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## CONTEMPORARY PROBLEMS OF DRUG ABUSE

## I. FRIDAY EVENING

*A. Introductory Remarks*

MR. PETER A. LEVIN: Good evening, ladies and gentlemen. I am Peter Levin and I welcome you to Contemporary Problems of Drug Abuse. At this point I would like to introduce J. Willard O'Brien, Dean of the Villanova University School of Law. Without Dean O'Brien's constant support and encouragement, this tremendous undertaking would never have been possible.

DEAN J. WILLARD O'BRIEN: My task this evening, as a speaker, is very brief but very pleasant. First, allow me to welcome everyone to this symposium. Second, I want to express the thanks of everyone connected with this symposium to Peter Levin. The program that Peter has assembled is extraordinary in every respect. Finally, I thank all of our visitors for being with us and hope that you all enjoy the program. Thank you.

MR. LEVIN: Thank you, Dean O'Brien.

The growing problems of drug use and abuse place a special responsibility upon students of law and medicine. For the most part, it is they who will be called upon to make the final decisions concerning those using drugs. They will have to know the differences among drugs, the reasons for their use, and how to deal with people who use them. Such knowledge will be expected even though the "experts" themselves cannot agree.

The lawyer will turn to those in the medical profession for a candid opinion about marihuana. He will hear opinions from some doctors that marihuana causes brain damage and leads to heroin use. He may think that is the correct answer until he hears from others in the medical profession who believe that marihuana causes no physical or psychological harm.

The lawyer will ask the medical profession for an opinion about heroin. He will be told by some doctors that heroin causes criminal behavior and is physiologically and psychologically damaging. He may again think that is the correct answer until he learns that other authorities believe that heroin causes no organic damage to the body or brain, that alcohol is a much more severe drug, and that certain addicts could function quite well on a good, clean supply of heroin.

Doctors will look for the reasons why people use drugs and will encounter conflicting data. The psychologists may say that the

people who use drugs have addictive personalities, are prone to becoming addicted, and are prone to becoming readdicted after being "cured". They may also say that the user's personality must be totally restructured in order to effect a cure.

Doctors may then turn to the sociologists who may say that, to the contrary, society is the cause of drug use — society creates addicts and society causes them to relapse into addiction. The sociologist may point to a sense of defeat and helplessness among slum dwellers, a sense of impotence to effect change, and the needs of people to belong to a group as factors that cause addiction and may, therefore, tell you that if an addict is returned to the same neighborhood, he will simply become readdicted.

Doctors may be given another answer by the biochemist. The biochemist may say that after a person uses a drug such as heroin a few times, the opiate molecules will have a direct effect on his nervous system which will adjust to their presence and will become dependent upon it. Thus, the doctor might be led to believe that a chemical imbalance causes addiction.

In addition to the problems of understanding the causes of drug addiction, lawyers and doctors are faced with the question of how to properly treat the addict. In attempting to find that answer they will learn that existing treatment for drug abuse has not produced impressive results. Large claims of success and large claims of failure have been made for various treatment modalities, but the claims are often disputed and largely unsubstantiated. There is no way that an attorney or doctor will be able to evaluate the various treatment approaches for different types of drug users. Most treatment centers have relatively narrow data collection programs and, therefore, any meaningful evaluation among the various programs is impossible.

The attorney or doctor will also learn that most treatment centers have selective admission criteria and do not handle the most criminally active or hard-core addicts, those who, in fact, may need the most help.

Many doctors become perplexed with the way the criminal justice system relates to drug addicts. A judge often has the choice of sending a drug addict to jail or of placing him in treatment. Some doctors may argue to the judge that an addict should not be placed in jail because he will be able to obtain narcotics there and may point out to the judiciary that 95 per cent of those who leave jail without any effective treatment become readdicted as soon as they return to the streets. Thus, they would prefer that the judge place the addict under treatment.

Unfortunately, the courts are often faced with the drug addict. Shoplifting, prostitution, and sale of drugs are common addiction crimes, but so, too, are robberies and homicides. Criminal activity related to narcotic addiction forces thousands of narcotic users into the criminal justice system each year. It has been estimated that over 50 per cent of all the property crimes in major cities are committed by addicts, causing a loss of over \$450 million a year.

Studies have shown that nearly all heroin addicts are arrested at least once during every 2 years of active addiction and spend an average of 15 per cent of their addicted life in jail. Over 60 per cent of those in our prison population have drug problems.

