someplace on an island in one of the lakes of Berlin every year — it is a convention, a kind of hardware Pugwash — where they devise schemes (to use the words in the "Fat Boy" addicted figure) that would make your flesh creep, to get ever-increasing commitments from their respective governments for arms.

In the same way, I have a fantasy of a kind of drug complex that meets, say, in Marseilles every year in the back of a candy store to figure out ways to scare the United States Congress.

I think one of the chief problems is the media. The other night I tried to follow the reaction to the report on television. I did not see ABC, but NBC did a fairly credible job — they interviewed Ray Shafer and Ron Nessen and indicated that the President was not very happy about the report. CBS, which in recent months has been doing these things much better than any other network had about 25 seconds of copy by Roger Mudd. I do not think any of the major networks or PBS had a special report that night. I had to ask myself: "If Nelson Rockefeller is making the proposals that he is making, if President

Nixon is urging a more punitive approach, if this is one of our major problems that people, rightly or wrongly, associate as being connected with crime, then do not the newspapers and the television news departments of this country have some kind of responsibility to indulge in other than the shorthand they usually use to describe this problem?"

When I first began working in this area, which was around May of 1970, I was horrified at the way the New York papers were attacking the methadone experiment which Dr. Dole was just developing. The code words used, the shorthand, and the frightening phrases used in the headlines and in the newscasts at night were most disturbing. Surveys have shown that if people retain anything from an evening television news show it is something that has been repeated. The repetition of words like "epidemic," "pusher," "junkie," and "needles" tends to fix them and their connotation in people's minds.

I am worried because I think that we are about to philistinize public policy. I think that one of the areas in which we must be very careful not to let that happen is the area of drugs.

The lack of attention that this report got is shocking. I have no answer, but I think it is shocking the way it went right through the media mill in one day. I think it will be lost, except in areas like this room. In groups like this, the debate will continue, but until you can get it properly before the public on television, the task of coping with the drug problem will not be any easier. Thank you.

DR. BRYANT: Last, but not least, we will have some comments from Mr. Hughes.

MR. ROBERT HUGHES: I would just like to begin by saying that I agree with most of what Mr. Vanocur said. The media is part of the problem.

The Commission found in its report that most efforts that have been made to stop what Mr. Sonnenreich referred to as the contagion of ideas that spreads drug abuse have been counterproductive. They have not worked because people did not know what they were doing when they took those actions. I would like to tell you a story that illustrates that.

Two years ago, in the spring of 1971, there was a record which was being played on many radio stations. It was a catchy little tune called "Once Over the Line" by Brewer and Shipley, two young folk singers. It mentioned Jesus and Mary, and there was the cryptic line, "One toke over the line." No one could ever get them to explain what they meant, but everyone assumed that because the word "toke" was associated with marihuana use, the song was about a guy sitting in

a railroad station thinking about Jesus and Mary, waiting for a train and smoking marihuana.

Shortly after the record came out, the FCC, through an order, notified broadcast stations all over the country that it had serious and pressing concern about the broadcast of records which the Commission said tended to promote or glorify the use of illegal drugs, such as LSD, speed, and marihuana. The immediate reaction from stations, especially stations that programmed progressive or regular rock, was to wonder why the Commission had no pressing concern about records which promoted the use of alcohol — Frank Sinatra singing, "Drinking Again" — or records which promoted the use of nicotine.

I was a reporter in Washington at the time covering the general range of news that comes from that city. I thought to myself, perhaps the assumption on which the Commission based its order ought to be questioned a little bit and ought to be investigated. I approached my bureau chief and said that I would like to do a long documentary on the question of whether or not rock music tends to promote or glorify the use of illegal drugs.

That was one of the most satisfying projects I have ever undertaken as a journalist. I was allowed to work full-time on it for about a week and a half. I tried to trace the origin of the FCC order. I would like to tell you the story of that in brief terms. At about the same time the order was promulgated, the military was having an immense problem with discipline in the service. Commanders found that for some reason they could not communicate with the young troops that they had under their command. The familiar story was one of discipline breaking down and people in Vietnam refusing orders to perform various tasks. The Pentagon has a guy who is pretty hip about what is going on in mass media, so they approached him and said, "Can you do something to tell our commanders how to communicate with young soldiers? You can't just slap them on the arm and say, 'What town are you from, son? You're doing a good job.' That doesn't work anymore." The fellow put together a presentation — slides, tapes, and live narration. One of the things he concentrated on was rock music and he mentioned the fact that certain drugs were mentioned in rock music. Their names were pronounced and people were said to get high and "get it on."

