NARCOTICS ADDICTION AND DRUG ABUSE

HEARINGS

BEFORE THE

SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE PROBLEMS OF NARCOTICS ADDICTION AND DRUG ABUSE

AUGUST 6, 7, AND 8, 1969

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ADDITIONAL INFORMATION

Senator HUGHES. Thank you, Mr. Reddish. You have been helpful, and we appreciate your willingness to come forward and testify.

Is Gloria Hardy here now?

I think the committee will recess now because of an executive Education Committee hearing, and Senator Dominick and I have to be there to get a bill out to act on before the recess.

We are going to reconvene at 1:30 rather than 2 p.m. I would like to call Mr. Jaffe as the first witness at 1:30 p.m.

The committee will recess.

(Whereupon, at 11:30 a.m., the subcommittee recessed to reconvene at 1:30 p.m., the same day.)

AFTERNOON SESSION

(The subcommittee reconvened at 1:30 p.m., Hon. Harold E. Hughes, chairman of the subcommittee, presiding.)

Senator HUGHES. The committee will come to order.

The Chair calls Mr. Jerome Jaffe, assistant professor, Department of Psychiatry, University of Chicago.

STATEMENT OF JEROME JAFFE, ASSISTANT PROFESSOR, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF CHICAGO

Senator HUGHES. Mr. Jaffe, would you proceed with your statement, if you would care to summarize it, or whatever you want to do.

Dr. JAFFE. Yes, Senator. My statement is in your hands.

Senator HUGHES. We will enter it into the record

(The prepared statement of Dr. Jaffe follows:)

PREPARED STATEMENT OF JEROME H. JAFFE, M.D., DIRECTOR, DRUG ABUSE PROGRAMS, STATE OF ILLINOIS DEPARTMENT OF MENTAL HEALTH; AND ASSOCIATE PROFESSOR OF PSYCHIATRY, UNIVERSITY OF CHICAGO

I appreciate the opportunity to present my views on the present state of research and treatment in the field of narcotics addiction. These views evolve out of my past experiences with programs in several parts of the United States and out of my more recent work over the past three years in planning, developing and directing a treatment program for the State of Illinois. Two years ago today there were virtually no public treatment facilities for narcotics users in the entire State of Illinois. In order to withdraw from drugs narcotics users were required to plead guilty to a misdemeanor and to petition the court to avail themselves of a bed in the hospital unit of the city jail. The legislature had acted upon a treatment and research program proposed to it by the Illinois Narcotic Advisory Council, but the legislation had not been signed.

Today, in Illinois there is a coordinated network of treatment serviecs that i s rapidly expanding. More than 1100 drug users have sought treatment voluntarily without any attempt to publicize the program. More than 500 individuals have been offered some form of treatment, and more than 325 are currently in active treatment. Of outpatients able to work more than 60% hold legitimate paying jobs. The arrest rate has dropped dramatically. More than 10 new patients are entering treatment each week. The multimodality program now in operation includes some of the best features of programs operative in other parts of the country (methadone maintenance, withdrawal, aftercare, and therapeutic communities), but it was designed specifically as a response to the problem of narcotics use in the Chicago area. Built into the program is a system of continuous evaluation that will permit it to continually modify its operations with changing conditions and to maximize its effectiveness in reaching clearly defined goals for specific subgroups within the narcotics using population.

We feel that we have demonstrated that it is possible to develop a multimodalty treatment system within a single administrative structure, and that such a system can reduce or eliminate much of the inefficiency and destructive rivalry that often characterizes the operations of single-modality treatment programs in other communities.

Given so intense an involvement with one program, it is difficult for me to claim total objectivity when evaluating other approaches to the problem. Therefore, I would like to describe the evolution and present status of that program and point out those features which may have special relevance for other communities.

BACKGROUND

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

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

PRINCIPLES AND PREMISES

These premises and principles are as follows:

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

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

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

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

Ideally, a treatment program should attempt to help all compulsive narcotics users become emotionally mature, law abiding, productive, nondrug using members of society who require no additional medical or social support to maintain this ideal status. But, this is an ideal set of goals, a set which society does not expect any other group with medical or psychiatric disabilities to meet. For example, we do not expect middleaged people with mild congestive heart failure to become marathon runners; we do not even insist that, after some arbitrary period

of treatment they abstain from digitalis, dieuretics, and visits to the doctor. The INAC took the position that compulsive drug use should also be thought of as a chronic disorder, in many cases requiring continued or intermittent treatment over a period of years. It followed, then, that while all treatment programs should attempt to help every individual reach all the components of the ideal set of goals, any evaluation of the overall effectiveness of any specific treatment must take into consideration that different programs tend to place their emphasis on different goals.

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

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

The INAC was aware, even while arranging these behaviors hierarchically, that they are actually often quite independent, and that some individuals may show behavior at the "upper" levels of the hierarchy without exhibiting the behavior at the "lowest" levels. For example, some patients may stop using illegal drugs and work at legitimate jobs and require no medical treatment, but continue nevertheless to engage in illegal activities; others may not use drugs nor engage in illegal activity, but may require prolonged or semi-permanent residence in a therapeutic community. In addition, some treatment approaches may be more effective in helping patients achieve one goal than another.

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

A MULTI-MODALITY PILOT PROGRAM

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

modalities, i.e., a multi-modality approach. As a minimum, the specific modalities or treatments to be developed, evaluated and compared to each other were:

1. Standard periods of hospitalization for withdrawal followed by group therapy in the community—narcotic antagonists such— as cyclazocine were to be evaluated in this context;
2. The use of oral methadone in the context of a rehabilitative program;
3. Residence in therapeutic communities such as Synanon or Daytop Village.

Descriptions of these methods and concepts are summarized and appended.