In spite of the high correlation between drug addiction and crime, many doctors will be surprised to learn that in 1962 the United States Supreme Court ruled that addiction was not a criminal act but, rather, was to be viewed as a disease.<sup>1</sup> The Court stated that the addict ought to be the object of legitimate programs of treatment and rehabilitation. However, many civil libertarians might argue that since treatment is sometimes ineffective, commitment to such programs may result in greater punishment than a prison sentence. Others argue to the legal profession that since the law does not make exceptions for the problems of others who commit crime, it should not create one for the drug addict. For example, no exceptions are made for the person who commits a rape because he has a sexual problem, for the person who commits a homicide because he has some psychological problem, or for the person who robs because he has no money to support his family.

All these issues confront the student of law or medicine when, as an attorney or doctor, he tries to make the appropriate decisions. Law and medical schools, by and large, have not provided adequate training to enable him to meet these problems. Contemporary Problems of Drug Abuse is the first large-scale educational effort aimed at our nation's future lawyers and doctors. Its purpose is to provide the basic framework of knowledge that is required to develop the appropriate expertise in the area of drug abuse.

Thank you.

It is now my great pleasure to introduce Robert W. Meserve, President of the American Bar Association.

MR. ROBERT W. MESERVE: I join Mr. Levin, Dean O'Brien, and Dr. Palmer in welcoming you to this national symposium. I bring you the greetings and the best wishes of the more

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

than 160,000 members of the American Bar Association. By the way, that is the only figure I am going to mention tonight; I am not going to talk about statistics.

My attitude toward statistics is that of the gentleman who had just reached the age of 70 and who was being consoled by his children on having reached that age. One of his sons said, "After all, Dad, remember there are six single women over 70 for every single man."

He said, "A more irrelevant statistic, I never heard in my life."

We are all concerned with the subject which has brought us together, and let me say that the presence of students of law and medicine here is perhaps the most encouraging element in what to an older generation is otherwise an extremely grim picture.

Obviously, I am not supposed to talk at length this evening. I am not an expert in the legal problems of drug control and of societal response to drug abuse. However, allow me to state briefly why the American Bar Association, as the pre-eminent national organization of the legal profession, is vitally interested in the question of drug abuse generally and has participated through its Law Student Division in the sponsorship of this symposium specifically.

In the past 18 months I have spoken to Bar groups in almost every state of the union. I can assure you that there is no locality where the problem of drug abuse has not come to the attention of men and women of the legal profession. I have no reason to doubt that the same is true of the medical profession. Lawyers become involved with drug abuse either professionally as defenders or prosecutors of individuals charged with drug-related offenses, or as advisers, as parents, and as citizens.

Drug abuse and drug addiction present the lawyer with a full range of problems. There are the immediate and practical problems of participating in the law enforcement and criminal justice systems, areas which, today, are confused at best. The tremendous diversity of statutory sentences for various drug offenses is indicative of the equally great diversity of both legal and public opinion concerning these offenses. Possession of certain drugs is punishable by a \$5 fine in some jurisdictions and by 10 or more years imprisonment in others. We know that use of some drugs — alcohol, for example — constitutes the statistically normal among some segments of society, while nothing produces a more violent or hostile reaction among other segments.

Similarly, confusion also dominates another level at which the lawyer must cope with these issues, the level of law reform. Here the lawyer functions both as a technician and as a leader. Although we can say with assurance that the present legal response to the use of

drugs is irrational, we cannot with equal certainty describe what a rational response would be. Perhaps the most disquieting aspect of our list is the marked lack of unanimity among members of the medical profession on the long-term medical consequences of the use of drugs or the physiological and psychological relation of one drug to another. We know that the existence and enforcement of drug control laws may result in other crimes, but we really do not know what we get in return for this social cost. The analogy to prohibition is both attractive and perhaps dangerous or simplistic in that important differences may be obscured, but perhaps it illustrates some of the issues that must be confronted.

Finally, on the jurisprudential level where the lawyer becomes a philosopher, the fundamental questions of man's relation to other men and to society arise. To what extent may society properly prevent an individual from doing something which is harmful to him as a individual, especially when the observed practical result of such a process may or may not be to do harm to others?

Lawyers, by training, solve problems, and I know of no reason why the many problems relating to the use and abuse of drugs cannot be solved eventually. Clearly, much more information must be obtained. Since the legal and medical professions have much to offer each other in this regard, this symposium is an obvious and a highly useful undertaking.