The presentation was meant to show commanders that if they wanted to communicate with their troops they should consider using radio, newspapers, or posters. Military memos just do not get the message to them.

Eventually, the presentation found its way to broadcasters at the White House and then found its way to the FCC where Commissioner Robert E. Lee saw it. Commissioner Lee was very concerned at the time about pornography in broadcasting. (This was long before the advent of cable T.V. showing X–rated movies and so-called "topless radio" where women call up and talk about their sex lives.) Commissioner Lee became concerned about the apparent appeal to drugs, so he began doing some investigating. He was the individual who pushed the order that went out to broadcasters, which most broadcasters interpreted as an attempt to censor so-called "rock lyrics."

I had an interview with Commissioner Lee. I should have brought the transcript; I find it very hard to repeat this quote without seeming to editorialize. I asked him what evidence he had, if any, that rock lyrics promoted the use of drugs. He said that he had none. I asked him if anyone had done any scientific studies on the question and he said that as far as he knew nobody had. I then asked him why he thought the lyrics promoted drug use and Commissioner Lee, as best I can recall, said, "Well, I remember in World War II when Kate Smith sang 'God Bless America,' and I think that helped us to win the war. If a song can do that, then perhaps 'One Toke Over The Line' can get somebody to try marihuana."

I do not want to make any editorial comment, but I found, for example, that the presentation which I spoke of went through considerable changes, depending upon the audience to whom it was presented. I saw the whole thing. The Pentagon invited me when the presentation was to be shown to some high school students. They played the Beatle song, "A Little Help From My Friends." You could hear the singing, "I get high with a little help from my friends," and the narrator said, "The drug message in the song comes through loud and clear," and stopped. I had a transcript of the same presentation as it was given to broadcasters at the White House. There, the narrator said, "The drug message comes through loud and clear to you, whether they realize it or not," seemingly to indicate that playing a record on the radio somehow triggers a mechanism in your head that causes you to take drugs. Yet, at the same time, there were no scientific studies whatsoever to back that up.

I checked with the person who designed some of the music programming for Muzak. (Muzak claims that its music can motivate people to work better in factories.) I asked him what their studies had shown and he replied that the basic part of music that works on people's psyches is rhythm and structure, chords and notes together.

He indicated that lyrics had no effect whatsoever. That, he said, was the reason why Muzak used no vocal music in any of its tapes.

Anyway, the Drug Abuse Commission found that rock lyrics dealing in any way, shape, or form with drugs were pulled off the air, including one very strong song which says, "God-damn the pusher man." (In this country, a broadcaster is risking complaints from the FCC any time he allows the word "damn" or "hell" on the air.) However, there were some stations in the country that felt there was a drug problem and that there was a need for that record. That record came off the air as well as others like "Don't Give Me No Goose For Christmas, Grandma," which had nothing at all to do with drugs.

I understand the Commission is going to publish an appendix which discusses the whole subject and I am sure it will be very interesting reading. I think it may well illustrate the dangers of taking action before knowing exactly what effects the action will have.

D. General Discussion

DR. BRYANT: We didn't have a chance to ask questions of Dr. Musto, so why don't we ask Dr. Musto to come and join Mr. Sonnenreich.

The front page of *The New York Times* yesterday carried a report that the Commissioners met at the White House with the President and received a frosty reception. I asked Mr. Sonnenreich about that but I will not give you his comments.

There was editorializing in the *Times* which raised the topic, "How is this Commission going to be received? What is really the attitude of those who are in a position to do something with the recommendations of the report?" To zero in on that, I think, whether the word "frosty" is used or not, you can realize that the kinds of recommendations made in the report are new, different, novel, and bound to be, in some sense, controversial. One of the reasons for that is that there is much public concern about crime and the relationship between crime and drug use. One of the things that came up in our panel this morning was that Mr. Leff disagrees with Mr. Sonnenreich, or says that the Consumers Union does, in terms of the effect or effectiveness of certain treatment approaches, such as methadone maintenance, in lowering or reducing the rate of urban crime.