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

THE STATE-UNIVERSITY COLLABORATION

Although these were rational recommendations, there was a major risk that even if the INAC's recommendations were accepted by the State Legislature, the program might still prove impossible to implement, particularly if it were funded on the usual two-year basis. Since there were no programs operating in the State, the most difficult obstacle was the absence of experienced personnel. Furthermore, even the recruitment of personnel could not be initiated until legislation and appropriations were passed and signed. The problem of recruiting appropriately trained personnel was even more perplexing. It could not be done under the existing personnel codes and the States was reluctant to change its personnel codes without proof that the changes were required. Yet without the personnel, no programs, and therefore no proof, could be developed.

The INAC turned, therefore, to the academic community for help. If the universities could recruit and house key personnel on the basis of an anticipated passage of the new legislation, the State, once the legislation was passed, could enter into a collaboration which would: (1) advance our knowledge in the field (a traditional interest of the academic community) and (2) establish a desperately needed medical-social service to the community (a newer interest of academic communities located in urban areas.)

The formula for this collaboration has been used successfully in other mental health areas and involves the vesting of responsibility and operational authority for both the university and state segments of the collaborative enterprise in one or more people chosen jointly by both groups. That is, these individuals would simultaneously hold university and state positions. Such arrangements pose risks to both university and state and repeatedly place the program directors in conflict of interest situations. Nevertheless, its inherent advantages for both parties outweigh its disadvantages. The university can participate in a large scale research and evaluation project on the efficacy of treatment without incurring a long-range commitment for continuing direct services to the community. The state can obtain a well designed and executed research design without making long-term commitments to highly specialized researchers. The most important benefits accrue to the state which, because of the peculiarities of the funding procedures, is often required to develop its own programs on an unrealistically short time base. New and potentially valuable programs are often cut off in their infancy because they cannot become demonstrably effective within a two or three-year period. By offering a modest (but long-term) grant to the university, it can enable the university to enlist the full-time efforts of experienced people. By working at first within the university they can initiate the first stages of the collaboration in a structure that is usually more flexible and more easily moved than the civil service structures of most large cities and states.

The involvement of the academic community yields one other major benefit. Having its major interest in evaluation rather than in the perpetuation of any given program, the university-based evaluation group can afford to be brutally

objective. In the State of Illinois program this notion of independent evaluation has been carried to a logical extreme. Through a grant from the Federal Government to the University of Chicago, we have made the jobs of the evaluators independent of any single treatment approach supported by the State.

Early in the course of the INAC deliberations, its Chairman, Dr. Harold Visotsky (who was the Director of the Department of Mental Health), had sought the advice and consultation of Dr. Daniel X. Freedman, the newly appointed Chairman of the Department of Psychiatry at the University of Chicago. Dr. Freedman, in turn, was responsible for interesting the author in joining the Department of Psychiatry at the University of Chicago and for providing the financial (as well as the moral) support for the overall planning of the program which eventually evolved. Since the architects of the program were already part of the University of Chicago's Department of Psychiatry, it was not illogical for this Department to join with the Department of Mental Health in trying to implement the program.

SPECIFIC PROGRAM COMPONENTS

Even after the participants, the premises and the situational demands were defined, the INAC and its University of Chicago collaborators still faced the problem of formulating specific plans and a timetable for the development of facilities, personnel, and treatment procedures. At this point another set of goals and principles evolved. This time, goals for the program rather than for the patients were established.

For example, as a general principle the INAC felt that wherever possible clinical facilities should be located for the convenience of patients rather than staff. Most narcotics users are unlikely to be able to own cars if they give up illicit sources of income. They must be able to reach the clinical facilities by walking or by public transportation. This is particularly important when treating those types of narcotics users who engage in few conventional activities. When such users give up illegal drugs they will have large blocks of unstructured time. If they are to make significant long-term changes, they will have to acquire a new set of associates and learn new patterns of speech and behavior. Facilities should be designed to provide a structure for filling empty time with new and constructive behavior patterns. Not only must the clinical facilities be accessible, but also comfortable and "possessable." The notion of "possessability" is particularly important. To be optimally effective the clinical programs must generate involvement in the treatment process. A new and imposing structure not only costs five times as much as a renovated old house, but unlike such an old house, a new structure cannot "belong" believably to a group of urban heroin users with police records and therefore is probably not as useful. Similarly, the size of the patient population at any given location should be small enough to permit a sense of group identity and individual participation. Superficially, such small units may appear to be less efficient economically. However, if efficiency is based on patients successfully treated per dollar rather than merely the total number of patients served per dollar, smaller units yielding greater involvement may actually be more efficient.

Other general operating principles include the employment of patients in the program wherever possible, and maximum articulation with other community agencies. But what this program emphasizes as the most critical considerations for establishing pilot programs for the treatment of drug abuse is the continual monitoring of the efficacy of treatment and the feedback of this information into the clinical process, so that as a result, the clinical process can be continuously modified.

CURRENT STATUS

The State of Illinois-University of Chicago collaborative program became operational in January of 1968 when a single patient began to receive methadone on an ambulatory basis. At that time there were about six staff members and its total operating space was a six-room apartment lent to it by the Department of Psychiatry of the University of Chicago. As each of the projected units became operational (the hospital withdrawal unit in June, 1968, the first short-term methadone unit in May, the first Gateway House unit in June, research and administrative offices in September, and the first half-way house unit in December) it became progressively more feasible to implement the research design previously described. Obviously, random assignment could not be initiated until all treat-

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

1. Three methadone outpatient facilities
2. Therapeutic communities operated by Gateway Houses Foundation, Inc. (an Illinois not-for-profit corporation)
3. A halfway house—crises center in the community for detoxified patients—some of whom are taking the narcotic antagonist, cyclazocine
4. A multimodality training and residential facility at the Tinley Park Mental Health Center

At present, all voluntary patients seeking treatment from the program and actively using narcotics are randomly assigned to one of the four units described above.