The cooperation of our professions in this area has important precedent. As many of you know, the Young Lawyers Section of the American Bar Association, in cooperation with young doctors all over the country, has sponsored an educational program on the medical and legal consequences of drug use designed for junior and senior high school students. Teams of doctors and lawyers have presented this program to tens of thousands of students. It has been supported by the voluntary contribution of time by hundreds of young professionals and by a grant from the Law Enforcement Assistance Administration.

When the majority of Americans lived in small communities, it was the doctor and the lawyer who were the natural leaders. Their status rested on their ability to deal with the problems the people had. To maintain that professional status and to fulfill the obligations to society which our professional privileges impose on us, we must continue to deal with the problems which face the people of today. This symposium and its promise of the involvement of students of law and medicine may go far toward coping with what I think we would all agree is one of the most acute problems of our day.

As I finish these brief remarks, I am reminded of the woman of a certain age who came up to the late Adlai Stevenson after he had made a very general speech and said to him, "Oh, Mr. Stevenson, your remarks were so superficial." He said, "Thank you very much," and she said, "I hope you will publish them." He said, "I will posthumously," and she said, "I hope to read them soon."

MR. LEVIN: Thank you very much, Mr. Meserve.

I would now like to call upon Dr. Richard E. Palmer, Secretary-Treasurer and member of the Board of Trustees of the American Medical Association.

DR. RICHARD E. PALMER: Mr. Levin, Dean O'Brien, Mr. Meserve, Dr. Jaffe, ladies, and gentlemen: It is indeed a pleasure for me to be here this evening to extend greetings from the American Medical Association. Insofar as drug abuse and drug dependence constitute serious medical and public health problems, the American Medical Association (AMA) is, of course, committed both to the dissemination of current reliable information to physicians, medical students, and others in the health professions, and to the encouragement of adequate treatment of drug dependent persons.

Insofar as drug abuse and drug dependence are concerned, they represent a complex social problem. The American Medical Association believes that it is important to undertake meaningful interprofessional dialogue in order to gain greater insight and in order to formulate workable approaches to the many issues involved. This symposium promises to further both these objectives.

The American Medical Association has cooperated with the American Bar Association in a number of different projects in the past. The National Interprofessional Code was developed and adopted by both organizations some twenty years ago. Annually since 1965, the National Medical and Legal Symposium has been sponsored by representatives of the American Medical Association and the American Bar Association, and we have an ongoing liaison committee.

In 1969, the American Bar Association and the American Medical Association issued a Joint Statement of Principles concerning alcoholism, the most serious and widespread of all drug dependencies. In that statement, the two groups declared that alcoholism should be regarded as an illness in medical and hospital care insurance contracts and that general hospitals should accept on a nondiscriminatory basis patients diagnosed as alcoholics. Moreover, they declared that state and local bar and medical associations should appoint committees to

work together on alcoholism problems especially on new legislation that would provide for treatment rather than punishment for the alcoholic.

As for the broad spectrum of drug abuse, the American Medical Association's interest dates back in recent years to 1963 when, in association with the National Research Council of the National Academy of Sciences, we issued a paper entitled "Narcotics and Medical Practice." This paper set forth the elements of sound medical practice in the use of morphine and other opiate analgesics in the management of patients with drug dependence of the morphine type. This was in its own way a milestone. It proved to be a major source of information for public and private treatment programs across the country and was used by the then Federal Bureau of Narcotics as the authoritative basis for determining what constituted legitimate medical practice in the use of these drugs.

In 1967, and again in 1971, the paper was reissued in modified form to take into account changing circumstances and the acquisition of new knowledge. It was updated to reflect the acceptance of ambulatory treatment with methadone under certain conditions, and the recognition of methadone maintenance techniques as proper medical practice under certain conditions.

Although drug dependence of the morphine type has been of major significance, the American Medical Association has not neglected other forms of dependence. Beginning in 1969, we published reports on diagnostic and treatment considerations involved in dependence of the barbiturate, amphetamine, hallucinogenic, and cannabis types. Last December we had a conference in Washington, D.C., on an often neglected aspect of drug dependence, medical complications arising from drug abuse. The conference was concerned not only with infectious diseases such as tetanus and hepatitis, but also with damage to the cardiovascular system, the liver and kidneys, the lungs, and other organs of the body.