I wonder if I could ask Mr. Sonnenreich to tell us what the Commission found and what questions they raised about the relationship between crime, drug use, and drug abuse.

MR. SONNENREICH: I will be glad to. There were several points made by Mr. Leff. The Commission does disagree with some of the findings that the Consumers Union made. It was something I did not have a chance to discuss earlier, but I think we should.

What we said is that when we looked at the treatment programs around the United States, we were very much concerned because there is now a tendency to lean on methadone maintenance as a panacea. We really know very little about how good such programs are if the goal is to cure the addict or reintegrate him into the society.

One of our problems is that we have a whole range of programs, none of which has really systematically been evaluated. The Special Action Office, as was discussed by Dr. Jaffe, is trying to evaluate those programs. Such an evaluation is long overdue. The original intent of Drs. Dole and Nyswander when they put together methadone maintenance was not to cure crime or to reduce crime; it was to help the individual by getting him maintained and stabilized so that they could do something with him in terms of job counseling, in terms of reintegrating him, and in terms of making him a functioning member of society. It was only when people started noticing that crime seemed to reduce that it shifted from a concept of helping the individual to a policy of law enforcement and control.

The studies that have been done with methadone are normally before-and-after studies and there are considerable statistical abberations in them. The Commission tried to point out some of them. There is no question that the methadone programs have some impact on the reduction of crime, but how much is unknown. The next question is whether that is the only thing that is important. Mr. Leff and the Consumers Union talk about an experimental heroin maintenance program to test whether or not methadone is the best drug to use for maintenance purposes. I submit to you that there is no such thing as an experimental heroin maintenance program. If you are going to allow people to inject the drug and if you are going to give them heroin, forget methadone maintenance.

As to the experiment in England — we have done studies in England, one of which we completed this year. We have been there and there is no question of what the drug of choice is going to be; it is going to be heroin. There is no question about the drug of choice in terms of methadone administration; it is going to be injection. If your primary concern is the reduction of crime, the answer is very simple — give the addict the drug and he will not go out and steal.

However, that may not be the complete answer either. We did a cohort study, rather Dr. Wolfgang did, in Philadelphia. The test

group was comprised of all boys born in the city of Philadelphia in 1945. From that and other studies we found that well before the subjects went on to use heroin, they had run-ins with the police, were delinquent, and generally had been "criminogenic." The real question is whether or not treatment of the symptom is going to relieve the criminality. I do not know the answer. It might reduce the property crime, but what about the assaultive crime? Nobody knows the answer to that question. Those very simplistic solutions of, "Well, that is going to eliminate crime," are just that; they have not been tested. We are very hopeful, but we certainly do not have the answer.

You have to be realistic when you talk about heroin maintenance, and you make the decision for yourself. The Commission does not support heroin maintenance, but it does support methadone maintenance. However, we feel that there is no doubt that heroin will supplant methadone if it is given as a treatment modality.

I also submit that there is a cultural difference between the United Kingdom and America which accounts for the difference in drug use in the two countries. We have a much higher index of heroin incidence in this country and it appears that we will continue to have a higher incidence. We also have a higher incidence of burglaries and a whole other range of criminal activities. Our reference to Japan was a reference to dealing with a drug problem singularly, focusing on only one drug at a time.

Our response is that those countries where there is widespread availability of the drug at a cheap price — such as in Thailand, Hong Kong, and the United Kingdom — have a wide range of drug use and drug dependence within their populations. The estimate of drug dependence within Hong Kong is approximately 20 per cent of the male population between 16 and 25. Whether that is good or bad is a subjective judgment. Whether the people can function or not is another subjective judgment because "functioning" is a subjective term.

However, it is clear that one does not just focus on property crime and then worry about whether there is going to be a black market. One does worry about availability because everytime a drug is opened up there will be availability. We are not talking about marihuana here; we are talking about a highly targeted drug, one to which certain populations are highly vulnerable. Based on those considerations, we feel that policy-making, not merely logic and philosophy must play a role in any availability decision. Policy-makers must speculate about an increase in drug use and the consequences of availability. It is a legitimate concern. As long as there are serious questions about it

and there is comparative data to weigh, one has to be cautious. Once you have built a cultural context in which people can use drugs or receive drugs, it is a very difficult thing to change.