Patients are not required to accept the treatment program to which they are assigned, but they must at least make the effort to participate in face-to-face interview with the staff of the assigned treatment unit. If, after such a personal interview, the patient still elects not to accept the treatment offered, he may return to the intake unit and after an arbitrary waiting period (currently four weeks) seek entry into any of the treatment units.

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

Since the procedures in this program's methadone units differ in some significant ways from the procedures described by Dole and co-workers (1966) a summary of the differences is in order. The outpatient methadone programs now operating in Chicago are entirely ambulatory (patients are transferred from heroin to methadone while still living in their own homes). The dosage is lower (the mean dosage of oral methadone is under 40 mg per day in contrast to the 100 mg per day used in the Dole-Nyswander program). There is no preselection of patients (the methadone treatment units accept patients regardless of past histories of barbiturate or amphetamine use, alcoholism or psychosis). Lastly, some patients enter a short-term methadone unit where they are offered methadone treatment for a maximum period of six months, after which they are expected to enter one of the other treatment units (therapeutic community, hospital withdrawal-aftercare, or long-term methadone maintenance).

PROGRAM EVALUATION

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

RESULTS TO DATE

Through today, more than 1,100 narcotics users have made contact with the program on a voluntary basis. Over 500 individuals have received some form of treatment, more than 320 are still actively engaged in treatment in one of the units, and about 10 narcotics users are entering treatment each week.

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

We are not yet able to provide such a detailed analysis. Yet, our preliminary analysis does indicate that for the narcotics users we have encountered thus far, some form of methadone maintenance is the most acceptable form of treatment. It is also the form of treatment which is most effective in keeping patients in continuous treatment and in which there is the highest rate of gainful employment. Based on man-weeks of exposure, the re-arrest rate is as low as for any other form of treatment, and the cost of treatment is lower than the cost of any other form of treatment we have employed.

We cannot claim that the system we are developing is appropriate for other communities where the size or the characteristics of the narcotics using population may be quite different. Where the size of the problem is small, it may be uneconomical to create so diversified a system. On the other hand, we must assume that the narcotics problem will not simply disappear and that the systems of care designed today will be with us a decade from now. It is, therefore, appropriate to ask whether, in those areas with significant problems, this Country can afford to approach the development of a system with less careful planning or less built-in evaluation than we have used in Illinois.

Appendix A

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

It is important to distinguish between the use of oral methadone maintenance as a rehabilitative technique and the current British practice of prescribing narcotics to addicts. With methadone, the dose of the drug and frequency of administration is determined entirely by the physician. Intensive efforts are made to direct the patient's energies, previously given over to the problems and mystique of the "junkie" subculture, into productive channels. Almost as important, the technique of dispensing all methadone in fruit juice makes it virtually impossible to use the drug intravenously; and in terms of the effect on behavior, differences in the route of administration cannot be flippantly dismissed by the simplistic assertion that a narcotic is a narcotic no matter how it is used. By contrast, in the British situation the addict is given a prescription for a narcotic, often unaccompanied by any effort toward rehabilitation. The prescription is usually for heroin, and the addict is free to administer the drug to himself by whatever route and with whatever frequency he chooses.

In New York City, the methadone maintenance approach is now being used with almost 1,000 former heroin users. In other parts of the country other inves-

tigators are studying modifications of the original Dole-Nyswander procedures to determine if the costs can be lowered, the flexibility of approach increased, or the risk of illicit redistribution of methadone can be reduced.

Appendix B

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

Appendix C

Self-help programs such as Synanon, Daytop Village, Phoenix Houses and Gateway Houses (a network of therapeutic communities established in Chicago in July of 1968) are run almost entirely by rehabilitated ex-addicts or by ex-addicts working in close collaboration with a professional staff. They usually entail several years of residence in a therapeutic community. Experience demonstrates that many former compulsive drug users are able to remain drug free and to function productively so long as they remain in residence. This is certainly a worthwhile achievement, even if it falls short of the ideal of totally independent function in the community at large. Of all the approaches now under evaluation; however, this one may be best suited to yield that elusive, ideal, long-term goal of drug free, productive behavior, without the need of continued medical or psychological treatment. It is also worth emphasizing that unlike the pharmacological approaches described for the treatment of narcotics use which are not relevant for the treatment of barbiturate or amphetamine abuse, the therapeutic community concept is equally applicable to all forms of drug abuse.

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

BIOGRAPHICAL SKETCH OF JEROME HERBERT JAFFE

Formal education:
Temple University: A.B., Psychology, 1954; M.A., Experimental Psychology, 1956.
Temple University School of Medicine: M.D., 1958.

Awards and honors:
Temple University, College of Liberal Arts:
Magna cum laude; Distinction in Psychology; Alumni prize: highest academic average; Psi Chi Award (scholarship and achievement in psychology); Psi Chi Honorary Society.
Temple University School of Medicine:
Summer Research Fellowship in Pharmacology, 1957; Babcock Honorary Surgical Society; Alpha Omega Alpha; Merck Award: outstanding achievement in Medicine during senior year; Mosby Scholarship Award: highest four year average in medicine.

Fellowships:
USPHS Post Doctoral Fellowship in Pharmacology, 1961–1964.
USPHS Research Career Development Award, 1964 to present.

Major interests:
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Experience and training:
Rotating Internship: U.S. Public Health Service Hospital, Staten Island, New York, 1958–1959.
Residency in Psychiatry: U.S. Public Health Service Hospital, Lexington, Kentucky, 1959–1960.
Psychiatric Staff: U.S. Public Health Service Hospital, Lexington, Kentucky, 1960–1961.
Post Doctoral Fellow, Interdisciplinary Program: Albert Einstein College of Medicine, 1961–1962.
Post Doctoral Fellow and resident in psychiatry: Albert Einstein College of Medicine and Bronx Municipal Hospital Center, 1962–1964.
Assistant Professor, Department of Pharmacology and Instructor, Department of Psychiatry, Albert Einstein College of Medicine, 1964–1966.
Assistant Professor, Department of Psychiatry, University of Chicago, 1966–1969.