Three other meetings sponsored by the American Medical Association in the drug abuse area have articulated a social as well as a medical concern. In 1967, we brought together narcotics agents, licensure agents, and representatives of large state and county medical societies in an effort to establish some workable method for more effective liaison between law enforcement and medicine in the drug abuse field. In 1968, we held a conference devoted to the drug abuse problem among youth. And, in 1972, we met to emphasize the role of medical societies in community programs of prevention, treatment, and rehabilitation.



In 1968, again with the National Research Council, the American Medical Association went on record as being one of the first professional organizations calling for more equitable treatment and penalties in the discretionary handling of persons convicted of possessing marijuana for their personal use. In the statement, *Marihuana and Society*, the American Medical Association and National Research Council also termed cannabis a dangerous drug and said its use should be discouraged, even though punishment for its possession should be less harsh and more in keeping with the magnitude of the effects. This position was reinforced by the House of Delegates of the American Medical Association this past December. At that time, it passed a resolution urging that the possession of marijuana for personal use be considered no more than a misdemeanor.

The original American Medical Association-National Research Council suggestions on discretionary handling of marijuana users, I might add, were applied in the Controlled Substances Act of 1970<sup>2</sup> to first offense convictions for possession of any of these scheduled drugs. The AMA testified many times before committees of both houses of Congress concerning bills which led to the final Act.

Another of our major concerns has been the function of the nation's medical schools in furnishing adequate information in appropriate ways on alcoholism and drug abuse. Two of our publications, *The Manual on Alcoholism and Drug Dependence, A Guide for Physicians*, have been distributed free of charge annually to one class in each medical school where it has been requested. In addition, our Council on Mental Health and its Committee on Alcoholism and Drug Abuse or Drug Dependence have established guidelines for instruction on both drug abuse and alcoholism.

In a position paper, the Council and the Committee identified the physician's key role with respect to drug abuse. They called the physicians the gatekeepers and their prescription blanks the key for many psycho-active agents. They urged that the education of future physicians encompass the dangers of encouraging or allowing patients to rely upon pills to solve their personal and social problems.

In concluding their paper, the Council and the Committee had this to say:

At some time toward the end of their medical school experience, students should have a chance to integrate their various considerations of alcohol and drug use and of abuse. Such integration could be provided through a variety of individual and group experiences, including participation in research projects,

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2. 21 U.S.C. § 801 (1970).

preparing papers on literature review, attending specific case conferences, participating in optional or required seminar-type discussions, assuming some responsibility for education about alcoholism and about drug abuse, and participating in preventive and therapeutic programs.

Whatever activities are chosen, they should be designed to integrate the student's total knowledge and understanding. Hopefully, this symposium will be a significant part of the integration process. We hope that you will carry back to your respective educational institutions new information and new ways of looking at drug abuse problems. You have our pledge that the American Medical Association will continue to work with medicine, with other concerned professionals, and with public officials to evolve better mechanisms for curtailing the abuse of drugs and for dealing intelligently and compassionately with its consequences. Thank you.

*B. Keynote Address*

MR. LEVIN: Ladies and gentlemen, there is no one in the United States more appropriate to give the keynote address at this symposium than the Director of the Special Action Office for Drug Abuse Prevention and the Special Consultant to the President of the United States, Dr. Jerome Jaffe.

DR. JEROME H. JAFFE: Good evening, ladies and gentlemen. I really appreciate this opportunity to speak to you at this symposium. I think the best way I can express my appreciation is to try to make my remarks as brief as possible. I view this symposium as an important process by which society continually examines its responses to social problems.

Our society, like every other society, responds to the use of drugs in a variety of ways ranging from attempts to control their availability to providing treatment for those who develop drug related problems. Inasmuch as all our responses are parts of a dynamic interacting process, we have to understand that process in order to be able to design a rational response. Yet, I think we all recognize that such an understanding is not sufficient without a clear-cut articulation of our goals. Of course, an articulation of goals is not just a matter of science and technology, but also includes values, attitudes, and beliefs. Moreover, our society, like most highly industrialized societies, is one where values, attitudes, and beliefs are continuously changing.

I think we can all agree on the most general of goals — the reduction of drug abuse and its social cost to society. However, there

is considerable disagreement when we become specific. Some believe that we need stricter penalties; others believe that we only need more research; some believe that we only need treatment; and a few believe that the lowest social cost occurs with total availability of all drugs. It is apparent that we have to be careful in setting goals so that the goals that we pursue in one area do not impinge upon goals that we are trying to achieve in others. We should also avoid setting goals that we cannot achieve. Unfortunately, at some point decisions have to be made about the effectiveness of these approaches so that human and monetary resources can be optimally allocated to achieve some set of goals. Looking carefully at the effectiveness of the various approaches is a relatively recent development, at least as far as the federal government is concerned.