So, we submit that you should not keep looking at the facile argument that heroin maintenance is going to reduce crime because it will not. In the Commission's judgment, there is no such thing as an experimental heroin maintenance program.

DR. BRYANT: I will allow Mr. Leff five seconds for rebuttal.

MR. LEFF: There is, of course, except in the case of a very, very few addicts, no cure and, indeed, the euphemisms that are used — treatment, rehabilitation, indeed sometimes cure — are unfair. They are unfair to the addict and they are unfair to the rest of society.

In England, at the end of 1971, 1,161 of the 1,555 registered addicts were receiving methadone. Of those, 229 were also receiving heroin, 156 were receiving heroin either alone or in combination with other drugs, and 238 addicts were getting still other drugs. I would suggest that what has happened in the United Kingdom, where there was essentially an all-heroin population, could also happen in the United States. In the United Kingdom, heroin has become virtually a trivial drug and methadone is the maintenance drug of choice.

MR. MARKHAM: I have to respond to that. What you have to say when you use those figures, Mr. Leff, is, if my recollection is correct, that something like 80 per cent of the methadone is injectable and, therefore, indistinguishable in effect from heroin — so you are really talking about an injectable.

MR. LEFF: Then let us discuss "injectable." In the United Kingdom, society does not find it reprehensible for an addict to inject the drug.

MR. MARKHAM: I am not talking about reprehensibility; I am talking about the kinds of drug you are using. "The British are turning over to methadone" argument is really a distortion of the situation.

MR. LEFF: We believe that the experimental testing should include testing injectable drugs against themselves and against oral drugs as well.

MR. VANOCUR: One thing I wish we could stop — and I do not know how to do it — is the making of comparisons to the British experience. I think the situations are incomparable.

MR. LEFF: I would point out that the United States and Britain started with the same base and we went one way and they went the other. Of course we have a large heroin population here — for heaven's sake — we have been maintaining a black market for close to 60 years.

MR. VANOCUR: But the British have a totally different approach to crime and violence.

DR. BRYANT: Good, let's stop that.
Are there questions from the floor?

PARTICIPANT: I am curious about a couple of things. One is that you, Mr. Sonnenreich, are from a presidential commission — a commission that was started by the President but to which he has become very unreceptive. How did that affect your work?

MR. SONNENREICH: First, it is a congressional commission. Presidential commissions are created by executive order. We were created by statute in the Comprehensive Drug Abuse, Prevention and Control Act of 1970.[18] It is a bipartisan Commission which means there are Democrats and Republicans on the Commission. (No American Party members.) We have four congressional members: two from the Senate — Senator Hughes, a Democrat, and Senator Javits, a Republican; and two from the House — Congressman Carter, a Republican, and Congressman Rogers, a Democrat. The nine other members were appointed by the President, but they too are bipartisan. It is generally referred to as a presidential commission because the majority of the members were appointed by the President, but that is not unusual.

As for the unreceptive reaction, it matters little. Since the subject is controversial, initial reaction does not concern me terribly. If you look back at the history of the *Prettyman Report* of 1963 and *The Challenge of Crime in a Free Society* in 1967, you will find that most of the recommendations, in time, get adjusted.

We are not terribly interested in having every single recommendation of the Commission adopted. What we want is for people to start rethinking the issue and rethinking the basic assumptions. If that is done we can all disagree legitimately, but first, at least, let us agree on certain logical sequences.

SAME PARTICIPANT: One other thing. Is there any similarity between your Commission and the LeDain Commission?

18. Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. 91-513, 84 Stat. 1236 (codified in scattered sections of 21, 42 U.S.C.).

MR. SONNENREICH: There was a similarity in terms of the marihuana recommendations. The LeDain Commission has not published all of its report yet.

DR. BRYANT: The LeDain Commission is a Canadian Royal Commission on the Nonmedical Use of Drugs.

PARTICIPANT: What are the medical advantages of addiction to methadone vis-à-vis heroin? And, second, is it true that it is much harder to withdraw from methadone than from heroin?