Present positions:
Associate Professor, Department of Psychiatry, University of Chicago, 1969 to present.
Director, Drug Abuse Program, Department of Mental Health, State of Illinois, 1967 to present.

Consultantships:
Illinois State Narcotics Advisory Council.
New York State Narcotic Addiction Control Commission.
National Institute of Mental Health.
Visiting Assistant Professor of Pharmacology and Psychiatry, Albert Einstein College of Medicine.
Visiting Lecturer, University of Texas, Medical Branch.

Memberships in organizations:
Alpha Omega Alpha.
Sigma Xi.
Chicago Medical Society.
Illinois State Medical Society.
American Medical Society.
American Psychiatric Association.
American Association for the Advancement of Science.

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Dr. JAFFE. I appreciate the opportunity to present my views. They derive from experiences in the United States and my work in the past 3 years in planning a program for the State of Illinois.

Two years ago in Illinois, we had virtually no treatment facilities. Today, there is a coordinated network of treatment services that is rapidly expanding.

More than 1,100 narcotic users have asked us for treatment. We have provided that treatment to more than 500, and at this time, more than 325 are in active treatment.

Of those people able to work——

Senator HUGHES. Could I interrupt you as you go along and ask how you adjust this type of voluntary treatment to comply with the legal structure that we have?

Dr. JAFFE. We spent a lot of time planning this with the cooperation of legislators in the State of Illinois, and they were represented, along with the police, the law enforcement agencies, social work agencies, on the Illinois Narcotic Advisory Council. We rewrote some of the laws of the State specifically to permit us to do certain of the things we are doing.

But generally speaking, there has never been any law against treating people who apply for treatment. The only issue was to make sure the treatments we were planning to use were in no way contradictory to the laws that existed, and wherever there seemed to be a conflict, the law was rewritten to exempt the projected programs of the Department of Health from the statutes.

I want to emphasize that we have built into our program a system of continuous evaluation that will permit this network of services to modify its operations continually with changing conditions, and to maximize its effectiveness in reaching clearly defined goals within the narcotics using population.

We feel that although we have been at this only about 18 months, that we feel it is possible to develop a multimodality treatment, and that such a system can eliminate much of the inefficiency that often manifests itself.

Having said that I can't claim to be totally objective with respect to the situation in Chicago, however, I would like to emphasize several general points. We believe that narcotic users are a heterogenous group. They started using drugs for different reasons, and continue to use them for different reasons. They have different experiences as a result of their drug use, and it is likely that more than one approach will be needed to rehabilitate so heterogenous a group.

Just as important to this appreciation of this heterogeneity is the idea of clearly defining the goals of treatment. What is it that we want to focus on primarily? Total absence from all drugs, or absence merely from illegal or illicit drugs? Is gainful employment our goal, or will we tolerate merely law abiding behavior, even if people never get around to holding jobs? We must also consider what time base we are talking about. Do we demand instant change, and at what cost?

The last point is that narcotics use is only one band in the spectrum of drug abuse. The technology now being used for narcotics users may not prove to be as effective with other types of drug abuse, such as abuse of amphetamines or alcohol.

It is important, therefore, that we attempt to continue to develop new techniques to deal with abuse of these other classes of drugs. Present methodologies have grown out of investments made in basic and clinical research over the last two decades. With present techniques, I believe that the present deleterious effects of narcotics use can be reduced or eliminated, given the time, money, and the structure.

It is unrealistic to expect to create a large-scale intervention system for other drug use in a few years or even 5 years hence if we do not support development of new techniques and attract creative minds into the field.

I think the program we developed in Illinois shows there can be no single statement about the effectiveness of a single approach. There can only be a statement about what types of individuals are moved toward what goals by which treatments and at what cost over a given period of time.

Our preliminary analysis does indicate that the narcotics users we have encountered thus far, some form of methadone maintenance is the most acceptable form of treatment. It is also the treatment that is most effective in keeping patients in continuous treatment, and in which there is the highest level of gainful employment. The arrest rate is as low as for any other form of treatment, and the cost of treatment is lower than the cost of any other form of treatment we have employed.

We cannot claim the system we are developing is best for other communities. Where the size of the problem is small, it may be uneconomical to create so diversified a system.

On the other hand, we must assume that the narcotics problem will not simply disappear, and that the systems of care designed today will be with us a decade from now.

It is therefore appropriate to ask whether in those areas with significant problems this country can afford to approach the development of a system with less careful planning or with less built-in evaluation than we have used in Illinois.

Senator HUGHES. Doctor, how are you supported financially?

Dr. JAFFE. We have an appropriation which is administered by the Department of Mental Health of the State of Illinois.

Senator HUGHES. How much is it?

Dr. JAFFE. This year, it is somewhat over $1 million total.

Senator HUGHES. Do you have support from the NIMH, too?

Dr. JAFFE. We have had, since last May 30, 1968, a grant at about the level of $500,000 a year from the National Institute of Mental Health to the University of Chicago, and the program I described, and that is described in my prepared statement is really a collaborative program between the State of Illinois and the University of Chicago, which is, in turn, supported by the National Institutes of Mental Health.

Senator HUGHES. Do you have local funds involved where you have these programs in Chicago?

Dr. JAFFE. There are local funds involved to the extent that one of the facets of this treatment system consists of several therapeutic communities, modeled after Daytop Village and Synanon. These have been supported in part by the University of Chicago, and in large part through a contract with the State of Illinois, but they are also free to seek contributions of goods and services from the community. There are no grants from Chicago or Cook County as such.

Senator HUGHES. You have heard the testimony this morning of former users?

Dr. JAFFE. Yes.

Senator HUGHES. You heard at least two witnesses, and I think three, testify to the ready availability of narcotics in the penal institutions?