Historically, the federal effort was directed almost entirely at what we might think of as the "supply-demand" equation. It was at least 20 years between the time that the Harrison Act<sup>3</sup> was passed to control the availability of drugs and the time the first two federal hospitals to treat drug-dependent people were built at Lexington and Forth Worth. During the next 30 years, these two hospitals represented the entire federal response in terms of treatment, training, education, and research. Then, in 1966, Congress passed the Narcotic Addict Rehabilitation Act<sup>4</sup> which created a federal civil commitment program, and authorized the funding of a few pilot programs for treatment of narcotics addicts on a voluntary basis in the community. In the summer of 1967, the Office of Economic Opportunity was given funds with which to initiate these programs.

In retrospect, while it seems that the response lagged behind the recognition of a growing problem, we should recall that until the 1960's most medical treatment was viewed as a private, local, and state responsibility.

In 1969 there was a further increase in resources for non-law enforcement activities. Other federal agencies began to develop programs to deal with various aspects of drug abuse, but the problems were often perceived from the viewpoint of each particular agency with no apparent mechanism for coordination.

As federal support for these "demand" activities, such as treatment, research, education, training, and prevention began to accelerate, it became apparent that, while a massive outpouring of funds was theoretically laudable, it might accomplish very little without some

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

4. Narcotic Addict Rehabilitation Act of 1966, Pub. L. 89-793, 80 Stat. 1438 (codified in scattered sections of 18, 28, 42 U.S.C.).

mechanism to set meaningful priorities and to coordinate the various efforts. To accomplish this task, the Special Action Office was created.

However, the task of coordination has not been simple. In 1971 more than 114 agencies scattered through at least eight of the major governmental departments were involved. While the Special Action Office is responsible for functions, it is not a funding agency and does not control or manage the various programs directly. We seem to have been delegated the responsibility without necessarily having the needed authority.

When the Special Action Office was first created, it was obvious that we would have to choose between mobilization and coordination. In June of 1971, we were faced with a number of difficult problems. One was the problem of heroin use among military personnel in Vietnam — some observers estimated that 15 to 20 per cent of all servicemen were addicted to heroin. Another was the apparent phenomenal gap in the United States between the availability of treatment for drug dependence problems and the demand for treatment. As far as we could ascertain, 30,000 narcotics users were actively seeking treatment but were unable to get it. In order to understand fully the significance of that figure one must appreciate the large efforts that go into the development of a treatment program. For example, we began to develop a program in Illinois in 1967. The planning itself took several months. While the program opened in 1968, it was not until 3½ years later, by June of 1971, that we finally got 2,000 people into treatment.

The federal government by 1971 had developed programs sufficient to treat only 16,000 people at any given time. Therefore, in June of 1971, faced with problems of the military, problems of the Veterans Administration, and with at least 30,000 people waiting for treatment, we set as a primary priority the availability of treatment.

The wide range of drug abuse problems and the diversity among people who at some point require some form of treatment made us realize that no single treatment or intervention approach could be adequate. Instead, we pursued a policy of developing a variety of treatment approaches, each, of course, with its own special advantages and disadvantages; each emphasizing one role of treatment over another; and each appealing, perhaps, to somewhat different groups within a heterogeneous population of drug users and addicts.

Some treatment approaches are more controversial than others, for example, the use of synthetic narcotics such as methadone in the treatment of chronic heroin addicts, or the use of civil commitment

and other involuntary approaches. We believe that the maintenance approach may be necessary for some long-term narcotics addicts, at least as an interim step toward full recovery. However, it is vital that this approach not be used indiscriminately, without concern for the hazards caused by illicit diversion of methadone from treatment programs. Over the past year we have worked very hard to develop new regulations that will minimize those hazards without interfering with treatment. We have also launched new research efforts that, if successful, will further reduce the hazards. Eventually, non-voluntary approaches to treatment may be required for at least selected groups of addicts, such as those who will accept treatment in lieu of prosecution for crimes committed. However, we continue to advocate maximum expansion of voluntary treatment before investing substantial resources in non-voluntary treatment programs.