MR. LEFF: Methadone is fully effective by mouth, which does away with all the needle-connected disease conditions; it is effective for a full 24 hours; it is effective in stable doses with minimal side effects and with safety, effectiveness, and acceptability to addicts already proven under actual field conditions with some 85,000.

DR. BRYANT: That is methadone from one point of view.

MR. SONNENREICH: There is a basic difference. Heroin by mouth is ineffective. You have to use it by injection. There are two forms of methadone treatment in the United States today. One is the saturation dose of about 130 milligrams in your orange juice. That is a very high dose. In other words, you saturate the person. It would be much more difficult to bring a person down from that dose level than it would be for the average run-of-the-mill heroin-dependent person. There is another dose that is being used with increasing frequency — 30 milligrams. Unfortunately, you can overshoot the 30 milligrams, and that is one of the concerns of the Bureau of Narcotics and Dangerous Drugs. In other words, it is not a blockading dose at 30 milligrams.

DR. BRYANT: You can also overshoot at 130.

MR. SONNENREICH: That is right, but it is a little harder to overshoot and get an effect when you are hitting at 130 milligrams a day.

MR. LEFF: May I add, Mr. Sonnenreich, that when one is on maintenance, you do not seek to bring him down, to withdraw him. That is detoxification. Maintenance means that you are maintained on a dose.

MR. SONNENREICH: I agree with you from a medical point of view. One of the problems, though, is whether people are going to overshoot. That is where you must blend the medical and the law enforcement considerations.

DR. BRYANT: I do not think we are really getting at the young man's question. The second part of the question is whether it is easier to detoxify, or get an addict off methadone, than it is to get him off heroin. That is not proved as far as I know, but there are a lot of people who are operating treatment programs who have observed that they think it is more difficult to get people off methadone.

One cultural factor that we should consider here is that the heroin that has been available to the street addict in this country for the past several months, maybe a year, has been low in quantity in terms of per cent purity. For that reason, there are a great number of addicts, we think, who really do not have a very heavy habit.

One of the perplexing, controversial sorts of problems facing the treatment program is that often a person with a light habit is taken from the street and put in methadone maintenance which may create for him a heavy habit to, admittedly, a synthetic opiate.

PARTICIPANT: I would like to ask Mr. Sonnenreich a question. You mentioned several studies of comparisons, cross-national research, and certain availability concepts in other societies. Have you done any studies of people who have gone from one availability context, say the New York ghetto, to another availability context, such as England? How does the American "hustle" (you alluded to that briefly) react in a different kind of cultural environment?

MR. SONNENREICH: We have not done a study of that, but we have the classic study of the American serviceman in Vietnam who was "addicted" and who came back into his own environment in the United States. There is no question about it, part of the reason some people choose heroin rather than alcohol is, in part, the "hustle." There is a life style that is involved with heroin use and it is not just a question of people saying, "I like this drug just for its effect." A lot of people like the drug for its effect, and crazy as it may sound, they also like that very undirectional approach to life. They have only one major goal — to shoot up everyday — and the question is: How do you do it? So, this is part of the "hustle."

PARTICIPANT: This focuses on another problem involving maintenance. When you maintain a person, you are trying to create a tolerance level so that he does not get high any longer but is still on the drug. When you start talking about heroin maintenance, you start getting into the question of whether a person should be allowed to shoot up and get high while he is being maintained or in treatment. What is your point of view?

DR. BRYANT: We are talking about a philosophical and a moral issue here. A number of people would say in relation to most of the treatment programs in this country — other than "Street" — that we have no heroin maintenance. We have methadone maintenance programs and methadone is administered in a way that does not provide a high.

This gentleman is asking why we are doing this. Why are we saying we want no highs? Who wants to comment on that?

MR. SONNENREICH: We want highs but we want you to take *our* highs. One of the things you notice when you start looking at methadone maintenance programs is that there has been a rapid growth of liquor stores around the clinics. You cannot walk into most of Bedford-Stuyvesant or other such areas without seeing that the addicts being treated take their methadone and then go next door to get bombed. There is a substitution. It is an obvious substitution and one of the interesting studies that the Commission has not performed — I hope somebody else will. I would like to see how many people we are taking off heroin and putting into the alcoholic category.