Dr. JAFFE. Yes.

Senator HUGHES. Have you made any survey of that in your own State?

Dr. JAFFE. I can't say we have made a systematic survey. My general impression is that they are correct, that it is possible to obtain a wide variety of drugs even while confined in prison.

Senator HUGHES. Is it possible to detect users? Is it possible medically to detect them while they are going through the courts?

Dr. JAFFE. A urine specimen will detect microgram quantities. It is very easy.

Senator HUGHES. Is there a means to detect these users before they are placed in an institution?

Dr. JAFFE. I don't see why not.

Senator HUGHES. Is it more complicated than a test for alcohol? If you arrest a man for drunk driving, don't you take a urine sample?

Dr. JAFFE. I don't know for sure. They have very sophisticated breath meters to indicate that someone may have alcohol in his system. The urine tests for drugs of abuse are simple. They are not quite as simple as blowing through a tube, but certainly as chemical tests go, they are relatively uncomplicated.

Senator HUGHES. I am asking these questions, realizing that they are outside your written statement, but because of your background. It would be possible to run periodic tests within the institutions to determine users within the institutions?

Dr. JAFFE. No difficulty at all. Last week, our own small laboratory ran 700 such tests on our outpatients.

Senator HUGHES. And there could be a control for this test?

Dr. JAFFE. I think there are a number of technologies being used for such tests which differ in how expensive they are, how complicated they are, and how sensitive they are.

I know that a group has been funded by the National Institutes of Mental Health to reevaluate the various ways that this can be done, and to determine the relative sensitivity and relative complexity of the various procedures.

So that I would say within a year it will be possible to choose from a number of methods, depending on which drugs you want to detect, and at what level of sensitivity.

Senator HUGHES. There are some 1,100, I believe you said, that you have on the program in Illinois, or through the program.

What social strata is represented basically?

Dr. JAFFE. Basically, all our facilities are on the south side of Chicago. Those who come to us are either the unemployed, or the lower class, mostly Negro, and mostly in their middle thirties. I would say that about 80 percent of our population is Negro, and of that group, about 80 percent are male.

The mean age is 35, and they have been using heroin for approximately 17 years.

Senator HUGHES. Heroin for 17 years?

Dr. JAFFE. On the average. They started using heroin 17 years before coming to us. Most of them have had their careers interrupted by periods in jail of anywhere from a few months to a few years, but this is the average. That means some people coming to us have been using heroin for longer.

We have had people as old as 72, who are physically debilitated, who are still able to get heroin on the south side of Chicago.

Senator HUGHES. We seem to have a common public impression in America that the addict or narcotics user is a criminal, which again gets back to the chicken or the egg question.

Could you relate your experience with respect to that?

Dr. JAFFE. I will go back to my statement——

Senator HUGHES. I mean other than violating the law in using narcotics.

Dr. JAFFE. The narcotics using population is heterogeneous. There are a large number of people who are noncriminal. They may be somewhat deviant, but they are basically not criminal, and become criminal only as a result of being involved in drug use.

I can't give you an exact percentage. It may be well over 50 percent of those we are looking at in Chicago, but then there are criminals who also use narcotics.

I think that it is reprehensible of a society to make the assumption that people are criminals first, and narcotics users second, even if there is a percentage of people who are indeed criminals first and narcotics users second.

Senator HUGHES. Do you have any statistical records of the cost of maintaining the average habit?

Dr. JAFFE. I have it, but I am not sure how reliable it is. The habits vary from $10 a day to $50 a day. Again, depending on economic situations, conditions, and what the addict does. Many addicts, in my experience, will often spend as much as they can get, so that how big their habit is is not so much a function of some pharmacological function, but what the source of their income is.

If someone is dealing, or has access to a lot of money, they may have a $50 habit. The same individual, under other circumstances, where they can't get a lot of money, may have a $15 habit. I would say it is rare to see someone who spends less than $15 to $20 a day for drugs. Obviously, what the source of income is ultimately will depend on the style of acquiring income.

Senator HUGHES. What are the youngest patients you have?

Dr. JAFFE. We have some as young as 15, and some as old as I believe, 72.

Senator HUGHES. What is your professional opinion on marihuana? Is it an addictive drug?

Dr. JAFFE. Not in the sense that heroin is. It is difficult to describe any drug, whether it be alcohol, or sleeping pills, with one statement, addictive or nonaddictive. They have different effects on different people.

Senator HUGHES. It has been the testimony here of every one of the ex-users that they began with marihuana. I didn't question them whether they began with alcohol before the marihuana.

What is your experience with those 1,100 people who have run through your clinics? Have you followed through on that?

Dr. JAFFE. We have asked how many used cigarettes, at what age did you first use alcohol, and so forth. I would not say it is uncommon for people to start with marihuana. Most people began with milk: mother's milk or milk from a bottle. Causality calls for more than a temporal sequence.

Senator HUGHES. In your professional opinion, you don't relate anything to the significance.

Dr. JAFFE. Only by defining one drug as being illegal, and by defining the users of that drug as being criminal per se. You both give them the excuse to deviate further, because they are already defined as being outside the limits of the socially acceptable, and you also force them to associate with people who may be dealing with other drugs.

Senator HUGHES. Does this inhibit them coming for help, medically, psychiatrically, or any other way?

Dr. JAFFE. Most marihuana users don't get into difficulty.

Senator HUGHES. I mean anyone, heroin users, cocaine users, because of the law——

Dr. JAFFE. The stigma attached to illegal drug use prevents people from confiding even in people they trust most, until the situation has gotten out of hand.

Senator HUGHES. Would you say they are afraid to come for help?

Dr. JAFFE. For those people who are not already known as active narcotics users, it takes out a certain amount of courage to seek out a treatment agency and say, "I am using heroin or cocaine."