Significantly, the different approaches to the drug user are not equally effective. We accept the proposition that it is the responsibility of government to determine the reasons for these differences in outcome and efficiency, and, where appropriate, redirect federal resources. A massive evaluation effort is now under way because the uncertainties clearly exist and the confusion is real. The evaluation should produce, initially, a careful assessment of the effectiveness of different kinds of treatment. However, it may be some time before we get definitive answers. Until data indicates that a different emphasis is required, we will continue to make a variety of treatments available for those who desire treatment, and we will continue to invest in the development of more effective treatment methods. This general policy has resulted in a multimodality treatment system for the country as a whole.

All treatment approaches funded directly by the federal government have grown dramatically; during the past 18 months, we have developed more treatment capacity than in the previous 50 years. We are now treating more than 60,000 people at any given time, the equivalent of more than 100,000 on an annual basis. Additionally, thousands more are treated in programs funded indirectly by the federal government through block grants and other revenue sharing devices. The combined federal, state, local, and private capacity is now estimated at more than 120,000 people at any given time, the equivalent of an annual capacity of more than 200,000 people.

It is our commitment to continue the expansion of treatment programs until no one can say he committed a crime to get drugs because there was no treatment available. The achievement of that

goal is contingent only upon a commitment on the part of state and local governments to continue their present levels of support.

There will be many accused of minor crimes or of simple possession of drugs whose willingness to consider treatment may not develop until they are arrested. We have developed a model program — Treatment Alternatives to Street Crimes (TASC) — that will link the criminal justice system more closely to the network of treatment and rehabilitation programs. The purpose of TASC is to identify drug users at the point of arrest. If ordinarily those individuals would be released pending trial, this linkage would permit them to be admitted directly into treatment programs. Since these programs are essentially local, the practices vary. In some programs, entering and remaining in treatment may be a condition of release. In others, progress in treatment may be considered heavily in a decision to prosecute or to sentence.

Generally, preventive efforts should flow from an understanding of the causes of drug use and of excessive drug use. However, with the exception of controlling drug availability, there is very little consensus about which of the many factors associated either with drug experimentation or excessive drug use can be modified.

Further, informing the public of the risks and consequences of drug use is a responsibility of government at all levels and of other social institutions, but if conveying knowledge about possible adverse effects has had any substantial impact on the rate of experimentation or addiction, the impact is clearly inadequate.

Unfortunately, many educational efforts do not have clearly articulated goals and few of the efforts relying on communication of information, whether through school systems, social institutions, or mass media, have been rigorously evaluated. Where evaluation has been attempted, the data do not show significant impact. We intend to refocus our efforts on providing creative pilot preventive approaches with more clearly articulated goals designed in ways which will permit objective evaluation.

All too often films, pamphlets, brochures, posters, and television spot announcements remain unevaluated in terms of their impact on various target audiences. The federal government has directed all agencies to stop all direct production and support of new educational and mass media materials relating to drug abuse until the impact of presently available material can be better assessed. This, of course, is going to require the development of the technology capable of assessing these activities; efforts aimed at this development are being made.

It is also clear that education is not synonymous with prevention, either prevention of initial experimentation or prevention of progression to heavy use and addiction. In some situations, the most effective way to reduce the social cost of drug use is to provide meaningful alternatives. Other effective approaches have involved early intervention efforts aimed at bringing drug users into treatment before drug use progresses to addiction or becomes incorporated into the individual's values.

There is one factor that most people agree is related to drug use, namely availability. Moreover, this is the one factor that society has traditionally expected government to control, and government at all levels has, in fact, devoted considerable energy to this effort. However, there are now some people who feel that this approach is inappropriate and is emphasized too much. This creates an interesting paradox because some of the groups that are saying there is too much emphasis on law enforcement and drug abuse control are the same groups that are advocating that new drugs, such as the barbiturates, the amphetamines, and other sedatives, be brought into the same control system.

We recognize that until 1969 the federal government's response to the demands was pitifully small. It has, however, increased each year since 1969. In moving toward our primary goal of making treatment available, the budget for treatment of drug abuse and related activities has gone from \$42 million in 1969 to \$419 million for fiscal year 1974.

Yet many people have now voiced concern about a possible over-response — overresponse even on the part of treatment. Only time will tell if that money is well spent. At present, we feel that we need not apologize for expending funds to increase the availability of treatment, to increase research, and to increase the capacity of states to make more of these decisions.