DR. BRYANT: Let me add also that while I agree with Mr. Vanocur's point that I wish we would stop talking about the British system over here, I do not think that some of the English experience is relevant to this issue because an awful lot of people get heroin, shoot heroin, get methadone, shoot methadone — and get high. One of the more interesting things you can do, if you are part of the drug industrial complex, as I am afraid a lot of us are, is to talk to the clinicians and psychiatrists who come from Britain to America. This is a moral issue of personal concern.

MR. VANOCUR: This gentleman is asking an important question. Methadone is a work ethic drug. It does not answer the problem that Mr. Sonnenreich raised — some people saying, "I do not want the work ethic. I do not want life the way it is supposed to be." I am not deploring this, nor am I putting the methadone thing down, but that is the way it is. The goal is to make useful citizens out of people on methadone.

MR. MARKHAM: There is a caveat here. There is a sort of willingness to believe that people who are stabilized on methadone do not experience a high. It is anecdotal and perhaps unreliable, but there are addicts who will say that is not exactly the truth. It is perhaps perceived by those who would remedy the ills of addicts as a work ethic drug. But it may not, in fact, be quite as neat as Dr.

Dole and many, many people who have come after him in this field would have us believe. In fact, there are a lot of people on methadone who do get high.

DR. BRYANT: It is according to how you define "high." There are a lot of people on methadone who are comfortable, perhaps.

PARTICIPANT: You mentioned the fact that a certain number of heroin-dependent individuals are essentially copping out of an effective way of life. What percentage of heroin addicted people are willing to accept a methadone maintenance program?

MR. SONNENREICH: Who knows? Realistically, we do not even know how many heroin-dependent people there are in the United States. (You may want to apply the famous rule of three — look at how many people are listed on BNDD records as being addicts, then take the New York Registry and multiply it by three on the assumption that you only catch one in three — or you may want to apply a fish-in-the-sea theory.) Since we do not know how many, I obviously cannot give you a percentage of how many people want to use methadone. One answer would be clearly that it is not going to be all of them. In any event, for the ones that would come into the program, the real question is whether they are the most antisocial — I believe "antisocial" is a legitimate word since we are talking about the social norm. If you think methadone is going to be the panacea, you are wrong — it is not.

DR. BRYANT: If it turns out that a substantial number of people do not volunteer to come in, what do we do with that group?

PARTICIPANT: I would like to ask a question of Professor Musto just to get an historical perspective. I was always under the impression that the original use of heroin was to treat morphine addiction. Is that true?

DR. MUSTO: For all practical effects, it is not true. The primary purpose for heroin, which is the trade name of the Bayer Pharmaceutical Company for diacetylmorphine, was as an ideal cough suppressant. They were looking for a cough suppressant that would have all the effects of opium (which is a magnificent cough suppressant). They added two acetyl groups to the morphine molecule and marketed it under the name of heroin in 1898. The next year, to solve the same problem with salicylic acid, they made sodium acetylsalicylic acid and called it aspirin. In 1899, a person could see joint ads for aspirin and heroin. Heroin addiction was reported in medical litera-

ture in the United States as early as 1902, only 3 years after it was marketed in Germany.

DR. BRYANT: Dr. Musto is destroying our myths.

PARTICIPANT: I would like to ask Mr. Sonnenreich if his Commission made any recommendation regarding the mode of administration of drugs. For example, if marihuana were legal, would it then be legal to inject tetrahydrocannibinal intraveneously?

MR. SONNENREICH: No, we made no recommendations as to the mode of drug administration. I am personally not terribly impressed with the suggestion that the method of administration is at all crucial. As to the tetrahydrocannibinal, our recommendations about cannabis do not apply to it. We were talking about natural products; we were not talking about synthetics. Obviously, everytime you inject something you will get a faster reaction. In addition, there are inherent dangers in using hypodermic syringes — but we did not make recommendations as to that.

One thing that I have noticed is that we are talking about a lot of little specifics. You are doing what I hoped you would not do — talking about the little nits and picks that may be nice and interesting in terms of resolving little questions. They do not get at any of the fundamental issues.

PARTICIPANT: One concern I have is that so far today we have discussed two models, the medical model and the therapeutic model. The Consumers Union, in its book, mentioned three models — the sociological, the psychological, and the medical — yet they never dealt with the sociological model. Has there been any kind of consideration of that model, in light of the often repeated claim that what we need is a solid prevention program which focuses upon the social and economic conditions that control people's lives?