There is a paranoia among drug users, which is not unjustified on the basis of their experience over the past three decades, and they really feel that most agencies are linked up in some way with the police, and that given fact that by virtue of simply for using a drug they can spend 5 years of their lives in jail, they are rather reluctant to seek any kind of help until things are quite desperate.

I might also point out, just to put it in balance, that there is a certain subsegment of drug users who don't seek help because they are having fun from drug use. They may not take steps until things get difficult.

Senator HUGHES. As a psychiatrist, have you found any definite lines of dependency or imbalance, or emotional instability, so that you can say that a certain thing seems to start a trend causing a need for a crutch?

Dr. JAFFE. It is difficult to make generalizations about a group so diverse. There are young people who feel alienated, mixed up, without goals in life, sometimes depressed, sometimes anxious. The drug may have many symbolic meanings.

The same way that somebody joins a motorcycle gang to find identity, some people join a group of drug users.

There are others who are relatively stable who belong to a circle where everybody uses drugs. They use drugs not because they feel out of touch with their subgroup, but because they want to conform to it.

As a result, some time later, they may find themselves caught up in something over which they have little control. But once having had treatment, their personality and treatment doesn't differ much from

some of their former friends who managed, almost by chance, to avoid becoming drug users.

Senator HUGHES. You say a person who is hooked can recover if they want to, and seek help?

Dr. JAFFE. There is no question about it.

Senator HUGHES. They are 100 percent recoverable if they have a desire?

Dr. JAFFE. I won't say 100 percent.

Senator HUGHES. At least from the physical detoxification.

Dr. JAFFE. Anybody can be detoxified. The problem is getting over whatever difficulties there are to permit people to reenter the mainstream of society.

Again, I keep talking about subsegments of this broad and heterogeneous group of people. Some have used narcotics the way some people take tranquilizers.

They can function with a narcotic but and they can't function without one. They use it as an antianxiety agent. They can be taken off the drug, and can't function. Kept on the drug, they manage to lead normal, useful lives.

I am not saying keep them on heroin, but perhaps an opiate-like drug would be beneficial.

Senator HUGHES. Are you doing any biochemical research on that, or is anything being done that you know of.

Dr. JAFFE. I believe such research is being done. I am not doing it.

Senator HUGHES. Would you say this is an area that should be researched? To find that you can maintain a balance by utilization of a drug would certainly indicate an imbalance without it.

Dr. JAFFE. I think that that has to be one of the first inferences that one should draw from, we will say, from studies with methadone, where people that in other treatment systems (no matter how supporting, or skilled the therapists) seem driven by a desire to use drugs, and preoccupied with ways of getting them, but given small doses of methadone each day, are able to live as normal, law-abiding citizens.

Senator HUGHES. You use methadone, do you not?

Dr. JAFFE. At least in the group we have seen, the methadone treatment seems to be the most effective and the most acceptable.

Senator HUGHES. As far as you know, does that have to be maintained for a lifetime?

Dr. JAFFE. I would make two statements to that. I am certain that for some people it does not. We have already withdrawn a small percentage of people whom we started on methadone. They continue to function well; some of them are on our staff. Their lives are normal, stable, they are effective members of the community.

So that we know that people can be taken off methadone and can do well.

I am sure, however, that there are others for whom methadone will be a form of treatment which should be maintained indefinitely.

Senator HUGHES. Is your main argument then, that supplying a drug that does not raise a high, apparently—I have had testimony here today that it did, as you heard.

Dr. JAFFE. I heard, but I was not convinced by the logic of the

argument. I am convinced by my observations of several hundred people, and my work with sophisticated instruments.

Senator HUGHES. Is the argument for using methadone that it enables a person to fit into the social structure, and hopefully, that they will not have to report to the clinic personally daily, or will they always have to report personally daily?

Dr. JAFFE. Our experience has been that the great majority of people are eventially able to be given medication to take home, to take it under their own supervision, at least a few days of the week, and to come to the clinic once or twice a week.

There are others, and perhaps these are ones who were criminals first and addicts only second who, given enough flexibility to do this, will abuse that privilege, and may skip the medication, may give it to someone else, but I think that this is true of any large population. There will be some that will treat this as medication, take it properly, and there will be others who will not.

Our experience is that most will take it under correct supervision. They will come to the clinic perhaps once a week, indefinitely.

Senator HUGHES. Are you familiar with the administration's recommendations recently in the field of narcotics?

Dr. JAFFE. I am not familiar with the details of it except as I have read them in the newspaper, and I am not sure that is an accurate reflection of what was said.

Senator HUGHES. I have that question in my mind, too, when I read the newspapers sometimes.

But I think we have to hope that it is, and that the editorials are on the editorial page.

Do you think that a law structured for possession of marihuana, providing a sentence of from 2 to 5 years is a good approach?

Dr. JAFFE. I have said it before, and I will say it again. I think such laws are barbaric.

It makes crimes where no crimes exist, and I think from a pharmacological point of view, such laws are totally irrational, and if drugs were people, they would be discriminatory.

The drugs that we sell in our cocktail lounges are equally deleterious to those whose possession we have defined as criminal offense. I think we are having a very difficult time getting warnings about tobacco on both sides of the package, and yet for one particular drug, merely to possess it brands someone as a felon.

Senator HUGHES. What do you recommend?

Dr. JAFFE. Well, I would recommend that those people who possess a drug merely for their own use (and that is easily determined if not self-evident. It doesn't take a bushel for your own use. You can tell the sellers from the mere users.)

If society decides that the drug should not be freely available, those people who insist on breaking that regulation should be treated the way you would treat people who make "U" turns, when making "U" turns is dangerous.

I think at some point for consistent offenders, you may have to escalate the sanctions and penalties. You may have to take some steps to put them in a situation where they can be supervised. I certainly think that we have enough criminals who are truly criminal

without branding as criminals those of our citizens who are otherwise law-abiding citizens.

Senator HUGHES. Do you have any general recommendations you can make to this subcommittee?