Most critics recommend what all of us want — bold innovation, but without mistakes; and rapid expansion, but with certain efficiency and effectiveness. Those of you who know the nature of institutions recognize that we cannot have both rapid expansion and simultaneous careful evaluation.

It has become increasingly common for every symposium to have at least one speaker who feels it necessary to tell those in attendance that they are idiots for showing concern for any drug other than alcohol. If this happens here, I hope you will pause before you berate yourselves for your poor judgment. Alcohol is indeed a major prob-

lem, a problem with a horrendous social cost, but it is not being ignored. In fact, there are programs for alcoholism in both the Veterans Administration and in the Department of Defense. Moreover, the private sector has multiple programs devoted to treatment and prevention of alcoholism, as do state and local governments. There is an entire institute within the National Institute of Mental Health devoted to the problem of a single drug — alcohol. Therefore, I certainly hope you will consider alcohol and its problems as you discuss other drugs that our society uses, but I think you should recognize that there is a certain illogic about an exclusive focus on it.

The history and the nature of non-medical drug use is such that the medical and social consequences of using a particular drug do not always correlate with the attitudes and use patterns that develop. Thus, the use of an artificial sweetener that in large doses has a cancer-producing effect in rats is prohibited while the smoking of material that is believed to be responsible for cancer in man is not. Inconsistencies in our overall response, however, must not be a justification for abandoning all efforts at developing a rational system that seems to minimize the harmful effects of drug use. Neither should the shortcomings of all constructive efforts be used as a reason for abandoning them entirely, as some may advocate. Fortunately, most of us recognize that this is not a realistic approach.

The medical utility and the medical and social consequences of different drugs dictate diverse approaches to their misuse for non-medical purposes. Thus, the approach to each drug necessarily involves varying degrees of legal regulation and control of availability, as well as varied allocation of resources to the different aspects of the problem, *i.e.*, the enforcement of drug control laws, the treatment of the adverse consequences of drug use, the public dissemination of information relating to use and abuse, and the development of increased understanding that will help us minimize the social costs resulting from the use of any drug in a modern society. No single approach has been able by itself to minimize the social cost of drug use, and it is not likely that any single approach ever will. Indeed, when we examine proposals to improve the situation, we find that most of them represent only a minor tinkering with the system.

Although there are some who advocate that all drugs should be freely available, most of those who have looked seriously at the problems of drug use recognize that the approach to each different drug requires a different degree of availability control, public education, and treatment.



Much of the disagreement in dealing with the drug problem centers around the question of how much human energy and concern should be allocated to a particular drug, and to the particular aspect of the effort which is selected to reduce social costs — control of availability or other preventive approaches. There are some who feel that these problems, as they affect the federal government, could be resolved through organizational changes. The Special Action Office was originally intended to have the kind of authority that would have permitted it to move functions from one agency to another, thus effecting a reorganization over a period of time. That power, unfortunately, was not granted, so that our efforts at coordination have taken somewhat longer than anticipated. At present, we have moved most discretionary funds into a single agency, the National Institute for Mental Health (NIMH). In 1969, the discretionary money for drug abuse prevention activity was spread throughout a dozen agencies, with over 66 per cent in NIMH. In 1974, it is expected that virtually 90 per cent of all discretionary resources will be in that single agency.

We should recognize that we are engaged in a dialogue involving more than the pharmacology of drugs. For many people, the idea of drug use of any kind runs counter to their fundamental values. It is the symbol as much as the substance. Inevitably, proposals about how a society should respond to problems of drug use touch upon what a society should be and say something about its fundamental values.

It is not likely that there will ever be total agreement among officials and, therefore, there will continue to be differences about the role of drug use in society. Yet we cannot wait until there is consensus. Policies are made, legislators continue to legislate, lawyers continue to litigate, and doctors continue to treat, although there are some who would deny that what they do is needed and others who would claim that what they do is not treatment.

Actions that are put forth as solutions to problems have costs and they have risks. Many of the costs and risks of our actions as a nation will be considered at this symposium. But as I look at this group, I suspect it is likely that some voices will be given more weight than others. I hope that as you listen to the many voices, you will also consider what voices are not being heard.

Ultimately, our responses to drug use must be responses that most of society can live with and accept. I seriously doubt whether we will quickly reach consensus, but if we continue to agree to discuss our differences, we shall have come far. Thank you.

MR. LEVIN: On behalf of all of you who have gathered here at Villanova Law School this weekend, I would like to thank Dr.