MR. LEFF: We discussed the three approaches, as I mentioned, but we did not dwell on them because we feel it is more important how the addiction manifests itself.

There are environments in which some addicts apparently are able to maintain abstinence, for example, Synanon, which is very well known. The head of Synanon has remarked, as we report in our book, that when ex-addicts leave the confines of Synanon, within two years 90 per cent of them are back on heroin. The alternative would appear to be that the addict must choose either to remain in Synanon or to return to heroin.

DR. BRYANT: We are running out of time but we will take a couple more questions.

PARTICIPANT: It is said that certain things are o.k. if they do not affect anybody else. For example, you said smoking cigarettes is o.k. since if one wants to end up with a lung that hangs down to his knee, it is his own business. I assume, likewise, if one wants to use drugs, that is his own business. Why is it that you decide that getting high is *your* business?

Secondly, I do not understand why you are perpetuating this myth about methadone. Clearly, from what you have stated today, it would take a lot longer to get off methadone than it does to get off heroin, just physically. The only advantage that I have detected so far is that one does not have to use a needle. Studies have shown that people in factories have been able to work on heroin as long as they had money enough to maintain their habit. People on methadone are able to work, too. What is so great about not having to use a needle?

MR. SONNENREICH: There is an advantage of methadone over heroin — it lasts for 24 hours in oral form. For whatever reason, society by and large does not like the idea of people shooting things into their veins unless a doctor does it for them. This is a hangup and maybe it is a wrong hangup, but it nevertheless is real.

You are saying, "Why do we object to a high?" The answer is that we do not object to a high. We are concerned about structuring the high along more acceptable channels. You may think it is fine to be high on a particular drug. We looked at it, and we recognized that drugs are used for mood alteration. The question is how many can you use and how many can society sustain.

Most societies accept a drug, or several drugs. The question that we had to answer from a policy point of view was: What should be the category of drugs or class of drugs that we think people can get high on? We understand that people get high. Nobody is objecting to people getting high.

SAME PARTICIPANT: My first point was that you and the Commission have appeared more concerned about the drugs which people are taking and the attitude that has developed than you were about the death that might result from cancer caused by cigarette smoking.

MR. SONNENREICH: That was not our function. I am also terribly concerned about mental retardation, but that problem was also not within the scope of the Commission's work. We were supposed to be

dealing with this one particular area. What we are and were concerned about can be seen in the history of drug use and its place in our society. Most societies accept drug use of one form or another and they structure it. We happen to be a highly mobile, highly affluent society and do not have all the institutional controls which structure drug use in other societies.

The Commission took the attitude that while others may worry about problems at the high end of the scale of drug behavior — the intensified, the compulsive use — we would concentrate on the structuring of the other kinds of use.

DR. BRYANT: I think you are pressing a point that is very good; we are all learning from it.

PARTICIPANT: I would just like to say that it sounds as if we are right on the verge of doing exactly what Dr. Musto spoke about this morning, that is, letting the overall pressures of society dictate, in a sense, or guide what law and medicine decide to do with the information. Society does not approve of people shooting things in their veins and society does not approve of them getting high from their medicine — which is the result of maintenance programs. I think we really ought to think about how much those kinds of pressures and the Puritan, if you will, standards of our society will influence: (1) the drugs we choose to maintain people with, and (2) the method or the style in which we let them take them.

MR. SONNENREICH: These basically are two of the points we were trying to make in the report. The most important recommendation we have, I think, is to change attitudes and ways of looking at drug use.

But make no mistake about it, anybody who says, "Well, that is a Puritan ethic; Max Webber is dead," is being highly unrealistic because you do not make policy in 180 degree sweeps. You make policy at 10 and 20 degree turns. You can be in the vanguard, and you can take a couple of steps ahead of people, but then you had better be absolutely certain that you draw the people through an attitude change to your position so that you can proceed to the next change.

We are not a country that works in radical sweeps. That is, perhaps, one of our strengths; it is also one of our frustrations, but it is a very, very important point. We do not want public policy to flip, because if it flips in this area it can flip in another area. The thing about which the Commission is most concerned is the practice of looking at the problem with blinkers on. It is a social problem within