Are you familiar with the Yarborough bill, of which I am a cosponsor, as a vehicle here?

Dr. JAFFE. I am generally familiar with it.

Senator HUGHES. Would you care to comment about it?

Dr. JAFFE. I think it is certainly a more rational bill than the others that have been proposed. I think it takes a more realistic view of human behavior in that it does not make the assumption that if you escalate the penalties high enough you can deter anything, and frankly, I think it is a much more humane bill, and one which the population, perhaps, has a right to expect from its legislators.

Senator HUGHES. How widespread do you think the problem is in the United States?

Dr. JAFFE. Which problem, sir?

Senator HUGHES. The problem of marihuana, let's say, first, if it is a problem.

Dr. JAFFE. Well, if we define the mere exploratory use of the drug as a problem, I would say that among those between ages 18 and 25, it is extremely wide-spread.

On the other hand, from my point of view, for example, as a non-smoker, I would find exploratory use of tobacco, just trying to see what a cigarette is like, a very widespread and dangerous problem.

I am not sure that I would define the exploratory use of a drug like marihuana as a problem. Youth will explore it, and perhaps to a greater extent than one drag on a marihuana cigarette.

If we ask what is the problem of people who are regular, consistent users of marihuana, I would think it is not as widespread as the mass media would have us believe, that there are people who perhaps use several times a week. I am not sure at what point that becomes a problem.

I think it is possible to overuse marihuana, just as it is possible to overuse almost anything. I think those who do overuse it and therefore get into difficulty with it, or at least in this country, are few and far between. But I must say I have no statistics on this, and I can base it on nothing more than on my own experience in talking to people, and in the last 10 years of being a therapist who is known to treat drug users.

I have known only one person who ever came and said, "I think I use too much marihuana, that is my main problem in life."

So I have to make the assumption that the problem of overuse is not a critical one in this country.

Senator HUGHES. Do you consider alcohol a dangerous drug?

Dr. JAFFE. I consider it a very dangerous drug, from the point of view of what it can do to those who can't control it.

Senator HUGHES. More dangerous than marihuana?

Dr. JAFFE. I can't state that scientifically. I think it is probably more dangerous to health and to life and behavior than marihuana.

Senator HUGHES. Is it more dangerous than tobacco?

Dr. JAFFE. I suppose it depends what one wants to die of. If you

don't want to die in an auto accident, I would say smoke cigarettes. If you don't want to die with one lung, drink alcohol and die in the auto accident.

Different drugs present different spectra of effects. They present different risks, and these risks are different for different people.

Generalities, sayings usually carry with them a grain of truth, and a rather large boulder of inaccuracy, and as a scientist, I feel that I have to give long answers because, an accurate answer, it must clearly define the question as well as qualify the answer.

Senator HUGHES. Young people say they are tired of the hypocrisy about the relationship of marihuana and alcohol, and the fact that their adult parents, or the adult delinquents, as they are sometimes called, are a generation of alcohol users following many generations of alcohol users, and that their recreational drug is marihuana, which is nonaddictive, and they ask: "Why do we live in an age of hypocrisy?"

I am asking these questions with an open mind, Doctor. I think it is necessary to get at the truth, whatever the truth is, as nearly as we can define it.

Dr. JAFFE. I am not sure that I fully agree with this bland assertion that the recreational drug of the younger generation is superior, or more meritorious than the recreational drug of the parent.

On the other hand, I think it is hypocritical of his parents, without scientific evidence, to brand the younger generation as criminal for their use of their recreational drug, while the older generation sells its recreational drug by the quart on Sundays. Given alcohol's known dangers, and given the known number of fatal accidents and violent crimes associated with the use of alcohol, there is a degree of hypocrisy, without going into the relative merits of the two drugs.

There are 5 million people who can't handle alcohol. It damages the body, it causes accidents, and is associated with violent crime.

The other dangers of the drug are generally unknown, and if we keep the laws the way they are, they will never be known.

Senator HUGHES. Do you say we should legalize marihuana, outlaw alcohol, or what?

Dr. JAFFE. You are asking me to be a social planner, and I am not a social planner.

I am not sure whether or not one should legalize a new drug, at least across the board. But, I would be very interested, in planning a controlled experiment, so that we could know whether or know what we have done makes sense—whether it is a logical approach to the solution of a specific problem.

Why do we always ask the question of "Should we do it, or not do it?" Why don't we let it be done in a specific area or with a limited group of individuals under specifically defined conditions, and ask, "What are the consequences of such legal access?" This seems far more logical than simply saying it should be made legal throughout the United States.

Senator HUGHES. Would you make this as a recommendation?

Dr. JAFFE. I think it would be interesting to see what would happen in specific circumstances if we were to carry out a controlled study of the use of marihuana in a specific area as a recreational drug. Maybe the use of alcohol would go down, and maybe nobody would get into difficulty.

Senator HUGHES. You say you can't make those decisions, but someone in the Congress is going to have to face up to the issue. Your testimony is very helpful to us, and that is the reason I asked you the question. I realize you are not a social planner or organizer.

Dr. JAFFE. I think social planners might be wise to attempt to carry out limited pilot studies prior to legislating widespread, major social changes, because I think that such studies are feasible.

They are not easy. They will require the cooperation of both States and localities. I am not sure which community will be first to carry out the legalization of marihuana within its geographical confines, and yet, I think so much could be learned from what would happen in one community. Would it really destroy the youth of that commuity? I don't know.

What it might do is free up a number of otherwise able policemen to prevent violent crimes in the street.

I don't think it has to be done nationwide immediately, but I would speculate—and I want to identify this as speculation—that it would be better to make a nationwide change immediately than to continue with the barbaric laws that we now have, that now make criminals out of basically noncriminals and given even a choice, I would have very little hesitation in saying what I would do. But, I hope those are not the only two alternatives.

Senator HUGHES. I will conclude, Doctor, by asking you just a couple more questions.

The people who are experiencing your controlled research, are any of them new veterans returning to this country from Vietnam?

Dr. JAFFE. Not that I know of.

Senator HUGHES. Do you have any knowledge of the experience of narcotics use among veterans?

Dr. JAFFE. There were certainly people returning after the Korean war who said they began their drug use in Japan.

I might point out that right now our population is largely in their thirties, and as a result we are not seeing people in their twenties. I can't—I don't think that the group that we are seeing may be representative of the people who are coming back to other parts of the country. There may be people who are seeing them (returning servicemen using drugs) and I wouldn't want my statement that I am not seeing them to be interpreted that this does not occur in other parts of the country.

Senator HUGHES. We at least have one narcotics treatment facility in the veterans hospital, and we will have a chance later on to find out what they are doing, the ages of the veterans involved, and so forth.

I hope we can get into the use of narcotics in the military in the course of our inquiry here.

Is there anything else you would care to add for the record that might be helpful to us, Doctor, in our consideration of this problem?

What place do you think the Federal Government has—I will ask this as a final question—in the whole problem of narcotics use, addiction, recovery, and education?

That is a broad gamut.

Dr. JAFFE. The Federal Government has taken leadership in introducing the severe penalties that now exist in most States. The Federal

Government circulates the uniform narcotics bills that are then adopted by most State legislatures, which cannot necessarily command the expertise about legislation that they believe exists at the Federal level.

Senator HUGHES. You say these are barbaric?

Dr. JAFFE. My statement about marihuana laws is that they are barbaric.

Therefore, I believe it is the obligation of the Federal Government to take the leadership again to roll back and modify those laws so that they are no longer barbaric.

So, in the field of legislation, they have, I believe, an obligation to lead in a sensible direction. I think that people should begin to question, and question in a rather rigorous way, whether or not deterrents really deter, that it is possible to escalate the penalty high enough so that people won't do what they are going to do anyway.

So far as I am able to tell, I don't think that in the field of drug use and deviant behavior that the deterrent is as effective as legislators or law enforcement people would like to believe it is.

Lastly, I think in another area the Federal Government has a responsibility, and I believe it is to make an investment in the future, so that when communities around the country begin to say, "It is time for us to do something, what shall we do?"—that there be a body of knowledge, if not a cadre of able leadership that can help those communities initiate the programs that they need to meet their own local problems.

This is somewhat different from the Federal Government directly offering money to a community. Very often that is a little bit too late. One should have been preparing that community to survey and come up with plans. What the Federal Government often does now is to expect the local community to have an expert to prepare a total attack on a problem, and then request funds to do it.

Very often, the community does not have the expert in residence, and so it can't even ask for the money. It can't even ask for help, because it doesn't have anybody who can ask.

So, I think there is a training function and a research function that the Federal Government must assume so that later—it may be only a few years later—it can help the communities to build programs, using this reservoir of knowledge, technology, and human talent available to the communities.

I think we have done this in other areas, we have done it in medical schools. We have supported medical schools and colleges. When communities want to create medical schools, there isn't a shortage of academicians. There is, but it would have been more acute if the Federal Government hadn't helped to train people. This is true in many, many areas. I think it should start to become true in the field of drug abuse.

Senator HUGHES. How many narcotics users would you estimate there are in America?

Dr. JAFFE. Narcotics users?

Senator HUGHES. That are hooked.

Dr. JAFFE. Well, it varies with the community, but I am sure that it is well over 100,000 at this time.

Senator HUGHES. And growing?

Dr. JAFFE. I have been out of New York a while. It is my understanding that New York continues to have new young people recruited into the system.

In Chicago, we are seeing a somewhat different situation, where it is static in many neighborhoods. The old people stay users, but the younger people do not begin to use. In some neighborhoods, there are now epidemics. Where 100 new users have come into the system within the past year.

I don't want to generalize, but I think there are areas, and I think New York is one, and I think California is another where there is a growing problem.

I think ours—in Chicago—is growing, but at a slower rate.

Senator HUGHES. Dr. Jaffe I want to thank you very kindly for your testimony. It has been very helpful to us. Your statement has been entered into the record in its entirety. I am not sure, but I think perhaps there may be members of the subcommittee who would like to submit questions to you in writing, particularly in relation to the Yarborough bill.

The chairman of the overall committee might want to do that with your permission.

Dr. JAFFE. Thank you.

Senator HUGHES. The Chair calls Weldon Smith, coordinator, narcotic programs, Department of Corrections, State of California.

STATEMENT OF WELDON H. SMITH, COORDINATOR, NARCOTIC PROGRAMS, DEPARTMENT OF CORRECTIONS, STATE OF CALIFORNIA

Senator HUGHES. Mr. Smith, you may present your statement.

Mr. SMITH. Thank you, Mr. Chairman.

I appreciate the opportunity to testify before this committee on behalf of myself and on behalf of the State of California. I would like to share some of our experiences with you and make some recommendations from my point of view, based upon our struggling with this problem for about 18 years.

I have submitted a statement, and I will summarize it briefly; there is more detail in the paper.

I have another paper that I would like to submit that I wrote for another committee; I misinterpreted the ground rules for this committee's presentation. I thought the paper I wrote for this committee was to be presented verbally and therefore due to the suggested time limitation was very short. So it lacks some detail.

Senator HUGHES. We will print it in its entirety in the record. If you would like to submit additional material, we would like to receive it, because the record will be held open.

(The prepared statement of Mr. Smith follows:)

PREPARED STATEMENT OF WELDON H. SMITH, COORDINATOR, NARCOTICS PROGRAMS, CALIFORNIA DEPARTMENT OF CORRECTIONS

I am going to speak today specifically about the use of hard narcotics and the drug preference among hardcore addicts—heroin. Not only has it been, and it is, the drug of preference for addicts, but it is also the drug of concern among the